In search of the public health paradigm for the 21st century: the political dimensions of public health

ILONA KICKBUSCH

There are increasing warnings of not only of a *"crisis in global health governance"* but also of a *"crisis in competency"* in public health.
With this in mind this paper discusses 21st century public health in view of the seminal trends which have led to a renewed political debate on public health and the characteristics of the new public health landscape as an amalgam of *"healthscapes"* and as *networks*.
While the use of *"healthscapes"* as an intellectual construct of analysis helps to visualize some of the global and fluid phenomena we are faced with in 21st century public health, the conceptualization of *public health as a network* helps to understand that it is an interconnected system that brings together various levels of governance, sectors and actors to improve health.
Within the last decade public health has prominently entered the political domain, due to geopolitical shifts, new pandemic threats and the strength of the global health industry. One of the central challenges of public health is how to harness collective action and innovation for health under these much altered circumstances. Public health training must reorient itself towards these new challenges. 21st century public health must be firmly based in fundamental norms, legal frameworks and governance mechanisms that provide a frame for network governance and the multitude of actors and should be geared towards helping reach the goal of obtaining citizens rights for all human beings of the world.

Keywords: public health; health policies; public health — trends; global health; global health governance.

Introduction

Something major has happened. Within the last decade the discussion of societal public health needs — health security, ageing, chronic diseases, inequality to name but a few — has again prominently entered the political domain. Approaches to public health are no longer discussed just in the technical and medical journals – they are part of the debates of government leaders, private entrepreneurs, military strategists, social innovators, trade negotiators and development advocates. Public health today clearly is a highly relevant social and political enterprise. Its central challenge is how to harness collective action and innovation for health

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Ilona Kickbusch is the Director of the Global Health Programme at the Graduate Institute of International and Development Studies in Geneva.

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under much altered circumstances**.** Yet the manifold organizational, social and political processes necessary to create healthier societies have not been high on the agenda of public health training and education. It is of no surprise therefore that there are increasing warnings of not only of a *"crisis in global health governance"* but also of a *"crisis in competency"* in public health. In part this is because of the natural time lag between the real world and educational institutions, but it is also due to the lack of priority given to the political dimension of public health. This is a gap that needs to be addressed urgently.

1. The seminal trends

Three seminal societal trends profoundly impact health at the beginning of the 21st century: the increasing interdependence and interconnectedness also referred to as *globalization,* the increasing influence and changing nature of the global market, also referred to as *consumerism,* and the extreme *inequalities* between nations and populations. Their interrelated effect is a defining feature of the emerging 21st century societal public health needs. These trends frequently constitute three overlapping and mutually reinforcing circles; this also means that the separation of the term public health from global public health is less and less relevant and major conflicts take place in the dynamics between the state, the private sector and the health interests of individuals and civil society organizations locally and globally. All public health action needs to be considered in its national/local and global dimension, otherwise quite simply it is not doing its job. This follows Anne Marie Slaughters statement: *Understanding 'domestic' issues in a regional or global context must become part of doing a good job. Increasingly, the optimal solution to these issues will depend on what is happening abroad, and the solutions to foreign issues, in corresponding measure, by what is happening at home"* (Slaughter, 2004).

Public health in turn has also created seminal trends: the most important being the increased life and health expectancy in most countries of the world. Population ageing is already showing a major impact on how societies are organized, not only in richer countries where the proportion of older people is increasing and people are living longer than ever, but also in poorer countries where the speed and impact of population aging is now significant. In 2002, 70% of the world's older people lived in developing countries (WHO, 2002).

Parallel to this development — and partly because of it — there has been a staggering increase in certain disease patterns: be it the growth of HIV AIDS in parts of the developing world, the increase in new and reemerging infectious diseases, or the rise of obesity and other chronic diseases in rich and poor countries.

Medical research and technological innovation is developing an extraordinary impact and speed and changing approaches to public health and medicine. As part of this development health has become one of the most rapidly growing markets, expanding from pharmaceuticals to include for example nutrition, new health technologies, health information and new forms of health enhancement. Most importantly people's expectations are changing: increasingly throughout the world health is no longer accepted as fate but is linked to human capability and global societal responsibility.

2. The fabric of public health action

Public health action today has brought together a new and extraordinarily diverse group of actors with different forms of power and legitimacy which all aim to give it direction. Does the present fragmented but crowded landscape represent the 21st century form of public health? Do we need to deplore it and aim to force it back into the 19th or 20th century architecture or is the challenge to find new forms of 21st century governance that can deal with the fluid complexity? (Fidler, 2007). Is it the new form of global governance already in place?

