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The role of public policy in health care promotion: A comparative perspective

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Abstract. This paper analyse the role of public policy in health care promotion in a comparative perspective. Public health has become a sensible issue, which takes up a prominent position in public and political debate. National health systems throughout the world face a common set of core challenges related to demography, epidemiology, developments in science and technology, medical demand and rising public expectations. These pressures are producing common challenges in the objectives and activities of health care in several key areas, including health promotion and the prevention of health problems. At the same time, it is also necessary to recognize the role of the political, legal and governmental processes, as well as the clinical and professional variables, in shaping different societal responses to health care promotion challenges. The approach this paper takes is to look at the documentary record for evidence of changes in the ideas and in the identity of actors that may be moving health care policy towards health promotion. This analysis is not definitive, as that would require detailed quantitative and qualitative empirical data about how health promotion is operating within the member states. However, this paper can provide a conceptual account for the determinants of health promotion and some important variables influencing the new governance in health promotion.

INTRODUCTION

The central role of public policy in influencing the health of populations emerged during the 19th century. During this period, legislation and engineering combined with public health advocacy led to environmental changes that had a significant positive impact on the health of the populations of the emerging industrial cities of Europe. The provision of clean water, sewerage and waste disposal systems, improved public hosing and food safety regulations all had substantial public health benefits. These advances were followed by the development of social welfare systems, the provision of free school education and legislation governing working hours and conditions. In each case, these policy directions had both direct and indirect benefits for the health and well-being of the majority of the population.

By the middle of the 20th century, most developed countries had achieved control of the major causes of communicable disease and associated premature mortality across most of their populations. Non-communicable diseases began to predominate as major causes

of premature mortality and morbidity. Biomedicine appeared to offer a major hope for addressing these issues. Health policy goals became focused on the provision of health care services and on ensuring widespread (if not universal) access to services and programs. The link between general public policies and population health outcomes became less obvious than it had been in previous decades. Responsibility for improving the health of the population was attributable to health care services, with little reference to the roles of other sectors. Access to high quality health care services was viewed as the central means by which further significant improvements in the health of the populations was to be achieved.

By the late 1970s, however, it had become apparent that the rapid growth in investment in health care services was not delivering corresponding improvements in the health of populations. The increasing cost of providing high quality health care services and the challenge of ensuring equal access to these services for the entire population propelled governments to review the directions of health policy in the 1980s. Many countries began to re-think the limits of medicine and the relative impact of formal health services and health services policy in improving the health of the population. This disillusionment with the existing services, programmes and policies for health found an outlet through the development and articulation of the contemporary concept of health promotion.

The approach this paper takes is to look at the documentary record for evidence in which health systems were seen to be responding both to the developing of science and technology, on the one hand, and to a variety of exogenous factors associated with patterns of morbidity, demography and mass culture, on the other. This paper considers the distinctive impact of the state on national and international health promotion trends. Taken together, these perspectives yield an encompassing overview of comparative health care promotion developments.

A TRANSFORMED FOCUS ON PUBLIC POLICY

In October 1986, the First International Conference on Health Promotion[1] was held in Ottawa, producing what is now widely known as the *Ottawa Charter for Health Promotion*. This conference was followed by others which explored the major themes of the Ottawa Charter on health public policy and on supportive environments for health.

In keeping with the concept of health as a fundamental human right, the Otawa Charter provided a contemporary model for effective public health action, defining health promotion as a combination of strategies that included "health public policy" alongside established approaches such as "developing personal skills" and mobilising communities for change. Recognition of these prerequisites highlights not only the intersectoral dimension of health, but also the inextricable links between social and economic conditions, the physical environment, individual lifestyles and health. Health promotion represents a comprehensive social and political process; it not only embraces actions directed at strengthening the skills and capabilities of individuals, but also action directed toward changing social, environmental and economic conditions to alleviate their impact on public and individual health. Health promotion is the process of enabling people to increase control over the determinants of health and thereby improve their health. Participation is essential to sustain health promotion action. As a result, the Charter reflected the role of public policy in shaping the economic and political environments, which so profoundly influence the health of individuals and populations. The Charter drew attention to the fact that health public policy is characterised by an explicit concern for health and equity in all areas of policy. The main aim of a healthy public policy is to create supportive environments to enable people to lead healthy issues. Such policy makes health choices possible or easier for citizens.

