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TO GOVERN THE HEALTH OR TO MAKE THE BILLS OF MORTALITY - THIS IS THE QUESTION FOR PUBLIC HEALTH IN POLAND

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ABSTRACT

In the article important moments in the development of public health at the global scale were presented, assuming that postwar evolution proceeded in two fundamental phases: the first – events which occurred to the proclamation of the Ottawa Charter and introduction of 'new public health' and the second – situations reported after Ottawa to the present time. The current challenges for public health in Poland were also discussed. It was proposed to differentiate two dimensions of public health capacity: internal (*ad intra*), which is with regard to the power centre, condition within the environment and external (*ad extra*), which refers to the relation with surroundings and population and enables to deliver sustain services and programmes. The possible strategies aiming at increasing *ad intra* capacity were also indicated.

Key words: *public health, health promotion, history, forecasting, capacity building*

INTRODUCTION

Health is of too high priority to be left for physicians and public's health is too crucial to be in charge of public health officers only. In Poland, the public health lesson has not been studied so scrupulously as it was done in more developed countries. West opinions were introducing gradually. However, many novelties have not been noticed on time. The examples constitute the facts that the model of health fields is still popularized, *Wilkinson* hypothesis is not discussed in the professional discourse, the primacy of the human being welfare and interest is not analyzed with regard to the interest of society which was specified in the Convention on Human Rights and Biomedicine. Furthermore, the first national report concerning the health inequalities was published at the end of 2012. The notion 'health promotion' has not appeared even once there while in the Marmot Review *Fair Society Healthy Lives*, it was employed for 19 times in the general content only. In the academic public health, the physicians are the predominant group. The 'silo mentality' (this notion is used more frequently at the World Health Organization debates) is present in the environment and these two problems are familiar to the operational institutions.

In Poland, the theoretic, demonstrative and discursive papers are hardly present. Furthermore, some papers which are available are of questionable quality. The forums concerning ideas exchange, confronting the opinions, correcting the mistakes are also lacking. Not enough studies are conducted and the ones which are carried out are the exemplification of biomedical and behavioral approach to health.

In our country, especially here, it is worth to look backwards prior to going forward. The objectives of the present article are: (a) recollection of the most important events in the evolution of public health (PH) worldwide; (b) analysis of present challenges for PH in Poland and indication of possible strategies aiming at increasing its *ad intra* capacity.

EVOLUTION OF PUBLIC HEALTH IDEAS AND ACTIVITIES

PH was subject to the evolution of multiregional nature – the progresses observed in different places, settings and periods constituted the elements of specified final effect. The milestones, which were selected subjectively, are presented in Table I. The description of all mentioned stages of new PH development exceeds the frames of this

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paper. Thus, only a few of them would be discussed. In the retrospection, it was assumed that postwar evolution proceeded in two fundamental phases: the first – events which occurred to the proclamation of the Ottawa Charter and introduction of 'new public health' and the second – situations reported after Ottawa to the present time.

THE ARISE OF NEW PUBLIC HEALTH (NPH)

The caesura for NPH was the year 1986. In November, under the auspices of the WHO, the First International Conference on Health Promotion (HP) was held in Ottawa (Canada), where 38 representatives of the most developed countries proclaimed the Ottawa Charter for Health Promotion (1). This Charter, which is defined as the new public health bible, provided the five actions to improve the health in each situation: (a) building healthy public policy, (b) creating supporting environment, (c) strengthening community action, (d) developing personal skills, (e) reorienting health services.

Within the years, it was emphasized that the major objective of the Charter was to modify the organization and operation of PH, especially with regard to the area of values. Both, the Charter and the conference held the subtitle "towards a new public health". In the speech opening the conference, dr *Halfdan Mahler*, the then WHO Director General, stated, i.a.: *the message of »a new public health«: a recognition of understanding health in terms of well-being and not disease and of understanding »public« as a true involvement of people in shaping their health* (2).

The idea of NPH was formed for about 5 years, mainly in the European bureau of WHO in Copenhagen. From the statements of persons being involved in the work transpires that the *Lalonde* Report, Declaration of Alma-Ata and Health for All strategy were above all the basis of a new approach.

