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The experience of health in an unequal society

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UK Health Watch 2005

**The Experience of Health in an
Unequal Society**

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Views expressed in UK Health Watch are those of the authors and do not necessarily reflect the position of the Politics of Health Group.

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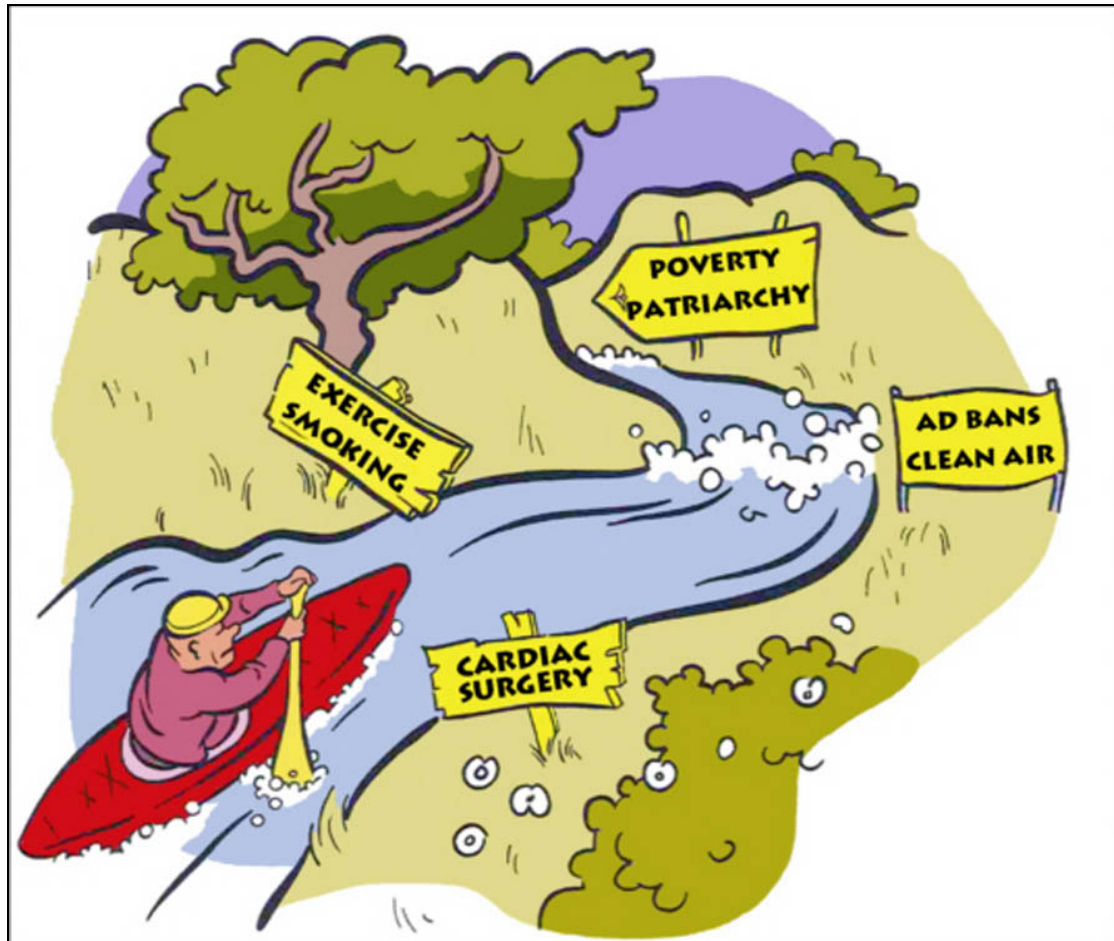
Cover: Michael Winters, based on an idea by the editorial group.

CONTENTS

Introduction	3
 Section 1. Health and Wellbeing: the Political Challenge	
Richard Wilkinson	8
<i>Inequality: what it does and how to reduce it</i>	
Clare Bambra and Alex Scott-Samuel	13
<i>The twin giants: addressing patriarchy and capitalism</i>	
Toba Bryant and Dennis Raphael	15
<i>Politics, public policy, and population health in the United Kingdom</i>	
Alex Scott-Samuel and Martin Rathfelder	23
<i>The Black report 25 years on</i>	
Peter Townsend	30
<i>Inequalities in health – the Welsh dimension</i>	
Evan Bates	32
<i>Health and healthcare in Northern Ireland</i>	
Dennis Raphael and Toba Bryant	38
<i>Public health concerns in the United Kingdom: Two steps forward, one step back?</i>	
 Section 2: Rhetoric vs reality	
a) People or Politics	
Priscilla Alderson	47
<i>Generation inequalities</i>	
Livingstone Musuro and Eileen O’Keefe	53
<i>The right to health: African migrant communities and HIV in the UK</i>	
Mark Burton and Carolyn Kagan	59
<i>Decoding ‘Valuing People’: Social policy for people who are learning disabled</i>	
Lisa Power	66
<i>A strategy for sexual health in the UK</i>	
Elsbeth Hosie and Kate Burton	70
<i>How does literacy affect health? – A case study</i>	
Julie Fish	76
<i>The health and health care needs of lesbian, gay, bisexual and transgender people</i>	
Sally Hargreaves, Judith Cook, Jane Shenton and Hermela Chassme	81
<i>Ensuring access to NHS care for asylum seekers</i>	
 b) The Health Care sector	
Sunanda Ray	86
<i>The NHS as part of global health</i>	

Sally Ruane	90
<i>Evolution of Independent Sector Treatment Centres and their impact on the NHS</i>	
Sarah Sexton	95
<i>GATS, privatisation and health</i>	
Nicola Ruck	107
<i>Planning health care for the Dyfi valley – a case study</i>	
c) Beyond Health Care	
Peter Draper and John Appleby	113
<i>Health and economic policy</i>	
Alan Cunningham	118
<i>Improving health - working for sustainability</i>	
Fiona Haigh	126
<i>Human rights and health in the UK</i>	
Section 3: Strategies for Action	
Kate Burton	133
<i>Community led – supporting and developing healthy communities</i>	
Paul Munster and Carole Zagrovich	137
<i>A community challenge to industry - industrial pollution around Teesside</i>	
Helen Steel and Dave Morris (The McLibel Two)	140
<i>Victory for McLibel two against UK Government</i>	
Lynne Kennedy and Debbie Fox	146
<i>Choosing Health? Choosing a better diet</i>	
	155
Authors' Biographies	
The Politics of Health Group Charter	162

Introduction



Refocussing Upstream¹

¹ Refocussing upstream is a key theme of this report and of public health generally. It was popularised in the 1970s by Professor John McKinlay, the New Zealand medical sociologist who established the New England Research Institute in Boston. It refers to the idea that the practice of medicine is equivalent to people who are constantly finding more efficient ways of pulling drowning people from a river. They are so engaged with improving their methods and technologies for doing this that they have no time to look upstream to see who it is that is pushing the people into the river in the first place (in other words the social, economic and political forces causing ill-health).

Graphic courtesy of New England Research Institute, Boston; adapted by Paul Blackburn, Division of Public Health, University of Liverpool.

INTRODUCTION

The experience of health in an unequal society.

UK Health Watch 2005 represents an alternative perspective on the experience of health in an unequal society. While it is hard to fault the rhetoric of the UK government on health inequalities and the social determinants of health, the reality for most of us is vastly different. This was emphasised in the recent status report (Department of Health 2005), demonstrating that after six years of New Labour government in the UK, inequalities in life expectancy and infant mortality have widened. It is a fact, much to our shame, that in the 21st Century the experience of health continues to be constructed by inequitable and unjust social and economic circumstances.

UK society continues to be modelled on the needs of competitive, entrepreneurial, educated, white people in middle England, and around the aim of generating capital. This is achieved at the expense of health and wellbeing, relying for its success on the traits of greed, excessive competitiveness, individualism, lack of care and selfishness - the alternative traits which characterised our welfare society at its inception being cooperation, reciprocity, collaborating for the common good, and emotional literacy.

