



Holistic health concept and health promotion movement: From the 20th to the 21st century

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Abstract

This paper traces the historical evolution of the holistic health concept and the global health promotion movement from antiquity to the digital age. Beginning with the humoral balance theories of Hippocrates and the philosophical synthesis of Greek and medieval traditions, it examines how the Enlightenment's mechanistic medicine and Cartesian dualism fragmented the human being into body and mind. The analysis then follows the twentieth-century reconstitution of holism through the World Health Organization's 1948 definition of health, Engel's biopsychosocial model, the rise of behavioral and mind-body medicine, and the institutionalization of health promotion in the Ottawa Charter of 1986. Drawing on classical sources and contemporary research, the paper argues that holistic health has progressively transformed from a metaphysical ideal into a scientifically grounded and policy-embedded paradigm that integrates biological, psychological, social, and environmental determinants of well-being. The discussion also explores recent developments such as digital health technologies, ecological and planetary health frameworks, and the continuing ethical and cultural challenges of implementing holistic approaches in diverse societies. By situating these transformations within the intellectual history of medicine, the paper concludes that holistic health represents not a departure from scientific rationality but its humanistic fulfillment—a dynamic equilibrium between person, community, and environment that defines the next frontier of health thought and practice.

Keywords: Holistic health, health promotion, preventive medicine, mind-body medicine, digital health, history of medicine

Introduction

Health has never been a fixed or static notion. It has continuously evolved in tandem with the transformations of human civilization, scientific understanding, and cultural worldviews. In the modern history of medicine, few conceptual shifts have been as influential as the transition from the reductionist biomedical model toward a holistic understanding of health that integrates biological, psychological, social, and even spiritual dimensions. This transformation was not sudden but rather the culmination of centuries of intellectual evolution and practical necessity. To trace this development is to understand how human beings gradually redefined what it means to be healthy—moving from the mere absence of disease to a dynamic state of well-being and potential realization. Before the twentieth century, Western medicine was almost entirely structured upon the logic of biological determinism. The biomedical model, formally articulated during the late nineteenth and early twentieth centuries, conceived disease as a malfunction of biological mechanisms and health as the restoration of normal physiological function. This perspective was rooted in Cartesian dualism, which separated body and mind into distinct entities. René Descartes, in *Meditations on First Philosophy* (1641/1986)^[10], regarded the body as a machine governed by the laws of matter, while the mind or soul was immaterial, autonomous, and ultimately outside the jurisdiction of natural science. This philosophical dichotomy provided an epistemological foundation for modern medicine, allowing physicians to study the body as an object independent of subjective experience. It was this very separation that enabled the rapid progress of anatomy, physiology, and microbiology during the scientific revolution. The discoveries of Louis Pasteur and Robert Koch in the nineteenth century validated the germ theory of disease, strengthening the conviction that

each illness must have a specific, identifiable cause located in the biological substrate (Bynum, 2008)^[6].

The biomedical paradigm achieved enormous success in the struggle against infectious diseases. Through vaccination programs, antiseptic surgery, and the discovery of antibiotics, it contributed decisively to the dramatic increase in life expectancy across the industrialized world. Yet its very success obscured its limitations. As the twentieth century unfolded, patterns of morbidity and mortality changed profoundly. With the decline of infectious diseases, chronic non-communicable illnesses such as cardiovascular disorders, diabetes, and cancer emerged as dominant health threats. Simultaneously, social stress, alienation, anxiety, and depression became widespread features of modern life (McGee, 2008)^[29]. The biomedical model, focused on repairing malfunctioning organs, was ill-equipped to address these diffuse forms of suffering that lacked clear physiological correlates. To “live unhappily” or “without meaning,” though not diagnosable within the conventional medical framework, represented a profound crisis in the human experience of health. Thus, by mid-century, scholars and clinicians began searching for a broader framework capable of integrating biological, psychological, and social dimensions of human existence. The limitations of the biomedical model were critically analyzed by George Engel in his seminal 1977 paper, “The Need for a New Medical Model.” Engel proposed the biopsychosocial model as an alternative, arguing that illness results not only from biological dysfunction but also from the interactions of psychological states and social environments. This framework reintroduced complexity, contingency, and human subjectivity into medicine. It also marked a return, in modern scientific terms, to ideas that had existed since antiquity but were long marginalized by positivist science.