Lalonde Report. The report entitled: "A New Perspective on the Health of Canadians" was prepared within 3 years and was published on the day of 1st May 1974 as the green paper (3).

It was the creation of the team composed of several persons under the supervision of *Hubert Laframboise*. The report was personally endorsed by *Marc Lalonde*, having a degree in law, who held the position of the Minister of National Health and Welfare in liberal government in this time. During the work, the team members conducted numerous studies and published several papers which were the elements of the final report. The research of *Thomas McKeown*, who since 1955 questioned the leading role of medicine in the increase of population and life expectancy, was the stimulus of further investigations.

In the report, the material for discussion, the thesis suggesting that the health of population is determined by four health fields, i.e.: human biology, environment, lifestyle and health care organization was stated. In the original version, these fields were not qualified. The commonly known division (20/20/50/10, respectively) origins from the American calculations on the top 10 causes of death in the USA, which were popularized in 1979. Among the five strategies aiming at improving the health status of Canadians, HP held the first place, i.e. *informing, influencing and assisting both individuals and organizations so that they will accept more responsibility and be more active in matters affecting mental and physical health*. As many as 23 detailed methods were suggested as the potential direction of HP activities, with the majority of them corresponding to the particular health conditions. Soon HP began to be associated with the behaviour changes and education.

The Canadian reaction to the report was not homogeneous (4). The report was criticized due to the presented method of lifestyle and environment issues analysis. The opponents claimed that strict distinction between environment and lifestyle is not justified because the lifestyle is determined by the particular environment, i.e. constitutes the social reflection of environment. The argument that lifestyle should be considered as sole responsibility of individuals and self-imposed risk also raised the objection. It was emphasized that it resembles the ideology of blaming the victim (5) which was described at the beginning of the 70s of XX century as the mechanism driving the racism.

Irrespective of the criticism, the report contributed to HP centers and community health centers development as well as integration of earlier existing schools of hygiene with divisions of medicine. It elicited also (not only in Canada) the masses of activities with the objective to modify the individual's lifestyle. Within the time, numerous of them proved to be not effective enough or totally ineffective and they became a disappointment to their authors. The fears regarding the incrimination of the victims were also confirmed. The explicit example was – afterwards – stigmatization of the whole social groups at the beginning of HIV/AIDS epidemic.

In 1984 in Toronto, the conference entitled *Beyond health care* was held. It was devoted to the idea of healthy public policy. *Trevor Hancock*, explaining the necessity of changes (*from public health policy to healthy public policy*) claimed that public health policy is directed to the sectoral activities of health system, dominated by the firm activities, obsolete. Healthy public policy should be multi-sectoral, holistic and innovative. He also proposed the mandala of health - model of the human ecosystem (6), comparable to the conception of *Urie Bronfenbrenner*. The social-ecological model of health determinants shortly became the leading idea

of NPH. In 1986, *Jake Epp*, the Canadian Minister of Health, has already used the language of NPH – about the new vision of health, quality of life, inequalities in health, public participation and healthy public policy (7). Subsequent events in Canada were not so beneficial. Nevertheless, the report contributed to the renaissance of public health. However, it may be stated that new public health and heath promotion appeared in opposition to the report.

The thesis that health care system is not exclusively responsible for the health of population was quite quickly introduced to the English-speaking countries, Great Britain and the USA. Apart from the scientific and cognitive value, it had also another advantage. With the raising level of health care costs, it authorized the political decisions aiming at reducing the expenditures on health care. By promoting the idea of HP, the central governments eagerly shifted the responsibility for health onto local governments and citizens – your health is in your hands (8).

