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The Ottawa Charter 30 years on: still an important standard for health promotion

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ABSTRACT

The World Health Organization's Ottawa Charter for Health Promotion has been considered a seminal document and template for health promotion since its inception and is still seen as a "gold standard" for health promoters worldwide who wish to improve health and reduce inequalities. Although its principles have been widely applauded, opportunities to transfer these principles into the radical changes and practical solutions needed globally to improve health have been missed. This paper examines how the Charter has influenced United Kingdom health care policies by examining two of the Charter's key strategies, creating healthy environments and reorientating health services. In the UK, currently, there remains an over emphasis on personal responsibility and behaviour change, rather than tackling fundamental societal-wide issues. Nevertheless, it is argued that the Ottawa Charter retains its relevance to the present day and that all policy makers and professionals working to promote positive health should revisit and take heed of its principles.

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Introduction

The World Health Organization's Ottawa Charter for Health Promotion (1986) has been considered a seminal document and template for health promotion since its inception and is still seen as a 'gold standard' for health promoters worldwide who wish to improve health and reduce inequalities (Watson 2008). The Ottawa Charter galvanised health departments around the world and put health promotion on the agenda of many countries as never before (Catford 2011).

The WHO Constitution (1946), the Lalonde Report (1974) and the Alma Ata Declaration (1978) were all key documents which had a major influence on the development of the Ottawa Charter which, subsequently was pivotal in guiding the development of the societal approach to health promotion. The Charter contributed to shifting the rhetoric and discourse upstream away from merely focusing on individuals who are at risk of developing ill health and towards organisations, systems and environments that can be used

to prevent ill health and promote good health. The Charter also called for a number of prerequisites for health and for the core activities of ‘advocacy’, ‘enabling’, and ‘mediation’ to be embedded into the work of health promoters. The principles set out in the Charter were developed further through a succession of documents arising out of international conferences in Adelaide, Sundsvall, Jakarta, Mexico, Bangkok and Shanghai (WHO 1991; 1997; 1988; 2000; 2006; 2016).

This paper will examine the legacy of the Ottawa Charter and discuss its influence on health promotion policies and practice. This paper will specifically review two key Ottawa strategies, those of creating healthy environments and re-orientating health services and focus on how these strategies have influenced the health promotion agenda in the United Kingdom. It will highlight the missed opportunities since the Charter’s conception and the way the principles of the Charter have been subsumed by political parties to conform to their own political rhetoric.

Five key strategies

The Ottawa Charter proposed a positive empowering view of health. It laid out five key strategies to promote a joined up, societal wide approach to effective health promotion (See Table 1). Although the underlying intention was that the five key strategies should be implemented together, the emphasis on one particular strategy over another has varied over the last 30 years. This choice has been influenced by government ideology and policies of the various political parties in power in different nations and at different times since the Charter’s publication. For example there tends to be a focus on the development of personal skills and encouragement of the individual to change their own lifestyle and take responsibility for their own health status whenever a more right of centre government is in charge (University of Leeds et al. 1998; Scott-Samuel et al. 2014; Thompson 2014). This contrasts with the emphasis on healthy public policy and community action which is more typical of left of centre governments.

In the UK, there was a discernible change in health promotion policy when, in 1997, a Labour Government replaced the 17 years of Conservative government that preceded it (Acheson 1998; DoH 1999; DoH 2002; DoH 2009; Marmot 2010). Individual lifestyle change tended to be of lower priority than the establishment of community Health Action Zones and an emphasis on tackling health inequalities at a societal level. Since the return of a Conservative government in 2010 the emphasis has returned to focusing on individual responsibility rather than how government and society at large can promote health (Kings Fund 2012; DoH 2014).

Spending on health care varies throughout the world, those nations with lower Gross Domestic Product (GDP) spend lower proportions on health than those nations with a high GDP. However there is great variability amongst even high income nations, in 2016, the United Kingdom spent 9.7% of its GDP on health, whereas the United States spent 17.2%

Table 1. The Ottawa Charter’s five key strategies for health promotion.

