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# Health promotion and quality of life: a historical perspective of the last two 40 years (1980-2020)

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**Abstract** *This article updates the previous text of the main author published in 2000, revisiting the scientific evidence that reaffirms the contribution of health to the quality of life of individuals and populations. More than the access to health services of any quality, it is necessary to face determinants of health in its entirety, which requires healthy public policies, an effective intersectoral articulation of public power and mobilization of the population. The authors revisit the emergence and development of health promotion, focusing on the analysis of the most promising health strategies for the increase in quality of life, especially in societies with high social and health inequalities, as in the case of Brazil, reinforced by the recent pandemic of COVID-19. Such strategies were concretized on healthy municipalities and intersectoral actions, in health and in all policies which confront social determinants, through their own foundations and practices that are closely related to innovations in public management for integrated and sustainable local development, in view of the 2030 Agenda and its Sustainable Development Objectives (SDG).*

**Key words** *Health promotion, Quality of life, SDG, 2030 Agenda*

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## Introduction

Living conditions and health status have improved continuously and sustainably in most countries, thanks to political, economic, social, environmental progress and advances in public health and medicine. Studies from different authors and reports on global[1,2] and regional health in the Americas are conclusive in this regard. In Latin America, for instance, life expectancy has increased from 72.3 to 76.9 years over the past 20 years. However, the same organizations are categorical in pointing out the persistence of profound inequalities between countries, within them, in regions and between social groups[3].

When examining the prevailing conditions of morbidity and mortality in the Americas, one can find a persistence of problems that have already been solved in many places (certain infectious and parasitic diseases and conditions related to urban infrastructure); the growth of chronic diseases such as cancer, neurodegenerative diseases, cardio and cerebrovascular diseases and external causes. New problems also arise (such as the contemporary COVID-19), increased drug addiction, violence and mental health problems. The main social response to such questions has been growing investments in curative and individual medical care, although it is identified that preventive measures, health promotion and improvement of living conditions are in fact the key reasons for the aforementioned advances.

This article is intended to discuss the contribution of health promotion, as a field of knowledge and practice, to the quality of life. To that end, these concepts and some strategies capable of operationalizing their interaction are discussed: healthy public policies requiring intersectoral action and a new social institutionality that has been materializing with health proposals in all policies, healthy municipalities, 2030 Agenda and its Sustainable Development Goals (SDGs). This text is an updated version of the article by Paulo Marchiori Buss, 2000. Health promotion and quality of life[4].

### Health and quality of life

Throughout history, politicians and thinkers have been concerned with the influence of health on living conditions and quality of life, and vice versa. In the 18th century, when he served as director general of public health in Austrian Lombardy, Johann Peter Frank wrote, in his famous *The People's Misery, Mother of Diseases (De populorum miseria: morborum genitrices)*, that poverty and poor living and working conditions and malnutrition were the chief causes of disease. He advocated, more than sanitary reforms, broad social and economic reforms[5]. In the first half of the 19th century, when referring to the health status of English people, Chadwick claimed that it was affected by the social and physical environment and that poverty was often the result of diseases for which individuals could not be held responsible, an important factor in increasing the number of poor people[6]. According to Sigerist[5], Chadwick wanted not only to alleviate the effects of the health and living conditions of the poor in England, but to transform their causes.

The role of medicine, public health and the health sector in tackling what would be the broadest and most general causes of health problems, that is, those that escape medical practice itself, has long been challenged. In Germany, for example, in the years leading up to the revolution of 1848, Rudolf Virchow led a powerful medical reform movement advocating that medicine is a social science. And politics is nothing else but medicine on a large scale[5].

In their already classic book, McKeown & Lowe[7] state that the improved nutrition and sanitation and changes in human reproductive behavior (especially the decrease in the number of children per family) were responsible for the reduction of mortality in England and Wales in the 19th century and the first half of the 20th century. Effective medical interventions, such as immunizations and antibiotic therapy, had a late and relatively important influence. On the world stage, classic studies, such as the English "Black Report" of 1980, in addition to a remarkable tradition of Canadian, North American and European studies, are lavish in showing the relationship between health and living conditions/quality of life.

The debate on quality of life/health and living conditions has also a reasonable tradition both in Brazil and in Latin America. Paim[8] published a review of studies in the field of medicine and social epidemiology linking living conditions and health. The author highlights the pioneering works of Josué de Castro, Samuel Pessoa, Hugo Behm Rosas (Chile), and more recent ones, such as Breilh and Gandra, in Ecuador, Laurell, in Mexico, and Monteiro, Possas, Arouca and those of the author himself, in Brazil. The relationship between health promotion and quality of life[9-25] is also highlighted in studies that have been published since 2000 in the Journal "Ciência & Saúde Coletiva".

