



Health promotion and holistic health management: An integrative framework

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Abstract

Global public health is confronted by interconnected twenty-first-century burdens: non-communicable diseases (NCDs), rising mental-health morbidity, population ageing, persistent health inequities, planetary environmental degradation, and the limits of hospital-centred biomedical care. Traditional biomedical and disease-prevention paradigms prioritise diagnosis, risk-factor screening and individual behavioural advice, yet insufficiently account for reciprocal interactions between physical, psychological, existential-spiritual, social, structural and institutional drivers of population well-being. This narrative theoretical review reconstructs an integrative conceptual framework for holistic health management grounded in landmark international health-promotion documents, biopsychosocial medical theory, social-determinants-of-health scholarship, and peer-reviewed holistic-well-being literature (Lu, 2026). Drawing upon documentary synthesis of World Health Organization (WHO) charters and declarations, alongside seminal journal articles, monographs and official population-health reports, this paper analyses the historical evolution of health-promotion thinking from narrow disease control toward multi-layered health governance. A four-dimensional holistic-health construct is elaborated, comprising physical, psychological, spiritual-existential, and social-relational domains. Each domain is interdependent, operating through recursive feedback loops mediated by individual lifestyles, social-support processes, built and socioeconomic environments, and public-policy regimes. This review explicitly rejects the widespread misinterpretation of the Lalonde Report's conceptual four-domain health-field model as fixed universal percentage weightings for heredity, healthcare, environment and lifestyle. Instead, health determinants are analysed along three analytical axes: level of action, modifiability, and policy leverage. A three-tier governance architecture is presented spanning individual capability-building, organisational-community enabling environments, and cross-sectoral public-policy intervention. Context-specific practical implications are discussed for implementation within Taiwan. The integrated model unites holistic-well-being perspectives, health-determinant science and multilevel governance into a single coherent framework. This work reinforces that contemporary health promotion is not an optional add-on to clinical healthcare services, but a person-centred, system-wide management practice re-embedding health within everyday lived experience, social relationships and public institutional design.

Keywords: Health promotion, holistic health, social determinants of health, biopsychosocial model, sports, exercises, well-beings

Introduction

The World Health Organization established health as a basic requirement which enables people to live well and creates strong communities and enduring social growth (WHO, 1948). The twentieth century health practice focused on defining health through its basic components which consisted of being free from disease and physical weakness. The health system dedicated its complete operational resources to perform medical evaluations and provide emergency care and handle patient recovery after they experienced sickness (Misselbrook, 2014) ^[29]. The second half of the twentieth century brought about an epidemiological transition which changed how populations worldwide experienced diseases because infectious illnesses switched to non-communicable chronic diseases which now include cardiovascular disease and many cancers and chronic respiratory illness and type 2 diabetes and common mental-health conditions (WHO, 2023a). The existing NCD cases stem from various changeable risk factors which include poor eating habits and lack of exercise and smoking and drinking alcohol dangerously and prolonged mental distress and negative social situations (Lim *et al.*, 2018). Public health researchers now understand that population health results need more than hospital-based medical care to solve their core problems because health risks and defensive

elements spread throughout homes and schools and workplaces and community spaces and urban settings and work laws and social support systems and multiple government programs (Frieden, 2010; Marmot *et al.*, 2008) ^[9, 26].

The WHO Constitution (WHO, 1948) established health as a complete state which includes physical and mental and social well-being in addition to disease-free status. The definition went beyond basic term expansion because it described health as an active positive state which humans achieve and it spread health responsibility from medical experts to people and their communities and government institutions. The Government of Canada released A New Perspective on the Health of Canadians through the Lalonde Report in 1974 (Lalonde, 1974) ^[21]. The document introduced the health-field concept which separated human population health into four main conceptual areas that include biological factors and environmental conditions and personal behaviors and medical service systems. Potvin *et al.* (2005) ^[34] created a heuristic analytical framework which served as their main research approach instead of developing universal statistical apportionment through empirical data. The Ottawa Charter for Health Promotion (WHO, 1986) established health promotion as a process which helps people gain better control over their health

while improving their health status. The document presented five essential strategic pillars which focused on developing healthy public policies and building supportive environments and enhancing community involvement and teaching personal competencies and transforming healthcare delivery systems. The Ottawa Charter established modern health promotion which blocked individual health education because it works to build social and physical settings that affect health (Rootman *et al.*, 2001).

The medical field experienced two essential model developments because Engel (1977) ^[7] created the biopsychosocial model which showed that biological factors alone do not explain how diseases develop or how patients experience their illnesses or their path to recovery. Medical understanding needs to include both psychological elements and social environment factors which exist in the current situation. The biopsychosocial model established a framework which allowed health psychology and positive psychology and social-network epidemiology and health-literacy science to develop their understanding (Murray, 2014; Nutbeam, 2000) ^[31, 32]. Health exists as a complete active system which goes beyond measuring individual body markers so management systems need to include emotional states and life values and personal beliefs and social connections and community involvement and environmental experiences (Dunn, 1959; Hettler, 1980 ^[6, 14]; Lu, 2026). This review adopts holistic health as its main perspective which unites modern health-promotion theories through its four interconnected domains that include physical health and psychological health and spiritual-existential health and social-relational health.

The WHO global health-promotion conferences established international standards which developed progressively through each conference. The Jakarta Declaration (WHO, 1997) established a connection between globalisation and poverty and urban environmental changes in addition to its established health promotion work. The Bangkok Charter (WHO, 2005) ^[34] established corporate responsibility as a vital element which needed partnerships between different countries for health promotion activities. The Geneva Charter for Well-being (WHO, 2021) ^[25] established health promotion as a part of four main global initiatives which include fair economic systems and complete health coverage and digital operations with responsible leadership and environmental protection. The twenty-first century health promotion objectives reach beyond personal health risk behavior changes because they seek to create national systems which support population health maintenance.

