Think health: what makes the difference?\textsuperscript{1}

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THINK HEALTH: WHAT PROGRESS?

We know that poverty kills, that dirty water kills, that tobacco kills. We know that children thrive on love, that communities are strengthened by social cohesion and that educated and empowered women are a determining factor for the health of a society. Most of the people in this room would agree that the level of health of an individual, a family or any group is strongly dependent on social and economic factors. We have heard this theme echoed in the many UN conferences, all of which have chosen health to be one of the benchmarks by which to measure progress in human development. The World Bank has stated recently:

The underlying threats to good health . . . are well known, and affordable solutions are frequently available.

And, most recently, the communiqué issued by the Denver Summit of the Eight Most Industrialised Nations has highlighted the need to take common global action on health, in particular on ageing and infectious diseases. It seems therefore that health is definitely on the political agenda, more so than when the Ottawa Charter [World Health Organization (WHO), 1986] was adopted. Yet as the global equity gap widens, access to a healthy life seems further removed for the citizens of some parts of the world than it was 10 years ago. This documents that we have still not fully understood the vital link between health and development.

The Ottawa Charter both listed the prerequisites for health namely—peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice and equity—and outlined the strategies for affordable solutions. There is agreement among the global health and development community that it is not the lack of money that hampers progress—it is the lack of health governance. The \textit{Human Development Report} of this year [United Nations Development Programme (UNDP), 1997] calculates that the cost of eradicating poverty would be about 1\% of global income and no more than 2–3 \% of respective national income. With the investment of this 1\%, a significant part of the global disease burden would disappear—freeing up resources to go beyond survival into creating healthier societies. The World Bank in its recent (1997) Sector Strategy Paper \textit{Health, Nutrition and Population} calculates global health spending to have been at about US$2330 billion in 1994; this is 9\% of global GNP and makes health one of the largest sectors in the world economy. Middle- and low-income countries account for 11\% of global health spending (US$250 billion)—84\% of the world’s population lives in these countries and they shoulder 93\% of the world’s disease burden. The World Bank expects a US$9 billion a year increase in low- and middle-income countries:

In principle this is enough money to pay for essential population-based preventive and curative services for

\textsuperscript{1} Edited text of the keynote address presented at the 4th International Conference on Health Promotion, New Players for a New Era—Leading Health Promotion into the 21st Century, Jakarta, 21–25 July 1997
the 900 million of the world’s poor who still do not have adequate access to these services.

And there is not just talk. The first action programmes are under way. The World Bank has significantly increased its lending in health and education, and other development banks are starting to follow suit. The UN Special Initiative on Africa will cover 10 years and make available US$25 billion to co-ordinate joint UN action in the key areas of education, health, peace, better governance, and water and food security. In addition, private investment in Africa has grown in view of the economic reform measures launched in over 35 African countries, so that quite a number have growth rates between 3 and 6%, some even as high as 8%.

We are always faced with the dilemma of whether to view the glass as half empty or as half full. Much progress has been achieved in health and development in the last 25 years—and our host country is no small example of this—but it is surely the mission of public health to remain constantly vigilant and draw attention to what has not been reached and what threats to health could be minimised by exercising foresight. The US Institute of Medicine has stated this mission of public health with great clarity and simplicity:

Fulfilling societies interest in assuring conditions in which people are healthy.

THE RISK TRANSITION AND THE NEW DRIVING FORCES

Throughout the world the health hazards are changing. The WHO Report Health and Environment in Sustainable Development, which analyses progress 5 years after the Earth Summit, makes the helpful distinction between traditional hazards related to poverty and ‘insufficient development’, and modern hazards related to rapid development that lacks safeguards and to unsustainable consumption. The former are rather quickly expressed as disease: you drink polluted water and get severe diarrhoea. The latter are more difficult and complex: a cancer-causing chemical may pass through the food chain for months and years, manifest itself in a tumour only after decades and not be easily subjected to a simple cause–effect relationship. Even more difficult to grasp and measure in their effect are the problems related to unsustainable consumption—where many health and environmental issues meet. Low- and middle-income countries do not have the choice anymore to first deal with the one set of hazards and then move to the next. While still grappling with many traditional infectious diseases, they also face the challenges of AIDS, tobacco, pollution and new hazardous lifestyles. The conflict is that frequently growth in these societies is generated through the development and support of unsustainable consumption. Development therefore only means health to a certain extent.