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In 2000, the Brazilian Association of Collective Health (ABRASCO) held a seminar on living conditions and health status where several Latin American authors discussed the subject "health and quality of life". The same has been happening in Brazilian congresses on collective health, epidemiology and social sciences and health, promoted by said entity in different circumstances. Two reviews, which were published simultaneously[26,27], explore different dimensions of the subject. In 2019, PAHO[3] data indicated advances in improving the health of the population of the Region of the Americas, while highlighting the work that still lies ahead. In particular, interventions that can and should come from the health sector.

In the articulation between health and conditions and quality of life, the development of health promotion as a conceptual and practical field can be identified, with flagrant inspiration from thinkers and pioneering movements in public health and social medicine. It will be discussed below.

**Health promotion**

Health promotion, as it has been understood in the last 30-35 years, represents a promising strategy to face the health problems that affect human populations. Starting from a broad conception of the health-disease process and its determinants, this strategy proposes the articulation of technical and popular knowledge and the mobilization of institutional and community, public and private resources in favor of quality of life.

A little more than thirty years after the publication of the Ottawa Charter[28], one of the documents that founded the contemporary concept of health promotion, this term has been associated with a set of values: quality of life, solidarity, equity, democracy, citizenship, development, participation and partnership, among others. It also refers to a combination of strategies: by the State (healthy public policies), by the community (strengthening community action), by individuals (development of personal skills), by the health system (reorientation of strategies) and by intersectoral partnerships. Health promotion works with the idea of multiple accountability for problems and solutions.

Health promotion reacts to the increased medicalization of social life and is a sectorial response that articulates several technical resources and ideological positioning. Although the term was initially used to characterize a level of care in preventive medicine[29], its meaning has changed and has also started representing a political and technical focus around the health-disease-care process.

The modern concept of health promotion has developed more vigorously over the past 30 years in developed countries, particularly in Canada, the United States and countries in Western Europe. Nine International Conferences[30] on the subject, held in the last 34 years – in Ottawa (WHO, 1986), Adelaide (WHO, 1988), Sundsvall (WHO, 1991), Jakarta (WHO, 1997), Mexico (2000), Bangkok (2005), Nairobi (2009), Helsinki (2013) and Shanghai (2016) – deepened their conceptual and political basis. In 1992, in Latin America, the International Conference on Health Promotion[31] was held, formally bringing the subject to the sub-regional context.

Sigerist *apud* Rosen[6] was one of the first authors to use the term, when he defined the four major tasks of medicine: promotion of health, prevention of illness, restoration of the sick and their rehabilitation. The author stated that health is promoted by providing decent living conditions, good working conditions, education, physical culture and forms of leisure and rest, for which he called for a coordinated effort by politicians, union and business sectors, educators and medical doctors.

Leavell & Clark[29] used the concept of health promotion when developing the model of the natural history of disease, proposing three levels and five stages at which preventive measures could be applied. *Primary prevention*, with measures intended to develop health as a specific protection of human beings against pathological agents or through environmental barriers. Education for health is an important element for this purpose, as well as: good nutrition patterns; proper personality development: parent education; sex education and prenuptial counseling; adequate housing; recreation; favorable conditions at home and at work; periodic health checks and advice and contact between doctors and their patients.

Health promotion, under the aforementioned modalities, proved to be insufficient to face chronic noncommunicable diseases. With the second epidemiological revolution[32], strategies of care started being associated with preventive measures on the physical environment and on lifestyles, rather than exclusively on the status of individuals and families.

The different concepts of health promotion can be brought together in two large groups[33].

The first concept relates to activities aimed at transforming individual behaviors, locating them within families and in community settings. In this case, the programs tend to focus on educational components related to behavioral risks that can be changed and are under people's control, such as smoking, high-fat diet, a sedentary lifestyle, reckless driving[29].

The second group emphasizes the leading role of general determinants of health conditions and is based on understanding a wide range of factors, such as food, housing and sanitation, working conditions, opportunities for lifelong education, physical environment, social support for families and individuals, responsible lifestyle and health care. Strategies are considered to be the result of policies and conditions conducive to the development of health through healthy choices and strengthening the capacity of individuals and communities to act. It formally emerged in Canada in May 1974, with the release of *A New Perspective on the Health of Canadians*, also known as the Lalonde Report[34]. Lalonde was the then Minister of Health of that country. The document's core motivation seems to have been political, technical and economic, as it aimed to face the rising costs of medical care, while relying on questioning the exclusively medical approach to chronic diseases, with few significant results.