Statistically we have on average never been healthier, but the truth is that we are “doing better and feeling worse” (Wildavsky 1977). Accounts over the last 20 and more years have repeated and reinforced the constant stream of evidence that in all aspects of health – physical, psychological, emotional and social – we are a country that is unequal and suffering. As Richard Wilkinson has demonstrated (Wilkinson 1996) this is, at least in part, because inequalities in health affect us all, and not just those who suffer the consequences of being ‘other’ - poor, black or excluded and discriminated against, for example, because of a disability or different sexual orientation. Health is often talked about as if it is a body part that can be strengthened or damaged, mostly by the actions of individuals themselves. This ‘commodification’ is clearly false – health is about power – political, social and economic power – which is so often denied to people who are ‘other’. In describing their experiences, this report shows that the government’s objective of creating empowered individuals is in fact resulting in disempowered ‘others’. For those who are concerned about this malaise, UK Health Watch 2005 is a resource to be used and built upon to provide the arguments and the tools for change.

UK Health Watch aims to illuminate the continuing (and accelerating) trends that feed neo-liberal politics and policies. It brings together diverse but critical thoughts on the state of health and health care in the UK and what we might do about it. Despite their mantra of ‘evidence based policy making’ politicians are all too often selective in choosing advice and research that coincide with a predefined individualistic approach to health – what has been called ‘policy based evidence making.’ This report offers some alternative strategies

based on sound research and on the experience of individuals and communities directly affected by health policy.

The Politics of Health Group's position: Bad policy means bad society means bad health.

Health is as good or bad as the society we create. The most sensitive indicator of the success or otherwise of that society is the impact it has on the health of its population. The contributions to this report demonstrate time and again the links between socio-economic inequalities, health inequalities and patronage of the neo-liberal agenda (for example the transfer of responsibilities of the State, and the conditional and draconian demands required to access welfare). Insofar as health is a human right, then the right to an egalitarian society is something to which we must never stop aspiring.

The Politics of Health Group (PoHG) believes that it is unacceptable that the potential to maximise good health is not available to all. Its charter encapsulates the different policy areas that impact on health (see page 161). PoHG campaigns to highlight the effect of global, national, and local political and economic decisions on health. Producing UK Health Watch is one part of that campaign.

Compiling UK Health Watch

UK Health Watch forms a strand of the recently launched Global Health Watch (People's Health Movement 2005), which itself was published as an antidote to the officially sanctioned WHO World Health Reports written from a restricted medical perspective. It was at the suggestion of Global Health Watch colleagues that PoHG agreed to produce a UK report.

Why is a UK version of Global Health Watch necessary? Because poverty and discrimination form the chain that links health and lack of health opportunity in every country and every community, and because we have extremes of absolute poverty - not just relative poverty as many complacently believe - in the UK.

The process of bringing the report together involved a call for contributions from any concerned groups or individuals who had something to say about the health and political challenges that we face. Our contributors come from a variety of backgrounds and the style and content of the articles reflect this diversity.

The report is broken down into three key sections. In the first section it is made clear that challenges to health and wellbeing are much more entrenched than politicians and policy makers would have us believe. Health is not so much a matter of choice but a result of economic, political, social and cultural inequalities in UK society. The second section describes the reality of the impact of health policy on individuals and communities, contrasting it with the government's rhetoric and aspirations for the health care sector and beyond. It explores themes of corporate social responsibility, health and sustainable development and human rights, and raises questions about the morality and hypocrisy behind much decision making about health. Finally,

we give some examples of action at local, national and international levels that challenge the status quo.

We are conscious that there are gaps in coverage – for example we know there is much to be said about the structural inequalities around mental health, gender and race and (given the Anglo-centric tendency of the report) we need to explore further how devolution has impacted on health inequalities in Scotland, Wales and Northern Ireland.

The aim of UK Health Watch is to produce an evolving account of the reasons for poor health in the UK, the appropriate and inappropriate ways in which we respond to health problems and the steps that various individuals and groups are taking to challenge the many ways in which our health is compromised. UK Health Watch will therefore be a living document and we invite further contributions that will address any deficiencies, build on UK Health Watch 2005 and take forward the debate. We hope it will act as a wake-up call to politicians and citizens alike.

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Section 1

Health and Wellbeing: The Political Challenge

INEQUALITY: WHAT IT DOES AND HOW TO REDUCE IT

Richard Wilkinson

In a recent review of 169 published analyses of the relation between income inequality and health, we (Wilkinson & Pickett forthcoming) found that the evidence overwhelmingly supported the conclusion that average standards of health tend to be better in societies with smaller income differences between rich and poor. We classified the studies as having “mixed” results if some but not all their results gave statistically significant support for the hypothesis, as “wholly supportive” if *all* their findings were statistically significant and supportive, and as “unsupportive” if none of their findings were statistically significant and supportive. Leaving out the papers with mixed findings, we found 83 percent of the remaining 36 international analyses were wholly supportive, and 73% percent of the remaining 63 studies of sub-national regions, states or provinces were wholly supportive. Only among the remaining 26 studies of small areas such as counties, tracts and parishes, were a minority (45 percent) wholly supportive.

The difference in the findings between large and small areas almost certainly arises because income inequality is related to health only where it serves as a measure of the scale of class differentiation in society. Social class pyramids tend to be national rather than local structures, and measuring income inequality at the local level means that instead of getting an overall picture of the extent of the whole hierarchy, you get merely small bits of it, each distorted by the residential segregation of people between rich and poor areas. Among humans and animals alike, how much of a social ranking systems there is, is perhaps the most important feature of social organisation. Human societies have of course varied from the most egalitarian to the most tyrannical hierarchies, and the position of societies between these two poles might be expected to have important effects. To begin with, we might expect that many of the problems that show a social gradient – like health inequalities or any other problems that tend to concentrate in poorer neighbourhoods – would be more common in more unequal societies.

In the *Impact of Inequality* I have outlined the evidence not only that both health and violence are worse in more unequal societies, but also that inequality has a major affect on the quality of social relations in a society – lowering trust and reducing involvement in community life. The data shows that inequality is profoundly corrosive of social relations – as many have long recognised. Most recently, using both international data and data for the 50 states of the United States, we have also shown that teenage pregnancy, violence and obesity (all associated with relative deprivation) are more common in more unequal societies (Pickett & Wilkinson, in press).

Not only is it becoming clear that where income differences are bigger, many of the problems associated with relative deprivation are more common, but also that how egalitarian a society is may be driving national standards of achievement in several different fields. Although many of the problems rooted in relative deprivation may share similar causal pathways, they are likely to do so to different extents. Some may be strongly affected by the amount of relative deprivation and inequality in a society and others only slightly.

Insofar as we are dealing with the effects of inequality, social class differentiation and relative deprivation, rather than with absolute living standards and absolute poverty, what are the causal processes? In health the social environment is important. Social status matters. So too do close relationships, friendship, wider social networks and involvement in community life. Because greater inequality increases the problems of low social status and reduces the quality of social relations, it would be odd if it were not detrimental to health. One of the important things about the psychosocial pathways through which circumstances affect health, is that their biological impact depends on the extent to which they induce chronic stress; and if aspects of people's social environment are sufficiently stressful to affect death rates, it would be surprising if they did not also have other behavioural consequences related to relative deprivation.

Studies of what raises levels of the stress hormone, cortisol, show that the social environment is the most potent stressor. A recent review of 208 reports of research looking at cortisol responses to experimental stressors concluded that what really raises levels of this stress hormone are unavoidable "threats to the social self" – principally threats to self-esteem and social status (Dickerson & Kemeny 2004). As the authors point out, it is a matter of whether people feel "valued by the group, are positively regarded, respected, and esteemed...and have high social standing" or, conversely, whether they "receive signals of rejection or disinterest from group members and are lower on the social hierarchy". Our capacity for shame and embarrassment, our fear of whether others will judge us positively or negatively, is a powerful source of stress. As reflexive social beings, we experience and know ourselves partly through each other's eyes.