The research review investigates four specific research goals which study the changing theoretical framework and worldwide policy environment. The research conducts a full assessment of health promotion theoretical frameworks which started with biomedical and preventive medical approaches and developed through the Lalonde health-field framework and the Ottawa Charter and all WHO international declarations that followed. The research presents a four-dimensional holistic-health model which unites physical and psychological and spiritual and existential and social and relational aspects into a single framework that shows all vital components and their mutual effects between different domains. The research team will perform a new examination of common public misconceptions about the Lalonde Report while they fight against the use of fixed-percentage determinant weights

through their tri-axial analytical system which measures action levels and change potential and policy intervention points. The research team will create a three-level health-promotion-governance model which will lead to development of specific operational methods that adapt to Taiwanese public-health environments in universities and workplaces and local communities.

The central thesis of this paper shows that health promotion activities should not function as separate activities which operate outside of standard clinical healthcare services. The system functions as a complete management system which moves health away from medical settings to become a part of daily life and social connections and public health administration.

Methods

This paper is a theoretical narrative review which uses documentary analysis together with conceptual synthesis methods described by Arksey and O'Malley in 2005 ^[1]. Through narrative theoretical reviews researchers build new integrative conceptual frameworks by analyzing core conceptual frameworks and important policy documents together with academic research findings instead of performing effect size aggregation like quantitative systematic reviews do. The main goal of this research involved discovering essential opposing elements which Rikki wanted to analyze for their differences and similarities between models to build a useful whole health promotion system based on Western holistic health development research (Lu, 2026) ^[24]. The research based its findings on five different categories which included official WHO health promotion documents and Canadian government archives for the original 1974 ^[21] Lalonde Report and academic publications about biopsychosocial medicine and social health factors and health promotion theories and health literacy and social support and spiritual well-being and holistic wellness and books about holistic wellness and salutogenesis and population health management and Lu's (2026) work on Western holistic health development and Taiwanese national health statistics and Ministry of Health and Welfare health policies.

The research team conducted their search through PubMed and Scopus and Web of Science and WHO institutional document repositories. The research team used multiple search terms which combined health promotion with holistic health and the biopsychosocial model and social determinants of health and Lalonde report and Ottawa Charter and health governance and health equity and spiritual well-being and social support and health literacy and Taiwan workplace health promotion and Taiwan campus health promotion. The selection process for materials did not follow any particular quantitative meta-analytic criteria because it focused on theoretical landmark works and highly cited empirical studies and official policy documents from grey literature. The last day for source documents to qualify for this study was September 2026. The research process needed four separate analytical stages for its execution. First, chronological reconstruction traced paradigm transitions in dominant health conceptions: from absence-of-disease biomedical frameworks, through primary-secondary-tertiary prevention, health promotion and contemporary well-being-and-sustainability-oriented paradigms. Second, building from Engel's (1977) ^[7] biopsychosocial model and the original 1948 WHO health

definition, the four-dimensional holistic-health construct was operationalised, distinguishing spiritual-existential well-being as an additional non-religiously-framed dimension alongside physical, psychological and social-relational domains (Lu, 2026). Third, the Lalonde health-field conceptual framework underwent comparison with subsequent social-determinant-of-health and health-impact-pyramid research (Frieden, 2010; Potvin *et al.*, 2005) ^[9, 34]. The study eliminated misleading fixed-percentage-weighting heuristics to create an analysis system which bases its evaluation on three criteria: level of action, degree of modifiability and policy-intervention leverage. Fourth, synthesised theoretical outputs were assembled into the three-layer integrative governance model, followed by contextual practical-strategy development for Taiwanese higher-education, workplace and community health-promotion contexts. The research team implemented bibliographic quality-control procedures. The research team verified all journal article references by using DOI numbers to find information in archival sources which PubMed and journal publishers maintain. International inter-governmental-organisation documents were retrieved directly from WHO official web repositories. The Ministry of Health and Welfare provides public access to Taiwanese governmental statistical data through their official website. The research team removed all unverifiable secondary citation claims from their analysis because these statements could lead to citation chasing which occurs frequently in narrative review studies according to Greenhalgh and Peacock (2005) ^[12].

Theoretical Evolution of Health Promotion

The classical biomedical model explains diseases through biological systems which produce pathophysiological changes and tissue damage and generate measurable biomarkers and visible clinical signs (Engel, 1977) ^[7]. The paradigm served as a foundation for major twentieth-century public health and medical care advancements which included disease prevention through vaccines and surgical breakthroughs and modern treatment methods and emergency medical care systems. The biomedical clinical approach to treatment produces major reductions in death rates when doctors treat patients who show symptoms of sudden infections and severe injuries and organ failure (Ghaemi, 2009) ^[10]. The model shows multiple documented weaknesses which prevent its application to populations that face multiple chronic diseases and their various causes. The long-term development of diseases through multiple years of lifestyle choices and social factors and environmental influences has made medical treatments based on single interventions less effective in reducing diseases that affect the entire population (McGinnis *et al.*, 2002) ^[27]. The biopsychosocial critique which Engel developed in 1977 ^[7] did not require medical professionals to stop using biomedical methods for diagnosing and treating patients. The approach required researchers to analyze patient illness experiences together with disease risks and recovery patterns through three distinct levels which included biological and psychological and social elements. The new theoretical framework established the necessary basis which future integrated care models and contemporary holistic health promotion approaches would build upon (Ghaemi, 2009; Misselbrook, 2014; Lu, 2026) ^[10, 29].