The history of public health indicates that the promotion and protection of the health of populations has not been a straightforward progression to better health and stronger institutions (Garrett, 2001). George Rosen, the great historian of public health, has defined *the medical and technical development* and *the social, political and economic factors* as the two major strands in the fabric of public health, that constantly are woven together to produce new patterns (Rosen, 1958). The political response to societal public health needs has been driven by economic utility, demographic concerns, political ideology, a fear of contagion, humanitarian commitment, medical discovery, a dedication to social reform and social justice — to name but a few. It has included the dark days of eugenics and the holocaust as well as various forms of social control through public health measures. Some approaches disappear, others continue to be of relevance or reappear in a new guise. And even today some of the most laudatory

global health initiatives hint at 19th century colonial public health which sprang into action only when white lives were threatened — today we speak instead of national security interests.

Throughout the 18th and 19th century public health developed as an integral part of the seminal restructuring of society. In particular it contributed to the consolidation of nation states, the building of local administrations and the creation of public sector organizations in an age defined by societal upheaval, industrialization and colonization. In the course of the 19th century — also based on the earlier mercantilist states — health became to be recognized as a factor contributing to economic growth, social stability and imperialist expansion — in consequence many early public health measures were deeply rooted in utilitarian political economy. This was not only the case in Europe and later the United States but also was a significant part of the Meiji Restoration in 19th century Japan, where, the political goal of *"Rich Nation, Strong Military"* made health an important object of governmental policy. The achievement of the goal required the production of healthy workers and soldiers and in consequence a "medical policy" called for a national system of public health (Fukada, 1994).

Yet this focus on the economic and political value of improved health was not the only driving force for better health over the last two centuries, indeed some authors contend that it was much less so than we assume today (Porter, 1994). Much of public health action was driven by ideological aspirations, humanitarian and philanthropic passion and moral and religious fervor. Then as today this commitment to health as a value in its own right rather than a means to an end created some of the strongest impact. Health had become a rallying issue for social and political movements since the European Enlightenment and the French revolution had declared health to be one of the rights of man, indeed health was part of the utopian vision of both the new citizen and the new society (Kickbusch, 2007). As such it stood symbolically in the center of modern enlightened governance. Health together with education was a key component of major secular philanthropic efforts to fight poverty which advocated improving both the hygienic competence as well as the social and physical environment of the poor and the working class, of humanitarian organizations such as the Red Cross Movement and finally health was part and parcel of moral and religious endeavors to fight the corrupting evils of the new society such as prostitution and alcoholism. Together these forces for both an instrumental and an intrinsic value of health created the backdrop for major governmental responses and citizens entitlements as well as societal shifts in perspective and expectation in relation to health. In European welfare states the social rights of citizens became as important a feature as their political rights — a balance that is now becoming an important part of the political debate in emerging economies.

The fragmentation we deplore today clearly also existed then: yet the arguments and the actors frequently intersected and Hamlin draws attention to the many formal and informal coalitions that were formed in Great Britain to move 19th century public health forward in the context of social reform (Hamlin, 1994). The most critical defining historical feature of these different approaches was that they all concluded — albeit for different reasons and with different strategies — that it was the obligation of a civilized and modern society to stamp out disease. Medical research needed to be harnessed, action was needed in many sectors of society, poverty needed to be addressed, sewage systems needed to be built, money needed to be raised, citizens needed to act responsibly, employers needed to change their mindsets, politicians needed to be enlisted. Dorothy Parker calls this coming together a "defining moral ecology".

3. The critical interfaces

There exist many proposals and efforts to move public health towards more innovation — both from within and from outside the public health sector — and many of them claim to be, or are defined as revolutionary. Lester Breslow classified the tectonic shifts in public health paradigms and practice as the first, second and third public health revolution (Breslow, 1999; Breslow, 2004), Fidler and Gostin (2007) consider the integration of the security and the public health realms a policy revolution and Alcazar speaks of a Copernican Revolution in health and foreign policy (Alcazar, 2008). The Ottawa Charter in 1986 proclaimed "the new Public Health" (International Conference on Health Promotion, 1986), the European Union in 2008 has positioned a Health in All Policies approach at the center of its new health strategy (Commission of the European Communities, 2007), new public health textbooks present new approaches based on social determinants of health and sustainable development (Aday, 2005; Baum, 2008) and a large literature on the rise of the new multi actor governance system of global health describes and analyses the upheaval that has reshaped the global health world, including totally new financing mechanisms.