How this relates to the three most important psychosocial risk factors for health – social status, friendship, and early experience – is not hard to see. Friends provide positive feedback, making us feel liked and appreciated. But if, in contrast, we have few friends and start to think people avoid our company, then we are filled with all kinds of social anxieties about whether we are unattractive, boring, stupid, gauche or whatever. And social status is of course related very directly to our sense of self worth and how we think others see us. Higher status can be a source of increased confidence just as low social status can make people feel looked down on and insecure. And the quality of early life experience, including both prenatal influences like maternal stress in pregnancy and poor attachment in early childhood, are thought to have a life long influence on confidence, security and personality development.

How much inequality there is does not simply affect how many people experience relative deprivation. Greater inequality almost certainly affects how important status is and how much people feel their social standing is taken as an indication of their “worth”. Bigger material differences lead to bigger social distances up and down the hierarchy. In more unequal societies it is as if some people count for everything and others for nothing, making us all more concerned with how we are seen. More hierarchical societies are marked by greater social divisions and more downward discrimination and prejudice against those lower on the social ladder. The divisiveness of widening income differences during the last two or three decades explains why social mobility has actually decreased in Britain and why there is less social mobility in Britain than in many other rich societies. Among the eight countries for which there are broadly comparable measures of social mobility (Blanden et al 2005), there is a close (and statistically significant) correlation showing that social mobility tends to be lower where income differences are greater. In this comparison, the most unequal countries with the lowest social mobility were the USA (the “land of opportunity”) followed closely by Britain. At the opposite end, with the lowest income differences and highest social mobility were countries like Norway and Sweden. The same tendency for income inequality to lead to wider and more rigid social divisions can also be seen geographically: as inequality increases so too does the segregation of the population into rich and poor neighbourhoods. The power and divisiveness of greater income inequality suggests that it is unrealistic to pursue greater equality of opportunity without at the same time moving towards greater equality of outcome. Indeed, greater equality of outcome is likely to be the best way of achieving greater equality of opportunity.

What can be done

After a long period in which income inequality increased and Britain became a more status conscious and hierarchical society, the Labour government has only just begun to reverse these trends. Inequality continued to increase from 1997 to 2000 before starting to decline (Brewer et al. 2005). The result is that we have only just regained the level of inequality when Labour first came to office, and even if the downward trend continues at the same rate, it may take 20 years to undo the damage of the Thatcher years and get back to the level of inequality that existed in 1979. There can be little doubt that Britain would have enjoyed faster health improvements and kept up with other countries if it were not for the continuous widening of income differences between 1979 and 2000.

A Labour government could do itself and the population a lot of good by reducing inequality more rapidly. There are lots of different ways of doing this: taxes and benefits, education policy, minimum wages, avoiding unemployment – all make a difference. However, one way of lowering inequality that is less easily reversed by successive government is to encourage democratic employee ownership and control of companies. Whether control is exercised through something like a traditional management structure made responsible to employees rather than to external share holders, or whether there are more direct forms of democratic participation,

such schemes make income differentials within the company more sensitive to democratic pressures. Employee ownership not only represents a real emancipation of employees, but also has several other major advantages likely to benefit health. These include the redistribution of capital assets and profits from external shareholders to employees, and an increase in control, which is well established as an important influence on health at work. We are currently arranging a formal evaluation of the health benefits of employee ownership across a number of companies.

The government could use tax incentives to advance a policy of employee ownership. Already the Chancellor provides tax incentives for companies to establish employee share ownership schemes, which are usually set up primarily as way of buying the acquiescence of labour to management decision rather than as genuine attempts to increase workplace democracy or equality. Nevertheless, where they are accompanied by more participative management methods, there is good evidence that they increase economic performance (Conyon & Freeman 2001; NCEO 2004). The productivity benefits explain why 20 percent of UK companies now have such schemes (Pendleton & Brewster, 2001) and why the government encourages them. But regardless of the reasons for their spread, they may eventually make employee buyouts easier. Indeed, the Employee Stock Ownership Plan Association (2005) in the US reports that employees already own the *majority* of shares in 2,500 companies.

Oakeshott (2000, p.104) suggests that full employee ownership “entails a movement from business as a piece of property to business as a working community”. Although the image of employee buy-outs has suffered because they have often been introduced in desperate circumstances as a way of saving jobs, what evidence there is suggests that there economic performance is good or very good (Oakeshott 2000). The famous Mondragon Corporation in the Basque region of Spain has, over half a century, developed into a group of over 120 employee-owned cooperatives with 40,000 worker-owners and sales of \$4.8 billion US dollars. Mondragon cooperatives are twice as profitable as other Spanish firms and have the highest labour productivity in the country.

What is important about employee ownership is not so much that it automatically changes the experience of employees and the nature of wage labour, but that it overcomes the most important obstacle to change. Some wholly employee owned companies – such as the John Lewis Partnership – may continue with something close to a traditional management hierarchy (with the very important difference that management is ultimately responsible to employees rather than to outside shareholders), others may develop much flatter and more democratic systems. But whatever they do, the log jam which has for so long denied employees collective control over their work and the institutions in which they work is broken, and new systems are once more free to evolve in the light of experience.

Employees may or may not decide that top management should be paid much more than average. But even if they decided two or three times as much is

appropriate, they would probably balk at ten times as much. And if employee owned firms became the dominant form of business organisation, norms might be expected to become more egalitarian.

The benefits of greater equality do not depend on reaching some egalitarian utopia: even the small differences in the amount of inequality in different market democracies have important effects. But to be confident of gains we need to extend democracy into the economic sphere. Rather than depending on governments to redress the continuing inequalities in pre-tax incomes resulting from the accumulation of wealth from other people's labour, we must establish the tax and legislative framework needed to create the institutional change that will permanently remove the underlying undemocratic sources of economic power.

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THE TWIN GIANTS: ADDRESSING PATRIARCHY AND CAPITALISM

Clare Bamba and Alex Scott-Samuel

Addressing patriarchy

Patriarchy - the systematic domination of women and men by other men – is arguably one of the root causes of all global poverty and inequality, violence, conflict and war. All of these phenomena result from power inequalities, which in turn largely result from the (universally endemic) display of excessive masculine gender roles. The insidious nature of this phenomenon is the result of its cutting across all nationalities, races and classes: excessive masculinity, in the form of emotional illiteracy, excessive risk-taking, and aggression, is as common among black as among white peoples, in the South as in the North, in the Cabinet room as in the public bar.

Research has demonstrated that in countries where there is greater domestic and political gender equality, there is less likelihood of militarism and violence in international crises (Caprioli 2000, 2001). Our own research suggests that patriarchy is also the root cause of the global phenomenon whereby men die at an earlier age than women (Stanistreet et al).

What is to be done? Addressing the origins of patriarchy itself, in addition to the more usual focus on its impact on women, has more radical implications for change. Patriarchal attitudes are reinforced through the parenting and socialisation of infants, children and adolescents. They can therefore, at least in principle, be directly tackled if there was agreement that prevalent patterns of parenting and socialisation need to change - or at the very least, that this should be among the top national priorities for research, policy development and action. While we may be some distance from this point, it's nonetheless clear that both the problem and the solution are ultimately in our collective hands.

Addressing capitalism

Patriarchy, poverty and inequality, violence and war cannot be considered outside the wider context of the capitalist economic system. Capitalism is an inherently inegalitarian economic and social system that thrives on the exploitation and appropriation of natural resources and the 'surplus value' of human labour. The fundamental underlying force of capitalism - the desire for profit - drives global inequality, particularly between the 'developed' and 'developing' world: refusal to 'drop the debt', the patenting of AIDS drugs, and the oil war in Iraq are all examples of the global oppression natural to capitalism. Similarly, in the UK, inequalities in health, education, opportunity and housing are all determined by the restrictive wages made possible under the capitalist economic system: lower wages are essential as they mean more

profit. Current neo-liberal free trade and globalisation are therefore just today's version of the historical 'naked, shameless, direct, (and) brutal exploitation' (Marx and Engels 1967) of the pursuit of profit.