The preventive medicine field has evolved to focus on medical interventions which now occur before disease onset instead of treating patients after their symptoms become apparent. The three-level preventive system which includes primary prevention and secondary prevention and tertiary prevention stands as the standard model. Primary prevention works to reduce disease occurrence in whole populations through vaccination programs and environmental cleanup efforts and general public behavior changes. The main goal of secondary prevention involves detecting diseases at their earliest stages through established screening programs. Tertiary prevention helps patients with chronic diseases by preventing their condition from getting worse while doctors treat their current illness and support them in achieving their best possible life quality. Preventive medicine developed the core analytical system which public health organizations use to create their plans through risk assessment and intervention strategies and outcome evaluation methods according to Gordon (1983) ^[11]. The traditional preventive medicine program continues to practice disease-centered approaches through its programming. The success of interventions becomes measurable through two main evaluation standards which track disease rate decreases and death rate reductions: The success of interventions shows through decreased stroke occurrences and reduced cancer detection numbers and better diabetes marker management (Nutbeam, 2000) ^[32]. Health promotion presents an additional broad inquiry about system development which enables people and their communities to achieve positive health outcomes instead of just preventing illness. Modern health promotion activities focus on developing health literacy skills and empowering communities and building social support networks and creating policies which support health promotion activities while working to reduce risk factors (Rootman *et al.*, 2001).

Lalonde's (1974) ^[21] A New Perspective on the Health of Canadians introduced a major conceptual shift which changed the way population health became understood. The health-field framework introduced four main elements which influence population health results through human biology and environmental factors and personal behaviors and healthcare service delivery systems. The study revealed that healthcare service numbers do not establish population health status because academic work showed this concept to be false (Potvin *et al.*, 2005) ^[34]. Health aetiology extends far beyond hospital-based clinical settings into everyday life-world circumstances. Textbooks and teaching materials and online public-health resources began spreading a damaging secondary error which showed fixed percentage numbers for heredity and healthcare and environment and lifestyle factors (heredity 10 %, healthcare 20 %, environment 20 %, lifestyle 50 %). Potvin *et al.* (2005) ^[34] document conclusively that these specific numerical weightings were not published within the original Lalonde Report. The document contains later heuristic models which scientists wrongly connect to the 1974 Canadian government document. The percentage values lack universal scientific proof which would make them suitable for predicting clinical results in single patients or for studying population health across different cultures. The numbers become distorted when people treat them as scientific facts which leads to major teaching problems and policy brief confusion and academic paper misunderstandings (Potvin *et al.*, 2005) ^[34]. This review therefore treats the four

health-field categories purely as descriptive conceptual domains rather than quantitative statistical apportionment. The Ottawa Charter for Health Promotion received official recognition from WHO in 1986 to establish the fundamental worldwide health promotion standards which exist today. The definition of health promotion as "the process of enabling people to increase control over, and to improve, their health" focused on human agency and empowerment. The five action pillars consist of public health policy development and environmental protection and community strength building and personal ability development and health service transformation according to Rootman *et al.* (2001). The Charter established its core transformation through a theoretical shift which moved health responsibility from individual behavior accountability to the dynamic relationship between people and their surroundings. The obstacles which people face to keep their protective health behaviors persist despite their knowledge of health and their motivation to stay healthy because of the food environments which promote obesity and their extended work hours and their lack of proper transportation systems and their social-economic status (WHO, 1986). The evaluation of health-promotion effectiveness requires assessment of social and material environments which determine available health options rather than focusing on personal control abilities and learning achievements (Nutbeam, 2000) ^[32]. The WHO health-promotion conferences following Ottawa continued to build upon its initial guidelines which they devised to solve emerging worldwide social problems. The Jakarta Declaration (WHO, 1997) combined research about poverty trends with studies about worldwide economic shifts and fast-moving city growth and deteriorating environmental conditions. The Bangkok Charter (WHO, 2005) ^[34] stressed the importance of international stakeholder cooperation together with corporate sector responsibility and the requirement to establish health promotion throughout multiple governance bodies. The Geneva Charter for Well-being (WHO, 2021) establishes a connection between health-promotion work and economic systems which provide equal opportunities and health care services for all people and digital technology management and environmental sustainability requirements. The timeline shows how health promotion evolved from its basic approach of providing personal health information to creating community-based systems which promote wellness for entire populations.

Theoretical Framework for Holistic Health

The holistic approach to well-being opposes the reduction of separate health indicators into simple numerical totals because it views human beings as complete systems which cannot be divided into parts (Hettler, 1980; Dunn, 1959; Lu, 2026) ^[6, 14]. The WHO established its basic health framework through three components which include physical and mental and social well-being in 1948. The biopsychosocial model from Engel (1977) ^[7] provides medical clinical support to analyze health through multiple perspectives. The review of theoretical material introduces a new spiritual-existential perspective which creates four complete health domains that include physical health and psychological health and spiritual-existential health and social-relational health. The four-domain expansion exists as an academic theoretical advancement which does not represent a permanent WHO-approved classification

system. Spirituality-existentiality exists as an independent concept from religious practices because it encompasses human existence through questions about life purpose and fundamental beliefs and self-transcendence experiences and meaning in life (Koenig *et al.*, 2012) ^[20]. The four domains exist as separate entities which do not function as independent units. The system operates through feedback which creates a dynamic system of operation. The example shows that prolonged lack of sleep creates problems for people when they try to control their emotions. People lose interest in social interactions through their behavior when affective disorders appear. Social isolation creates an increase in personal stress levels which people experience as subjective stress. The body experiences sleep pattern disruptions because of elevated chronic stress which produces a worsening cycle of stress effects on sleep patterns. The multiple-domain cyclical patterns between different domains explain why holistic health models with multiple dimensions provide better understanding than disease management systems which focus on diseases (Steger *et al.*, 2013).