The Ottawa Charter identifies three basic strategies for health promotion. Health promoters were encouraged to advocate, to mediate and to enable rather than dictate, to rule and to "blame the victim". Through advocacy, health promotion action aims to make the underlying determinants of health as favourable as possible. These include political, economic, social, cultural, environmental, behavioural and biological

[1] The adoption of the Ottawa Charter in 1986 (WHO, 1986) brought to light the strategic significance of developing healthy public policies. Such policies are characterized by an explicit concern for health in all sectors of government jurisdiction (education, transportation, revenue, etc.). Healthy public policies thus promote the creation of a physical and social environment that allows the public to lead a healthy life (Nutbeam, 1998).

conditions. Health promotion action also seeks to reduce the differences in current health status and to ensure equal opportunities and resources to enable all people to achieve their fullest health potential. This includes a secure foundation in a supportive environment, access to information, life skills and opportunities for making healthy choices. Finally, the prerequisites and prospects for health cannot be ensured by the health sector alone; coordinated effort is needed across all sectors –government, public, private and community. Health promoters therefore have a major responsibility to mediate between different interest groups in society for the pursuit of health.

These tasks were reinforced and extended in the Bangkok Charter for Health Promotion in a Globalized World which stated: "All sectors and settings must act to: (i) advocate for health based on human rights and solidarity. (ii) Invest in sustainable policies, actions and infrastructure to address the determinants of health. (iii) Build capacity for policy development, leadership, health promotion practice, knowledge transfer and research, and health literacy. (iv) Regulate and legislate to ensure a high level of protection from harm and enable equal opportunity for health and well-being for all people. (v) Build alliances with public, private, nongovernmental and international organizations and civil society to create sustainable actions.

Since the Otawa Charter, there has been an increasing growth of discussions and publications on health care delivery and medical organization in countries throughout the world. Health promotion has come to be understood as a central public health action, which is directed towards improving people's control over all modifiable determinants of health. What is evident is that health promotion requires a diverse set of skills, disciplines, platforms and levels of authority coupled with adequate human and financial resources as well as political will. The challenge for health promotion is how to achieve this and sustain it over time. The challenge is to assess objectively the strengths and weaknesses of alternative capacity-building structures at local, regional and national levels. Although the mechanisms for effective health promotion may be poorly researched, the tasks for health promotion have remained remarkably constant over the last 25 years. The specific challenges identified in the Ottawa Charter (WHO 1986) are still as relevant today –*build healthy public policy, develop personal skills, strengthen community action, create supportive environments and reorient health services*. These agendas for action have commonly become the framework for many

health promotion strategies at local, regional and national levels as they simply and clearly set out the mix of action that is required.

Table 1 reports the major areas of health-related behaviour covered by for health promotion that are typically targeted by health education and outreach campaigns, such as smoking, nutrition (obesity prevalence) physical activity and reproductive behaviour (Gonorrhea/Chlamdya rates, abortion rates). Diabetes prevalence was included in this subset to reflect the fact that the epidemic of diabetes has become a major policy concern. According to the OECD, evidence begins to mount that it is possible to prevent diabetes through a healthier life-style (OCDE, 2004:10).

Table 1. Summary table of recommended indicators

Area	Indicator Name	Numerator	Denominator
Health Promotion			
HP	Obesity Prevalence	People with a body mass index greater then or equal to 30.	Total population
HP	Physical Activity	Number reporting engaging in leisure-time physical activity	Total population
HP	Smoking Rate	Number of smokers	Population 18 and over
HP	Diabetes Prevalence	People with diabetes	Total population
HP	Gonorrhoea/Chlamydia rates	Cases diagnosed with Chlamydia or Gonorrhoea infections	Total population
HP	Abortion Rates	Number of abortions	Female population between 15 and 45 years of age

Fonte: OCDE 2004.[2]

[2] Martin Marshall, Sheila Leatherman, Soeren Mattke and the members of the OECD Health Promotion, Prevention and Primary Care Panel. *Selecting Indicators for the Quality of Health Promotion, Prevention and Primary Care at the Health Systems Level in OECD Countries*. OECD 2004.

HEALTH PROMOTION AND HEALTH POLICY IN THE EU

Improvements in health status are only marginally affected by health care systems; most such advances come instead from improved environmental conditions and public health, better nutrition, and increased living standards. Major inequalities in health status and longevity by socioeconomic status have persisted and have even worsened in some countries, reflecting the wide range of health influences associated with social class differences and income inequalities. Most forms of mortality are preventable or can be delayed, but they depend greatly on social and environmental conditions and on healthier behaviour. Important risk factors include smoking, diet, exercise, substance abuse, risk-taking and violence.