New types of public health pioneers and organizations have emerged in the last two decades — highly committed, impatient with traditional structures, processes and financing mechanisms and willing to take risks. These innovators are social entrepreneurs of a new type — reinventing public health practice by doing, particularly at the local and the global level, where there seems to be more policy space for innovation than within national systems. They have shown that a simple expansion of a traditional public health approach — for example with more funding — is not sufficient. They point to the requirement to reinvent public health processes. From such a perspective three critical interface arenas for innovative public health action emerge:

- *The Interface global-local*: Public health can no longer be pursued just at the national level — *its borderless nature* requires a complementary approach of strong national and global institutions, mechanisms, instruments and funding, as well as commitments to both development and to global public goods;
- *The Interface public health and other sectors and actors*: The public health sector can no longer deal with the emerging challenges on its own — *broad health determinants* require a Health in All Policies approach, network governance and broad public and private partnerships and accountability at all levels of governance;
- *The Interface technical excellence and political commitments*: public health can no longer be seen as a purely professional and technical endeavor — establishing *its renewed ethical base* is a political process that needs the strong voice and the support of civil society and of political and other leaders to address the equity, exclusion and human rights issues at stake.

There is consequently a clear need for improved and concerted public health leadership based on an understanding of public health as a global, multi disciplinary and multi stakeholder enterprise driven by science, social entrepreneurship and political action.

In order to fully grasp the changing nature of public health in the 21st century we need to use different visualizations and metaphors. There are two defining features of the 21st century public health landscape: the first is the *expansion* and *fluidity* in terms of geography, of issues, of policy arenas and of actors. The second is the *extreme exclusion* of large populations from access to basic survival needs. It is vitally important to understand how intensely these two features are interrelated and how critical the cooperation of public health communities that so far remain separate has become: the domestic public health professionals and those committed to international health relations and to development. Only if this is overcome will we move towards more sustainable solutions.

4. The 21st century public health landscape

A 21st century public health perspective needs to overcome a simplistic separation of public health landscapes into developed and developing countries. It needs to understand overlapping realities: many of the 21st century public health problems are global and local at the same time, such as infectious disease threats or the obesity epidemic and need to be approached through networked and collective action at all levels of governance; some of the greatest health inequalities are now found in the rapidly emerging economies and need primarily to be addressed through national policies of redistribution, which in turn relate to their newly found position in the global marketplace. The most extreme health needs are situated in countries "at the bottom" which need significant global political commitment to overcome their exclusion.

One way to address this challenge in the international community has been the acceptance of the Millennium Development Goals in 2000 (Collier, 2008). But by 2015 — the date for the achievement of the Millennium Development Goals — most of the 5 billion poor people in the world will live in emerging economies; indeed many of the goals will show progress precisely because of the rapid development in very populous countries such as India and China. Hot then do we approach the roughly 50 countries with about one billion people "that are falling behind and sometimes falling apart". They would need a new approach that does not consider them country by country but as a joint global commitment to health as a global public good. In view of the seminal trends and the characteristics of the new public health landscape this paper discusses 21st century public health not so much in institutional and functional terms but as an amalgam of *"healthscapes"* or as *networks.*

The term "scapes" has been introduced by the anthropologist Arjun Appadurai (1996) to describe the major flows in the fluid and global world in which we live, he defines a variety of global "scapes" — ethnoscapes, mediascapes, technoscapes, financescapes and ideoscapes — which are more or less borderless and constantly in motion. He explains that the traditional spatial models and strategies do

not suffice any more as events become spatially more extended and temporally accelerated. Public health conceptualization could consider *"healthscapes"* as a useful intellectual construct of analysis to visualize some of the global and fluid phenomena we are faced with in 21st century public health, which increasingly has to deal with the flow of people, images, goods and services. Clearly much of the global health discourse — for example in relation to HIV/AIDS, avian flu or SARS can be explained and analyzed in these terms. But healthscapes are also a helpful visualization in relation to non communicable diseases such as tobacco, obesity or alcohol**.** They can be both tangible and virtual: the healthscape of chronic disease could consist of the density of fast food joints in relation to playgrounds within a certain physical area for example, it can mean the density of virtual messages in relation to body image or it can relate to food deserts.

