EMERGING HEALTH ISSUES:

THE WIDENING CHALLENGE FOR POPULATION HEALTH PROMOTION

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The 6th Global Conference on Health Promotion
Bangkok, Thailand, 7-11 August 2005
Abstract

There is a widening spectrum of tasks for health promotion in today’s world. Since the Ottawa Charter (1986), substantial political, social, economic and environmental changes have occurred. While many broadly-averaged measures of population health are improving, various other indices of health and its determinants are faltering. There are emerging risks to health from demographic shifts, large-scale environmental changes, the cultural and behavioural changes accompanying national development, and an economic system that emphasises the material over other elements of well-being.

Reinforcement of inter-sectoral health promotion is needed (including engaging with the development, human rights and environmental movements). Not only must health promotion often transcend the health sector, but, increasingly, it must engage beyond national boundaries. The Ottawa Charter argued for “healthy public policy” – yet that was in a world that largely predated HIV/AIDS and a surge of other infections, unyielding widespread poverty and under-nutrition, worldwide declines in freshwater and soil fertility, recognition of climate change as a health threat, and escalating chronic disease burdens in developing countries. The need for that policy-level approach has heightened.

Examples of emerging health risks and trends include:

- **Infectious diseases**: Many diseases have emerged since the late 1970s, while others have unexpectedly increased. Reasons include persistent poverty, urban crowding, environmental changes (mobilising new microbes), altered sexual relations, intensified food production, increased mobility and trade, and tardy vaccine development.

- **Regional life expectancy declines**: Life expectancy has unexpectedly declined in various countries. Factors linking these declines suggest that others could follow. Relatedly, the demographic and epidemiological transitions have faltered. In some regions, declining fertility has overshot that needed for optimal age structure, while elsewhere mortality increases have reduced population growth rates despite continuing high fertility.

- **Millennium Development Goals, health and sustainability**: Several health-related MDGs appear unlikely to be achieved. Most policy-makers do not understand the link between environmental sustainability (MDG #7) and health. Sustainability entails maintenance of Earth’s ecological and geophysical systems, and social cohesion, as the basis for health.

These large-scale risks to health present great challenges. Beyond engaging with other sectors, and across levels of society, health promotion must also address population health influences that transcend national boundaries and generations. The **big task** is to promote sustainable environmental and social conditions that bring enduring and equitable health gains.
Introduction

The 1986 declaration of the Ottawa Charter reflected a growing awareness that, in many parts of the world, declines in the social, economic, political and environmental conditions that underpin population health were jeopardising the goal of *Health for All by 2000*, signed 8 years earlier in Alma Ata. This awareness stimulated fresh strategies to induce healthier behaviours for both communities and individuals, reflected in phrases such as “healthy choices should be easy choices” and calls for “healthy public policy”. The Charter also emphasised the important, but often latent, health-promoting role of informed and empowered communities.

The forces driving the upward trajectory in global health evident in the decades before 1978, including the development and dissemination of improved health technologies, health services, decolonization and foreign aid, gave Health for All credence. But many of the underlying social forces that stimulated to the Ottawa Charter have intensified, despite the efforts of those concerned with health advancement and protection, and despite large increases in formal evidence and understanding of the fundamental determinants of health. Indeed, the foundations necessary to *maintain* current health levels are now at risk, while in some regions hard-won health gains have already been reversed.

Periodic attempts to reverse this trend, such as the Millennium Development Goals (MDGs), have slowed but not reversed this slide. Indeed, the rate of deterioration in the fundamentals needed for good global health appears to be quickening.

Two fundamental causes for these “emerging health risks” are: (i) economic policies that emphasise markets and intensified throughput over other elements of social, environmental and personal well-being, and, relatedly, (ii) Earth’s ever-diminishing spare “bio-capacity” available for exploitation. While an economic system that disproportionately benefits the powerful is hardly new, this co-exists with a human population with an expanding capacity and aspiration to appropriate and critically transform nature on a global scale.

