Faculty of Health,
Education and Life Sciences

BIRMINGHAM CITY University

A New Politics for Health:
The Birmingham Health Charter

Briefing Pack

Wednesday 23 November 2016, 9am – 4.30pm
City South Campus, B15 3TN

THE EQUALITY TRUST

Politics of Health Group

Briefing Pack

Introduction and background

Thirty years ago the Ottawa Charter for Health Promotion established a radical basis for public health, calling on national governments, corporations and communities to change the conditions in which we live and work in order to achieve greater health equity. Sadly there remains a great deal to achieve. The Ottawa Charter was part of a 'new' public health movement that emerged during the 1980s based on an increasing awareness of the social influences on health and a desire to tackle inequality in health by promoting the principle of Health for All. Despite this:

"In England, people living in the poorest neighbourhoods, will, on average, die seven years earlier than people living in the richest neighbourhoods....People in poorer areas not only die sooner, but they will also spend more of their shorter lives with a disability"[1]

These geographical patterns of health inequity are repeated across the country so that the number of years an individual can expect to live in good health can be predicted by the level of economic and social deprivation in their area. Recent policy decisions have contributed to a widening of inequalities in the UK as drastic budget cuts affect the provision of welfare and services and changes forced on the NHS in England (especially since the Health and Social Care Act, 2012) threaten health and wellbeing.

The Politics of Health Group–in partnership with Birmingham City University and the Equality Trust–will be marking the 30th anniversary of Ottawa with a one-day national conference in Birmingham on 23 November, preceded by 'pre-conferences' in London, Birmingham, Sheffield and Chester.

During 2016, we are aiming to involve organisations and activists from across the UK to reignite a movement for health justice. It will build upon and strengthen the Ottawa Charter's provisions, working to focus momentum for challenging the social and political determinants of health inequality. See more at: https://www.eventbrite.co.uk/e/a-new-politics-for-health-moving-forward-from-the-ottawa-charter-registration-22733319972

[1]Fair Society, Healthy Lives–The Marmot Review. Strategic Review of Health Inequalities in England post 2010. Published by The Marmot Review February 2010 ISBN 978–0–9564870–0–1.

Briefing pack aims

This short briefing pack has been prepared to stimulate thought and discussion about the nature of the Ottawa Charter, to raise critical questions about the themes within the Charter and their relevance today and to kick start the process of producing a new Charter around which we can create a more effective public health movement.

It will be used as the basis of the pre-conferences but can also be used by any individual or group who wishes to participate in the process of developing the new Charter. Please complete our **online** survey so we can use your thoughts about the questions raised in this pack and your priorities for a new charter as the basis for discussion at the event on 23 November 2016. A sample set of facilitator's notes are also appended (Appendix 1) for anyone who wishes to use them.

History of the Ottawa Charter

The Ottawa Charter for Health Promotion was written and signed at the first World Health Organisation (WHO) International Conference on Health Promotion in 1986. Focusing on five aspects of health promotion (which will be developed and reimagined in the Birmingham Health Charter), the Ottawa Charter is considered to be the initial response to the growing global demand for a new public health movement. The full Charter is available here;
http://www.who.int/healthpromotion/conferences/previous/ottawa/en/

The Ottawa Charter has enabled the development of subsequent international projects in health promotion; most recently, the creation of the Bangkok Charter for Health Promotion in a Globalized World, in 2005 and other statements on health promotion endorsed by who including an up to the 2016 statement.
http://www.who.int/healthpromotion/conferences/en/

Building upon the foundations of health promotion established by the Ottawa Charter, the Bangkok Charter recognises contemporary challenges to public health in the 21st century. Health inequality, the effects of urbanisation and climate change were discussed, culminating in the signatories of the Bangkok Charter calling upon the United Nations to consider the development of a Global Treaty for Health.

The World Health Organisation considers the Ottawa Charter to be the first in a series of "Milestones in Health Promotion". As the initial catalyst of the global public health movement, thirty years later the Ottawa Charter for Health Promotion is held in high regard by the WHO and to varying degrees of regard by governments, non-governmental and voluntary organisations.

"There is a possibility with health promotion that health will be viewed as the ultimate goal, incorporating all life" World Health Organisation, 2009.

The Ottawa Charter maintained that the promotion of good health should be delivered through the following means:

1 Promoting Healthy Public Policy

2 Creating Supportive Environments

3 Strengthening Community Actions

4 Developing Personal Skills

5 Reorienting Health Services

Questions for discussion

1 To what extent are these five themes the right ones for today's political and economic situation taking into account the growth of neoliberalism and globalisation?

