"Education crucial for social change"

Interview with Pekka Puska

Pekka Puska is the Director General of the National Public Health Institute in Finland, with a background as a doctor in medicine, and master of social sciences. He has been involved in public health research and expert functions since the 1970s. Unusual for a top researcher he has also been an active politician, and member of the Finnish parliament 1987–1991, representing the Province of North Karelia.

Internationally he has gained most fame as the leader of the so called North Karelia Project. This project started in 1972, and aimed at reducing deaths in coronary heart diseases in an area of Finland where mortality of this disease was record high. The project is quoted as one of the most successful health promotion cases in the literature. Puska has also long been involved in the work of WHO, as an expert since 1994 and as the director for chronic disease prevention and health promotion 2001–2003 in Geneva. During that time he, among other things, coordinated the work for the Global Strategy on Diet, Physical Activity and Health, which was endorsed in 2004 by the World Health Assembly.

Against the background of the discussion raised by Michel Craplet (2007) in this issue, NAT asked for an interview with Pekka Puska to find out his view on the role of education in health promotion, particularly when it comes to life-style related problems, such as alcohol: Is there a role for education and how can that role be defined? What can alcohol research and policy learn from the North Karelia Project and other health promotion projects?

Pekka Puska (PP): I have worked all my active professional life with the promotion of healthy life styles. I would like to start with some broad and general comments. When we discuss education and policy and the effectiveness of various measures there are of course numerous different perspectives on the matters, that all can be justified. The perspective differs for instance between different scientific disciplines, such as educational science or psychology where the emphasis is on knowledge and behaviour, or sociology or social policy, where the focus can be on diffusion of innovations or on policy measures.

The question of evidence-base is also complicated. For some measures in the health field the evidence base is very good, particularly for restricted interventions, like effects of pharmaceuticals or surgical procedures. But when we come to health promotion or policy type of interventions, it is much more difficult to get clear evidence on effectiveness.

Evidence is, however, not the only decisive factor. To take an example from the tobacco area: the tobacco producers asked for the evidence of the effectiveness of a ban on tobacco advertisements. But the obvious counter question is: is it ethical to advertise a product that will kill every second user? Choice of policy measures involve, in addition to scientific evidence, issues like ethical aspects, human rights and, in democracy, wish of the people, when the politicians take their decisions.

There are many limitations to our evidence base for both policy and health promotion measures. Most of the evidence comes from relatively short term projects, for one thing. We know very little of effects of more long term programmes or reforms. We know more about the effects of changes in legislation on for instance access to risky products: the consequences for behaviour are often immediate. The long term effects of education on behaviour must always be much more difficult to grasp.

Health promotion to influence long term

changes in general health related lifestyles basically aims at social change. It is my strong opinion that education is an extremely important background in that process. I have no doubts that control policy measures are the most effective for short term changes. But how do you reach a situation where these decisions are made? You need to influence policy makers through shaping public agenda and public opinion.

Earlier we used to criticize the "blame the patient" approach, i.e. when patients are criticized for not behaving rationally or following medical instructions. Today I have the feeling that in many meetings there is the approach "blame the politicians" criticizing politicans for not following the recommendations of the researchers in their choices of policy. To my mind that is not a very fruitful attitude.

My experience from successful health promotion programmes is that you should direct the message to policy makers, the private sector (the industry) and the general population at the same time. But the general population is in the centre of the process. Mobilising the people is the key in social change. The industry listens to their consumers and the politicians to their voters.

In the North Karelia Project we achieved a dramatic change in the dietary habits of the population. In that case it was clearly the people who pulled the decision makers, and not vice versa. When people started to request and consume low-fat milk and eat less butter, the politicians changed the subsidies to the farmers, away from being based on the fat content of the milk. In the 1970s, the industry was not interested in producing healthier food; today they are queuing outside my door to ask for collaboration to market their new health related projects.

And behind this is to a high degree education – in the sense "enlightenment" (the Finnish world for education, "valistus" and the Swedish "upplysning" are both derivates of the words for light), new knowledge that can mobilize people.

NAT: Can you tell us more about the role of education in the North Karelia Project?

PP: In our project we worked with the health services, the schools, various NGOs, industries, the media. You have to do all this – there is no magic bullet.

The education efforts were extensive. We produced various leaflets, worked with newspapers, made tv-programmes, printed books. The messages were spread by nurses and NGOs, in the health services, in schools, we worked with the industry. We trained over 1000 lay leaders to diffuse the information.