The scale of these synergistic problems is unprecedented. If it seems overstated to call this combination “dangerous”, bear in mind that the WHO constitution argues that “Unequal development in different countries in the promotion of health and the control of disease . . . is a common danger” for humankind as a whole. To this long-recognised danger of grossly unequal health development must now be added the danger of unprecedented environmental change.

This paper discusses six selected contemporary emerging health issues, all relevant to and reflective of increased global health inequalities. The first four are the challenge of infectious diseases, urbanisation, declines in regional life expectancy, and the relationship between health and global environmental change, including to the climate. The UN’s (2000) Millennium Development Goals are then viewed in the context of sustainability and health. Finally, we discuss the faltering of the global epidemiological and demographic transitions. We explore the linkages between these six issues, and conclude that health promoters must give heightened emphasis to population-level influences, and must expand alliances with other government sectors and other social reformers in order to improve population and community health.

Other emerging health issues which cannot be discussed in detail here include: (i) population ageing (including long periods of dementia-based dependency); (ii) the changing nature of work, including employment casualisation and the gulf of economic power separating consumers from workers; (iii) the increasing burden of road traffic accidents in low-income countries; (iv) the increasing likelihood of destructive acts of terrorism and bioterrorism, and (v) the increasing burden of mental health problems.

This paper does not consider in any detail the Health Promotion strategies needed to address these emerging health issues. Rather, the paper reviews the changing health-risks which highlight how today’s world differs from that of the Ottawa Charter in 1986. However, we identify a systems-based understanding and a capacity to think on a larger scale and longer term as an underlying principle needed.
1. Emerging and re-emerging infectious diseases

In the early 1970s, it was widely assumed that infectious diseases would continue to recede: sanitation, vaccines and antibiotics were at hand. The subsequent generalised upturn in infectious diseases was unexpected. Worldwide, at least 30 “new” infectious diseases have been recognised since 1975.5 HIV/AIDS has become a serious pandemic. Several “old” infectious diseases, including tuberculosis, malaria, cholera and dengue fever have proven unexpectedly problematic, including because of increased antimicrobial resistance,6,7 new ecological niches, weak public health services and activation of infectious agents (e.g., tuberculosis) in people whose immune system is weakened by AIDS.

Diarrhoal disease, acute respiratory infections and other infections continue to kill more than seven million infants and children every year.8 In parts of sub-Saharan Africa mortality rates among children are now increasing.9 While persistent poverty has preceded and shadowed most of these conditions the spread of some, such as SARS and West Nile Fever, have been promoted by trade, affluence and air travel.

This recent upturn in range and burden of infectious diseases reflects a general increase in opportunities for entry into the human species, transmission and long-distance spread. The underlying influences include increases in population size and density, greater mobility (including for air-travellers, migrants and refugees), population age-distributions unfavourable to development10 and conducive to violence,11 persistent poverty – especially in overcrowded and unhygenic slums, encroachment on undisturbed ecosystems and human-induced large-scale environmental changes (such as ongoing changes to the world’s climate system. These causes are further complicated by conflict and warfare, gender-based violence, political ignorance, denial (as has occurred with HIV/AIDS in parts of sub-Saharan Africa), iatrogenesis (as with HIV in China) and vaccine obstacles.

While specific new infectious diseases cannot be predicted, there is now improved understanding of the conditions favouring disease emergence and spread: (i) new human-microbe contacts, as in animal domestication and forest clearance;12,13 (ii) disturbance of natural ecosystems and their various internal biotic controls;14 and (iii) poverty, crowding, social disorder and under-nutrition – and, at the other end of the nutritional spectrum, people with impaired immunity due to poorly controlled diabetes (an obesity-associated disease on the increase globally).

The apparent failure of WHO’s Roll Back Malaria program15 shows the risk of stand-alone (vertical) approaches to disease and the difficulties in operating outside older institutions. Yet the program raised new funds, increased high-level awareness, and led to political pledges of support. This encapsulates a dilemma for health promotion. Enthusiasm, while necessary, is insufficient. Technical advice, attention to detail and genuine collaboration are essential.