Health: from Hippocrates to Cartesian Mechanism

The notion that health is a state of harmony rather than the mere absence of disease has deep roots in ancient thought. Hippocrates, often regarded as the father of Western medicine, had already advanced a naturalistic view of disease in the fifth century BCE. Rejecting supernatural explanations, he posited that the human body is composed of four humors—blood, phlegm, yellow bile, and black bile—and that health depends on the proper balance of these fluids (Hippocrates, 400 BCE/1923) [21]. Disease, therefore, was the result of disequilibrium. Importantly, Hippocrates also recognized that mental states, diet, environment, and lifestyle influence this equilibrium. The physician's task was not merely to cure but to assist nature in restoring balance. This early holistic approach was echoed in Greek philosophical traditions: the Pythagoreans emphasized harmony between body and soul as the essence of health (Guthrie, 1962) [19], while Plato described the healthy individual as one in whom the rational, spirited, and appetitive parts of the soul cooperate in proportionate order (*Republic*, 380 BCE/1999). Thus, the ideal of *holos*—wholeness—was inscribed at the very origins of Western medical and philosophical reasoning.

During the medieval period, Western conceptions of health became interwoven with Christian theology. Within monastic communities, health was conceived as the triadic harmony of body, soul, and spirit. Healing practices combined herbal medicine, nursing care, prayer, and moral confession (Park, 2006) [35]. Though later dismissed by Enlightenment physicians as superstition, this integration of physical and spiritual care preserved an enduring intuition: that illness involves moral and emotional dimensions inseparable from the material body. By the sixteenth century, however, the scientific and humanistic revolutions gradually disentangled medicine from theology. Paracelsus rejected scholastic dogma and insisted that healing must consider the individuality of the patient, including temperament, environment, and cosmic influences (Pagel, 1982) [34]. Thomas Sydenham, often called the father of modern clinical medicine, stressed observation and empathy. He maintained that the good physician must “see and feel with the patient,” addressing both physical and emotional suffering (Bynum, 2008) [6]. These Renaissance and early modern physicians anticipated a central tenet of later holistic medicine: that care must encompass the totality of the human being.

Despite these continuities, the nineteenth century's triumph of laboratory science relegated such holistic intuitions to the margins. When the microscope became the symbol of medical authority, the patient's subjective experience was overshadowed by objective signs and measurements. The Cartesian mechanism of the body appeared complete; disease could be localized, quantified, and excised. Yet by the early twentieth century, the human cost of this reductionism was increasingly evident. The industrial world produced unprecedented material prosperity but also psychological alienation. Health ceased to mean well-being in a moral or social sense; it became a technical condition of normal biological functioning. The reemergence of holistic perspectives during the twentieth century was thus both a scientific and existential reaction against this fragmentation.

Revolutionary Definition of Health by WHO

A major milestone in this redefinition occurred in 1948 when the World Health Organization adopted a revolutionary definition of health as “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity” (World Health Organization [WHO], 1948) [42]. For the first time, an international institution codified a tripartite conception of health, explicitly integrating mind and society with body. This definition symbolized a paradigm shift from the medicalization of disease toward a comprehensive philosophy of human flourishing. It was no coincidence that it emerged from the ruins of the Second World War. The collective trauma of global conflict had exposed the inadequacy of purely somatic models of recovery. Psychological wounds—what would later be known as post-traumatic stress disorder—were pervasive, and social reconstruction required more than rebuilding hospitals. It demanded restoration of meaning, community, and emotional security (Berridge, 2007) [3].

