Looking back, looking ahead—health promotion: a global challenge

IAN POTTER
Health Promotion and Programs Branch, Health Canada

INTRODUCTION

It is an honour that Canada once again has the opportunity to participate in a significant milestone in the progress of the modern health promotion movement. This year there have been many celebrations throughout the world celebrating the tenth anniversary of the Ottawa Charter for Health Promotion, which was born at the first International Conference in Ottawa, Canada. Since 1986, the Ottawa Charter has been translated into 50 languages. It has been used throughout the world as a basis for health planning, policy development and academic endeavours.

In Canada, we also had occasion this year to celebrate 25 years since the publication of *A New Perspective on the Health of Canadians*. This document was the first to suggest that environments, lifestyle and human biology were as important as health care in influencing people’s health. It was also the first government document in the world to identify health promotion as a key strategy and policy for improving health.

It is therefore timely to take stock. This conference will assess the achievements in health promotion that have been made around the world and look into the future. The theme for the conference—*New Players For A New Era*—is also timely.

The world as we know it is in the midst of a global revolution in trade, politics, finance, communications, research, technology and the movement of people. As we become increasingly connected, we will need to build alliances around common concerns. Threats to health result from environmental degradation, poverty and disease which do not suddenly stop at national borders.

Many of the ‘new players’ at this event come from developing countries. These countries are not new to health promotion. Indeed, since the Declaration of Alma Ata in 1978, they have used health promotion techniques under the banner of primary care to better the health status of people in their countries. Canada and other industrialised countries have as much to learn from their experiences as developing countries have to learn from ours.

In this paper I should like to:

- outline some of the things we have learned in Canada during the 10 years since the creation of the Ottawa Charter;
- consider the global challenges that are ahead of us;
- explore how we, as partners in health promotion, can address these challenges.

In doing so I will take an optimistic view of the future, despite the severity of the challenges we face. Indeed, there is a growing body of literature suggesting that the young optimist will live a longer, healthier life. People know in their hearts how important it is to take an optimistic

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view in the face of great challenges. Recently, when we asked Canadians what factors have the greatest effect on their health, ‘a positive state of mind’ ranked in the top five.

LOOKING BACK: WHAT HAVE WE LEARNED?

Like most other countries, Canada has gone through some painful reductions in government programming in order to reduce our national and provincial deficits over the last 10 years. At the same time, we have undertaken a process of health care restructuring and reform. Health promotion as a way of working has continued to grow and evolve, particularly at the grassroots level. Despite a recession, we have witnessed the birth of a consortium of 12 Centres for Health Promotion at universities across Canada (two of which are WHO collaborating centres), the integration of health promotion into public health programs across Canada, some progress in the creation of healthy public policies and the growth of community action programs for children, youth, women, older adults and other groups.

In our efforts to improve health, we have in one sense, gone ‘back to basics’ by putting more emphasis on the main determinants or ‘prerequisites for health’ as they are called in the Ottawa Charter. This process culminated in the release of a document called Strategies for Population Health, which was endorsed by the federal, provincial and territorial Ministers of Health in 1994. This document speaks to the growing body of evidence about what makes people healthy or sick.

We have learned that socio-economic status is the single most important determinant of an individual’s health. In countries all over the world, people with high socio-economic status are healthier and generally live longer. But there is another dimension to this picture. When we look at the overall health of a whole population, the distribution of income and social status is, in fact, a more important factor than per-capita income or what a country spends on health care. The narrower the spread of income in a given society, the higher will be its overall health status.

Other major determinants of health include social support, education, employment and working conditions, physical environments, biology, personal health practices and coping skills, healthy child development, health services, gender and culture.

We call our renewed emphasis on broad determinants ‘population health’ because it emphasises strategies that affect the whole population in areas that are outside of health care, while continuing with our work in health promotion and health care.

Over the last 10 years, we have learned a fair bit about the importance of intersectoral collaboration as a tool for ‘healthy public policy’. In preparation for a recent WHO meeting on intersectoral collaboration which was held in Halifax, the Canadian Public Health Association prepared an analysis of intersectoral collaboration in Canada. Their report concluded that effective progress could be made by alliances among a variety of sectors, at a variety of levels. In addition to health, key groups that need to be involved include the economic, environmental, education, employment and social service sectors. Voluntary, professional, business, consumer and labour organisations need to be participants along with governments at all levels.

Building these kinds of alliances is a time-consuming, delicate, but necessary process. Since improvements in health lead to improvements in productivity and quality of life, the health sector can serve a catalytic role in bringing other sectors together. At the same time, however, we must resist the temptation to make health the only goal. If we are to be successful at drawing other sectors to our cause, we must be sure that their own goals and agendas are addressed as well.