Accompanying the concern with escalating health care costs has come a new emphasis on individual responsibility, improved lifestyles, and prevention of illness. Having reduced leverage over macro level policies relating to inequalities such as the redistribution of income, health policymakers have concentrated on changing individual behaviours. Legislative initiatives have been taken to control smoking and alcohol use through taxes and regulation and to reduce accidents through regulation of transportation and workplace conditions, strong efforts have been invested at individual level to reduce smoking and drug use, change diet, promote safe sexual behaviour, and the like.

The issue of prevention was first explicitly raised by the Lalonde report (1974)[3], soon followed by the Forward Plan for Health issued by the Public Health Service of the United States[4]. Subsequently, many other countries also developed elaborate goals to promote the health of the population by focusing on changes in individual behaviour. One example of this new agenda was found in *the Year 2000 objectives* of the US Department of Health and Human Services (1991). However, a major deficiency of these efforts was poor specification of the causal processes underlying targeted risks and uncertain technologies for altering behaviours. Objectives often functioned more as symbolic aspirations than as practical strategies.

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[3] Lalonde, M. *A New Perspective on the Health of Canadians: A Working Document*, 1974.
[4] US Department of Health, *Education and Welfare*, 1975.

In Europe, health promotion is a matter for member states, not for EU level action (Art. 152 EC)[5]. All member states have some form of public national health system. All seek to ensure near universal access to comprehensive service, although the details and the mechanism employed vary considerably. The health promotion policy of each member state reflects its history, political traditions, wealth and state of development. Various typologies for categorizing health care systems have been developed. Of course, these typologies serve mainly a heuristic purpose: no system conforms directly to an ideal type. Instead, each of them uses different combinations of policy measures, utilizing and incorporating ideal types to different extents. Approximately, half of the member states are based on a social insurance system, or *Bismarckian health care system*, the other half on a taxation-based or *Beveridgian national health system*.

Variations among the different state systems include the payment bases of social insurance, the centralization or decentralization of administration and the size of the covered population (Freeman, R & Moran, M 2000). One commonality, however, is that all health care systems in the EU rely on a mix of revenue sources. This mix includes a combination of either, progressive taxation or income-related social contributions and after-premium financial compensation, risk pooling, or risk selection prohibition, as well as adequate risk adjustment across insurers and regions, user charges and voluntary or private insurance. Ultimately, both taxation and private funding play some role in the financing of every system.

Despite their differences, all member states currently face challenges to their existing health care systems. These include changing demography (old populations), changing disease patterns (multi and chronic disease outstripping infectious disease), new expensive technologies (specially biotechnology and information technology products), changing consumer/patient expectations, post-Fordism (changing patterns of employment and contribution to welfare institutions) and welfare austerity (especially in the Eurozone as governments must meet the budgetary commitments required by economic and monetary union). At the same time, the health of European populations became increasingly recognized as a crucial element of the EU's competitiveness.

[5] See also *Standard Eurobarometer 68*. Public Opinion in the European Union, 2008: p.110-115.

Given the different institutional infrastructures, resource bases and levels of development of their respective health care systems, the challenges are experienced differently by each member state (Marmor, Freeman, Okman 2005). All face increased financial pressures on state and health budgets, and all are constrained by political reasons to preserve the commitment to existing paradigms of health care based on the principles of equal access and financial solidarity – whether through taxation or through social insurance.

Facing these challenges, all member states are examining their health care systems and seeking to modernize them, so as to continue to meet the goals of providing access to high quality care, on the basis of need, while ensuring financial sustainability. This modernization agenda comes from various perspectives and takes different forms in different member states. At its core, however, there is a shared believe that these apparently contradictory goals can be achieved by increasing efficiency in health care provision and, to some degree, by a realignment of the balance between responsibility of the family, the state and the market[6].

One way to move toward more efficient provision is to use new regulation and governance practices of our health systems. New governance is a broad concept, describing several processes and practices involving normative elements but do not operate through traditional "command and control" models employed by formal legal institutions. Such alternative arrangements are emerging across EU member states. They focus on the three interconnecting aims of "access", "quality" and "financial sustainability". Interest in, and support for, models of regulation and governance that differ from "command and control" model have focused on, among many other things, their greater efficiency and effectiveness in achieving social goals (Ayres, I.& Braithwaite, J. 1992). Examples can be found in health care promotion. For instance, almost all EU member states have embraced some form of quality management as a way of ensuring access to high quality health care for patients as well as to secure efficiency gains. Many member states have detailed comprehensive quality monitoring systems although not all of them fully implemented. Several systems involve central bodies endowed with the power of oversight and the authority to make final determinations regarding standards. Many systems also involve participation of partners

[6] Esping-Andersen, G. Why We Need A New Welfare State, Oxford University Press, Cambridge, 2002.

in setting and modifying standards based on new evidence and technological and scientific developments[7].

