Health Improvement; Health Education, Health Promotion and the Settings Approach

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Abstract

This paper develops the argument that the 'Healthy Cities Approach' extends beyond the boundaries of officially designated Healthy Cities and suggests that signs of it are evident much more widely in efforts to promote health in the United Kingdom and in national policy. It draws on examples from Leeds, a major city in the north of England.

In particular, it suggests that efforts to improve population health need to focus on the wider determinants and that this requires a collaborative response involving a range of different sectors and the participation of the community. Inequality is recognised as a major issue and the need to identify areas of deprivation and direct resources towards these is emphasised. Childhood poverty is referred to and the importance of breaking cycles of deprivation. The role of the school is seen as important in contributing to health generally and the compatibility between Healthy Cities and Health Promoting Schools is noted. Not only can Health Promoting Schools improve the health of young people themselves they can also develop the skills, awareness and motivation to improve the health of the community.

Using child pedestrian injury as an example, the paper argues that problems and their cause should not be conceived narrowly. The Healthy Cities movement has taught us that the response, if it is to be effective, should focus on the wider determinants and be adapted to local circumstances. Instead of simply attempting to change behaviour through traditional health education we need to ensure that the environment is healthy in itself and supports healthy behaviour. To achieve this we need to develop awareness, skills and motivation among policy makers, professionals and the community. The 'New Health' education is proposed as a term to distinguish the type of health education which addresses these issues from more traditional forms.

Ⅰ. Introduction

There are 8 cities in the UK that officially belong to the World Health Organisation Healthy Cities Network: Belfast, Glasgow, Liverpool, London Borough of Camden, Manchester, Newcastle-upon-Tyne, Sheffield, Stoke-on-Trent.

Leeds, located in the North of England with a population of 715,402, is not one of them. But many of the principles which have guided the Healthy Cities movement can be seen in practice within Leeds and, indeed, many other cities within England and the UK. These principles are also evident in recent national policy developments, particularly those tackling complex health problems such as inequality.

This paper starts by briefly revisiting these core principles and demonstrates, using Leeds as an example, how they can be recognised within initiatives to improve health in England. It also draws attention to other settings for health, such as the Health Promoting School, and their compatibility with the Healthy Cities approach. Using child pedestrian injury as an example, the argument will be put forward that the settings approach supports an emphasis on the wider environmental influences on health rather than a narrow focus on risk behaviour. It concludes by reasserting the importance of building up evidence to support the dissemination of this approach.

Ⅱ. Tackling health inequalities

'A healthy city is a city which places the health and well being of its citizens at the heart of its decision making process'(Centre for Urban Health Healthy Cities Project, undated). It has a vision of health that is holistic and recognises that health is influenced by:

- living and working conditions
- the physical and socio-economic environment
- access to good quality health and care services

Developing Healthy Cities therefore needs:

- political commitment and leadership
- partnerships between different sectors
- the active involvement of the community

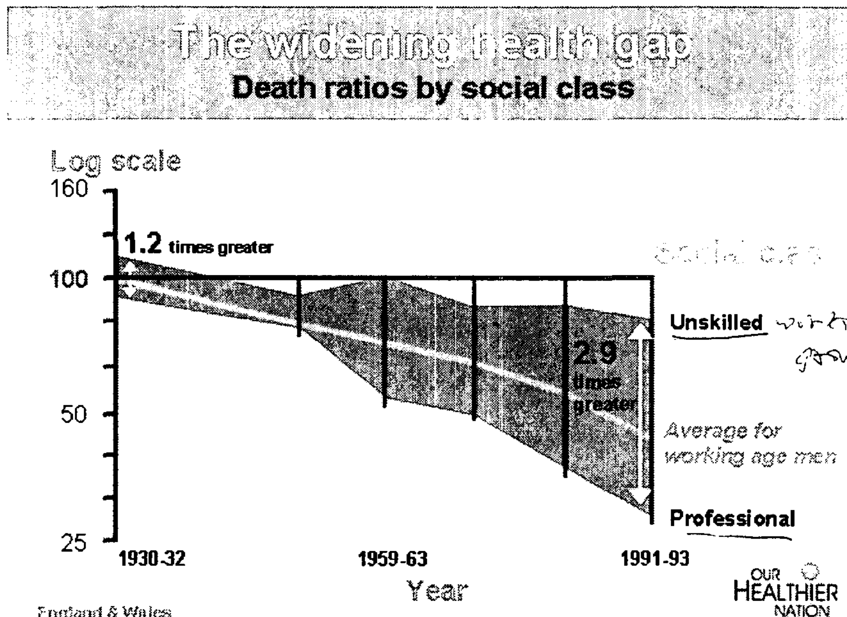
In England it is recognised that coordinated action is needed if we are to tackle complex problems at the local level and achieve sustainable economic growth, social and physical regeneration and improved public services. To this end, Local Strategic Partnership have been set up within local government areas across the country to bring together, at a local level, the different parts of the public, private, community and voluntary sectors (Neighbourhood Renewal Unit, undated). Of particular importance is the involvement of the local community to ensure that the needs of local people are met. In Leeds The Local Strategic Partnership is known as The Leeds Initiative (Leeds Initiative, 2004) and it has recently produced a community strategy, *Vision for Leeds*, setting out its long-term vision for the area as a whole - a vision which includes health as one dimension (Leeds Initiative, 2004). How does this compare with a Healthy Cities approach? If we look at the 4 key elements of the Healthy Cities approach (WHO Regional Office for Europe, 2002b) we can see remarkable similarities:

- Political commitment
- Establishment of new organisational structures to manage change
- Commitment to developing a shared vision for the city
- Investment in formal and informal networking and cooperation.

The Leeds' vision for health is that:

> Leeds will be a healthy city for everyone who lives, visits or works here, promoting fulfilling and productive lives for all. We will reduce inequalities in health between different parts of the city, between groups of people and between Leeds and the rest of the country.

This statement draws attention to the issue of inequality in health - an issue which is receiving considerable attention nationally following the enquiry into inequalities in health chaired by Sir Donald Acheson (Acheson, 1998). There are well recognised links between poverty and deprivation and poor health. Poverty is clearly associated with poorer housing, environment and lifestyle factors such as diet and exercise. As levels of absolute poverty have fallen in urban industrialised countries and the health of the population has improved as a whole, we have noted that the health gap between the highest and lowest socio-economic groups has widened (see the graph below).



Relative poverty, as opposed to absolute poverty, seems to be an important factor here and has been defined as:

> a standard of living so low that it isolates people from the rest of the community. To keep out of poverty they must have an income which enables them to participate in the life of the community.(Supplementary Benefits Commission, 1979, cited in Dahlgren and Whitehead, 1991)

Nationally the government has instituted a wide-ranging and comprehensive plan of action to tackle health inequalities (Department of Health, 2003). The Local Strategic Partnerships in the 88 most deprived areas of the country have access to additional resources through the Neighbourhood Renewal Fund -

- To improve outcomes on worklessness, crime, health, skills, housing and the physical environment.
- To narrow the gap between the poorest neighbourhoods in England and the rest of the country.

Indices of Deprivation have been developed (DETR, 2000) to compare different areas of the country. On the basis of this Leeds comes around the middle taking the country as a whole - 146th out of 354. However this overview of the city masks the existence of small pockets of deprivation. The city can be divided into 33 smaller areas or wards and 7 of these are among the bottom 10% of wards in the country. If we compare coronary heart disease (per 100,000) between the best and worst areas in Leeds, for example, we find:

Ward name	rank within Leeds		coronary heart disease standardised mortality rates
	index of multiple deprivation	health domain only	
worst			
City and Holbeck	1	2	307.91
Seacroft	2	3	236.92
Harehills	3	6	210.31
best			
Otley and Wharfedale	31	31	159.88
Wetherby	32	33	162.55
Horsforth	33	30	160.57

It is important therefore to focus attention and resources at the small area level if we are to tackle inequality. There are also areas in Leeds with high levels of childhood poverty. Children in low income households have poorer health and are also more likely to drop out of school, become teenage mothers and, when they become adults, to have lower incomes themselves (Micklewright, 2003). By the time they reach school age, many children from disadvantaged backgrounds are already so far behind that they cannot benefit from educational opportunities to the same extent as their peers from more privileged backgrounds. In effect, they become locked into a cycle of deprivation. Breaking this cycle of disadvantage is challenging. A whole range of national initiatives has been developed (Department of Health, 2003). One example, operating at the local level, is provided by the Sure Start local programmes (Sure Start, undated) which work with families of children up to the age of four living in the most deprived areas. They aim to promote the physical, emotional and social development of children so that they are not disadvantaged and can flourish at home and when they go to school. A key feature of these programmes is the active involvement of parents in identifying and prioritising needs and the mobilisation of a multisectoral response to meeting them.

III. Healthy schools

The contribution of education to enhancing life chances and health generally is well recognised. The Healthy Cities movement was the first of the settings for health to be implemented. This was rapidly followed in Europe by the Health Promoting Schools network. The National Healthy Schools programme in England and Wales was launched in 1999. Within each local government area, partnerships have been established between health and education to implement healthy schools programmes. In Leeds there is an active healthy schools programme. Each local programme must conform with quality standards set out in the National Healthy School Standard (Department for Education and Employment, 1999). Nine specific themes are included

within the standard.