Alma Ata Declaration. In September of 1978, under the auspices of WHO and UNICEF, the conference concerning the primary health care was held in Alma Ata (USSR, nowadays the Republic of Kazakhstan). During this conference the visionary Alma Ata Declaration was proclaimed (9). The conference and Declaration referred to the provisions of WHO Constitution of the year 1946. After 30 years, they re-discovered what the health is and emphasized the right to health. It was stated that achieving of possibly the highest level of health is the most important social goal worldwide and existing health inequalities cannot be accepted. It was also highlighted that the governments are responsible for the people's health who have the right to decide on health care organization. The primary health care (PHC) was accepted to be the most important type of care. PHC should be adjusted to the needs, should be comprehensive and connected with other sectors of social life and sustained.

The performance of these assumptions has never met the expectations. Soon after the proclamation of Declaration, the global oil crisis occurred which hindered the restructuring of health care systems in LMICs. In the majority of developed countries, the politicians have not accepted the rule that the society is to decide on the health care system organization and have not noticed the necessity of comprehensive PHC. In these countries, PHC was directed mainly to the curative activities and was centrally controlled (10). At the end of XX century and in the present time, the reorganization of PHC system was commonly replaced by implementing the market mechanisms (11).

In 2008, WHO undertook the efforts to revive the idea of PHC. Alma Ata Declaration is considered to be the compass for family medicine and integration of PH and PHC constitutes nowadays one of the most expected method of reaction to economic crisis and insufficiency of health system.

Health for All by the year 2000 (HFA). The global strategy HFA emerged gradually since 1977 as the result of WHO work with the assistance of United Nations (12). It was formed from earlier agreements from Alma Ata and emerged under the climate of worldwide political optimism. Finally, it was accepted at the World Health Assembly in 1981 and the possibility of confrontation between the East and West appeared soon. Nevertheless, several successes were reported at the global scale but the global population could not achieve the desired health status. The initial enthusiasm was disappearing with each year. However, the slogan 'health for all' was introduced to the PH language illustrating the idea of equity and social justice as well as the symbol of common access to PHC. Now is the age of universal health coverage.

The scientific progress. Apart from the documents of political nature, the studies results had also significant impact on the development of NPH. The cohort study entitled *Framingham Heart Study* conducted in the years 1948-1994 (and afterwards) should be quoted. In the aforesaid study, the risk factors of cardiovascular diseases were differentiated by the end of 70s of XX century (13). The *Alameda County Study,* conducted in the multi-ethnic county in the years 1965-1999, revealed e.g. connection between the marriage, social interaction and mortality. During the spring of 1985, *L. Breslow,* one of the principal investigators in *Alameda* wrote: *the stage is set for a new public health revolution* (14), which portended the changes. In the later time, *Breslow* wrote that the development of HP resulted from the increase of life expectancy which triggered the interest of health, not the disease (15).

The known was the cohort study entitled *Whitehall study I*, initiated in 1967 by *Donald Reid* and *Geoffrey Rose,* which enrolled the British men in the Civil Service. After more than 7 years of observation, it was demonstrated that (16) the risk of death due to the coronary heart disease was 3.6 times higher in men of the lowest grade of employment (messengers) than for those of the highest grade (administrators). In 1981, *G. Rose* suggested for the first time two preventive strategies – i.e. high-risk strategy, addressed to exposed persons and population strategy directed to the general population. He also formulated the thesis on prevention paradox (17).

In August of 1980, the report of "Working Group on Inequalities in Health", known as "Black Report", was published. The group was appointed in 1977 in Great Britain and was supervised by *Douglas Black.* From the report transpired that ill health and deaths are not equally prevalent in different social groups and

these differences have deepened since the formation of *National Health Service* (*NHS*) in 1948. The report has not been widely popularized. It was commissioned during the ruling of Labour Party and was finished when *Margaret Thatcher* from the Conservative Party was in charge. The successive British report covering this subject entitled "The Health Divide. Inequlities in Health in 1980's" was published in March of 1987 at the decline of Mrs *Thatcher* ruling.

The papers of *Aaron Antonovsky* were of high significance. While searching the factors which decide whether the ones develop the disease and others remain healthy, he has formulated the theory of salutogenesis (18).

