INTRODUCTION

Fifteen years ago, a set of possible concepts and principles for health promotion was put forward for discussion by the WHO Regional Office for Europe WHO (WHO, 1984). Those concepts and principles informed and underpinned the Ottawa Charter 2 years later (WHO, 1986) and have provided the basis for the many health promotion innovations emanating from Europe ever since. These have included projects, e.g. Healthy Cities, Health Promoting Schools, Health Promoting Hospitals and, more recently, the Investment for Health approach to implementing health promotion. All have had their origins in the European Region (Ashton, 1992; WHO, 1991; WHO, 1992; WHO, 1994b; WHO, 1996b; WHO-EC-CE, 1992; WHO-EC-CE, 1997).

However, there is evidence that the overall impact of these innovations has been relatively limited in the region [see, e.g. (De Leeuw, 1989; Tsouros, 1990; Grossman and Scala, 1993; Jensen and Schnack, 1994; Sidell et al., 1997; Pelikan et al., 1998; Ziglio, 1998)]. At the same time, the European Region has changed dramatically since the endorsement of the Ottawa Charter—geopolitically, economically and in terms of social development—with new challenges emerging all the time (Ziglio, 1993; Ziglio, 1998).

In this light, rather than give an overview of health promotion in Europe, this paper takes a developmental approach to European innovations in health promotion, in the context of the remarkable changes which have been transforming European society. It considers the kind of health promotion strategy likely to be most effective in Europe in the future and concludes that it is vital to reassert the centrality of health to human and social development. This implies revisiting approaches to sustaining and improving health, and recognizing, implementing and sustaining effective measures. The authors emphasize the importance of an intense focus:

- on the key underlying processes which create health; and
- on the systems and capabilities that need to be developed to ensure effective, sustainable action.

TAKING STOCK OF PROGRESS—THE OVERALL PICTURE

Since the Ottawa Charter, much health promotion activity has taken place and the practice of health promotion within a number of countries has developed considerably. The implementation of a wide range of health promotion initiatives has generated much collective experience within Europe and added considerably to both knowledge and progressive change. Specific segments of the population, e.g. older people, young people, women, migrants, disabled and chronically ill people, have been involved in a variety of activities aimed at improving or gaining more control over their health (WHO, 1998b). Programmes and projects have been conducted in a variety of
regional and social settings, e.g. cities, schools, workplaces and health care organizations.

At the same time, the European Union (EU) —comprising 15 member states with a combined population of ~300m, and having 10 applicant countries in various stages of membership negotiation—has steadily enlarged its role in public health in the 1990s, through the Treaties of Maastricht and Amsterdam. Some international projects, e.g. the WHO/Council of Europe/EU (European Commission) ‘Health Promoting Schools’, have provided for health promotion development to be systematically planned on a multi-country basis, implemented with strong sharing of experience, and monitored, evaluated and developed step by step. In their turn, such projects have helped to stimulate moves in some countries towards a more strategic approach to programme development and a more ecological approach to health through intersectoral action and community development at the local level (WHO-EC-CE, 1992; WHO-EC-CE, 1997; WHO-EC-CE, 1998).

In the last few years, some European countries (e.g. Switzerland, Austria, Estonia) have been setting up Health Promotion Foundations (WHO-HEA, 1998). These foundations have provided funding for organizations and NGOs to develop programmes of health promotion that addressed specific issues related to lifestyle and behavioural factors. These programmes have provided valuable contributions to climate building and the dissemination of health promotion thinking. Such development still has to prove, however, to what extent it can tackle the real health determinants prevalent in European countries today. So, although the foundations are instrumental in sustaining many of the organizations involved in health promotion in countries, they may lack the power to steer the policy agenda towards major issues related to the social and economic determinants of health (e.g. inequities, healthy public policies). Unless this strategic approach to health promotion is present in foundation-funded programmes, their impact and scope may be rather limited. An effective approach might be to use foundations to move the thinking of organizations by issuing terms of reference demanding that programmes are created to address health determinants relevant to the country/region the programme will be launched in. For foundations to operate effectively they need to be part of an overall infrastructure where the three functions of health promotion (enabling, mediating and advocating) are properly developed. This is a condition which is still rarely met in Europe and elsewhere.

