In 1981, Robert Anderson and I undertook a study tour to Canada in order to understand what was happening in health promotion—at the program and policy level. Canada was the only country known to us that had a Health Promotion Directorate—we had heard of successful ventures like “PARTICIPATION”—and we were going to find out what it was all about.

In 1980, I had been asked by the WHO’s Regional Office for Europe to draft the health education approach for the 1980-1984 work program. It had become clear that health promotion was more than a subcategory of health education and that the Regional Office would be willing—subject to approval of Member States—to create a new program, called Health Promotion, as of 1984. The office was not thinking of renaming the health education program, but of creating an additional program with its own staff, budget, philosophy and approaches. We, therefore, came to Canada; we listened, we looked and we learned a lot.

For this reason, we have felt at ease with each other’s work over the last five years. The contact with Canada has been regular and exciting. Ideas and programs have been exchanged in both directions.

THE REGIONAL/INTERREGIONAL PROJECT ON HEALTH PROMOTION

I will talk of health promotion in a global sense, although I do not use the word global literally. I am speaking from the vantage point of the WHO Regional Office for Europe, where I have been asked to run a “regional/interregional project on health promotion,” created by the Director-General of WHO, Dr. Halfdan Mahler, to clarify the relevance of health promotion for all Member States and all Regions.

This project has been approached in several steps. The first step was to develop a basic paper—at a national level it would be called a green paper—clarifying what we meant by health promotion.

A lot of preparatory work had been done at the Regional Office for Europe—particularly with the production of “A Discussion Document on the Concept and Principles of Health Promotion” (most people just call it the yellow document). This was produced in 1984 to mark the start of the health promotion program of the European office. It came at the right time. This new “something” called health promotion, which was gaining mo-
The Discussion Document defines health promotion as the process of enabling people to increase control over, and to improve, their health. This perspective is derived from a conception of "health" as the extent to which an individual or group is able, on the one hand, to realize aspirations and satisfy needs, and, on the other hand, to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living; it is a positive concept emphasizing social and personal resources, as well as physical capacities.

Five major principles of health promotion are put forward.

1. Health promotion involves the population as a whole in the context of everyday lives, rather than focusing on people at risk for specific diseases.
2. Health promotion is directed towards action on the determinants or causes of health.
3. Health promotion combines diverse, but complementary, methods or approaches.
4. Health promotion aims particularly at effective and concrete public participation.
5. Health professionals—particularly in primary health care—have an important role in nurturing and enabling health promotion.

Five subject areas are stated:

1. access to health;
2. development of an environment conducive to health;
3. strengthening of social networks and social supports;
4. promoting positive health behaviour and appropriate coping strategies—a key aim in health promotion; and
5. increasing knowledge and disseminating information related to health.

Was this only relevant for the industrialized world or for the developing countries? To answer this question we called an international study group that met in Copenhagen in 1985 with representatives from all over the globe. The result of this meeting was twofold:

First: The background paper was accepted as having relevance far beyond the industrialized nations. There was a feeling that with health promotion we were perhaps experiencing what we experienced when primary health care (PHC) was first discussed, only the other way around: PHC, it was said at first, is only relevant to the developing world—poor care for poor people. Health promotion has sometimes been seen as the icing on the cake of health care for the rich; making those that have it all even healthier. The study group felt this was not the case, but it stressed that the entry point for health promotion was different. In the developing world, where the health care systems are not yet as fossilized as in the old world, health promotion might, from the start, be an integral part of health policy and primary health care. Whereas in the industrialized world, it has become a challenge to the established systems of sickness management and medical care because it is serious about prevention participation and healthy public policy. Therefore, strategies and actors of health promotion may be quite different in different parts of the world—but the basic philosophy is not.

The World Health Assembly Technical Discussions reiterated the direction of these statements and stressed that we, as the rich, cannot build our health on the exploitation of the poor. This is the most serious commitment of global health promotion.

Second: It is important to bring together the experiences gained in the industrialized countries in the field of health promotion programs and policies. This gave birth to the idea of the
The Ottawa Health Promotion Conference brings together 200 participants from around the globe to share experiences in health promotion policy and programs, focusing on five issues:

1. building healthy public policy;
2. strengthening community resources for health;
3. creating environments for health;
4. learning and coping; and
5. reorienting health services.

It will end—we hope—with a joint declaration, representing a consensus view on health promotion.

Let me now place health promotion in another global perspective, understanding global in the sense of a mutual way of thinking, or, more academically expressed, as a paradigm.

A FAMILY HISTORY

I am proud to have been asked to give the opening address to the annual conference of the Canadian Public Health Association. But I am particularly pleased to be able to talk about health promotion in the context of a public health association. The material on the conference we are planning has a subtitle: Towards a New Public Health. Let me explain how this came about and why we believe it is crucial.

