

Journée prévention en santé

Historique, débats
contemporains et enjeux de la
promotion de la santé

Eric Breton
professeur à l'EHESP,
titulaire de la Chaire Inpes
« Promotion de la santé » à l'EHESP

14 décembre 2010

Résidence internationale de Paris





Remerciements

- L'Institut national de prévention et d'éducation pour la santé (Inpes) qui finance la Chaire
- La Société française de santé publique
- La Fédération nationale d'éducation et de promotion de la santé



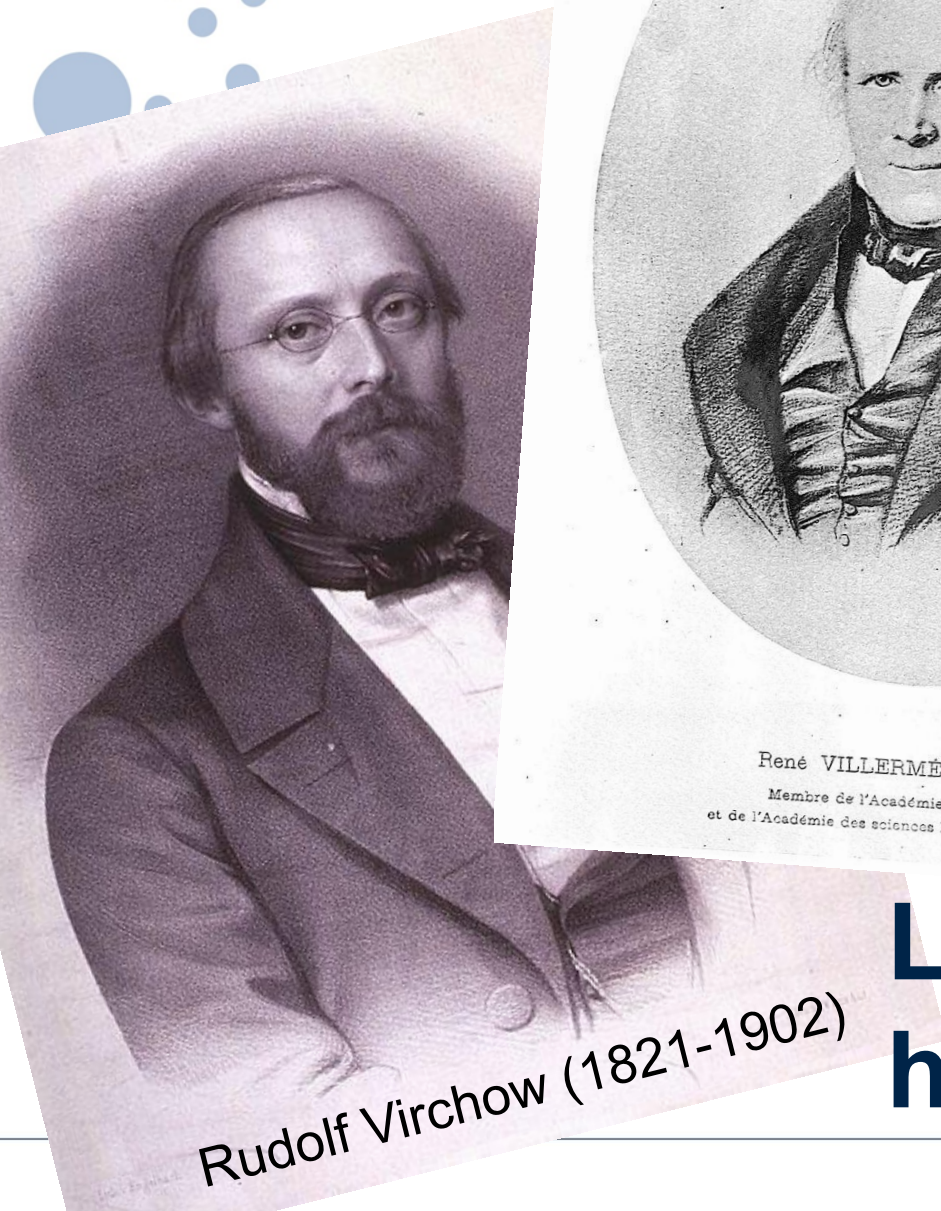
Sommaire

- Evolution du champ de la santé publique
- Enjeux et débats
- Le rapport du Centre d'analyse stratégique



Phases historiques de la santé publique moderne

- Mouvement hygiéniste (19^{ième} s.)
- Lutte bactériologique (1861)
- Education sanitaire (20^{ième} s.)
- Travail d'ingénierie sociale (2nd Guerre mondiale-)
- Nouvelle santé publique : Promotion de la santé (≈1980-)



