DEBATE

Ottawa to Bangkok: changing health promotion discourse

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SUMMARY
The discourse of the 2005 Bangkok Charter for Health Promotion in a Globalized World represents a radical departure from that of the Ottawa Charter that, in 1986, staked a place for the health promotion field in mainstream public health. Via a critical analysis of the discourse in these two Charters, this paper illustrates a shift from a ‘new social movements’ discourse of ecosocial justice in Ottawa to a ‘new capitalist’ discourse of law and economics in Bangkok.

The Bangkok Charter’s content may identify ‘actions, commitments and pledges required to address the determinants of health in a globalized world through health promotion’, but this paper shows how its discourse works to naturalize and perpetuate many of detrimental determinants associated with ‘globalization’.

Key words: critical discourse analysis; Ottawa Charter; Bangkok Charter; health promotion discourse

Unless the global public health community is serious about identifying, naming and tackling the underlying political barriers and vested interests that lie in the way of health promotion, we run the risk of changing little.1

In early July 2005, the World Health Organization (WHO) was inviting public comment on the draft Bangkok Charter for Health Promotion in a Globalized World, the first update to the 1986 Ottawa Charter. Two members of the People’s Health Movement (PHM), a grassroots organization dedicated to fulfilling the ‘Health for All’ promises of the 1978 Alma-Ata Declaration on Primary Health Care, started a conversation about the new Charter on the group’s email forum. In noting the Charter’s ‘tepid’ language and other problems, they wrote:

‘We are concerned that this document will thus be cynically used as a roll-back position... We believe that the PHM could make a material difference to improve this document... The Ottawa Charter is widely used... we believe that a well framed Bangkok Charter could be a valuable tool in the fight for ‘health for all’.2

The group’s subsequent comment on the new Charter seemed not much heeded. In August 2005, participants in the Sixth Global Conference on Health Promotion ratified the Bangkok Charter (Bangkok Charter, 2005). A PHM press release soon followed, attacking it as ‘an inadequate and timid document’.1

I agree with these PHM members’ assertion that these documents matter in health


promotion, their implied approval of the Ottawa Charter and their group’s concerns about the Bangkok Charter. I also think that identifying and naming the politics and interests embedded in these Charters is a small but necessary step towards using, or resisting, their texts and subtexts. Here I begin to take that step, using text-excavating tools of critical discourse analysis (CDA). I ask what political, social and economic agendas the Bangkok Charter language advances, ignores and conceals in comparison with the Ottawa Charter.

BACKGROUND

The Bangkok Charter is the first health promotion charter since 1986, when participants in the First International Conference on Health Promotion adopted the Ottawa Charter for Health Promotion. The Ottawa document defines itself as a ‘charter for action to achieve Health for All by the year 2000 and beyond’ (Ottawa Charter, 1986), in reference to the Alma-Ata Declaration. As Nutbeam writes, ‘the Ottawa Charter has been phenomenally influential in guiding the development of the concept of health promotion, and in shaping public health practice’ (Nutbeam, 2005). Ottawa steered health promotion away from dominant health education models of individual behaviour change towards a ‘socio-ecological’ version of health promotion that addresses structural determinants of health. It (re)defined the assumptions and widely expanded the scope and goals of health promotion practice. It played a central role in constructing a new health promotion discourse, one encompassing socio-economic contexts, going beyond individual lifestyle to wellbeing and embracing community empowerment and participation (Robertson and Minkler, 1994). Ottawa also emphasized ecological sustainability, holism and interdependency.

By August 2004, WHO was organizing the sixth global health promotion conference. ‘To determine how best to respond to the many global changes and trends that are critically affecting health and well-being’, WHO formed a 16-member committee to lead the way to a new charter for health promotion that would build on Ottawa (WHO Health Promotion Unit, 2005). This committee drafted and finalized the new Charter on the basis of the input from health promotion circles, 3 weeks of public comment online and feedback from the conference participants. These participants officially adopted the Bangkok Charter in August 2005.

Both conferences were by WHO invitation only, though Ottawa had fewer invitees, representing fewer, and almost exclusively developed countries (38 versus over 100 countries). As the resulting 1986 Charter admits, ‘discussions focused on the needs in industrialized countries’. For Bangkok, WHO invited delegates ‘in accordance with health promotion partnership principles and the best-practice evidence in each WHO region’ and considered ‘balance in gender and geographic regions’. So, in addition to responding to changed global contexts, this new Charter also offered the chance for more global input.

