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# Implementation of the Bangkok Charter on Health Promotion in a Globalized World: experience and challenges of selected high income countries in Europe

*Health inequalities are still prevalent in high income countries and remain a major challenge for health promotion. (WHO Regional Office for Europe 2002; WHO Regional Office for Europe 2005). The poor health of people is due to limited life opportunities in key areas, among others and most notably, low education, unemployment and social exclusion as well as environmentally conditioned behaviors such as tobacco use, harmful use of alcohol, unhealthy diet and sedentary lifestyle. There are strong links among limited life opportunities, unhealthy behaviour and poor health; and, thus, an urgent need to tackle the social and economic causes of poor health (Wilkinson & Marmot 2003; WHO Regional Office for Europe 2002).*

*The Bangkok Charter for Health Promotion in a Globalized World (WHO 2005a; Broesskamp 2006) urges all sectors to act together to achieve health for all by addressing the underlying causes of health through four commitments to make the promotion of health (a) central to the global development agenda; (b) a responsibility of all ministries of governments at the global, regional, national and local levels; (c) a key focus of communities and civil society; and (d), a requirement for good corporate practice.*

*To fulfill the commitments set out in the Bangkok Charter, priorities for action need to be identified and models and methods for practice developed. Moreover, they must be developed based on country experience. Progress has been made in placing health at the centre of the development agenda but what developmental issues should health promotion engage in and how?*

*To overcome the traditional restricted role of the health sector, which does not cover many of the underlying causes, Sweden has set out mechanisms and processes to tackle the social and economic causes of poor health, including reports to the national parliament, defined roles and responsibilities for different sectors and allocation of earmarked and regular budgetary resources (Hogstedt et al. 2004). In the UK, health is now also considered a "corporate" (whole of government) issue. Finland has made "health in all policies" the priority for its EU Presidency in 2006. Switzerland has set out in its vision paper on prevention and health promotion the need for different sectors to work together (Bundesamt für Gesundheit 2006). How the whole of government approach can be promoted and managed remains unclear and the experience from Sweden, the UK, Finland and Switzerland will be instructive.*

*Non government organizations (NGOs) including professional associations within and outside public health, have been increasingly active in health promotion. However, there is still room for improvement in collaboration between health and welfare NGOs in many countries, for example, in initiating and shaping health promotion in a coordinated manner. There is also a need to put in place mechanisms and processes for NGOs at the national levels to build institutional capacity to promote health and respond to global issues that affect health.*

*Interactions between health promotion and the private industry are increasing but there are still limited models and methods as to how best the corporate sector can be engaged to promote health by reducing the harmful effects of trade, products, services and marketing.*

*The Bangkok Charter also recommends a set of action strategies to strengthen health promotion: advocating for health based on human rights; investing in sustainable health promotion; building alliances with all sectors, including the private sector; regulation and legislation for health; and, building capacity to promote health. Capacity refers not merely to the expertise of individual practitioners to apply models of best practice, but also to other areas of concern, including policy, finance, information systems and partnership. Again, models and methods for practice are required*

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*to map out the appropriate strategies. Human rights are considered a high priority on the EU development agenda and meeting the need of disadvantaged people is a focus. (European Commission 2004). To expand the finance base for health promotion, a legislated special levy on products such as tobacco and alcohol is in place in Finland and Hungary for funding health promotion. In Austria, through the Health Promotion Act, mandatory funding from general revenue is available for health promotion. Medical insurance companies in Switzerland contribute a sum of CHF 2.4 per insured person for health promotion, whereas in Germany, the sickness funds contribute EUR 2.6 per insured person. As set out in its vision paper, Switzerland has made a commitment to increase health promotion funding to 3% of the health budget. The contributions of health promotion to a sustainable social health insurance system and to national health have also been recognized in Germany and Finland where social health insurance schemes have commenced investing in health promotion. In Switzerland, it is proposed by the draft vision paper to include in the Swiss Constitution a right to health promotion for every Swiss.*

*The development of models and methods for practice needs to be evidence based. Evidence of the effectiveness of health promotion interventions in combating communicable and chronic diseases is available (International Union of Health Promotion and Education 1999; WHO 2002a; WHO 2002b; WHO 2005a; WHO 2005b). However, interventions that have been proven effective in tackling social and economic causes of poor health need to be expanded, for example, in education, employment and social participation opportunities. While the link between higher education and health is known, there is a need to expand the evidence base of school health interventions in promoting easy access to education or higher education for the disadvantaged and reducing the health and achievement gaps between the rich and poor. Effective interventions that aim to achieve income maintenance through employment, particularly employment opportunities for young people are also lacking. Interventions that have been shown effective in reducing social exclusion among migrants and minority groups are needed, particularly, at the policy and institutional levels. Models and methods are also very much in need to encourage the private sector to be socially responsible.*

*The focus on tackling the social and economic causes of poor health also implies a shift in the focus of capacity building, from targeting diseases and risks to health to the underlying causes of poor health, from targeting individual behaviour to organizational behaviour and from health sciences to social and political sciences. It poses an additional challenge for the implementation of the Bangkok Charter, and the experience in Europe in this area will provide valuable guidance.*

*To conclude, for the effective implementation of the Charter at the country level, WHO is developing a global framework for health promotion strategy in which a set of priorities for action, models and methods as well as benchmarks for reporting progress will be included. The country experience is critical to the development of the global framework.*

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