Rudolf Virchow (1821-1902)

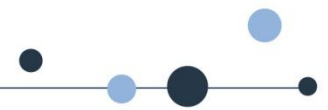


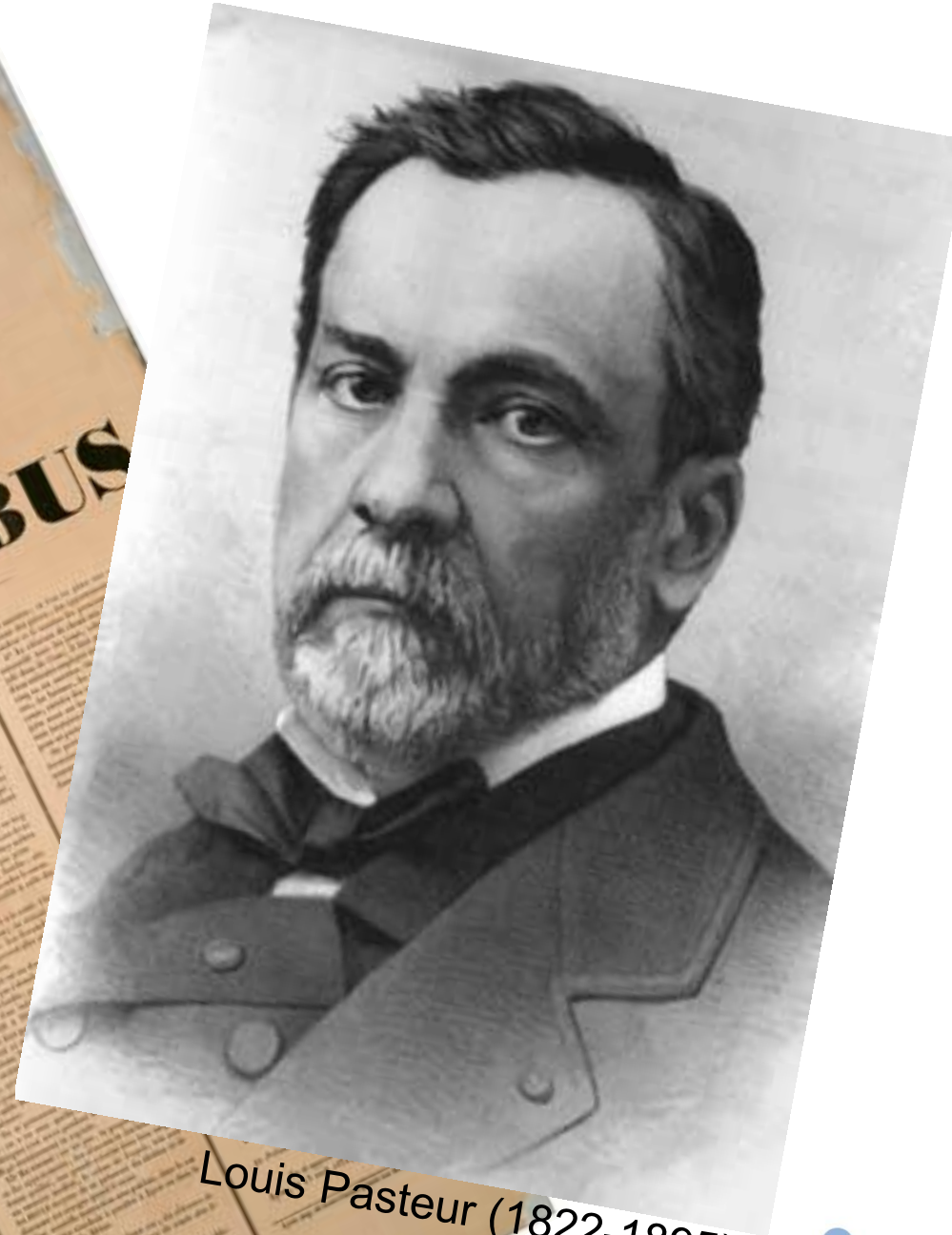
René VILLERMÉ, 1782-1863
Membre de l'Académie de Médecine
et de l'Académie des sciences Morales et Politiques.



Florence Nightingale (1820-1910)

Le Mouvement hygiéniste





Louis Pasteur (1822-1895)

La lutte bactériologique

BRITISH MEDICAL JOURNAL

LONDON SATURDAY SEPTEMBER 30 1950

SMOKING AND CARCINOMA OF THE LUNG

PRELIMINARY REPORT

BY

RICHARD DOLL, M.D., M.R.C.P.