Quality management systems are linked to transparency and open reporting requirements, such as the use of performance indicators concerning the quality, safety, and accessibility of care provided hospitals[8]. These characteristics of the health care governance system are promoted as important elements in enhancing patient choice, and implicit increasing effectiveness in health care provision. Another example is the increasing prevalence of governance systems supporting evidence-based medicine. Many member states have established nationally evaluated clinical guidelines and diagnostic and treatment protocols that currently form the basis of health care professionals' practice (Brotons, 2001). Health care professionals are encouraged to use these guidelines and protocols[9].

Countries at different stages of development have utilized a variety of health promotion delivery approaches. For example, an emphasis on regulatory responses to support tobacco control inevitably requires the strong engagement of national governments and legislative bodies[10]. More devolved service measures such as promoting and providing immunization means that health professionals and health services need to be engaged actively. A focus on educational approaches for children, such as encouraging healthy eating, needs the active engagement of schools and kindergartens. An infrastructure development to provide more and safer recreational spaces requires the contribution of town planners and local governments. Hence, the list goes on, the combination of responses and responders are seemingly endless.

When the health governance is weaker or less structured, there are calls for separate health promotion agencies or authorities. A government capacity and engagement grows

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[7] For instance, the Danish National Board of Health published in December 2007 a report called: "Evidence in Health Promotion and Disease Prevention" to provide an account of how evidence can be understood in the area of health promotion and disease prevention.

[8] Kahan & Goodstadt (1999) explore a set of questions that assess the potential benefits of continuous quality improvement with respect to health promotion organizations.

[9] There are national guidelines documents for Patient Oriented Health Promotion, for instance, "The Evidence of Health Promotion Effectiveness. Shaping Public Health in a New Europe", published by the European Commission, International Union for Health Promotion and Education in 1999, or the Guidelines prepared by the European Review Group on Prevention and Health Promotion in Family Medicine and General Practice.

[10] According to Christopher Hood (1983, 1986) governments have essentially four resources at their disposal – informational, financial, coercive and organizational- and can utilize those resources for either of two purposes: to monitor society or to alter its behaviour.

up, these organizations tend to react as competitors, disempowering central horizontal agencies generating confused relationships and erratic activity. Similarly, when health services are focused solely on treatment and care services, specialized health education and promotion units emerge at local level to fill the gap.

POLITICS, THE STATE AND HEALTH PROMOTION

Politics and government deserve special consideration as actors influencing health promotion in health care systems. This much is suggested by the many health system typologies that use some form of government intervention as a defining dimension (Björkman 1985). Such typologies alone, however, do not guide us on how and why different public sector roles come to be established. While societies face common health system pressures, these are filtered through collective decision-making processes to produce the reimbursement, regulatory, and other health policy decisions that shape a particular service delivery structure (Immergut 1990, 1992).

These observations are consistent with an upsurge of interest in the role of the State within comparative social analysis. According to this perspective, the State is capable of autonomous policy choices, which, in turn, may have far-reaching impacts not only on the allocation of resources, but also on a society's political dynamics[11]. Whether such autonomy actually is exercised depends on the polity's degree of independence from organized private interests and dominant economic classes. But numerous forces in the contemporary world seem to be pushing in this direction, including the expansion of state capacities and increasing involvement of states in "transnational structures and international flows of communication" (Skocpol, 1985, p.9).

Several studies have used comparative analysis to examine the impact of health politics and policymaking on the evolution of national health care systems. Through this approach, researchers seek to weight the social determinants of policy and, in particular, to distinguish culturally specific from other determinants of policy outcomes. A principal theme is the impact of political institutions on policy design. For example, Immergut (1992, 2007) studied the development of national health insurance legislation in Sweden, France and Switzerland. She concluded that different health policy

[11] See Skocpol, T and Amenta, E, *States and Social Policies*, Annual Review Sociology, 12:131-157.

outcomes resulted from different rules of the game in these societies, which determined group influence and the framing of debates.