- Personal Social and Health Education
- citizenship
- drug education (including alcohol and tobacco)
- emotional health and well being
- healthy eating
- physical activity
- safety
- sex and relationship education

and to ensure that the initiative is responsive to local needs:

- local priorities
- school priorities

The Health Promoting School is recognised as a major setting for health promotion. In countries with universal education it has the potential to reach the overwhelming majority of young people at a formative stage in their development. It also offers opportunities for reaching staff and families and involving the wider community in a number of ways. The health promoting school acknowledges that what is taught in the curriculum should be supported by the school environment and ethos and practices within the school. Efforts within the school will also be more effective if supported by parents and the wider community. For example, good school education on nutrition will be undermined if the food choices available in the school dining room are not healthy and families either don't know how to or are unable to provide healthy diets. Education about the importance of hand washing and hygiene will be less effective if the school does not have adequate facilities for washing hands and also if the message is not reinforced by families. The three main elements of the health promoting school are therefore:

- health education provided in the curriculum
- the environment and ethos of the school
- relationships and partnerships with families, the wider community and services

such as the school health service

The health education provided should meet the needs of pupils as they mature and also use teaching methods that actively involve pupils. It is unrealistic to expect young people to take control of their health if they are treated in school as passive recipients of knowledge. In health promoting schools not only are active learning methods used in the classroom, but pupils are also consulted and have a voice in planning developments. The health promoting school, as well as promoting the health of individuals, should also encourage collective concern for the community's health and the development of responsible and active citizenship. Tones (1996) has suggested that the curriculum of the health promoting school should include the following areas:

- health knowledge to develop awareness and understanding of the factors that influence their health:
- lifeskills to develop the competencies needed to take action to improve their own and their community's health
- social education to raise consciousness about the wider determinants of health, concern for the health and welfare of others and motivation to take action to improve health.

As would be expected, healthy schools and healthy cities are compatible in approach and are potentially mutually supportive. Within England the National Healthy School Standard had been seen as a vehicle for addressing a range of health and education objectives. Health Promoting Schools can also use the energy and creativity of young people to identify local needs and priorities to inform the development of local strategies - essential elements of Healthy Cities and the Local Strategic Partnerships I mentioned earlier.

Furthermore, Health Promoting Schools can contribute to reducing health inequalities by reducing risk taking behaviour and encouraging healthy active lifestyles (HM Treasury and Department of Health, 2002). While any school can become a Health Promoting School, those in the most socially deprived communities are being

specifically targeted. The target is that by 2006 all schools with more than 20% pupils eligible for free school meals will have achieved the highest level of the National Healthy School Standard.

Ⅳ. Achieving balance between educational and environmental approaches

All too often, public health problems are defined narrowly in terms of risk behaviour and the response is to develop behaviour modification programmes rather than programmes which address the major determinants. Let us take road injuries to children as an example. Although the UK has good road safety overall, each year among 0-15 year olds there are approximately:

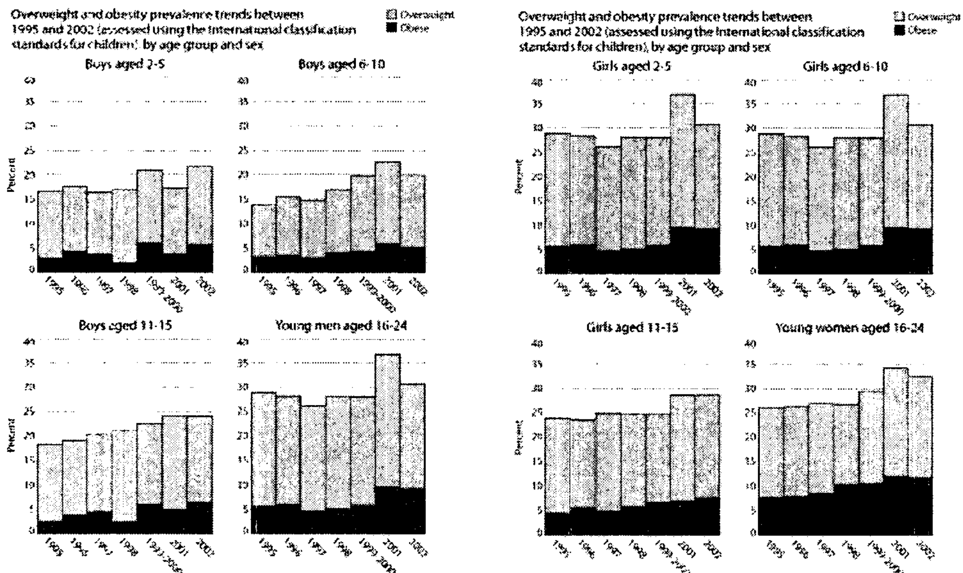
16 000 pedestrian casualties of which 3 000 are serious, and about

100 deaths accounting for 2% all deaths in this age group.

