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INFRASTRUCTURES TO PROMOTE HEALTH: THE ART OF THE POSSIBLE¹
(Updated Version)

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Executive summary

The purpose of this paper is to identify the organisational structures, skills and other resources that constitute the infrastructure needed to promote health.

We begin by highlighting some of the key barriers that continue to impede health promotion so many years after the Declaration of Alma Ata and the Ottawa Charter.

The paper shows that building an effective infrastructure for the promotion of health should concentrate on three key objectives, namely:

- to develop the necessary skills to ensure that health promotion becomes a major issue in political and bureaucratic circles,
- to identify and make far better use of existing infrastructures, and
- to develop dedicated infrastructures for the promotion of health.

For health promotion to be taken seriously at the national and local level, training and practice need to be radically altered to include the 'art' of health promotion, such as coalition building, advocacy, negotiation, partnership, communication and presentation skills, in addition to the training and practice in the 'science' of promoting health. In this way, a critical mass of skilled, innovative and dedicated professionals can develop.

Simultaneously, recognising that most sectors have the capacity to influence population health, health promotors need to work much more effectively with and through existing infrastructures. Creating synergies between the health sector and other sectors avoids the duplication of infrastructure and provides access to organisations and structures whose knowledge, skills, networks and specialised expertise can contribute significantly to good health. Whether it is business leaders, members of parliament, school principals, human rights lawyers, transport officials or urban planners, health promotors need to be proactive, creative and convincing if they want to build successful and lasting partnerships with other sectors.

Dedicated structures are needed to catalyse and drive the promotion of health as well as ensure that it is carried out in a consistent and cohesive manner at a national level. Such structures are likely to be housed within the health sector, yet it is important to ensure that they work across many sectors, with civil society, and at various levels of government.

The paper concludes by emphasising that effective national health promotion programmes do not happen by chance. They result from the political and social recognition of the value of health, a commitment to learning and change, imaginative leadership at all levels, a commitment of finances and human resources, and a capacity to develop a common purpose among a broad constituency of players.
1. Introduction

Why is it, 22 years after the Declaration of Alma Ata and 14 years after the Ottawa Charter, that infrastructures to promote health are often so fragile, so transitory and sometimes non-existent in many countries?

Why, if we have known what to do for many years, is promoting health so difficult? Why have we not been able to apply systematically and evenly across the globe what we have known and learnt in the last 30 years? Why are infrastructures in non-health sectors so under-appreciated and under-utilised?

Why are public health and health promotion still marginalised and placed outside the main game both in developed and developing countries?

We begin section 2 by highlighting some of the barriers at the heart of this frustration - the political, social, economic and cultural barriers that stand in the way of infrastructure for the promotion of good health.

Even though many of these obstacles are seemingly insurmountable, section 3 examines how these barriers can sometimes be overcome by making better use of existing infrastructures. These are presented in relation to the essential elements of health promotion, namely, workforce development, community capacity, healthy public policy, research, monitoring and evaluation, dissemination and communication, working through sectors other than health, and reorienting illness services to promote health. Our message, particularly in low resource countries, is to start by identifying existing infrastructures, learning how they operate and how to work with them.

Section 4 presents options for additional infrastructures specifically set up for the promotion of health. Whilst co-opting existing infrastructure, if done correctly, can guarantee increasingly effective intervention, the existence of dedicated infrastructures ensures a cohesive and focused approach to health promotion. Dedicated infrastructures are needed to catalyse national, provincial and local action, to stimulate non-health sectors, to avoid random intervention, and to provide long term vision.

The paper concludes by challenging us to develop new skills and new approaches to many old problems. The promotion of health requires a great deal more than the practical application of good science. Given the social, political and cultural spheres in which we operate, we require highly developed political and communication skills. This is the art that will allow us to overcome old obstacles, turn old adversaries into partners and allies, garner the human and financial resources we need and ultimately lead us to better health.

In this paper, infrastructure refers to institutions, organisations, and associations; the human resources and competencies associated with them; and the finances needed to develop and support them. In addition to this, we will also talk about the ideas, the social movements and the individuals, champions and leaders that catalyse change and build infrastructures that promote our physical, mental and social well-being.

The paper examines infrastructures to promote health, broadly speaking, not just infrastructure for the narrow ‘discipline’ of health promotion. That being so, it could be said that all
infrastructure within society is available to promote health. So we look at infrastructure from the perspective of people whose primary responsibility is to promote health.

The paper not only examines infrastructure that is ‘top-down’, such as governmental structures but also ‘bottom-up’ community-based structures, private sector structures and so on. We strongly believe that these two structures must work synergistically. Former President Ramos of the Philippines borrows a local metaphor to explain this. He talks about the way bibingka, a kind of rice cake is prepared. Bibingka is baked in a clay oven, with heat applied from the bottom and from the top. Skilled bibingka makers have to learn how to apply the heat evenly. In talking about HIV/AIDS he said so often programs fail because of the lack of art - the lack of even heat. (AIDS Society for Asia and the Pacific, 1998)

2. Barriers to health promotion: what is stopping us?

Over the last decade, the international community has gathered countless examples of best practice in the promotion of health, yet many of these achievements have not been replicated in a systematic way. Studies have shown that unless the political, social, economic and cultural climate of a country is conducive to reform, local success stories are unlikely to be scaled up to nation-wide transformations (World Bank, 1998).

In this section, we briefly look at some of the political, social, cultural and economic obstacles that have overtly or covertly blocked progress towards “Health for All”. A better understanding of these obstacles is essential to develop the boldness, courage, imagination and even cunning needed to overcome them.

Key barriers have been, and continue to be, the vested interests of the political, business, medical and academic establishments. As noted by Holland and Steward, given that the determinants for health are inextricably linked to political, social and economic realities, their identification is likely to clash with the interests of one group or another (1988:206). Further they say that when the group that is being antagonised is in a position of political and/or economic power, the protection of their interests often takes priority over the improvement of population health.

The promotion of population health requires a redistribution of resources, both within the health sector and in other sectors. The underpinning philosophy of the Health for All movement requires that less costly and more comprehensive services be provided to a much greater percentage of the population. It also requires the provision of equitable access to these services – measures often unpopular among politicians, the medical profession and urban elites, who resist the erosion of public subsidies for health services; and even among health workers who may not want to relocate to rural areas (Birdsall & Hecht, 1992:10).