Member of the Statistical Research Unit of the Medical Research Council

AND

A. BRADFORD HILL, Ph.D., D.Sc.

Professor of Medical Statistics, London School of Hygiene and Tropical Medicine; Honorary Director of the Statistical Research Unit of the Medical Research Council

In England and Wales the phenomenal increase in the number of deaths attributed to cancer of the lung provides one of the most striking changes in the pattern of mortality recorded by the Registrar-General. For example, in the quarter of a century between 1922 and 1947 the annual number of deaths recorded increased from 612 to 9,287, or roughly fifteenfold. This remarkable increase is, of course, out of all proportion to the increase of population—both in total and, particularly, in its older age groups. Stocks (1947), using standardized death rates to allow for these population changes, shows the following trend: rate per 100,000 in 1901–20, males 1.1, females 0.7; rate per 100,000 in 1936–9, males 10.6, females 2.5. The rise seems to have been particularly rapid since the end of the first world war; between 1921–30 and 1940–4 the death rate of men at ages 45 and over increased sixfold and of women of the same ages approximately threefold. This increase is still continuing. It has occurred, too, in Switzerland, Denmark, the U.S.A., Canada, and Australia, and has been reported from Turkey and Japan.

Many writers have studied these changes, considering whether they denote a real increase in the incidence of the disease or are due merely to improved standards of diagnosis. Some believe that the latter factor can be regarded as wholly, or at least mainly, responsible—for example, Willis (1948), Clemmesen and Busk (1947), and Steiner (1944). On the other hand, Kennaway and Kennaway (1947) and Stocks (1947) have given good reasons for believing that the rise is at least partly real. The latter, for instance, has pointed out that "the increase of certified respiratory cancer mortality during the past 20 years has been as rapid in country districts as in the cities with the best diagnostic facilities, a fact which does not support the view that such increase merely reflects improved diagnosis of cases previously certified as bronchitis or other respiratory affections." He also draws attention to differences in mortality between some of the large cities of England and Wales, differences which it is difficult to explain in terms of diagnostic standards.

The large and continued increase in the recorded deaths even within the last five years, both in the national figures and in those from teaching hospitals, also makes it hard to believe that improved diagnosis is entirely responsible. In short, there is sufficient reason to reject that factor as the

whole explanation, although no one would deny that it may well have been contributory. As a corollary, it is right and proper to seek for other causes.

Possible Causes of the Increase

Two main causes have from time to time been put forward: (1) a general atmospheric pollution from the exhaust fumes of cars, from the surface dust of tarred roads, and from gas-works, industrial plants, and coal fires; and (2) the smoking of tobacco. Some characteristics of the former have certainly become more prevalent in the last 50 years, and there is also no doubt that the smoking of cigarettes has greatly increased. Such associated changes in time can, however, be no more than suggestive, and until recently there has been singularly little more direct evidence. That evidence, based upon clinical experience and research, is mainly to the use of tobacco. For instance, in a study of 1939) found that only 3 out of 86 male patients with cancer of the lung were

while 20% of the "healthy" smokers and 10% of the non-smokers.

Schrek and his colleagues (1947) reported that 82 male patients with cancer of the lung were again of 10% of the non-smokers.

of 10% of the non-smokers.

Wynn (1947) reported that 10% of the non-smokers.

epidermoid, and 10% of the non-smokers.

types of bronchitis, and 10% of the non-smokers.

smokers"—that is, 10% of the non-smokers.

ette a day for the last 20 years, and 10% of the non-smokers.

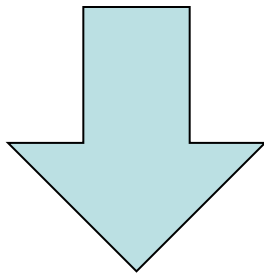
had smoked more than 20 cigarettes a day.

L'accroissement [des décès par cancer du poumon] semble avoir été particulièrement rapide depuis la fin de la première guerre mondiale

L'Education
sanitaire

Phase
d'éducation à
la santé

Information



Changement de
comportement





Emergence de la Nouvelle santé publique

Rapport Lalonde (1974)

La santé est fonction :

- de la biologie humaine
- des habitudes de vie
- de l'organisation des soins de santé

Et de l'environnement !