NPH has derived from the experience of population-based preventive programmes aiming at preventing cardiovascular diseases, which were introduced in the late 60s and early 70s of the XX century in the developed countries. The most important programmes were conducted in the North Karelia (Finland) and the USA – in the State of Minnesota, in *Pawtucket* (*Rhode Island*) and three communities, and afterwards in five cities in the vicinity of *Stanford* (California). In 1985, the programme began in the Wales – *Heartbeat Wales*. In 1986, it was already acknowledged how the lay opinion leaders and the diffusion of innovation could be used for health-related purposes (19).

Social background. Furthermore, numerous world-wide events which occurred in the last decades of XX century should be remembered with the examples being the war in Vietnam, intensification of feminine and grassroots movements, sexual revolution, interest of environment issues (*U Thant* report, 1969) and sustainable development (*Brundtland* report, 1987), oil (1973-1974, 1979-1981) and debt crises (since 1982), assistance for starving Africa (song *We Are the World,* 1985; concert *Life Aid*, 1985), appearance of HIV/AIDS epidemic (the first cases were reported in the USA in 1980), disaster at the Chernobyl Nuclear Power Plant (April 1986), raising health care expenditures etc. All of them had an influence on social and cultural climate and striving for the changing of *status quo*. The health-related issues became perceived in a manner it was presented by *Louis-René Villermé* (1782-1863), *Lemuel Shattuck* (1793-1859), *Edwin Chadwick* (1800-1890), *Fryderyk Engels* (1820-1895), *Rudolf Virchow* (1821-1902) and *Henry Sigerist* (1891-1957) who in 1945, presumably, for the first time used the notion of 'health promotion' in relation to the tasks intended for medicine, others than preventing diseases.

NEW AND OLD PUBLIC HEALTH

According to the definition of 1986, NPH is *professional and public concern with the effect of the total environment in health* (20). It was emphasized that the notion is based on the old definition of PH, which especially in the XIX century was focused on undertaking the efforts to reduce the risk factors for health coming from the physical environment. Nowadays, it covers also the social and economic environment, e.g. high unemployment. It was noted that the term should be also referred to the environmental concerns with the exception of issues concerning the personal health services for individuals, even the preventive ones, e.g. vaccines or birth control. It suggests that initially NPH was to break with the tradition and distance from routine PH activities. Several years later in the dictionary of HP (1998), the differences between old and NPH were retained. However, it was stated that it may be unnecessary in future if a new approach will be added to the main stream of activity (21). Furthermore, other definitions and interpretations of NPH exist in the literature.

NPH was proposed to be the continuation of 'the old', not its substitution. The implementation of new term was above all the return to the source (to social machinery and health). The provisions regarding the right to health, resulting from the birth, can be found at *Winslow*, in the preamble of the WHO Constitution and the Universal Declaration of Human Rights. Worth mentioning is the fact that in many quotations of PH definition formulated by *Winslow,* the last fragment on the right to health was omitted. It is difficult to adjudicate whether it results from complicated stylistics or axiological reasons. In many successive, popular definitions of PH, the right to health is not articulated explicitly. The example could be the definition of *Donald Acheson,* which is nowadays used by WHO EURO. *Winslow* emphasized the significance of social machinery for health. In the memories on him, it is highlighted that he has never accepted the barriers between the prevention and treatment – neither the ones related to the organization, nor to the physicians awareness (22).

The implementation of new term provided also the prospects to prevent the problems and challenges which routinely were not considered as health-related issues. It was also the reaction to the insufficient effectiveness of previous activities of biomedical and behavioural nature, conducted almost exclusively in professional structures of health sectors.

The leaders of HP directed their attention to the positive health, not the opposite of disease, the necessity for wider considering the social, economic and cultural health determinants, the importance of respecting significant values (equity and solidarity in health, quality of life), necessity of implementing the new processes (e.g. community empowerment and policy development) and engaging new actors/ participants (sectors other than health-related and professionals of other disciplines).