Despite the fact that there need be no trade off between equity and efficiency in the provision of primary health care, governments persist in patterns of spending for the few and the rich. They continue to erect large hospitals simply because they are visible and popular and thus very useful vehicles to secure votes. Therefore, even though the current patterns of spending are further entrenching existing gaps with regard to access to health, they are maintained in order to better serve those with political power and influence (Birdsall, 1992: 166).
This is compounded by the fact that the demand for the promotion of health is not as easily discernible as the demand for health services. There is no spontaneous waiting list or queue for population health. As Musgrove points out, ‘ignorance is particularly likely to cause a mismatch between need and demand on preventive services, where the need does not depend on being already sick or hurt’ (1995: 3). There is, therefore, no popular pressure to urge politicians to incorporate such issues in the political agenda. And the result is an infrastructure for illness rather than an infrastructure for health.

Most countries are faced with an infrastructure that provides for the affluent members of society and which cannot be accessed by those who have less and are often in greater need of such infrastructure. This is a variation of Tudor Hart’s Inverse Care Law (Tudor Hart 1971, Green & Kreuter, 1999). The promotion of Health for All requires a reversal of this law, so that policies, investments, resources, people, institutions and status are oriented to those with the least rather than those with the most.

As outlined above, this reorientation is difficult for it may require a major confrontation with the political system of the day. In addition, redistribution of health services will almost certainly result in clashes with the medical profession. Medical and nursing training is increasingly biased against primary care and population health (Konner, 1993), yet inappropriately trained medical and nursing staff often end up in positions that determine population health planning (WHO, 1988:28-29) and resource allocation. Thus, by virtue of the predominant culture within medicine (laboratory research and treatment over prevention and promotion) and the interests of the pharmaceutical industry, attempts to reorient or invest new resources into the promotion of public health are frustrated.

In many countries, even academia is against population health. As the reviewers of progress toward “Health for All” remarked 12 years ago, [some] universities are ‘simply aloof from efforts to extend services to the under-served. [T]hey scoff at subjects that carry the terminology of prevention and equity, and are more centres of scepticism and cynicism about Health for All than points of sparkling leadership to deal with national problems’ (WHO, 1988:56).

A fourth group that continues to obstruct the promotion of health, is that comprised by some sections of the private sector –such as the tobacco and alcohol industries- whose lobbying power outweighs that of the health sector. Effective health promotion requires governments to regulate, control and even ban the activities of some very powerful industries. Yet governments are often rendered toothless when such industries are donating significant amounts to political parties, employing large numbers of people, and selling goods that provide taxes on which governments may become very dependent.

Culture has proven to be a complicated and, at times convenient, barrier to the efficient implementation of measures to promote health. This has and continues to be the case for issues such as HIV/AIDS, reproductive health and girls and women’s health. In many countries, the major roadblocks are those that prevent female education and participation outside the household and discriminate against women with regard to nutrition, medical care and schooling (Mechanic, 1992).

Inequity itself is also a powerful promoter of the status quo. As mentioned above, the Inverse Care Law results in situations whereby those with the least economic resources are
marginalised by policy, by lack of access to services and preventive measures – such as education for girls and women (Caldwell, 1986).

Finally, one of the major blocks is the lack of appropriate skills of those charged with the promotion of public health. In general, we lack the political experience and the advocacy skills to push public health into the ‘main game’ and to have health valued by political leaders and decision makers, not to mention the skills and culture to plan, organise and implement effectively.

This section has provided a very brief overview of the most salient obstacles for the attainment of Health for All. Please note that this is not an exhaustive list of all barriers, and that the omission of financial resources as a main obstacle to promote health is intentional, as this paper tries to suggest that many untapped resources are already within reach.

3. Looking, learning and partnering: achieving the best results with existing infrastructure

In this section, we examine some of the infrastructures that can be used to support each of the central elements of health promotion. We also provide ideas and examples of how these can be utilised. It is our contention that, in many cases, those entrusted with the promotion of health need to make better use of existing structures, firstly by identifying the potential of such structures, and secondly by adopting creative approaches that will bring other sectors into mutually beneficial partnerships.

In identifying, and expanding on existing infrastructures or building new infrastructures it is important to answer two questions

Are the infrastructures equitably distributed?
Are the actions of the infrastructure equitably distributed?

The case study “The Equity Gauge project” which establishes a set of benchmarks by which progress towards equity in health and health care provision can be monitored over time, can give ideas on how to usefully apply these two questions (Equity Gauge 2000).

3.1 Including the art into health training

The training of the public health workforce, including the nursing and medical workforce, needs to be radically reoriented to include the art of promoting health as well as the science. This is so they can both understand and start to overcome some of the political, social and cultural barriers discussed in the previous section. This reorientation is also needed in the training of those directly or indirectly involved in promoting health, and in other sectors such as local government, law, education, business, sport, arts, transport and religion.

As a result of these changes, undergraduate and postgraduate courses and in-service training would include coalition building and partnership skills, campaign and advocacy skills, listening and negotiation skills, as well as presentation and communication skills. Management training would also be incorporated into the public health curriculum, so that performance management and support, professional development, rewards and acknowledgement become the norm rather than the exception in health promotion. In short, this reorientation recognises
that an excellent knowledge of disease prevention, for example, is simply not enough for effective health promotion.

The global battle against tobacco smoking clearly illustrates this point. The network of anti-tobacco groups that has been set up to fight the power of the tobacco companies, is an example of effective campaigning, media advocacy and coalition building across the globe. Whilst a thorough understanding of the harmful effects of smoking is necessary to substantiate the network’s arguments, it is simply not enough. The words of Prof. Stan Glantz, one of the champions of the anti-tobacco movement, clearly illustrate that the issue of tobacco control is unequivocally in the political domain:

"The tobacco industry is the disease vector for heart disease and cancer. To control any disease you need to understand how it is spread. The difference between the tobacco industry and malaria is that mosquitoes don’t make campaign contributions and hire public relations firms." (Glantz quoted in Levy, 1995)

To implement this reorientation, we need not set up new schools of health promotion. Rather, what is needed is a central body (such as a national public health research and education committee) charged with the responsibility of overhauling existing schools of medicine, public health, and nursing to produce a new generation of professionals-cum-activists who understand how governmental, social and cultural systems work, and how they can be used to promote health, rather than diminish it.