Finally, this is a microbially-dominated world, and we must understand and approach our relations with microbes primarily in ecological (not military) terms. We cannot banish the world’s infectious agents; but we can eliminate some, control many, and we have knowledge of how to reduce human population vulnerability and avert conditions conducive to infectious disease occurrence – both of which should be foci of health promotions strategies. We would thus achieve a more sustainable approach to human-microbe co-existence.

2. Urbanisation: gains and losses for population health

Most of the recent global population increase has been absorbed by towns and cities in developing countries. The urban environment is rapidly becoming the dominant “human habitat”. Few cities have been able to adequately plan and provide social and material infrastructure essential for health, resulting often in un- and under-employment,16 slums and other high-risk environments. Rapid urbanisation transforms many values and behaviours, alters social relations, and leads to various health gains and losses. In recent decades, rural-to-urban migration yielded a net health gain in many developing countries (as in European countries in the nineteenth century). This is no longer assured. Losses include breakdown in family and community relations; amplified violence and drug-abuse; reader spread of many infections; road trauma; air pollution; a distorted daily energy-balance in an ‘obesogenic’ urban environment;17 and, for many, a search for meaning and spiritual connection unfulfilled by consumerism.18
Empirical evidence and understanding of how some health risks are embedded in urban design, infrastructure (especially transport systems), housing, marketing strategies and retail choices have recently increased – as has the understanding of how these ‘urban’ health risks are modulated by socioeconomic and other disparities. This growing awareness of the urban environmental and social contextual influences on health risks, in contrast to a focus on personal behaviours and consumer choices, underscores the important ecological dimension that health promotion strategies must embrace if enduring health gains are to be achieved.

3. Declines in regional life expectancy: Reflecting what?

The upward trajectory in life expectancy forecast in the 1980s\textsuperscript{19} has been challenged by recent major reversals in several regions, especially in Russia\textsuperscript{20} and sub-Saharan Africa.\textsuperscript{21} Although these could either be temporary aberrations or be unconnected to one another, identifiable factors appear to link these declines – declines that may presage other falls in life expectancy.

The dramatic decline in life expectancy in Russia since 1990 has been unprecedented for a technologically developed country. Many proximal causes have been well-documented, including increases in alcoholism (especially binge drinking), suicide, violence, accidents and cardiovascular disease.\textsuperscript{22} These factors suggest a society facing a collective crisis of social disintegration and crisis.\textsuperscript{23} As recognised with malaria and HIV in sub-Saharan Africa, these adverse health consequences are of sufficient consequence to further depress population health.

In sub-Saharan Africa, HIV/AIDS has combined with poverty, malaria, tuberculosis, depleted soils and undernutrition,\textsuperscript{24} deteriorating infrastructure, gender inequality, sexual exploitation and political taboos to foster a runaway epidemic that has reduced life expectancy, in some cases drastically. In turn, adverse health and human capital losses, caused both by disease and the out-migration of skilled adults has helped to “lock-in” poverty. In parts of sub-Saharan Africa childhood mortality has increased, not only directly from AIDS but also because of a loss of parents and other carers.\textsuperscript{25} More broadly, indebtedness and punitive development policies, including charges for schooling and health services, often introduced as a consequence of structural adjustment programmes, have also hurt population health in Africa, following decades of earlier improvement.\textsuperscript{1} The intersectoral implications for health promotion are clear.

Conflicts – most notoriously in Rwanda\textsuperscript{26} – has also been on a sufficient scale to temporarily reduce life expectancy for some populations. Age pyramids skewed to young adults have almost certainly played a role in this violence,\textsuperscript{27} together with resource scarcity, pre-existing ethnic tensions, poor governance and international inactivity when crises develop.

4. Global environmental changes (including climate change)

Sustainable population health depends fundamentally on the viability of the planet’s life-support systems – the integrity of the natural environment. For humans, achieving and maintaining good population health and wellbeing is the true goal of sustainability. Human societies have devised social structures, economic systems, technologies and environmental management practices primarily to enhance human security, wellbeing and health.