METHODS AND MOTIVATIONS

In this study, I use CDA theory and methods to analyze the discourse of the Bangkok Charter, particularly in comparison with the Ottawa Charter, to glimpse how its language reflects and constructs social, political and economic agendas for health promotion.

Critical discourse analysis

All discourse analysis aims to better understand the meanings of language in use, i.e. how text and context interact and convey meaning. Critical discourse analysis ‘approaches language as both reflecting and perpetuating power structures and dominant ideologies in society’ [(Lupton, 1992), p. 147]. Prominent CDA theorist Fairclough describes it as ‘discourse analysis “with an attitude”’ [(Fairclough, 2001), p. 96].


In both perception and practice, discourse analysis risks being an elitist, academic exercise in ‘idle perusal of arcane documents’ [(Southwell, 2000), p. 313]. However, if ‘language about health, like all language, positions and creates relationships among individuals, environments and institutions’ (ibid), then analyzing that language is hardly an idle pursuit. Certainly, these Charters are hardly arcane documents. As the WHO background paper to the Bangkok conference states, ‘the relevance of the Ottawa Charter lies not only in the influence it has had on establishing the field of health promotion as a key public health function and a new professional orientation but in the influence it has exerted on health policy development overall through the change of perspective that it has advocated’.5

That said, analysing discourse outside the context of practice, as I do here, is a highly incomplete project. This paper takes only the small step of beginning to analyse the Charters themselves. However, this should provide a window—however small and positioned—onto how the language use in these Charters constructs relationships among individuals, environments and institutions in health promotion practice so that, as practitioners, we can better use or resist these positionings.

**CDA in the health promotion literature**

Perhaps, because of health promotion’s roots in biomedicine and psychology, the field has not widely embraced qualitative methods such as CDA. However, the ‘socio-ecological approach’ advocated in the Ottawa Charter includes understanding social constructions of health and illness. Discourse analysis provides one tool for illuminating these constructions.

Led by Lupton (Lupton, 1992; Lupton, 1995), a handful of discourse analyses have appeared in the health literature. Here, I draw on several papers discussing general health promotion discourses: (Stevenson and Burke, 1991; Robertson, 1998b; Robertson and Minkler, 1994). Several papers focus on particular texts (Finer et al., 1998; Bent, 1999; Wilson, 2001; McKinlay et al., 2005). One focuses on health policy documents (Sykes et al., 2004). Two recent papers have renewed Lupton’s call for using CDA to make explicit how the language use in public health produces and reproduces power relationships (Cheek, 2004; Cook, 2005). Here, I heed that call.

**Method**

CDA does not pretend to the objectivity and neutrality claimed by scientific research methods and I hardly pretend to have an unbiased stance on the Charters. However, following several close content readings, I systematically applied each of the CDA tools described below to each Charter in its entirety. Space does not permit a full accounting of these results, but I use them heavily to illustrate analysis and discussion below.

Following Fairclough, I used several textual analysis tools in search of how these specific texts create ‘orders of discourse’ with ‘relatively durable’ social language structures [(Fairclough, 2003), p. 3].

**Tools used**

Conducting CDA feels like picking locks, probing texts with various tools and listening for inner tumblings of discursive structures and meanings. I tried several tools to meddle with these locks. Because the Charters are so short (circa 1600 words each), I was able to comb through them with each tool several times. On electronic copies, I marked the discursive forms and practices I found with each tool.

I started by marking modalities, moods and nominalizations in the texts. **Modality** indicates probability with words such as ‘can, will, may’ and necessity and responsibility with words such as ‘must, should, need’. I focused particularly on the latter, called deontic modality. Grammatical **moods** distinguish between declarative, interrogative and imperative sentences. **Nominalization** refers to changing words or phrases (normally verbs) into nouns; Fairclough offers the example of nominalizing ‘employees produce steel’ as ‘steel production’ [(Fairclough, 2003), p. 220]. This abstracting removes social agents and can naturalize assertions.

I started with these tools mainly for their ease of use. Mood did not give me much insight, since both Charters are mainly declarative, but nominalization gave me a toehold in

the texts. I extended this analysis to look for other discursive means of removing agents, namely what I’ll call ‘adjectivization’, or converting verbs to adjectives to similar effect of nominalization, and passive verbs without specified or implied actors. To further this search and to contextualize my mood analysis, I created a spreadsheet with columns listing every main clause subject, verb and object in each Charter. For passive verbs, I noted actors or their absence in a fourth column. This approach also highlighted who and what the Charters cast as main subjects and actors.