3.2 Improving Community Capacity

Successful community capacity depends on the existence of forums, groups or associations where people can come together, develop common purposes, support each other and catalyse wider action and influence. These include self-help support groups (such as people living with AIDS), religious groups, youth groups, credit co-operatives, women’s groups, health committees, service clubs and industry groups (such as farmers’ groups or manufacturing workplaces).

How do these groups emerge? Why do some take root and spread while others wither on the vine? Let us take Jamkhed for example (Arole & Arole, 1994). It is a well known primary health care project among very poor rural villages in Maharashtra, India. It began in 1970 and has seen infant mortality rates drop from 176 to 19 per 1000 births in poor and marginalised communities.

Jamkhed, like many other successful community health projects, began with inspired ideas, based on the principles of equity and social justice, espoused by persuasive, forceful and, in this case, humble, patient and persistent leaders. They had the skills to build confidence in others, namely, among the 250,000 villagers who became participants and leaders in the project, and among national and international agencies who became supporters. The project has encouraged the acquisition of new skills and knowledge among the poorest villagers, and has fostered the development of a common purpose and common values. The gathering of accurate and relevant information constitutes the project’s backbone, and the data obtained has been used to identify what needs to be done as well as to demonstrate progress. The data is

\[2\] Approaches to learning these skills are already being developed in a broader context by the School for Social Entrepreneurs in the United Kingdom (see website of the School of Social Entrepreneurs - www.see.org.uk)
owned by those who need it most and to whom it is most relevant: the communities themselves.

Determined and committed leadership, and the empowerment of those whom the work targets, are, therefore, the essential ingredients to develop community capacity. Even though the inception of such groups primarily responds to grass-root needs and motivations, there are a number of measures that could be adopted at a national, provincial and/or local level that would facilitate the formation and effective functioning of such groups. Firstly, authorities can systematically recognise and promote the work of outstanding community leaders and public health champions through the establishment of award programmes and scholarships. Secondly, policy-makers can include community consultation and participation into different areas of the policy-making process. For example, community consultation should constitute an integral part of the funding agreements between the national budgetary authorities and the provincial governments and local councils. Thirdly, they can fund expansions of their programmes!

Critical questions remain unanswered. How can planners and decision-makers learn to trust such groups and appreciate the contribution that they can make? How can we encourage government officials to promote the participation of communities and the development of shared purposes, such as the Jamkheds of this world?

3.3 Making full use of existing channels to influence policy

Important as it is to create new and dedicated infrastructures to develop policy, regulation and legislation that support good health\(^3\), it is vital to take maximum advantage of the existing capacity, organisations and skills both inside but particularly outside the heath sector.

Existing capacity can be found within government departments, within academic institutions and in non-government organisations. The most successful policy is usually brought about by a coalition of like-minded organisations and individuals, with a blend of analytic, planning, advocacy and communications skills, who are prepared to play politics to get health "into the main game"\(^4\). Timing, vision and leverage are crucial at the policy-making level. Once an opportunity arises, it is necessary to have immediate access to evidence to solidify an argument, and if the opportunity is missed it is often lost to a more insistent lobbyist, department or ministry (WHO, 1988: 26).

Similarly, we need to identify the main players in the game and understand their motivation. For example, in tobacco or alcohol policies different departments within the same government (such as treasury, or business and industry, or labour and employment) may have different views and their interests may conflict with those of the health sector. Acknowledging, and working with and around these differences becomes part of the real art of health promotion.

One of the potentially most fruitful areas to focus on is economic and fiscal policy, for it has a wide-reaching influence on all other sectors. Financial incentives have very powerful effects on

\(^3\) For an analysis of infrastructures dedicated to the promotion of health please see section 4

\(^4\) Take for example the Surface Transportation Policy Project, based in Washington DC. It is a privately funded broad coalition of community groups. Over the last ten years, though careful planning, campaign and advocacy work, it has been a major driver in changing US policy from one of huge road and automobile dependence, to one that is much healthier, based on improving public transport, revitalisation of inner urban areas, and provision of exercise and bicycling facilities. For further information see [www.transact.org](http://www.transact.org) or [www.tea21.org](http://www.tea21.org).
individual and collective behaviour and, used positively, can encourage many other sectors to invest in health promoting measures.

One example comes from Peru where, until recently, television companies who donated free time for health promotion messages were charged a tax of 18 percent of the normal cost of that free time. This acted as a considerable disincentive to give air-time to promote healthy living. After fierce lobbying from the communications industry, which wanted to set up a campaign to cut drug abuse among young Peruvians, the tax was dropped. Soon after that, the health promoting campaign against drugs booked more TV time than any other advertising campaign for any product in Peru’s history.

The law is a powerful modifier of collective and individual behaviour, and is another channel that could be more effectively utilised by promoters of health. Legal policy can provide an avenue for pressing for greater equity in health. Human rights legislation may be used to challenge discrimination in the workplace or to press for better access to resources or services for marginalised groups. It can protect the rights of children, women and other groups divorced from the levers of power, for example by ensuring girls equal access to schooling.

In recent times this avenue has been used most extensively in HIV anti-discrimination legislation, achieved by working with local human rights lawyers, human rights watch groups and government legislators (UNAIDS/IPU, 1999).

Another interesting development with regard to the use of policy in the advancement of health, is a South African initiative which illustrates the need to not only develop new policy, but to also develop the capacity to monitor the effects of existing policies. The Equity Gauge Project in South Africa was set up to develop benchmarks to measure progress toward equity in health and health care. The findings are then “re-invested” into the policy-making wheel and are used to inform resource allocation and budgeting.

3.4 Establish Strong Partnerships to Maximise Research Capacity

Once again, whilst the existence of dedicated infrastructures to conduct and co-ordinate research to inform the actions of those who promote health is our ultimate goal, much could be accomplished by strategically using existing resources to access essential data, and learning to work with and influence the culture of the research community.