Table I. Timeline of evolution of ideas and activities in public health

Year, period	Sponsor / initiator / principal investigator /author	Event / thesis
1920	*Charles-Edward Amory Winslow*	The definition of public health
1946	International Health Conference, New York	WHO Constitution
1948	UNGA	Universal Declaration of Human Rights
1948-1994	National Heart, Lung and Blood Institute, Boston University; *Thomas Royle Dawber et al.*	Framingham Heart Study (Massachusetts, USA)
Since 50s	A lot of centres	Many theories on behaviour origin/change, communication etc., and models of intervention planing
1955	*Thomas McKeown et al.*	Relation between medicine and the rise of population in England and Wales
1958	*Goeffrey Vickers*	Public health as redefinition of unacceptable
1965-1999	United States Department of Health and Human Services, National Institutes of Health, National Institute on Aging; *Lester Breslow, George Kaplan et al.*	Alameda County Health and Ways of Living Study (California, USA)
1966	*Avedis Donabedian*	Evaluation of the quality of medical care
1967-1977	Department of Health and Social Security, Tobacco Research Council; *Michael Marmot et al.*	Whitehall Study I (London, UK)
60-70	Finland, USA	Populaton-based CVD prevention programmes
1974	Long Range Health Planning Branch; *Hubert Laframboise et al., Marc Lalonde*	Report “A new perspective on the health of Canadians”
1974	*Ivan Illich*	Iatrogenesis
1977	*Georg L. Engel*	Biopsychosocial medical model
1978	WHO, UNICEF	Declaration of Alma Ata International Conference on Primary Health Care
Since 1979	*Aaron Antonovsky*	Salutogenesis
1979	*Urie Bronfenbrenner*	Socio-ecological model of human development
1980	Working Group on Inequalities in Health; *Douglas Black et al.*	Black Report
1981	WHO, UN	Global strategy “Health for all by the year 2000”
1981	*Goeffrey Rose*	Prevention paradox
1984	Canadian Public Health Association; *Trevor Hancock et al.*	New public health movement - from public health policy to healthy public policy
1986	WHO, Canadian Public Health Association	1st Global Conference on Health Promotion; new public health
1987	WHO	Healthy Cities Project
1988	*Donald Acheson*	The definition of public health
1988-2013	WHO	Gobal Health Promotion Conferences in: Adelaide, Sundsvall, Jakarta, Mexico, Bangkok, Helsinki
Since 90s	A lot of centres	Strengthening of health promotion/ public health capacity
1991	*Goran Dahlgren, Margaret Whitehead*	Rainbow model of health determinants
1991-1993	Members of the European Communities	Treaty on European Union, art. 129: “Health protection requirements shall form a constituent part of the Community’s other Policies”
1994	US Core Public Health Functions Steering Committee	Essential public health services
1996	*Richard Wilkinson*	Relative income hypothesis
1997	Council of Europe	Convention on Human Rights and Biomedicine, art. 2, 3
1998	WHO, *Essential Public Health Functions Working Group*	Essential public health functions
1999	WHO, Europe	Health 21
1999	*Milton Terris*	Neoliberal triad of anti-health reform
1999	WHO, Europe, European Centre for Health Policy	Gothenburg consensus paper on Health Impact Assessement (HIA)
2000	People’s Health Movement	People’s Charter for Health
2002	CDC, PHLS, Center for Health Leadership & Practice-Public Health Institute	Principles of the Ethical Practice of Public Health
2002-2004	*Derek Wanless*	The durability of NHS system is dependent on prophylaxis and health promotion
2004	*Robert Beaglehole et al.*	Public health in the new era
2006	Presidency of Finland in the Council of Europe	Health in All Policies (HiAP)
2008	WHO	Tallin Charter on health systems
2008-2010	WHO, Commission on Social Determinants of Health; *Michael Marmot et al.*	Health inequalities worldwide, in Europe, England
2009	*Joeffrey Koplan et al.*	Differentation of international and global public health)
2010	WHO, Governement of South Australia	Adelaide Statement on Health in All Policies
2012	*Tim Lang, Goef Rayner*	Ecological public health
2012	WHO, Europe	Essential public health operations

Furthermore, the individual, not only the population, became the centre of interest.

