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# THE CYCLE OF CONFLICT: THE HISTORY OF THE PUBLIC HEALTH AND HEALTH PROMOTION MOVEMENTS

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Although the immediate sources of both health promotion and the 'New Public Health' are located in the 1970s, many of the ideas associated with these movements have much deeper roots. This short review sets the development of health promotion and the 'New Public Health' in a wider historical framework. Although we are concerned mainly with the UK, the key features are common to many other national contexts. Most histories of the development of public health, and more recently of health promotion, fail to acknowledge that while methods and motivations may vary, co-ordinated community action to ensure a better life is as old as civilization and remains a feature of every community today. In histories of public health there has been a tendency to assume that concern for better health as a prerequisite for better life is a relatively new, medically led and Eurocentric concept. This assumption is symptomatic of a historic interpretation that seeks to medicalize what has been, and remains, a complex and contested social phenomenon. What is required is a reassessment of the development of public health and health promotion that takes account of the social conflict inherent in these movements. In doing so, it should not be taken as self-evident that we have necessarily built up a sophisticated and objective understanding of the contribution of public health and health promotion to better health. Finally, it is also necessary to bear in mind the fundamental purposes of health promotion and public health, and the extent to which they represent different conceptions of the aspiration to health.

The phrase 'public health' as currently used embodies many of the confusions, vested interests and singular interpretations that have resulted from a simplistic interpretation of its historical development. It could even be argued that the term public health is often used in a spirit of what might be described as conspiratorial confusion – a point made by Alan Milburn as UK Secretary of State for Health:

> 'Public health' understood as the epidemiological analysis of the patterns and causes of population health and ill health gets confused with 'public health' understood as population-level health promotion, which in turn gets confused with 'public health' understood as public health professionals

> trained in medicine. So by series of definitional sleights of hand, the argument runs that the health of the population should be mainly improved by population-level health promotion and prevention, which in turn is best delivered, or at least overseen and managed, by medical consultants in public health. The time has come to abandon this lazy thinking and occupational protectionism. (Milburn, 2000)

The minister's evident frustration testifies to the current confusion over definitions of purpose and territorial responsibility among health professionals. Implicit in the above quotation, and most other current discussions of public health, are elements of a definition that have, in fact, been in widespread use over the past 75 years. The goals of public health are usually stated to be preventing disease and promoting health, and the mechanism for realizing these objectives to be organized interventions directed at particular groups or the community as a whole. Clearly, therefore, public health has always been associated in some way with health promotion. While this dual identity has been a source of strength, as noted below, it has also proved to be an effective source of friction. Even before the terms public health and health promotion came into use, dilemmas in defining the objectives of such interventions were apparent. In Britain the first public health manifesto was issued on 25 January 1796, in response to the social upheavals associated with the industrial revolution. This remarkable 'Heads of Resolutions for the consideration of the Board of Health' in Manchester resisted the invitation to censure the labouring people for their moral delinquency; instead, it called for their protection through state intervention involving 'a system of laws for the wise, humane, and equal government' of working conditions (Maltby, 1918: 121–2). Looking forward to the thinking of a much later date, the Manchester manifesto firmly located the root causes of ill health in the prevailing economic system. Although this episode demonstrates that general social activism and a strong liberation philosophy predate modern conceptions of public health, in the event such movements failed to bring about widespread improvements in health, owing to the absolute dominance of forces of economic production.

During the 1840s the early public health movement predominantly focused on sanitary conditions, motivated by a desire to reduce Poor Law support and promote economic efficiency. However, at the same time an alternative perspective which saw patterns of disease as a reflection of social conflict was being put forward by writers such as Friedrich Engels. In *The Condition of the Working Class in England*, in 1844, Engels (1973) cited the mode of economic production as the principal cause of ill health. His justification for public health intervention was one based on notions of social justice rather than efficiency of production.

Most histories of public health label this supposed start of the modern public health movement in the 1840s as the *sanitation phase*, a period characterized by adoption of a medical perspective and concentration on environmental issues such as housing, working conditions, the supply of clean water and the safe disposal of waste. Under the supervision of the newly-invented Medical Officers of Health (MOH), the sanitarians focused on improving the health of working people by bringing about changes in their conditions of everyday living. The motivating forces of this early public health movement were both

economic advantage and, to a lesser extent, the maintenance of social cohesion between the working poor and the middle and upper classes.

A more critical perspective is provided by Turshen (1989), who suggests that attempts by some historians to portray public health doctors as the health champions of working people are misplaced. Turshen argues that what working people themselves wanted was radical social and economic change, not environmental engineering or minor social legislation designed to mitigate the worst effects of capital production. The safe disposal of waste and the supply of uninfected water yielded real and measurable reductions in infectious disease, but the inadequacy of the sanitarian approach to health was exposed by the Interdepartmental Committee on Physical Deterioration, which reported in 1904. This committee revealed the enormous extent of ill health associated with poverty and economic exploitation, but rather than resulting in significant changes to the social and economic determinants of health, the committee's findings became the springboard for what is often termed the second, *personal hygiene*, era in public health intervention. Winslow (1952) characterizes this as focusing on education and hygiene, which relocated the responsibility for health improvement with individuals, as opposed to collective community action or state intervention. Newsholme's report of 1913 typifies the then prevailing medical public health attitude that poverty was not in itself a cause of infant deaths (Newsholme 1936:179–82). Instead, this report maintained that it was the removable evils of 'motherhood ignorance' about infant care and 'poor personal hygiene' that were to blame.

The second stage of public health, occupying the first half of the twentieth century, generated a vast array of clinics and other institutional services to deal with the needs of such vulnerable groups as mothers, infants, school children, and those suffering from particular diseases such as tuberculosis. Inevitably, these services required the employment of a large workforce, with the result that this period became the heyday of the MOH and public health departments of local government. These services brought about greater contact with individuals and families, and 'health education' figured prominently in this work. Increasingly, in the UK the conceptualization of health promotion was dominated by health education in schools. While this state-sponsored health education was underpinned by what we would now call a 'victim blaming' philosophy, an alternative 'liberation and empowerment approach' to health education was also being developed by lobbying groups such as the Children's Minimum Council, the Committee Against Malnutrition and the National Unemployed Workers Movement (Lewis, 1991).

The achievements of public health in the first part of the twentieth century were heavily publicized, not least by figures such as Sir Arthur Newsholme and Sir George Newman, Chief Medical Officers of the time. Both conducted their apologetics in the language of missionary zeal and in a paternalistic spirit, which invited uncritical admiration rather than objective understanding (Newsholme, 1936; Newman, 1939). As in the sanitarian phase, the personal hygiene era brought genuine health gains, but also disadvantages. On the eve of the Second World War, we might characterize public health professionals as bureaucratic, complacent, eugenic and preoccupied with national economic objectives. Worse, in the light of evidence relating to health during the inter-war

depression, was not only that public health professionals had made little impact on the problems identified by the Interdepartmental Committee on Physical Deterioration, but also that its elite had manipulated the official statistics to disguise the limitations of its competence (Webster, 1982).

In sum, although the public health establishment during its second phase made every effort to show that its health education services embodied a genuine attempt to empower and liberate the population, this was only true to the most limited extent, and the limitations were recognized by social activists on both the right and left. In the late 1930s new thinking about public health emerged from such sources as the maverick Peckham Health Centre, from the eugenicist Richard Titmuss, and in the form of 'Social Medicine' as advocated by John Ryle (1948). The idea of Social Medicine was to apply a biomedical paradigm to populations. At least in the UK, this was largely an academic construct limited to an intellectual elite and not extending its influence beyond a few university public health departments, with the result that it was ignored by the dominant medical public health establishment.