What is to be done? Revolution, or an egalitarian evolution of the capitalist system, is the only long-term solution to the problems of inequality that capitalism creates. However, interim measures to enhance equality within capitalism can also have positive (if not universal or permanent) effects. For example, reducing the income inequalities within a capitalist economy has a positive effect on health and the more equal a society, the better the health of that society (Wilkinson 1996). We must therefore strive for enhanced economic equality via redistributive taxation, enhanced social security, full employment and more equitable wage and pension structures for both men and women.

The twin giants

The UK welfare state was designed in this 'reform of capitalism' mould and was famously set up to combat the five giant evils – disease, ignorance, squalor, idleness and want (Cmd 6404 1942). It is therefore something that should be defended against the onslaught of neo-liberal inspired privatisation and funding reductions (as in the current Keep Our NHS Public campaign). However, it should also be acknowledged, as a recent report by the Joseph Rowntree Foundation (Joseph Rowntree Foundation 2005) does, that almost 60 years later the task of fighting the five giants is still beyond our welfare system. This is not surprising given the structural restraints of the twin giants that continue to dominate our society – patriarchy and capitalism – and which perpetuate and thrive upon widespread class and gender inequalities. The five giants are but the manifestations of these wider underlying social and economic structures of inequality. Therefore, in order to make a real difference in the battle against these evils, we need to re-establish the importance of widespread radical and collective political agency against the two structural giants – patriarchy and capitalism.

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The Twin Giants

POLITICS, PUBLIC POLICY, AND POPULATION HEALTH IN THE UNITED KINGDOM

Toba Bryant and Dennis Raphael

Summary

The example of the United Kingdom is used to illustrate the role that political and economic forces play in influencing public policy. The public policy situation in the UK is contrasted with nations such as the USA, Canada, and Sweden. The UK is seen as having public policies that appear to be more progressive than the US and Canada, but it lags far behind those seen in Sweden.

Introduction

Social determinants of health such as income and its distribution, availability and affordability of housing and food, stability and quality of employment, and the provision of health and social services profoundly influence health. Public policy decisions made by governments influence the quality of these social determinants of health. This article examines the political, economic, and social forces that shape public policy in the UK and other developed nations with similar traditions such as the USA and Canada. Sweden is used as a comparison nation since it has a very well developed welfare state. We argue that government actions in public policy domains not usually considered as health-related have strong influence upon population health and citizen well being.

What is Public Policy?

At a minimum, public policy is decisions made by governments. The following definition of public policy is useful:

Public policy is a course of action or inaction chosen by public authorities to address a given problem or interrelated set of problems. Policy is a course of action that is anchored in a set of values regarding appropriate public goals and a set of beliefs about the best way of achieving those goals. The idea of public policy assumes that an issue is no longer a private affair” (Wolf, 2005).

Esping-Andersen argues that a primary concern of modern welfare states such as the UK is to provide sufficient economic resources to support citizens across the life-span (Esping-Andersen, 2002). Changes in the occupational structure of post-industrial societies require the accumulation of “cognitive and

social capital” among citizens. It is especially important to provide children with these assets: “Since it is well established that the ability and motivation to learn in the first place depends on the economic and social conditions of childhood, policies aimed to safeguard child welfare must be regarded as an investment on par with and, perhaps, more urgent than educational investments” (p. 9).

These key public policy issues show similarities with population health formulations that emphasize the accumulation of health assets across the life span. In particular Shaw and colleagues emphasize the importance of societal supports for significant transitions across the life span such as entering and leaving school, gaining and possibly losing employment, and entering retirement (Shaw, Dorling, Gordon, & Smith, 1999).

There are a variety of explanations as to how such commitments come about. Some argue these commitments reflect the capacity of progressive political forces such as “left political parties” and working class power to influence the policy change process. Others look at the influence of civil society and the extent to which political and cultural traditions support equitable approaches to governance. The elements outlined above – the role of the state, the balance between the market and political forces, and civil society – all contribute to understanding how public policy is made. One important indicator of the general shape of public policy is the extent to which nations distribute resources among the population.

Overall Spending on Transfers

The OECD regularly provides indicators of government operations including provision of supports and services. Transfers refer to governments taking fiscal resources that are generated by the economy and distributing them to the population as services, monetary supports, or investments in social infrastructure. Such infrastructure includes education, employment training, social assistance or welfare payments, family supports, pensions, health and social services, and other benefits.

Among the developed nations of the OECD, the average public social expenditure is 21% of GDP. There is rather large variation among countries with Sweden among the highest public social spender at 31%. The UK at 20% ranks higher than Canada (18%) and the USA (14.6%) (Organization for Economic Cooperation and Development, 2003).

The OECD identifies three main domains of social transfers: pensions (about 8% of GDP); health (5.5%); and income transfers to the working-age population (4.7%). Spending in support of families and children averages almost 2% of GDP. Table 1 shows expenditures on health, income support, pensions and social services in the UK, USA, Canada, and Sweden as a percentage of GDP in 1998.

Table 1: Social Spending as a Percentage of Gross Domestic Product, 1998

Country Total	Income Support	Health	Pensions	Social Services
Canada 18	3.0	6.3	5.5	4.0
United States 14.6	1.8	5.9	6.1	.8
United Kingdom 20.8	4.3	5.0	6.5	4.0
Sweden 31	7.0	6.5	8.0	9.0

Source: OECD (2003). Society at a Glance: OECD Social Indicators. Paris: OECD.

In non-health areas, Sweden spends much more than Canada, the USA, and UK. Sweden and other Nordic countries have very different orientations towards social spending than Anglo-Saxon nations. Sweden's welfare states is one of the oldest having begun building its state programs in the 1920s (Burstrom, Diderichsen, Ostlin, & Ostergren, 2002). Most western countries, including Canada, the USA, and UK, developed their welfare states after the Second World War (Teeple, 2000).

As an illustration of the role governments play in promoting health and well-being, consider the incidence of poverty before government programs and benefits are applied (Nelson, 2004). The pre-transfer poverty rates in the 1990s for UK was 28.8%; for Sweden was 28.3%; for the USA, 23% and for Canada, 21%. However after benefits were applied, Sweden's rate dropped to 3.3%, Canada's was reduced to 11.4%, but the UK remained high at 16.4% and the USA at 18.6%. Clearly, leaving poverty reduction to market forces cannot be an effective approach to poverty reduction.

Poverty Rates as an Indicator of Progressive Public Policy

An essential indicator of the general approach to public policy is the extent to which nations are committed to reducing the incidence of poverty. Poverty profoundly affects health and well-being, and, at the very least, sets individuals upon disadvantageous health and educational trajectories (Auger, Raynault, Lessard, & Choinière, 2004). Poverty reduction is essential for the accumulation of cognitive and social capital, essential for an informed and productive work force (Esping-Andersen, 2002). Table 2 shows that using the commonly accepted international indicator of poverty as receiving income less than half the median population income, -- an indicator of ability to participate in a normal way in society, UK rates are high (Rank, 2004).

Table 2: Rates of Poverty Using Relative and Absolute Rates for Various Groups in Canada, USA, UK, and Sweden during the 1990s.

Country	Percentage of Population below 50% of Median Income			Percentage of Population below U.S. Poverty Line
	Overall	Children	Elderly	Overall
Canada	11.4	15.3	4.7	7.4
United States	17.8	22.3	20.7	13.6
United Kingdom	13.2	20.1	13.9	15.7
Sweden	6.5	2.6	2.6	6.3

Source: Rank, (2004). *One Nation, Underprivileged: Why American Poverty Affects Us All*. New York: Oxford University Press.

The different poverty rates of these countries reflect different orientations to social provision. In a sense, these nations represent profoundly different manifestations of what is normally termed the welfare state. The UK has a less developed welfare state than other modern industrialized nations.

Welfare States and Public Policy

According to Esping-Andersen, Social Democratic, Liberal, and Conservative welfare states form a continuum of government support to citizens ranging from high government intervention welfare systems in the Social Democratic (SD) countries to residual welfare systems as seen in Liberal Nations (LN) (Esping-Andersen, 1990, 1999). Conservative (CN) nations fall midway between these others in service provision and citizen supports.

