Three Challenges to the Ottawa Spirit of Health Promotion, Trends in Global Health, and Disabled People

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ABSTRACT

Health promotion according to the 1986 Ottawa Charter of the first global health promotion conference¹ “is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment.” In this commentary, I explore three powerful challenges to the spirit of the Ottawa Charter and to global health.

The first challenge is the departure from the WHO definition of health;² the second challenge relates to the appearance of the transhumanist/enhancement model of health which includes human performance enhancement beyond species-typical boundaries as part of the concept of health. The third challenge consists of the limited involvement and understanding of disabled people with their different models of ‘disability/impairment’ (medical, social, transhumanist/enhancement) in the discourse of global health and health promotion.

Not dealing with these challenges impairs the ability of health promotion to deal with global health problems, the ‘health’ needs of marginalized groups – in particular, disabled people – and the Millennium Development Goals.³

MeSH terms: Social justice; human rights; public health; health promotion; disabled people rights

RÉSUMÉ

La promotion de la santé, selon la Charte d'Ottawa issue de la première conférence internationale pour la promotion de la santé en 1986¹, « est le processus qui confère aux populations les moyens d'assurer un plus grand contrôle sur leur propre santé, et d'améliorer celle-ci. Cette démarche relève d'un concept définissant la “santé” comme la mesure dans laquelle un groupe ou un individu peut d'une part, réaliser ses ambitions et satisfaire ses besoins et, d'autre part, évoluer avec le milieu ou s'adapter à celui-ci. » Dans notre commentaire, nous étudions trois entraves importantes à l'esprit de la Charte d'Ottawa et à la santé mondiale.

La première des trois entraves est la dérogation à la définition de la santé de l'OMS²; la deuxième est l'apparition du modèle « transhumaniste » ou « amélioré » de la santé, où la notion de santé englobe des améliorations aux performances humaines qui transcendent les limites propres à l'espèce. La troisième entrave est l'insuffisance de la participation et de la compréhension des personnes handicapées – dont les modèles (médicaux, sociaux, transhumanistes/améliorés) « d'incapacité/de déficience » sont différents – dans le discours sur la santé mondiale et la promotion de la santé.

En ne tenant pas compte de ces entraves, nous compromettons la possibilité pour la promotion de la santé de composer avec les problèmes de santé mondiaux, de répondre aux besoins de « santé » des groupes marginalisés – tout particulièrement les personnes handicapées – et d'atteindre les Objectifs du Millénaire pour le développement³.

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In this commentary, I will explore how the change in relation between health and well-being, the appearance of the transhumanist/enhancement model of health and the invisibility of disabled people in the health promotion discourse may influence trends in global health pursuits and the mandate and scope of health promotion, and how it might impact on the usefulness of health promotion policies for disabled people. I note these as three challenges.

Challenge One: Is health a determinant of well-being or is well-being a determinant of health?

The World Health Organization (WHO) definition of health, adopted in 1948 and still valid today, identifies physical, mental and social well-being as different determinants of health.² This understanding is reflected in the Ottawa Charter¹ but no longer in the ‘2005 Bangkok Charter for Health Promotion in a globalized world’ of the 6th Global Health Promotion Conference,⁴ which omits the term social well-being. Indeed current sentiments⁵ and practices^{6,7} often do not treat well-being as a determinant of health but set “well-being” as the umbrella term, defining health as “the absence of disease” and omitting the ‘social health’ component present in the WHO definition of health. The concept of “health” then is subtly but powerfully redefined to just mean “medical” determinant of “well-being.”

Which concept and definition of health is used – “health” as a medical determinant of well-being (non-WHO scenario) or “well-being” as a determinant of health (WHO scenario) – has important implications for the existing models and determinants of health and disability/impairment.^{8,9}

Challenge Two: The transhumanization of health, disease, well-being and disability/impairment

One can employ different meanings of health and ‘determinants of health’ within the discourse around health promotion and global health.

The **medical model of health and disease** limits health to cover “medical health” and characterizes health as the normative functioning of biological systems, whereas disease/illness is defined as the subnormative functioning of biological

systems. Locating the cause of and solution for “ill medical health” comes in two sources.

Medical determinants of medical health place the cause of subnormative functioning within the individual’s biological system, leading to medical interventions towards the species-typical norm on the level of the individuals (medical, individualistic cures).

Social determinants of medical health identify external factors as the cause of the “ill medical health” or the subnormative functioning of the individual. This includes, for example, contaminated water that leads to bacterial or parasitic infections, or job insecurity that contributes to stress and heart disease.

Unfortunately, this version of the medical model is often misleadingly referred to as the “social model of health” or as the “social determinants of health”. It is misleading because the model addresses social factors contributing to “ill medical health”/“medical illness”.

A real social model of health would examine how social determinants influence “physical, mental, and social well-being” and would not be limited to looking at how social determinants influence and worsen “medical health.”