For a short time planners looked to Social Medicine as the means to revitalize public health. In fact, Social Medicine failed to consolidate its influence, with the result that in the UK epidemiology was its only long-term legacy. This approach is, in turn, being increasingly challenged as embodying a simplistic, biomedical and professionally dominated idea of health (Peterson and Lupton, 1996). Nonetheless, the abortive Social Medicine movement underlined the limitations of the previous era and, in this respect, prepared the ground for health promotion and was one of the factors causing the medical profession to invent the 'new public health'.

Social Medicine accepted that 'health' implied a 'positive' condition, representing much more than freedom from communicable diseases. Achievement of positive health implied a changed attitude to the causes of ill health, involving reference to the 'whole economic, nutritional, occupational, educational, and psychological opportunity or experience of the individual or community' (Ryle, 1948:11–12). The success of Social Medicine depended on a new form of collaboration, in which all medical personnel, 'ordinary health workers and the general public', engaged in genuine teamwork (Leff, 1953: 15). Where necessary, this form of medical intervention also required commitment to social and political action (Crewe, 1945). Although Social Medicine was a British product, it was influenced by thinking elsewhere, particularly in America, and especially by Henry Sigerist, who is generally credited with having been the first to attach special importance to 'health promotion' and to the principles later embodied in the Ottawa Charter (WHO, 1986). Sigerist believed that the primary task of medicine was to 'promote health', and declared that medicine should be seen as a social science. It was 'merely one link in a chain of social welfare institutions', central to which was 'socialised medicine', for which he was also a leading advocate (Sigerist, 1941; Sigerist 1943: 241). Although Social Medicine made little impact in the UK, it was more influential in North America and WHO circles, which ultimately became the main sources for igniting the health promotion movement in the 1970s.

The introduction of the National Health Service in 1948 revolutionized health care in the UK. However, the benefits were distributed unevenly and the

activities most relevant to health promotion were located in the most neglected corners of the new service. As one of its most radical changes, the NHS reduced the functions of public health departments, thereby turning the once powerful MOH into a minor functionary in charge of only a small rump of preventive services. While health care was transformed, public health professionals were launched into a phase of disorientation. In a move which seemed symbolic of this collapse of influence, the government abandoned its health centre programme. This had been the only important new function promised to the MOH, and many of the hopes for the realization of Social Medicine's potential had depended upon the creation of health centres (Lewis, 1986; Webster, 1988: 381–8).

At the time of the NHS reorganization of 1974, which completely eliminated local government involvement in the health service, an attempt was made to rescue public health activity from extinction by repackaging it as community medicine, but this too was a failure (Lewis, 1986). In particular, the 1974 changes deprived community medicine specialists of their control of environmental health departments and shifted them back into hospital administration, and also abandoned the annual reports that were a key component of the watchdog role of the MOH. Continuing erosion of confidence led to a further rescue effort in 1988, based on the recommendations of the Acheson Report, which reintroduced public health medicine as the name of the specialty.

Alongside the decline in medically dominated conceptions of public health during the 1960s and 1970s, the empowerment conception of health education continued to grow in influence. It was not until 1976–77 that the UK government issued its first prevention policy documents, but these timid efforts made no permanent mark (Webster, 1996: 660–86). They simply restated the contention that ill health was largely the responsibility of individuals whom, through ignorance, were not looking after themselves. It was implied that ill health, rather than being related to poverty, was attributable to affluent lifestyles. Reflecting the barrenness of thinking about promotion, the commentary on health education of the Royal Commission on the NHS was also entirely lacking in insight (Royal Commission on the NHS, 1979: 44–7). With respect to prevention and promotion, perhaps the most important changes were incidental features of the 1974 NHS reorganization, which gave environmental health officers new professional autonomy under local government, and also established health education as an embryonic specialism in the NHS.

Under the NHS public health medicine limped along with its traditional routines, but it failed to respond to new challenges and it avoided confronting the continuing problems of ill health associated with poverty. The mounting economic crisis of the 1970s prompted new concern about poverty and public health, and stimulated yet another rebirth of Social Medicine. The new social awakening centred around the problem of 'inequality' (Townsend and Bosanquet, 1972). In the field of health, this concern reached its classic expression in the Black Report of 1980 (Townsend and Davidson, 1982). The findings of the Black Report drew together a great deal of evidence that highlighted appalling inequalities in health, maldistribution of resources, and irrational disparities in the provision of seemingly every type of service, including those relating to prevention and promotion (Hart, 1971; Culyer, 1976; Dowling, 1983).

In light of the above brief history, it is not surprising that the impetus for

new thinking about public health and health promotion came from outside the UK. The context of this reappraisal was provided by a confluence of forces: first, the rising tide of radical critiques of the medical establishment and the health industry in the western economies; second, a mood of self-criticism within health services concerning their shortcomings, especially with respect to the needs of the poor and the developing world; third, growing concern in western governments over the escalating cost of health care; and finally, the dramatic impact of the oil price rises introduced by OPEC states at the end of 1973. This date marked the end of the golden age of the welfare state, introduced an era of retrenchment, and provoked a rethinking of every aspect of health care. One of the early products of this rethinking was the development of empowerment models of health education and the concept of 'health promotion'.

The three seminal documents that launched the heath promotion movement were the Lalonde Report *New Perspectives on the Health of Canadians* (1974), and WHO's *Global Strategy for Health for All by the Year 2000* (1981) and the Ottawa *Charter for Health Promotion* (1986). Together, they set out a vision for health improvement that went beyond sanitation engineering, lifestyle health education and preventive and caring health services, and mark the advent of the *health promotion* phase of public health. Health promotion was concerned principally with empowering citizens so that they could take control of their health and in doing so attain the best possible chance of a full and enjoyable life. The principal methodologies included community development, empowerment, social marketing, advocacy, organizational development and the formulation of integrated health strategies. Bunton (1992) contended that health promotion represented a new form and conception of health intervention. It 'deliberately tried to address issues of power, political, economic and social structures and processes'. MacDonald (1997) suggested that because health promotion is intrinsically revolutionary, governments have, since its conceptualization, been trying by elaborate means to accommodate it and have displayed great ingenuity in appearing to absorb its radical ideas without in reality disrupting the status quo. As governments seek to embed health promotion within the existing medical and health care-dominated agenda, attention is drawn away from the challenges that it presents for society – most radically to set health, rather than the creation of wealth, as the overarching goal of society. As we have seen, this is not a new idea but rather a re-emergence of much earlier calls for health to take priority over wealth creation.

Kelly and Charlton (1995) have, however, pointed out that health promotion is characterized by a difficulty which arises from the failure by its advocates to address their unspoken assumptions about the relationship between social autonomy and social structure. They suggest that this is especially problematic when considering the effects of social inequality on oppressed groups:

> Here the emphasis is on social determinism among the oppressed while maintaining a place for the idea of free will among non-oppressed groups. Empirically this may seem to be the way the world operates, and politically it may make sense to construct things in this way, but theoretically and epistemologically it does not work. (ibid.: 89)

Stevenson and Burke (1991) are even more critical of health promotion, arguing that it weakens struggles for social equity and political change to the extent that 'with its emphasis on organic harmony and consensus among diverse identities and its tendency to develop methodological "resolutions" to political problems, health promotion mystifies rather than clarifies the nature of social barriers to meaningful change' (ibid.: 281).

Health promotion and the 'New Public Health' possess common characteristics. Both are closely associated with the WHO *Health for All* strategy, and both seem to consist of multiple and disparate strands. Draper believes that the new public health takes a 'comprehensive view of health hazards in the human environment, from the physical, chemical and biological to the socio-economic' (1991: 10). Baum (1990) has argued that the 'new' public health carries the same flaws as many understandings of health promotion, in that it is underpinned by the assumption that change can be achieved through consensus building, while history teaches us that it is conflict and challenges to existing power structures that promote health.