Physical health includes more than just being free from diagnosed organic diseases because it also involves normal body function and the ability to perform daily activities and the body's natural defense mechanisms (WHO, 2020). Physical exercise stands as the fundamental adjustable factor which helps people protect themselves from health risks. The international guidelines from WHO (2020) suggest adults should perform 150–300 minutes of moderate aerobic exercise or 75–150 minutes of vigorous aerobic exercise each week while they should also do muscle-strengthening activities twice per week. The main health promotion objectives focus on making people move during their everyday activities while they work to decrease their sitting time and develop permanent movement habits instead of promoting intense sports training (WHO, 2020). The evaluation of nutritional health depends on complete dietary intake patterns instead of studying individual supplement intake. The assessment process needs to focus on three main areas which include food variety and fruit and vegetable and whole grain consumption and complete protein intake at proper levels and optimal fat content and reduced free sugar and salt intake according to WHO standards from 2023b. The physical health foundation includes sleep health which remains an overlooked essential element. Research studies which controlled human experiments and observational epidemiological investigations have shown that people who sleep poorly or disrupt their sleep patterns develop glucose metabolism problems that increase their risk for type 2 diabetes and cause hormone changes which affect their appetite and weight gain (Buxton *et al.*, 2010; Knutson *et al.*, 2007) ^[4, 19]. People exhibit their behavior through four different actions which they perform as separate activities. WHO defines mental health not exclusively as absence of depressive, anxiety or other psychiatric-disorder diagnoses, but as a state of well-being in which individuals realise their own abilities, cope adaptively with normative life stressors, work productively and contribute toward community life (WHO, 2022). People should focus their attention on building their stress coping abilities and their emotional control skills to achieve essential psychological wellness development. The research work of Gross (2002) ^[13] shows that various emotion control methods generate different psychological effects which affect people in different ways.

People who practice cognitive reappraisal during emotion generation processes develop better long-term psychosocial outcomes than those who use expressive suppression because expressive suppression creates problems for social interactions and physical health. Mental health promotion programs need more than basic instructions to "always stay positive" for their success. The interventions need to teach people practical skills which will help them identify their emotions better and understand their feelings and control their emotional responses. Public health achieves its highest practical value through structured support which helps students and working adults establish daily routines while teaching them time management skills and improving their ability to seek help and access social support systems (Jorm, 2012) ^[18].

The concept of spiritual-existential health needs precise boundaries to separate it from religious institution activities which conduct worship services (Koenig et al., 2012) ^[20]. It shows that people experience existential meaning through their personal values and their life purpose and their ability to transcend themselves during special moments which happen outside religious contexts (Steger et al., 2013). Logotherapeutic theory shows that people who face extreme life difficulties can maintain psychological stability by selecting their attitudes and actions and their methods to extract meaning from life (Frankl, 1984) ^[8]. People who discover their life purpose develop enduring motivation which enables them to follow self-care routines for their health maintenance (Steger et al., 2013). People experience higher subjective well-being when their daily decisions match their essential life values (Value congruence forms another key constituent element). People develop subjective emptiness and burnout when their work and school and family duties conflict with their essential values even though their medical test results stay within normal limits (Shirom, 2011). Researchers need to apply great caution when they try to establish direct relationships between religious-spiritual elements and physical and mental health results through statistical analysis because they must stay alert to challenges which affect measurement tools and medical assessment procedures and cultural differences (Koenig et al., 2012) ^[20]. Religious or spiritual beliefs should not make claims about their ability to produce better health results through the practice of holistic health promotion. The programs need to support various cultural perspectives while they develop organized sessions which let people investigate their values and find their life purpose (Koenig et al., 2012) ^[20].

The concept of social-relational health requires people to develop lasting supportive relationships while they need to feel personal belonging and they must take part in their family and educational and work and community activities (Berkman & Syme, 1979) ^[2]. The research by Cohen and Wills (1985) ^[5] which introduced stress-buffering and main-effect social-support theories continues to serve as the essential base for modern social-epidemiological studies. Social support creates two separate protective effects which protect well-being but also function as a stress buffer when people face sudden difficult situations. Social connectedness stands as an essential social resource which determines how human bodies react to stress and predicts future population health outcomes based on mortality patterns (Berkman et al., 2000; Holt-Lunstad et al., 2015) ^[3, 15]. The concept of social-relational health includes the development of skills

which enable people to listen actively and show empathy through perspective understanding and to express them constructively while handling conflicts through negotiation and resolution techniques. People can now connect with others through digital communication tools which enable distant social contact but these tools fail to create strong emotional relationships with others (Orben et al., 2019) ^[33]. The solution to loneliness and social disconnection requires people to engage in planned activities which let them meet others face-to-face or through purposeful digital interactions with campus-community groups and voluntary-service activities and workplace-team-building programs and family network development and community involvement initiatives (Holt-Lunstad et al., 2015) ^[15].

The four-dimensional holistic-health model serves as a primary analytical tool which enables users to demonstrate the multidirectional connections between different domains through their feedback systems. People who exercise regularly experience better sleep patterns and improved mood states. People who possess strong psychological resilience will maintain their positive health behaviors. Social support networks that function properly help people control their body responses to stress while they become more likely to seek assistance. People who believe in their life purpose find inner drive which helps them maintain their health practices. The holistic-health system becomes vulnerable to full system collapse when any one of its domains experiences ongoing disruptions. The basic mathematical process to add up separate domain results does not provide a suitable method for conducting applied health management work. The best practical analytical method includes two essential steps which involve evaluating health domains through a comprehensive approach and studying feedback loops between different systems. The process requires you to find main vulnerability areas and create maps which show how behaviors and social interactions and environmental factors cause these conditions. The process needs you to build multi-targeted interventions which work across various domains through joint development. The treatment of chronic insomnia patients' needs sleep hygiene education to combine with assessments which evaluate work-related stress and emotional control abilities and social connection strength and personal beliefs about life direction. The process of helping socially isolated people requires more than telling them to make friends because we need to evaluate their mental state and their ability to understand themselves and their physical environment.