I say often that if you want to succeed with a health programme you have to do the right thing and do enough of it. One key to successful education of the public is thus to repeat the health message, which should not be too complicated, repeat it over and over again, and use different channels.

Alcohol had actually no big role in the project. One reason was that at the time the project started, alcohol consumption in the region was actually very low – the situation is different now.

NAT: What can the alcohol educationists learn from your project?

PP: One important question in health projects is whether we start from disease(s) or risk factor(s). WHO has in its prevention programmes an integrated approach, and does not favor vertical, disease focused programmes, but will rather target risk factors that influence a whole range of diseases.

On the other hand, to get the attention of the public, of politicians and the media, you need a certain focus on specific disease threats. If I were in the alcohol field I would put more emphasis than today on the health harms, even if it is not an uncomplicated issue.

When we compare tobacco, alcohol and food from the perspective of health promotion, we must consider from health promotion point of view that there are similarities and differences. Tobacco is very harmful when consumed as intended. There is no evidence that alcohol is harmful if consumed in moderation. When it comes to food, you

have to eat to live, the question is what you eat. So you have to approach all these questions in somewhat different ways, even if there are similarities.

In the case of alcohol, it is obvious that from a public health point of view you need a population based approach, since the sum of negative effects of drinking are related to the total consumption. For this reason you should also work with the whole community. But there is a special challenge when it comes to alcohol in the fact that moderate drinking is not shown to be harmful.

Another challenge is the alcohol industry, which is particularly powerful and in the case of liquors and beer globally very centralized. The industry puts enormous resources on advertising and other promotion of their products. If alcohol education could get 10 % of those resources it would have a real impact.

NAT: If you were to design a national alcohol program for Finland today, like the North Karelia Project, what would be the ingredients?

PP: For a successful project, you need partnership between various sectors of society, but you also need leadership. Partnership is very much emphasized in the present Finnish alcohol programme, but the leadership is too weak to my mind. This is related to the fact that in the present world, with important global, regional, national and local aspects of public health questions, the national level is still crucial, but somewhat weak.

The alcohol field looks very fragmented today. There are social issues, health issues, economic issues among others and many different players. What is needed is a long term national project, with strong and dedicated leadership, a clear health message, fairly specific targets and a defined set of intentions with inbuilt continuous evaluation with feedback, and reasonable resources for this.

NAT: Compared to tobacco, where the effects on third party from smoking are clearly health related, the negative consequences of drinking for the surrounding are mostly social. Would you in spite of that concentrate on the health message?

PP: You are right that the consequences, for instance for children of heavy drinking parents, is something that should be emphasized more. I know that the children's ombudsman has become more active in this question.

Much of the emphasis from politicians in the tobacco field has been on protecting children from starting smoking. Some projects have been successful in delaying the onset of smoking among children. On the other hand you cannot raise children as non-smokers to a society, whether adults continue to smoke. Adults are the role models and adults lead the society. The same is at least as true for alcohol – to protect the children you need to influence the grown-ups. Once again you come back to the population based approach.

Even if it is evident that there are many social harms related to drinking, I would still put an emphasis on the easily grasped health effects. And I think we are starting to get more publicity for them now in Finland.

NAT: The role of education can be somewhat special when you think of the low income countries in the world. With your international experiences, what do you think about that?

PP: It is a fact that chronic non-communicable diseases, like cardiovascular diseases, and other lifestyle related diseases are growing in importance also in low and middle income countries. Another truth is that poor countries have no possibility to solve these problems by building more hospitals or hiring more doctors. Prevention through influencing lifestyles is particularly important in those countries.

Education can initially be of great importance, just by disseminating correct and basic knowledge about risk products like alcohol. For instance, I once met a young man in Africa who told me he had stopped smoking because there was a health warning on the cigarette box. You would not very easily find someone like that in Europe.

It is also very important to try to influence the policy of the low income countries. WHO has a central role here. The tobacco framework document was a very important step, in the case of dietary questions a global strategy on diet, physical activity and health was adopted in 2004. It is to my mind too early to discuss a convention, like for tobacco, but a framework like that on diet and physical activity could be developed. The efforts from the Nordic countries to strengthen the alcohol issue in the World Health Organization are very important.

Tobacco, alcohol and food are all becoming more and more global and regional issues. If you want to achieve change you must think globally and act locally.

Interviewer
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