If health promotion and the new public health have a major distinguishing feature, it would appear to be the conviction that health is a right – as opposed to older ideas of health as a necessity for national efficiency, or as a moral duty of citizens. However, even this claim does not withstand critical examination. The 'health as a right' concept can be traced back for thousands of years and, like 'health as a means to efficient production', represents a recurrent theme. The health as a right concept has, however, continuously been subordinated to a more politically and capital sensitive paradigm which emphasizes individual and environment solutions to poor health over social and economic ones.

Yet it is possible to make an even more critical assessment of the new public health movement. It is arguable that the new public health – a concept developed largely by medical practitioners working in the public health field – represents an assault by the medical profession, intent on recapturing the commanding heights which were lost to the globally developed and more inclusive notion of health promotion. Evidence of this reassertion of public health is evident in much of the UK government's recent health strategy. The term health promotion is noticeable by its absence, despite the fact that internationally the phrase is used as an umbrella term that includes the subset of public health. As indicated in the quotation from Alan Milburn above, it seems that the case for interdisciplinary and intersectoral partnerships to promote health is now accepted by the UK government. The recently established Health Development Agency in England seems to be a concrete expression of this acceptance, although only time will tell whether the agency will receive the governmental support it needs to be effective.

The public health and health promotion professions embody – and tolerate – conflicting ideas of why and how health should and could be improved. The meaning of public health and health promotion are themselves contested and open to a range of understandings. The origins of these conflicts lie in the contested nature of health itself, of the causes of ill health, of the methods for reducing ill health and promoting well-being, and fundamentally, in the motivation for such interventions. The historical record suggests that one expression of these conflicts has been through the cyclical invention, abandonment and

reinvention of the 'social model' of health and disease which, when advocated, quickly falls out of favour due to the fact that it inevitably brings its supporters into direct conflict with the state and existing economic interests. Alongside this, the history of public health has also been one of a long battle for occupational domination by the medical profession. Given a widespread acceptance of the complexity of improving health, and the UK government's moves to develop multidisciplinary public health leadership, the traditional hegemony of the medical profession is clearly no longer sustainable.

The promotion of health depends upon the engagement of a wide number of sectors and professions. Public health promotion has always been, and remains, a collective activity. Only if we are prepared to recognize the historic conflict, and the contested nature of health promotion and public health, will it be possible to develop a deeper understanding of how the battle could be more effectively fought on behalf of those currently deprived of their rights to health. In the light of history, it is clear that the fundamental test of health promotion is yet to come as it struggles to exercise any influence at all in world increasingly shaped by global economic forces.

# 1.1

# PRACTISING HEALTH FOR ALL IN THE UK

Maddy Halliday

This chapter outlines the key strengths and weaknesses of the Health For All (HFA) strategy and the challenges faced by those trying to work within it in the UK. The chapter discusses two short case studies.

## HEALTH FOR ALL AND HEALTH 21

HFA is the World Health Organisation's global public health strategy, with different versions serving different world regions such as Europe, the Americas and Africa. The HFA regional strategy for Europe is the one which relates to the UK. The original HFA strategy was developed in the late 1970s (WHO, 1981, 1985), but during the 1990s was updated and further developed to become Health 21, a new strategy for the 21st century (WHO, 1999a). Health 21 represents a challenging approach to health, informed by debates within diverse health and social movements across the world (see Box 1.1.1).

**BOX 1.1.1** HEALTH 21: A CHALLENGING STRATEGY FOR HEALTH IN THE TWENTY-FIRST CENTURY

*Visionary* – presenting desirable goals for improving health, embracing physical, mental and social well-being, within a social–ecological approach to public health
*Value-based* – expressing a commitment to social justice, equity, participation and other progressive 'liberal' values
*Evidence-based* – informed by an understanding of the holistic and complex nature of health, its biological, social and environmental determinants and the range of political, social and technical interventions necessary to protect and promote health
*Practical* – offering a coherent framework for the development of international, national and local health policies, programmes and services

Over the past 20 years HFA has inspired a world-wide movement, expressed most strongly through primary health care initiatives in developing nations and WHO's Healthy Cities Projects, which have been established across Europe and globally.

Health 21 builds on this and provides stronger links to the United Nation's other 'big' strategy – Agenda 21, the global and local strategy for sustainable development (United Nations, 1992, 1993). Health 21, as its predecessor, is formally endorsed by member states of the UN, including the UK.

While there are many positive aspects to HFA/Health 21, there are also weaknesses in the strategy and, despite its huge support, its success is debatable given that health indicators in many parts of the world, particularly Africa and Eastern Europe, have deteriorated rather than improved over the past 20 years. The problem for HFA is that the main social, economic and environmental determinants of health are heavily influenced by the structures and organizations of global capitalism, which take little notice of human health or ecological consequences. As do all visionary, desirable expressions of human intent, such as the Declaration of Human Rights and Agenda 21, HFA needs the support of political and civil society, and particularly of those who hold the most power. Without such support, strategies such as HFA remain simply statements of desires. Given that WHO is a relatively weak UN agency, it has not been able to influence strongly the policies and practice of powerful international agencies, multinationals and nation–states.

HFA has inspired the support of many national and local groups and professionals, but it has barely influenced mainstream socio-economic policy. Powerful international agencies such as the International Monetary Fund and the World Trade Organisation pursue policies which generally increase wealth for a few while increasing poverty and environmental degradation for many, particularly people in developing nations. Some nation–states, including the UK, have also pursued social and economic policies which have increased health inequality (Department of Health, 1999a; Mitchell et al., 2000). Other nations have been involved in protracted wars, reversing many decades of health improvement.

Does this mean that HFA/Health 21 has failed? I would say it has not. It could be accused of being naïve in its presentation, in that it does not explicitly articulate the political reality of improving health, but of course if it did so, nation–states and international agencies would not sign up to it. HFA is a balancing act. It presents a visionary way forward in a way which secures formal support from powerful nations and bodies and which also encourages a global 'grass-roots' movement to emerge, working to achieve its goals (WHO, 1998). In this way HFA might gradually, over decades, achieve a deep-rooted change in attitudes, policy and practice. The key question is, given the threat to human health of global warming, whether we have time left to achieve such change. In the light of available evidence, it is uncertain whether we do. Rather than blame HFA for its failure, the real problem is the human-created system – capitalism – that is destroying the life support systems on which we depend.

## HEALTH FOR ALL IN THE UK

Over the past 20 years in the UK there has been only moderate engagement with HFA by government, health agencies and other bodies. There are a number reasons for this relative neglect. First, HFA represents a paradigm shift in terms of its approach to health. Health 21 is consistent with the 'new public health' but not mainstream approaches to health, which are still dominated by a bio-medical approach. Second, the political values of successive Conservative governments between 1979–97 were explicitly opposed to the liberal values of HFA. Third, there has generally been low awareness and understanding of HFA within the statutory, professional, academic and voluntary sectors as, given the above factors, it has not attracted sufficient support and resources to enable effective promotion, dissemination and implementation. And finally, unlike Agenda 21, HFA has received little media interest in the UK (Halliday, 1994).

Despite these difficulties, grass-roots support for HFA in the UK grew during the 1980s and 1990s, particularly among 'progressive' health practitioners and community groups, often leading to the formation of Healthy City and Health For All projects. In 1988 the UK Health For All Network (UKHFAN) was formed as a membership organization for HFA/Healthy City projects. Despite considerable funding difficulties, the UKHFAN has continued to provide a range of services and activities. In 1987 the UK Public Health Association was formed, and while the UKPHA is not an explicit HFA organization, its philosophy and approach to public health are informed by HFA and many PHA members are actively involved in local HFA initiatives.