Health promotion emerged out of health education. There are many reasons for this. I will state just two: first, health educators became more aware of the need for positive approaches in health education—enhancing health, creating health potential rather than focusing on disease prevention; second, it became self-evident that health education could only develop its full potential if it was supported by structural measures (legal, environmental, regulatory, etc.). The issue was—as formulated by Nancy Milio—how to make healthier choices the easier choices.

Let me explain the process further in terms of a family history. Health promotion did what naughty children often do. It started fighting with its parents, claiming to know it all, to be more modern and more up-to-date; stating its readiness to try new things like media and marketing. For a while things were sadly competitive; health education felt threatened and health promotion was forgetting some of its well-founded roots. The next step involved doing something parents also find hard to swallow. Despite this crazy childhood, the child was growing up to be quite a serious adolescent and, after a while, it outgrew the parents. This is roughly the stage reflected in the Discussion Document mentioned earlier. It became the umbrella concept for a whole group of approaches that aimed to promote health in a serious and ecological manner.

But still the child, or rather, the young promising adult, was all too often still living with its health education parents and, for all the promise, did not quite know where to go. Then, as sometimes happens, it suddenly became clear. It could aim to join up with a family that had a great history and tradition, that was integrated, prevention-oriented and had a sincere commitment to the welfare of the public: public health. So happily it set off in that direction—only to find that now the challenge had become really great. And the child was in trouble again, because where it went, it did not find a strong public health lobby ready to take up the challenges of the 1980s and 1990s. It found that, compared to the strong interest groups around the “health care system” (what has been called the medical-
industrial complex), public health was lame and weak. Despite all the lip service paid to prevention, only the smallest of efforts and the least of funds were actually going into it. That is where we stand.

Now let me explore, on a more analytical level, the issue of health promotion as the approach of a new public health, the differences between the old and the new public health, the new forcefield of public health that emerges from a health promotion concept and some of the strategies and mechanisms that need to be considered.

PUBLIC HEALTH HISTORY

Each country has its great heroes of public health. Recently we launched our new journal, *Health Promotion*, in London on the spot where John Snow had tried to shut down the Broad Street water pump in 1854, in order to control cholera. By sound scientific inquiry, he had been led to understand that cholera was a waterborne disease. It took another 30 years until the President of the General Board of Health, John Simon (who had held office for most of this period), was willing to acknowledge that Snow's discovery "may still be counted the most important truth yet acquired by medical science for the prevention of epidemics of cholera."

As Sidney Chave said: It needs time, place and person, as in epidemiological inquiry, to get public health action. Each country can tell similar stories. I have seen some of them in a film made by the CPHA. I particularly remember the impressive part about an angry public storming out to murder the medical officer. At least it showed that he had great public prominence—more than public health can claim now. But the film also shows—without being conscious of it—the stages of public health which have led to the loss of its true essence and reformatory power.

After its "sanitary" stage, based on environmental thinking and social control through the poor law, public health was transformed into preventive medicine. The germ paradigm that overtook the miasma theory led to the rapid growth of individualized approaches based on immunization. The linkage to the poor law (its social component) and to sanitation (its environmental component) moved more and more into the background of public health. In several countries, this led to important organizational consequences, i.e., having public health officers report to the health authorities (therefore reporting back to their own system of provision and taking away its intersectoral links) rather than to the local authorities. The linkage to the poor law was broken by moving more and more of those services provided on an individual basis into private practice (e.g., maternal and child health) or at least behind the closed doors of the doctor's office, thereby robbing it of its social components. This is what I would term the phase of the medicalization of public health.

In the course of this process, starting roughly at the turn of the century, public health moved from immunization (a straightforward PHC activity) to complex screening procedures, making public health activities diagnostic rather than preventive. What follows, with a strong upsurge in the 1960s and 1970s, is a focus on behavioural epidemiology. This epidemiological focus on public health has been boosted by reports such as "Healthy People" and the Lalonde report. Both had a world-wide influence, encouraged by WHO, on the focus of public health action, the financing of research and programs and the training of professionals.

Within this context, health education had to deliver what "snapshot epidemiology" wished to change: risk factors had to be reduced at an individual level. The negative consequences of this approach—particularly blaming the victim—have often been put forward and I do not need to repeat them. But, seen with a long-term development view in mind, this move from preventive medicine to behaviour modification has opened a door (a Pandora's box, some might say) to moving the focus of health care thinking and planning.
from the planning of medical care service to other arenas. Milton Terris stated in 1984 that the Lalonde report was "establishing a new era in health planning, instituting a profoundly revolutionary change from almost exclusive concern with health resources to a primary emphasis on health outcomes."