With regard to access to information, in almost every country, there are several existing sources of data that, if properly analysed and packaged, serve many of the needs of health promotion (see Table 1). In order to access these data, effective working partnerships must be created with the "owners" of the information, remembering that, like with all partnerships, cooperation must be mutually beneficial.

[^5]: It is nevertheless important to ensure, as far as possible, that the data is accurate, as the analysis of bad data can be damaging in the long term.
Table 1: Sources of information for use in promoting health

<table>
<thead>
<tr>
<th>Source of data</th>
<th>Type of information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surveillance systems</td>
<td>Patterns of disease and ill-health</td>
</tr>
<tr>
<td>Health information systems</td>
<td>Service use, morbidity, mortality, distribution and consumption of health commodities</td>
</tr>
<tr>
<td>Behavioural surveys</td>
<td>Patterns of risk behaviour, perceptions of health and illness</td>
</tr>
<tr>
<td>Economic statistics</td>
<td>Living conditions, areas of vulnerability, expenditure</td>
</tr>
<tr>
<td>Customs and excise</td>
<td>Tobacco and alcohol consumption</td>
</tr>
<tr>
<td>Police</td>
<td>Illegal drug use, domestic violence, traffic accidents</td>
</tr>
<tr>
<td>Market research firms</td>
<td>Consumption, media exposure, attitudes, practices</td>
</tr>
<tr>
<td>Academic research</td>
<td>Various (e.g. social determinants of health, behavioural surveys, economic analyses etc)</td>
</tr>
<tr>
<td>Insurance industry</td>
<td>Morbidity, health care consumption, accident exposure</td>
</tr>
<tr>
<td>Corporate industry</td>
<td>Consumption, distribution systems, occupational health</td>
</tr>
</tbody>
</table>

A well-informed health promotion intervention will be based on good evidence which often requires inter-sectoral research. A lot of useful research is already available and simply needs to be collated, thus establishing strong links with researchers from varying disciplines is a first necessary step.

In order to ensure that research is turned into action, it is imperative to cultivate the relationship between the academic community and policy-makers. This relationship must begin by an acknowledgement of the fact that researchers and government officials belong to two very distinct cultures, followed by a development of shared perceptions and a recognition of the value of each culture’s respective role (Murthy quoted in Chen, 1992: 213).

Of equal importance is the establishment of links between researchers and practitioners. This partnership will provide the practitioners with quality information as well as access to a machinery (e.g. universities and research institutes) that is best equipped to monitor and evaluate the impact of intervention or provide training in self-evaluation. As a result of this cooperation, researchers will gain first hand information about the community and the effects of intervention, which will in turn enable them to tailor future research to the needs of the community (Findley, 1992:15). The ultimate goal is for research to be informed by practice, and for practice to be informed by research. Monitoring and evaluation are crucial to successful efforts to promote health. Building infrastructure to provide evidence is a key factor in determining the sustainability of a programme. Without good evidence of effectiveness, most health promotion programmes, regardless of how good they are, tend to lose support both from those implementing the programme as well as those providing the funding.

3.5 Communicating better

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6 An excellent example of the link between practitioner and researcher is the relationship between the Centre for Behavioural Research in Cancer (CBRC) and the Anti Cancer Council of Victoria, (ACCV) Australia. The research, monitoring and evaluation done by CBRC has been the foundation of ACCV’s progress in such areas as tobacco control and skin cancer prevention, and in turn the research that is carried out is strongly influenced by the needs of the practitioners. For further information see Lancet, Vol 354, October 2, 1999:1186 or see their website: www.accv.org.au

7 The exception to this rule are programmes driven by other forces, often political, such as the so-called zero tolerance approach to illicit drugs.
The right to information is both a fundamental human right and a cornerstone in the promotion of good health. The challenge in most countries is not the lack of infrastructure but more the appreciation of which blend of the current infrastructure to use, and how to use it.

Communications channels include "old" technology mass media such as radio, print and television and "new" technology, such as the internet, as well as a whole range of formal and informal channels through religious organisations, women's organisations, professional associations, schools and workplaces, to name the most obvious.

The challenge is to make better use of the systems that exist, given that expertise in these areas is rare within the health sector8. Getting to know key people within the communications sector (be it 'modern' or 'traditional') who are sympathetic to health issues is crucial to working out how best to disseminate information.

The best understood communications infrastructure is the mass media. Radio, television and the print media can carry messages to vast numbers of people almost instantaneously. Those messages can be direct, in the form of information campaigns using dedicated media space. Or they can be diffused through the regular content of the print and broadcast media. Editorials and news articles, soap operas, films, pop-songs, chat shows, documentaries – all can carry messages promoting healthy living and shaping the attitudes that in turn shape people’s lives9.

Two recent and successful examples of the potential for capitalising on television audiences are the soap operas Soul City (South Africa) and Wind Blows Through Light and Dark (Viet Nam). Both have contributed to demystifying AIDS, reducing the stigma that surrounds it and promoting public discussion around the issue of safe sex. Soul City has addressed many other issues besides HIV, and combines serious research and consultation with communities and governments, with real technical expertise in television drama.

Finally the advertising industry, which exists to shape attitudes and consumption behaviour, can also be a powerful partner in communications10.

3.6 Working with and through other sectors

While many sectors may have a peripheral interest in physical and mental health, most do not see it as their central mandate. The transport sector is concerned with shifting people and goods around in an efficient way, the education sector seeks to create a literate population able to meet the challenges of the future, the private sector aims to meet its customers' needs in ways that maximise returns to shareholders, the sporting sector aims to train first-class athletes and win matches.

And yet all of these sectors can make a valuable contribution to the promotion of health. The art of successful partnerships with other industries is to find out how health promotion goals best overlap with the goals and mandates of a specific sector. We have to be able to work out

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8 For the most comprehensive listing of communications initiatives in health see the Communications Initiative's 'Drum Beat' and 'Media Beat' on their website www.comminit.com
10 Please refer to page 8 for an example of successful use of advertising to promote health in Peru.
'what is in it for them'. Other sectors will be prepared to work towards goals they see as central
to their own mandate. No company or institution, on the other hand, is likely to take on health
promoting work if it does not perceive any direct benefit from the partnership. Once again,
successful partnerships depend on shared goals.