One can be in good physical health but suffer from poor social well-being. Conversely, having excellent social well-being can help individuals deal with physical health problems.

The New Kid on the Block: The Transhumanist/Enhancement Model of Health^{8,9}

The very meaning of health and well-being and related determinants becomes even more contested due to advances in science and technology – in particular the converging of nanotechnology, biotechnology, information technology and cognitive sciences (NBIC) – which increase our ability to change/modify, ‘enhance’ the human body (structure, function, capabilities) beyond species-typical boundaries.¹⁰⁻¹⁴

These technological advances allow for a third generation model of health and disease – the transhumanist/enhancement model – in which human performance enhancement beyond species-typical boundaries is part of the concept of health, characterizing health no longer as *norma-*

tive functioning of biological systems but *optimum* functioning. Within the transhumanist/enhancement model of health,⁹ the concept of health no longer has the endpoint that someone is “healthy” if the biological systems function within species-typical, normative frameworks. Within the transhumanist/enhancement model, the human body – no matter how conventionally “medically healthy” – is defined as limited and defective, in need of constant improvement made possible by new technologies appearing on the horizon (a little bit like the continual software upgrades we do on our computers). Good health in this model is the concept of having obtained maximum (at any given time) enhancement (improvement) of one’s abilities, functioning and body structure.

Disease, in this case, is identified in accordance with a negative self-perception of one’s non-enhanced body. Medical and technological interventions on the level of the individual that add new abilities to the human body or improve on existing abilities are seen as necessary remedies. Enhancement medicine is the new field providing the remedy through surgery, pharmaceuticals, implants and other means.⁹

The transhumanist/enhancement model extends our current notions of disability and impairment.^{9,15-17} The transhumanist model of health and disease sees every human body as defective and in need of improvement. In other words, an unenhanced human being is, by definition, “disabled” in the impairment/medical/patient sense. The only way out of the label is to enhance oneself beyond species-typical boundaries. Anyone who cannot afford the enhancement of their body will be labelled as impaired. The transhumanist/enhancement model leads to a new social group, the so-called “techno-poor” disabled.

Thus, the issue of how we define health, disease, well-being and disability/impairment has an important impact on the implicit goals for furthering the population health agenda.

Challenge Three: Health promotion and disabled people

Disabled people are for the most part absent from the health promotion, global health and public health discourse, espe-

cially in regards to the social determinants of ‘health’ debates. This strikes one as strange, taking into consideration the stated purpose of health promotion and that:

- 1) More than 80% of disabled people live in developing countries, 150 million of them between the ages of 10-24;¹⁸
- 2) Disabled people have limited access to education (can be as low as 3%), employment and basic health care (can be as low as 2%), live mostly in poverty and experience profound economic and social exclusion. They are prevented from fully participating in their families and communities and from benefitting from their socioeconomic rights;¹⁹
- 3) The elimination of world poverty and meeting the Millennium Development Goals (MDG)³ is unlikely to be achieved unless the rights and needs of disabled people are taken into account;²⁰
- 4) There has been progress on the UN Convention on the rights of disabled people²¹ and many other positive national legal advances in this area;²¹
- 5) There have been efforts in international documents to address the invisibility of disabled people, such as the recommendations of the UNESCO World Conference on Science^{22,23} which state, among others:
 - Paragraph 25: “that there are barriers which have precluded the full participation of other groups, of both sexes, including disabled people, indigenous peoples and ethnic minorities, hereafter referred to as disadvantaged groups.”
 - Paragraph 79: “The full participation of disadvantaged groups in all aspects of research activities, including the development of policy, also needs to be ensured.”
 - Paragraph 81: “Governments and educational institutions should identify and eliminate, from the early learning stages on, educational practices that have a discriminatory effect, so as to increase the successful participation in science of individuals from all sectors of society, including disadvantaged groups.”
 - Paragraph 91: “Special efforts also need to be made to ensure the full

participation of disadvantaged groups in science and technology, and they should include: removing barriers in the education system; removing barriers in the research system; raising awareness of the contribution of these groups to science and technology in order to overcome existing stereotypes; undertaking research, supported by the collection of data, documenting constraints; monitoring implementation of and documenting best practices.”

- 6) The Closing Statement by the Global Forum for Health Research at the conclusion of Forum 8, its 8th annual conference on health research,²⁴ which stated, among others:

“Point 3. Achieving all the MDGs will require addressing health and its determinants in a comprehensive way and will necessitate further health research focussed on the needs of developing countries. This research must encompass the spectrum from the biomedical sciences (such as affordable and accessible drugs, vaccines and diagnostics) to health policy and systems research, social sciences, behavioural and operational research. It must give systematic attention to cross-cutting issues of poverty and equity, including taking account of inequities based on gender, ability, race and social class/caste; the needs of both the aged and the largest generation ever of young people 0-19 years; and the needs of other specifically disadvantaged groups such as migrants and refugees.”