Sweden is representative of SD welfare states, while the UK, USA, and Canada are LN welfare states. Conservative welfare states (CW) such as France, Germany, and Italy tie benefits to one’s occupation and earnings, and tend to stratify citizens rather than promote equality. Esping-Andersen defines the LN welfare state as involving means-tested assistance, modest universal transfers, and modest social insurance plans. Means testing refers to benefits in the LN welfare state being primarily geared to low-income groups. Social assistance is limited by traditional, liberal work-ethic attitudes that stigmatize the needy and attribute failure to individual, rather than, societal failures. LN nations limit welfare benefits since it is believed generous benefits lead to a preference for welfare dependency rather than gainful employment. The nature of benefits in LN nations result from an implicit – and frequently explicit -- view that low-income or poor people, due to moral failings. This individualistic view fails to acknowledge the structural causes of low income such as high unemployment rates that have plagued all OECD countries since the 1980s. Differences in the form the welfare state takes should be related to overall population health, and indeed, there is evidence to this effect.

Welfare States and Population Health Profiles

Navarro and Shi drew upon Esping-Andersen's insights to identify nations governed predominantly from 1945-1980 by social democratic (Sweden, Finland, Norway, Denmark, and Austria), Christian Democratic (Belgium, Netherlands, Germany, France, Italy, Switzerland), or Anglo-Saxon Liberal political parties (Canada, Ireland, UK, US) (Navarro & Shi, 2002). They then compared these nations on a range of political, economic, and population health indicators.

Anglo-Saxon liberal political economies such as the UK had the lowest health care expenditures and the lowest coverage by public medical care. They had greater incidence of low wage earnings, higher income inequalities, and the highest poverty rates. These economies derived the greatest proportion of income from capital investment rather than wages. These Liberal countries have the lowest improvement rates in infant mortality rates from 1960 to 1996.

Clearly then, politics influences public policy and population health. What are the specific forces that determine the trajectory that a nation takes in its establishment of a welfare state? Esping-Andersen argues that unique historical and cultural forces set a nation on a general path (Esping-Andersen, 1999). For the Nordic nations, the advanced welfare state developed as a result of alliances established between workers and farmers supported by the presence of electoral democracy that applied proportional representation (Esping-Andersen, 1985). In the UK such alliances have been weakened by 20 years of Thatcherism.

Political, Economic, and Social Forces that Shape Public Policy in Liberal Economies

Within the typology of welfare states, there is room for national variation. Both global and national political, economic and social forces influence public policy and the shape of the welfare state in the UK. The rise of neo-liberalism has influenced welfare state policies in the UK and elsewhere. Coburn defines neo-liberalism as a political ideology that is committed to a market economy as the best allocator of resources and wealth in a society (Coburn, 2000). It perceives individuals as motivated by material and economic concerns. Competition is considered the primary market instrument for innovations. An unfettered market ensures economic development and a fair distribution of resources. The rise of neo-liberalism in the UK during the Thatcher years increased income inequalities and the weakening of social provision.

How can we strengthen the welfare state?

The UK has a relatively weak welfare state as compared to other nations. What do we know about the determinants of a strong welfare state that can assist those wishing to resist these threats and strengthen public policy in the service of health?

The influence of "left political parties" is important to the development of the welfare state and its maintenance in the post-industrial capitalist era. These

parties support redistribution of wealth and advocate for universal social and health programs. Rainwater and Smeeding used data from the Luxembourg Income Study to consider the role that left representation played in reducing child poverty (Rainwater & Smeeding, 2003). The UK poverty rate is worse than would be expected considering its history of left-party cabinet share. It also performs poorly in poverty rate compared to its spending vis a vis other nations.

One important process that has assisted left political parties in having influence is proportional representation in elections. Esping-Andersen identifies proportional representation as essential to the development of the Nordic welfare state (Esping-Andersen, 1985). Alesina and Glaeser provide an extended examination of how proportional representation enhanced the growth and influence of left political parties, thereby strengthening the welfare state (Alesina & Glaeser, 2004).

It is also important to consider the public's self-perceived political position. The *1999-2002 World Values Survey and European Values Study* (Inglehart, Basanez, Diez-Medrano, Halman, & Luijkx, 2004) reported how respondents in each of the four countries located themselves on the political spectrum in 1990 and 2000 (Table 3).

Table 3: Self Positioning on Political Scale by Country, 1990 and 2000

Country	Political Right		Political Centre		Political Left	
	1990	2000	1990	2000	1990	2000
Canada	26	25	58	54	16	21
United States	29	32	54	51	17	18
United Kingdom	27	16	50	58	24	26
Sweden	35	32	37	34	28	34

The UK has the largest decline among those who position themselves on the right between 1990 and 2000. Canada, the USA and UK all have a significant proportion of their populations in the political center. Canada and Sweden increased their left proportion between 1990 and 2000. The UK does not have proportional representation. If this were the case, then the voices of this increasing significant minority in would not be able to be ignored even with the election of a non-Labour government.

Labour Union and Labour Density

The strength of labour is an important determinant of the strength of the welfare state. The proportion of the work force that belong to unions in Sweden is 79%, UK 29%; Canada 38%; and the USA 13% (Navarro et al., 2004). Union power has been under attack in the UK. These findings beg the question, Whose interests are served by discouraging unionization and the development of institutions that serve the interests of the working class? Research into population health seldom considers the implications of such forces on population health and well-being, particularly of the groups that are least well-off as a result.

Conclusion

Health and social spending can be politically contentious yet in the end determine the health and well-being of citizens. Political ideology profoundly influences income redistribution and the policies that affect income, social, and health inequalities. However, there has been little, if any, penetration of these concepts into population health research and discussion. Directing the health sector's gaze to broader political and economic factors may be the most effective means of improving population health and reducing inequalities in health.

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THE BLACK REPORT 25 YEARS ON²

HEALTH INEQUALITY AND POLITICAL HYPOCRISY

Alex Scott-Samuel

'Inequality is not inevitable!' was my concluding assertion in a 1986 Lancet review of action to address health inequalities since the Black Report. I wasn't just hoping to raise the spirits of chronic sufferers from hegemonic Thatcherism - I was actually referring to an Israeli study demonstrating associations between the egalitarian social organisation of kibbutzim and reduced gender differences in members' life expectancy.

At that time, such optimism might have seemed justified: despite the Tories' continuing excesses, Labour-led local authorities were busy producing 'local Black reports' and the recently released World Health Organisation European Health for All strategy was explicitly prioritising equity and the social determinants of health.

The Labour Party was getting the message too: shadow health secretary Michael Meacher had set up a series of advisory groups, whose progressive proposals led to commitments in Labour's 1987 Health for All Charter to eliminate the sources of health inequalities through public policies.

Seven years earlier I had been one of the enthusiasts who, having waited four months for health secretary Patrick Jenkin to release the Black Report over the August bank holiday, had sent my cheque to the DHSS Policy and Planning Unit and obtained one of the 260 typescripts that represented the initial publication run. The Guardian reported at the time that 'some of its authors are very unhappy about its treatment at the hands of the department. They feel that they have to try to find some other way of making it available - if a publisher can be interested. Whether the DHSS would agree is not clear'.

Inspired by this, I took the law into my own hands and reproduced pages 355-369 - the summary and recommendations - together with Patrick Jenkin's dismissive introduction, in the autumn edition of the journal *Radical Community Medicine*.

Government aside, there was widespread enthusiasm in the health community for the Black Report's analysis, and for its reformist and redistributive prescriptions.

The publication in 1987 of Margaret Whitehead's successor report, *The Health Divide*, added to the momentum. And after the fall of Margaret Thatcher, the

² These articles first appeared in *Health Matters* Issue 60, Summer 2005

acknowledgement of health inequalities by the Major government - albeit in the restricted form of NHS responses to health 'variations' - drip-fed the health community's optimism.

In the first two years of New Labour government, this optimism was further encouraged. The green paper *Our Healthier Nation* recognised a socioenvironmental model of health, and emphatic rhetorical commitments to tackling health inequalities appeared to be reflected in a range of multisectoral policy developments.

But by the turn of the century, Labour's embarrassingly evident deference to the market increasingly contradicted its rhetoric on challenging inequality. Traditional Labour commitments to the public nature of the public sector were replaced by enforced use of private finance and insistence on widespread contracting out services to the private sector.