-
- (1) Build healthy public policy
 - (2) Create supportive environments
 - (3) Strengthen community action
 - (4) Develop personal skills
 - (5) Reorient Health Services
-

(Organisation for Economic Cooperation and Development 2017). The percentage spent on health as a proportion of GDP in developed nations has been increasing year on year, as a result of an increase in the ageing population and the care needed for people living with chronic disease (WHO 2014; Eurostat 2017). The role of health promotion in preventing or limiting chronic disease and improving quality of life is widely acknowledged and a central tenet of the Ottawa Charters and subsequent charters. However, in 2015, a joint EU action group published a report into the funding of health promotion in 14 EU countries. The report found that:

Most Partner Countries highlight the fact that funding for health promotion and disease prevention is inadequate and forms a very small proportion of overall health budgets. (Chronic Disease and Healthy Aging Across the Lifecycle CHRODIS 2015, 5)

It therefore takes significant political will and provision of adequate funding to successfully drive forward the principles of the Ottawa Charter.

Two key Ottawa strategies which gained impetus in the UK after the Charter's publication were creating supportive environments, as part of which a settings approach was used to generate key health promotion initiatives and re-orientating health services to make sure health promotion became more embedded in mainstream health care services (Tones and Tilford 2001). Below follows an assessment of how these two key strategies were implemented in the UK and an assessment of the degree of success they have attained.

Creating supportive environments

The Ottawa Charter's creating supportive environments strategy acknowledged that we interact closely with the variety of environments we come into contact with. These environments need to be safe but also need to support our physical, social, spiritual, economic and political health needs (WHO 1991; WHO 2016). In an effort to create supportive environments the settings approach to health promotion was developed, (Baric 1993; Poland, Green, and Rootman 2000) This recognised the fact that health promotion should be embedded into all aspects of life, including home, work, leisure and within health care. This whole systems approach, led to a range of health promotion settings being identified internationally and policies and initiatives being generated to promote health within these locations, including:

- health-promoting hospitals
- health-promoting schools
- health-promoting workplaces
- healthy prisons
- healthy cities
- healthy islands. (WHO 2017)

For some of these settings, health-promoting hospitals and health-promoting schools for example, a significant amount of academic material has been generated, including descriptive studies, evaluations, some systematic reviews and theoretical papers. However, despite their vital importance, health-promoting family doctor services, (in the UK known as general practice), have received scant attention (Baric 1993; Watson 2008).

Baric (1993) clearly distinguished the difference between health promotion in a setting and the concept of the health-promoting setting. The former may merely involve certain

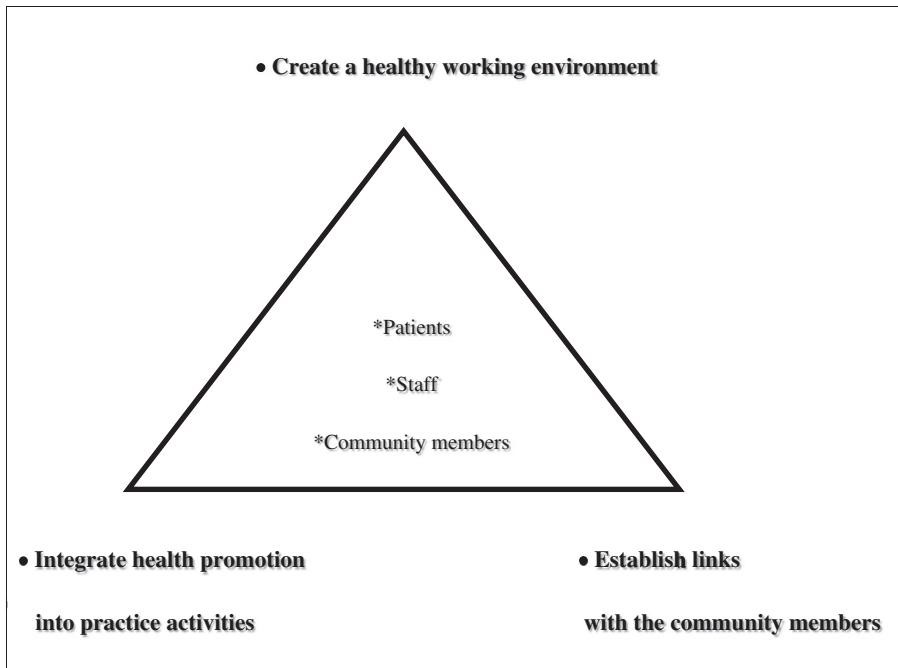


Figure 1. Three criteria for a health-promoting general practice.

aspects of health promotion that are carried out as part of the normal interaction with patients, whereas the latter is a more comprehensive and co-ordinated approach. The health-promoting general practice is essentially the gold standard. In order to become a health-promoting setting, Baric (1993); Tones and Tilford (2001); Watson (2008) suggested that those involved should undertake the commitment to three conditions:

- (1) creation of a healthy working environment
- (2) integrating health promotion into daily activities
- (3) reaching out into the community.