In a similar vein understanding *public health as a network* — that is as an interconnected system that brings together various levels of governance, sectors and actors to improve health — can provide a helpful starting point. 21st century public health action has to some extent become as borderless as the world we live in — functionally and geographically: it can no longer clearly delineate national and global public health action and it can no longer clearly delineate the borders of sectoral public health processes. Healthy public policies, global policy networks, public private partnerships, global alliances and advocacy networks, international law, as well as new financing mechanism such as global funds are cases in point. Public health is pressured to act in many policy realms simultaneously — trade, development, security, foreign policy, agriculture, education to name but a few — and to develop new synergistic mechanisms, instruments and processes for public health action.

Anne-Marie Slaughter (2004) has underlined in her book "The New World Order" that the governance networks in the 21st century are based on regular and purposeful interaction that combines national and international activity. In a recent document this is underlined as follows: "*Formal treaty-based institutions need the eyes and ears that can be provided by issue-based networks of national officials; those networks, in turn, can often benefit by creating one or more central nodes that provide a secretariat function. And networks of corporate and non-governmental actors can be connected as well. Taken together, a networked order can provide the global collaboration we need while preserving the national freedom we want"* (USA. Princeton Project on National Security, 2006).

5. Consumerism and 21st century determinants

The shift from the industrial society of the 19th and 20th centuries to the knowledge societies of the 21st century is a ground-breaking as was the shift from the agrarian to the industrial world — and they are similar in their deep impact on health, this increasing the need for innovation.. The changes in our way of life are shaping our lifestyles and have created a situation where many of the patterns of everyday life — for example our eating and food shopping patterns — and new forms of social stratification — for example new forms of social in- and exclusion — endanger our health. Health challenges such as obesity are as much an expression of our way of life in the 21st century as cholera was of the newly urbanized industrial 19th century,, obesity is the symbolic disease of our global consumer society.

Obesity — indicates the Foresight Report is not only a disease, it is a "complex multi faceted system of determinants" and it makes the case "for the futility of isolated initiatives" (Foresight, 2007). Contrary to the public health problem of smoking there is not one enemy to pinpoint — the global tobacco industry — but a plethora of actors who fulfill many different functions in society. Only part of the risk pattern can be localized — both the problem *and* the solution are systemic. Obesity will be a test case for 21st century public health as was the introduction of water and sewage systems at the end of the 19th century. Such systemic challenges can only be resolved through great political commitment, willingness to innovate and social action – including social entrepreneurship — at all levels of society. This is why the concept of Health in All Policies (Kickbusch, 2008) has gained such prominence as an innovative approach to health governance.

Traditionally public health was part of the social contract between the citizen and the state — developed in different ways in different countries in some cases more centrally on other more decentrally managed. The new factor in 21st century health is not only that industry has become a strong voice in public health but that there has been an worrisome equation of the role of the citizen and the consumer and in many cases the citizens right to health seem to suffer in the face of consumer rights to access goods and services. Benjamin Barber maintains that *"A new cultural ethos is being forged that is intimately associated with global consumerism*" (Barber, 2007). Part of the problem he draws attention to is that the market identity is cosmopolitan while the political and civic identity is increasingly parochial — a gap

in democratic governance that many of the international Non governmental organizations are trying to address this imbalance they advocate for global agreements on matters related to non communicable diseases.

6. Strategic orientations of 21st century public health action

The understanding and organization of public health is always a reflection of the contemporary social relations (Hamlin, 1994), a changing context usually leads to a reconsideration of the public health focus and the willingness to act politically. As indicated in the introduction three areas of refocus are of particularly relevance for 21st century public health: the interface between national (local) and global action; the interface between the many sectors and actors and the interface between the two strands of public health, the technical and the political. With great simplification we could say that for a significant period in the 19th century the focus of public health was national and political and then for the large part of the 20th century moved to being national and technical, it then moved to being global and predominantly technical — and is now challenged to be global and political.