Furthermore, children living in the most deprived wards in England are 3 times more likely to become a pedestrian casualty than those in the most affluent areas (Grayling et al., 2002).

More and more parents are taking their children to school by car. Over the last 20 years the proportion of children going to school by car had doubled despite the fact that many live close enough to school to walk (Department for Education and Skills and Department for Transport, 2003). The use of cars to transport children to school significantly increases the amount of congestion on the roads and the risk to other children. The problem is made worse by drivers trying to avoid traffic jams on major routes taking short cuts through residential areas - often in the more overcrowded and deprived areas - and increasing the risk to residents. As towns and cities become more congested with traffic, children are less also less likely to play on the streets.

At the same time there has been an increase in the proportion of overweight and obese children as shown in the figures below - an issue of major current concern (Sproston and Primatesta, 2003).



Diet is, obviously, partly responsible, but the fact that young people are not taking sufficient exercise is also a contributory factor. Nationally, surveys have shown that only 55% boys aged 2-15 and 40% girls achieve the recommended 60 minutes of moderate activity most days (5 or more) a week (Prescott-Clarke and Primatesta, 1999) and more recently 70% boys and 61% girls (Sproston and Primatesta, 2003).

It is evident that we can't think narrowly in terms of specific health behaviours. Pedestrian safety, transport to school, physical activity and obesity are all inextricably linked. The problem of child pedestrian safety is complex in terms of the multiplicity of factors that combine to cause it and in terms of its wider ramifications. The response, if it is to be effective, has to be capable of tackling this complexity. It is not sufficient to merely provide health education to children to improve their road safety behaviour, nor to educate drivers to adhere to speed limits. The Healthy Cities movement has been at the forefront of developing integrated responses which focus on

the environmental factors which influence health directly and also health related behaviour. Furthermore, it has advocated the active involvement of communities in identifying the solution to problems.

One example of this broader approach involves schools. Schools in England are being encouraged to produce transport plans outlining their local strategy to reduce dependency on cars for transporting children to school and to encourage other forms of transport - particularly active methods such as walking and cycling. The production of the plan should involve all key stakeholders such as teachers, parents, school governors, pupils, local government, local education and transport departments, police, health authorities and health promotion officers, transport companies and neighbourhood and community groups. The involvement of pupils in identifying and prioritising issues to address is of central importance. The benefits of school travel plans have been identified as follows (Department for Transport, undated):

- cut traffic congestion and pollution
- improve children's health and fitness
- teach road safety skills
- reduce accidents
- involve children in changing their own environment
- provide a focus for classwork within the national curriculum
- build links within the school community
- reduce parental time escorting children
- increase use of public transport.

Since 1999 transport plans covering 10% schools have been developed providing a range of solutions to local problems. These can be broadly categorised into methods that involve structural change and other 'softer' methods. Structural change may involve the introduction of traffic-calming measures such as speed bumps, the introduction of 20 miles per hour speed limits around schools and in residential areas, road improvements and traffic lights and, within schools, the provision of parking areas for

bicycles. Softer measures include provision of crossing patrols, road safety education and initiatives such as walking buses. Whitkirk School in Leeds, for example, has set up a 'walking bus' as shown in the illustration. Many parents are concerned about their children's safety if they walk to school. The 'walking bus' has a volunteer parent 'driver' at the front and another 'conductor' at the back to check on safety. The children get exercise, chat to their friends and learn valuable road safety skills.

A second example of a community initiative to improve streets in residential areas is provided by Home Zones. These are pilot schemes that involve modifying street design so that the needs of pedestrians and residents come first. Vehicles are not excluded, but the speed and movement of vehicles are controlled by imaginative street design. People and vehicles share the street space, but the needs of pedestrians are put first. A Home Zone has been set up in The Methleys area of Leeds - an area of about 300 houses with very small yards or gardens and most of the public space is on the streets. The Home Zone introduced the following changes:

- narrowing the road entrance to the area
- raising the road surface to the level of the pavement with coloured paving, staggered planted areas to reduce the forward flow of traffic - (planted areas are maintained by both the local council (trees) and the local community (shubs and smaller plants)).
- artwork on walls and designs incorporated into the paving.