NEW PUBLIC HEALTH DEVELOPMENT

The successive definitions of public health. The term NPH is used also nowadays, however, rarely. Other definitions were also introduced, e.g. used by particular stakeholders on a international arena and in national contexts. In the analysis of 15 definitions (23), which were published in the years 1998-2011, the noticeable differences in their content were presented in terms of: (a) the range of included PH functions and tasks for employees, (b) approach (normative or descriptive), (c) the range of considered social and economic factors which were associated with health (e.g. globalization, climate change, homelessness). The inclusion of health determinants at the meso and macro level to the definitions, indicates that nowadays 'old' and NPH are convergent and the borders between them became less sharp.

The current example of PH openness to the new trends and challenges are issues connected with the usage of genetic studies (genomics), irrespective of the fears of eugenics and supremacy of medicine, or emergency preparedness and emergency management. For others – global PH which takes into account the factors influence on health at the supranational level, e.g. globalization. It is also confirmed by the offer of 2004, which was formulated by *Robert Beaglehole* and co-authors, to define the public health of the new era, modern as: *collective action for sustained population-wide health improvement*. With this definition, the authors indicated the most important directions of activities: (a) leadership of the health system, (b) collaboration across all sectors, (c) multidisciplinary approach to all determinants of health, (d) political engagement in public-health policy, (e) partnership with the populations served (24). In 2012, *Tim Lang* and *Goef Rayner* proposed (slightly worn-out) the term 'ecological PH' which derives from earlier approaches and integrates PH in terms of sanitary, environmental, biomedical, social, behavioural and techno-economic models (25).

It may be assumed that such the development of events is perfectly characterized by the opinion of *Goeffrey Vickers*. A half century ago while serving as the Secretary of *Medical Research Council,* he claimed that: *The landmarks of political, economic and social history are the moments when some condition passed from the category of the given into the category of the intolerable. I believe that the history of public health might we be written as a record of successive re-defining of the unacceptable* (26).

NPH progression. Generally, in the 90s, the opinion that new public health is equivalent to the health promotion definition according to the Ottawa Charter has been established in the community of practitioners and PH researchers. However, in the USA, the continuation of native opinions on HP, slightly different from the ones specified in Ottawa Charter, is noticeable. It did not interfere with the fact that in 1994 among the essential PH services, the HP aspects were placed. Furthermore, many important and evolving proposals and ideas origin from the USA, e.g. PRECEDE-PROCEED model, health literacy and syndemics, i.e. coexistence of several epidemics. In 1999, *Lester Breslow* wrote about the third public health revolution, third era of health which aims at striving for health, welfare and improvement of quality of life. Thus, the opinion of *Milton Terris* that the first revolution consisted in limiting the communicable diseases, the second – strived for reducing the chronic diseases and change of behaviours were continued (27).

Having analyzed it more precisely, following Ottawa two fundamental tendencies can be noted in the history, i.e. – development of theoretical and empirical base of NPH/ HP as well as consolidation and institutionalization and penetration of these ideas and progresses to the health system.

The issues connected with the scientific methodology of HP were put in sharp focus. Due to the fact that epidemiology was no longer considered to be the queen of the sciences, the necessity to conduct the studies on pluricausal context of health and usage of many scientific instruments such as e.g. qualitative methods was emphasized. The consequences of resignation from the gold standard of biomedical sciences, i.e. experimental research design where the participants are randomly assigned to either the control or experimental group (RCTs) were recursively discussed. The following issues, i.a.: health promotion capacity, ethical aspects, the range of professional competences, the methods of performance and measurement of effects of leading health promotion processes – empowerment and participation – were also analyzed. The new challenges such as privatization, commercialization and individualization of health care and the risk resulting from the operation of great international corporations were also discussed.