Gouvernement
du Canada

Government
of Canada



NOUVELLE PERSPECTIVE DE LA SANTÉ DES CANADIENS

un document de travail

Marc Lalonde

Ministre de la Santé nationale et du Bien-être social



Programmes de prévention des maladies cardio-vasculaires



The Stanford Three Community Study (1972-78)

The Stanford Five City Project (1978-88)

The Minnesota Heart Health Program (1980-90)

The Pawtucket Heart Health Program (1982-93)

The Pawtucket Heart Health Program: Community Changes in Cardiovascular Risk Factors and Projected Disease Risk

Richard A. Carleton, MD, Thomas M. Lasater, PhD, Annlouise R. Assaf, PhD, Henry A. Feldman, PhD, Sonja McKinlay, PhD, and the Pawtucket Heart Health Program Writing Group

ABSTRACT

Objectives. Whether community-wide education changed cardiovascular risk factors and disease risk in Pawtucket, RI, relative to a comparison community was assessed.

Methods. Random-sample, cross-sectional surveys were done of people aged 18 through 64 years at baseline, during, and after education. Two cohorts were recruited from the comparison community and two from Pawtucket. Data were analyzed using multivariate methods.

Introduction

The age-adjusted death rate for most forms of atherosclerotic disease has declined substantially in the past three decades.¹ Atherosclerosis is a multifactorial disease, and risk factors and risk

factors in the populations receiving the educational message relative to comparison populations.

Between 1978 and 1980, research grants were awarded by the National Heart, Lung, and Blood Institute for the Heart, Lung, and Blood Institute for the Stanford Five City Program,¹⁸ and the Pawtucket Heart Health Program.¹⁷ The hypothesis to be tested in the Pawtucket Heart Health Program is that the educational message will lead to a reduction in cardiovascular disease risk in Pawtucket.

We have emphasized the results of our cross-sectional surveys. Cross-sectional surveys have strengths and weaknesses. The major strength is that they provide a point-in-time characterization of the target population. At the same time, they do not include individuals who die or who left the community after participation in the intervention process. They do not include individuals who died or who left the community late in or after the educational program. With the Pawtucket Heart Health Program, we have addressed these limitations by using a population-based design. We have conducted a longitudinal study of the educational message in Pawtucket, RI, and in a comparison community. We believe that the educational message will lead to a reduction in cardiovascular disease risk in Pawtucket.

More effective programs will probably be those that affect the many factors that influence risk-related behaviors. We believe that the most effective programs will integrate efforts at the individual, community, state, and national levels to change both policies and practices through television and other advertising media. Well-funded advertising campaigns, such as those run by the tobacco industry,²¹ and grocery store displays of foods not designed to facilitate eating patterns²² are widespread. We suggest that the most plausible explanation for the Pawtucket Heart Health Program results relates to inundation of the people of both cities by information provided through other channels and by other agents both during and after the education effort.

References

1. Centers for Disease Control. Trends in atherosclerotic heart disease mortality—United States, 1980-1988. *JAMA* 1992;268:1837.
2. Report of the Expert Panel on Genetic Causes of Coronary Heart Disease. *Am Heart Assoc* 1992.
3. Kannel WB, Dawber TR, Kagan A, et al. Summary of the Framingham Study. *National Cholesterol Education Panel on High Blood Cholesterol in Adults (Adult Treatment Panel II)*. *JAMA* 1993;269:3015-3021.
4. The Health Benefits of Smoking Cessation: A Report of the Surgeon General. Washington, DC: US Dept of Health and Human Services; 1998. DHEHS publication CDC 98-8416.
5. *Reducing the Health Consequences of Smoking: 25 Years of Progress. A Report of the Surgeon General*. Atlanta, Ga: Centers for Disease Control and Health Promotion, National Center for Chronic Disease Prevention and Health Promotion, National High Blood Cholesterol in Adults and Treatment Panel II; January 1993. NIH publication 93-1098.
6. National Institutes of Health Consensus Development Panel on the Health Implications of Obesity. Health implications of obesity development. *Am J Prev Med* 1995; 10(3-4):1077.
7. Hypertension Detection and Follow-up Program Cooperative Group. Five-year follow-up of the Hypertension Detection and Follow-up Program. III: reduction in stroke incidence among persons with high blood pressure. *JAMA* 1982;247:1615-1622.
8. Research Group of the Lipid Research Clinics Coronary Project. The Lipid Research Clinics Coronary Project: reduction in incidence of coronary heart disease. *JAMA* 1984; 251:2019-2028.
9. Solmon JT, Sizer JS, Taylor CB, et al. Behavioral risk factors for coronary heart disease. *JAMA* 1988; 259:127-34.
10. Solmon JT, Sizer JS, Taylor CB, et al. Behavioral risk factors for coronary heart disease. *JAMA* 1988; 259:127-34.
11. Solmon JT, Sizer JS, Taylor CB, et al. Behavioral risk factors for coronary heart disease. *JAMA* 1988; 259:127-34.