Re-conceptualising Health Determinants

The Lalonde health-field conceptual framework provides permanent heuristic benefits because it shows health problems arise from various factors yet it never served as a universal statistical prediction model (Potvin et al., 2005) ^[34]. The field of population health research developed systems which contain multiple levels of interconnected systems. The researchers at McGinnis et al. (2002) ^[27] studied how various elements affected population health while they also focused on creating workable policy solutions. The health impact pyramid framework which Frieden (2010) ^[9] created shows that structural-level upstream interventions produce larger population effects than individual behavioral recommendations which target people directly. The present analysis of determinants has

moved past basic four-cell classification to develop systems which explain cause-effect relationships through multiple levels. The review assesses health determinants through three analytical questions instead of using deceptive fixed percentage distribution methods. The main operating level of this determinant exists within which system between individual and interpersonal-organizational and community-environmental and institutional-policy domains? The factor shows which level of direct adjustment that people can make through their personal efforts? Public policy intervention enables simultaneous changes to population group conditions which affect multiple major population segments. The study of sleep behavior demonstrates this analytical method because people show their sleep patterns through their actions yet these patterns stem from large-scale social systems which include work hour rules and nighttime noise in neighborhoods and street lighting policies and digital work habits. People make their own decisions about what to eat but their options get restricted because food systems control what is available and stores set prices and governments watch how products get advertised and schools and hospitals follow specific rules about what they can serve. The multi-axis analytical approach provides a superior understanding of governance complexity when compared to basic fixed-percentage-lifestyle weightings.

Human biological endowment, including inherited genetic variation, age-related physiological change and pre-existing disease susceptibility, generates important inter-individual health-outcome differences. Human bodies develop essential variations in their health results because they inherit different genetic traits and their bodies change with age and because some people develop diseases before others. According to Hunter(2005) ^[17], multiple complex chronic diseases develop through gene-environment interactions which operate as active systems instead of following predetermined genetic patterns. People should focus on their ability to change environmental and behavioral elements which block their path to better health instead of worrying about their genetic makeup. Medical risk surveillance and disease prevention screening become suitable when families show positive disease history but this does not prove that family members will definitely develop disease. The practice of health promotion needs to develop preventive methods which stem from genomic risk assessment instead of making unchangeable predictions about health outcomes. Clinical healthcare services which follow formal procedures operate as essential safety-net providers. Specialists need to provide medical care for patients who develop acute illnesses or experience severe worsening of their chronic diseases or who sustain traumatic injuries or develop serious infections or show signs of major mental health problems. Health-promotion theory maintains healthcare systems as vital components yet works to decrease the current social dependence on medical treatment which only appears after symptoms develop. The healthcare system reaches its peak when patients manage their health independently while doctors provide scheduled prevention and emergency medical care for people who show signs of serious illness. The healthcare delivery system reaches its highest point when patients handle their health independently while doctors provide scheduled preventive care and emergency medical assistance for people who show signs of critical illness.

Human health behavior options face restrictions because environmental factors establish specific boundary conditions which determine when these actions become possible. The physical environment consists of six main elements which include air quality in the surroundings and safe drinking water availability and noise levels and housing conditions and park accessibility and road safety for vehicles. Social-environment dimensions consist of five elements which include cultural norms and social network composition and structural discrimination and organizational workplace culture and community-level social trust. The economic environment consists of five main elements which include household income stability and work environment conditions and educational levels and home buying costs and official social welfare system structures according to Marmot *et al.* (2008) ^[26]. The analytical mistake occurs when health-promotion programs require people to change their behavior while they fail to recognize the social and environmental systems which create these problems. The Ottawa Charter continues to influence present-day policies because it calls for supportive environments and healthy public policy initiatives. Through urban planning active travel infrastructure and smoke-free environment rules and workplace mental health support systems and human-friendly work policies and accessible healthy food options organizations and governments can eliminate physical obstacles which stop people from making healthy choices. Health policies which bring big changes to population health need more than just repeating individual self-discipline messages because they work best when healthy choices become built-in elements of institutional structures (WHO, 1986).

Health promotion requires lifestyle domain factors as essential targets which include people's eating habits and their exercise routines and their sleep patterns and their substance usage and their stress coping methods and their social behavior. Multiple low-risk lifestyle behavior patterns which emerge together have been shown to create survival advantages according to data from extensive prospective cohort studies (Li *et al.*, 2018). The model presents lifestyle as a human-controlled element but this approach oversimplifies this complex subject. People must follow strict limitations when they decide their actions because their family earnings and their official work schedules and their community traditions and their home care duties and their food availability and their transportation options and their social protection systems determine their choices (Wilkinson & Marmot, 2003). Health-promotion programs need to help people develop their own abilities but they should stay away from showing health problems as results of individual moral shortcomings because of lacking determination. The ethical precondition serves as the fundamental basis which supports both unified holistic health management and public health work that fights to achieve health equality.