The onus is on “selling” these shared goals to other sectors, making it clear how activities that
contribute to their “core mandate” can simultaneously promote healthier living. This invariably
means speaking in the language of the sector or institution in question – “rights” language
might be used in forging partnerships with development NGOs, while the language of cost-
effectiveness and the bottom line will be more appropriate to private enterprise. Again, there is
much to learn from lobbyists in other fields in terms of forging successful alliances with
different partners.

While most sectors have something to contribute to the advancement of health, some have
obvious advantages. It is wise to start with the sectors where the impact is likely to be the
greatest. Education, transport, business and industry, urban planning and infrastructure,
defence, police, prisons, environment, labour and employment provide obvious entry points to
other sectors.

The education system provides perhaps the single most important structure for the early
promotion of health. Much of this can be integrated into regular curricula around health, well-
being, family life and so on.

In addition, the promotion of health in schools has moved beyond simply integrating health
issues into the curricula to understanding that the way schools are run and organised can have
a profound effect on improving the health of their students (and teachers). The Health
Promoting Schools movement is founded on the philosophy that interconnects curriculum
development, teaching and learning with the school’s organisation, ethos and environment, and
with partnerships and services in the wider community (WHO 1997, Patton et al, 2000)

The education system is also a consumer of teaching materials. Opportunistic health
promoters are able to provide materials on health promoting themes for adult literacy
campaigns, youth skills programmes and more. For example, clever health promotion
professionals may use language-teaching programmes for senior bureaucrats as a “back door”
for materials on healthy public policy.

Sports and the arts are two other sectors which have great potential for promoting better
health. They, in a sense, have been the fundamental raison d’être of health promotion
foundations such as VicHealth and Healthway in Australia11. Both were established by creating
a new hypothecated tax on cigarettes and creating an independent statutory authority to
replace tobacco sponsorship in the sports and the arts with health promotion messages such
as smoking cessation, nutrition, exercise and skin cancer prevention. The funds created by the
new tax were also invested in health promotion research and health promotion in schools,
local government, business and the health sector.

These sponsorship strategies which were initially financed by a hypothecated tax on cigarettes
(see Section 4), have matured from simply replacing one message with another to a more

11 For further information see the Volume 3, No 1 issue of the Health Promotion Journal of Australia, 1993,
which is entirely devoted to Health Promotion Foundations.
sophisticated partnership with the sport sector. Outcomes now include message delivery, access to sporting and arts role models for health promotion, changing the environments of the sporting clubs and arts venues to become smoke-free, encourage responsible alcohol consumption and serve healthy food. The next evolution of the partnership is to recognise the strong social role that sport and arts play in contemporary culture and to promote projects that focus on developing social connectedness and good mental health in the poorest sections of the community.

Business and industry are increasingly better understood by those interested in promoting health. Several industries have a direct impact on the physical environment of local communities and sometimes even the globe. Mining, pulp and paper production and the fossil fuel industries are obvious examples. Increasingly, companies in these industries are investing in environmental initiatives, often to establish their credentials among consumers as good corporate citizens.

But industry and commerce affect health and welfare in other ways. Perhaps most importantly, industry and commerce are major sources of employment, which determine the resources people have at their disposal when making choices about their lives and their health. People may be directly exposed to risk of physical and mental ill-health through their work. The workplace may equally provide opportunities for reinforcing healthy living. Many companies have come to see their workforce as an important investment and, as a result, they are prepared to spend money maintaining the physical and mental health of that investment. In some countries, healthy workplace initiatives have generated peer pressure within the private sector, with companies competing for qualified staff partly on the basis of the healthy working environments they offer.

Selling health promotion to business is not easy, and has to be done in a language and style that business people will understand. The experience that UNAIDS has documented in relation to HIV prevention and business sector is well worth looking at. (UNAIDS 1998)

Other sectors such as the communications sector12, the insurance industry13 can also be very influential partners in the promotion of health.

We conclude this section with a word of caution. Despite their fine rhetoric about working with different sectors and partners, it is often the international agencies, be they UN agencies or bilateral aid agencies who find real difficulty in leading by example, and they often actually exacerbate inter-sectoral division within governments rather than reduce it. The work of UNAIDS, which is based on constructive collaboration among the UN family on the issue of AIDS, has been hampered at all levels by a lack of skills and willingness of the UN partners to see beyond their own organisational or sectoral advantage.

### 3.7 Reorienting Illness Care Services

As stated earlier, infrastructure for illness predominates over infrastructure for health. So it seems sensible to work with the illness care services (including primary health care services) to ensure they are given clearly defined responsibilities for contributions to promotion of health.

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12 See page 10
13 See page 19
This issue is explored in more detail in the technical paper on ‘reorienting health systems and services with health promotion criteria’ by D. Lopez-Acuna et al (2000).

Let us take hospitals as an example. It is important to understand that the incorporation of health promotion within the mandate of a hospital does not detract from, but rather it complements, its main function as a curative institution (Berger et al 1999). Hospitals have at least four roles, namely to serve patients, as a workplace, as centres of health knowledge and finally as organisations with their own policies, rules and so on. (WHO 2000). Much can be done to promote health in each of these areas. Working to improve patient services can include developing a charter for patients’ rights, patient satisfaction surveys, health education services and patient support services. To ensure that the hospital is a healthy workplace safety audits can be undertaken, staff health surveys, programmes to improve the physical environment and improving staff nutrition and food safety. To become involved with the community hospitals can initiate health campaigns, provide health education services to the community, and can reach out to those who are most disadvantaged. The reorientation of hospitals to promote health will not occur until management and staff are reoriented - staff become aware of health and value it, and the hospital functions in a way that empowers those that work in it. (WHO 2000)

4. Dedicated infrastructures for the promotion of health

In this section, we present options for infrastructures that act as catalysts and drivers for the promotion of good health. Although there is always debate as to what are the most effective infrastructures, and where they should be located, there is a very high level of agreement for the need for, and advantages of, having dedicated 'driving forces' both inside and outside government to promote health.

This section describes some of the institutions that can promote health over the long term. It should be stressed that it is not necessary (or even desirable) for a country to build up all of these institutions simultaneously. A careful analysis of existing structures, government capacity, human capacity, resources and priority needs must precede any expansion of the health promotion infrastructure.