Even the NHS succumbed, as Blair and his like-minded health secretaries Milburn and Reid went far beyond Thatcher in handing out public money to private sector healthcare providers from a wide range of countries. This NHS privatisation was described as 'promoting equity' through the 'empowerment' created by offering patients a choice of treatment locations. Blair even imported an academic inequalities expert into 10 Downing Street as his health policy adviser.

Perhaps the clearest indication of the emptiness of New Labour's continuing rhetoric on health inequalities is the absence of any suggestion that these inequalities are decreasing. If this is ever to happen, we will require action that addresses the 'upstream' root causes of health inequality rather than the downstream diseases (and their proximal determinants), which merely represent its current face.

One hundred years ago we had the same health inequalities between rich and poor, although their face then was that of infectious diseases and their immediate precursors.

Eliminating health inequalities requires us to voyage upstream from diseases and their immediate context to deal with their real causes - the gendered, power-driven economic and social inequalities that are an intrinsic feature of the neoliberal ideology with which we are indoctrinated.

I cannot do better than to end with the words of John Hewetson, anarchist GP and author of the original Black report, *Ill Health, Poverty and the State*, which he wrote while in prison as a conscientious objector during the second world war and which was published by Freedom Press after his release in 1946. 'The achievement of full health demands a radical change in our economic system. It requires nothing short of the abolition of poverty, the placing of production on a basis of needs... Full health is a mirage until profit economy is swept away. But it will be easily realised when the means of life are freely available to all.'

WHATEVER HAPPENED TO THE BLACK REPORT?

Martin Rathfelder

The Black Report made 37 recommendations. Here Martin Rathfelder examines how each of them fared over the subsequent quarter of a century

<p>1. School health statistics should routinely provide, in relation to occupational class, the results of tests of hearing, vision, and measures of height and weight.</p>	<p>There are figures on babies and breast feeding by social class, but none on hearing, vision, height or weight.</p>	<p>2. A non-means-tested scheme for free milk should be introduced, beginning with couples with their first infant child and infant children in large families.</p>	<p>Resources now go on fruit in schools, although milk is still available for poorer families. In some schools milk is being provided free of charge to all children.</p>
<p>3. Appropriate government departments should consider how progress might rapidly be made in improving the information on accidents to children.</p>	<p>Information is now much better. Wales leads in having an almost comprehensive system for collecting accident data from all emergency departments.</p>	<p>4. Areas and districts should review the accessibility and facilities of all ante-natal and child health clinics in their areas and take steps to increase utilisation by mothers.</p>	<p>There has been very little work in this area in the last 25 years. The innovative work of Boddy et al in Edinburgh on antenatal care does not seem to have been taken up.</p>
<p>5. The Health Education Council should be provided with sufficient funds to mount child accident prevention programmes.</p>	<p>The HEC bit the dust a long time ago. But the Child Accident Prevention Trust was established in 1981.</p>	<p>6. Savings from the current decline in the school population should be used to finance new services for children under five. A statutory obligation should be placed on local authorities to ensure adequate daycare for children under five.</p>	<p>Surestart is one of Labour's great successes. It works partly because it departs completely from Black's top down approach. Part-time education is available for all three and four-year olds for 12.5 hours a week, set to rise to 20 hours a week.</p>
<p>7. Development of the National Food Survey into a more effective instrument of nutritional surveillance.</p>	<p>Now under the Food Standards Agency, this has become the national diet and nutrition survey.</p>	<p>8. Every opportunity should be taken to link revitalised school health care with general practice and intensify surveillance and follow up.</p>	<p>The evolution of Children's Trusts is intended to produce more integrated and responsive services.</p>

<p>9. In the General Household Survey steps should be taken to develop a more comprehensive measure of income, or command over resources.</p>	<p>The GHS continues to cover income, but measures of wealth remain notoriously difficult in every sense.</p>	<p>10. An assessment which determines severity of disablement should be adopted as a guide to health and personal social service priorities of the individual.</p>	<p>There has been some progress in joint assessment and in considering limitation of activities both in health and in social security.</p>
<p>11. The importance of the problem of social inequalities in health and their causes as an area for further research needs to be emphasised.</p>	<p>There was an ESRC-funded programme on health inequalities, from 1996 to 2001. 'Inequalogists' seem to be everywhere now.</p>	<p>12. A working group should be set up to consider the present functions and structure of hospital residential and domiciliary care for the disabled elderly in relation to their needs.</p>	<p>Few long term wards remain in hospitals. Sheltered housing is now provided mostly by housing associations.</p>
<p>13. Resources within the NHS and the Personal Social Services should be shifted more sharply than so far accomplished towards community care.</p>	<p>Still a good idea - and governments of all flavours have pledged to do it. But hospital power has hampered progress.</p>	<p>14. Joint funding should be developed, and further funding introduced if necessary within the existing NHS budget, to encourage joint care programmes.</p>	<p>Joint work between health and social services has become more common, even though joint funding is now uncommon. Intermediate care has been a growth area.</p>
<p>15. The professional associations, secretary of state and health authorities should accept responsibility for making improvements in the quality and geographical coverage of general practice.</p>	<p>Distribution of GPs towards poor areas has not improved very much, although the various schemes for salaried GPs may prove more effective than previous efforts.</p>	<p>16. Criteria for admission to, or continuing residence in, residential care should be agreed between the DHSS and the local authority associations, and steps taken to encourage rehabilitation.</p>	<p>All parties now advocate helping people to remain in their own homes as long as possible. The residential home industry is declining, and extra care sheltered housing is a breakthrough.</p>
<p>17. Resources to be allocated should be based upon the future planned share for different services including a higher share for community health.</p>	<p>Funding arrangements have changed, but wide agreement that community health needs more resources has not translated into hard cash.</p>		

<p>18. The functions of home helps should be extended, to permit a lot more work on behalf of disabled people.</p>	<p>Role enlargement in home care is increasing. Direct payments now enable disabled people themselves to decide the help they need.</p>	<p>19. The level of child benefit should be increased to 5½ per cent of average gross male earnings.</p>	<p>Increasing child benefit was one of Labour's first acts in government - but is still only about 3.5 per cent of average gross male earnings</p>
<p>20. Larger child benefits should be progressively introduced for older children.</p>	<p>Child Tax Credits now play this role, but are means tested.</p>	<p>21. National health goals should be established after wide consultation and debate. Measures that might encourage desirable changes in people's diet, exercise, and smoking and drinking behaviour should be agreed.</p>	<p>We now have national targets on reducing inequality in life expectancy. New measures on smoking and diet are shortly to be implemented. But there is little agreement on measures to increase exercise or reduce drinking</p>
<p>22. An enlarged programme of health education should be sponsored by the government, and necessary arrangements made for optimal use of the mass media especially television. Health education in schools should become the joint responsibility of LEAs and health authorities</p>	<p>Health education has been out of favour, but seems to have been rediscovered in Labour's white paper Choosing Health. Health promotion in schools is a joint responsibility and is seen as very important in achieving sustained lifestyle change.</p>	<p>23. The maternity grant should be increased to £100.</p>	<p>Universal maternity grant was abolished, but the (means-tested) Sure Start maternity grant is £500.</p>
<p>24. Stronger measures should be adopted to reduce cigarette smoking, to include: a. legislation rapidly to phase out all advertising of tobacco products;</p>	<p>This has been achieved, at last.</p>	<p>25. An infant care allowance should be introduced over a five year period.</p>	<p>No progress here, although Labour increased means-tested benefits for young children significantly in 1997</p>