Underdevelopment as well as unsustainable consumption are associated with factors of economic and social development which the progress report calls ‘driving forces’. It is these driving forces that create the conditions in which threats to health can develop or be averted. They include [according to the United Nations Research Institute for Social Development (UNRISD)]:

- the spread of liberal democracy;
- the dominance of market forces;
- the integration of the global economy;
- the transformation of productions systems and labour markets;
- the speed of technological change;
- the media revolution and consumerism.

These driving forces and the pressures they exert are linked to many different players, interests and sectors. The new dimension is the speed of change and the fact that many of the players are now global, as alluded to in the title of this conference: new global regulatory agencies such as the World Trade Organisation (WTO), transnational companies, regional groupings such as the European Union (EU) or the Association of South East Asian Nations (ASEAN), media conglomerates and global non-governmental organizations (NGOS).

The impact of these driving forces applies as much to the physical environment as to the social environment, and it effects health through both of these channels. Indeed, health promotion must concern itself much more systematically with the interaction between physical and social environments at local and global levels. It must aim to grapple with the resulting disturbance of the social ecology of our societies, and propose an organised social response in the form of salutogenic public health strategies.
REINFORCING THE SOCIO-ECOLOGICAL PERSPECTIVE OF HEALTH

Building the Ottawa Charter on the firm foundation of a social model of health, and highlighting the importance of sustainability and ecological factors 5 years before the Rio Earth Summit, showed foresight and is surely one of the main reasons why the Charter remains as significant as it is: as research and experience expand, its premises and strategic approaches are shown to be sound. Contrary to many others, I do not think that we need a ‘health promotion theory’. I consider health promotion a theory-based process of social change contributing to the goal of human development, building on many disciplines and applying interdisciplinary knowledge in a professional, methodical and creative way. I am also not particularly convinced that the application of clinical terminology to health promotion—such as ‘evidence-based’—is the right way to go.

In my view, health promotion is ‘determinants based’. By this I mean to express that it bases its strategies on best knowledge of how health is created and how social and behavioural change is best effected. It aims to maintain health as a resource and prioritise investment in health through the following four questions.

- What creates health?
- Which investment creates the largest health gain?
- How does this investment help reduce health inequities and ensure human rights?
- How does this investment contribute to overall human development?

This is how the Ottawa Charter was constructed. We know that certain social factors (such as social support) improve and strengthen health; we know that others (such as lack of self-esteem) endanger it; and we know that this is usually a long-term and cumulative process, patterned by many interdependent variables. Whereas we can aim to build models of influence, they will never quite reflect the reality of people’s everyday life and decision-taking, which is further influenced by their values, norms, emotions and aspirations. In my view, health promotion outcomes are measures that show that the determinants of positive health have been strengthened within a given nation, community and/or setting. They are those elements which contribute to the health, quality of life and social capital of a society. And they can only be ‘produced’ by an organised, partnership-based community effort. This is a significant shift that looks not only at how other sectors produce health, but also at the wider societal contribution of the health sector. The concern of societies will increasingly be social not physical health.

Take, for example, an Index of Social Health which has been developed in one of the largest WHO member states—the USA. It is based on 16 measures including infant mortality, teenage suicide, dropout rates, drug abuse, homicide, unemployment, and poverty among the elderly. The index ranges between 0 and 100. From 1970 to 1992 the index showed a decline from 74 to 41. The Human Development Report 1997 (UNDP, 1997) reports that in 35 countries the human development index had declined. This means that the overall well-being within those societies had decreased significantly. No one agency or sector can respond to this, indeed it needs a new type of health governance to respond. Some authors have proposed to speak of a ‘socially toxic environment’ which affects the most vulnerable populations first and worst: in particular, children and young people. What a paradox if those that are to benefit from sustainable development in the next generation are deeply hurt socially as they grow up. Childhood needs supportive environments for its development and it is not incidental that child development ranks first in those policies and strategies that attempt to deal with determinants of health.