Population health results from complex systems which include various elements that create multiple causal connections. People develop their actions based on their surroundings which public policy can transform through environmental changes. Healthcare services help people control their diseases while medical care allows patients to develop their ability to handle their conditions through self-management. Functional social support resources create better psychological well-being which predicts future

health-related behavior adoption patterns. The design of intervention questions needs to focus on finding vital operational intervention points which exist in particular community settings instead of searching for the most critical factor. The design of intervention packages should include various sectors which work together to achieve their goals. This review therefore proposes a two-layer conceptual architecture. The upper outcome layer corresponds to four-dimensional holistic health (physical-psychological-spiritual-existential-social-relational). The lower determinant layer incorporates biological endowment, lifestyle behaviours, healthcare-service provision, physical-social-economic environments and institutional-policy conditions. The two layers maintain an ongoing feedback relationship which people regulate through their actions and their stress reactions and their social connections and their access to resources and their belief in their own abilities.

Health-Promotion Application within the Taiwanese Context

Taiwan maintains complete universal health coverage together with its fully developed public health administrative framework. The population continues to face health problems because of its aging demographic structure and the high numbers of non-communicable diseases and cancer patients and the insufficient mental health services and the existing health inequalities and the uneven distribution of medical facilities across different regions (Ministry of Health and Welfare [MOHW], Taiwan, 2025)^[28]. National mortality statistics indicate that cancer, heart disease, pneumonia, cerebrovascular disorders, and diabetes remain the leading recorded causes of death, underscoring the need for ongoing chronic disease prevention and population health monitoring (MOHW, Taiwan, 2025)^[28]. The current preventive policies include organised population-screening programmes which have been extended for their operation. Health promotion needs to extend its activities past the expansion of disease screening services. Screening functions as a disease-specific preventive tool which aims to detect particular illnesses. Holistic health promotion goals include quality of life perception and psychological strength and community relationships and life purpose discovery. The development of Taiwanese health governance needs continuous teamwork between different sectors which includes education and labour regulation and urban planning and food policy and environmental protection and social welfare and health sector agencies (Huang *et al.*, 2022)^[16].

Students at universities experience a vital stage of life development which brings new ways of living and emerging social responsibilities and their first attempts to create their future path. People develop their health-related behaviors through family units but they eventually learn to control their own actions. The health outcomes which people experience throughout their lives depend on their young-adult behavior patterns for sleep and diet and physical activity and substance use and stress management (Lu, 2026). Physical education classes alone cannot serve as the foundation for effective campus health promotion because students need more than brief health lessons and individual counseling sessions. The system requires unified development which creates campus environments that focus on total health for students (Lu, 2026). The design of

holistic health campuses incorporates all four components which make up holistic health. The physical health elements consist of campus-based physical exercise facilities and school-based food programs which provide balanced nutrition and educational programs about sleep health and medical checkup programs for disease prevention. The psychological health services offer students access to stress management educational programs and emotion literacy training and simplified mental health support services and mental health crisis recognition training programs. Students at this institution find support for their spiritual and existential wellness through their life education classes which they access through their service learning programs and their career exploration work. The development of social-relational-health goals occurs through student involvement with peer networks and their participation in student organizations and their commitment to service work and their efforts to create a supportive campus community. The different elements of this system work together to provide educational content which students' access through their regular academic work and their daily activities on campus instead of operating independently as separate programs.

Workplaces serve as the main daily environments which working-age people spend their time in. Employee health programs which only provide yearly health assessments fail to generate meaningful results because they do not address the necessary changes in work duties and time schedules and management supervision and workplace mental health safety systems (Lu, 2026). The workplace receives complete holistic health management through its combination of safety standards and physical activity support and healthy food choices and shift work that protects sleep and psychological safety environment and management training for support skills and work-life balance protection and employee purpose-based activities according to Ottawa Charter principles for environmental backing and service transformation (WHO, 1986). Workplace health promotion exists as a component of human resource strategy which also operates under corporate sustainability governance systems according to organisational management standards. The training program for managers should include two essential modules which teach employees to identify workplace stress and develop psychological safety skills. The design of work tasks should include natural opportunities for physical movement during daily activities. Employee-assistance programs need to connect their operational systems with health-risk-assessment procedures which staff members require. The evaluation system for organizational programs needs to combine employee self-reported well-being data with standard administrative information about employee absences and medical expenses (Lu, 2026).

Health equity-directed community health promotion programs have moved past basic service delivery because they now identify specific obstacles which prevent different population groups from accessing healthcare services (Wilkinson & Marmot, 2003). It shows that social-environmental interventions which start at the top produce better results than individual-based lower-level treatments (Frieden, 2010)^[9]. The development of high-quality community health promotion programs requires

organizations to establish permanent community-based organizations which provide continuous health education resources and transportation networks and food availability programs and long-lasting social connections between people (Huang *et al.*, 2022) ^[16]. The local governance system of Taiwan includes multiple actors who perform their functions through municipal health bureaux and district health centres and community development associations and educational institutions and private businesses and non-profit organizations. The process of going from temporary standalone project execution to community-based governance systems requires residents to become active partners in program development through their involvement in needs assessment and problem ranking and intervention creation and evaluation processes.

Integrative Theoretical Model and Formal Theoretical Propositions

1. Three-Layer Integrative Model

The research paper develops a three-level self-referencing conceptual framework through its narrative review which builds on previous investigations. The first layer of the model Holistic-health-outcome contains four domains which depend on each other for their existence: physical health and psychological health and spiritual-existential health and social-relational health. The health-determinant layer consists of five elements which include biological endowment and lifestyle-behaviour patterns and healthcare service availability and physical-social-economic-environmental factors and institutional-policy-regime structures. The Governance-intervention layer contains three different levels of intervention which start with individual capability development and move to organizational and community environmental development and finally reach public policy changes through multiple sectors. The system operates through recursive feedback which replaces the traditional one-way causal links that three-layered systems use. The governance-intervention process creates changes in the determinant-layer conditions which then transform the four-dimensional holistic health outcome states. The population health outcome patterns which emerge from this process create changes that affect how people develop their capabilities and their willingness to engage in civic activities and their needs for community resources.