The appropriate mix of institutions will vary according to needs and resources. Each of the components of the system has different strengths: some may have a comparative advantage in the collation and use of information for health promotion, others in increasing political commitment and funding for health promotion. Some will do especially well in developing partnerships for service delivery, others in reducing inequity by supporting the needs of marginalised communities. Still other structures, particularly networks, will support health promotion professionals working across all of these fields.

Whilst the structures themselves are important, the functions they carry out must justify their existence. This point cannot be over-emphasised, for the existence of any given structure in name only or without the necessary resources in terms of funds, skills or personnel can retard good health, rather than promote it!
Possible institutions discussed here include:

- A directorate for health promotion in the health ministry
- A public health research council
- Inter-sectoral organisations for health promotion
- A commissioner for public health
- Independent health promotion institutions, publicly and privately funded
- Insurance industry programmes
- Issues-based health promotion organisations
- Associations and networks of health promotion professionals

### 4.1 Government-led Structures to Promote Health

Governments have significant influence over health policy even in countries where the majority of services are privately delivered. Strong support for health promotion within government can make it easier to construct the partnerships that are needed across sectors to further the interests of community health.

Government agencies have a special responsibility to ensure that national health promotion activities reach the poorest and most disadvantaged. In truth, however, some groups are marginalised precisely because government is ill-equipped to reach them or meet their needs. In these cases, government may support the reduction of inequity indirectly by funding non-government organisations that are better equipped to promote health and well being among the disadvantaged.

It became clear from the feedback during the Fifth Global Conference on Health Promotion that any investments in dedicated infrastructure must be accompanied by explicit commitments that the infrastructure serves the community, and does not become self-serving. This may seem obvious, but experience tells us that it is often easier said than done. One mechanism to assist this is to ensure regular movement and exchange of staff between government and non-government sectors, be this at the international, national or local government level.

It would also seem obvious that the infrastructures that are set up to support promotion of health, should actually be health promoting themselves. The fact that in general we do not practice what we preach should provide some motivation for leaders and managers in health promotion to reflect on, and change, the way their organisations work.

#### 4.1.1 Directorate for health promotion

Government leadership in health promotion is best provided by a dedicated, highly-placed unit within the Ministry of Health. This unit must have enough power to provide continuity and keep health promotion high on the agenda, even when sections of the medical profession, consumers and the pharmaceutical industry continue to lobby for more spending on curative services. As we have mentioned before, it is vital that advocacy, communication and partnership skills become part of the culture of the unit. This group must develop the capacity to work with and through other parts of the health sector as well as other sectors in society.
As health systems are decentralised, it becomes increasingly important that professionals with interest and skills in promoting health work at the provincial and district level, where they are better able to support local communities in defining and addressing issues that affect their health and well-being. A model which twins a National Health Promotion Directorate within the ministry of health with designated health promotion co-ordinators in every province has been developed by South Africa. The Health Promotion Directorate has a dedicated budget for health promotion activities and has provided significant leadership in re-orientating health services, stressing the importance of tackling the social roots of health issues such as violence.

A health promotion directorate will typically take the lead in national needs assessment and strategic planning for health promotion as well as securing funding for priority health promotion structures and initiatives, and building human capacity for health promotion.

Given that most health ministries continue to be structured around vertical, disease-specific programmes, the health promotion directorate should support programmes moving towards interventions that consider the wider lifestyle, psychosocial, economic and cultural determinants of health. An example of such structure is the Estonian Centre for Health Education and Promotion.

4.1.2 Public Health Research Council

Other structures need to be put into place to direct various aspects of the national health promotion agenda. National governments have the responsibility to develop national capacity in research and education in health promotion and public health. This can be done through a national public health research and education council, which could in turn be part of a national medical or social science research council.

To be effective, the authors suggest these councils have to:

- Clearly define priorities for research and education
- Establish how to build capacity that is multi-disciplinary (e.g. through centres of excellence)
- Build capacity across research and education groups, and ensure they are tightly linked to practitioners and decision makers
- Monitor and support international collaborations
- Recognise and support key researchers and educators
- Prevent key researchers and educators from being 'poached' by richer nations

4.1.3 Inter-sectoral organisations for health promotion

Recognising that almost every sector has an impact on the physical and mental well-being of the population, some countries have formed inter-sectoral organisations for health promotion. Often formed under the leadership of the Ministry of Health, these institutions usually include representatives from other ministries including (but not limited to) justice, education, labour and local government. Professional associations, private sector and other non-government organisations are usually also represented.

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14 See the Estonian Centre's website www.tervis.ee/etk/etk(eng).html
Fiji, for example, created a National Health Promotion Council in 1997. FijiHealth, as the council is known, includes members from 10 ministries and representatives from employers, workers and consumers unions. A host of other sectors are also represented – religious, medical, academic, voluntary and sporting, to name but a few.

Although not in health promotion specifically HIV/AIDS programmes in Uganda and Thailand (generally viewed as the most effective programmes in developing countries) have both had supra-ministerial, inter-sectoral organisations to direct their programmes in the formative years of their national responses.

4.1.4 An office of the commissioner for public health

In some countries, a commissioner for public health (sometimes an ombudsman or surgeon general) is able to provide strong leadership around population health issues. A high-profile commissioner for public health can provide a focal point for national debate around healthy living, and can influence senior government peers to tackle priority issues.

This institution is especially worthwhile where advocacy and policy-development are important priorities in expanding health promotion in a country. In the United States, for example, the Surgeon General has been instrumental in promoting epidemiological evidence as a basis for decision-making in public health, in the face of often strong opposition from religious or industry groups.

4.2 Independent Structures to Promote Health

Government-led health promotion structures can provide vital political leadership for efforts to influence the environments which dictate the choices people make about their lives and their health. However, many of the goals of health promotion are long-term, and some are controversial. As discussed earlier political and other priorities often limit the ability of governments openly to tackle threats to health and well-being head-on.

One solution is for governments to work in partnership with independent institutions, institutions that are insulated from short-term political priorities and are able to maintain continuity over time. This is especially important where issues of equity are at stake: marginalised groups are rarely major sources of votes, so there is little political pressure to support the health and well-being of these groups.