Canada’s experience in implementing healthy public policies related to tobacco illustrates some of the difficulties that can arise when putting this strategy into action. We learned that a strong, sophisticated health alliance is required to balance the power and influence exerted by a giant, global industry. We learned first hand about the importance of price controls, agricultural alternatives, media advocacy and legislation to protect children and non-smokers. We learned about the difficulties there are in balancing the rights of individuals and interest groups.

We have learned valuable lessons about other health promotion strategies as well. One of these is the need to ensure that ‘reorienting health services’ toward an emphasis on health promotion and disease prevention becomes a reality, not just an empty slogan.

Canada’s publicly funded, universal system of
health care continues to be a priority for the federal government and the people of Canada. Canadians see a universal health care system as part of their national identity as caring and compassionate people.

At the same time, we have learned that investing in health care has limits in terms of improving the health of the population. Indeed, most of the factors that determine who will be sick and who will be well fall outside of the health care system. Pouring more and more money into medical care is not the answer.

LOOKING AHEAD: THE GLOBAL CHALLENGES

I shall turn now to some of the major global challenges that all of us share and explore the implications of these challenges to health promotion.

Since the optimistic days of the Ottawa Charter for Health Promotion, we have witnessed a redrawing of the world’s political and economic map. Globalisation—which is characterised by our increasing economic and social interdependence—can be viewed as a threat to the health of our populations, or as providing us with some major opportunities to work together for a healthier world.

As the world becomes more connected, the nature of disease will also become globalised

Infectious disease is no longer a concern solely for developing countries. AIDS and the reappearance of tuberculosis in many developed countries has taught us the importance of remaining vigilant in our public health and health promotion efforts to control and prevent infectious diseases. At the same time, improved health and longevity in developing countries means that these nations now join developed countries in dealing with increases in chronic diseases such as cancer, heart disease, diabetes and osteoporosis.

Preventing and slowing down the progress of infectious and chronic diseases will require the use of information technology to build global information systems and networks. This will allow us to share what we have learned and to avoid ‘reinventing the wheel’.

Changing disease patterns and increased pressures on health care services have important implications for health promotion. Health care services must strive to become an integrated and cost-effective continuum of care that starts with health promotion and includes primary and continuing care in the community, acute care in hospitals, and compassionate care for the dying. This system must be accountable to the community it serves. We can no longer afford to spend large amounts of money on medical and health interventions that cannot demonstrate their relevance and effectiveness.

When resources are scarce, decision-makers require clear, timely and reliable evidence. Evidence-based decision-making depends on a solid base of research and the ability to translate research results into understandable language and choices.

Until now, this has been somewhat problematic for health promotion. However, in the 10 years since the birth of the Ottawa Charter, the Canadian Institute for Advanced Research and others from around the world have amassed and synthesised the considerable evidence on the determinants of health. At the same time, the University of Toronto Centre for Health Promotion has led the way in consolidating the evidence on health promotion—what works and does not work. Like medical care, health promotion must be accountable to the people.

Some of the products and lifestyle habits exported to developing countries will have a negative health impact

International trade in tobacco and the associated advertising of tobacco products is one clear example. The world’s consumption of tobacco has increased by 75% over the past 20 years. Most of that increased consumption has occurred in developing countries where multinational corporations advertise their products as an inexpensive way to appear Western, sexy, adventurous and upper class. In the early 1990s, tobacco caused about three million deaths per year worldwide. By the year 2020, we can expect that number to rise to 10 million tobacco-related deaths, with 70% of those deaths happening in developing countries.

The tobacco battle in Canada has shown us that the combination of comprehensive approaches proposed in the Ottawa Charter is one of the best ways to frame and manage tobacco as a public health issue. We also recognise the importance of developing global approaches which include the development of international instruments to address tobacco control. That is why last month, Canada hosted the
first preparatory meeting to begin work on developing the World Health Organization’s framework convention for tobacco control. That kind of approach must now become a world-wide one. We must work together, to share what we have learned and to cooperate in research, program, and policy development.

**Increases in development and trade that lead to prosperity will have a positive effect on health in many countries**

There is a danger, however, that increased competition in open markets may lead to a widening of the gap between those that ‘have’ and those that ‘have not’ within nation states. Increasingly, men and women with lower levels of education will lose out in the competition for employment. The stresses and strains of unemployment erode an individual’s physical and mental health and have significant repercussions on the health of other family members.

An increased emphasis on cost controls as a way to compete in the global market has also influenced the nature of work. In some countries, it has led to increases in child labour. In my country and others, we have seen an increase in the number of ‘non-standardised’, casual and part-time jobs, especially for young people. Even in countries as privileged as Canada, a job does not guarantee an escape from relative poverty.

Efforts to decrease inequities must pay increased attention to the roles that gender and culture play in influencing health. In practically all cultures, women’s roles are viewed as subordinate to men’s. And while women in industrialised countries live longer than men, their quality of life is often compromised by violence, low wages, double workloads, and isolation in old age. All of us must give explicit recognition to the need for gender equity (for both women and men) in policies, programs, access to health care and research.