The central point was that you could plan not only for sickness services, you could also plan to reduce individual risk factors. This was an astoundingly optimistic and naive view of how easy it was to achieve behavioural change and a total neglect of ethical issues involved in doing so. However, the word lifestyles was on the map. Health planning and health economics had begun to move beyond health care to the social arena and into communities. The next stage of public health must be to move from planning for risk factors to planning for health: setting goals for policy action, not solely for individual behaviour.

**PLANNING FOR HEALTH**

Let me now go back to the work of the European office of WHO. What has been happening over the last few years is perhaps an example of what was and is happening in a number of Member States, including Canada. The office felt proud that it had established a strong program in health education; it felt even prouder when it followed this up with a health promotion program that established itself rapidly and had great support from Member States. The timing had been right.

The Office was also producing a target document based on the regional strategy of Health for All by the Year 2000, influenced by "Healthy People" and the Lalonde report. As an aside, the planning officer was recruited from Canada. The idea was goal-setting for health. The health education group was called into the process, which began in 1981, of developing the lifestyle target document.

This is important: health education was made part of developing the overall health policy of the organization, not just attached as a handmaiden at the end. In the process, the experts, called in to develop the lifestyle section, refused to target this section along the lines of goal-setting for risk factors but aimed instead at a wholistic health promotion approach. It developed (after much political negotiation) a set of five targets reflecting a new type of lifestyle approach. The first three targets reflected the preconditions for healthy behaviour: healthy public policy, social environment, information and education—stressing that these were targets to be achieved through change of policy by the governments of the respective countries. It then included two general behavioural targets: increasing positive health behaviour and reducing negative health behaviour. Of course, in everyday life behaviours are not divided out like this, but, in a political document, it was important to state that there can be a positive focus on well-being and health potential, rather than just a focus on what damages health. These targets are supplemented by two others in the first part of the document—actually the first two targets—reducing inequality and developing health potential.

A health promotion agenda was therefore formulated and included in the overall health policy document of the Regional Office and gives the basis for the development of a national health promotion policy, either as a separate enterprise or as an overall attempt. Basically, it spells out a new public health agenda.

What is new if you take a detailed look at this work and similar attempts all over the world? In general, a new view of what is "public" and what is "health" emerges. Comparing the old and the new public health, you can analyze the differences along the following matrix of five elements. These are the elements of what Minister Epp has termed a vision of a new health policy. It includes:

1. Understanding the context of the new public health: the cost crisis, the strength of interest groups, the global and envi-
nvironmental responsibility, and the lifestyle of societies.
2. Rethinking the understanding of health itself: understanding it not as an outcome measure but as something dynamic, a process and resource, something valuable both to individuals and society as a whole.
3. Refocusing problems and priorities: the conditions we deal with are more complex, more social in nature and need deep understanding to be tackled. For example, every fifth young woman in BC has an eating problem that manifests itself in anorexia nervosa or bulimia; work and family stress may be a greater health hazard than smoking; and what we call risk behaviours may be symptoms of something more serious.

I say this to stress that health promotion is not just for the healthy (the icing on the cake) but is a general approach to lifestyle (societal lifestyle) related issues and aims at developing health potential, wherever the starting point. In another context, we have termed this as developing non-medicalized and non-addictive coping strategies which are linked to a new understanding of ourselves and our bodies, which understand that bodies are not just biological but social entities.

4. Integrating new actors: health promotion goes far beyond health professionals. It is a public undertaking. Indeed most of the health promotion thinking has been developed by the public who are most often quite expert in thinking about their health—think of the women’s movement, the self-help groups, the elderly groups, the environmentalists, the peace movement. If health promotion is to be integrative, think of all the actors you could have for health within a community, including producers, shopkeepers, town planners. The new public health movement needs yet to be truly established.

5. Integrating policy thinking: the new public health needs the link to political action that was a defined element of the major reforms of the old public health. Chadwick’s great changes were linked to the poor law, to societal planning and to a notion of societal change. Think of the consequences of the 1833 Factory Act that made it unlawful to employ children under the age of 9 years in the factories, limited their hours of work and set up a system of inspection to follow it up. Where are similar public health acts today—and where is the lobby to push for them?

These five elements illustrate three new foci for the role of the health sector:

1. ensure access to health, i.e., reduce health inequalities;
2. create advocacy for health; and
3. move beyond health care.

The key words are intersectoral action and public participation.

A FORCEFIELD OF PUBLIC HEALTH

In order to reach such goals public health needs strategies. The cigarette industry has strategies, the media have strategies, even some political parties have strategies, but where is the public health strategy we will rally around? The joint paradigm has begun to emerge; its translation into action is now paramount. WHO has tried to give some support to this with its target document. In the health promotion program, we have supplemented the Concept and Principles document with two further steps: a “framework for health promotion policy” and a “framework for health promotion programs.”