The public health policy of the New Labour government (Department of Health, 1999b; Secretary of State for Scotland, 1999) reflects some understanding and support for HFA and the new public health, although it does not adequately apply its approach and strengths. This policy shift can be attributed, at least in part, to the strength of the growing new public health movement in the UK as represented by the UKPHA and UKHFAN, although the government does not readily acknowledge this. Nonetheless, the change of government has provided, for the first time in 20 years, a real chance to build support for Health 21 in the UK.

The national picture outlined above is also found at local level in the UK, where a large number of HFA/Healthy City initiatives have struggled to influence health policy and practice and improve health. The two case studies which follow illustrate this experience.

## GLASGOW HEALTHY CITY PARTNERSHIP: LESSONS FOR THE PUBLIC HEALTH MOVEMENT

Glasgow Healthy City Partnership was established in 1996, building on its predecessor Glasgow Healthy City Project. From 1988 onwards, both the project and the successor partnership had a WHO Health City designation.

The Partnership serves the population of Glasgow, which is now around 660,000. Glasgow's population has some of the best and worst health in Scotland and the UK, reflecting patterns of wealth and deprivation in the city. Poor health

is particularly marked in Glasgow, as ten of its electoral wards have the highest premature mortality rate in the UK. Not surprisingly, these wards also experience severe social and economic deprivation on a wide range of indicators including unemployment, receipt of benefits and free school meals, single parent families, and post-16 education (Sherwood and Halliday, 1998).

Poverty and poor health in Glasgow are not new, nor is its position as bottom of the UK's health league table. These problems go back to the development of Glasgow as a major industrial city 150 years ago, which brought low wages, pollution and unsanitary conditions. While living conditions and pollution improved dramatically during the twentieth century, Glasgow's economic fortunes ebbed and flowed with periods of high and low unemployment. The progressive collapse of Glasgow's main industries from the 1970s (shipbuilding and textiles) led to major social and economic problems, reflected in its poor health profile.

In the past 25 years the city council and economic development agencies have tried to improve Glasgow's economic fortunes, with some success. Glasgow now is the second biggest shopping centre in the UK outside London and is a major site for service industries. Despite this, many of the new jobs have been taken by people living in more affluent areas outside Glasgow, while unemployment and associated social problems in the deprived communities remain prevalent. Regeneration initiatives in Glasgow continue to try to solve these problems, with partial success.

The result of this situation is continued poor health and this is the challenge which led to the Glasgow Healthy City Project and then the partnership. After 12 years the project/partnership can be credited with some successes. It has raised awareness of the health problems which Glasgow faces, and it has improved understanding of the determinants of health and the measures necessary to improve health. It has supported joint working between public and voluntary agencies, the development of community health projects across the city and, more recently development of proposals for Healthy Living Centres. It has also secured the integration of health goals within the city regeneration strategies and programmes, and has developed a range of linked health programmes, including women's health, tobacco and child health.

But it has achieved much less than would have been possible without a multitude of obstacles, similar to those experienced by HFA at international and national level and other HFA/Healthy City projects in the UK. First, given the huge health challenge in Glasgow, the project/partnership were not established with sufficient authority, power or resources. This is illustrated by the relatively low grading for the initiative's co-ordinator, its small staff team and modest development budget. Over the years, the success of the initiative enabled its resource base to be protected during times of cuts and even led to some increase in resources, but progress was slowed by the poor resource base relative to the task. Second, while it was easy to secure formal support from Glasgow's health board and the city council, this did not lead to meaningful support and engagement by these organizations as a whole. Project/partnership staff and allies had to spend many years 'working the system' to build support, but this could quickly be undone with political and key staff changes. With notable exceptions, most politicians and senior management in both organizations failed to

promote or support the initiative in a proactive manner. Third, until the election of the 1997 New Labour government, the initiative had to work to improve health locally in a hostile national environment. This made it very difficult to achieve anything but marginal gains.

From the author's experience and various research and evaluation initiatives, these three issues – lack of power and resources; organizational failure to engage; hostile national policy environment – reflect the main obstacles to successful local HFA/Healthy City initiatives in the UK. Although the national policy environment has improved to some extent (Hamer and Ross, 2000), issues of power, resources and organizational failure remain. These problems affect not only HFA/Healthy City initiatives, but also the Health Action Zones in England. The reason for these problems is complex but there are three important contributors: the dominance of a bio-medical approach to health generally makes it hard for alternative perspectives on health to secure support and resources; correspondingly, the dominance of the NHS in health planning and the relatively weak role of local government make it difficult to develop an inter-agency public health strategy; and the poor understanding of public health issues both in and outside the NHS leads to a lack of motivation to engage with HFA/Healthy Cities.

There are a number of measures which could improve matters. Access to public health learning opportunities should be improved, both in mainstream education and occupationally based training schemes, and the development of a multi-disciplinary approach to public health covering a range of professions. Such an approach should include a range of professional groups within the NHS, local government, voluntary sector and academia. The UK Multi-disciplinary Public Health Forum is arguing for such developments, although is still fairly focused on the NHS. Formal joint responsibility for public health planning between the NHS and local government is needed, with better integration of health dimensions into public policy and plans, such as community planning. More broadly, we need improved public education about the creation of health and its links to sustainable development, to increase awareness and influence political debate and action.

A few organizations in the UK, such as the UK Public Health Association, the Society for Health Promotion Specialists and the UK Health For All Network, are arguing for such change. They are supported, to varying degrees, by public sector, union and professional organizations such as the Faculty for Public Health, Institution of Environmental Health Officers and local government associations. Sadly, however, it is unlikely that Health For All in the UK will ever be able to realize its potential without broader public and political support. I hope, in time, organizations such as those cited above are able to help foster the public interest and political will for such changes to be realised.

## HEALTHY SHEFFIELD[1]

Sheffield is a city of almost half a million people, well known for its industrial pre-eminence in the nineteenth and early twentieth centuries. Since the 1970s economic decline has led to widening inequalities within the city, closely related

to the geographic divisions of the city. The east of Sheffield contains many of the large public sector housing estates that provided the labour force for the steel industry. Intermingled with these are smaller areas of private sector housing which are home to many of the economic migrants recruited to the city in the boom years from Pakistan, the Yemen and the Caribbean. On the west of Sheffield most of the middle class live: academics, public sector managers, and those who manage and own the more successful private sector businesses. Since the 1970s the city has under-performed in economic, educational and health terms but while the west of the city compares well to successful areas elsewhere, the east side has some of the poorest wards nationally.

The strategy of city leaders has emphasized economic regeneration. This approach, which has been championed by the city's strategic partnership 'Sheffield First', can be summarized as building on existing specialist expertise, attracting new businesses and ensuring that the city has an educated and skilled workforce. Although some elements of the strategy focus on inequality, this is within the context of economic regeneration.

## THE HEALTH FOR ALL APPROACH IN SHEFFIELD

Sheffield has had a Health For All project since 1987, jointly funded over the years by a range of partners including the health sector, local government, and the academic and voluntary sector. Since it began there have been six co-ordinators, which perhaps indicates the stresses and frustrations associated with the work. For much of its existence, the Healthy Sheffield partnership existed outside of mainstream activity – one local director of public health described it as a 'guerrilla organization'. Whether its aims and methods were ever as radical as this implies is questionable, but it certainly provided an alternative analysis that:

- promoted a multi-sectoral approach to tackling inequalities;
- developed techniques for involving the socially excluded in decision-making;
- piloted local community development interventions;
- suggested a different set of priorities to those promoted by the establishment at a local and national level.

