

Policy and partnership for health promotion — addressing the determinants of health

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Health promotion is the process of enabling people to increase control over their health and its determinants. This is done by strengthening individual skills and capabilities and the capacity of groups to change the many conditions, particularly the social and economic causes, that affect health (1–3). The value of health promotion has recently been reaffirmed (4, 5). It is a core function of public health and a cornerstone of primary health care. It is both effective and cost effective (6–8), and the links between health, health promotion and human and economic development are increasingly recognized (5–9).

In 1986, health promotion came into full force through the Ottawa Charter for Health Promotion. The Ottawa Charter, adopted at the first WHO Global Conference on Health Promotion and reinforced by further conferences held in Adelaide, Sundsvall, Jakarta and Mexico City, sets out a clear agenda to pursue health for all by addressing the broad determinants of health such as shelter, education, food and income. Through joint efforts with others, including the International Union for Health Promotion and Education, academic institutes and many professional associations and ministries, health promotion has successfully shifted the focus from behavioural change at the individual level (with a disease orientation) to health-oriented behaviour and other determinants such as a healthy diet, physical activity, personal hygiene, education for women and social connectedness, through the use of combinations of the five Ottawa Charter Action Areas. They apply across different age and population groups in different settings such as schools, workplaces and communities. The Action Areas are designed to build healthy public policy, create supportive environments, strengthen community

action, develop personal skills and reorient health services. Along with the advancement of health-supporting policies and environments, there have been positive behavioural and lifestyle changes at the population level which lead to the reduction of, for example, heart diseases, road injuries, HIV/AIDS and other infectious diseases (10, 11). The changes are largely confined, however, to people of a higher level of education and socioeconomic background and are much less evident among the lower socioeconomic groups. Renewed effort is required to narrow the equity gap.

The context of health promotion has changed markedly since the Ottawa Charter was adopted. New patterns of consumption and communication, urbanization and environmental changes as well as public health emergencies are critical factors that influence health. Rapid and often adverse social, economic and demographic changes also affect working conditions, learning environments, family patterns and the cultural and social fabric of communities. The role of the state has changed and many states have limited their commitment to the provision of health services funded from government revenue. All these changes have been accelerated by globalization, which also opens up new opportunities for cooperation to improve health and reduce transnational health risks. Greater effort is needed to bring health closer to the centre of the development agenda.

To manage the challenges and opportunities of globalization at global and national levels, collaboration and engagement of all sectors of society are required to ensure that the benefits for health from globalization are maximized and equitable and the negative effects are minimized and mitigated. To this end, participants in the 6th Global Conference on Health Promotion, held

in Bangkok, Thailand, on 7–11 August 2005, spelt out four new commitments in the Bangkok Charter for Health Promotion in a Globalized World: to make the promotion of health central to the global development agenda, a core responsibility for all of government, a key focus of communities and civil society, and a requirement for good corporate practices (2).

An expansion of the five Action Areas is also required to narrow the equity gap. For example, building capacity to promote health is a priority — “capacity” referring not merely to expertise of individual practitioners but also to other areas of concern including policy, partnerships, health promotion finance and information systems (12). It is also necessary to include the private sector when developing health promotion policies.

In addition to advocacy for health based on health rights and solidarity, the Bangkok Charter urges all sectors and settings to invest in sustainable policies, actions and infrastructure; to build capacity to promote health; to regulate, including through legislation, for a high level of protection against harm; and to build alliances with public and other sectors. The Bangkok Charter also calls for more conscientious effort to sustain the effectiveness of health promotion by developing benchmarks for monitoring and plans for implementation of a worldwide partnership to fulfil its four commitments. ■

Acknowledgements

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References

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Ref. No. 05-027201