In the Charter, the activities of the fifth action area, i.e. re-orienting the health care system/ health services were characterized quite schematically. It aimed at increasing the role of wide-range activities and focusing the actions on population health outcomes, not only on individuals. Surprising is the fact that none of the worldwide health promotion conferences have covered this subject. It is difficult to adjudicate whether is was not considered to be the issue of high importance or the vision (courage?) of changes was lacking. After the years it is believed that the lowest progress of NPH/HP was observed in this area. Looking for the methods to include HP in the conservative structures of this sec-

Table II. Essential Public Health Operations (EPHOs), WHO (2012)

Essential Public Health Operations (EPHOs)			
Core EPHOs requiring public health skills and expertise to deliver them		Enabling EPHOs	
EPHO 1	Surveillance of population health and well-being	EPHO 6	Assuring governance for health and well-being
EPHO 2	Monitoring and response to health hazards and emergencies	EPHO 7	Assuring a sufficient and competent public health workforce
EPHO 3	Health protection including environmental, occupational, food safety and others	EPHO 8	Assuring sustainable organizational structures and financing
EPHO 4	Health promotion including action to address social determinants and health inequity	EPHO 9	Advocacy, communication and social mobilization for health
EPHO 5	Disease prevention, including early detection of illness	EPHO 10	Advancing public health research to inform policy and practice

tor in 2009, the usage of the term 'social vaccine' was proposed to present this subject (28) in order to refer to the professional connotation.

Integration of NPH with health system. With all the difficulties associated with the evaluation of actions, the effectiveness of HP (especially the behavioural approach) in achieving the health-related goals as well as its cost-effectiveness were demonstrated in numerous papers. Despite of this, too few actions consistent with the five-element formula specified in the Ottawa Charter are conducted worldwide.

With the insufficiencies at the implementation level, many HP ideas (intersectoral collaboration, healthy public policy) have penetrated to the health systems. According to the Tallin Charter (2008), the health systems are not only health care but also the programmes of managing the diseases, prevention, health promotion and efforts aiming at influencing other sectors to address health aspects in their policies (29). The processes of integration with health system are also noticeable in fundamental strategic WHO documents such as 'Health 21' and 'Health 2020'. The old notion, i.e. 'healthy public policy' was replaced by 'health in all policies'. Nowadays, the following notion is used: 'whole-of government and whole-of-society approach' (30). In September 2012, the resolution of the WHO Regional Committee for Europe accepted 10 essential public health operations (EPHOs) (31), of which HP is of separate function (Tab. II).

CAPACITY OF PUBLIC HEALTH AND HEALTH PROMOTION WORLDWIDE

At the decline of previous century, *Beaglehole* and *Bonita* formulated the thesis that public health is at the crossroads and cannot satisfy the expectations regarding the improvement of health status worldwide (32). Among the reasons of such situation were, i.a. increase of poverty, environment degradation, globalization, privatization of health services, purchaser-provider split and issues connected with goals, professional identity and abilities of public health practicioners. It should be added that numerous barriers of political and economic nature hindered the implementation of PH and HP in particular countries. In the world of politics, the short-term prospects prevail, employee rotation is high and average life expectancy in political life amounts to a few years. And yet, the solution of tasks connected with the improvement of population health requires may years, even generations. The leadership is required. The successive economic crises contributed to the establishment of priorities other than health-related ones as well as to the loss of financial stability of health care. The raising expenditures of health care favoured the allocation of resources for curative medicine. It was simpler as the treatment is of higher importance than prevention in the society awareness. It was also attractive for physicians and providers.

CAPACITY OF PUBLIC HEALTH AND HEALTH PROMOTION IN POLAND

It is supposed that all the aforesaid obstacles of the PH development were present in the country. The long-term experience suggests that equally important were also misunderstanding of NPH/ HP ideas, their identification with health education or its underestimation. It is possible that the psychological mechanism, i.e. backfire effect was present here. It disturbs the understanding of the basic facts by the audience and people exposed to the rational arguments, pay greater attention to their previous opinions, even those wrong (33).

Periodically, since at least 10 years the faith in enacting the act on public health revives as well as regulating the tasks and structures, however, the projects have never exited from the interest of some players. So far, there has not been broader discussion between politicians, researchers and practitioners on its direction and content. The widely used mechanism of public consultation while projecting the legal acts, as the numerous examples showed, is unreliable.

The slowdown of economy is a fact. In the world of politics, where the long-term prospects are rare, it favours the decisions which are of totally temporary nature. The temptation of economizing on PH may be very strong because politically more profitable is providing (especially adding) the money for the treatment of children than for programmes aiming at changing the behaviours, social support, community development and even patient education.