Recently Healthy Sheffield has changed again. It was commissioned to work with the director of public health to redesign the city's health partnership, seeking to bring together the strategic planning of health services with policies addressing the root causes of ill health. This approach has seen Healthy Sheffield being subsumed within a broader health partnership – 'Sheffield First for Health'. The advantages and disadvantages of this are that advocates of Health for All principles are at the table but their voice remains weak. In the context of national and local concerns the priority remains the performance of the health and social care sectors. In its current manifestation the health city office – costing £100,000 annually compared to the £500m spent by the health sector in Sheffield – continues to provide services that remain consistent with Health For

All principles. The approach taken by the Healthy City team consists of the following elements:

- *Partnership* – supporting the development of effective partnership working at a strategic level, with an emphasis on ensuring the active engagement of the voluntary and community sectors.
- *Resources* – providing the resources for effective partnership working, these include ensuring that demographic information is presented in a manner that identifies links between exclusion and ill health and producing up-to-date information on multi-sectoral activity.
- *Models* – developing and promoting models that provide alternatives to purely medical interventions, in particular, ones that break down cultural and professional barriers between the socially excluded and professional service providers.
- *Strategies* – developing strategies to address the root causes of ill health by bringing together policy-makers (particularly those responsible for addressing social exclusion) to develop a joined-up approach that targets excluded communities. An important element of this work is developing health impact assessment methodology not just as a tool to evaluate major policy change but also as a mechanism to give the non-health sector confidence in the contribution that it can make.

In summary, we are concerned with working at the interface of organizations and interest groups. By providing and developing these tools the team seeks to support statutory agencies, addressing their concern to engage staff and community members in their work, at the same time as keeping the door open for community members to represent their interests and put pressure on services.

## NOTE

1 This case study was written by Mark Gamsu.

# 1.2

## BUILDING A UK PUBLIC HEALTH MOVEMENT: A PHOENIX FROM THE ASHES?

Geof Rayner, Chair UK Public Health Association

From campaigns to alleviate third world debt to the protection of rare species, citizens movements have come alive in the UK – and across the world – in the past 20 years. But one movement – the public health movement – has been slower to ignite, despite many urgent reasons for it to do so. How might a mass movement be rekindled? Is there anything to learn from the environmental movement and consumer movement?

Environmental and consumer campaigning 'took off' in the last quarter of the twentieth century. The first was driven by a public perception that neither states nor international institutions were doing enough to protect the planet from unbridled industrialization and urbanization. In fact, many concluded, international institutions like the World Trade Organisation were part of the problem. The harmful results were everywhere: they encompassed the local – a rural landscape consumed by housing, town bypass roads, fears of contaminated foods – and the global – the devastation of natural habitats with early signs of imbalance and exhaustion to the earth's fragile ecosystem. Environmentalism became a common cause for those at either end of the political spectrum.

All of this was generated by a growing perception that environmental threats touched everyone. But movements are also born of activists, not of passive members. Opinion studies suggested that around one in five adults (18 per cent) could be described as 'environmental activists' (defined as people who have carried out five or more 'green' behaviours in the previous two years) while a slightly larger proportion (24 per cent) avoided using the services or products of companies that they felt had a poor environmental record (MORI, 1996). Of course, a much wider section of society blended 'a degree' of environmentalism with 'a degree' of consumerism, and the question of the core values of the consumer movement was uncertain. While the *avante garde* of consumers may have seen themselves as environmentalists, mainstream consumers merely sought out 'good value'. Although the income gap between top and bottom earners had grown ever greater, the comfortable middle had grown too, with profound implications not only for political parties but for social movements.

Such movements encompassed many different motivations in their membership and were vehicles for, or connected to, a wide span of personal beliefs. Whatever the combination of elements in play, the appeal was strong enough to attract subscriptions on a mass scale. Friends of the Earth, Greenpeace, the Royal Society for the Protection of Birds, to name but three, attracted over a million members between them. The consumer movement was different. Perhaps recognizing perhaps that consumers as a whole lacked an altruistic vision, the Consumers Association sought to offer more concrete benefits, such as comparative reviews of goods and services, and even holidays. Surprisingly, perhaps, this instinct to offer value for money – even to the extent of organizing lower car prices (with obvious environmental implications) provided few limits to the association's broader policy advocacy.

Alongside these high points of citizen activism, where exactly did the public health movement stand? In Victorian times, it seemed fairly clear: public health was tightly joined to both environmentalism and consumerism, forming part an array of social forces encompassing citizens groups, rising professions, progressive local authorities, town planners, sanitarians, co-operators, temperance advocates, lobbyists for clean food, and many others. By the last quarter of the twentieth century, however, public health had lost any appeal it may have had. The pejorative term 'nanny state' conjured up an image of spoon-fed do-gooding at a time when, according to opponents, rugged individualism was required. Compare this with the vitality of some elements of environmentalism, with their publicity-conscious tree climbing, tunnel digging and polluter teasing.

Anyone surveying the UK for mass-scale, vision-driven campaigning focusing on public health and well-being would have been disappointed. Although, in the 1990s, there were organizations that wanted to develop a profile like that of Friends of the Earth or Greenpeace – for example, the Public Health Alliance, the Association for Public Health or UK Health for All Network – they lacked both resources and impact. This is not to say that health campaigning was invisible. On the contrary, messages about cancer, heart disease, HIV/AIDS, drugs, safe driving, and so on were prevalent. Professional and voluntary health-related organizations abounded. So why hadn't a movement developed? The failure of the public health movement to offer much more than the sum of its parts requires some explanation and, in fact, there are several.

One reason is historic, originating in the way public health campaigners had worked from their earliest days. Voluntary associations dedicated to eradicating a specific disease or tackling a particular health threat have been a core part of the public health movement in the UK and abroad since its earliest days (Teller, 1988). Part of the success of public health action has been the result of the diverse disciplines it incorporated, including epidemiological, ecological, engineering, sanitary, and lifestyle perspectives. Public health activism has long had a scientific and modernizing flavour, and the association with scientific medicine, statistical measurement and research was an important means for establishing its case in the political arena, but in truth early public health measures were built as much on inspiration as on science.

But there may also have been a negative side to the 'single issue' approach. Over time, campaigners competing for public support sought to differentiate themselves from one another with the result that, in public debate, a holistic

understanding of health was undermined. What caused the illness which 'heart' campaigns, for example, were addressing? Was it smoking, fatty food, lack of exercise, or was the real problem lack of diagnostic facilities or acute care beds? The public could be forgiven for being confused.

'Nannyism' may also have been a factor in explaining the movement's poor appeal. Since its earliest days, public health thinking had embraced the regulatory state, beginning with the sanitary revolution, which had embedded public health institutionally and professionally within the central and local state. There was also, to put it crudely, a 'health police' function, particularly in the early years of sexually transmitted disease prevention. To many people – especially the poor – many public health practices had an undesirable supervisory strand: less facilitation of better health or campaigning about injustices, more attempted control of lifestyle. In our modern, less deferential era, such approaches have become unsustainable.

A third reason was the urge among public health campaigners for respectability and professionalism. When they started, many of the professional bodies and multidisciplinary associations had a radical edge, but over time a narrowing of vision and role led to a conservative focus on ensuring benefits to members, such as professional accreditation, career-building or education.

If the public health movement had lost the plot, had anyone noticed? By the end of the Second World War public health measures were taken for granted, established in statute and practice. Professional groups jostled for influence and, occasionally, lifted their heads above the parapet to utter polite words of protest. In some cases, associations made eloquent attempts to restate their vision (Chartered Institute of Environmental Health, 1999). The resurgence of a movement was encouraged by the emergence of several issues which were being actively ignored by government: extensive health inequalities, repeated concerns over food quality, the growing power of anti-health forces, led by the tobacco industry, and evidence of a gradual decline in social and community infrastructure.