The WHO definition resonated with the broader humanistic currents of mid-twentieth-century thought. It paralleled the existential psychologists' call to acknowledge personal authenticity and self-realization as health criteria. Abraham Maslow's hierarchy of needs and Carl Rogers's person-centered therapy both reflected this holistic reorientation. At the same time, sociologists began to conceptualize illness as a social role rather than merely a biological condition, emphasizing the interplay of individual and environment. Yet critics quickly pointed out that the WHO's formulation was utopian. The phrase “complete well-being” seemed unattainable and unverifiable (Callahan, 1973) [7]. To declare that only those in total equilibrium are healthy implies that almost everyone is sick, an absurdity both conceptually and pragmatically. Moreover, psychological and social well-being lack universal metrics; what counts as “well” varies across cultures and contexts (Boorse, 1977) [4]. Nevertheless, the definition's symbolic significance cannot be overstated: it reintroduced the holistic dimension into global health discourse, legitimizing the integration of psychosocial factors into policy and research.

The postwar decades witnessed a proliferation of movements that sought to operationalize this broader conception of health. The psychological aftermath of war made evident that suffering is not confined to the body. As veterans returned with invisible wounds—nightmares, anxiety, emotional numbness—medicine confronted conditions it could not diagnose with stethoscopes or microscopes. The emergence of psychiatry, psychology, and the interdisciplinary field of mental hygiene reflected an urgent societal need to address the mind as integral to health. The “mental hygiene movement,” gaining momentum in the 1940s and 1950s, promoted community mental health centers aimed not only at treating severe disorders but also at preventing distress through education and counseling (Grob, 1991) [18]. These initiatives symbolized a democratization of care, extending concern for mental well-being beyond asylums into ordinary community life. They also institutionalized a preventive and participatory ethos that would later underpin the health promotion movement.

Health Promotion

In the 1970s, behavioral medicine emerged as another critical bridge between biological and psychosocial approaches. Drawing on psychology, sociology, and epidemiology, this interdisciplinary field demonstrated that lifestyle behaviors—smoking, excessive alcohol consumption, poor diet, and physical inactivity—are major determinants of chronic disease (Schwartz & Weiss, 1978)^[38]. The landmark Framingham Heart Study, initiated in 1948, provided empirical evidence linking these modifiable behaviors to cardiovascular risk (Dawber, Meadors, & Moore, 1951)^[9]. By emphasizing prevention and behavior change, behavioral medicine reframed health as an active process of self-regulation and environmental adaptation. This conceptual turn laid the foundation for what the WHO would later call “health promotion”: enabling individuals to increase control over their health. Meanwhile, research on stress physiology reconnected the mind and body in scientific terms. Hans Selye’s theory of the General Adaptation Syndrome (1950)^[39] demonstrated that psychological stress triggers physiological responses—hormonal, cardiovascular, immunological—that can lead to disease if chronic. The stress response, once a survival mechanism, became a pathology of modernity. Subsequent studies confirmed that prolonged stress compromises immune function, elevates blood pressure, and accelerates aging (McEwen, 1998)^[28]. These findings dismantled the Cartesian barrier by showing that subjective emotions manifest as measurable biological events. In this way, mind–body medicine emerged as a legitimate scientific domain, bridging Eastern contemplative wisdom and Western empiricism.

Indeed, the late twentieth century witnessed an unprecedented dialogue between Eastern and Western conceptions of health. In the 1970s, Jon Kabat-Zinn at the University of Massachusetts Medical School adapted Buddhist mindfulness meditation into the secular *Mindfulness-Based Stress Reduction* (MBSR) program (Kabat-Zinn, 1982)^[25]. This method combined meditative attention with clinical psychology to alleviate stress, chronic pain, and emotional dysregulation. Rooted in the Buddhist principle of present-moment awareness but stripped of metaphysical doctrine, MBSR embodied a new synthesis: experiential insight verified by empirical research (Kabat-Zinn, 1990)^[26]. The success of mindfulness therapies demonstrated that subjective awareness could be therapeutically cultivated, offering a scientifically acceptable form of self-healing. Scholars such as Herbert Benson and Jon Kabat-Zinn thus transformed spiritual practice into behavioral medicine, reaffirming the holistic unity of mind and body within a clinical framework (Schwartz, 1999)^[37].