« Les programmes les plus efficaces seront probablement ceux qui agiront sur différents facteurs sociétaux influençant les comportements à risque [...] les plus efficaces seront ceux qui intégreront des efforts de modifications des politiques et pratiques tant au niveau de la communauté, de l'état et du pays ».

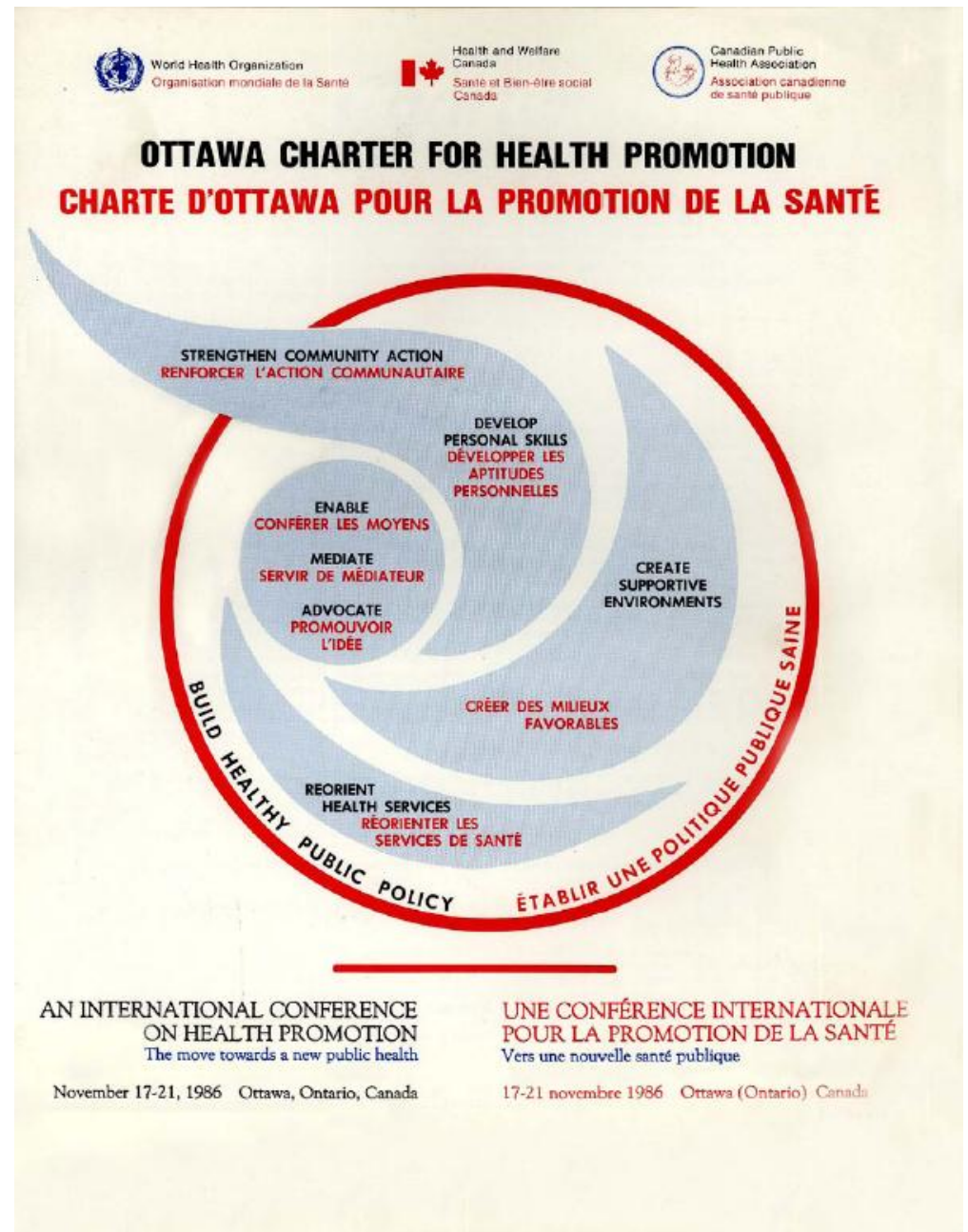
La Nouvelle santé publique et le Mouvement de promotion de la santé

Perspective socio-écologique

Déterminants sociaux de la santé en amont des facteurs de risque

Agenda de justice sociale

Participation des populations





La promotion de la santé

« La promotion de la santé est le processus qui confère aux populations les moyens d'assurer un plus grand contrôle sur leur propre santé, et d'améliorer celle-ci. »

(OMS, 1986)

René Dubos (1901 – 1982)

Dubos, René. (1961)
Mirage de la santé.
Paris, Denoël.