At the same time, questions were being raised about the ability of health services to cure every ill. The health improvements which had been the success stories of the past century were slowing, and some were even reversing. For example, in Wales 14 per cent of 15-year-old boys and 22 per cent of 15-year-old girls smoked at least weekly in 1989–90; by 1993–94 the figures had risen to 18 per cent and 27 per cent, respectively. In addition, income inequality widened dramatically: in 1979–80 the proportion of households receiving below 40 per cent of mean average income was under 5 per cent. By 1996–97, it was almost 15 per cent. The UK was becoming a service and information-based economy, in which highly paid jobs contrasted with low-paid, non-routine jobs undertaken by women, school leavers, students and older, pre-retired men – the latter a group whose health has improved least over the past 40 years. Poverty in the UK, amidst mass affluence, cannot be ignored.

Through all the social, economic and cultural changes single issue campaigns persisted, and some even thrived. Food became the most prominent focus for public health campaigning in the UK. Evidence emerged not only that families were losing skills in cooking and nutrition but that our industrially driven food industry was encouraging obesity. However, most public attention

was focused on food scares. Bovine Spongiform Encephalopathy (BSE) was first identified as a disease of cattle in 1986 and it was not until a decade later that it was linked to new variant Creutzfeldt-Jakob Disease (nvCJD), prompting a £4 billion 'rescue' involving the mass slaughter of herds. The later official BSE inquiry confirmed the lassitude of official thought and action, with civil servants in MAFF presenting a continually optimistic view of the evidence, and the inability of Department of Health officials to enforce public health priorities (Phillips, 2000).

Not only was public confidence in British meat found wanting, but also, progressively, confidence in government science. As a direct consequence of BSE and later concerns over genetically modified organisms, opinions polls have demonstrated that scientists in voluntary campaigns were held in higher esteem than official scientists.

A further – and possibly dominant – factor underlying the difficulties facing the public health movement in the post-war period may be the 'medicalization' of health. Although medical science never claimed that it would cure all ills and most doctors would emphasize the importance of living conditions in improving health, medicine has crowded out other models of intervention. During the twentieth century the belief grew that solutions to health problems could be scientifically discovered in the laboratory, prescribed, purchased, or to use the epithet increasingly common to the NHS, 'delivered'.

So far, mostly the obstacles have been considered. What are the opportunities for the growth of the public health movement? There is no public disinterest in health: on the contrary, judged by opinion polls health is consistently a highly rated concern for the population. When MORI asked people to judge which, among a list of ten or so things that might be 'most important for you personally in determining how happy or unhappy you are in general these days', 'health' was rated first (59 per cent), followed by 'family life' (41 per cent), 'marriage/partner' (35 per cent) and 'job/employment' (31 per cent). These came far ahead of education received (7 per cent), housing conditions (9 per cent) or even financial condition/money (25 per cent) (Worcester, 1998).

If these values are widely shared, they might encourage optimism about the rebirth of a public health movement. Unfortunately, however, the beliefs which underlie these responses are contradictory. The influence of medicalization has already been mentioned: when a group of 18 to 24-year-olds were asked to list the greatest achievements of the twentieth century, the lunar landing came third, the defeat of Hitler second and the winner was . . . the first heart transplant. Another issue related to health beliefs is that we are ill-acquainted with conceptualizing risk. For example, we disregard the safety of the mundane. We discount serious risks because we face them every day. We accept smoking, although it is the greatest preventable cause of disease, but we worry about the risks of rail travel – many times safer than road transport – because tragic and shocking rail accidents speak to our fears of not being in control (the car, by contrast, is seen almost as an extension of ourselves). Ironically, the corollary is also true: our faith in doctors may be linked to the fact that we do not tend to come into contact with them very often against the observance of a pervasive ethic of security in medicine.

Thus health belief harbours a central paradox: health is interpreted in

terms of more apparently abstract threats – things read about in the press, the observable living environment, how we feel, and powerful images of the role of medicine. These do not fit together or match up. The abstract threats are far removed and breed anxiety; medicine can do little about the factors which influence our health and well-being.

Against this background, the principles, beliefs, and approaches of the modern public health movement, as codified in creeds like Health For All, are remote and unfamiliar. Once understood, they still seem difficult for us to make use of individually, because they refer to the workings and structure of society. Even when the idea of healthy public policy has a reference point at an individual level – the benefits of walking as part of a sustainable transport policy, for example – society prepares us with counter-beliefs. While the car is now designed and sold with strong appeal to our fantasies, the alternatives – walking, or reliable trains – appeal only to our needs.

So how can the public health movement move forward? It is clear that the movement carries a lot of heavy baggage from the past; its vision has dimmed and become obscure to the public; it has tendencies to tribal divisions and professional infighting; and it has often been aligned with the regulatory state. Since the environmental and consumer movements have tapped public concerns in ways in which public health have not, are there lessons there which should be learnt? Or are there other changes which might support the rebirth of a public health movement?

Let us deal with the last question first: because the public health movement is more institutional in character it is important to link what it does with what government thinks. The *Health of the Nation* strategy (Department of health, 1992) was launched by a Conservative government in 1990, and the Labour government's *Saving Lives: Our Healthier Nation* (Department of Health, 1998b) was launched eight years later. Key developments in Labour's approach included the emphasis on tackling inequality (later followed up in Sir Donald's Acheson et al.'s (1999) *Report of the Independent Inquiry into Health Inequalities*), the emphasis on communities, better 'joining up' of government actions, and the commitment to multi-disciplinary actions. Although *Saving Lives* rejected the individualistic focus of *Health of the Nation*, glaring defects remained. Local authorities were given scant attention; the role of industry and the press was ignored, while the role of the NHS – and the medical model of health – was overemphasized. Nevertheless, it was an advance. *Saving Lives* understood that health is influenced by factors that go beyond the biological and individual: social, economic and political influences – the so-called determinants of health – are seen as critically important. Yet it established targets and outlined ways of achieving them that focused exclusively on health trends and potential risks, rather than the social and cultural context within which healthy public policy could be developed.

Because action on health inequalities, the physical and social regeneration of neighbourhoods, and the modernization of professional practice is now central to government across the UK (albeit with national variations), it brings government strictures on public services into reasonable proximity with the arguments of the public health movement. Coincidentally, the launch of *Saving Lives* occurred at almost the same time as the launch of the new combined public

health association, the UK Public Health Association (UKPHA). The association's purpose was, in part, to work with the grain of these developments in government thinking, at the same time as attracting a new constituency of workers who saw a public health component to their job, and also to appeal to a wider audience – voluntary campaigners and others – as concerns about health issues grew.

Although the fact that environmentalism and consumerism have attracted so many supporters can encourage this new association and the movement associated with it, its area of work and capacity to bring in members are different. Perhaps, in some respects, it can do its job better. While environmentalists have not fought shy of using scare tactics (phrases such as 'Frankenstein foods', for example), the fact that the public health movement includes many (like nutritionists) who work with people, rather than just issues, gives it a strong reality test. The arguments concern people and communities rather than inanimate nature, so for the 'new' public health movement people, not the environment, come first.

Summing up, the aims of the public health movement must be:

- to develop and spread a vision of a healthier society – and not simply add to 'health scares';
- to promote the view that health is more than about waiting lists, hospitals and visits to the doctor – while not denigrating medicine, encouraging it to see the bigger picture;
- to argue for healthy public policy – across transport, food, employment, etc.;
- to build support for public health thinking among employees of the NHS and local government;
- to engage the voluntary sector, the environmental movement, the consumer movement, the professions and the public;
- to campaign for 'health justice' by showing the full consequences of health inequalities;
- to combat anti-health forces, presenting an alternative, sustainable health perspective not just across the UK but also in Europe and all points beyond.