In today’s world, global environmental changes pose new risks to human health, on an unprecedented spatial-temporal scale. Over recent years, evidence has accrued of complex human-induced environmental changes at global/worldwide scales – climate change, stratospheric ozone depletion, biodiversity loss, regional downturns in the productivity of land and oceans, freshwater depletion, and disruption of major elemental cycles (especially sulphur, phosphorus and nitrogen – resulting in environmental nitrification). Over the coming decades, these long-term change processes could exact a great health toll via physical hazards, infectious diseases, food and water shortages, conflict and an inter-linked decline in societal capacity.

Material living standards and life expectancy have increased greatly in most countries during the past half century. However, trends in measures of “inclusive” wealth which account for the true economic costs of the drawdown of natural and social capital (the support systems needed for biological production and social harmony) are less favourable. These data reveal that the true increase in net
income is less than supposed, and in some populous countries is actually declining. More fundamentally, the juxtaposition of regions with declining inclusive wealth may generate harmful synergies, including conflict and health declines.

We currently extract "goods and services" from the natural environment about 25 per cent faster than they can be replenished. Correspondingly, there is now little unused "biocapacity" to draw down. In combination, we are therefore transmitting an increasingly depleted natural world to future generations, and this will have inevitably have adverse health consequences. While the distribution of these adverse effects is likely to be unequal, and – for many – lagged, it is not inconceivable that this decline could eventually harm the entire human population.

Global climate change is attracting increasing attention. Fossil fuel combustion for industrial processes, agriculture and transport has caused unprecedented levels of atmospheric carbon dioxide and other heat-trapping gases. The majority expert view is that climate change, which is likely to also involve significant hydrological and agricultural changes, is now underway. WHO has estimated that, globally, over one hundred thousand deaths annually result from recent change in the world’s climate relative to the baseline average of 1961-1990.

The most direct risks to future health from climate change are posed by heatwaves (exemplified by the estimated 25,000 extra deaths in Europe in August 2003), cyclones and floods. Climate-sensitive biotic systems will also be affected. This includes: (i) the vector-pathogen-host complex involved in transmission of various infections (both vector-borne infections and those due to various bacteria such as salmonella), (ii) the production of aeroallergens, and (iii) the agro-ecosystems that generate food. Recent changes in infectious disease occurrence in some locations – tickborne encephalitis in Sweden, cholera outbreaks in Bangladesh, and, debatably, malaria in the east African highlands – may partly reflect regional climatic changes.

Altered climate and ecosystems, biodiversity losses, and other large-scale environmental stresses will, in combination, affect the productivity of local agro-ecosystems, freshwater quality and supplies, and the habitability, safety and productivity of coastal zones. Such impacts will cause economic dislocation and population displacement. Conflicts and migrant flows would increase, and, variably, a mix of violence, injury, infectious diseases, malnutrition, mental disorders and other health problems would result.
Figure 1. Major pathways by which global and other large-scale environmental changes affect population health.

These and other categories of global environmental changes, often acting in combination, pose serious health risks to current and future human societies (see Figure 1). The important message from this diagram is that, increasingly, human health is influenced by social-economic and environmental changes originating well beyond national or local boundaries. The major, perhaps irreversible, changes to the biosphere’s life-support system, including its climate system, increase the likelihood of adverse inter-generational health impacts.

5. Emerging health issues and the Millennium Development Goals

In 2000, UN member states agreed on eight Millennium Development Goals (MDGs), with targets to be achieved by 2015. Four MDGs refer explicitly to health outcomes: eradicating extreme poverty and hunger; reducing child mortality; improving maternal health; and combating HIV/AIDS, malaria and other infectious diseases. Figure 2 indicates the relationships of the MDG topic areas to the emerging health issues discussed in this paper.
Figure 2. Relationships between: (i) social and environmental conditions and their underlying economic and demographic influences, and (ii) the Millennium Development Goal topics. (Three of this paper’s main issues – urbanisation, environmental changes, infectious diseases – are explicitly represented as boxes.)