However, in a number of countries, health promotion has been reduced to a service function—to be purchased, rather than planned as a collective good crucial to human development (Beauchamp, 1997; WHO-HEA, 1998). The implications of this for health promotion at a population level can be considerable. The reasoning behind the move to commissioning in health care is readily understood. Its main intention is to clarify the relations between inputs and outcomes, and to establish and manage accountability for the use of resources, thus allowing contracts for specific clinical or supporting services to be drawn up, costed and agreed. However, applying this approach to health promotion exposes a number of weaknesses, as most of its work is not susceptible to slicing into discrete packages and managing in this way. In particular, being treated as a ‘service’ to be bought—more often than not from providers operating wholly within health care—fails to recognize that the promotion of health cannot be left to the health sector alone.

It is also likely that the commissioning process reduces the opportunities for partnership and alliance building. By setting tightly defined outcome measures, against which success or failure are measured, health promotion activity can be reduced to an easily deliverable, easily measurable set of activities which do little to resolve the underlying causes of poor health and which may even increase rather than reduce inequality in health. A further potential danger comes from having many locally based commissioners, all with their own priorities and programmes. This can result in a fragmented approach, the duplication of effort and the lack of a co-ordinated strategy at a national level.

While the concept of accountability—in which the providers are accountable for the service they provide and the commissioners are accountable for commissioning the most appropriate service—is critical to the appropriate use of resources, the case of health promotion poses the following important questions which need to be answered.

- Are the activities being commissioned the most appropriate activities?
- Will these activities lead to an improvement in health at the population level?
- Is the commissioning based on democratic principles?
• Are the determinants of health being addressed through the commissioning process?
• Is the commissioning process taking place in the context of long-term investment for health?

If the answer to each of these questions is ‘yes’, then the commissioning of health promotion is a process which could result in major health benefits. If, however, the answer to one or more of the questions is ‘no’, then the commissioning process may be acting detrimentally to the health and well-being of individuals, and of society as a whole. In the last decade these questions have been the subject of debate in many European countries.

Determinants of health: knowledge and action
Since the Ottawa Charter our knowledge of health determinants has been increasing rapidly. Our understanding of the importance of socio-economic resources has expanded (McKeown, 1976; Fitzpatrick, 1982; Blane et al., 1993; Evans et al., 1994; WHO, 1995a; Blanc et al., 1996; Wilkinson, 1996; Bartley et al., 1997; WHO, 1998a). The role of social and cultural resources, e.g. social networks, social capital, social integration and cohesion, and the interplay of these assets with psychological resources for coping with change is beginning to be more widely recognized. However, the balance of research effort is still tilted towards disease rather than health creation or salutogenesis (Badura and Kickbusch, 1991). There is no doubt that we still need to learn much more about the relationships between different determinants and how to measure these, and about the methodologies that address the complexities of social system change. By contrast there has been a huge plethora of work on lifestyles that has been developed in association with the predominant mode of action, which is still about individual behaviour (Whitehead et al., 1998). However, while the messages of lifestyle and personal behaviour have been taken on board by much of the population, and there is correspondingly greater awareness of the need for personal responsibility for health, the ability of many people to act upon this knowledge and understanding is generally severely limited by the absence of a conducive cultural, social and economic environment.

Oversimplified approaches
Despite an apparent widespread acceptance of a socio-ecological model of health amongst people working in health promotion, most health promotion activity has continued to be issue based or else has focussed on only one determinant at a time. Rhetoric has largely failed to become reality. Thus, much of the change that has actually happened has been first-order change, involving relatively small-scale and minor adjustments, and without any major impact on the determinants of health or policy development (WHO, 1998c).

Second-order change, which involves a paradigmatic shift leading to new structures, processes actions and outcomes, has barely begun to happen. It will not happen until the starting point for action is the creation of health, not an issue or problem, a disease or death, but health itself. Nor can it happen until it is accepted that social systems are complex and interwoven, and their interconnections are crucial to the creation of health.

Infrastructure deficits
Correspondingly, while the multifaceted concept of health underpinning the Ottawa Charter is much more in keeping with people's experience and understanding in their everyday lives, such a holistic approach is still not reflected in institutional structures, organizational decision-making and policy actions. The latter continue to be mainly issue or sector based, rather than focused on the complex inter-relationships among sectors. Many programmes have not been properly supported by appropriate funding and infra-structures (WHO-HEA, 1998). There remains an almost universal failure to operationalize those aspects that emphasize health as a social and collective good.