In summary, the existing discussions around a) the very concept of disability and impairment (medical, social transhumanist/enhancement), b) the nature of problems disabled people face (medical, social or transhumanist/enhancement), and c) the discussion around the most appropriate solutions for these problems, should have an impact on health promotion and global health policies.

Facing the challenges

Many statements of the charters of the six global health promotion conferences and documents dealing with global health issues take on different meanings depend-

ing on how one defines health, disease, well-being and disability/impairment and whom one involves as stakeholders. It is essential that future global health promotion conferences – such as the 19th IUHPE World Conference on Health Promotion and Health Education in Canada in 2007 – and the fields of health promotion, health technology assessment, health research and public health investigate, evaluate, and act, taking into account the above-mentioned challenges and defining terms such as health very accurately to prevent ambiguity.

A new health policy, health research, health promotion and public health agenda is called for to address:

- the diversity of concepts of disability and impairment;
- the needs of disabled people and other marginalized groups;
- the impact of advances in science and technologies on health and disease models, health promotion and determinants of health and well-being;
- the impact of advances in science and technologies on disability and impairment models;
- the emergence of the transhumanist/enhancement model of health, disease and disability/impairment, which fuels the increased medicalization and the transhumanization of medicalization (the acceptance of enhancing human body structures, functions and capabilities as being part of the medicalization framework), of human body structures, functioning and capabilities⁹ and the appearance of a new field of medicine called enhancement medicine.

If the above-explored challenges are not taken into account, it is to be expected that health promotion and health research will be unable to deal with the global health challenges and will not help to meet the Millennium Development Goals,³ but rather might actually contribute to the marginalization, exclusion and poor health of groups and individuals.

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BOOK REVIEWS/RECENSION

Compassionate Cities: Public Health and End-of-life Care

Allen Kellenhear. London and New York: Routledge, Taylor & Francis, 2005.

Some books should be compulsory reading for every person in the health and social sciences. "Compassionate Cities" could do much to shift the prevailing view of dying and loss as illnesses that require professional interventions to a view that sees these states as normal life events that are best addressed by communities of families, friends, and supportive others. This is the fourth book by Kellenhear that builds on the theme that death is a natural state that is no longer treated as such in modern societies. His sociological and palliative care background provides him with the insight to craft an alternate approach, one that builds on current public health principles.

In his 1999 book, *Health Promoting Palliative Care*, he argued that dying could be viewed as a time of growth and opportunity, as opposed to a difficult decline ending in death. His book led me to reflect that 90-95% of the Canadians who die each year, some 200,000 persons, receive care from non-specialists such as family members and friends, general duty nurses, and family doctors. Although it could be said they do not have access to palliative care specialists, it could also be that they do not need "specialized" care. The reader is oriented to thinking of dying as a natural state, one that is often many years in length, during which much living should occur.

Compassionate Cities takes this normative view of dying, and aging (as a common prerequisite), and builds upon the theme that non-specialist caregivers are not only the norm but also the best option for providing the kind of end-of-life care that is needed. The book begins with two chapters that describe what is wrong with organized care and other current approaches for the dying and bereaved. The theory of "Compassionate Cities" is introduced and defended in the next four chapters. The final three chapters operationalize Compassionate Cities.

If there is any criticism of this book, it should be with respect to the title. Although this book builds on the World Health Organization's concept of Healthy

Cities, Kellenhear is really advocating for compassionate communities. Not only does he clearly identify why we need compassionate communities for improved end-of-life care, but he also provides a carefully considered framework to enable such communities.

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Global Status Report on Alcohol 2004

World Health Organization. Geneva, Switzerland: WHO, 2004

The *Global Status Report on Alcohol 2004* is an updated edition of an earlier report (1999) with the same title. It is an excellent reference source for teachers, students, policy-makers and social scientists. The WHO estimates that 76 million people worldwide have diagnosable alcohol use disorders, and that alcohol consumption is related to more than 60 types of diseases and injury. Alcohol use and abuse are important in our societies.

This report consists of two parts: the first, in print format, is an overview and comparative analysis of regional and global indicators; the second, in CD-ROM format, presents 189 individual country profiles.

The 8-page Canadian profile consists of data on use, heavy episodic use and consequences. After having peaked in the early 1970s, Canadian use is now slightly more per capita than in the early 1960s. The sources for most of these data are the 1998-9 National Population Survey and the 2000-1 Canadian Community Health Survey. Data on each country is limited; however, there are some interesting regional comparisons. For example, regions with low child and adult mortality (such as the combined region of Canada, USA and Cuba) have high consumption levels but alcohol is consumed in less detrimental ways leading to lower acute consequences (e.g., injury) and higher alcohol-related chronic diseases (e.g., alcohol abuse and dependence).

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