We are still at the very beginning of how to measure socially toxic environments and their effect on health and how to measure human responses (at individual and community levels) to environmental stressors—particularly because of the cumulative and often long-term effects. The Koster health project in Sweden is trying to do this as part of their contribution to Agenda 21 (UN, 1993). Obviously, inequity is a component, as are violence (real and virtual), fear, and lack of security and trust. Somehow ‘Joe Camel’ belongs here as does the marketing of alcopops. Creative measures include cultural indicators such as those developed at the Annenberg School of Communications, which indicate that the average American child will have witnessed more than 8000 murders and 100 000 other violent acts on TV by the time he or she leaves elementary school (Stossel, 1997). Another approach is to measure social capital, which is defined as
the processes (features of social organisation) between people which establish networks, norms and social trust and facilitate coordination and cooperation for mutual benefit.

Those involved in social epidemiology and salutogenic research have long known that coherence, belonging, social support, networks, and religious ties make a difference to health; indeed, that social bonds, love and caring (giving as well as receiving) seem to be a protective factor even under the worst of circumstances. What we know less about is the influence of the many new factors related to media, new information technology, advertising and marketing—in short, the marriage between the information and the consumer societies. And we know even less about the social impact of these changes in the low- and middle-income countries. What does this mean for the 2 billion teenagers we will have on this planet by the year 2001? Are their life options widening or being reduced?

One of the many reasons we need partnerships with the communications industry, the lifestyles industry and the health care industry is to explore these kinds of issues jointly—because the joint exploration can mean the development of joint values, a joint social responsibility and joint action. The claim that sustainability means to not leave our children a world that is worse than the present applies to social health as much as it does to trees and whales. For health promotion this means that we are challenged to expand the settings approach in several directions:

- beyond organisational settings and organisational development to social spaces and social development—such as childhood, being female and growing old;
- towards understanding the full impact of the information technology revolution as a major driving force and its effects on human development and health;
- towards marginalised and excluded populations, their settings—slum dwellings, remote regions—and their health and social needs;
- towards a better understanding of ‘social toxicity’ and ‘social capital’, and a revisiting of health promotion programmes with this perspective.

In short, we need to widen the understanding of supportive environments as expressed in the Ottawa Charter.

**HEALTH LITERACY**

I would like to propose that a key challenge for health promotion lies in combining strategies for building social capital with strategies that build intellectual capital for health. We know that education is one of the strongest predictors for health—and that women’s education is one of the strongest predictors of family and community health. Increasingly, literacy programmes are using health issues as their entry point because of its high relevance to people’s everyday life. Under ongoing conditions of change, traditional health knowledge does not suffice and in all societies there is a constant need for new health knowledge—in view of new hazards and risks, new treatments, and new ways to maintain health. Health learning becomes a necessary component throughout the lifespan—a productive factor so to speak: as society changes, as one’s own living conditions change, as one’s body changes. In the new version of the health promotion glossary we have introduced the term ‘health literacy’, meaning it to widen what in the Ottawa Charter we had called ‘developing personal skills’: information and knowledge on health, understanding the social components of health, ability to negotiate the environment, understanding and weighing risks of individual and social behaviour, coping skills, caring skills, skills to use the health sector, and a shift from fatalistic acceptance of health problems towards implementation of health knowledge.

The increasing importance of health literacy must lead us to explore new places of and for learning, new methodologies and new vehicles. Participatory learning through the settings approaches is one—the use of the communications media and information technology is another. Community radio, soaps for health, health on the Internet, social marketing, media advocacy using the many channels of adult learning, and creating alliances with the communications and the adult learning community open up increasing possibilities that we must explore more systematically and relate to the social gradients in health behaviour. Can health literacy balance the social gradient? What kind of knowledge is it that makes the difference?