Lack of healthy public policies
This explains the difficulty of finding outstanding examples of healthy public policy—a principal objective of the Ottawa Charter and target 13 of the HFA strategy for Europe (WHO, 1991a; WHO, 1991b). Target 13 aims to support the development of healthy public policies to promote and sustain health in the European Member States of WHO. In order to achieve this target, intersectoral policies and health promotion programmes should be in place at both national and sub-national levels of policy-making and
Commitment to healthy public policy varies between member states. In this respect, the development in the UK is very interesting and worth noting (see Box 1).

Without doubt, in many countries there has been a growing awareness that the promotion and maintenance of people’s health cannot depend upon the health care sector alone. This awareness, however, has not corresponded with systematic action and reviews of the legislative, financial, organizational, managerial and educational potentials necessary for a structured approach to health promotion. When progress has been made, it has often been fragmentary and half-hearted (WHO, 1998c).

Legislative, financial, managerial, educational and administrative support to health promotion should have been strengthened, and investment for health increased, far more than has been happening in the majority of European countries.
(WHO-HEA, 1996; WHO-HEA, 1998). Participatory practices could have been more widely introduced at country, regional and local level to involve people in policy-making, implementation and evaluation (WHO, 1998c).

In Europe, there is still a great awareness deficit among policy-makers of the impact of their policies on health, though the European Union has begun to introduce measures to subject policy initiatives in other fields to health impact assessment (EC, 1997). This needs to be extended and widely adopted throughout Europe. The opportunities for investment for health, the social benefits of having strong health promotion infrastructures, and the funding and supportive mechanisms for promoting health, have not yet found their correct and necessarily high position in the debate and policy-making of most European countries.

Summary of trends
Reports from member states and specific country surveys carried out by the Health Promotion and Investment Programme of WHO/EURO (WHO, 1996a; WHO, 1996b; WHO, 1996c; WHO, 1996d; WHO, 1998a; WHO, 1998b; WHO, 1998c) reveal both negative and positive developmental trends in progress towards a structured approach to health promotion. Box 2 summarizes the main positive and negative developmental trends of the 1990s.

SUSTAINING THE VISION BUT REVISITING THE MEANS

Social and political difficulties
Since the early 1990s, the promotion of health and adoption of healthy lifestyles have often been hampered by social and political difficulties in many European countries. Drastic reduction of social welfare, diminished scope of social policy, economic scarcity and fiscal upheaval risk eroding progress even further in many member states in both western and eastern Europe. In many instances, countries' economic and political priorities are often inconsistent with, and even militate against, progress towards the achievement of health promotion objectives. The evidence demonstrates that in Europe the development of healthy public policy remains an elusive HFA target.

Ottawa Charter principles
The principles underlying the Ottawa Charter still stand. However, this review points to the need to revisit the means by which its vision of health promotion can be realized, especially in view of the many changes which have occurred in Europe in the last decade. On one hand, the philosophy underpinning the Ottawa Charter has come to be accepted more widely, which indicates a gradual change in consciousness. For example, the European Charter on Environment and Health, in emphasizing the relationships between health, well-being and the environment, explicitly identifies the need for governmental and public action at all levels in the interest of health (WHO, 1994c). Its principles, priorities and strategic elements also draw attention to the relationship between social and economic development, health and well-being. The Charter advocates that a higher priority should be given to individual and community health rather than to a simple definition of economic growth. It also advocates research to support policy development. The Charter has led to a strong implementation process in the majority of European Region member states. Similarly, Agenda 21 also underlines that development must be equitable in order to be sustainable, and needs to be intersectoral with a recognition of community interdependencies. Agenda 21 has been widely taken up at a local level in the European Region.

Hastening policy change
On the other hand, this growing consensus on values has been inadequately reflected in policy development. This is not altogether surprising as it is well known that radical change and shifts in policy take upwards of 20 years. Transformation is dependent on a change in consciousness, a paradigm shift. To understand how such change is to be brought about, we need to focus on how we can encourage people to develop new ways of working, and design processes and infrastructures able to operationalize the broad vision of health promotion. This requires a shift in emphasis to the policy level, aiming to establish health promotion as central to human development. The challenge is to demonstrate convincingly to policy-makers that health and development are related in a virtuous circle, just as Marmot has argued in the case of work and health (Marmot, 1998). Health leads to development and development leads to health.
Box 2: Developmental trends in public policy in the 1990s.