Many of the MDG targets are already in jeopardy. While all MDGs are inter-linked, the ‘environmental sustainability’ MDG has fundamental long-term importance. Without it, the other concomitants of sustainability – economic productivity, social stability and, most importantly, population health – are unachievable.

Striving for sustainability should not, however, overshadow tackling the existing, immediate, social and environmental problems that directly affect the health-related MDGs. But, by similar token, we cannot ignore the connections of population size and economic growth with health status, poverty and environmental sustainability. The burgeoning environmental impact of humanity’s collective ‘ecological footprint’ reflects the ongoing increases in both the levels of per capita consumption and population size. Therefore, an additional reason to advance the MDGs is because that will help slow population growth rates, and that will reduce our collective ecological footprint.

6. The faltering demographic and epidemiological transitions

Both the demographic and epidemiological transitions have become less orderly than previously predicted. In some regions (including parts of Europe, Russia, Japan, and possibly China) declining
fertility rates have overshot the rate needed for an economically and socially optimal age structure, while in other countries population growth has declined substantially because of the reduced life expectancy discussed above. Further, the health dividend from a reduction in poverty may still be only partial because of the emergence of “diseases of affluence”, including those due to obesity, tobacco use and air pollution.

During the Green Revolution (which coincided with the period before the drafting of the Ottawa Charter) a prevalent view was that unconstrained population growth has little impact upon environmental amenity and other conditions needed for human well-being. This view has recently been re-evaluated, signifying a return to an earlier, more cautious approach to the benefits and costs of rapid population growth. There is increasing recognition of the likely adverse effects, including high unemployment when population increase outstrips growth of opportunity. Hence, unsustainable regional population growth is characterised by age pyramids excessively skewed to young age, high levels of under- and un-employment, and intense competition for limited resources. These circumstances predispose to a social milieu inimical to public health. Indeed, if there is also significant inequality and/or ethnic tension, catastrophic violence can result.

Although they have vastly different demographic characteristics, there are links between the life expectancy declines in Russia and parts of sub-Saharan Africa, particularly the erosion of public goods. Viewed on an even larger scale, these set-backs accord with certain elements of a global class system, in which privileged groups in both developed and developing countries act (often in concert) to protect their own position at the expense and health of others.

While inequality is intrinsic to all human societies, its current scale and accelerating growth, in the context of a declining stock of spare “bio-capacity” (the capacity of the Earth’s biological and other natural processes to provide, replenish and absorb – see above) jeopardises the already faltering demographic and epidemiological transitions. Hence, future population growth may slow not only because of a decreased fertility linked to increased life expectancy (in some regions), but because of persistently high death rates elsewhere.

On the other hand, the resurgent awareness of these related issues, the publicity surrounding the MDGs, the ongoing campaigns against poverty and Third World debt, calls for public health to address political violence, and the renewed vigour of social movements for health (e.g., the People’s Health Movement) afford new potential resources and collaborations to the global health promotion effort.

Globalisation, trade, economic policy, and public health: Towards a unifying explanation for faltering health

There is intense debate about the health benefits of the complex social, cultural, trade and economic phenomena that comprise “globalisation.” Well-informed advocates have differing viewpoints – perhaps inevitably, given the complex mix of factors that allow alternative explanations of health consequences that might otherwise be attributed to globalisation. The debate itself, however, indicates that the net gain or loss for population health from globalisation is unclear.

As described above, the rate of gain in average global life expectancy has recently slowed, as has the ‘classical’ epidemiological transition associate with ‘development’. These changes to a blunt but powerful indicator of population health question the proposition that globalisation confers widespread health benefit. Further, many of the health (and other) dividends that might be attributed to globalisation have alternative explanations – for example, health gains in many developing countries may actually be the time-lagged result of development policies and technologies introduced before the era of structural adjustment and partial economic liberalisation. The accelerated demographic transition in China has also played an under-recognised role in that country’s rapidly growing wealth, as did China’s earlier investments in health and education.