Independent or autonomous institutions may well be funded completely or in part with government money. Although this should not compromise their ability to work consistently towards long-term outcomes even in the face of changes in political priorities, it sometimes does. Nevertheless, in general, organisations outside government can react more quickly to emerging needs, can work on politically sensitive issues, and can work with communities that are beyond the reach of government structures. What follows is a description of some such institutions.

4.2.1 Independent, publicly funded health promotion institutions

In an increasing number of countries, health promotion foundations that are constitutionally independent from government, but that are funded in whole or in part by public money, are
emerging. The independence of these bodies can be guaranteed in the institution’s statutes and by broad representation on their board of directors.

There are a wide variety of funding mechanisms. The Swiss Health Promotion Foundation is funded by a surcharge of SFr 2.40 (US$ 1.6) on every individual’s health insurance payments. Since virtually everyone in Switzerland has health insurance, this adds up to an annual budget for the Foundation in the order of SFr 16 million (US$ 10.5 million).

The Austrian Health Promotion Foundation, in contrast, is funded by a direct treasury allocation of some ASch 100 million (US$ 7.3 million) a year. The fund answers to a board whose membership includes four ministries, the medical and insurance industries, and representatives of regional and local government. The use of funds is dictated by the charter of the foundation rather than by political priorities. Around half goes to support innovative projects that aim to influence the environment in which people make decisions about their health and lifestyles. The foundation leverages its money by insisting that all the projects it supports attract co-funding from other sources. It also funds research and the development of structures to support health promotion.

Other countries have yet other models. The Thai cabinet recently endorsed a bill establishing a statutory health promotion body, Thaihealth, attached to the influential Office of the Prime Minister. Two percent of tobacco and alcohol taxes will be earmarked to fund the foundation, giving it a budget of up to US$ 40 million annually.

In Australia and New Zealand, similar models have operated successfully for some time. Healthway and VicHealth are two state based foundations which were founded with the specific aim of buying tobacco sponsorship out of sports and the arts, and replacing it with sponsorship that promoted healthier living. In Victoria, an extra seven percent was added to the tax on cigarettes, and that new money – about A$ 25 million a year (US$16 million) was provided to the foundation.

It is worth mentioning, however that the use of a “sin tax” on unhealthy products to promote health has sometimes proven controversial. Using their inimitable skills of deception, cigarette companies have turned the tax to their advantage in some Latin American countries, claiming that every packet of cigarettes sold contributes to promoting health and welfare.

While all of these institutions share some characteristics, their working methods differ. Some act largely as funding bodies for groups and agencies working to promote health and well-being in priority areas. Others are involved in implementing key initiatives themselves, while still others concentrate on advocacy and public information.16

The success of independent, publicly funded institutions depends partly on strong leadership, a productive relationship with government and good networking skills. A diverse governing board representing the interests of beneficiary communities as well as potential partners in the private sector, government and other key sectors can be critical in ensuring that the health

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15 For further information see Healthway’s website [www.healthway.wa.gov.au](http://www.healthway.wa.gov.au) or VicHealth’s website [www.vichealth.vic.gov.au](http://www.vichealth.vic.gov.au)

16 For information on how to set up a foundation see or VicHealth’s website [www.vichealth.vic.gov.au](http://www.vichealth.vic.gov.au)
promotion foundation fulfils its role in identifying synergies and accessing the infrastructure of other sectors.

4.2.2 Non-government health promotion institutions

The NGO sector has a significant role to play in health promotion, especially in tackling inequity. Many nongovernmental organisations (NGOs) have long experience of working with marginalised and disadvantaged populations. Many also have a clear view of the intimate links between health status and broader development issues. They are therefore well placed to push forward the integrated efforts to develop people’s resources, capacities, health and well-being that will become a cornerstone of health promotion in years to come.

The structures of NGOs vary too widely to allow them to be described here, although many are at least partly voluntary in nature and some rely on funding from international or bi-lateral agencies. It is worth noting that NGOs that support communities in defining and coping with their own health and development needs tend to have more long-term success in health promotion than organisations that simply deliver a package of health-related services.

Privately-funded health promotion foundations occupy a significant niche in the structure of the “health promotion industry” in many countries. Many of these concentrate their efforts on neglected areas of public policy, often giving grants to support activities at the community level. The U.S.-based Robert Wood Johnson Foundation, for example, currently spends some US$ 360 million a year to support research and projects at the community level in areas such as access to affordable health care for the poor and the prevention and mitigation of substance abuse.

4.2.3 Insurance industry programmes

Insurance companies, whose contributors pick up the bill for ill health and death benefits in many developed economies, have every interest in reducing exposure to the determinants of ill health. They can be powerful partners in promoting greater health and welfare, for example by offering lower premiums to companies that actively promote physical and mental health in the workplace. As HIV strengthens its grip on the South African workforce, insurance companies are searching for ways to meet the healthcare needs of policy-holders without discriminating against those who are HIV positive – a group commonly excluded from health insurance policies in the past. New “no-test, capped benefits” policies ensure that people with HIV will be able to afford a combination of at least two drugs that will help slow viral replication.

Another interesting example is found in the car insurance industry. In Victoria, motor accident personal injury insurance is a monopoly business in the hands of the Transport Accident Commission (TAC). The TAC believed that if it could bring down the comparatively high rates of road accidents, it would not only save lives, it would also save money.

Information campaigns alone had made little difference to road safety. At the end of the 1980s, over 700 people were dying on Victoria’s roads every year. Research showed that the major causes of accidents were speed, alcohol and fatigue. So the police, assisted by TAC, invested in more radar and alcohol testing equipment, and implemented tough measures designed to reduce speeding and drunk driving. These enforcement services were backed up by safer roads, community road safety groups, legislation requiring mandatory wearing of seat
belts, at the same time as an extremely graphic mass media campaign warning of the consequences of dangerous driving (as mentioned earlier, strong partnerships with the media are very powerful).

The results were dramatic. Road deaths fell from a peak of 776 in 1989 to 548 a year later, and less than 400 several years later to stabilise at around half of the levels seen a decade ago. The accident prevention programmes currently costs TAC some A$ 24 million (US$ 15 million) a year. The company estimates that it has saved about A$ 1.2 billion (US$ 750 million) in payments to accident victims and their families in the nine years since the campaign begun, and has saved approximately A$4 billion in total costs to the community. Third party insurance premiums have been cut, and are now among the lowest in Australia.