Then, drawing from critical theory generally and Gee (2005) and Fairclough in particular, I asked how the texts constructed the way social goods—e.g. health, income, education—should be distributed.

ANALYSIS AND DISCUSSION

The Bangkok Charter’s content may be about responding ‘to the many global changes and trends that are critically affecting health and well-being’, but its discourse works to perpetuate many of them. In this section, I discuss my findings at a macro-level and then frame them within particular discursive shifts from Ottawa to Bangkok.

Timid and veiled

The PHM accused the Bangkok Charter of timidity, particularly in reference to reaching the Health for All goals. Certainly, whatever agendas Bangkok’s discourse is promoting, it promotes them less directly than Ottawa’s. For example, the use of deontic modality words is proportionately over a third higher in the 1986 than in the 2005 Charter (35 versus, 24 instances of words such as ‘must’ and ‘critical’). The actions Bangkok casts for health promotion are also milder than Ottawa. When ‘health promotion’ is the subject in Bangkok, it ‘is based on’, ‘offers’, ‘is’, ‘contributes’, and ‘must become’. In Ottawa, health promotion ‘puts’, ‘directs’, ‘goes beyond’, ‘demands’, ‘generates’, ‘works’, ‘supports’, and ‘increases’. (These are complete lists.)

Moreover, Bangkok obscures subjects/actors via nominalizations, ‘adjectivization’, and actorless passive verbs at least three times more often than Ottawa.6 Such veils are not just timid, they conceal assertions by removing agents and causes. For example, the following language from Bangkok obscures cause and effect via nominalization, adjectivization and actorless passive voice all in one phrase: ‘exclusion of marginalized… peoples have increased’ (italics mine).

Certainly, as the Bangkok document observes, ‘the global context for health promotion has changed markedly since the development of the Ottawa Charter’. It identifies several changes relevant to health, including ‘increasing inequalities’, ‘commercialization’, ‘environmental change’ and ‘urbanization’. However, by veiling the agents and causes of these changes via nominalization, the Bangkok discourse affirms them by naturalizing them and making it difficult to point to how we could reverse them. Consider the even further concealment within ‘environmental change’ of not only the causes but also the nature of the change. Contrast this with two nominalizations in Ottawa, ‘resource depletion’ and ‘pollution’, which clearly herald changes for the worse.

Central examples of this removal of agency in the Bangkok Charter are ‘globalized’ and ‘globalization’. This brings me to the specific discourses in these Charters.

New social movements to new capitalism

The health promotion discourse changes dramatically between the Ottawa and Bangkok Charters. The central shift my results pointed to is from what I’ll characterize as a ‘new social movements’ discourse of ecosocial justice in Ottawa to a ‘new capitalism’ discourse of law and economics in Bangkok. In this section, I present evidence of this discursive shift, discussed in terms of several subdiscourse changes underlying it.

In 1991, Stevenson and Burke characterized the discourse of health promotion at the time as ‘typical of the discourse of new social movements’, with themes of democratization, equity and diversity and an overall critique of

6 In this count, I excluded passive verbs where the implied actor is a health promoter as well as the common health-related nominalizations ‘promotion’ and—in the 2005 document—‘determinants’.
Western technical rationality [(Stevenson and Burke, 1991), p. 282]. Robertson and Minkler later characterized this as a ‘new health promotion’ discourse emphasizing action on socio-economic health determinants and community participation and empowerment (Robertson and Minkler, 1994). Both papers mention the Ottawa Charter as an example and a source of these discourses.

In contrast, the discourse in the Bangkok Charter represents what Fairclough calls the discourse of new capitalism. He describes this as ‘a restructuring of relations between economic and non-economic fields which involves an extensive colonization of the latter by the former’ [(Fairclough, 2001), p. 127] and ‘the re-scaling of relations between global, regional, national and local’ [(Fairclough, 2003), p. 220]. New capitalism poses the rescaling as ‘a matter of the transformation of capitalism’ rather than of agentless ‘globalization’ (ibid). Robertson notes a shift in health promotion discourse in Canada from ‘new health promotion’ to a ‘population health’ discourse (Robertson, 1998b). With parallels to Fairclough’s new capitalism, she writes, ‘if we probe a little deeper into the theoretical foundations of population health what we find is an implicit theory that social change is brought about by adjustments in the economy’ (p. 160).

Below, I show this ‘order of discourse’ shift from Ottawa to Bangkok framed within two sets of discursive changes: from democracy to technocracy and from socio-ecology to economy. These sets emerged as the most apparent in my analysis, as well as most illustrative of the central ‘new social movements’ to ‘new capitalism’ shift.