Not only has traffic flow been slowed, there is more space available to the local community and the environment as a whole has been improved. The environment is now much more suitable for children to play. One example of the way the space can also be used for community activity is the setting up of a community cinema - films are projected from the bedroom of one house onto the end of another house painted white to be a screen. Members of the community bring their own chairs.

Experience derived from the pilot Home Zones indicates that success is dependent on having at least two out of three of the following features:

- a champion within the local council (local government) who will be a strong advocate for the Home Zone
- a strong external facilitator independent of the residents and the local council
- strong residents' or tenants' groups

(Transport2000, undated)

A particular feature of the Methleys Home Zone was the very strong residents group and the involvement of the community in the development of the project.

V. Conclusion

In conclusion, I have argued that even though cities may not be official 'Healthy Cities' signs of adopting a similar approach are evident at a number of levels. I have provided examples including the overarching issue of inequality and the need to identify and focus attention on areas of deprivation. The importance of education generally - pre -school and at school - was mentioned as one means of breaking cycles of deprivation and the compatibility between Healthy Cities and Health Promoting Schools was noted. Specific examples of school-based and community-based initiatives which address pedestrian safety were also provided to emphasise the importance of a holistic response developed **with** local communities.

Health is influenced by a whole range of factors including housing, education, employment the environment, transport, crime and above all poverty - the so-called wider determinant of health. The Healthy Cities movement has led the way in demonstrating that partnerships and co-ordinated action are essential to tackling these wider determinants and achieve health improvement. Traditional health education which focuses narrowly on behaviour change is unlikely to be effective on its own. The emergence of health promotion recognised that a supportive environment is essential as well - one that is healthy in itself and also encourages healthy behaviour. We have much to learn from the experience of Healthy Cities and it is important that this is disseminated to those in positions of power and influence. This requires initiatives to be evaluated to build up robust evidence about what works. We also need to develop awareness and skills among communities to enable them to identify their own priority needs and take collective action to address them. Above all we need to work together and develop partnerships between sectors and with communities to achieve health improvement goals. All this requires the development of awareness and skills among policy makers, professionals and the community and a new orientation for health education. To distinguish it from more traditional forms of health education we might refer to it as The New Health Education (Tones and Green, 2004) and its role is concerned with developing the knowledge and skills and commitment to take this type of approach forward.

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국문요약

건강 향상: 건강 교육, 건강 증진 및 배경적 접근

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이 논문은 공식적으로 건강한 공동체로 지정된 "건강한 공동체 접근"의 반경에 확장된 논쟁을 발전시켰으며 영국과 국가적 정책에 건강을 증진시키기 위한 노력을 더욱 더 폭넓게 한 요소들을 제시하였다. 그것은 영국 북부의 주요 도시 Leeds에서 나온 예에서 나왔다.

특히 그것은 더 넓은 결정을 가진 자들에게 시민 건강의 향상시키기 위한 노력을 제시하였고, 그것은 또한 지역 사회의 참여와 다양한 요소들이 포함된 집합적인 대응이 요구된다. 불평등은 주요 문제로 인식되었으며, 빈곤 지역의 색출 및 그들을 향한 즉각적인 도움이 강조되었다. 어린 시절 가난과 빈곤에 대한 순화적 타파의 중요성이 언급되었다.

학교의 역할은 건강한 공동체와 위에서 언급된 건강증진 학교들 간의 적합성과 일반적으로 건강에 기여하므로 그 중요한 요소로 보여진다. 건강 증진 학교는 젊은이들의 건강을 향상시킬 뿐만 아니라 그들 또한 지역 사회의 건강을 증진시킬 수 있는 동기유발과 인식, 그 기술들을 향상시킬 수 있다.

어린이 보행자 상해를 한 예로 사용하면, 이 논문은 그 문제와 원인은 단지 좁은 의미에서만 이해해서는 안 된다고 주장한다.

건강한 사회 운동은 우리에게 그 답은 가르쳐 주었고, 만약 그것이 효과적이라면 정책 결정 자들은 이에 주시하고 지역 환경에 적용시켜야 할 것이다. 단지 전통적인 건강 교육을 통한 행동 변화의 시도 대신에, 환경 그 자체가 건강이며 건강한 행동을 지지한다는데 인식이 필요하다. 이것을 성취하기 위해 우리는 정책 수립자들, 전문 직업인들 그리고 공동체 사이에 동기유발과 기술, 인지력을 발전시킬 필요가 있다. 이 "새로운 건강"교육은 더욱 전통적인 형식에서 제기된 건강 교육의 형태를 구별하기 위한 용어로 제시되었다.