Through these developments, holistic health evolved from a philosophical ideal into an interdisciplinary scientific paradigm. Yet this transformation also reflected changing social realities. As economies globalized and digital technologies advanced, patterns of communication, work, and leisure reshaped both disease profiles and conceptions of selfhood. Mental health, once confined to psychiatry, became a universal public issue. According to recent WHO estimates, more than one billion people worldwide experience mental or neurological disorders, and depression has become a leading cause of disability (WHO, 2022). The growing prevalence of stress-related and psychosomatic

illnesses has rendered the integration of psychological and social determinants into health policy an imperative rather than a luxury. In this sense, the twenty-first century continues the historical trajectory set in motion by Hippocrates, reformulated by the WHO in 1948, and continually renewed by behavioral and mind–body medicine: health as a dynamic equilibrium among body, mind, society, and environment.

Health: Individuals, Societies, and Environments

The late twentieth and early twenty-first centuries have witnessed an extraordinary diversification of health concepts and practices, driven by technological change, social transformation, and an increasingly complex understanding of human well-being. The emergence of digital health, the globalization of health promotion, and the institutionalization of preventive medicine collectively signify the maturation of the holistic paradigm. Health is no longer understood merely as a biomedical status or even as a psychosocial equilibrium but as a relational and ecological phenomenon—a continuous negotiation between individuals, societies, and their environments. This expanded vision represents the culmination of a historical movement toward wholeness that began in ancient philosophy and found modern expression in global health policy.

The digital revolution has fundamentally altered the landscape of health care and self-care. Artificial intelligence, big data analytics, mobile applications, and wearable sensors have democratized access to health information, transforming the individual from a passive patient into an active agent of health management. Digital platforms such as *Headspace* and *Calm* offer guided meditation and mindfulness training, reaching millions of users worldwide (Montag, Tomasik, & Elhai, 2019)^[30]. Sleep tracking devices and heart rate monitors enable continuous self-observation, while telemedicine and online counseling provide psychological support across geographic boundaries. These innovations illustrate the technological materialization of the holistic ideal: the integration of body, mind, and environment through interactive feedback systems. In principle, digital tools embody the promise of empowerment—they allow individuals to monitor their physiological and psychological states, adjust behaviors, and prevent disease. Yet this techno-holism is not without ambivalence. The digitalization of health raises ethical concerns about privacy, data ownership, and the potential commodification of intimate aspects of life (Elhai et al., 2018)^[11]. The very technologies designed to reduce stress may also reinforce surveillance, dependency, and isolation. Moreover, algorithmic personalization risks pathologizing normal emotional fluctuations, blurring the distinction between ordinary unhappiness and clinical disorder. Thus, while digital health represents a new stage in the historical evolution of holistic thinking, it also exposes the tension between self-knowledge and self-control that has haunted modern medicine since its inception. A truly holistic digital health paradigm must therefore balance technological precision with humanistic ethics—integrating empathy, transparency, and respect for autonomy alongside data-driven efficiency.

Parallel to these technological developments, the global health promotion movement institutionalized holistic health at the level of policy and social organization. The

conceptual foundation for this movement was laid by the WHO's expansion of health beyond the medical sector. In 1978, the Alma-Ata Declaration on Primary Health Care proclaimed that "health for all" could only be achieved through community participation, preventive education, and intersectoral collaboration (WHO, 1978). This declaration reoriented health systems from curative medicine to comprehensive care, emphasizing that health is produced in everyday life—in homes, schools, workplaces, and communities—rather than in hospitals alone. The term "health promotion," formally defined by the WHO in 1984 as the process of enabling people to increase control over and improve their health, represented the operational synthesis of the holistic ideal.