La santé n'est pas un
état statique...

C'est un processus
dynamique...



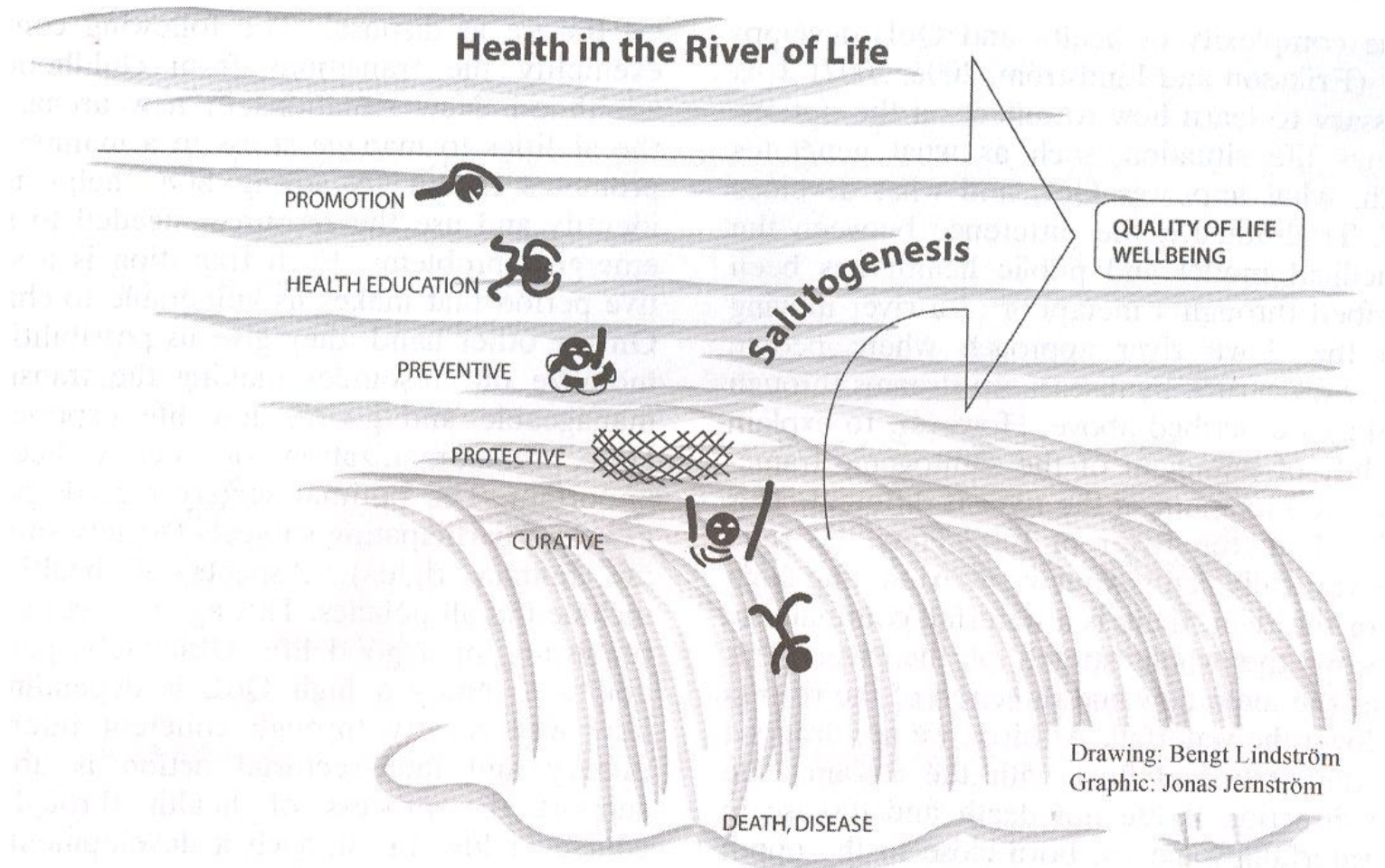
La métaphore de l'intervention en amont/aval (suite et fin)



La métaphore de l'intervention en amont/aval (suite et fin)