There is no lack of proposals of how to address 21st century health challenges — to use Dorothy Porters term — in the various theatres of power: the state actors such as the G8 or G20 frame them differently from the non state actors such as the People's Health Movement or the food industry. But it is imperative to underline the significance of the fact is that health is now discussed in so many places at so many levels. The multitude of activities and players also constitute a process of learning and trial and error: the goal is to find a new balance between national and global, collective and individual, state and market responsibilities for health and to address the role and accountability of the many actors in the health arena and beyond. In our analysis we sometimes forget just how recent this development is — and how short lived it could prove to be. Fidler (2008b) draws attention to the fact that it was a series of health crisis that led to the increased interest in global health law, because the existing instruments did not work any more. But once they seem resolved or once other crisis — such as the environment, energy or food — gain the attention of policy makers health could drop off the agenda without having resolved the major governance challenges. It could help to develop strategies in relation to three major healthscapes. Each of these types assumes and activates a distinct 'imaginative geography' (Sparke, 2006. 7) that visualizes the terrain of global health in a distinct way.

a) *The market healthscape* sees the world as borderless and flat. Based on its premise that ideally markets are the best solution to most problems of this world this school of thought is increasingly concerned with market solutions for health systems, the efficiency of health systems, the growth of health consumer markets and the contribution of health to human capital. It is in this healthscape that many of the big transnational economic players in global health reside — many public health advocates are not fully aware just how big and diverse this global health market is and how rapidly it is growing, particularly in the emerging economies. This is the landscape of major trade negotiations, global investments in hospital systems and markets for health consumer goods — and while it maintains to be borderless it clearly excludes the bottom billion, who have neither access to markets no to health. Understanding this healthscape goes far beyond ideological critique — it is a key political challenge for public health in view of the definition of health as a public or a private good and the role and accountability of the private sector in 21st century health.

b) The healthscape of investment and charity: it is here that most of the global public health actors reside, in particular the development agencies but also the global health foundations and to some extent the United Nations Agencies. They base much of their thinking on the analysis of the WHO's Commission on Macroeconomics and Health — chaired by the economist Jeffrey Sachs (WHO. CMH, 2001). It calculated that countries with the weakest health and education find it much more difficult to achieving sustained growth — they are in a poverty trap. The access to global markets — the route out of the poverty trap — is only possible if the poor are healthy. *"To break this vicious cycle, the rich countries would have to help"* (Sachs, 2005).

This is the approach that sits best with traditional disease and programme based public health thinking — allowing for the mix of public health and medical expertise, the wish to do good and a resounding economic investment argument to be implemented together with the development agencies and large foundations. It has perhaps best caught the imagination of many players

being able to combine a commitment to do good with what seems a sound and pragmatic economic argument. It is full of innovation and social entrepreneurship for public health, predominantly in the area of infectious diseases; it has created new institutions and mechanisms and attracted major funding especially by the new philanthropic "investors" in the global public health marketplace.

It is essential though for the future of 21st century health that public health advocates understand the deeper impact of this approach. As attractive as it is and as many individual lives that it has saved, it leads to the near total neglect of the second strand of George Rosen's public health fabric: it depoliticises global health (Sparke, 2009) and neutralizes many of the issues at stake. Indeed through the sheer strength of its force has contributed significantly to eclipse the political determinants of health, health systems based strategies and key instruments of global governance such as laws and charters. Laurie Garrett (2007) has stated this unequivocally: *"In the current framework such as it is, improving global health means putting nations on the dole — a 20 billion annual charity programme."* This cannot be the principle on which 21st century public health advocates base their approaches. The must heed this warning and must work to urgently redress this imbalance.

c) *The inequalities healthscape:* this is the healthscape of many non governmental organisations, many professional public health associations and academics: it is concerned with market failure and it maps the landscape of global health inequalities in relation to economic inequalities. Sparke (2009) outlines how approaches consider economic inequality as a form of pathology, *"it makes it possible to see the vast asymmetries that exist amidst global economic interdependencies while also enabling much more nuanced analyses of how local patterns of health and affliction are codetermined by political-economic forces"*. However Sparke makes a very important distinction: one can examines the health effects of inequality as an independent variable usually by comparing nation states, or one can conceptualize inequality as a symptom of more systemic economic processes that produce health vulnerabilities in and, just as importantly, across different spaces.

7. Summary

Recently more analysis has been attempted to address the global forces and flows that influence the patters of health inequalities across spaces (Labonte *et al*., 2007). Paul Farmer argues in the best tradition of Rudolf Virchow when analysing the situation in Haiti he speaks of the *"structural violence*" which reflects asymmetries of power and need a very different type of analysis than the mapping of Gini coefficients. It also underlines that global public health must be concerned with these global landscapes, with the global flows and with the political determinants that produce them.