These conditions are shown for the health-promoting general practice in Figure 1. It should be noted that this health-promoting setting is not just for the patients but also for staff and community members. Similarly, a health-promoting school aims to involve pupils, teachers, parents, ancillary staff and others in the community.

Success of the settings approach since Ottawa appears mixed. For those settings, where there is a body of evaluation evidence it appears stronger where specific components of a setting have been addressed rather than holistic developments (Whitehead 2004; Groene and Jorgenson 2005; Stewart–Brown 2006; Lee et al. 2013; Langford et al. 2015). Health promoters have found it easier to develop discrete interventions within certain settings rather than to fundamentally change whole organisations or systems, that is the setting itself (Whitelaw et al. 2001; Hancock 2011). For example there may be a specialist project to provide health care for homeless people within a certain inner city area, but institutional and political changes to enhance care for the homeless and tackle the root causes of homelessness are less in evidence. Such a phenomenon has been labelled ‘projectism’ and leaves many health promoters often feeling that they are merely acting at the margins, working on short-term

projects which lack sustainability and make little long-term difference (Thompson 2014). Health promotion practitioners have reported what has been termed as ‘moral distress’, the feeling that they are a minority workforce working within large health care systems which do not value their input (Sutherland 2015). This ties in with the funding disparity awarded to health promotion compared with mainstream health services mentioned above. Many argue that there are needs to a fundamental shift within political systems and the ways in which society is organised in order to make the key changes envisaged by Ottawa (Hancock 2011; Wilkinson and Pickett 2011). Raphael (2013a, 2013b) argues that a nation’s pro health promotion rhetoric does not always match its commitment to the provision of good quality health promotion services. England is one of the nations that he evaluates to be high on rhetoric and low on activity.

There is therefore the need for coordinated action for the settings approach to fulfil its initial promise. Within health services, schools, workplaces and communities there are a wide range of key people such as teachers, nurses, social workers, police and doctors who could work towards bringing about institutional changes to ensure their settings are more health promoting. However, it is important to recognise that such workers have their core functions within their organisations and may place lower emphasis on promotion of health. Nurses are perhaps obvious participants in health promotion practice, but their input is largely confined to one-one patient consultations; they rarely get the chance to influence policy at a strategic level or change the systems of which they are a part (Kemppainen, Tossavainen, and Turunen 2012; Keleher and Parker 2013). It is therefore essential that such professionals receive support from a professional health-promoting workforce, which is able to assess areas for improvement within organisations and work alongside key players to instigate positive changes (Ingliss et al. 2011; UK Public Health Register 2017).

Unfortunately, however access to a qualified and experienced health promotion workforce is far from universal. In the UK, the responsibility for public health and health promotion was transferred in 2010 from the health service to local government. Before this move, the UK had relatively well resourced health promotion units. Health promotion specialists within these units were involved in training, coordination, campaigning, research and evaluation of health promotion activities. In addition to specialist health promoters, other health, education and community workers had health promotion as part of their roles. Building a sustainable health promotion workforce and strengthening its role in tackling the social determinants of health has been a key tenet of policies leading on from the Ottawa Charter (WHO 1997; WHO 2016).

However, although there are variations between the constituent countries of the UK, in many areas, resources have been significantly reduced (Watson and Lloyd 2014). In autumn 2015, the UK Government confirmed on-going cuts to the public health budget of 4% year on year until 2020. In 2015, the UK Parliament set up a health committee to examine the implication of this which concluded that;

Cuts to public health and the front-line services they deliver are a false economy as they not only add to the future costs of health and social care but risk widening health inequalities (UK Parliament 2015).

The above reiterated the 2014 Five-Year forward view which stated:

the future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health. (NHS England et al. 2014).

In the UK, there is a growing consensus that there needs to be an increased investment in ill health prevention and health promotion if the setting approach is to be successful and professionals within other sectors are to be supported to incorporate health promotion within their existing role (Wanless 2002; Marmot 2010; BMA 2015; Watson and Lloyd 2016).