**Participatory democracy to global technocracy**

From Ottawa to Bangkok, the discourse shifts from health promotion being a democratic people project to technocratic law and policy work. The texts mark this in several ways, including shifts to functions rather than people, global over local, rights instead of needs, improved health opportunities instead of social justice and policy over education.

**People to functions**

Ottawa foregrounds people, whereas Bangkok emphasizes policy and functions. Ottawa casts people early and often as actors and subjects, including:

> An individual or group must be able to... People cannot achieve their fullest health potential unless they are able to take control... People in all walks of life are involved... Health is created and lived by people...

When Ottawa does cast people in roles, the language still tends to humanize them; for example, ‘make the healthier choice the easier choice for policy makers as well’ acknowledges ‘policy makers’ as people making hard choices.

In contrast, Bangkok casts people nearly exclusively in functional roles and sectors, especially as ‘civil society’, ‘governments’ and the ‘private sector’. As actors and subjects, people (as ‘communities’) appear only twice: once two-thirds of the way into the document, ‘communities and civil society often lead’, and then a few sentences later, ‘communities are highly effective’.

**Local diversity to global unity**

Ottawa explicitly constructs people as diverse and complex (e.g. having ‘differing interests’ and coming from ‘all walks of life’) and requires local and contextualized solutions (e.g. ‘flexible systems’, ‘diverse but complementary approaches’, adaptation to ‘local needs and possibilities’). The only thing that is ‘global’ in the Ottawa Charter is ‘responsibility’ for the ‘conservation of natural resources’.

In comparison, Bangkok tends towards the global—‘global governance’, a ‘global development agenda’, with a nod to local in ‘global and local engagement and action’. For example, it advocates ‘an integrated policy approach’ and argues that ‘to manage the challenges of globalization, policy must be coherent’. Its discourse glosses over diversity in people and contexts. It mentions difference with, for example, ‘women and men are affected differently’; but is in the effects of globalization, rather than among people (it is also an example of passive voice disguising agents). The new Charter also notes that the ‘private sector’ influences ‘local settings’, acknowledging the local but only as the object of economic actors.
Needs to rights

Ottawa mentions human needs six times, rights not once; the Bangkok Charter talks almost exclusively about human rights. Rights language is supported by most corners of the health promotion field as useful for fighting legal battles. However, rights language is also part of an individualistic, legalistic discourse (Robertson, 1998a). It ‘has no terms for those dimensions of the human good which require acts of virtue unspecifiable as a legal or civil obligation’ [(Ignatieff, 1985), p. 14]. For example, the Ottawa Charter states, ‘health promotion generates living and working conditions that are safe, stimulating, satisfying and enjoyable’. Rights can only help get you to safe.

Social justice to improved health opportunities

The Ottawa Charter names a wide range of social goods essential for health and demands social justice and equity in their distribution, whereas Bangkok emphasizes improving health generally (‘the health of populations’, ‘progress towards a healthier world’) and promoting equal opportunity for, not equity in, health.

For example, Ottawa says ‘health promotion focuses on achieving equity in health... reducing differences in current health status and ensuring equal opportunities and resources’. In contrast, Bangkok poses legislation to ‘enable equal opportunity for health and well-being for all people’. So, in this Ottawa discourse, health promotion ensures not just equal opportunities, but also equal resources. In Bangkok, health promotion simply enables equal opportunity.

Similarly, the participants in Ottawa pledge ‘to advocate a clear political commitment to health and equity’. The Bangkok Charter, as its purpose, ‘affirms that policies and partnerships to empower communities, and to improve health and health equality, should be at the centre’. Note not only the difference between health and equity versus ‘health equality’, but the grammatical distancing in the Bangkok discourse from even this milder claim via subclauses and the qualifying ‘to improve’.

This shift also includes a move from socially proactive to biomedically defensive health promotion. Bangkok wants health promotion to ‘ensure a high level of protection from harm’, contribute to ‘tackling... diseases and other threats to health’, ‘increase health and collective health security’, ‘address all the harmful effects’, and ‘reduce transnational health risks’ (italics mine).

Educated people to proven policy

The 1986 Charter assumes people and communities should be developing and implementing health solutions (e.g. ‘strengthening public participation in and direction of health matters’, ‘accept the community as the essential voice’, ‘health promotion works through... community action in setting priorities, making decisions, planning strategies and implementing them’). It tasks health promotion with supporting this with education, requiring ‘full and continuous access to information, learning opportunities’ and ‘providing information, education for health and enhancing life skills. Enabling people to learn, throughout life.’