The intellectual breakthrough came in 1986 with the Ottawa Charter for Health Promotion, a document that redefined health as "a resource for everyday life, not the objective of living" (WHO, 1986). This formulation marked a decisive break from the defensive, disease-centered conception of health. Rather than viewing health as a static condition, the Charter conceived it as a capacity—a dynamic potential for participation, creativity, and resilience. The Charter identified five key action areas: building healthy public policy, creating supportive environments, strengthening community action, developing personal skills, and reorienting health services. Together, these strategies extended the scope of health governance beyond medicine to encompass social justice, education, labor, housing, and environmental policy (Nutbeam, 1998) [31]. The philosophical implications of this reorientation were profound. Health became a relational and political concept: not merely an individual possession but a collective good shaped by social structures and power relations. The Ottawa Charter's vision resonated with the emerging theories of social capital and empowerment. Sociologist Robert Putnam (2000) [36] argued that networks of trust and reciprocity—what he termed social capital—have measurable effects on health outcomes. Communities with dense social ties exhibit lower morbidity and mortality, not only because of material support but because belonging itself reduces stress and fosters resilience. Similarly, research in community psychology demonstrated that empowerment—the sense of control over one's life and environment—predicts both mental and physical health (Israel et al., 1994) [24]. These findings validated the Charter's call to strengthen community action: the path to health lies as much in social connection as in medical care.

Holistic and Cultural Pluralism

The holistic scope of health promotion also demanded cultural pluralism. Although the WHO's framework emerged from Western public health discourse, its universal applicability required engagement with diverse cultural conceptions of well-being. Anthropological research revealed that non-Western societies often conceive health not as individual autonomy but as harmony within community and nature. African Ubuntu philosophy, for instance, locates personhood in relational being—"I am because we are"—and thus interprets health as social integration (Becker, 1997) [2]. East Asian traditions emphasize balance between body, mind, and environment, echoing Taoist and Confucian notions of self-cultivation. The adaptation of health promotion policies to local contexts—whether through traditional healing practices,

community rituals, or family-based interventions—illustrates how the holistic ideal must be translated rather than imposed. This cultural pluralism constitutes both a challenge and a source of vitality for the global health promotion movement.

Concrete national strategies exemplify how the Charter's principles have been institutionalized. Canada's "Active Living Strategy," launched in 1997, promoted physical activity as a foundation of personal and social well-being, integrating sports policy with community planning and education (Health Canada, 1997) [20]. The European Union's "Health for All" initiative, initiated in 1988, aimed to reduce health inequalities across member states through coordinated policies addressing housing, employment, and social protection (European Commission, 2003, 2012) [13, 14]. At the community level, health promotion evolved into participatory programs emphasizing social cohesion and mutual support. The "Healthy Cities Movement," launched by the WHO in 1986, embodied this approach by encouraging municipalities to redesign urban environments to foster physical activity, environmental sustainability, and social interaction (WHO, 1988). These efforts operationalized the holistic vision at multiple scales, turning abstract philosophy into everyday practice.

Institutionalization of holistic health also required new forms of education and knowledge. The concept of "health literacy," introduced by Simonds (1974) [40] and refined by the WHO (2009), expanded the meaning of literacy itself—from the ability to read and write to the capacity to obtain, interpret, and apply health information in daily decision-making. Health literacy transforms individuals from passive recipients of medical advice into active participants in their own care. It aligns with the Ottawa Charter's principle of empowerment: people must have both the knowledge and the skills to manage their well-being. Consequently, many countries incorporated health literacy into school curricula and lifelong education programs. In the United States, the Department of Health and Human Services (HHS, 2000) established national guidelines linking health literacy to public health outcomes. In the European Union, health literacy became a key component of the "Health for All" framework, promoting access to reliable information across linguistic and socioeconomic boundaries (Nutbeam, 2008) [32]. These educational reforms institutionalized holistic health not as a temporary campaign but as a permanent civic competence.

Parallel to educational initiatives, the institutionalization of preventive medicine solidified the structural basis of holistic health care. The preventive paradigm—often summarized as primary, secondary, and tertiary prevention—embodies the shift from episodic treatment to lifelong health maintenance (Bynum, 2008) [6]. Primary prevention seeks to eliminate causes before disease occurs through vaccination, environmental sanitation, and lifestyle education. Secondary prevention focuses on early detection via screening and regular checkups, while tertiary prevention mitigates complications and promotes rehabilitation. By encompassing the full trajectory of disease, this tripartite model operationalizes the notion that health is a continuum rather than a binary condition. National health systems across the globe have adopted variations of this model, with demonstrable results: infectious disease mortality has plummeted, chronic disease management has improved, and health expectancy has increased (WHO, 2022). Preventive

medicine thus institutionalizes the historical aspiration of Hippocrates—to preserve rather than merely restore health—using the tools of modern science.