2. Proposition 1: Four-Dimensional Holistic-Health Domains Demonstrate Dynamic Complementary Reciprocal Relationships

The four health domains of physical and psychological and spiritual-existential and social-relational health operate through active mutual interactions instead of working as separate additive elements. Health-related behaviors together with stress response mechanisms and social support systems and meaning-making abilities produce effects which spread throughout various outcome domains. People who get good social support will experience lower personal stress levels which lead to better mental health and better sleep and more physical exercise. People who understand their life purpose well will develop self-care motivation which leads them to perform protective behaviors that result in better physical health outcomes. Health promotion

programs need to find vital system points which produce feedback loops that either help or hurt the system.

3. Proposition 2: Lifestyle-Behaviour Modifiability Is Conditionally Moderated by Surrounding Environmental Supports

The links between lifestyle-behavior patterns and overall health outcomes may vary, owing to the presence of social, material, and environmental supports. People need health knowledge and self-efficacy at the personal level but they will fail to maintain their healthy actions when their workplace and home environment and community settings lack proper support. The theoretical framework moves health promotion from individual self-control approaches to person-environment alignment models which follow Nutbeam's (2000) ^[32] base public health framework about health literacy and empowerment.

4. Proposition 3: Social-Relational-Support Exerts Cross-Domain Protective Holistic-Health Effects

Social-relational-support creates direct protective benefits which defend psychological health and social relationships but it establishes indirect protective effects which benefit physical health and spiritual existence. The theoretical basis of this proposition stems from Cohen and Wills' (1985) ^[5] fundamental social-support theory which explains main effects and stress-buffering mechanisms. People can develop new coping methods through their relationships with others who provide emotional support and share information and offer practical help and assessment of their situation which helps them deal with difficult times while reducing feelings of loneliness and building a sense of connection with others.

5. Proposition 4: Public-Health-Policy Prioritisation Ought To Be Guided By Policy-Intervention-Leverage Criteria Rather Than Fixed Health-Determinant Percentage Rankings

Proposition 4 states that public health policy needs to follow five operational criteria for sequencing and resource allocation when multiple health determinants affect society. The selection of public health interventions for multiple health determinants needs five operational criteria to determine the sequence of implementation and resource allocation. The five practical criteria for assessment include the ability to reach large populations and the need for system-level intervention and the ability to change and the duration of intervention and the expected effects on health equity. Decision-making evaluations should refrain from employing ranking systems that derive fixed percentage weights from data, independent of their original context. The system prevents policy-based resource distribution problems which occur when funding distribution focuses too much on individual behavior programs instead of environmental system changes.

6. Proposition 5: Holistic-Health-Promotion Management Requires Transition from Discrete Siloed Service Offerings Toward Integrated Inter-Service Platforms

Proposition 5: Health-promotion-service systems which connect physical health resources to psychological and spiritual-existential and social-relational well-being resources through ongoing needs tracking and official

professional referral systems prove more effective in handling multi-morbidity cases which require complete health management than standalone services that operate separately. Organizations can establish service integration by placing different professional groups together in one physical space which operates as a single administrative unit. The system needs steady individual requirement detection methods together with active service connection systems which enable different professional teams to work together. The campus health service system shows how physical fitness support and nutritional guidance and mental health counseling and career value exploration and service learning program access points form a network which lets students access total health promotion resources without needing to wait for medical diagnosis.

Discussion

The health promotion practice operates together with holistic well-being perspectives to form a single integrated system. The health promotion academic field offers operational intervention frameworks which demonstrate the correct path to enhance population health results. The evaluative normative frameworks in holistic health systems establish specific health improvement objectives which they work to achieve. Health promotion activities will develop into limited programs which focus only on physical activity and dietary recommendations and disease screening when they lose their connection to complete health wellness views. Theoretical concepts about holistic health well-being need practical health promotion implementation systems to become applicable in real-world situations according to Lu (2026). Theoretical concepts achieve operational usefulness through the combination of theoretical frameworks which maintain their original conceptual meaning. The health-field report from Lalonde (1974) ^[21] created its lasting historical impact by proving that healthcare volume does not determine population health results although it failed to generate permanent numerical distribution ratios. The current study of population health relies on exact statistical research to analyze social and economic structural factors which scientists use to build policies that support individual development and modify environmental systems at their origin. Nutbeam (2000) ^[32] showed in his research from twenty years ago that health education needs to teach people more than just reading public health materials. Health literacy growth enables people to find health information while they learn to evaluate its content before they use it effectively which leads to community power development through social engagement. Health promotion with high impact requires methods which push people to develop their personal capabilities instead of simply giving them more health information.

The use of lifestyle-determinant explanations to explain health outcomes creates essential ethical problems when these explanations transform into hidden moral assessments of how people experience health. The focus on individual behavior as the main cause of disease risk leads people to view health problems as moral failures which result in obesity being seen as sloth and depression as lack of willpower and sleep problems as simply poor self-control. The holistic health promotion approach requires medical staff and policy setters to recognize both environmental limits which affect health outcomes and the personal factors which determine healthcare access. Health promotion

messages need to support people in developing personal control yet they must prevent the spread of health problems through public discussions which use blame to talk about population health issues. Health equity commitments maintain the essential ethical practice standard which Wilkinson and Marmot established in 2003. The addition of spiritual-existential well-being to health promotion frameworks creates new ethical problems and theoretical challenges which affect their development. The delivery of applied programs requires three boundary-setting principles which prevent formal religious systems from serving as health benchmarks and spiritual status from becoming numerical scores and demand that all intervention activities protect personal autonomy and cultural diversity. The operational framework of secular practice enables spiritual-existential-health support through its emphasis on value assessment and purpose discovery and meaning construction. The program offers education through life-education curricula and career-reflection workshops and community-service projects and artistic and cultural activities and nature-based reflective experiences and secular mindfulness-based practice sessions (Koenig *et al.*, 2012) ^[20].