The fundamentals of the Lalonde Report are found in the concept of the health care field, which brings together the so-called *determinants of health* and includes four components: human biology, environment, lifestyle and health care organization. In that document, the author concluded that almost all of Canadian society's efforts to improve health, as well as bulk of direct health care expenditures, were focused on the health care organization. However, the main causes of illness and death were rooted in human biology, environment and lifestyles.

In 1978, the World Health Organization (WHO) called, in collaboration with the United Nations Children's Fund (Unicef), the 1st International Conference on Primary Health Care, which was held in Alma-Ata[35]. The conference set the goal of "health for all in the year 2000" and recommended eight points considered to be essential to achieve this goal: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; water supply and basic sanitation; maternal and child health care and family planning; immunization against major infectious diseases; prevention and control of endemic diseases; appropriate treatment of common illnesses and injuries; and distribution of essential drugs.

Perhaps the hallmark of this conference was the proposal for Primary Health Care (PHC). But other less publicized points must be highlighted: reaffirming health as a right; repudiation of social inequalities; the need for a new world economic order; government responsibility for the health of citizens; and the right of the population to participate in health care decisions. The conclusions and recommendations from Alma-Ata brought important reinforcement to the advocates of health promotion strategies, which culminated in the 1st International Conference on Health Promotion, held in Ottawa, Canada, in 1986.

As already mentioned, this second conception restores, albeit in a different way, the propositions of 19th century sanitarians, such as Villermé, in France; Chadwick, in England, and Virchow and Neumann, in Germany, for whom the causes of the epidemics were both social and economic as well as physical, and the remedies for them are prosperity, education and freedom[32].

Hartz[36] comments that promotion can also be considered an axis to be privileged in training, investigation and evaluation in the field of public health, aiming at the reorganization of the system of care and intersectoral articulation. The importance of recursive integration of practices-training-research, mediated by the "concept" of socio-sanitary space in evaluation studies, has served to document collaborations from different sectors and spheres of activity, and to show conflicts, differentials in resources and power and social inequalities. However, the search for a solution to the controversies that arise leads to innovations, organizes spaces for reflexivity and facilitates the integration of different actors.

Gutierrez[37], in a reading appropriate to Latin America, in addition to the elements already mentioned, highlights the role of the community and the non-delegable responsibility of the State. In summary, the concept of health promotion has been developed by different technical and social actors, in different circumstances and social backgrounds. In Charts 1 and 2, you can see a brief (and certainly incomplete) chronology of the development of the field of health promotion in the world and in Brazil, according to Buss[38].

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**International Conferences on Health Promotion**

*Ottawa Conference* – With the participation of about 38 countries, mainly from the industrialized world, the 1st International Conference on Health Promotion had as its main product the so-called Ottawa Charter, which became a term of reference for health promotion ideas all around the world. For this reason, it will be given more space than the description of the others[30].

The Ottawa Charter defines health promotion as the process of empowering the community to work on improving their quality of life and health, including greater participation in the control of this process. The document emphasizes that health is a major resource for social, economic and personal development of a people, as well as an important dimension of their quality of life, going beyond the idea of healthy life-styles. It also declares that the conditions and prerequisites for health are: peace, education, shelter, food, income, stable ecosystem, sustainable resources, social justice and equity. According to the Charter, health advocacy, enablement and mediation are the three fundamental strategies for health promotion.

The document states that health promotion aims to ensure equal opportunities and means to enable all people to achieve their fullest human potential: supportive environments, access to information, life skills, and opportunities for making healthy choices. Social and health professionals have a responsibility to contribute to achieving this purpose.

The Ottawa Charter proposes five areas for action: (1) designing and implementing healthy public policies; (2) creating supportive environments for health; (3) strengthening community action; (4) developing personal skills; (5) reorienting the health system. The implementation of healthy public policies implies the construction of health as a priority for politicians and leaders of all sectors, materializes through legislation, fiscal measures, taxation and organizational changes, and is carried out through intersectoral actions that lead to equity in health, equitable income distribution and social inclusion policies.