La perspective salutogénique de Antonovski





Promotion de la santé: des balises

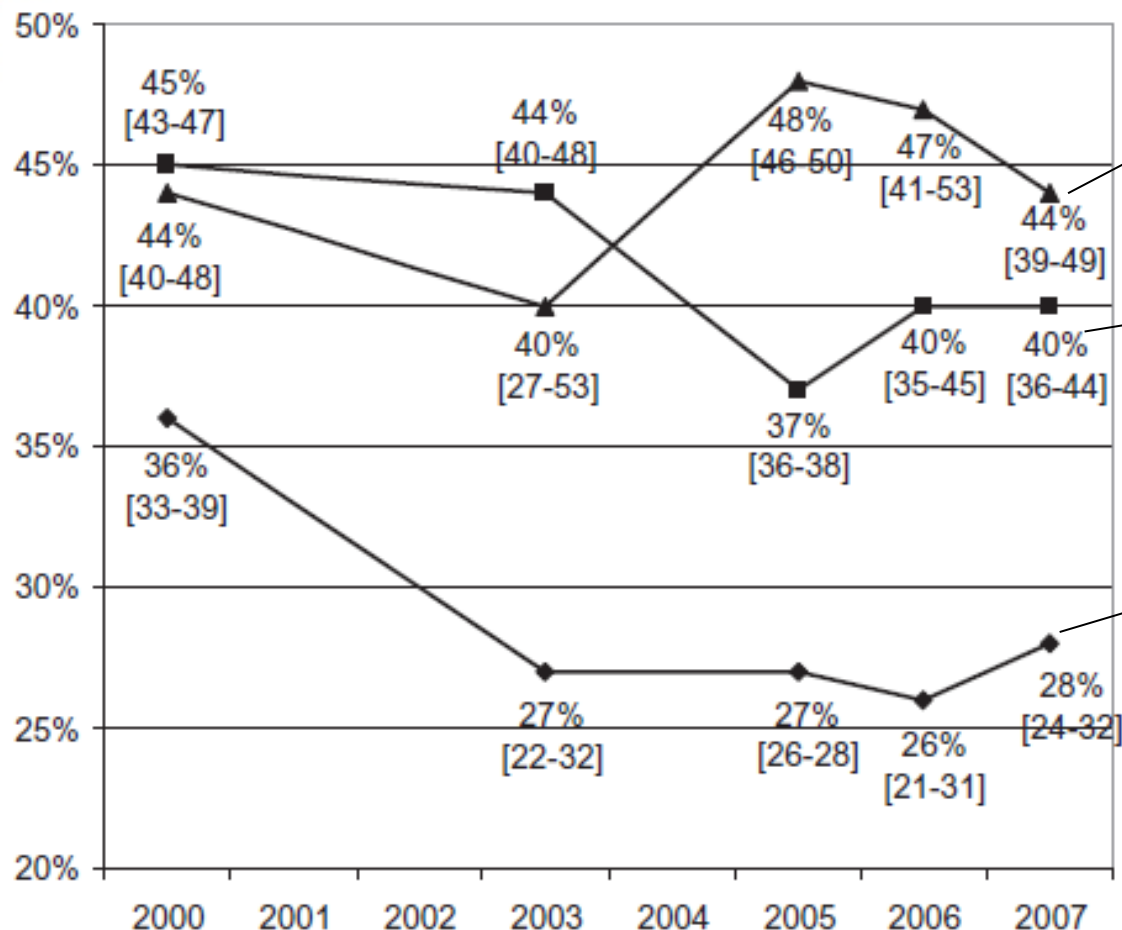
- Santé plutôt que maladie
- Facteurs de risques → déterminants de la santé
- Perspective socio-écologique de la santé
- Approche par milieu
- Politiques publiques comme moteurs de changement
- Agenda de justice sociale → ISS



Ce qui implique

- Primauté aux aspects associés aux milieux de vie
- Pas de gains sanitaires significatifs sans mobilisation des pouvoirs
- Epistémologie constructiviste et pluralisme méthodologique
- Milieux de pratiques comme incubateur d'innovations

Prévalence du tabagisme parmi les cadres, les ouvriers et les chômeurs, 2000-2007



Chômeurs

Ouvriers

Cadres supérieurs
et professions
libérales

Tiré de Peretti-Watel et al.,
2009, p.1720



Action sur l'hypertension

Ce qui est fait...

- Dépistage
- Education (nutrition, exercice, tabagisme)
- Ingénierie sociale (amélioration de l'accès aux fruits et légumes frais, etc.)

Ce qui est laissé de côté

- Statut social
- Stress associé au travail: ↑travail-↓contrôle
- Discrimination
- Détresse psychologique
- Résider dans un quartier défavorisé



Il faut agir sur les milieux de vie

C'est-à-dire là où les gens travaillent, s'amuse, s'éduquent, aiment et vivent les joies et difficultés de la vie.