The standard evaluation process for health management systems focuses on medical condition results which measure blood sugar levels and blood pressure control and hospital admission rates. The clinical metrics continue to function as essential instruments which track the development of serious diseases. The health-assets evaluation method serves as an essential component of holistic health promotion which promotes its implementation. Health assets consist of personal resources which people have gathered through their life experiences that include their physical abilities and their understanding of health and their mental strength and their social network support and their personal sense of life meaning and their ability to obtain both official and unofficial assistance (Morgan & Ziglio, 2007) ^[30]. McGinnis *et al.* (2002) and Frieden (2010) ^[9] recommend public policy goals should advance past basic risk reduction to create permanent health-supportive social structures. The concept of health exists as a continuous development which people can maintain and invest in socially to build a common community resource that develops over time (Morgan & Ziglio, 2007) ^[30].

Practical Implementation Strategies for Holistic-Health-Promotion Delivery

The practice of individual-level holistic health management requires simple repeated self-assessment procedures which function as its main evaluation system. Physical health assessments track how people usually exercise and their sleeping patterns and their food choices and their progress with recommended preventive health screenings. The psychological health assessment evaluates how much stress people have dealt with and which emotions they experience most and their ability to function daily and their personal choice to get professional help. The process of spiritual-existential-health-reflection involves people to assess their fundamental life targets and their current alignment between their actions and their fundamental values and their emotional experience of life meaning. The assessment of social-relational-health requires evaluation of family relationships and available friend support and workplace and educational environment connections and community

involvement levels. The appraisal process allows for separate optimization of each dimension instead of requiring simultaneous optimization across all four domains. Organizations should pick two essential strategic targets to focus their operational activities during each implementation cycle. Educational institutions and employers need to shift their organizational health promotion initiatives from occasional standalone lectures to continuous environmental transformations which become standard practice. The campus environment requires several interventions which should provide students with physical activity access and healthy food selection and educational content about sleep and stress and mental health service navigation and organized student group activities. The workplace environment needs specific controls which consist of scheduled work hours and protected work assignments and manager training programs and established break times and workspace setups and psychological safety initiatives and sufficient employee assistance resources.

The development process of community health programs needs to establish direct connections with local residents who should participate in all stages from initial requirement discovery through final result assessment. The process of determining health needs for local communities occurs through participatory methods which help identify health priorities based on what people in the area actually need. The intervention packages for older adult communities need to combine physical exercise programs with nutrition support and social activities for reducing loneliness and initiatives to enhance neighborhood safety. Youth-oriented community programs should provide mental health support services together with career development resources and programs which help young people establish social relationships while teaching them about digital media health literacy. Community health promotion succeeds when organizations develop solutions which match local needs instead of using identical program models from different areas. The Health-in-All-Policies framework from WHO shows that health ministries need support from other sectors to achieve effective health governance at multiple levels (Ståhl *et al.*, 2006). Urban planning choices determine whether active travel becomes possible but education policies in schools help people of all ages achieve better health literacy. The way food systems operate through governance determines how communities develop their dietary patterns. Social welfare programs control how people who need assistance can get access to their resources. Healthcare institutions continue to play essential roles within the complete health governance system but they can develop their functions to work as health promotion allies instead of focusing only on disease treatment. Primary care clinics function as disease treatment centers which also provide patients with lifestyle guidance and teach them self-management of chronic conditions and direct them to mental health services and established pathways for external medical assistance. The system needs to build stronger links between clinical health services and community health promotion resources because these connections will enable patients to receive continuous care when they move from hospital environments to their normal residential areas. The system implements a structural connection which enables clinical care delivery to operate as one unit with community-based health promotion activities.

Conclusion

The development of modern health-promotion thought in intellectual history shows how dominant social health definitions have expanded through various stages. Theoretical development follows a linear path which starts with biomedical disease-control approaches before moving toward preventive medicine and finally reaching the Lalonde period which studied health origins in daily life settings and environmental spaces. The Ottawa Charter period introduced empowerment-based priorities which focused on creating supportive environments and developing community action and individual abilities and transforming health service delivery systems. Health has evolved from its original focus as a hospital-based medical issue into a public matter which needs both personal and community-based management systems. The World Health Organization's Geneva Charter for Well-being (2021) ^[25] links health-promotion goals to social fairness and economic system development and digital technology management and environmental protection initiatives which create new directions for health-promotion work beyond traditional public health boundaries.

The research paper introduced a complete health framework which includes physical and psychological and spiritual and existential and social and relational elements that demonstrate full reciprocal links between each element (Lu, 2026). Physical health provides the essential base which allows people to perform their basic daily activities while psychological health enables people to develop their abilities for handling stress and understanding their mental state. People find personal meaning through spiritual-existential health which also helps them establish essential values and determines their life path direction. Social-relational health brings essential relationship-based support resources which let people find their place in society while enabling them to take part in community activities. The four health domains experience simultaneous influence from multiple health determinant systems which include personal health behaviors and medical care availability and genetic makeup and environmental factors and government policies. The study solves a common public health education mistake which shows the Lalonde Report health framework through separate percentage numbers for heredity and healthcare and environment and lifestyle. This research method exists as a permanent academic-policy resource through its systemic analysis of multiple determining factors. The Health Promotion Field requires policymakers and practitioners to identify specific intervention points which they need to act upon instead of learning fixed percentage-based rules. The process requires simultaneous execution of three intervention levels which focus on individual skill development and community support establishment and national policy transformation.

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