Before finishing this section, it is important to stress that the Director of Public Health leadership role is pivotal to the work of health promotion and the health of our communities (Watson and Tilford 2016). Their own actions and those of their staff are vital for motivating and supporting the range of current and potential health promoters. Well-resourced and robust multi-disciplinary public health departments will be vital to creating supportive environments and tackling our pressing public health challenges.

Re-orientating health services

The Ottawa Charter stated that health services needed to move away from its emphasis on clinical and curative services and invest more in health promotion. (WHO 1986). However, as the burden of disease has grown the disparity between money spent on acute hospital services and the amount spent on primary care services, (the site of much health promotion activity) has also grown, (Health Foundation 2015). Despite Ottawa, there is little evidence that a re-orientation of health services has occurred systematically anywhere in the world (Wise and Nutbeam 2007; Ziglio 2011).

A 2013 report estimated that a mere 4% of the UK's NHS budget was spent on prevention programmes, (PHE and NHS, 2013), and called for local groups which commission clinical services to reallocate provision away from in patient and acute services to community and prevention services. However, those of us who have been working with health promoters for many years are aware of this demand which although regularly revisited never seems to be implemented in any sizable way.

In general, health services continue to pursue medical model interventions, including assessment and management of coronary heart disease risk factors, screening services and immunisations, but action on other areas of prevention and the wider determinants of health has become the responsibility of local public health departments. Unfortunately, the transfer of this responsibility coincided with a period of sweeping cuts in funding for local government services and as such departments in many parts of England have been dramatically reduced (Watson and Lloyd 2014; Kings Fund 2016; Public Finance 2016).

The UK Government's flagship health promotion policy for health services during the last few years has been Making Every Contact Count (MECC). The key aim for this strategy is to use every contact with an individual as an opportunity to maintain or improve his or her mental and physical health and well-being (NHS Future Forum 2012; Bennett 2015; Public Health England 2016).

The emphasis for this initiative is again primarily focused on lifestyle change, including targets of weight reduction and stopping smoking, but this emphasis does not match the philosophy of the Ottawa Charter. Although the Charter advocated strategies to both re-orientate health services and develop personal skills, MECC can be seen as a very narrow interpretation of these. Ottawa advocated an holistic whole systems approach to change and promoted empowerment, with clients setting their own priorities and goals rather than being steered towards achieving a prescribed target matching health and government agendas.

What is more the MECC policy has been broadened out from an initiative for health care professionals to one which utilises a ‘wider public health workforce’ which is defined as:

Any individual who is not a specialist or practitioner in public health, but has the opportunity or ability to positively impact health and wellbeing through their (paid or unpaid) work (Centre for Workforce Intelligence and Royal Society for Public Health 2016, 18).

Moreover, although many people do talk to some form of health practitioner every day, not all of these will be ideal opportunities for talking about specific lifestyle change issues. Many health professionals already assess the individual needs of their patients with sensitivity and discretion and opportunistic advice may or may not be appropriate (Watson 2012). Frontline staff must be allowed to listen to the individual needs of their patients.

It is essential that the MECC initiative is backed up by a raft of services which can provide specialist and on-going support to individuals embarking on lifestyle change to ensure high rates of success, a maintenance of motivation and guard against individuals being set up to fail due to poor support (Thompson 2014; Kings Fund 2015). Unfortunately, it is these on-going specialist support services run by public health departments which are being subjected to large scale funding reductions.

The way forward

The 25th and 30th anniversaries of the Ottawa Charter prompted a number of distinguished writers to reflect on the legacy of Ottawa (McQueen and Salazar 2011; Saan and Wise 2011; Alla 2016; Christie 2016; Labonté 2016; Potvin and Jones 2016; Kickbusch and Nutbeam 2017). Running through this commentary has been the identification of the many contextual changes over the last 30 years including: globalisation, major developments in media technology and the internet.

Labonté (2016, 1), for example, comments;

The acceleration of economic crises and economic inequalities in a more complex and multipolar world pose dramatically new challenges for those committed to the original vision of the Charter.

The Ottawa Charter was generated at a time when there was continuing influence of a number of social movements which informed the core philosophy, values and approaches advocated in the Charter. Is it asking too much of a document generated 30 years in very different times to have continued relevance and usefulness? It may be time to reassess the future usefulness of the Charter and, if required, to suggest alternatives. This has been the task of recent meetings in Birmingham, UK (The Equality Trust 2016); Shanghai (WHO 2016) and Vienna (EUHPE 2016; McKee et al. 2017).