2 What impact have these themes had on inequalities in health relating to social class groups, ethnicity, disability and gender?

Each theme will now be explored briefly in turn

1 Promoting Healthy Public Policy

What the Charter Says

Health promotion goes beyond health care. It puts health on the agenda of policy makers in all sectors and at all levels, directing them to be aware of the health promotion consequences of their decisions and to accept their responsibilities for health. Health promotion policy combines diverse but complementary approaches including legislation, fiscal measures, taxation and organizational change. It is coordinated action that leads to health, income and social policies that foster greater equity. Joint action contributes to ensuring safer and healthier goods and services, health public services and clearer, more enjoyable environments. Health promotion policy requires the identification of obstacles to the adoption of healthy policies in non-health sectors, and ways of removing them. The aim must be to make the healthier choice the easier choice for policy makers as well (WHO, 1986)1. The concept was reformulated as Health in All Policies (HiAP) in the Adelaide statement on health in all policies (WHO, 2010) and the global conference in Helsinki in 2013.
http://www.who.int/social_determinants/hiap_statement_who_sa_final.pdf
http://www.who.int/healthpromotion/conferences/9gchp/en/

What has been implemented from this within the UK?

The Conservative Government of the 1980s was dismissive of the connection between health and broader social influences, and little action taken. The election

of a Labour Government in 1997 signalled a significant policy departure from the previous administration by making a commitment to improving population health and reducing health inequalities. Several independent enquiries recommended approaches to improving health that looked beyond the health sector (Acheson, 1998; Wanless, 2002; Marmot, 2010). This was accompanied by an emphasis on 'joined-up government' and partnerships at central, regional and local levels. However, there are few examples of joined-up government being implemented. Health Impact Assessments were intended to be formal tool to assess the health consequences of policy. So far, rather than informing policy formulation these tend to be conducted after policy development. While there is increasing recognition about the political and social determinants of health, the policy rhetoric around health promotion remains centred on personal responsibility, behaviour change and drug-based intervention. There is little discussion about the extent to which policy decisions beyond health affect peoples' ability to take personal responsibility and make healthier lifestyle choices.

What is missing from the Ottawa Charter on this?

There needs to be greater consideration of the way in which the dominant political paradigm of neoliberalism restricts the potential for healthy public policy. More emphasis needs to be given to influencing policy development from the bottom-up including advocating for better use of formal mechanisms, such as Health Impact Assessments. In addition, there needs to be greater awareness about the influence of social position on health outcomes and the health damaging consequences of increasing social inequality. Challenging the dominant individualised interpretations of health has the potential to increase the legitimacy and acceptability of interventions at the social level among policy makers and the general public.

Questions for discussion

1 How can we raise the profile of the political determinants of health or re-politicise health and health inequality?

2 How can we promote, at national government level, a movement away from downstream, individualised interpretations of health and health inequality towards more upstream, collective interpretations?

3 What can be gained by considering the policy process and relations between central and local government?

4 What should be included in the Birmingham Charter on this theme?

2 Creating Supportive Environments

What the Charter Says

Our societies are complex and interrelated. Health cannot be separated from other

goals. The inextricable links between people and their environment constitutes the basis for a socio-ecological approach to health. The overall guiding principle for the world, nations, regions and communities alike, is the need to encourage reciprocal maintenance–to take care of each other, our communities and our natural environment. The conservation of natural resources throughout the world should be emphasized as a global responsibility.

What has been implemented from this in the UK?

The Charter contributed to theoretical understanding about health and place, thinking about healthy settings in the frame of socio-ecological systems. The Charter set out the basis for thinking about the ways in which different people, policies and material resources relate to each other within particular social and spatial settings to influence health. Settings based public health interventions (workplace settings, schools and place-based communities) have been prevalent since the Charter's publication.

Area-based initiatives (ABIs) were identified by the Labour Government as a key tool for improving the health and wellbeing of residents in areas of socio-economic disadvantage and addressing inequalities in health (Department of Health, 1999b, 2003, 2004), as shown by the plethora of short-term (typically 2–7 years), localised initiatives during its 13-years in office. ABIs were defined by the Government as

"publicly funded initiatives targeted on areas of social or economic disadvantage, which aim to improve the quality of life of residents and/or their future life chances and those of their children" (Government Offices for the English Regions, no date).