**POSITIVE TRENDS**

- There is an increasing awareness of the need to develop a modern health promotion strategy in keeping with the concepts and principles of the Ottawa Charter and HFA policy.
- There is more interest and action in member states in developing settings-based health promotion programmes. Many countries are investing in intersectoral co-operation between the education and health sectors with the aim of establishing health-promoting schools. Activities in the workplace and health care settings are also on an upward trend throughout the European Region.
- There are a growing number of health promotion initiatives by bodies outside the health sector, e.g. labour unions, education sector, voluntary organizations, self-help and consumer organizations, and industry.

**NEGATIVE TRENDS**

- The role given to health promotion in health care reform processes has been minor or insignificant in many member states.
- The budget allocated to, and utilized specifically for, health promotion is far too small. On average it is much less than 1% of the health budget of member states—far too little for sustainable action.
- In the great majority of member states, institutional arrangements for health promotion policy development and implementation are very weak or inappropriate. Some countries have established intersectoral and interministerial arrangements which could be highly instrumental for creating the appropriate policy development infrastructure for healthy public policy. However, in practice such arrangements have produced only limited progress, mainly because their mandates have not been clearly designed, nor have they appropriate and sufficient technical assistance for their roles. Without a clear mandate for health promotion, they tend to remain at the periphery of government policy-making.
- Although several member states have established national and, in some instances, also subnational, centres or agencies for health promotion, most have a remit too limited to enable them to be strong players for implementing effective and sustainable action in the five action domains identified by the Ottawa Charter.
- Programmes are often *ad hoc*, issue based, and use health education as the main, if not the only, means of implementation. A comprehensive, credible, well-designed strategy and implementation measures, properly supported by financial, infrastructure and other development means, are absent in most member states—north, south, west or east in the European Region. Programmes tend to be weak or limited in scope and time, resources and staffing.
- Modern training in health promotion is available in only very few member states.

**Investment for health**

This implies a new dialogue with those who govern expenditure and policy throughout Europe, to engage their interest in the consequences of their actions for health and the corresponding implications for long-term social and economic development. Positive strategies can be adopted to reach an understanding of different value systems, find common ground and seek change (Levin and Ziglio, 1997; Ziglio, 1998). With well-planned, concerted and sustained action in many societies over many years, the principles and values that underpin health promotion might be progressively brought to the forefront of public policy. By this means, the determinants of health might be influenced in the long term, which could have a significant impact on the quality of life of European people and their ability to realize their full potential. That is a long-term social investment issue not a series of short-term financial tactics.
STRATEGIES TO ENCOURAGE INVESTMENT FOR HEALTH

Meaning of investment for health
The Jakarta Declaration states that current investment for health in many countries is inadequate and often ineffective. This statement is true for many, if not all, European countries. If health is truly regarded as a crucial social and individual resource, and therefore an investment, health promotion can be considered an investment strategy in social and economic terms, as well as for health. In that case the definition of health promotion needs to be extended thus:

the process of enabling individuals and communities (people) to increase control over the determinants of health and thereby (and to) improve their health.

It follows that health promotion strategies then become investment strategies, i.e. they are strategies which maintain and create health equitably and are integral to sustainable social, economic and human development policies. Three key questions then become the focus in the identification of appropriate policies for health (Kickbusch, 1997), in line with human rights.

• Where is health promoted and maintained in a given population?
• Which investment strategies produce the largest population health gains?
• Which investment strategies help reduce health inequalities?

Policy-makers and health planners in Europe do not yet place these questions at the centre of their thinking. (WHO, 1996d; Ziglio, 1998).

Influencing policies towards investment for health
To help policy-makers at different levels grasp this new paradigm, both conceptually and operationally, WHO/EURO has, since 1994, been undertaking a number of innovative demonstration projects which address these three questions. These are summarized in Box 3.

The outcomes of these projects show that there is great capacity for innovation and change at the various levels of decision-making: national, regional and local. The projects have identified both potential barriers to change and also the most effective strategies to achieve change. All confirm that individual health promotion programmes and projects can only achieve their health objectives if there are appropriate comprehensive strategies at the relevant policy level. Otherwise, they underperform or fail. A critical success factor is keeping in view the bigger picture, and the interconnections between policies, when dealing with individual decisions in particular areas.

As the Jakarta Conference declared, the development of knowledge and practical expertise in this area demands further work, conducted through partnerships at different levels of decision-making.

The main lessons learnt from these demonstration projects are shown in Box 4.