Environmental dimensions have increasingly expanded the holistic paradigm into what might be called *ecological health*. The recognition that human well-being depends on sustainable ecosystems has given rise to new interdisciplinary frameworks such as “planetary health” and “One Health,” which integrate human, animal, and environmental health (Whitmee et al., 2015) [41]. The Healthy Cities Movement exemplifies this ecological turn. By redefining urban space as a determinant of well-being, it links architecture, transportation, public policy, and environmental planning to health outcomes. A healthy city, in WHO’s formulation, “continually creates and improves its physical and social environments, enabling people to support one another in all functions of life” (WHO, 1988). This vision extends the holistic principle from the individual to the collective, from body to biosphere. Health becomes an emergent property of ecosystems, echoing ancient philosophies of harmony between humanity and nature while grounded in modern environmental science.

Despite these advances, the holistic paradigm faces enduring theoretical and practical challenges. Conceptually, the very breadth that makes the idea of holistic health appealing also renders it ambiguous. The WHO’s original phrase “complete well-being” remains problematic because it conflates ideal and reality. Few individuals experience permanent equilibrium; to define health in absolute terms risks turning the entire population into patients (Callahan, 1973) [7]. A more workable approach views health as a dynamic process of adaptation and resilience—a capacity to maintain balance amid continual change. The biopsychosocial model, when understood dynamically, allows for fluctuation and recovery rather than perfection. Empirical research now emphasizes resilience, emotional regulation, and social support as key determinants of well-being, reflecting this processual understanding (Antonovsky, 1987) [1].

Cultural adaptability constitutes another challenge. The holistic ideal often carries Western liberal assumptions about individual agency and autonomy that do not easily translate into collectivist or spiritual traditions. In many societies, health is inseparable from family obligation, ritual practice, or divine relationship. Efforts to globalize holistic health must therefore adopt an intercultural hermeneutic: not a universal template but a flexible dialogue among traditions. In East Asia, for instance, Confucian self-cultivation and Daoist naturalism have been integrated with modern wellness practices, producing hybrid models that resonate locally while engaging global discourse. Such synthesis demonstrates that the holistic paradigm is not a fixed doctrine but a living tradition, capable of perpetual reinvention. Practical barriers persist as well. Health resources remain unevenly distributed both within and between nations, creating a gulf between the ideal of holistic care and the reality of scarcity. In low- and middle-income countries, access to basic medical services often takes precedence over psychosocial or preventive interventions. Even in affluent societies, health systems are frequently organized around acute treatment rather than long-term well-being. Professional specialization, while advancing technical expertise, can fragment care and obscure the

person behind the disease (Engel, 1977) [12]. The shortage of interdisciplinary professionals trained in both biomedical and psychosocial domains further hinders holistic implementation. To realize its potential, holistic health must be supported by structural reforms that promote equity, education, and collaboration across sectors.

Digital Health and Humanistic Care

The rise of digital health also introduces new ethical and psychological dilemmas. Data privacy, algorithmic bias, and over-reliance on technological mediation threaten to undermine the human dimension of care (Montag et al., 2019) [30]. The challenge is to harness technology without surrendering empathy—to ensure that artificial intelligence enhances rather than replaces human intelligence in the therapeutic encounter. Ethical frameworks emphasizing transparency, informed consent, and algorithmic fairness are essential to sustain trust in digital medicine. Moreover, human contact itself must be preserved as a therapeutic resource. The tactile presence of a caregiver, the tone of voice, and the shared moment of vulnerability constitute elements of healing that no machine can replicate. The holistic vision, if it is to remain truly whole, must include not only information and efficiency but compassion.