In theory, free trade, via the mutual benefits of comparative advantage, can benefit all populations. In reality, wealthy populations are likely to continue tilting the economic and political playing field so that the theoretical shared gains of free trade (as, indeed, was predicted by some 19th-century trade theorists). Indeed, a powerful real-politic impediment to the complete removal of trade-distorting national subsidies is that this would probably entail a greater relative economic loss for wealthy
countries than for the poor. The economic disadvantages incurred to date through partial market
deregulation have largely been confined to relatively poor, politically weak, populations. Any
suggestion of broadening these economic stringencies to more powerful populations, especially to
their subsidised agricultural sectors, provokes great opposition.

The current dominance of economic theory and criteria, in government, presents a major challenge to
health promotion in tackling fundamental impediments to wide and enduring gains in health. The
narrow focus of the World Trade Organization, in largely discounting the adverse social, 
environmental and public health impacts of its championing of ‘free-trade’ policies, underscores the
problem. Today’s dominant economic theory evolved when environmental limits were considered
remote.\textsuperscript{49} Besides, these theories assume that increased per capita income will offset the non-costed
losses (‘negative externalities’), whether those affect social welfare, environmental resources, or
public health. Critiques of these theories\textsuperscript{27,45} consistently note that the harshest costs of modern
economic practices fall upon ecosystems and populations with little current economic power or value
– including generations not yet born.

Many indices of inequality, including in health, income, and the risks from climate change, have risen
in recent decades.\textsuperscript{26,50} To date, much of the critical commentary on this\textsuperscript{51} has been largely conceptual,
emphasising the adverse experiences of the disadvantaged and unborn. Meanwhile, the practical
feedback actually received by the main beneficiaries of modern economic policy is mostly positive –
and hence misleading. Hence, a major challenge for the promoters of health (and other forms of
justice) is to adduce stronger evidence to convince policy-makers to promote these public goods,
even though this may diminish the relative privilege of those policy-makers and their constituencies.

This is a tall order – but an essential task for health promotion. The diverse challenges of modern
globalisation cannot be ignored. Mobility of capital brings development, but its fickleness risks
capricious flight, with consequent economic and public health hardship. Deregulated labour conditions
facilitate cheap goods, but concentrate occupational health hazards among powerless workers.\textsuperscript{52}
Increased labour mobility and steep economic gradients weaken family and community structures,
contribute to “brain drain” (including of many health workers)\textsuperscript{53} and promote inter-ethnic tensions. All
these endanger or erode the health of vulnerable populations.

In summary, global and regional inequality, narrow and outdated economic theories and their
misleading price signals, and an ever-nearing set of global environmental limits are endangering
population health. On the positive side of the ledger, there have been gains in literacy, information
sharing, and food production (environmental costs notwithstanding) and access to food in some
regions, and new medical and public health technologies continue to confer large health benefits.
Overall, though, reliance on economic processes to achieve social goals and to set priorities, and on
technological fixes for environmental problems, are poorly attuned to the long-term improvement of
global human well-being and health. For that, a transformation of social institutions and norms, and,
hence, of public policy priorities is needed.\textsuperscript{54} The criterion of population health should be a powerful
lever in that process of change. That is part of the modern task of health promotion.

**Emerging Health issues: The challenges for health promotion**

This paper has explored the widening spectrum of tasks for health promotion in today’s world. Since
the Ottawa Charter (1986), substantial political, social, economic and environmental changes have
occurred. While many broadly-averaged measures of population health are improving, various other
indices of health and its determinants are faltering.

The sources of many contemporary risks to population health are of large spatial and temporal scale;
they affect whole systems and social-cultural processes (in contrast to the many continuing health
risks from personal/family behaviours and localised environmental exposures). These newly
recognised risks to health derive from demographic shifts, large-scale environmental changes, the
cultural and behavioural changes accompanying national development, and an economic system that
emphasises the material over other elements of well-being.

These emerging risks to health present a huge challenge. The wider community, including most
governments, are not yet well attuned to understanding or responding to these larger-scale influences
on health. They fall outside the popular focus on health risks in relation to personal behaviours,
specific environmental pollutants, doctors and hospitals. In countries where the prevailing ethos promotes individual choice and responsibility, there are few economic incentives to promote the population’s health or other public goods.