<p>b. sponsorship of sporting and artistic activities by tobacco companies should be banned;</p>	<p>To come into effect, finally, this year.</p>	<p>26. Provision of meals at school should be regarded as a right. Representatives of local authorities and community dieticians should be invited to meet parents and teachers to seek agreement on the provision and quality of meals.</p>	<p>Jamie Oliver is working on this one, and there is a campaign, particularly in Scotland, for universal free school meals - which are already available in Hull.</p>
<p>c. regular annual increases in duty on cigarettes in line with rises in income should be imposed;</p>	<p>Was implemented, but further increases are inhibited by the threat of smuggling from lower duty areas.</p>	<p>27. A comprehensive disablement allowance for people of all ages should be introduced</p>	<p>Disability Living Allowance was introduced in 1992 with this intention.</p>
<p>d. tobacco companies should be required to submit plans, in consultation with Trades Unions, for the diversification of their products with a view to the eventual phasing out of harmful tobacco products;</p>	<p>Unfortunately, for some reason tobacco companies did not embrace this suggestion.</p>	<p>28. Representatives of the DHSS and DE, HSE, together with the trade unions and CBI, should draw up minimally acceptable and desirable conditions of work.</p>	<p>Labour introduced the minimum wage, and the EU has rules on hours of work and holidays, but neither has entered the debate on acceptable conditions of work.</p>
<p>e. a stronger, well-presented warning should appear on all cigarette packets;</p>	<p>This has been implemented, and further gory illustrations are about to be introduced.</p>	<p>29. Government departments, employers and unions should devote more attention to preventive health through work organisation, conditions and amenities.</p>	<p>The workplace as a setting for health promotion is now recognised. HSE is increasingly interested in wellbeing at work, as well as traditional health and safety issues.</p>
<p>f. the provision of non-smoking areas in public places should steadily be extended;</p>	<p>To be implemented in government buildings in 2006, and everywhere, except pubs without food, in 2008.</p>	<p>30. Local authority spending on housing improvements under the 1974 Housing Act should be substantially increased.</p>	<p>It fell. Government intervention in housing has considerably reduced, although the 'decent homes standard' has had a big impact in social housing.</p>

<p>g. a counselling service should be made available in all health districts.</p>	<p>Recent years have seen big investments in smoking cessation, and particularly in nicotine replacement therapy.</p>	<p>31. Local authorities should increasingly be encouraged to widen their responsibilities to provide for all types of housing need that arise.</p>	<p>Local authorities now have a strategic role in housing and look at all local needs - but they no longer build houses.</p>
<p>32. Screening for neural tube defects and Down's Syndrome on the one hand, and for severe hypertension in adults on the other, should be made generally available.</p>	<p>Screening for neural tube defects and Downs Syndrome is now routine, and use of folic acid is also reducing neural tube defects. GP screening for severe hypertension is now more or less routine.</p>	<p>33. Policies directed towards the public and private housing sectors need to be better coordinated.</p>	<p>Current policy is to further reduce the role of local authorities in the management of housing.</p>
<p>34. The government should finance a special health and social development programme in a small number of selected areas, costing about £30m in 1981-82.</p>	<p>Health Action Zones, perhaps? Area-based funding is now a favoured approach to tackling inequalities, but has important limitations.</p>	<p>35. Special funding for health and local authorities should be developed to encourage better planning and management of housing, including adaptations and provision for disabled people.</p>	<p>Joint funding as it was has gone, but pooled budgets and cross-sector working are at last becoming widespread, especially for disabled people, mental health and children's services.</p>
<p>36. Greater co-ordination between government departments in the administration of health related policies is required.</p>	<p>There is a low profile Cabinet committee on public health, and having a minister for public health must help a bit too.</p>	<p>37. A health development council should be established with an independent membership.</p>	<p>The HEA became the Health Development Agency, recently amalgamated with NICE.</p>

INEQUALITIES IN HEALTH – THE WELSH DIMENSION

Peter Townsend

The National Assembly for Wales has embarked on a novel strategy. A National Steering Group to allocate NHS resources more fairly was set up in 2000. Its report in 2002 entitled *Targeting Poor Health* (Townsend, 2001) made three particular recommendations to reduce inequalities in health and access to health care – 1) to adopt a direct needs formula for the allocation of NHS resources more equitably by area, 2) to improve financial information, particularly in tracing costs to recipients of care, and 3) to establish a dual strategy for health covering action outside as well as inside the NHS. The report was accepted by all parties in the Welsh Assembly Government, and a Standing Committee was established to implement the recommendations. As a first step early in 2004 most of an additional £30m was allocated to 5 of the Local Health Boards, among the total 22, whose funding was found to be furthest below the average required to meet the health needs of local populations. Further steps towards establishing equity of NHS resources by local area in future years are anticipated, together with joint action with professionals and organisations to reduce inequalities within areas.

Some of the steps taken are new to the UK. As the basis for allocating funds a new “direct needs” formula was devised. It is based on the Welsh Health Survey, which provides detailed information about the conditions of health of a substantial representative sample (30,000) of the population of Wales. Among 18 indicators covered are arthritis, back pain, respiratory illness, heart problems, mental illness, cancer and diabetes. The survey is unique to the UK and in 2004-5 has been extended in scale to provide data for the populations of 22 Local Health Boards, and in its scope by age to children. The formula displaces previous methods of using service utilisation as a proxy for need, and the data are considered to be more comprehensive, practicable and reliable than alternatives on offer. (Gordon et al, 2001).

A second novelty has been to pilot advocacy and equity training grants in selected areas. These illustrate respectively changes that have to be made both outside and inside the NHS to reduce inequalities in health. The advocacy grants are intended to devise means for NHS staff, groups and organisations to develop means of advocating action by non-devolved bodies, including the UK government, to adopt measures, for example on child benefit, incapacity benefit and other redistributive allowances, that equalise both health and access to health care. The equity training grants are intended to allow professional NHS bodies time and resources to find improved methods of serving patients who are hard to reach, to develop strategies to improve the health, or prevent the ill-health, of communities and families living in material and social deprivation.

A series of reports at different stages of work from 2000-2005 has been published, and a final report will be published later by the WAG in 2005. This

will include recommendations to complement measures at national level with much stronger action at local level. Equity measures to be adopted separately by the 22 Local Health Boards are envisaged to make a bigger contribution in achieving genuine equity of access to health and social care than action nationally. Joint and collaborative action is longer term, and more sustainable, than the perpetuation of top-down, or market-led, authority.

HEALTH AND HEALTHCARE IN NORTHERN IRELAND

Evan Bates

Health standards in Northern Ireland are often lower than in other regions and countries of comparable income and wealth; and some people are more likely than others to experience avoidable ill health and premature death.

I have tried to provide a review of health standards and inequalities in Northern Ireland, a partial analysis of the determinants of those health patterns, and a brief commentary on some relevant political and social initiatives. It is best that I acknowledge the shortcomings of this paper in advance - I hope that some readers will find it helpful, despite its omissions, flaws and idiosyncrasies.

Health standards and inequalities

Lacking information, I cannot comment on patterns and trends at a level that would address wider issues of functioning, wellbeing and happiness in our society. I can comment with more confidence on narrower indicators of physical and mental health, in a UK context.

Since 1950, life expectancy has increased by 9 years for men, and 11 years for women (Department of Health 2004a). Infant mortality rates have fallen from 13.2 deaths per 1000 live births in 1981 to 4.7 deaths in 2002. The 2002 stillbirth and perinatal mortality rates were both worse in Northern Ireland than in England, Scotland or Wales, however. Age-standardised mortality rates for 2001 show Northern Ireland with 977 deaths per 100,000 population, trailing England (937 deaths), but better than Wales (988 deaths) and Scotland (1089 deaths). Deaths related to respiratory and circulatory diseases (and, less significantly, road traffic accidents) account for the higher mortality rate in Northern Ireland compared to England. In 2001/2, adults in Northern Ireland were less likely than in England, Scotland or Wales to report a 'good' state of general health (Office of National Statistics 2004). There is also evidence of lower mental health standards in Northern Ireland, compared to England and Scotland (O'Reilly and Browne 2001).