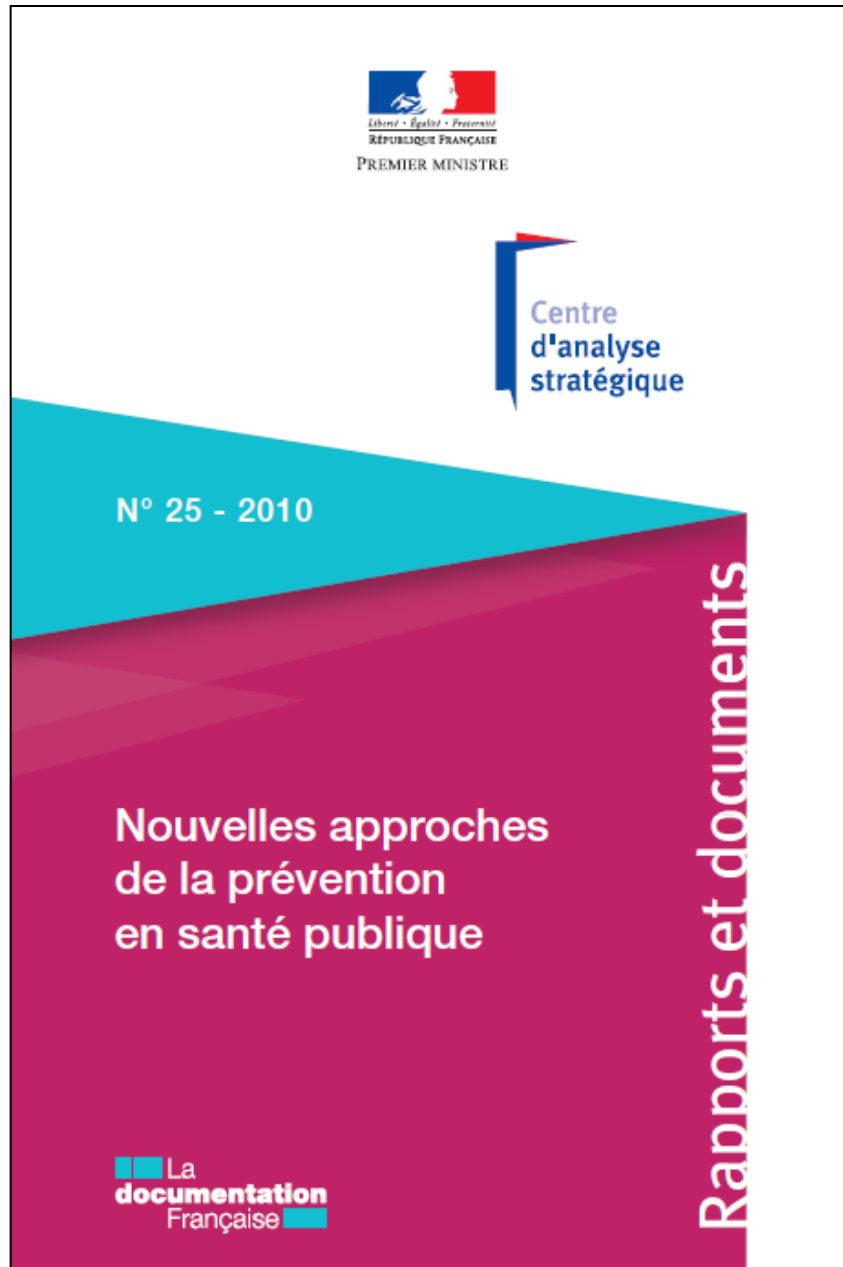


Les défis

- Le péril du « *Elle te plaît ma sœur ?* » (travailler dans des secteurs ou milieux autres que la santé)
- Financement recherche et action
- Evaluation impact sur déterminants sociaux



Un pas en avant ?





Le rapport du Centre d'analyse stratégique

- Éducation à la santé (formule améliorée?): mais dans les faits → ingénierie sociale (qui échappe au contrôle du citoyen)
- Vision étroite de la prévention (Axée sur prévention secondaire: ex. les fumeurs)
- Analyse des coûts-bénéfices de la prévention centrée sur programmes de dépistage
- Approche "top-down"
- La cible c'est l'individu (non les groupes)
- Individus dominés par pulsions (participants passifs)
- Les comportements sont désincarnés de leur contexte social






Conclusion

La promotion de la santé :

- N'est pas un hasard historique
- Se pose comme une solution aux inégalités sociales de santé

Défis

- Multisectorialité
 - Financement recherche et action
 - Evaluation impact sur déterminants sociaux
- 



**MERCI POUR VOTRE
ATTENTION!**