These strategies are being developed around what I have come to call the forcefield
of the new public health which will, we hope, carry us beyond the health field. It is based on an integrated, ecological vision of public health that does not aim at a division between individual and environment but sees them as a totality. I have tried to set out this forcefield in the model (Figure 1) illustrating the title of your Annual Conference of this year: Health Promotion: Strategies for Action. The forcefield works at all levels—national, regional, local.

FIGURE 1. New Public Health Forcefield (Kickbusch, 1986)
The triangle of the forcefield links healthy public policy, community action in health and health promotion.

The aim is to put more health into public policy in order to create healthy environments and bring more health into everyday life. The health agenda is seen therefore as a political, a social and an individual responsibility. The forcefield stresses that they are in constant interaction and that changes along one line of the forcefield will influence the others.

On the right side you see the double strategy of health promotion: advocacy for health and enabling towards health. Both strategies need to be based on sound analysis, but given a much wider research agenda than has been the case to date. The data needed for a new policy-relevant analysis (i.e., from economics or political science) or for a reality-based social epidemiology are of an interdisciplinary mode we have yet to get accustomed to. In order to support community action for health, health promotion uses a variety of approaches including health education, social marketing, community mobilisation, community diagnosis and baseline epidemiology, which require a wide array of skills. The aim is perhaps best described as creating a positive social climate for health which mobilizes community interests in health.

On the advocacy side, the advice on planning for health, rather than just sickness services, is the major task. It means developing alternative strategies, policy options, feasible modes and time scales. It assists with advising on mechanisms for intersectoral action and accountability on health matters. The circles indicate where new roles and possibly new organizational mechanisms have to be found for the new public health analysis. For example, accountability could be the role of an independent health promotion policy research unit, or a quango or a ministerial department. Advice on health planning could be part of the functions of a health promotion directorate or independent committees that report to the government office. Community action for health could involve new types of independent health forums or local health councils that go far beyond just a legitimatory function.

The two half circles on the diagram represent the mediating function of health promotion. They are placed at two key junctions; the one representing intersectoral action between government departments, the other, (in the centre of the forcefield so to speak) indicates interaction between government, major interest groups (industry, medicine, labour) and community forces. An example of this has been given by WHO with regard to the marketing of breast-milk substitutes. This is an ongoing and difficult balancing function that requires great skills.

Already this rough outline shows that health promotion personnel would not come from a newly created discipline but would be a pool of different expertise from lay and professional sources, from a variety of disciplines and areas of society. It also makes clear the new types of skills required: analysis, strategic thinking, negotiation, social competence, creativity, to name just a few. Some would call these post-industrial qualities.

In the centre, between the policy sector and the social sphere, you find symbolically the other societal sectors and interest groups that can either be mobilized towards health or actively oppose health, i.e., some industries, the media, powerful interest groups. Usually though—in contrast to consumers—they have regular access to the centres of power. Through lobbying and regulatory mechanisms it is, for example, the cigarette industry, not the welfare mother, which is regularly able to put its view to leading bureaucrats and politicians. We have played this through for tobacco policy and antismoking action and it is very productive and exciting.

**CONCLUSIONS**

The thinking in terms of such a forcefield indicates that there is much to do. Yesterday’s structures do not fit the realities of today and will not lead us safely into the future. The
health care crisis the world over reflects this situation. Health promotion will not be achieved by renaming offices of health education.

In many cases, the organization of public health as a whole will need to be rethought, especially to adequately ensure its two cornerstones, intersectoral cooperation and public participation. As a consequence—dare I say it—the organization of the health care system as a whole needs to be rethought and moved from its curative focus to that of health promotion. This brings it closer yet to the roots of public health and to social policy in the wide sense of the word. I would like to remind you of two statements accepted by the Member States of WHO in the 1970s: to accept health as one of the major social goals of governments, that is to say, a major component of the public good and to aim at ensuring that, by the end of this century, the citizens of this world will lead both a socially and an economically productive life.

A health promotion policy would, as a first step, reestablish the link between health and social well-being, between social and individual quality of life. It would not enter into what critics have called "the political production of lifestyles" (like the goal-setting documents that see health as an outcome) but as a democratic participatory "policy of lifestyles," as for example the lifestyle section of the WHO target document aims to outline.

Consequently, developing a positive notion of what we call a "policy of lifestyles" means turning the current ways of programming lifestyles into ways of democratizing their political production and cultural orientation. Strengthening civil society in its efforts to regain more control over its own reproduction in this sense becomes a key issue if we want to proceed from welfare state to welfare society.

It seems to be necessary, when talking of such matters, to state repeatedly that health is a social project linked to political responsibilities and not a medical enterprise. I hope that our societies will one day be praised by future historians for both our ability to promote health and our ability to cure illness, or to put it in other words—which are implied by an ecological philosophy—a society that as a whole is expert in maintaining well-being and in healing.

That, if anything, is a challenging agenda for the year 2000 and beyond, and Canada seems to be well on its way to become a leader in the public health of the future.