**GOVERNANCE FOR HEALTH**

Health promotion as a social change and development strategy sits uneasily in any sectoral view
of the world—it sits particularly badly in a health sector that focuses on service provision and that is increasingly dominated by an economic rationale. The world of health policy—with some notable exceptions—is still far removed from shifting the priorities from health services to investment in health. And we should not fool ourselves by jumping onto the economic bandwagon by advertising that health promotion would provide the most cost-effective solutions. Insisting on health promotion strategies as outlined in the Ottawa Charter in a climate of short-term cost-effectiveness is not for the faint of heart as many of you here will testify. There is never enough money, never enough support, never enough time. The examples documented for this conference show it can be done, frequently through new ways of working together in partnerships, across sectors and across public/private boundaries. But still we must reinforce our effort for investments for health and development.

Yet we need to state clearly that the present traditional sectoral forms of policy-making and public administration do not fit the integrated nature of many of the problems that societies need to solve in the face of change. A integrated approach to health within government is needed and, increasingly, there are suggestions that measures of health and well-being become the benchmarks against which to assess the overall development level of a society, rather than focusing on narrow economic indicators. Health status is a very sensitive indicator—major shifts can be mapped within short periods of time in both directions. For example, within just 30 years Japan’s life expectancy has grown to be the longest in the world: 76 for men and 82 for women. Other Asian countries are moving in a similar direction, our host country among them. In contrast, life expectancy in eastern Europe fell consistently within the same period, finally to plummet at the end of the 1980s, with the first signs of increase in some countries in the last couple of years. Data show us very clearly that the respective health systems or health expenditures do not correlate with the magnitude of the change. Indeed, we can see in some societies that health care expenditures can become unsustainable, as they take resources away from investments in health. The Ottawa Challenge to reorient health systems now means establishing criteria for sustainable health systems—systems that aim to produce health as well as providing lifespan care. The health system must as much be subject to health impact statements as should other sectors.

The increase in health status has been highest when there is a combination of factors: economic growth, equitable distribution of income, high investment in education, and social cohesion. The futurist Alvin Toffler predicts that in 2020 the world’s healthiest and longest-living populations will be in Asia. Yet first clouds are appearing on the horizon: not only the slowing down of the extraordinary economic boom period, but an increasing discussion, as in Japan for example, about the loss of social cohesion, which in turn will have a significant effect on and be influenced by an unprecedented situation for any society—by 2015, one in four Japanese will be 65 or older. A recent article by Nicholas D. Kristof (New York Times Service) in the Herald Tribune mirrored the concerns faced by Japanese society today:

A fundamental question for Japan is whether it can move to a more market oriented system without disrupting the sense of community that for centuries has been at the root of Japanese society.... Some Japanese wonder whether these developments will lead to a society that values wealth more than cooperation and social responsibility.

Will the successful outcome for one generation constitute both a social and financial crisis for the next? When do we see the cut-off points? What effects the shift? When does economic growth turn into unsustainable consumption?

Since the health care reform debates in many countries are dominated by issues of financing and pushing government to shed many of its functions and responsibilities, one key function has remained very much in the background: the socially integrative role that governments play in maintaining a common purpose and protecting the public good. Economically speaking, this belongs to the ‘large externalities’ which are usually seen to be a wide range of measures that support the public good, for example accepted public health measures (clean water, food safety, etc.). They need to be expanded to encompass their social nature. Increasingly, we are learning that just as the market does not fully regulate itself except in economic textbooks, so does ‘social capital’ not just exist of its own accord. A tendency has been to downplay or downright cut the role of the state in service
provision—but we do not yet know the consequences of this privatisation and the lack of social cohesion and common purpose this might entail.

It is this social vacuum which ‘governance’ must help to fill by increasing the interactions between the state (and, indeed, why not health promotion agencies) and society by bringing together the range of players that have an interest in functioning and active communities. Governance initially developed at the city level and as a horizontal coordination between multiple social agents: at its best it is democratic, participatory and accountable to the stakeholders. The Healthy City approach is a model for bringing together different stakeholders and increasing participation in decision-making, and only those cities that have understood this to be at the essence of the project have truly succeeded.