A focus on health politics and state policymaking can help to explain both the process of health promotion convergence and circumstances when divergence occurs. Increasingly confronted by similar kinds of health system problems, societies are also exposed to the same policy thinking about effective health promotion system management. But the processing of these ideas in specific cultural and political contexts is subject to variation. As Skocpol points out, not only do states differ in their capacity for autonomy, but states have differing capacities in different policy sectors. Seeking to combine political and new governance explanations for the health sector evolution, Wilsford[12] (1991) maintains that "there is a universal logic in health care that drives policies toward the same goals across countries and across cultures. This holds in spite of the fact that over the short term there is clearly broad variation across countries and cultures in the timing of policy, in the nature of policy instruments, and in the distribution of health care responsibilities". Yet, even in the long-term, it is difficult to predict the stubbornness of exceptionalist trends in a nation like the United States, which repeatedly has stood on the verge of universalizing health insurance coverage, then faltered, and whose per capita medical costs are so high relative to other countries. Recent developments in the new health care policy in the US seem to reinforce this expectation.

IS THERE A CONVERGENCE AMONG COUNTRIES?

The concept of health systems moving toward convergence in response to certain scientific, technological, economic and epidemiological imperatives has commonly been misunderstood or misrepresented. Based on Denis Bouget[13] policy convergence, there are three main positions within the debate on policy convergence: (i) all countries converge towards best practice. (ii) clubs of countries converge towards shared policy solutions. (iii) and each country endogenously develops its own policy changes through

[12] Wilsford, D., Doctors and the State: The Politics of Health Care in France and the United States", Durham, NC, Duke University Press, 1991, p.5.
[13] Bouget D., « Convergence in Social Welfare Systems: from Evidence to Explanations », *European Journal on Social Quality*, vol.6, n°1, 2006, p.109-126.

national trial and error processes. Translating to the arena of health promotion, the hypothesis of convergence does not imply that health care systems, which develop out of the particular historical and cultural background of a nation and its dominant ethos, will not continue to have distinct social and cultural characteristics reflecting the ideological orientations and socio-cultural context of a country. Nor does the concept negate the importance of competition among health professions for defining and controlling the division of labour. Finally, there is no implication that the convergence hypothesis indicates automatic change outside the unique history and political dynamics of any society.

Many social, historical and situational factors affect the particularities of any health care system, and no exact form of organization is inevitable. At any point, there are alternative pathways a nation can follow. Cultural processes, local politics, and even individual personalities may be sufficiently dominant to overcome probabilistic trends. What the convergence hypothesis does imply, however, is a certain macro process in which a narrowing of system options takes place, compared with those theoretically possible, due to forces that generally lie beyond the control of particular national actors or institutions and to which more and more societies are being exposed.

In the recent comparative health literature, the convergence hypothesis has received strong empirical evidence. For example, a study of health policy in OECD nations concluded that the most remarkable feature of health care system reform among the seventeen countries was the degree of emerging convergence. At least, six fundamental types of convergence affect countries that vary greatly in government, culture, stage of economic development and population characteristics: The six major areas of health promoting convergence are: (i) Nations are concerned with cost control and efforts to improve efficiency and effectiveness of health services. (ii) As a consequence of the foregoing, and of the realization that health promotion is substantially a product of the circumstances outside the medical care system, many nations are developing initiatives to promote health and improve health-related behaviours. (iii) More nations are concerned about inequalities in health outcomes, as well as access to medical care, and seek to develop initiatives to reduce them. (iv) All nations are struggling with the effects of technology and specialization, and many are seeking to develop or strengthen their primary health care systems. (v) There is growing interest throughout the world with

patient satisfaction and increased efforts to enhance patient participation, choice and voice in the organization of health services. (vi) With aging populations and growing prevalence of chronic disease, nations are giving attention to the linkage between health and social services and seeking to reduce fragmentation so evident in this area. Whether intentionally or not, the reforms follow in the general direction to those pioneered in other countries.

HEALTH PROMOTION: A RESTRICTIVE OR ENGAGING POLICY?

Europe increasingly suffers from lifestyle related diseases triggered by an unbalanced diet, physical inactivity, smoking or alcohol abuse. The challenges facing health care planners, such as an ageing population and growing problems of obesity, tobacco consumption and sexually transmitted disease, are best tackled through a coordinated approach to public health planning, which involves legislation as a prominent component[14]. The question which remains unsolved is whether restrictive or engaging policies are the best way to persuade the public to make healthier lifestyle choices.