The challenge constitutes the reform of science in Poland which commenced on the day of 1st October 2010. The acquisition of grants for research is dependent on the attainments of the applicant, especially on the number of publications in English-language journals with IF and Hirsch index. These criteria do not correspond with the actual status of PH in Poland and trigger the mechanism of vicious circle, i.e. you should have IF to be able to conduct research but in order to obtain it, you have to conduct studies. In the internal systems of employees metric assessment, original publications are of greater importance than the reviews. The letters and commentaries are of no measurable value. Thus, hardly anyone writes it and the discussion is disappearing. Interdisciplinary and transdisciplinary studies are lacking. The system of application (and articles) evaluation is questionable because the reviewers of the biomedical background have difficulties in evaluating the 'soft' studies and those representing the world of social sciences with the assessment of 'hard' aspects. The physicians have the decisive voice in the PH environment. They do not only provide their point of view on health but also constitute the group (not numerous in the Polish research community) which promotes the methods of numerical evaluation of colleagues work. Given the fact that this system is exceptionally beneficial for medical sciences, which was indisputably proven at the illuminating conference in the Polish Academy of Sciences, it is not surprising (34).

Since PH is the art and practice, the question arises how to transfer the attainments described in English to the everyday practice of persons who do not use this language, e.g. in local governments. Especially when the structures and mechanisms of knowledge translation have not been developed. Having remembered about the culture-specific PH nature, the simple extrapolation of the research results conducted abroad cannot be reliable. With such the reformative assumptions, public health in Poland will be – at the most – science without art.

PROSPECTS TO INCREASE THE CAPACITY IN POLAND

Nowadays, in the era of successive crisis, it is noticeable that the health systems became dysfunctional and require the improvement. The control of risk factors requires the knowledge, why people are exposed to them. The elimination of causes of causes of ill health is needed, i.e. return to PH and HP, devoid of habits, prejudice and conflict of interests.

The necessity to increase the PH/ HP capacity is the sign of the times. The different elements (dimensions) of capacity and the methods of its strengthening were characterized in numerous papers (35).

Taking into account the Polish context, it is worthy to propose another dimension of analysis – internal and external capacity. *Ad intra* capacity demonstrates the power centre, condition within the environment, efficiency and productivity of organization and work force belonging to the formal PH structures. *Ad extra* capacity refers to the relations with surroundings and population, enables to deliver sustain services and programmes and resolve the health problems of population. This division should not exclude all forms of hybridization of both dimensions while delivering the services. Initially, all internal issues should be resolved to realize PH mission, propose attractive message for population, launch effective interventions. The strengthening of *ad intra* capacity is required. Otherwise the PH employees could not be the leaders in health system, could not manage the health. The making of the bills of mortality will only remain. But these have been made since 1538 in England on the basis of parish register of christening and funerals.

What should be done then? As usual, the Ottawa Charter provides a good advice. The following strategies aiming at strengthening *ad intra* public health capacity may be proposed:

1. To develop the policies: the vision of abandoning the silo; advocacy of the act on PH; development of PH research system; inclusion of social, economic sciences etc. and their representatives; establishing the research priorities reflecting the needs; striving for the system of preferential grants for PH; well-planned interventions; monitoring and evaluation of progresses to collect the arguments.
2. To change the environment: planned advocacy in health and social-related issues; striving for stable structures and financing; realistic and fair criteria of research, their impact and social activities evaluation; database on good practices; intersectoral collaboration; promotion of volunteer work.
3. To empower the community: promotion of leader of changes; reviving the discussion; influence on policy-making; collaboration, not the competition among the professionalists.
4. To train the skills: modern pre- and post-diploma education; the list of professional competences; interdisciplinary skills; lifelong learning, knowledge translation; accreditation and certification system.

5. To change the health services: long-term assistance of PHC; inclusion of PH professionals into development of mass screening programmes, collaboration with purchaser; clear hints and guidelines for work in health care sector.

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