The creation of supportive environments for health implies the acknowledgement of interdependent relationships between sectors: protection of the environment; monitoring the impact of environmental changes; winning the right to work, leisure, housing, school, among others; access to information and learning opportunities; education for health at home, at school, at work and in other collective spaces.

At all stages of life, the development of personal skills and attitudes conducive to health involves institutions, particularly those of education and health, in empowering people through the acquisition of knowledge, access to goods and services and increased political power of individuals and the community.

For the reorientation of health services, the Charter proposes to overcome the biomedical model, which is centered on disease and curative medical care. The expected results would be transformations in the organization and financing of systems and services, emphasizing health promotion and the training of professionals with a different mentality.

*Adelaide Conference* – The Adelaide Conference, held in 1988, focused on healthy public policies in all areas, identifying intersectorality and public sector accountability, not only for the social policies it makes or fails to make, but also for economic policies and their impact on the health status and the health system. The final document reaffirmed the global vision and the internationalist responsibility for health promotion: it established that, due to the economic, social and health gap between countries, developed countries have an obligation to ensure that their own public policies result in positive impacts on the health of developing nations[30].

*Sundsvall Conference* – This 3rd Conference held in Sweden in 1991 was the first to focus directly on the interdependence between health and environment. It took place in the effervescence prior to the first of the great United Nations initiatives planned to prepare the world for the 21st century: The United Nations Conference on Environment and Development, Rio-92. The awareness of individuals, social movements and governments about the risks of a collapse of the planet, in the face of the countless and profound environmental aggressions resulting from the mode of production and consumption of contemporary societies, was gradually increasing. The event brought the environmental issue not restricted to its physical or natural dimension, but also social, economic, political and cultural. It clearly referred to the spaces where people live: the community, their homes, their work, their recreational spaces and the economic and political structures that determine access to resources to live and make decisions. It underlined four aspects: (1) the social dimension, which includes norms, customs and social processes that

**Chart 1.** Health Promotion: a brief chronology.

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| 1974 – Lalonde Report: A New Perspective on the Health of Canadians / Uma Nova Perspectiva sobre a Saúde dos Canadenses |
| 1976 – Prevention and Health: Everybody's Business, DHSS (Great Britain) |
| 1977 – Health for All by the Year 2000 – 30th World Health Assembly |
| 1978 – International Conference on Primary Health Care – Alma-Ata Declaration |
| 1979 – População Saudável/Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention, US-DHEW (USA) |
| 1980 – Relatório Black sobre as Desigualdades em Saúde/Black Report on Inequities in Health, DHSS (Great Britain) |
| 1984 – Healthy Toronto 2000 – Campaign launched in Canada |
| 1985 – European Office of the World Health Organization: 38 Health Goals within the European Regions |
| 1986 – Alcançando Saúde para Todos: Um Marco de Referência para a Promoção da Saúde / Achieving Health for All: A Framework for Health Promotion – Canada's Ministry of Health Report. |
| Ottawa Charter for Health Promotion – 1st International Conference on Health Promotion (Canada) |
| 1986 – VIII National Health Conference (Brazil) |
| 1987 – Launch of the Healthy Cities Project by WHO |
| 1988 – Adelaide Statement on Healthy Public Policy – 2nd International Conference on Health Promotion (Australia). |
| From Alma-Ata to the year 2000: Reflections at the Midpoint – International Meeting promoted by the WHO in Riga (USSR) |
| Brazil – Brazilian Constitution, article 196: Health is everyone's right and duty of the State, guaranteed through social and economic policies aimed at reducing the risk of disease and other health conditions and the universal and equal access to actions and services for its promotion, protection and recovery.1989 – A Call for Action – WHO document on health promotion in developing countries |
| 1990 – United Nations World Summit for Children, NY. |
| 1991 – Sundsvall Statement on Supportive Environments for Health – 3rd International Conference on Health Promotion (Sweden) |
| 1992 – United Nations Conference on Environment and Development (Rio-92) |
| Santa Fé de Bogotá Declaration – International Conference on Health Promotion in the Region of the Americas (Colombia) |
| 1993 – Caribbean Charter for Health Promotion – 1st Caribbean Conference of Health Promotion (Trinidad and Tobago) |
| United Nations Conference on Human Rights (Vienna) |
| 1994 – United Nations Conference on Population and Development (Cairo) |
| 1995 – United Nations Conference on Women (Beijing) |
| World Summit for Social Development (Copenhagen) |
| 1996 – United Nations Conference on Human Settlements (Habitat II) (Istanbul) |
| 1997 – United Nations World Food Summit (Rome) |
| 1997 – Jakarta Declaration on Health Promotion into the 21st Century – 4th International Conference on Health Promotion (Indonesia)2000 – 5th Global Conference on Health Promotion (Mexico City) |
| 2000 – United Nations Conference on the Millennium Development Goals |
| 2005 – 6th Global Conference on Health Promotion (Bangkok) |
| 2006 – National Health Promotion Policy (Brazil) |
| 2008 – Report from the Global Commission on Social Determinants of Health (WHO) |
| 2009 – 7th Global Conference on Health Promotion (Nairobi) |
| 2012 – United Nations Conference on Environment and Development (Rio +20) (Brazil) |
| 2011 – WHO World Conference on Social Determinants (Rio de Janeiro) |
| 2013 – 8th Global Conference on Health Promotion: Health in All Policies (Helsinki) |
| 2014 – National Health Promotion Policy (Brazil), revised and updated version |
| 2015 – United Nations Conference on Sustainable Development Goals (SDGs) and launch of the 2030 Agenda |
| 2016 – 9th Global Conference on Health Promotion (Shanghai) |
| 2018 – Global Conference on Primary Health Care (Astana) |
| 2019 – United Nations High-Level Meeting on Universal Health Coverage |

