Ottawa revisited: ‘enable, mediate and advocate’

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SUMMARY
The Ottawa Charter for Health Promotion represents a turning point in public health thinking. The key messages and approaches, such as ‘enabling, mediating and advocating’, of this historical paper have not lost their timeliness and they are still considered to be the lessons for those health policy-makers who are willing to move beyond the health sector and to push health higher on the political agenda.

Key words: health promotion; public health; Health in All Policies; governance for health

Now that the fifth Jubilee of the first International Conference for Health Promotion is approaching I am often carried back on the waves of my memory: how did I live through ‘Ottawa’ as a junior expert in the health ministry of my country? Did I fully understand the significance of the event in the snowstorms of November 1986? This was definitely not the case. Similar to Fabrice del Dongo in Stendhal’s ‘The Charterhouse of Parma’, who did not feel the smell of the history in the blood and muck of the Waterloo battlefield, I could not sense that aura, just enjoying the meeting and learning from enthusiastic and wise experts—something unconventional in public health at that time.

For me, the then flourishing North Karelia Project of Finland and the nascent Heartbeat Wales program provided an entry point to the health promotion team of the WHO Regional Office for Europe led by Ilona Kickbusch. She engaged me in the steering group of the Ottawa Conference in 1985 as the only representative from a communist country. It was not easy to bring the concept back to Hungary, as many key decision-makers in health policy were hostile to the new ideas. However, reform communists and young social scientists created an alliance to make health promotion acceptable.

That is why the Ottawa Conference, for Hungary, had an immediate impact long before the major political changes: by elaborating the first national public health strategy (Kökeny, 1988), a type of document which had never been drafted in Central and Eastern Europe. The associated institutional frameworks as well as a state health promotion fund were established by 1988 and Hungary quickly connected to many of the setting networks such as the Healthy Cities. Unfortunately, a year later, the massive political transition swept away all of these developments, and in the early 1990s my country turned back to the old models. The spirit remained alive, and in the last 20 years there have been a lot of initiatives and, of course, ups and downs in health promotion.

Twenty-five years have passed since the birth of The Ottawa Charter for Health Promotion (WHO, 1986). Who would have thought that the health promotion race would have been
running for so long? Across the world there are government health promotion strategies, foundations, journals and university departments. One can say without exaggeration that although the document was ahead of its time, the fortunate combination of a social determinants approach and a commitment to community action created a unique breakthrough in public health or, as Breslow (1999) stated, the beginning of a public health revolution.

The WHO have organized seven global conferences on health promotion so far: all have reinforced the foundations we put down in Ottawa. However, the balance of the original areas shifted, and certain policy elements became more dominant. This explains why The Nairobi Call to Action (WHO, 2009) urges a repositioning of health promotion with more emphasis on local capacity building.

Originally the Ottawa Charter identified three broad strategies (Green and Tones, 2010) for working to promote health:

- **enabling** by creating a supportive environment, but also by giving people the information and skills that they need to make healthy choices,
- **mediating** between different groups and different sectors to ensure the pursuit of health and
- **advocacy** to ensure the creation of conditions favorable to health.

In addition, the Charter introduced the five key action areas including ‘build healthy public policy’ which has been refined in many policy documents as the notion of ‘Health in All Policies’ during the EU presidency in Finland (Stahl et al., 2006).

It is worthwhile to assess how these approaches have been developed. As an implicit effect of the Ottawa Charter created by a new generation of public health professionals, a new divide emerged between the concepts and practices of the holistic world of health promotion and the narrow-minded disease professionals. This often led to conflicts of ideologies and practical interests and competition for power and resources between the two ways of thinking. I vividly remember the debates of the early 1990s in Hungary: tertiary care physicians jealously warned policy-makers not to provide resources for health promotion on one hand, and health promoters urged not to finance the ‘coronary bypass surgery by the medical mafia’ on the other.

But by the end of the 1990s, health promotion decreased in radicalism, and its clash with the rigid medical model of prevention and healing seemed reconciled. A reappraisal of the medical discourse and the empowerment approaches was pushed onto the agenda through the progress of evidence-based health technology and a strong need for alliance building in health policy. Political expectations also contributed to the recognition of the long untapped, last area of the Ottawa Charter: the reorientation of health services, in particular to better address lay communities in health system reforms.

And what has happened with the early buzz words: ‘enabling, mediating and advocating’?

The decade after the Ottawa Conference was a period of gaining experience in the institutionalization and implementation of different policies based on ‘enabling, mediating and advocating’ and the important process of capacity-building—developing the financial, organizational and human resources for health promotion. However, very few countries got to the successful implementation of a functioning, non-ephemeral Ottawa Charter-based national public health strategy: enabling was mostly well articulated, the technology of mediating was in the learning phase with many stakeholders, while public health intelligence has not been efficient in advocating health matters into non-health fields.

By the new millennium, it became more and more apparent that appreciating the causes and consequences of globalization requires a clear understanding of action on the determinants of health. New opportunities such as the social media and new challenges like climate change have emerged that were really unforeseen at the time of the Ottawa Conference. The original terminology of ‘enabling, mediating and advocating’ started to find its channels in a more comprehensive, interconnected and interdependent world.

Nowadays the public health community (decision-makers, researchers and field workers) face the toll of the economic and financial crisis while protecting and promoting the health of their population. A number of impacts of the economic recession on the social and economic determinants of health have been identified by public health experts with specific mechanisms in accordance with the principles of the Ottawa Charter. Increasing inequities in health status are occurring at a time of labor market change characterized by increasing unemployment and
job insecurity. Mental health can be affected as a result of any loss of social status, the triggering of depression and increased harmful escapist activities. There are risks due to changing patterns of nutrition and more limited options for leisure time. Another key challenge to be faced is the poor and fragile health of those already socially excluded.

The effects of the economic downturn on policies related to public health are just beginning to emerge. Deficit management and severe reductions in tax revenues have an extremely negative impact on state budgets. How can governments allocate appropriate public health funding in the light of reduced revenue? Even considering health as a basic investment and health promotion as an increasing social capital, further analysis of the health economic dilemma is needed.

Responding to this challenge, horizontal integration of health promoting elements in different public policies, health impact assessment of the key developmental processes, and a more astute identification of the public health implications of demographic, labor market, social and technological changes could indicate new entry points.

It has been recognized in the draft new European policy for health by the European Office of WHO—Health 2020 (WHO, 2011) as well. This paper proudly draws on the lessons of Ottawa by reinventing the classical triad of ‘enabling, mediating and advocating’ in a new frame called ‘governance for health’ (Kickbusch, 2009). The health promotion race started in Ottawa is still being run, and in true relay fashion we may be handing the baton to new generations, and the views and cheers of the spectators may have changed—but the basic premise remains.

REFERENCES