The 2005 Charter suggests that health promotion is a policy task requiring ‘an integrated policy approach’, ‘strong intergovernmental agreements’ and ‘government incentives and regulations’. It invokes a scientific and technical discourse in posing health promotion solutions, for example: ‘using tools such as equity-focused health impact assessment’, ‘an established repertoire of proven effective strategies’, ‘knowledge transfer and research’, ‘demonstrated their effectiveness’, ‘better application of proven strategies’. Even education becomes technical as ‘capacity building’ and ‘health literacy’.

Socio-ecology to economy

Ottawa constructs sociology and ecology as the framework for health promotion, explicitly taking ‘a socio-ecological approach’. It cites as a ‘guiding principle... the need to encourage reciprocal maintenance—to take care of each other, our communities and our natural environment’.

In the Bangkok discourse, economics has largely colonized these fields; for example, ‘effective mechanisms for global governance for health are required to address all the harmful effects of trade, products, services and marketing strategies’. Discursively, this proposes cleaning up messes of new capitalism, but not questioning their sources. Similarly, the Charter notes that the private sector ‘can contribute to lessening wider global health impacts’ by complying with regulations, reserving the
‘should’ for governments and civil society, cast as responsible for business practices via regulation and consumer choice (italics mine).

Several subdiscourses form part of this ecology to economy shift. In a shift from Ottawa, the Bangkok Charter breaks a whole into parts, recasts people as consumers and reorients from work and workers to employers.

**Whole to its parts**

Ottawa casts health and its promotion as an integrated whole. Bangkok poses health promotion approaches in structural-functional parts. For example, Ottawa claims that ‘our societies are complex and interrelated. Health cannot be separated from other goals’ and that ‘caring, holism and ecology are essential issues’. Bangkok suggests that ‘each sector—intergovernmental, government, civil society and private—has a unique role and responsibility’, and devotes a section to each.

**People to consumers**

As discussed previously, the Bangkok discourse structures people in functional terms. One of these functions is as consumers. Following comments on what ‘communities and civil society’ do, need to have, and are capable of, the Charter asserts what the public should do: ‘civil society needs to exercise its power in the marketplace’. A few sentences later, it again casts the public as consumers: ‘ethical and responsible business practices and fair trade exemplify the type of business practice that should be supported by consumers and civil society’.

**Workers to employers**

Ottawa foregrounds work, whereas Bangkok foregrounds employers. For example, Ottawa constructs the workplace as a sociological issue under social control: ‘Work and leisure should be a source of health for people. The way society organizes work should help create a healthy society’. In Bangkok, it becomes an economic issue under employer control: ‘the private sector, like other employers and the informal sector, has a responsibility to ensure health and safety in the workplace’.

**CONCLUSION**

A feminist discourse theorist notes ‘how social movement frames gain wide appeal but over time lose the progressive formulation that incited their production or, more are used to counter progressive goals’ [(Naples, 2003), p. 89]. The discursive shifts in these Charters imply that this has happened within health promotion.

The Bangkok Charter claims that it ‘complements and builds upon’ the Ottawa Charter. But rather than building on Ottawa’s socio-ecological frame, it locates elsewhere, on the busy construction grounds of new capitalism. As we construct a world of ‘rapid and often adverse social, economic and demographic changes’, the Bangkok Charter suggests that health promotion should rely on twin building inspectors of regulation and legislation to enforce code and ‘manage the challenges of globalization’. Its discourse accepts and reinforces the structure itself, obscuring the very ‘determinants of health in a globalized world’ it hopes to address. This makes it difficult to use this new Charter as a tool to help us name and tackle them.

Bangkok also radically scales back health promotion goals from striving for social justice to simply improving health opportunities. Some might applaud this as more realistic or as an appropriate step back from becoming an overreaching ‘health promotion Mafia’ (Tiban et al., 2005). In several ways, the rescaling makes it more relevant to less developed countries. For example, Ottawa’s discourse equates ‘safe, stimulating, satisfying and enjoyable’ conditions, but of course, the latter three are a luxury compared with safety. Also, in poorer contexts, Bangkok’s foregrounding immediate life-and-death health threats over relative issues of equity can seem sensible.

However, our ‘globalized world’ and Bangkok’s discourse produce and reproduce those threats. I prefer Ottawa’s socio-ecology, which tasks health promoters with asking communities what kind of worlds we should build and supporting the building, over Bangkok’s task of coping with the messes we are making without stopping to question their sources.

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