The Shanghai Declaration builds on the Ottawa Charter’s heritage and positions health promotion within the 2030 UN Agenda for Sustainable Development (UN 2016). It makes clear the continuing relevance of health promotion and pledges to tackle unacceptable health inequities. According to Kickbusch and Nutbeam (2017), the ambitious agenda that has been set will require transformational change at international, national and local levels. Shanghai recognised that while health needs to be high on the political agenda, the political commitment to health promotion had found different expressions in differing political systems and context specificity was critical. Within the UK, the two key strategies under

discussion in this paper were taken forward by the adoption of a settings approach and a call for fiscal changes to enable the reorientation of health services to optimise fairer access.

The Vienna Declaration, on the other hand, which was adopted at a joint meeting of the European and the Austrian Public Health Associations, reiterated commitment to the principles of the Ottawa Charter and concluded that its ideas were seen to have stood the test of time (EUPHA 2016). The Declaration expanded the prerequisites for health, in recognition of changes since 1986. It examines the public health function in taking Ottawa forward and concludes with four pledges on: high-quality information systems; advocacy for health; making health effects of policies visible; and the creation of motivated and highly qualified workforces.

The role of the Institute of Health Promotion and Education

Over the years, members of the Institute of Health Promotion and Education (IHPE) have been heavily involved in taking forward the Ottawa Charter. Their roles have included: health promotion specialists, managers in statutory and third sector organisations and academics. Many have used this journal to document their ideas and activities. In addition, the institute's website documents past history as well as detailing examples of current activities (ihpe.org.uk).

IHPE members have for a long time promulgated approaches that are in line with the Ottawa Charter, promoting empowerment, facilitating community action and working within a raft of agencies and settings to promote health. As well as lobbying for change and contributing to policies at both local and national levels members have been involved in producing key articles and core texts that have endorsed and carried through the principles of Ottawa Charter (Baric 1988, 1992; Tones 1992; Baric 1993; Tones and Tilford 2001; Watson 2008; Warwick-Booth, Cross, and Lowcock 2012; Thompson 2014; Watson and Lloyd 2015). Within the UK for example, the institute is currently urging the government to take a long-term strategic approach to promoting health that not only focuses on individuals but also creates supportive environments (Watson and Lloyd 2014). The Institute is also currently recommending, the introduction of compulsory Personal and Social Education in all schools. Whole school approaches to health that involve key members of the community should be encouraged and schools should be supported in becoming health-promoting schools. These recommendations are of course in line with the Ottawa Charter.

Conclusion

The Ottawa Charter offered a blueprint for planning health promotion and documents from subsequent international conferences developed the thinking around the constituent elements of the Charter and to varying degrees, took into consideration social, and economic changes impacting on health. Much has changed since 1986. Some prevalent global public health challenges of the 1980s, such as provision of water and sanitation are still relevant while others, such as obesity, have assumed greater significance. Globally, as well as in the UK, there remain significant challenges and the recognition of major and widening social inequalities in health.

The Ottawa Charter emerged, in part, as a response to an over emphasis on an individualistic approach. With the development of the health promotion movement and other

influences, there was some decline in this emphasis and increase in activities directed towards the underlying determinants of health. However, during recent years in association with dominant ideology there has been a shift back towards individualistic approaches. This has particularly been the case in the UK.

The 25th and 30th anniversaries of Ottawa have seen the publication of a number of reflections. These have, *inter alia*, referred to the successes as well as lack of achievements across the five key strategies of Ottawa. However, most commentators have endorsed the key elements of the Charter and its underpinning values and see it as having continuing relevance, a position with which we concur. Where the UK is concerned a relaunch of the Ottawa Charter principles is proposed, with a renewed emphasis on the development of healthy settings and measures to redistribute health services to focus more on promotion and prevention.

In conclusion, although there are well documented achievements across the key strategies of the Ottawa Charter there is still much work to be done. The Charter and the WHO documents which succeeded it offers a valuable template for health promotion. However, implementers should incorporate a stronger emphasis on redressing health inequalities, and undertake appropriate evaluation activities to further develop the evidence base.

Disclosure statement

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