The political power is shifting, as is the economic power, the recent establishment o the G20 is clear expression of this. A new geography of power has emerged which is very different from the short unilateral period following the collapse of Soviet Union. Presently global health governance is being conducted in a non polar world, a context which provides a new dynamic for multilateral institutions, as they can strengthen their role as platforms and brokers between the myriads of actors as well as well as gain acceptance for strengthening international law for health. The emerging economies and new power centers are also increasingly using the existing institutions — such as the World Health Organization — to increase their own influence on global decision making for health. In 1945 at the San Francisco Conference the Brazilian and the Chinese delegations argued that "medicine is one of the pillars of peace" and this in turn led to the proposal for a single health organization of the United Nations. These countries are today again two of the central players, they could again play a key role in moving global health governance to a new plane. There are also new players such as the European Union which is slowly flexing its global muscle and exploring its role in 21st century health governance. 21st century public health has to move out of the charity mode. It must be firmly based in fundamental norms, legal frameworks and governance mechanisms that reflect the network governance and the multitude of actors. *'The very values of an enlightened and civilized society demand that privilege be replaced by generalized entitlements — if not ultimately by world citizenship then by citizens rights for all human beings of the world'* (Dahrendorf, 2002). This is the basis for an adequate response to the societal public health needs at the beginning of the 21st century. Global health governance should be geared towards helping reach such a goal.

□ References

ADAY, L. A., ed. lit. — Reinventing public health. San Francisco, CA : Jossey-Bass, 2005.

ALCAZAR, S. — The Copernican revolution in health and foreign policy. Geneva, Switzerland : Graduate Institute Geneva, 2008. (Working Paper; 2).

APPADURAI, A. — Modernity at large : cultural dimensions of globalization. Minneapolis, MN : University of Minnesota Press, 1996.

BARBER, B. — Consumed : how markets corrupt children, infantilize adults, and swallow citizens whole. New York, NY : W. W. Norton and Company, 2007.

BAUM, F. — The new public health. Oxford, UK : Oxford University Press, 2008.

BECK, U. — Weltrisikogesellschaft. Frankfurt, Germany : Suhrkamp, 2007.

BRESLOW, L. — From disease prevention to health promotion. *Journal of the American Medical Association*. 281 : 11 (1999) 1030-1033.

BRESLOW, L. — Perspectives : the third revolution in health. *Annual Review of Public Health*, 25 (2004) xiii-xviii.

BUSE, K.; HEIN, W.; DRAGER, N., ed. lit. — Making sense of global health governance : the policy perspective. Basingstoke, UK : Palgrave Macmillan, 2009.

COLLIER, P. — The bottom billion : why the poorest countries are failing and what can be done about it. Oxford, UK : Oxford University Press, 2008.

COMMISSION OF THE EUROPEAN COMMUNITIES — Together for health : a strategic approach for the EU 2008-2013 : white paper. [Em linha]. Brussels : Commission of the European Communities, 2007. (Official document COM (2007) 630 Final). [Consult. Agosto 2008] Disponível em http://ec.europa.eu/health/ph_overview/Documents/strategy_wp_en.pdf.

DAHRENDORF, R. — Die krisen der demokratie. Munich, Germany : Beck Verlag, 2002.

FARMER, P. — Pathologies of power : health, human rights, and the new war on the poor. Los Angeles, CA : University of California Press, 2003.

FIDLER, D. P. — Reflections on the revolution in health and foreign policy. *Bulletin of the World Health Organization.* 85 : 3 (2007) 243-244.

FIDLER, D. P.; GOSTIN, L. O. — Biosecurity in the global age : biological weapons, public health, and the rule of law. Stanford, CA : Stanford University Press, 2007.

FIDLER, D. P. — Influenza virus samples, international law, and global health diplomacy. *Emerging Infectious Diseases.* 14 : 1 (2008a) 88-94.

FIDLER, D. P. — Global health jurisprudence : a time of reckoning. *The Georgetown Law Journal.* 96 : 2 (2008b) 393-407.

FORESIGHT — UK Foresight Programme — Tackling obesities : future choices. London, UK : Foresight, 2007.

FUKADA, M. H. — Public health in modern Japan : from regimen to hygiene. In PORTER, D. ed lit. — The history of public health and the modern state. Amsterdam, The Netherlands : Rodopi, 1994.

GARRETT, L. — Betrayal of trust : the collapse of global public health. New York : Hyperion, 2001.

GARRETT, L. — The challenge of global health. *Foreign Affairs*. 86 : 1 (2007) 1-17.