The Ottawa Charter suggests that equity and social justice are prerequisites for health. These values serve as a counterpoint to the competitive pressures of a globalisation. Studies with developed countries show that growing disparities in income have a serious detrimental effect on the health of lower-income groups, even though their absolute income is higher than the average income in some developing countries.

We will need to advocate and implement social policies and health promotion activities that protect vulnerable people and empower them to be part of the solution. This is not an easy task, particularly when government deficits are high and resources are limited. I am convinced, however, that this is, both ethically and strategically, the right thing to do. The degree to which we are able to enhance equity within and between our borders will determine whether or not health for all can be attained.

**For the first time in history, more of the world’s citizens will live in urban environments rather than rural ones**

The 21st century promises to be the age of the city, and the implications for health status are enormous. Too often, massive urbanisation is associated with increases in violence, pollution, slum housing, feelings of isolation and threats to food security.

Our experience in the ‘Healthy Communities/Healthy Cities’ movement provides us with some of the tools we need to thrive, not just survive in urban environments. The vision of a ‘Healthy City’ (or ‘Healthy Community’ as we call it in my country) was born in Canada in the early 1980s. Cooperative work with WHO EURO led to rapid growth of the concept around the world. Today, there are over 1000 cities and towns recognised by the global Healthy Cities Network. Canada has 330.

The Healthy Cities movement and other health promotion success stories in schools and workplaces point to the value of what is often called the ‘settings’ approach—reaching people where they live, work, learn, worship and play. They also confirm the effectiveness of public participation and community action as strategies that promote population health.

**Environmental issues such as climate control and degradation will affect the global community**

Invariably, threats to the physical environment land high on the list of a Healthy City’s concerns. Over the last 10 years, the idea of sustainable, human-centred development has been gaining ground. All of us will need to make compromises at both domestic and international levels. Industrialised countries that consume high levels of energy must take the lead in encouraging lifestyle changes in their own countries. However, this in itself is not enough. We will need to ensure that big business and governments cooperate to implement and respect intersectoral policies that
promote the global goal of sustainable, health-enhancing, human-centred development.

**Healthy child development still remains a global challenge that none of us can afford to neglect**

Population health studies suggest that children who grow up in nurturing, loving environments become healthy adults who are full contributors to society. Childhood poverty, illiteracy, early school leaving, forced labour, poor nutrition, neglect and abuse are the seeds of anger, despair, adolescent suicide, adult illness and premature death.

Urged on by non-governmental organisations and the public, federal, provincial and territorial first ministers in Canada have made a renewed commitment to improving the well-being of children and poor families. The National Child Benefit package provides for policies that will re-invest millions of dollars in Canada’s children. This will be complimented by a Community Action Program for Children that includes community-based health promotion activities such as home visiting, food supplementation and head start programs for aboriginal children.

Internationally, we have made great strides in recognising the rights of the child. But in the face of new global trends, a clearer strategy for action is now required.

**New information and communication technologies will help governments and others make more effective decisions for health**

Distance learning, global surveillance, interactive health networks, human resource development, telemedicine, social marketing and health education are some of the potential uses of modern information technology. Computers enable children to meet and talk with other children who are continents and oceans away. They help patients become knowledgeable consumers. They help isolated people share common problems and solutions. In Canada, we have found that teenagers prefer to learn and talk about sex education issues through the anonymity of ‘cyberspace’.

Last month, the Canadian government and the World Bank hosted the conference *Global Knowledge 97: Knowledge for Development in the Information Age*. Working sessions at that event looked at the global challenges and opportunities for knowledge, science and technology in health, sustainable development and global partnerships.

Again, however, there are some fundamental challenges in how we use information technology. We must ensure that privacy and individual rights are fully protected. In centralising and cataloguing information, we must be careful that we do not lose traditional knowledge and the value of learning by experience and storytelling.

Information technologies must be used to reduce inequities, not enlarge them. Building supportive environments for health must include policies and programs that share information technology both within and between our countries.

**IN CONCLUSION**

Sometimes we miss the obvious when it is right in front of us. We forget that public policies which invest in sustainable human health are as important to our future as traditional policies in economic development. We look for high-tech medical solutions when community action, social justice and skill development is what is really needed. We forget the power of the three-page Ottawa Charter for Health Promotion in favour of complex models and long reports.

In 1995 and 1996, the Canadian Public Health Association, with funding from Health Canada, carried out a large consultation process with over 1000 stakeholders in health promotion and sectors such as justice, education and income support. They concluded that the values, principles and strategies outlined in the Ottawa Charter are as relevant today as they were 10 years ago.

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**Address for correspondence:**
Mr Ian Potter  
Assistant Deputy Minister  
Health Promotion and Programs Branch  
Health Canada  
Room 540, Jeane Mance Building  
Ottawa  
Ontario K1A 1BA  
Canada