# 1.3

# PROMOTING SOCIAL AND COMMUNITY DEVELOPMENT IN SHEFFIELD: A REFLECTION OF TEN YEARS WORK

Lee Adams and Frances Cunning

This chapter reflects on ten years of promoting health in Sheffield, where we managed a health authority department and worked in partnership with a range of agencies, notably Sheffield City Council. We will show how we tried, explicitly, to draw upon, develop and articulate a coherent set of principles and evidence base for our work, and will describe how this work developed.

For much of the ten years in question, from 1989 to 1999, we were working under a Conservative government, but we also experienced a year or so of a New Labour administration, and will show how national policy impacted on our work at local level. Much of our inspiration came from other sources, especially WHO's Health for All (HFA) programme (WHO, 1981), and its local expression in Healthy Sheffield. We were also heavily influenced by our own backgrounds and training, the evidence on inequalities in health and their causes, the views of local people, professionals and our staff, who came from a diverse backgrounds, including social science, nursing, teaching, research and medical work. We shared strong values consistent with those of HFA, but developed them further locally. We must also pay a debt of gratitude to other health promotion specialists and community development and health activists who inspired us. We were both active in the Society of Health Promotion Specialists and developed a radical perspective which drew on sociology and social policy, political science, ecology and sustainable development, and applied these to health.

## THE THEORETICAL AND EVIDENCE BASE

In 1988 we inherited a small department of health promotion with a mixed reputation, unclear role and no connection to the new healthy city initiative, Healthy Sheffield, described in a previous contribution. We were fortunate in having some excellent staff, far-sighted management and the support of the health authority. It was therefore possible to set out a vision, recruit new staff, and redesign our approach. At the same time we began to develop a working relationship with colleagues in Sheffield City Council and the voluntary sector.

At its peak the department had over 40 staff, and the work described below is a testament to their efforts and the collective philosophy we hold.

We would describe the approach which evolved as a social model of health. We believe that many things – primarily social, economic and environmental factors – influence health. We were also motivated by the very obvious inequalities in health across Sheffield. In response to the research evidence available (Marmot and McDowell, 1986; Blane et al. 1990; Wilkinson, 1996) we focused our efforts on the root causes of ill health. Although we accepted the limitations of the Health For All strategy – an essentially reformist approach which we felt could not achieve its goals – its focus on prerequisites for health and the principles of partnership, community participation and equity were still very radical in the late 1980s. It was rare for a health promotion unit (as we were then called) to take this approach (Adams, 1993), which was very much against the mainstream of national policy (Thomas, 1993).

We also looked to the principles of the Ottawa Charter, an influential statement of good practice that emerged from a WHO health promotion conference in 1986 (WHO, 1986). The Ottawa Charter suggested that health promotion work should operate in several distinct domains: changing public policy, creating supportive environments, strengthening community action, developing personal skills, and re-orienting health services. It also set out three ways in which health could be promoted: through advocacy, empowering people to argue for rights and opportunities; enablement, to reduce inequalities; and mediation, working across sectors. This was a touchstone for us in developing our approach, and still has great relevance today.

Over ten years, with our departmental colleagues, we continually discussed our theory base and focus, trying to refine what we did to achieve our aims. By the mid-1990s, based on these discussions, we had reached the following definition:

> The promotion of health is concerned with maximizing individuals' and communities' involvement in improving and protecting their quality of life and well-being. Health promotion aims to address equity in health, the risks to health, sustainable environments conducive to health, and the empowerment of individuals and communities by contributing to healthy public policy, advocating for health, enabling skills development and education.

While none of us were entirely satisfied with this, it does capture some of our thinking at the time. By then we had picked up further influences, including work on tackling poverty and health (Benzeval et al., 1995), a seminar on the development of theory (Adams and Armstrong, 1996) and sustainable development (United Nations, 1992b), all of which reinforced our focus on poverty and renewed our commitment to action, with a more environmental approach to our work.

By 1998, it was possible to set out a model which evolved both from our practice and from what we felt was a strong evidence base. Essentially there were three strands to the model: *levels* of work, *principles* and *domains*. In order to be effective, we believe that work for health needs to be undertaken at different levels. In Sheffield we used five levels, based on the work of Benzeval et al. (1995) and the Ottawa Charter (WHO, 1987), as follows:

- working to influence national and international social, economic and environment policy;
- working to change local policy and environments;
- working to change and improve local services;
- working with communities, taking a community development approach;
- working to promote the health of individuals.

The principles were those we helped to develop at Penrith (Adams and Armstrong, 1996):

- the right to health, the right for individuals to live in a society where health is promoted and protected;
- equity, concerned with the redistribution of power and resources, to enable the reduction/elimination of inequalities;
- empowering or enabling people to have control over their lives and health: community development helps in this process; we acknowledge some people needed practical help, support and advocacy for this to be achieved;
- anti-oppressive, challenging systems, services, policies and people who oppress and discriminate against others on grounds of race, class, ethnicity, sexuality, gender, ability or age;
- inclusive and democratic, involving people as much as possible in determining needs, planning and action;
- focused on well-being and development, not illness or parts of the body: a holistic approach based upon felt needs, avoiding blaming individuals for ill health over which they have no control;
- futurity: regard for the health of those not yet born;
- acknowledgement of the limits of what can be achieved at local level: action must take place at national and increasingly international level.
- spirituality, the process of individuals and groups developing their own sense of place in the world, how they connect with all life and across generations, and with the non-material.

The domains we considered to be the 'building blocks' for health included housing, warmth, positive relationships, education, freedom from violence, good food, meaningful and safe work, a healthy environment, support, sense of purpose and self-esteem. Similar aspirations can be found in the manifestos of various organizations, such as Oxfam, and the UK Public Health Association, suggesting a consensus on basic health rights.

These three strands influenced our work and, as two staff wrote in 1994, the action flowing from these was to 'build up the building blocks for health, empower individually and collectively for people to get the most out of the systems and services, empower collectively to challenge the structures that determined their health experience'(Adams and Pintus, 1994).

## THE POLICY CONTEXT

It is interesting – even amazing – that we were able to undertake this work, with the approach outlined above underpinning it explicitly, given such a hostile political and professional climate. Perhaps Sheffield's radical history, the chartist and anarchist movements of past centuries and a radical local government, including health campaigns in the 1980s, enabled us to argue for a social approach to health. Certainly, we and many of the people we worked with had been attracted to Sheffield because of this reputation.

The national context of the NHS influenced us in several ways. The creation of the internal market in the NHS in 1991 and the first national public health strategy *Health of the Nation* (Department of Health, 1992) both had a major impact. To ensure that we maintained a strategic focus we became very involved in commissioning both health services and health promotion work from hospitals, community health services and the voluntary sector, rather than leave the health authority and become 'service providers' ourselves.

The *Health of the Nation* was a huge step forward in legitimizing public health activity but its focus on individual lifestyle and neglect of a social understanding of health were disappointing. This did not support our approach, so that our work had to encompass issues such as skin cancer prevention and other disease-based activity, which we tried to tackle in the ways described above. We also tried to ensure that local health services also did so, for example, our contracts all required anti-poverty work. However, broad holistic approaches to women's health, for example, had to be refocused on parts of women's bodies with the potential for disease. But we still managed to progress holistic work such as a maternal health strategy that emphasized prevention, partnership, and a woman-centred approach as well as service provision. Other Conservative government initiatives such as *Local Voices* (NHS Management Executive, 1992) – increasing patient and community involvement – and moves towards a 'primary care-led NHS' provided some opportunities for radical practice. For example, we initiated a comprehensive health authority strategy for community participation, and helped draw up a community development strategy with one primary care commissioning group. It was a case of working to fulfil government demand, but in such a way as to remain true to our principles.