Health promotion must, of course, continue to deal with the many local and immediate health problems faced by individuals, families and communities. But to do so without also seeking, to guide social-economic development and the forms and policies of regional and international governance is to risk being “penny wise but pound foolish”. Tackling these more systemic health issues requires multi-sectoral policy coordination at community, national and international levels, via an expanded repertoire of bottom-up, top-down and “middle-out” approaches. The essential task is that of population health promotion.

Reinforcements for the work of population health promotion must come from:

1. **Research**: Better understanding of large-scale sources of health risks, and intervention strategies, requires a capacity for systems-level interdisciplinary analyses, informed by an ethical framework. The UN’s Intergovernmental Panel on Climate Change provides a good model of interdisciplinary research that incorporates assessment of health risks. The research gaps exploited by proponents of unhealthy products and practices to oppose health-promoting reform should be filled, though some scientific uncertainty is inevitable and should not be used to excuse inaction. There is also need for better monitoring of indicators of wellbeing, social development and equity.

2. **Education**: The rising generations must understand better the ecological envelope within which the human species lives. We are a part of, not apart from, nature – and are ultimately accountable in nature’s currency. Hence, the essence of “sustainability” is that we must learn to live on the natural world’s terms, not on our own presumptuously detached (and ultimately destructive) terms. That requires changes in educational curricula and social norms.

3. **Politics and governance**: Our nineteenth-century political legacy of narrowly self-interested nation-states can be described (with some poetic licence) as a modern analogue of ancestral warring tribes. This self-centred short-termism appears to have been ‘programmed’ into the human species by the primordial evolutionary struggle for survival. Its downside, in an increasingly interconnected and inter-dependent world, is that it now threatens humanity with the adverse consequences of self-interested, non-sustainable, social, economic and environmental behaviours. We must deploy our (largely latent) ability to anticipate and shape the distant future, in order to override these counter-productive drives.

4. **Business**: This sector remains a key (potential) partner for population health. This sector can play a key role, for example, in countering emerging infectious diseases and human-induced global environmental problems. There is (at last) a growing acceptance by the pharmaceutical industry of the need to provide cheaper drugs in high-need low-income countries. There is great health promotion potential in relation to health-endangering production processes (e.g. local air pollution and greenhouse gas emissions), and in the distribution and sale of products and services harmful to health such as tobacco and energy-dense food. Business is beginning to respond to the wider health implications of its commercial actions. The sector must be encouraged to recognise that – for both ethical and self-interest reasons – there is an urgent need for corporate social responsibility to protect the health of people, workers, environment and social relations.

Health Promotion should engage effectively with the private sector in three relevant domains: corporate social responsibility, consumer and environmental advocacy, and government stewardship. Meanwhile, it must be alert to how some companies, such as major tobacco transnationals, have sought to corrupt the concept of corporate social responsibility by their actions.

**Conclusion**

The contemporary challenge for health promotion extends that foreseen in 1986. However, the essential principles of the Ottawa Charter are still valid. Tackling today’s systemic population health issues requires working at community, national and international levels. There is need for proactive
engagement with international agencies and programs that bear on the social-economic fundamentals in disadvantaged regions/countries. Many low- and middle-income countries require financial aid from donor countries to achieve the health-related Millennium Development Goals, to deal with emerging and re-emerging infectious diseases, and to counter the emerging health risks from human-induced global environmental problems. Linkages should be strengthened between the health sector, and civil society, including those struggling to promote development, human rights, human security and environmental protection.

We urgently need an increased understanding that “sustainability” is ultimately about optimizing human social and biological experiences – especially wellbeing, health and survival. That requires changes in social and political organization, and in how we design and manage our communities (especially modern urban environments). We must live within the limits of the natural world.

Beyond engaging with other sectors, and across levels of society, health promotion must also now address population health influences that transcend national boundaries and generations. The big task is to promote sustainable environmental and social conditions that bring enduring and equitable gains in population health.
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