CONCLUSIONS: LESSONS LEARNT AND PRIORITIES FOR FUTURE ACTION

Within the European Region, health promotion will need to respond to the challenges and seize the opportunities of an increasingly dynamic and technologically changing continent, with its complex and growing international interdependencies. Health promotion efforts are essential and must be intensified. These require an integrated approach able to link with, and influence, social, economic and human development. There is a pressing need for ensuring that health promotion is positioned at the heart of (healthy) social and economic development.

The principle of intersectoral working, which is the basis for health promotion, is generally accepted in theory. In order to make progress in practice, there is a need to modernize institutional arrangements in both Western Europe and in the countries of Central and Eastern Europe. The current organizational, legislative and institutional mechanisms in the great majority of member states are not conducive to intersectoral action for the promotion and maintenance of health. There are few signs that countries are yet willing and committed to introducing the required structural innovation for systematic health promotion programmes and policies.

Political, economic, social, cultural, environmental, behavioural and biological factors are interwoven, and all play a role in determining and sustaining the health of a population. There is growing recognition that the ways in which
Box 3: Summary of innovative investment for health demonstration projects in the European Region of WHO.

AUDITING INVESTMENT FOR HEALTH OPPORTUNITIES

The Ministers of Health and the Presidents of the Parliaments of Slovenia and Hungary invited the Investment for Health Programme of the European Office of the World Health Organization to undertake an in-depth audit of the national approaches, and new opportunities to promoting the health of the citizens. The auditing was to include relevant aspects of policies and programmes, both public and non-governmental, along the strategic principles described above.

To deliver this service, it is crucial to have access to necessary descriptive and analytic data, and also to have access to the opinions of a variety of involved groups including consumer groups, health professionals, administrators, and political leaders at local and national level. This international auditing conducted by WHO/EURO aimed at providing the following outputs.

- A unique opportunity for mutual learning during the process.
- A consensus-building exercise within the country requesting the audit.
- A strategy for investment in health promotion designed to provide the Parliaments and Ministries of Health with recommended priorities for discussion, debate and action.
- An advocacy tool for the field of health promotion.
- Greatly enhanced European visibility for the countries requesting the audit in the field of health.

DEMONSTRATION PROJECTS ON INVESTMENT FOR HEALTH

So far, three demonstration projects have taken place: one in the autonomous provinces Trento and Bolzano, one in the autonomous Region of Valencia and one in Chemnitz, Saxony. These projects have been organized around local expertise supported by a WHO Project Team and additional resources when needed [see (WHO, 1994a; WHO, 1995b; WHO, 1996a; WHO, 1997)].

Box 4: Lessons learnt from European Investment for Health Demonstration Projects.

A strategy for health promotion in the European region needs to achieve the following.

1. Further develop political and managerial understanding of the determinants of population health and foster a focus on health rather than engagement in health care issues.
2. Affirm the place of health promotion at the heart of social, economic and human development, and influence such development to optimize health, equity and sustainability.
3. Encourage the establishment of infrastructures that create the capacity for sustainable intersectoral action at national, regional, local and international levels.
4. Develop tools to assist countries and regions to assess the potential for investment in key sectors and to identify the channels of accountability for population health in those sectors.
5. Identify incentives which would encourage all the stakeholders who are related directly or indirectly to the promotion and maintenance of the quality of life of populations to come together to work for health.

Society fosters the economy, regulates employment, provides education, assists its members in times of economic or other difficulties, sets up strategies to counteract poverty, crime and drug abuse, and stimulates equitable and sustainable economic and social development have a decisive impact on health.

The consequences for health of relative social disadvantage are now well documented. So too is the impact of sudden and huge economic shock.
The demographic and mortality crises in the east of the region parallel those suffering famine or war. Between 1989 and 1994, both birth and marriage rates fell by up to 40% in several Eastern European countries. Over the same period, male death rates in Russia doubled from such causes as cardiovascular disease and violence, while life expectancy declined to below retirement age. Several of the worst affected countries have now stabilized, demonstrating the existence of social and cultural capital which has provided the resources and abilities to deal with the shock of economic change (Whitehead, 1994; Cornia and Paniccia, 1995; Cornia, 1997). This points to important lessons for investment considerations and approaches.