Source: Updated by the authors from the original article by Buss[38]

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**Chart 2. Health** Promotion in Brazil: decade by decade – 1970-2010.

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| **1970s** |
| . Criticisms about the model of care centered on medical and hospital care. Social medicine. Social sciences in health |
| . Thesis "The Preventivist Dilemma", by Sérgio Arouca |
| . First primary care/community medicine projects (Montes Claros/MG, Papucaia/RJ and Niterói/RJ) |
| . Emergence of the "Sanitary Movement" |
| . International Conference on Primary Health Care and Alma-Ata Declaration in Brazil |
| . Creation of Cebes (1976) and Abrasco (1979) |
| **1980s** |
| . Movement for the re-democratization of Brazil |
| . Political leading role of the "sanitary movement" |
| . Preparation of the 8th National Health Conference, with broad civil society participation (1985) |
| . 8th National Health Conference, stating health promotion principles. WHO publishes the Ottawa Charter (1986) |
| . Constituent Process, with great participation of the "sanitary movement" (1986-1988) |
| . Federal Constitution, with health promotion characteristics (Article 196) (1988) |
| **1990s** |
| . Organic Health Law, restating the promotion principles of the Constitution (1990) |
| . Organization of Health Councils at all levels: social participation, equal composition, intersectoral representation (1991) |
| . Rio-92, United Nations Conference on Environment and Development |
| . National Health and Environment Plan: prepared, but never left the drawing board (1995) |
| . As from 1995, PACS and PSF; NOB 96 (Basic Attention Floor); National Opinion Survey on Health; Debates on Healthy Municipalities |
| . Creation of the Health Promotion journal (Ministry of Health) and 1st National Forum on Health Promotion (1999) |
| **2000s** |
| . Strengthening of the Family Health Program (PSF) and the Community Health Agents Program (PACS) |
| . National Primary Care Policy (PNAB, 2006). |
| . National Health Promotion Policy (2006). |
| . National Commission on Social Determinants of Health (CNDSS) (2006-2008). Report "Social causes of health inequities in Brazil" |
| **2010s** |
| . Transformation of the PSF into "Family Health Strategy" (ESF) and new versions of the PNAB. |
| . RIO +20, United Nations Conference on Environment and Development (2012) |
| . National Health Promotion Policy (2014), updated version. |
| . Establishment of the Department of Health Promotion (DEPROS), in the new Primary Health Care Secretariat (SAPS) in the Ministry of Health (2019) |

Source: Updated by the authors from the original article by Buss[38].

affect health, and it warned of the breakdown in traditional relationships due to increasing social isolation and loss of values; (e) the political dimension that requires governments to guarantee democratic participation in decision-making processes and the decentralization of resources and responsibilities; (3) the economic dimension, which underlines the need to scale resources for social, health and sustainable development sectors; (4) the use of women's skills and knowledge, including in the political and economic sectors[30]. The document mentioned local experiences from all over the world, forming scenarios for action in the so-called *Sundsvall Pyramid of Supportive Environments*: education, food and nutrition, housing and neighborhoods, social support and care, work and transport. Such experiences were brought together and reviewed in a WHO report[39].

