Health promotion and chronic disease: building on the Ottawa Charter, not betraying it?

In the first issue of Health Promotion International for 2001, a number of prominent health promotion academics took issue with the WHO (Mittelmark et al., 2001). They raised concerns about linking health promotion to a narrower disease prevention and control agenda, by structurally locating it in the new Department of Health Promotion, Non-Communicable Disease Prevention and Surveillance. There is no doubt that many in the health promotion community see this as a threat. Nevertheless, there may also be value, in a broader sense, in viewing the link between health promotion and the emerging agenda in chronic, non-communicable disease (NCD) control as a strategic opportunity.

Fifteen years on from Ottawa, health promotion can be seen in many respects to have made great progress. A strong evidence base for the effectiveness of health promotion has been established, and many health authorities now include some level of health promotion responsibility within their organizational structures. As Ilona Kickbusch noted in her commentary on the 5th Global Conference in Mexico (Kickbusch, 2001), health promotion’s ideas and arguments have been widely adopted, as evidenced, for example, in last year’s World Development Report (World Bank, 2000). They have been reinforced through recent research on the social determinants of health, and on health development and social capital (Marmot and Wilkinson, 1999).

The Mexico conference also highlighted, however, that despite the many gains, health promotion still remains largely on the margin of the health system itself (Moodie et al., 2000). Slow progress has been made on the ‘reorienting health services’ agenda of the Ottawa Charter, and health promotion perspectives have had little impact on the health sector reform debates of the past decade. This is perhaps not surprising given that the implementation of health system reorientation has received little attention at the post-Ottawa conferences (Lopez-Acuña et al., 2000). Health promotion has therefore had little in the way of considered policy and operational frameworks to bring to the debate.

While health promotion is clearly a societal endeavour, its primary base of activity and support within government usually lies with the health sector. A strong commitment to health promotion within the health system not only enables health ministries to play an important leadership and advocacy role in relation to other sectors, but it can also potentially mobilize the enormous resources of health care to contribute to health development and health equity.

An important strategic question for health promotion at the start of the 21st Century is therefore ‘what would a health promoting health system look like, and how could such a system be achieved?’. Lopez-Acuña and colleagues noted in Mexico that as the limitations of health care reforms based on models of economic efficiency alone are better understood, issues of quality of care are now coming to the forefront in reform debates. They argue that this ‘shift in the focus of reforms will provide a window of opportunity for reorienting health care systems and services with health promotion criteria’.

Signs of this new focus are being seen in a range of policy papers, research reports and new programmes, which are seeking to respond to the increasing burden of chronic illness. This is a problem already dominating health care in the West, and is rapidly emerging as a major challenge facing the newly industrializing countries in the context of the ‘epidemiological transition’ from infectious to non-communicable diseases.

This movement for change recognizes that systems of care designed to respond to acute and
Enabling people to learn, throughout life, to prepare themselves for all of its stages and to cope with chronic illness and injuries is essential. This has to be facilitated themselves for all of its stages and to cope with chronic illness and injuries is essential. This has to be facilitated.

The principles and approaches of health promotion need to be embedded across the continuum of care as part of this ‘second wave’ of health reforms. This offers health promotion the opportunity to strengthen alliances with clinicians, health service managers, policy makers and patient and consumer groups in reorienting health services as discussed in issue 16(1) of this journal (Levin-Zamir and Peterburg, 2001). The Ottawa Charter called for individuals, community groups, health professionals, health service institutions and governments ‘to work together towards a health care system which contributes to the pursuit of health’. The shifts taking place in the frameworks of understanding regarding the effective management of chronic illness provide an entry point for this to occur.

Alongside the new agenda in health care reform, recent studies have shed new light on chronic disease aetiology, which call attention to the need for upstream preventive action. But despite the fact that both upstream and downstream approaches are essentially concerned with preventing or managing the same conditions, there is little dialogue between those working at opposite ends of the spectrum. ‘Chronic disease’, in a sense a metaphor for the health problems of modernity, provides a language that can bridge these two worlds.

The new ‘upstream’ prevention paradigm is informed most notably by the emerging life course perspective in chronic disease epidemiology (Kuh and Ben-Schlomo, 1997) and by other aspects of social determinants research. These reinforce the need to move beyond the earlier ‘static’ model of prevention focused on modifying the classical risk factors in adults, to one that recognizes the interactive and cumulative impact of social and biological influences throughout life, with a particular emphasis on the contribution of the early years (McMichael, 1999). From this perspective, maternal and child health, adolescent health and healthy ageing strategies can all be seen as contributing to a comprehensive agenda to reduce the incidence of chronic disease, in addition to being important in their own right.

In addition, many of the strongest findings in social determinants research are in relation to the major non-communicable diseases and conditions, such as coronary heart disease, obesity and type 2 diabetes. These suggest that low levels of social support, lack of personal control and low socio-economic status are all important contributors to chronic disease, and thus strengthen the evidence base for wider health promotion strategies.

Diet, physical activity and tobacco smoking clearly remain the most important proximal causes of chronic disease. However, even here, new understanding of the upstream determinants of individual behaviours suggests new avenues for alliances and initiatives. For example, tackling car dependency and physical inactivity means working with the transport sector and urban planners to complement more traditional informational strategies and media campaigns.
Support for such initiatives from clinicians, who see the benefits for their patients in having a more supportive environment in which to manage their diabetes or recover from a heart attack, provides health promotion with important allies in influencing intersectoral policy debates.

Interestingly, the full range of approaches canvassed above are summarized in the World Health Organization’s *Global Strategy for Prevention and Control of Non-Communicable Diseases*. The Director-General’s report to the 53rd World Health Assembly on the Global Strategy recommended that member states develop implementation plans incorporating the following elements:

- generating a local information base for action;
- establishing a programme for promotion of health across the life course and prevention of non-communicable diseases;
- tackling issues outside the health sector that influence prevention and control of NCDs; and
- ensuring health sector reforms are responsive to the challenge of NCDs.

While there is little here that is inconsistent with the Ottawa Charter and more recent developments in health promotion thinking, strong health promotion leadership could ensure that principles such as equity, empowerment and community development underpin and are embedded in how chronic disease strategies are conceived and implemented.

Health promotion, and disease prevention and control, are not one and the same, and attempts to reduce the former to the latter should be resisted. Health promotion has an enormous task ahead, of which the chronic, non-communicable disease agenda is but one component. But if common ground can be found between health promotion and chronic disease prevention, health development would sit on firmer terrain, and health promotion’s prospect of moving from the margin to the mainstream in health system debates would be enhanced. Health promotion should seize the opportunity changing circumstances offer.

Colin Sindall
Reviews Editor

**REFERENCES**