An innovative, collaborative approach is required to ensure that a wide range of health promotion initiatives, programmes and policies are planned and implemented in an integrated manner. It is increasingly confirmed through practical experience that ‘Health promotion demands coordinated action by all concerned: by governments, by health and other social and economic sectors, by non-governmental and voluntary organizations, by industry and by the media’ (WHO, 1986). In Europe, we are fast learning that health promotion programmes and policies can be better implemented when countries recognize that they are capable of both producing health outcomes and of contributing strongly to healthy social and economic results. In a nutshell, this is what WHO/EURO puts forward as the Investment for Health approach to the development of health promotion.

Investment for Health should increasingly be seen by countries as an approach, at all levels of policy-making, for optimizing the health-promoting impact of a wide range of policies. These policies include, e.g. education, income maintenance, health care, labour, housing, agriculture, transport, tourism, energy, communication. The approach involves identifying relevant policy attributes; considering factors that may enhance or inhibit policy change; assessing change options that offer benefits both to health goals and the primary intent of a specific policy sector; and planning the political process of achieving the necessary legislative, regulatory, financial, organizational or educational changes.

During the 1990s, European governments, faced with the escalating costs of a producer-driven high tech health care system, have pursued health care system reforms. These have tended to focus on the production of, rather than the demand for, health care. Currently, some 90% of the European member states are undertaking health care reforms, often simply aiming at a reduction of costs, and not taking into account the broader picture. As the Ljubljana Charter points out, this is a severely limited downstream approach [(WHO, 1996c); see also (Saltman and Figueras, 1997)]. This severe limitation needs to be recognized and the illusion of control, through short-term technical responses, needs to be abandoned, because such responses deal only with the margins of the central issue, which is the creation of health.

Experience in the European region increasingly suggests that this important aspect of health care reforms necessitates paying attention to national and local management arrangements for health promotion, and that these are likely to be at risk if they are not explicitly considered as part of the reform process. Success is most likely to be founded on:

- creating and sustaining a national centre and/or regional centres for health promotion, as part of the general arrangements for public health, to act as a focus for analysis and action, to run country-wide and/or regional programmes, and to lend support to the development of local expertise and the implementation of local programmes;
- establishing and sustaining local expertise in health promotion and appropriate organizational arrangements, and in acting as a local focus for intersectoral motivation, support and action;
- defining the skills and expertise needed, and setting up appropriate training programmes;
- enhancing capacity in relevant research disciplines and information systems.

In Europe, considerable change has taken place since the development of the original vision which was incorporated in the Ottawa Charter. Political, economic, social and technological change have generated new health challenges, not least the challenge of dealing with rapid change itself. Whereas 10 years ago European societies were based on the provision and purchase of goods and services, societies today increasingly exchange information and knowledge. All this is resulting in constantly evolving patterns of everyday life, evolution in how people work, relate to each other and spend their leisure time. In under 7 years, the European region
of WHO has expanded its official membership from 32 to over 50 countries, as the former Eastern Bloc has been geo-politically transformed. The changes have taken place at a very rapid rate and people have varied in their ability to respond to the change.

The impact of economic globalization of the economy, the domination of multinational corporations and the primacy placed on private profit and company shareholders at the expense of the majority of people, all highlighted in the Jakarta declaration, have been especially painful in Europe, where there had been a long period of stability. The additional strains of transition among the former Eastern bloc states have created high levels of uncertainty and anxiety about the future. In the whole of Europe, unemployment has affected a wide sweep of people who have never before experienced joblessness or underemployment. These include skilled workers, technicians, sales people, managers and administrators. At the same time, those in work are experiencing stress from work overload and have a fear of job insecurity. Fear of an uncertain future rather than of the present reality is the key. Research indicates that, while many people are experiencing short-term unemployment, the vast majority find new work. It is the core of the long-term unemployed who are experiencing the most problems. The nature of work is changing to their disadvantage. The absolute amount of work has not diminished but there is inequality in the distribution of the means of earning a living. Thus, there are widening inequalities between people within countries and the already socially disadvantaged are hardest hit.

In line with the outcome of the Jakarta Conference, in Europe we have learned that the commitment to health promotion demands an approach that emphasizes consultation, negotiations and more opportunities to put health high on the agenda of policy-makers. Governments continue to play a major role in health. But health is also influenced greatly by corporate and business interests, non-governmental bodies, community organizations and single individuals. Their potential for preserving and promoting people’s health should be encouraged, and alliances forged to provide the impetus for health action. Promoting health is going to need to take on a more assertive role across the range of policy reforms under widespread review in many European member states.

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