Areas of social and economic disadvantage were often defined in policy according to aggregated individual scores in relation to the indices of multiple deprivation (IMD) (Communities and Local Government, 2010). This conceptualisation of disadvantage was based on the idea that

"some areas suffer from a combination of linked problems such as unemployment, low incomes, poor housing, high crime environment, bad health and family breakdown" (Social Exclusion Unit, 2001, p.10).

Although targeting areas of disadvantage as a means of addressing health inequalities was not a new idea, Labour ABIs were distinctive in their focus on 'social exclusion' as one of the key causes of health and social problems in these areas. The concept of social exclusion, which has been closely associated with ABIs, has diverted attention away from the processes that constrain the actions and opportunities of people living in targeted areas. There remains no firm evidence about the ability to use such initiatives to improve health (Judge & Bauld, 2006), or to reduce health inequalities (Thomson, 2008). This raises some real concerns about the value of ABIs as a tool for addressing inequalities in health. It shows that poorer health and social outcomes among people in deprived areas are unlikely to be

improved through action targeted on these areas in isolation.

A number of important environmental protection measures have been implemented since the publication of the Ottawa Charter Legislation prohibiting smoking in public places came into effect in England in July 2007. A strong case was made in achieving this legislation for the impact of smoking in the workplace. The smoke free legislation has been associated with dramatic reductions in smoking rates and smoking-related diseases (Bauld, 2011).

What is missing from the charter on this?

The predominant conceptualisation of deprived areas as self-contained entities needs revision. The charter needs to acknowledge the interplay between global processes and decisions and local conditions. Greater consideration of the ways in which settings are shaped by wider power structures is needed.

Questions for discussion

1 Is the focus on areas of deprivation a good tactic for reducing health inequalities?

2 How can the co-ordinated action by health and social justice campaigners that influenced the smoking ban be mobilised to address other public health issues?

3 What should be included in the Birmingham Charter on this theme?

3 Strengthening Community Action

What the Charter Says

Health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health. At the heart of this process is the empowerment of communities, their ownership and control of their own endeavours and destinies. Community development draws on existing human and material resources in the community to enhance self-help and social support, and to develop flexible systems for strengthening public participation and direction of health matters. This requires full and continuous access to information, learning opportunities for health, as well as funding support (WHO 1986).

What has been implemented from this within the UK?

The intention was to put empowering communities at the centre of the decision making process, ensuring that there was access to information and learning opportunities and funding support. Money has been available in the past aiming to bring about improvements in local areas and increase the quality of life of local people. Between 1996 and 2003 City Challenge, Urban Challenge and the Single Regeneration Budget (SRB) existed with the aim of simplifying the funding process

by providing resources to support regeneration initiatives carried out by local regeneration partnerships. National organisations have been available in the past to support developments in community action. The Community Development Foundation who from 1967 to 2016 were the leading national organisation in community development and engagement. Their leading passion was empowering communities where local people were at the centre of change. Recent austerity and political changes have removed this focus.

What is missing from the charter on this?

Much of what the Charter suggests regarding the need to strengthen community action is pertinent today. We know that collective and collaborative action empowers communities to take ownership of the development of their location regardless of age, gender, ethnicity and socioeconomic status. Clearer pictures emerge of local priorities if this process is guided and lead by those communities. This doesn't happen overnight and requires supportive infrastructures.

Austerity measures have resulted in the reduction and fragmentation of health promotion services focusing on short term individualistic outcomes and the dissolution of community workers. Identifying assets within communities doesn't preclude identifying sustainable resources to develop, maintain and sustain them.

Questions for discussion

1 Is the focus on community action lost from strategic documentation (global and international and local)?

2 Has austerity removed support for community action in public health teams?

3 Is the third sector the likely lead in this area?

4 How can we re-energise a commitment to support communities to take a lead in developing the communities that they live in?

5 What should be included in the Birmingham Charter on this theme?

4 Developing Personal Skills

What the Charter says

Health promotion supports personal and social development through providing information, education for health and enhancing life skills. By so doing, it increases the options available to people to exercise more control over their own health and over their environments, and to make choices conducive to health. 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 in school, home, work and community settings. Action is required through educational, professional, commercial and voluntary bodies, and within the institutions themselves.

What has been implemented from this within the UK?

This focuses on giving people the information and skills that they need to make healthy choices. On the face of it this section is just as relevant today as it was 30 years ago. There have been a number of initiatives in public health and health promotion departments across the UK to raise awareness about factors which influence health and ways in which individuals can improve their health. The most recent of these was the Health Trainers initiative. A whole body of health practitioners – nurses, physiotherapists, occupational therapists, pharmacists etc, have become involved in discussions about the Ottawa Charter and their role in promoting health. This has further extended to individuals working in local authority, voluntary sector and community settings, although this has been limited because of the continual changes in public health services in the UK.