*Jakarta Conference* – It was the first Conference held in a developing country. From its subheading "New players for a new era", community action was reinforced as a fundamental dimension of health promotion. The conference reinforced

the five strategies described in the Ottawa Charter, showing that actions are most effective when simultaneously focused on all. Five priorities were defined for subsequent years: (1) promoting social responsibility for health, through healthy public policies and private sector commitment; (2) investments in the health sector in conjunction with education, housing and social areas; (3) consolidating and expanding partnerships at all levels of government and society; (4) increase community capacity and empower individuals through education, leadership training and access to resources; (5) defining preferential settings for action (schools, workplaces and others)[30].

*Bogota Declaration* – This is how the document that launched the health promotion proposal in Latin America is known. It states that the Region must create conditions that guarantee general well-being as a fundamental purpose of development. It starts from the analysis that, plagued by inequalities there were exacerbated by the prolonged economic crisis and macro-economic adjustment policies, Latin America faces deteriorating living conditions for the majority of the population, increased health risks and reduced resources to tackle them. The health promotion challenge includes transforming exclusionary relationships, reconciling economic interests, social purposes, solidarity and social equity[31]. The document sets out five principles or assumptions:

(1) Overcoming economic, environmental, social, political and cultural inequalities; and those related to the coverage, access and quality of health care services. (2) Alternatives aimed at simultaneously overcoming the diseases caused by backwardness and poverty and those derived from urbanization and industrialization. (3) Reaffirmation of democracy in political and social relations. (4) Achieving equity by identifying factors that favor inequity and proposals for action to alleviate its effects; (5) Integral development of human beings and societies. This document outlined three strategies for health promotion in the Region: (1) drive forward the culture of health, changing values, beliefs, attitudes and relationships; (2) emphasize health promotion strategies: (3) call, encourage and mobilize a great social commitment to make health policy a priority. It also defined eleven essential commitments to achieve the proposed goals:

(1) Promote the concept of health conditioned upon political, economic, social, cultural, environmental, behavioral and biological factors, with health promotion as a strategy. (2) Call on social forces to implement the health promotion strategy. (3) Encourage public policies of equity and healthy environments and options. (4) Establish cooperation mechanisms between the social and institutional sectors. (5) Reduce unproductive spending and the proliferation of centralizing bureaucracies, sources of inefficiency and waste. (6) Strengthen the population's ability to take part in decisions that affect their lives and to choose healthy lifestyles. (7) Eliminate the effects of inequality on women. (8) Encourage dialogue between different fields of knowledge. (9) Strengthen the sector's capacity to call and mobilize social health production and show the responsibilities of different players in its construction. (10) Recognize, as workers and health agents, people committed to health promotion processes. (11) Encourage health promotion research, generate appropriate science and technology and disseminate knowledge.

*Mexico Conference* – The 5th International Conference on Health Promotion was held in Mexico City, in 2000, and its goals were: (1) to assess the impact of health promotion on health and quality of life, especially for people living in adverse circumstances; (2) to raise health to a prominent place in the development program of international, national and local organizations; and (3) to encourage the establishment of health alliances between different sectors and at all levels of society. In the Declaration entitled "From Ideas to Actions", the following points stand out: placing health promotion as a top priority in local, regional, national and international policies and programs; ensuring the active participation of all sectors and civil society in the development of promoting actions; supporting the preparation of country-wide action plans for health promotion; and establishing and strengthening national and international networks which promote health[30].

*Bangkok Conference* – In 2005, this 5th Conference emphasized the globalization processes that the world is going through and the promotion of health. While they recognized the opportunities for cooperation arising from information and communication technologies and the expansion of efficient mechanisms for global governance and exchange of experiences between countries, problems were pointed out, such as the growing increase in inequalities within countries and among them, new patterns of unhealthy consumption, environmental changes and a growing and disordered urbanization process. In the final Charter, the need for active participation by civil

society to achieve "Health for All" was reiterated and four commitments were established: (1) focus on the global development agenda; (2) core responsibility of government; (3) importance of communities and civil society; (4) investments in good corporate practices. At the end of the document, participants made a call for action and requested the United Nations to assess the benefits of establishing a Global Treaty for Health[30].

*Nairobi Conference* – The 7th Conference in 2009 was the first one held on the African continent. The Declaration of the event, entitled *"Call for Action"* reinforced the importance of promoting health, strengthening leadership, investing in the health of the workforce, training communities and individuals and improving participatory processes[30].