This model has recently been adapted by the South African state of KwaZulu Natal, where over 20 people die each year for every 10,000 vehicles registered (compared with just over 1 per 10,000 vehicles in Victoria). The programme is in its infancy but the results so far have been impressive. Road deaths have fallen by 14 percent in just the first year of the programme17.

4.2.4 Issues-based groups

Many health promotion organisations have been set up around a single health issue, and more commonly still around a single disease. Many countries have dedicated bodies working on issues around cancer, HIV and AIDS, asthma, obesity, or malaria. They typically work to increase awareness of the issue, to promote prevention, to conduct research and to access resources. They can act very successfully as clearing houses for information, planning and experience between different practitioners in that single field.

Beyond the narrow confines of disease, foundations and other bodies exist in an extremely wide range of areas which have an impact on people’s lifestyles, health and well-being. Such bodies may lobby for more public transport, promote sports in slums, or work to increase access to credit for women in rural areas. Their work should be recognised as health promoting and they should be included in the structures which support health promotion.

4.3 Networks and professional associations

Health promotion can not and should not be a centralised endeavour. It is, however, highly recommended that there be some central body that brings together the myriad institutions and professionals working to promote health and well-being.

4.3.1 Associations of professionals working in health promotion

Health promotion is one of the least regulated and most-decentralised areas of health. While this has its advantages, it does mean that professionals in the area do not generally speak with a strong voice. A professional association of health promoters can fill that gap, lobbying with government for a higher profile and more resources for health promotion, encouraging the restructuring of the health industry away from the treatment of ill health and towards the promotion of good health. A professional association can also contribute to workforce

17 For detailed information and up-to-date statistics on the impact of the Victorian strategy to reduce road accidents please refer to the TAC website (www.tac.vic.gov.au)
development and oversee professional and ethical standards in health promotion. A journal may be of great use in sharing expertise.

4.3.2 Health promotion networks and support services

While many existing health promotion institutions concentrate on a single issue, it is increasingly clear that the roots of many health problems are shared – poverty, marginalisation, commercial or peer pressure favouring poor lifestyle choices.

To maximise synergy and minimise overlap, a forum that allows for the sharing of research, experience and lessons is needed. The shape of this forum or network is likely to be profoundly influenced by emerging technologies such as the Internet. But it may well be based in a central health promotion institution that also supports health promotion professionals in other ways, for example by taking the lead in training and research related to health promotion.

There are a number of health promotion networks working both internationally and intra-nationally such as health promoting schools, health promoting hospitals, healthy cities, health promotion foundations and the International Union of Health Promotion and Education. These can all be very useful international contacts and supports for advancing health promotion in a country.

5. Challenges for the future

If we look at what has happened in developing the infrastructure necessary to promote health, and as importantly what hasn’t happened and why, several challenges emerge.

The first is that the promotion of health still lies outside the main game. In other words, not only is health low on the political agenda in most countries (as evidenced by the ranking of most Ministers of Health in the national political hierarchy), but public health is way out-manoeuvred by the demands of curative medicine.

How do we get in the main game, into the inner sanctum of decision making and resource allocation? Promoting health has a large political component, and unless we add new approaches to our current scientific methods and learn new skills, we will only endure ongoing frustration.

New skills and approaches that will enable us to overcome some of the political, social and cultural barriers include:

- Coalition building, partnership skills
- Campaign organisation and skills
- Presentation and communications skills
- Focus on recognition and promotion of public health champions
- Increasing awards and rewards in promotion of health
- Innovative fundraising capacity e.g. hypothecation of taxes, financing by the insurance industry, support form the philanthropic sector

Management training in public health needs to move into the modern world and address day to day operational issues such as performance management, professional development of staff, staff selection and working in teams.
The small 'p' political skills need to become essential ingredients of radically altered undergraduate and graduate training in public health and health promotion.

The second major challenge is to learn to work with and through existing infrastructures, rather than duplicating existing infrastructure or by ignoring its existence. This involves learning new skills to work out where the synergies lie between health and other sectors, rather than simply telling other sectors that they should be interested in health. Whether it is human rights lawyers, transport company officials, school principals, business leaders, sporting association presidents, religious leaders, city mayors, or NGO directors partnerships will only work if there are shared goals, and if there is a clear understanding of what each party can gain from the partnership. Those charged with the promotion of health have to get out of their offices, and into the street, and as Nelson Mandela put it 'get into the shoes' of others to find out how they understand promotion of good health, and the meaning and significance it has to them.

There do need to be dedicated infrastructures for promoting health, more often than not housed within the health sector but with the training, skills and perspective to be able to work across many sectors and at various levels of government. This infrastructure needs to act as the central driver for developing new skills, maximising joint action with other sectors and other partners.

Finally, but most importantly, successful and effective national infrastructure to promote health is not possible without an understanding of, and a sincere dedication to the value of health. Therefore, viewing health as a primary resource for individuals, families and the community at large, is a pre-requisite for infrastructure development (National Health and Medical Research Council, 1996).

Perhaps two of the best examples of commitment to health at all levels are the Ugandan and Thai national programmes (Pothisiri et al 1999) to address the problem of HIV/AIDS. Although they are often cited, it is precisely because they have been supported from the highest political levels and from a community base, because they have put together a comprehensive approach, and because they have attracted considerable local and international support. Both have created new infrastructure whilst co-opting existing infrastructure in other sectors and at the community level.

This has not been easy and the programmes have evolved a great deal over the years. In Uganda, for instance a major issue was moving from an ineffective, abstinence and fidelity-only discourse in the late 1980s to one that recognised the realities of human behaviour and backed condom promotion in the late early 1990s. Both the Ugandan and Thai national programmes encountered huge opposition from the health sector when they moved to multi-sectoral programmes, and moved to include the voices of people living with HIV/AIDS in central decision making.

Good programmes don’t just happen. They result from placing a high value on health, courageous leadership at all levels, a commitment to learning and change, a commitment of finances and human resources, a capacity to develop common purpose among a broad constituency of players, and a comprehensive package of the elements of health promotion described above.
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