What is missing from the Ottawa Charter on this?

This aspect of the Ottawa Charter is dependent upon capacity-building – developing the financial, organisational and human resources for health promotion. Over the last decade health promotion services have been fragmented and dismantled and there is no infrastructure to provide and develop personal skills in local communities which leaves a huge implementation gap. Further, health information and skills development has been more accessible to white middle class populations in the UK. Working class people, Black Asian and Minority Ethnic Groups and migrant and refugee communities have considerably less access to relevant, appropriate information about their health. There are small, short term, ad hoc health promotion projects on specific communities, but there is no UK wide strategy.

Questions for discussion

1 How relevant is Developing Personal Skills to public health today and are public health practitioners equipped with skills to work with all sections of the population?

2 Has this aspect of the Ottawa Charter received appropriate attention?

3 What things do we need to put in place NOW to develop personal skills in all sections of the population?

4 What should be included in the Birmingham Charter on this theme?

5 Reorienting Health Services

What the Charter says:

The responsibility for health promotion in health services is shared among individuals, community groups, health professionals, health service institutions and governments.

They must work together towards a health care system which contributes to the pursuit of health. The role of the health sector must move increasingly in a health promotion direction, beyond its responsibility for providing clinical and curative services. Health services need to embrace an expanded mandate which is sensitive and respects cultural needs. This mandate should support the needs of individuals and communities for a healthier life, and open channels between the health sector and broader social, political, economic and physical environmental components.

Reorienting health services also requires stronger attention to health research as well as changes in professional education and training. This must lead to a change of attitude and organization of health services which refocuses on the total needs of the individual as a whole person.

What has been implemented from this within the UK?

Over the last 30 years, more screening programmes have been introduced, and there has been some expectation on healthcare staff to address patients' unhealthy behaviours (for example smoking, lack of physical activity, poor diet). However, the focus of health services across the world remains overwhelmingly 'medical', that is, on the treatment of illnesses. The ever-increasing scope and cost of treatments, through advances in technology and drug developments, means that the biggest attention–and budget–is always given to this aspect. In the UK, as budgets for the NHS are increasingly inadequate to meet all the needs of our populations, community and political preferences tend to be to maintain and /or improve clinical hospital services. Recently in England, health promotion and public health services have been moved out of the NHS and are now provided by local authorities (councils)

What is missing from the Ottawa Charter on this?

The erosion of budgets for public services and pressure on them to demonstrate short term results to justify funding, work against investment in projects that might improve population health and reduce inequalities. New technologies (like wearable devices) and social expectations put the responsibility for living healthily onto individuals.

Questions for discussion

1 Where should responsibility for addressing the social, political and environmental factors that affect health lie–what is the role of health services?

2 How can health services become truly 'health promoting'?

3 What should be included in the Birmingham Charter on this theme?

Appendix 1:

Guide for Facilitators at regional pre-event meetings

New Politics for Health

The following is intended as an optional guide to holding a regional meeting. It can be amended to suit local circumstances, interests and expertise. Please ensure that however the session is organised, the key points generated by the questions in the briefing pack are noted and used to complete the online questionnaire that is associated with the pack, link below.

Consider holding five workshop session–one per theme to be run twice so participants can choose to attend two workshops each on a different theme. Assuming the meeting will last three hours including 10 minutes plenary introduction, 20 minute tea break and 10 minute plenary summary and farewell each workshop could last 1 hr 10 minutes.

Workshop session guidance notes

1 **Welcome and introductions: 20 minutes**

Including brief summary from each participant of work experience and any activism

2 **Introduce purpose of session: 10 minutes**

The idea is to feed in the findings from these regional meetings into the national event taking place on November 23rd, the aim of which is to develop a new Charter for Health that could kick start action to challenge lack of policy and strategy on the political, social and economic determinants of health.

- Identify good practice locally/regionally around the workshop theme including case studies of local interventions (eg Sheffield Healthy Cities)–what helped it to work, who was involved, who were the key people to influence
- Identify key issues for discussion at the national event in November
- Identify potential partners to involve in a new movement for public health

3 **Brief overview of Ottawa Charter: 15 minutes** See Charter in briefing pack.

4 **Discussion: 40 minutes**

Each workshop to work through questions in briefing pack and record responses. Any other questions or discussion points in the light of 2 above to be recorded..

5 **Providing Feedback**

Please complete feedback from your event via this link

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