*Helsinki Conference* – This 8th Conference launched the challenge of building strategies with a focus on "Health in All Policies". The conference deepened the implications of decisions in all areas on health and the search for synergies between them, in favor of equity. The event's statement drew the attention of political authorities to the consequences of their decisions for the well-being and health of the populations. The following actions were proposed: (1) to adopt the Health approach in All Policies; (2) to ensure sustainable structures and processes that make this approach effective; (3) to strengthen the capacity of Ministries of Health to involve other sectors of government, through leadership, partnership, advocacy and mediation, to achieve health outcomes; (4) to develop human resources, institutional capacity and technical skills that facilitate the health objective in All Policies; (5) to adopt transparent auditing and accountability mechanisms that build trust between governments and citizens; (6) to establish safeguards against conflicts of interest that harm health in commercial investments; (7) to encourage civil society and public engagement in the development, implementation and monitoring of Health in All Policies[30].

*Shanghai Conference* – This 9th Conference was held in 2016. Its focus was to promote health through the adoption of appropriate measures and through the achievement of the Sustainable Development Goals (SDGs). The Declaration of the event contains four major themes and a set of commitments: (1) Political decision-making in favor of women's rights, displaced populations and the growing number of people affected by humanitarian and environmental crises. (2) Use of governance strategies to promote welfare. (3) Acknowledgement of cities and communities as essential environments for health. (4) Recognition of knowledge for health as a fundamental element for the promotion of health equity. The Declaration ends with a "call for action" so that the commitments made speed up the implementation of the SDGs through political commitment and financial investment in health promotion[30].

## Healthy public policies, intersectorality and healthy municipalities

In the debate on health promotion, special emphasis should be given to healthy public policies, governance, integrated social management, intersectorality, the strategies of healthy municipalities and local development. As already stated, the acknowledgement of the contribution of public policies to the health of populations is not new. It dates back to the beginnings of the Modern State, around the 17th century, although the advent of the microbiological era, in the mid-19th century, restricted the scope of sanitary action, depriving it of its character of social intervention and emphasizing its technical and sectorial character.

However, in a curious and even paradoxical way, the relationship between public policies and health has gained importance again in recent years, not so much because of its benefits, but because of the harmful effects generated. The effects of policies that drove the urban and industrial economy throughout the 20th century are notorious and sometimes dramatic: social inequalities, irreparable environmental damage in some cases, morbid social environments of sociopathy and psychopathy, for instance.

The contemporary idea of healthy public policies involves a double commitment: that of placing health at the top of the public agenda, promoting it from the administration sector at the discretion of the government, and the technical commitment to emphasize, as the focus of intervention, the determining factors of the health-disease-care process. Its perspective exceeds in scope the environmental actions of the traditional public health and even the urban policies to expand services and collective consumer goods. It implies an innovative (re)formulation of both the concept of health and the concept of State (and, therefore, public policy) and its role in society.

The new conception of State, underlying the proposal of healthy public policies, is one that (re)establishes the centrality of its public character and its social responsibility, that is, its com-

mitment to the common good and interest. In a perspective of state reform, it implies an effort (institutional design) to overcome deficits in efficiency/effectiveness (ability to *do* what should be done) and representativeness/sensitivity (ability to *define* what needs to be done, according to the interest and needs of society).

An important point in the health promotion framework is the overcoming of the idea of public policies as initiatives that are monopolistic or exclusive to the state apparatus. In participatory forums, which are expressive of the diversity of social interests and needs, public policies tend to be committed to health in the "health in all policies" line.

Another fundamental aspect is the empowerment of the organized population, through the widespread dissemination of evidence on the relationship between health and its prerequisites, as well as the construction of efficient mechanisms of action. In a new allocation of duties and rights between the State and society, between individuals and collectives, between public and private, the participation issue is an institutional and political prerequisite for defining the "health we want".

An important precaution is to prevent the defense of healthy public policies from implying the subordination of other government sectors, generating resistance and causing isolation. With interdisciplinarity as its cognitive foundation and intersectorality as its operational tool, healthy policies must give rise to or be based on horizontal pacts with partners from other government sectors and other epistemic communities, such as urban planners, educators and environmentalists, so that they are not limited to a socially stillborn bureaucratic normativity. The longed-for intersectorality can be defined as *the process in which the objectives, strategies, activities and resources of each sector are considered according to their repercussions and effects on the objectives, strategies, activities and resources of the other sectors*[31].