Most recently, the new Minister of Public Health in the United Kingdom has put forward the proposal to create ‘healthy living centres’ throughout the UK. Their common purpose would be ‘to promote health, helping people of all ages to maximise their health and well-being’ and they would be targeted at groups who experience worse health than the average or who are not readily attracted to existing facilities for health. This is very similar to the brief developed for ‘healthy city centres’ aiming at bringing together aspects of social, physical and environmental health. Increasingly, strategies need to be of this integrated nature—which means that they will need to be financed in new ways—since they cut across accepted sectoral budgets.

Models exist in using money from national lotteries, creating special funds and foundations and in dedicated taxes, in particular from tobacco sales. One of the most interesting approaches has recently been launched in Brazil for the financing of health and social services, but it is also the approach that has met with most difficulties and opposition.

At the end of 1995 the then Minister of Health of Brazil presented to Congress the proposal for a taxation equivalent to 0.2% on all financial transactions going through the banking system in Brazil (public or private). It was approved in 1996 and was expected to raise around US$5 billion to supplement the health budget; by June 1997 it had become clear that the amount for the year would exceed US$7 billion. Originally this money was to be used for priority areas, including health promotion—in practice it has been used to minimise the US$1 billion deficit of the health sector. The future of this law is unclear; the opposition is great from those for whom it means greater accountability in financial transactions, from those who are opposed to the ‘redistribution’ effect and from those who oppose the money being used to pay for problems that have arisen through other political crises. Yet this example brings to the fore what the discussions about environmental taxes and value added taxes are increasingly bringing to the debate: that ‘public goods’ such as ‘health’ which benefit the whole of society need to be financed in new ways that reflect the overall societal responsibility for and benefit of health. An idea that has also come forward is to introduce a levy on expenditures for marketing and advertising, which would serve health promotion and health literacy, so as to move away from a simplistic ‘sin tax’ concept. This is interesting to explore, given the fact that US$260 per capita globally are spent every year on packaging and marketing products, while many countries have to make do with US$5 per capita to spend on health.

**THE INTERDEPENDENCE**

‘Think globally is good bumper sticker advice, but it is a daunting task’ is a sentence I read recently. It is all the more true because globalisation is not really global. Transnational business activities are highly concentrated and the majority of the world’s population is still outside of this system—yet the processes of globalisation are changing the character of nations and the quality of life everywhere. It is by nature intrusive, whatever its effects. With the lack of decision-making structures and law enforcement at the global level is another level where governance has worked as a set of interacting guidance and control mechanisms. Peace-building, human rights and the environment are usually cited as examples—indeed the Earth Summit of 1992 is seen as the turning point in global governance, putting it firmly on the map. The WTO is seen as the most far reaching and powerful of these new governance structures, probably followed by the Global Climate Convention and hopefully the Global Convention on the Rights of the Child, which has now been signed by all but two countries. WHO is presently exploring the possibility of a global convention on tobacco. We will clearly see these types of agreements increasing, sometimes undermining national standards, sometimes going far beyond
them. New norms, new standards, new rules of conduct, accountability and decision-making need to emerge from this new situation. Peacebuilding and development policies play an increasing role in the health agenda—drug-growing and trafficking from poor countries to the more affluent parts of the world is as much an issue as tobacco subsidies in the EU and export of cigarettes to developing countries. They illustrate the interdependencies in all directions. Health promotion should position itself firmly in this context of global health governance.

In this context, too, financing proposals speak of global taxation for servicing the needs of the global neighbourhood—environment, health, education and poverty reduction. The Organisation for Economic Cooperation and Development (OECD) Development Assistance Committee declared their support for halving income poverty by 2015 and achieving education and health for all by that date. In the global economy of US$25 trillion, the ratio of the poorest to the richest was 78 to 1 in 1994, compared to 30 to 1 in 1960. The most straightforward approach would be to tax all currency exchange transactions (US$1 trillion a day) at 0.003% or less. Other proposals include a ‘tax’ on the transactions of those industries that benefit most from a peaceful world: travel, transport, communications. A tax on mobility—for example on airline tickets—has been proposed regularly. Think of the scope of tourism: it is the world’s largest industry, it has 10% of the global work force, 10% of world GNP, 10% of all consumer spending. And it is dependent on health: safe food and water, safety from epidemics and infectious diseases, and hygiene standards, to name but a few. Globalisation offers great opportunities, but only if it is managed more carefully and with more concern for global equity.