Despite these challenges, the trajectory of medical thought reveals a remarkable continuity. From Hippocrates’ humoral balance to Engel’s biopsychosocial integration, from the WHO’s comprehensive definition to the Ottawa Charter’s social empowerment, the history of holistic health reflects humanity’s enduring aspiration to reconcile the fragmentation of modern life. Each era reinterprets this aspiration according to its conditions: the ancient physician sought harmony with nature, the modern clinician seeks integration across disciplines, and the digital citizen seeks balance within networks of information. What unites these pursuits is a moral insight as much as a scientific one—that health is a form of relationship: with oneself, with others, and with the world.

In the early twenty-first century, the COVID-19 pandemic reaffirmed the urgency of holistic thinking. The crisis demonstrated that viruses do not respect boundaries—biological, social, or political. Health systems built solely on biomedical interventions struggled to address the psychological toll of isolation, the social inequities of vulnerability, and the environmental origins of zoonotic disease. The pandemic thus revealed that holistic health is not a luxury but a necessity for global survival. It underscored that resilience depends on social solidarity, emotional intelligence, and ecological stewardship as much as on vaccines and ventilators. In this light, the holistic paradigm reemerges not merely as an ethical ideal but as a pragmatic framework for navigating an interconnected world.

Conclusion

The development trajectory of the holistic health concept reflects the deepening of human understanding of health’s essence. From the pre-20th century dominance of the biomedical model to the paradigm shift triggered by WHO’s 1948 health definition—expanding beyond physical absence of disease to encompass physical, psychological, and social well-being—the concept has undergone a complex evolution. Far from a novel idea, it represents a historical return to traditional wisdom (ancient Greek “body-mind

balance,” medieval “spiritual harmony,” modern humanistic medicine’s “treating both body and soul”) reshaped by modern science (OpenAI, 2023) [33]. Psychology and behavioral medicine have been pivotal to this modern reconstruction. Post-WWII psychiatric advancements institutionalized mental health, while behavioral medicine enabled targeted intervention in health behaviors. The integration of stress research and psychosomatic medicine fostered dialogue between Eastern and Western health thought, and 21st-century digitalization and socialization have further enriched holistic health’s form. Yet, challenges persist. Theoretically, ambiguous definitions, inadequate cultural adaptability, and interdisciplinary integration barriers demand resolution. Practically, uneven health resource distribution, difficulties in clinical implementation, and digital health’s ethical risks require mitigation. Correspondingly, a clear, operable theoretical framework should be established to advance cultural localization and interdisciplinary research; practically, resource allocation must be optimized, the medical system transformed, and digital health regulated (Lu, 2022) [27].

The health promotion movement, marked by the 1986 Ottawa Charter, constitutes a milestone in medical and health thought. It shifted health’s paradigm from “disease defense” to “resource empowerment,” elevating it from an individual medical issue to a multi-dimensional social engineering involving policy, communities, environments, and individuals. Its “holistic governance” logic and “five action guidelines” provide a practical blueprint for holistic health’s institutionalization.

Historically, the movement has progressed through “theoretical breakthrough → global practice → institutional integration.” The Ottawa Charter’s core ideas provided an ideological foundation, validated by national initiatives. Health literacy education, the institutionalization of preventive medicine, and healthy city development have integrated fragmented efforts into a systematic “education-prevention-environment” model of institutionalized holistic health.

From a health thought history perspective, the movement embodies a return to holistic health’s social practice. It inherits traditions of “body-mind balance” and “treating both body and soul” while translating traditional wisdom into actionable social initiatives via modern public health and behavioral medicine’s empirical methods.

Ultimately, the historical evolution of the holistic health concept and the health promotion movement illustrates the dynamic interplay between science, philosophy, and culture. What began as a metaphysical intuition of harmony has become an empirical and institutional reality—embedded in global health policy, educational systems, and technological innovation. Yet its essence remains unchanged: the conviction that human beings are more than the sum of their parts. To cultivate health is therefore to cultivate wholeness—within the body, within society, and within the planet that sustains them. The challenge for contemporary medicine is to uphold this wholeness amid the pressures of specialization and commodification. If the twentieth century was the age of curing disease, the twenty-first may become the age of sustaining balance. In that pursuit, the long journey from Hippocrates to the digital era continues, guided by the timeless insight that to heal the person, one must heal the whole.

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