In 1997, with a change of government, we had high hopes for public health becoming a national priority. The way ahead was set out in the White Paper *The New NHS: Modern, Dependable* (Department of Health, 1997) and later in the public health strategy *Saving Lives: Our Healthier Nation* (Department of Health, 1998b). The commitment to reducing inequalities, and indeed eliminating child poverty in 20 years, was welcome and the proposal for primary care groups and trusts to have responsibilities in public health as well as health care was encouraging. In addition, new powers for local authorities to promote social, economic and environmental well-being and duties of partnership on several public bodies allowed health concerns to legitimately appear on several policy agendas. This strengthened our role in local regeneration work and initiatives such as SureStart. Despite this welcome progress, the government has not given public health the same priority as illness services. Although promoting the idea that the

NHS must take more responsibility for health inequalities is welcome, policy to strengthen the public health infrastructure remains essential.

## THE WORK

In 1997, in line with our developing philosophy, we gained the agreement of the chief executive to rename our department the Department of Social and Community Development. This more accurately reflected the work we were doing, and avoided the negative connotations which the term 'health promotion' had developed for some colleagues through being associated by successive governments with activity in primary medical care. Towards the end of the ten-year period under consideration, the departmental programme included:

- health needs assessment, identifying inequalities;
- developing health strategy in partnership with local people;
- developing policy to address inequalities, and ensuring policy informs resource allocation;
- ensuring services were effective, addressed inequality of access and fulfilled quality standards;
- work in partnership to ensure sustainable development;
- co-ordinating the authority's approach to area-based working and regeneration, including community development;
- co-ordinating the authority's work in involving the public and enabling a joint approach with other agencies;
- contributing to developing primary care.

These followed from the model we developed, and the work took place across all the identified levels, trying to embrace the principles we had agreed. A snapshot of work in 1997 is shown in Table 1.3.1. In practice work was focused on particular population groups, such as men, gay men, women, lesbians, children, young people, black and ethnic minority communities, people with disabilities, older adults and communities living in poverty. We also undertook disease-focused work to fulfil government policy, such as coronary heart disease, cancer prevention and HIV work. However, we tried to avoid a disease-based or settings-based approach, as it did not seem appropriate nor did it fit with our philosophy, and we feared it would divert attention from the root causes of ill health. As well as setting a health promotion agenda for others in the NHS, staff led on several areas of commissioning for the authority. All this work contributed to the development of our thinking, and gave us an opportunity to ensure all providers with whom we had a contract adhered to our principles and carried out certain annual objectives. Over time these became quite sophisticated, and included work to address poverty and environmental issues as well as a more traditional focus on providing health education as part of clinical work. Trusts did not receive extra money for this: they were expected to deliver as part of their contracted activity. We had few problems gaining agreement, though the work itself was inevitably mixed, with some delivering much more than the requirement and others much less.

Each Trust had a member of our staff assigned to them to support and develop their work, and this proved essential.

Alongside a health authority reorganization, we restructured our department into three teams – primary care, poverty and discrimination – with the aim of concentrating on the root causes of ill health. This arrangement helped to focus our thinking and activity in these areas. In the late 1990s we worked with officers from Sheffield City Council in developing a new approach called Area Action to the diverse areas of the city. The health authority, city council and community health services trust had a director and senior officer attached to each area, who liaised with the council area panels and worked with local people. Four deprived areas were agreed as the highest priority and we provided a member of staff to each area, particularly to help in securing regeneration funds such as the Single Regeneration Budget, SureStart, Education Action Zone, On Track, and New Deal for Communities. This innovative work assisted several areas in gaining significant resources, developing strong area forums, and enabling greater local participation in policy and planning.

Each staff member in the departmental team had a portfolio of work, an area role, a role in commissioning and a responsibility for a health issue or a population group. Some also had a management role. Our staff came from a range of backgrounds, including nursing, teaching, social sciences and environmental work. Many had postgraduate qualifications in health promotion. The skills available in the department included community development, advocacy, participatory approaches, management of change, organization development, project management, facilitation, training, policy analysis, strategic planning, brokering and negotiation, all of which were applied to a social model of health. Staff went through programmes of personal development to acquire and sustain these skills.

Table 1.3.1 below gives a snapshot of work ongoing in 1997, and other examples are reported elsewhere in this book (see Greig and Parry's contribution and that of Standish, this volume).

**Table 1.3.1** A snapshot of work of the department in 1997

| Population group work | Health issues | Policy and planning |
|---|---|---|
| Black and ethnic minorities | Transport | Acute sector development |
| Women, including pregnant women | Housing | Community and primary care sector development |
| Men | Sexual health | Area based work in 12 areas of the city |
| Children | Substance abuse | Strategic partnership development to increase well-being in the city |
| Young people | Nutrition | |
| Older people | Accident prevention | |
| Carers | Mental health | |
| Travellers | | |
| People with disabilities | | |
| People with certain conditions, e.g. HIV, asthma | | |

*Note:* Work was generally a matrix of the above areas of action. For example, nutrition work related to several population groups and various geographical areas, and we undertook reviews to improve dietetic and nutrition services.

Apart from our work to support Healthy Sheffield and the establishment of the Area Action initiative, we also worked to influence citywide strategy. The health authority was a key partner in Sheffield First, a strategic group of chief executives, senior business people and elected councillors. A strategy to regenerate Sheffield was developed, with a member of our team seconded to support this, in particular the aspects relating to community development. We gradually became influential in city planning and ensuing action, and argued successfully for the social and economic strategies to be combined.

## CONSTRAINTS

Inevitably, not all was plain sailing. Over the years we encountered a range of problems. Perhaps the biggest was the size of the agenda – it was hard to set clear priorities with so much need. The workload was huge, though some of this was of our own making. Resources were a further problem. During this period Sheffield was in a difficult financial state and no local organization had many resources for development. We had to be creative with what was a very small budget. The health promotion unit in the city council, with which we worked very closely, closed due to staff cuts in the early 1990s, and we also lost a number of our own staff who, due to tight budgets, were not replaced.

In some cases particular people opposed or blocked our activities, sometimes due to their own competing interests and in some cases because there was a lack of understanding of our approach. In addition, Sheffield's health authority was a demanding workplace, with a 'cutting edge' ethos – and we tended to make it more so. While our approach gave us a broad remit, there were inevitable tensions between departments which made for a sometimes stressful environment.

## CONCLUSION

This has been a brief overview of the work of Sheffield's health promotion department over a ten-year period. Despite a hostile political climate and severe financial constraints for much of this time, we were still able to take forward radical work. We influenced local policy and services, enhanced Sheffield's bid for Health Action Zone status and for WHO status for the Healthy Sheffield initiative. We feel that clear objectives together with an explicit approach based on sound principles and linked to an evidence base helped us gain support from both the NHS and the local authority. Our approach remains valid today and we believe there is plenty of potential for others working in the statutory sector to go further than is perhaps realized in developing a radical agenda.

Looking back, there are a number of lessons which we would draw from all of this. First, a critical mass of health promotion specialists is necessary, drawn from a broad base of disciplines and skills. Second, to gain the benefits of this diversity it is crucial that staff share core values and beliefs. Time must be taken to develop a shared approach, and this may require protected 'time out'. Third, although the dedication, commitment and capability of staff enriched

discussions and enabled a strong model to emerge, a lot still depended on personalities – both within the department and in positions of power.

The strength of partnership working and the resultant ability to influence agendas, funding and outcomes, speak for themselves. It is ironic that while the political climate has changed, and the rhetoric of partnership and promoting health is mainstream, pursuing a radical programme of work feels just as difficult now as it did in the early 1990s. Even in an apparently supportive political environment it may be hard to hold onto a clear and principled vision.

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