HAMLIN, C. — State medicine in Great Britain. In PORTER, D. ed lit. — The history of public health and the modern state. Amsterdam, The Netherlands : Rodopi, 1994.

KICKBUSCH, I. — The end of public health as we know it : constructing global health in the 21st century. Hugh R. Leavell Lecture at the World Federation of Public Health Associations (WFPHA) 10th International Congress on Public Health, Brighton, UK, April 2004. Available online: http://www.ilonakickbusch.com/public-health/publichealthinteh21st.pdf. Accessed in August 2008.

KICKBUSCH, I. *et al.* — Global health diplomacy : the need for new perspectives, strategic approaches and skills in global health. *Bulletin of the World Health Organization*. 85 : 3 (2007) 230-232.

KICKBUSCH, I. — Health governance : the health society. In MCQUEEN, D. *et al.* ed lit. — Health and modernity : the role of theory in health promotion. New York, NY, USA : Springer Science, 2007.

KICKBUSCH, I. — Moving global health governance forward. In BUSE, K.; HEIN, W.; DRAGER, N. ed. lit. — Making sense of global health governance : a policy perspective. Basingstoke, UK : Palgrave, 2008.

KINGDON, J. W. — Agendas, alternatives and public policies. 2nd ed. New York : Harper Collins College Publishers, 1995.

LABONTE., R. *et al.* — Towards health-equitable globalisation : rights, regulation and redistribution : final report to the Commission on Social Determinants of Health. Geneva, Switzerland : WHO, 2007.

INTERNATIONAL CONFERENCE ON HEALTH PROMOTION, 1, Ottawa, 21 November 1986 — Ottawa Charter for Health Promotion. *Health Promotion*. 1 (1986). iii-v.

PORTER, D., ed. lit. — The history of public health and the modern state. Amsterdam, The Netherlands : Rodopi, 1994.

RUGER, J. Prah — Normative foundations of global health law. *Georgetown Law Journal*. 96 : 2 (2008) 423-443.

ROSEN, G. — A history of public health. New York, NY : MD Publications, 1958.

SACHS, J. — The end of poverty. New York : The Penguin Press, 2005.

SLAUGHTER, A. M. — A new world order. Princeton, NJ : Princeton University Press, 2004.

SPARKE, M. — Political geographies of globalization (2) : governance. *Progress in Human Geography*. 30 : 21 (2006) 1-16.

SPARKE, M. — Unpacking economism and remapping the space of global health. In WILLIAMS, O.; KAY, A. ed lit. — Global health governance : transformations, challenges and opportunities amidst globalization. London, UK : Palgrave, 2009.

USA. INSTITUTE OF MEDICINE (IOM) — The future of public health. Washington, DC : The National Academies Press, 1988.

USA. INSTITUTE OF MEDICINE (IOM) — Who will keep the public healthy?: educating public health professionals for the 21st century. Washington, DC : The National Academies Press, 2003.

USA. PRINCETON PROJECT ON NATIONAL SECURITY — Forging a world of liberty under law : U.S. national security in the 21st century : final report of the Princeton Project on National Security. Princeton, NJ : Princeton Project on National Security, September 27, 2006. (The Princeton Project Papers).

WHO — Active ageing : a policy framework. [Em linha]. Geneva, Switzerland : Ageing and Life Course Programme.

Noncommunicable Disease Prevention and Health Promotion Department. Noncommunicable Diseases and Mental Health Cluster, 2002. [Consult. Agosto 2008]. Disponível em http://whqlibdoc.who.int/hq/2002/WHO_NMH_NPH_02.8.pdf.

WHO. CMH — Macroeconomics and health : investing in health for economic development : report of the Commission on Macroeconomics and Health. Geneva : WHO, December 2001.

WHO. CSDH — Achieving health equity : from root causes to fair outcomes : CSDH's Interim Statement. [Em linha]. Geneva, Switzerland : Commission on Social Determinants of Health, 2007. [Consult. Agosto 2008] Disponível em http://whqlibdoc.who.int/publications/2007/interim_statement_eng.pdf.

□ Resumo

À PROCURA DO PARADIGMA DA SAÚDE PÚBLICA PARA O SÉCULO XXI: AS DIMENSÕES POLÍTICAS DA SAÚDE PÚBLICA

As chamadas de atenção sobre uma "crise na administração global da saúde" estão a aumentar falando-se, também, de uma "crise nas competências" em saúde pública.