Perhaps what is most worrying of all is the lack of governance on behalf of people who are not rich, educated, or skilled as the word is understood in the global marketplace—that is, most people. Health advocacy must become much more powerful, citizen driven and human rights oriented. Step by step, globalisation from below is widening and the global summits have significantly contributed towards this—the non-governmental organisations (NGOs) are beginning to occupy global public space. They speak up for a global civic ethic of rights and responsibilities, and call on public accountability. Health and environmental impact statements are part of this development. This is where the new information technology does make a significant difference in giving ordinary citizens a voice and allowing advocates to communicate without having to buy expensive airline tickets. All kinds of networks are forming and I hope that the WHO networks will also contribute to this new global web for health that is in process of being generated.

OUTLOOK

Which is the world’s healthiest country? Is it the one with the highest life expectancy? Is it the one which ranks highest on the human development index? The one that has the highest health budget? The one that has the least social gradient in health? Is it the country with the lowest burden of disease?

From a global perspective, I would plead for an accounting system similar to the one that ranks Costa Rica as the world’s healthiest country. This ranking is based on a new proposal to link health and ecological indicators in a measure called the ‘ecological footprint’: it calculates the ratio of life years produced to eco-productive land/resources consumed. I quote:

By 1991 Costa Rica delivered a life expectancy of 76 years to its citizens, compared with an average of 77 years for the world’s 22 richest countries. It did this on a national income of $1,850 per capita, compared with an average of $21,050 for the 22 richest nations. . . . In general poor low-consuming societies (with a high health status) are characterised by a high level of literacy and independence among the female population and high levels of investment in health and education compared with other countries in their income bracket. (Hertzman, 1996)

This puts the high life expectancy in rich countries into perspective and it shows that policy-makers in developing countries do have a choice. Could they maintain the same high health status while consuming less of the world’s resources? Is their health sustainable? What does this mean for low- and middle-income countries as they develop further and set health expectancy as a goal? Can we continue at a level of national and international governance to look continually only at part of the pie? A futurist, Frederik Pohl, has proposed recently that each level of governance should have a ‘Department of Consequence’ which informs policy-makers and citizens of the costs and benefits of investing in different sectors and in different ways. For each
one of us individually, health probably means those components spelled out in the Human Development Report:

a long healthy and creative life, a decent standard of living, freedom, dignity, self esteem and the respect of others.

The poverty of one-quarter of the world’s population is more than income poverty: it is the denial of choices and opportunities for living a tolerable life. That is basically what WHO means when it speaks of health security and health as a human right. I hope that this conference contributes to that global conscience with a strong will to act on the factors that create or destroy health.

We need to work with the global paradox, meaning both more action on the social health issues at the local level and the global level. This means to:

- harness some of the new driving forces for health;
- position health promotion as much part of the social and human development agenda as part of the health agenda;
- position health promotion as a key element of good governance — thus opening new avenues for health governance, financing and accountability; and finally
- understand fully the changes in the global system of health production and to work towards a more systematic global response.

All this can only be done in partnership, in facing conflicts and negotiating solutions. It is the ongoing challenge of a new public health. It is truly a new common agenda because, just as with communicable diseases, no longer is my health safe if your health is not safe, violence is as much an epidemic as is tobacco or tuberculosis. Health is a public good, a global commons, a global resource. It is a process in which we continually strive to move forward. It is a journey of discovery as expressed poetically by Oscar Wilde:

A map of the world that does not include Utopia is not worth even glancing at, for it leaves out the one country at which humanity is always landing. And when humanity lands there, it looks out and, seeing a better country, sets sail. Progress is the realisation of Utopias.

In this sense, let us move health promotion into the 21st century.

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