Forging a State that operates in the logic of intersectoral public action involves developing a new social institutionality[40], understood as the set of state bodies in charge of the design, coordination, execution and financing of social policies, including health policies. This new institutionality depends on the configuration of a social authority, or the group of those responsible for social policies, who coordinate intersectoral policies and other development-oriented arrangements. This social authority should have a position at the same level in the power structure as the economic authorities, with clearly defined planning and execution roles, in addition to guaranteed funds in the budget allocation.

Several countries on the continent have been looking for institutional designs that articulate government instances, both intra- and inter-sectorally, with civil society. In the case of countries with a federative structure like Brazil, coordination between the various administrative levels and the social subsectors is also necessary. Such an approach necessarily requires the creation of inter-institutional networks and a new organizational culture that requires improving the quality of the human resources involved and generating new forms of relationships and communication between the different spheres of the state apparatus[40].

In Brazil, over the last three decades, a series of experiences in public management and social mobilization has given rise to the organized implementation of an intersectoral action perspective, under the label of integrated and sustainable local development[41]. Recently, driven by the 2030 Agenda and the definition of the Sustainable Development Goals, initiatives have been created with a view to achieving the proposed goals. Latin American public health can really contribute effectively to the theoretical and practical construction of such proposals, mainly through the "Healthy Municipalities" strategy, a model that contains the requirements for the preparation and implementation of policies for health through intersectoral actions.

The "healthy cities" movement emerged in Europe, in the same year (1986) that the aforementioned Ottawa Conference was held. According to Ashton[42], the project aims to develop local action plans for health promotion, based on WHO's principles of health for all. Currently, the initiative involves many locations in several networks on five continents. The establishment of the program in a municipality generally includes four phases: beginning with the determination of priorities, preparation of an action plan, unification of the organizing committees and the execution of activities and creation of information systems for monitoring and evaluating the initiatives.

Supported in the Santa Fé de Bogotá Declaration[31] by most Latin American countries, the healthy municipalities movement reached Latin America in the early 1990s. The movement proposes to restructure the health system and articulate it with other systems, by shaping integrated policies and programs for human development and welfare. According to PAHO[43], this approach

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focuses on action and participation, as well as health education and communication for health, aiming to expand the community's ability to improve their physical and psychosocial conditions in the spaces where people live, study, work and play. This movement advanced rapidly in the Americas region in the 1990s, reaching more than 500 municipalities in virtually all countries on the continent. Two "Latin American Meetings of Municipal Health Departments" have already been held, one in Cuba (1994) and another in Brazil (1996) to consolidate the initiative and exchange experiences.

The configuration of healthy municipalities varies according to each location, ranging from sectoral programs and those aimed at promoting healthy individual behaviors to quite comprehensive proposals that reach different dimensions and sectors. Many countries have established national networks to exchange experiences and to seek advantages and incentives in negotiations with other levels of government. A huge challenge that still remains is the identification of the best forms of social institutionality for integrated and participatory local management.

Finally, a reminder: technological innovations – tools, services and digital platforms – have great potential to contribute to health promotion and disease prevention. Solutions, such as applications, online forums, blogs, social media, among other novelties, can expand the possibilities for people to communicate for the sake of a healthy life. However, just as digital media can expand the benefits, the European Union Report, published in 2019[44], warns that the lack of safe access to digital resources and the lack of knowledge to use the available tools can exacerbate health inequities.

## Conclusions

Health professionals, social movements and people's organizations, politicians and public authorities have responsibilities for the positive or negative repercussions that public policies have on the health status and living conditions. The healthy municipalities strategy is one of the initiatives that can enable, through a new social institutionality, health promotion through intersectoral action.

Here, as in everything in the health field, there are no ready-made recipes. Mediation between the population and government, as well as education for the exercise of citizenship and social control, are invaluable contributions to health promotion that cannot be neglected or lost.

The change in legislation, the introduction of innovations in the Community Health Agents and Family Health Programs and the expansion of the basic care floor can, in the Brazilian case, cause an extraordinary boost to the quality of life and health status, under the health promotion perspective.

Global commitments, such as the 2030 Agenda, associated with local development proposals, can contribute greatly to the establishment of pro-health alliances and to innovations in public management, around processes such as the intersectoral approach to healthy public policies[45].

Advocating for health and promoting health among politicians and civil society movements is a form of activism that falls on those who work in the sector and, in Brazil, believes in SUS (the Brazilian Universal Healthcare Program).

## Collaborations

PM Buss, ZMA Hartz, LF Pinto and CMF Rocha participated equally in all stages of updating the scientific article originally published in 2000 by the first author. PM Buss revised the entire text.

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