We have ample evidence from everyday life that people at large do not agree on what constitutes a "right choice" of lifestyle, even when they know that that choice has influence on for future individual health. For decades, we have known that smoking causes disease but still some people choose to smoke, even when there are no apparent determinants in their social background or environment, which influence them to do so. Banning smoking or levying heavy taxes on tobacco may be right for other purposes but it does nothing to involve or empower individual patients and members of the public who smoke or may want to start smoking. The same could be said about patients who are obese –banning certain kinds of processed foods may promote health in a restrictive and authoritarian sense, but will not empower those who consume the products to make informed and independent choices for themselves.

Social research evidence shows that patients generally feel insufficiently involved in decisions relating to their care; that tests and treatments were in most cases not properly explained to them; that information was often insufficient and inappropriate; and that there was rarely anyone available for patients to talk about their anxieties and concerns.

[14] Francesco Branca, Haik Nikogosian and Tim Lobstein, *The Challenge of Obesity in the WHO European Region and the Strategies for Response*, 2007.

Research shows that engagement of patients in managing their own health care can not only improve their experience but it often results in more effective utilisation of health services and better public health outcomes (Coulter and Rozansky, 2004). Yet, health care systems have been slow to develop explicit training tools which enable partnerships between health professionals and patients, to support them in self-care and self-management of chronic conditions, and to share decisions that concern their health situation. One major recommendation for greater patient engagement lies in building health literacy and ensuring professionals and patients to help themselves in managing their own health. Health care systems have different but scarce options available to promote this development. The health sector requires careful strategic planning and reform of the health service infrastructure but also, fundamental changes in public and professional roles and attitudes. There are two essential components: (1) On the one hand, health policymakers need to provide the tools which patients and citizens require in order to get engaged in health and health care. (2) On the other hand, there is a need to prepare providers of care, the health professionals, through education and training, so that they become prone to help and facilitate patient and public engagement.

There is a need for finding ways to broaden public and patient access to high quality information on health and health care issues, which they can use to make decisions related to their choice of life style and treatment. A bureaucratic emphasis on policy making and legislation fails in the quest to empower patients and members of the general public. In order to do that successfully, public health systems need to give the highest priority to the development and dissemination of information, which suit the requirements of patients, not those of legislators and policymakers.

The second component towards increased patient and citizens engagement in health has to do with the way doctors and other health care professionals are educated and trained. Education should facilitate doctors' awareness and responsiveness to patients' evolving needs, and help them to adjust their attitudes and practices to meet the changing requirements and expectations. On the other hand, it is crucial that patients cooperation and awareness become part of the decision-making process.

CONCLUSIONS

The health society has expanded itself far beyond the ever-rising expectations of the curative medical care system. To be considered as a right, health can be promoted, managed and reproduced by addressing its own determinants, as well as by influencing individual and social behaviour and lifestyle. It is also a necessity. Human health, as much as the environment, is a key sustainability issue: HIV, AIDS, SARS, influenza, mental health and obesity, all are warning signs that our way of life may be at odds with our health.

While a great deal is known about promoting health care, we are far from developing an appropriate analytic framework and operational tools to produce structural and procedural positive variations among individual nations. No particular set of economic, organizational, political or cultural factors suffices. Scientific medicine is a sub-world culture with rapid communications tools. Countries readily borrow ideas from one another. The history of each health care system, to the extent that we have adequate social and political histories, makes clear that no particular form is inevitable but that it depends on the actors and circumstances prevalent at any particular time. While there are many internal variations among health promotion systems reflecting national history, culture and politics, a productive way of understanding health promotion developments, is to focus on the exogenous factors that increasingly put common burdens on systems throughout the world. The strength of these factors is not identical from one country to another, and they occur at varying rates and interact in different ways. Nonetheless, they provide an excellent test tool to monitor and evaluate the evolution of health promotion in its principals outlines.

A new breed of policy strategies for health promotion put too much emphasis on health promotion through legislative measures. New governance mechanisms will need to be established to separate political responsibility for the curative care system from overall governance for health and well-being. More attention should be paid to finding ways of engaging patients directly in their own care through self-care and self-management of chronic conditions. Although legislators have a role to play here, real change must happen from the bottom to the upper level. Public health policy-makers must ensuring that high quality information is available and disseminated, but it is even more crucial that this information will enable patients and citizens to make decisions that are right for

their health. Developing the way in which health care professionals are educated and trained, to prepare them for partnerships with patients and to ensure their responsiveness to patients' evolving needs, may well be another key component of a move towards greater patient and citizen engagement. Changes along these lines to the way health care is delivered will not only have the potential to improve public health, they will genuinely empower patients and citizens.

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