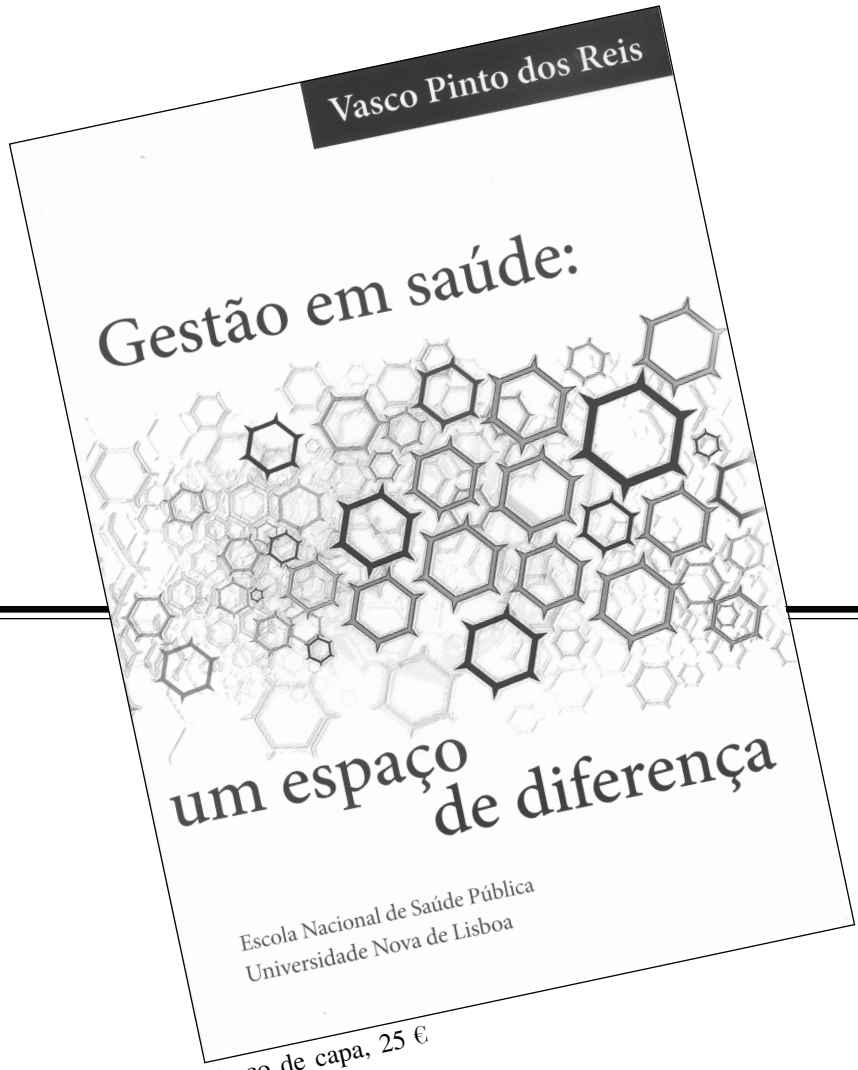
Este artigo aborda, por um lado, a problemática da saúde pública do século XXI, em virtude das tendências seminais que conduziram a um debate político renovado sobre ela, e por outro, as características da nova saúde pública como uma amálgama de "healthscapes" e *networks*.

Enquanto o termo "healthscapes" ajuda a visualizar alguns dos fenómenos globais e fluidos que se enfrentam na saúde pública do século XXI, a conceptualização da saúde pública como *network* permite compreender que a saúde pública é um sistema interligado que reúne diferentes níveis de governação e vários sectores, envolvendo diferentes actores e tendo como objectivo melhorar a saúde.

A saúde pública da última década incorporou, de forma destacada, o domínio político devido às deslocações geopolíticas, às novas ameaças pandémicas e ao peso da indústria global da saúde. Saber como aproveitar a acção colectiva e a inovação para a saúde sob estas novas e muito diferentes circunstâncias é um dos desafios centrais da saúde pública, devendo a formação nesta área reorientar-se, também, para estes novos desafios.

A saúde pública do século XXI deve estar firmemente baseada em normas fundamentais, em quadros jurídicos e em mecanismos que forneçam um modelo para a administração em rede e o envolvimento de diferentes actores, tendo em vista a obtenção de direitos de cidadania para todos os seres humanos do mundo.

Palavras-chave: saúde pública; políticas de saúde; saúde pública — tendências; saúde global; gestão global da saúde.



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