People living in areas of social and economic deprivation within Northern Ireland are more likely to experience avoidable ill health and premature death. An analysis covering 1997-2001 showed that the standardised mortality rate for people aged under 75 and resident in deprived areas was 33% above the Northern Irish average. Life expectancy for men and women in deprived areas was 71.9 and 77.6 years respectively, compared to the average for men and women of 74.9 and 79.9 years. For the same period, infant mortality in deprived areas was 25% above average; in 2001, the teenage pregnancy rate was 70% above average; and the cancer incidence rate was 15% above

average during the period 1993-9 (McWhirter 2004). The gap in health standards between areas of advantage and disadvantage is reported to be widening (Department of Health 2002). There are variations linked to age and gender, and to other social groupings, such as religion [O'Reilly and Browne 2001, Northern Ireland Census 2001]. Irish Travellers, though comparatively small in number, experience appalling levels of ill health, and they have a lower life expectancy than average (Northern Ireland Census 2001, Department of Health 2002).

The determinants of health

The overall improvements in life expectancy in Northern Ireland during the last century are consistent with international trends for industrialised countries. In the decades up to the 1970s, much of the improvement probably related to fewer deaths in childhood, linked to better control of infectious disease. Since the 1970s, life expectancy for adults in late middle age has probably improved. Expectancy of years free from limiting long term illness has increased, but by only a small margin - people are living longer, but in poor health. Estimates of the contribution of health care services to improved life expectancy attribute up to 20% of the years gained to better healthcare, with the relative contribution of better healthcare probably increasing in the last thirty years (Sussex 2000). Reductions in tobacco use in recent decades will have also contributed to increased life expectancy. I can only speculate that these patterns and trends, apparent in other industrialised countries, have relevance in Northern Ireland.

I want to turn to certain determinants of particular relevance to health inequalities within Northern Ireland.

Government has recognised that 'a large proportion of this unnecessary premature death and disease is determined by social and economic inequalities' (Department of Health 2002). A more recent Government-funded report by Hillyard et al reported that 'Northern Ireland is one of the most unequal societies in the developed world' (Hillyard et al 2003). Hillyard also suggested that 'inequality in Northern Ireland is increasing'. Hillyard concluded that the 'disabled are nearly twice as likely to be in poverty as the non-disabled'. The youngest group of households are twice as likely to be in poverty compared with the oldest. Women are more likely to be poor than men. The level of poverty is 1.4 times as high in households where the household respondent is Catholic compared with households where the household respondent is Protestant. Many people however will think the most significant finding is that well over a third (37.4 per cent) of all this society's children are being brought up in poverty'.

People in certain areas (such as west and north Belfast) have borne the brunt of political violence, and one would have expected that there would be an associated detrimental impact on health. There is some evidence of this (O'Reilly and Browne 2001), but the link to health is meshed with the impact of

high levels of multiple deprivation within the same areas, and socio-economic inequality in relation to other areas.

The private healthcare sector in Northern Ireland is small in comparison to England, and publicly funded (and provided) healthcare services are still the norm. Resource allocation to the public healthcare system has been growing, but at a rate slightly lower than in England. While acknowledging the commitment and dedication of staff, and the high quality of care received by many patients, we have missed opportunities to improve the public healthcare system:

- Access delays for outpatient appointments and elective admissions are widespread - over 4000 patients were waiting one year or more for elective admission, as at March 2005.
- There is evidence that people in deprived areas have greater access problems; and people from deprived areas are less likely to receive elective treatment than might be expected, given patterns of disease (The Royal Hospitals 2003, Dixon et al 2003). The capitation-based formula for distribution of funds within the public healthcare system is still based on historical utilisation patterns (Department of Health 2004b) - disadvantaging people in deprived areas, where there is a higher proportion of unmet need. In addition, the funding formula focuses on age as a cost driver, rather than proximity to death - for acute care, proximity to death is a better factor to consider, given that people in deprived areas are more likely to die prematurely (Seshamani et al 2004).
- Decision-making about the planning and delivery of services in the public healthcare sector has been hampered by political instability, and as a result of fragmented organisational arrangements within the sector. Service integration, rationalisation of acute services and workforce development are obvious areas where faster progress could have been beneficial. Investment in information and communications technology to support the delivery of healthcare has been low. Had these issues been addressed in a more timely manner, it is reasonable to conclude that the public healthcare system could have made a greater contribution to raising health standards and reducing health inequalities.
- The public healthcare sector, of course, also affects people's health in other ways. The sector employs around 60,000 staff, and spends over 3 billion UK sterling of public funds each year. The sector has substantial capacity to influence employment patterns, and the health of workers and their families (Council of Civil Service Unions 2004). The sector could have leveraged some procurement decisions in support of disadvantaged communities (while complying with European Union requirements); and it could have done more to modify its impact on the environment (Coote 2002). There are some

examples of relevant initiatives both in Northern Ireland and elsewhere, often involving joint working with trade unions and local communities; but much more is possible in Northern Ireland.

A healthier future?

Since 1997, Governments in Northern Ireland have produced many policies and proposals pertinent to health. They have included a policy to target social need, soon to be replaced with an anti-poverty strategy (Office of First Minister 2005a); a strategy to improve relations between sections of our society (Office of First Minister 2005b); a review of public administration (including the public health care sector) (Review of Public Administration 2005); a cross-Departmental strategy (Investing for Health) to raise health standards and reduce health inequalities (Department of Health 2002); and more recently a consultation document setting out a vision for improving health standards and reducing health inequalities in the period up to 2025 (Department of Health 2004). There are also initiatives for encouraging economic development, reforming the educational system, and creating further employment opportunities. An independent review of health and social care provision is due to be completed in mid 2005.

At face value, this is an impressive array of policies and proposals - and there are others, too numerous to mention, which will affect health and health inequalities. There has usually been extensive consultation about these policies, and comments by consultees are often accessible through Departmental websites. These comments include both support and criticism, from varying perspectives.

- My own view? There is much to welcome in these new Government policies and proposals; overall health standards (if measured by life expectancy) will probably continue to rise in the early part of the twenty-first century. I have less confidence that these achievements will be sustainable; and I doubt that these policy measures will be sufficient to avoid a further increase in health inequalities within our society. My reasoning is as follows:
- We have become accustomed to sustained economic development. The UK (including Northern Ireland) spends less on healthcare than many countries of comparable income and wealth, but there has been a rapid increase in expenditure in the last few years, reducing this gap. I may be unduly pessimistic, but changing global circumstances (financial, political and environmental) may make sustained economic development an unreliable assumption in the coming century. Many industrialised countries would find that funding for healthcare becomes difficult to sustain if economic development were to slacken, or if changing global circumstances altered Government priorities.

- Investing for Health (Department of Health 2002) was a ground breaking policy document, strongly making the point that social and economic issues must be addressed to improve health standards and reduce inequalities. It set a broad range of objectives and goals for achievement by 2010. Although initially prominent in the annual Programme for Government, some of the objectives and goals no longer have such prominence; and some targets have been lowered. There seems to be a re-emerging emphasis on 'lifestyle' issues, and on personal responsibility for one's health. The anti poverty strategy has not yet set targets for reducing poverty and social exclusion; A Healthier Future (Department of Health 2004), though, has forecast a possible further widening of the gap between rich and poor.
- Overall, A Healthier Future set out a depressing vision of our society in 2025, in addition to this widening gap between rich and poor; a society with more people experiencing age-related chronic diseases; a society with a greater burden of mental ill health; a society at greater risk of both terrorist and disease-related global threats; a society where technological advances and consumerism will have stimulated new demands for healthcare. A Healthier Future attempted to model the potential impact of changes in lifestyle behaviour, but without consideration of more fundamental choices and tradeoffs.

It seems to me that we need more reflection and discussion about the type of society we want in future. We could choose to work towards a society that will be more equitable than envisaged in A Healthier Future. We could place a greater emphasis on environmental considerations, and on the health of future generations. We could give more consideration to the health of people outside Northern Ireland. We could choose to spend a higher proportion of public funds on creating a healthier and more inclusive society - an investment that would reduce the incidence of chronic diseases, and the associated need for healthcare.

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PUBLIC HEALTH CONCERNS IN THE UNITED KINGDOM: TWO STEPS FORWARD, ONE STEP BACK?

Dennis Raphael and Toba Bryant

Summary

In this article we consider current public health preoccupations in the United Kingdom. We show how these preoccupations reflect and reinforce existing models of public health and public policy. While there is much to commend in current UK approaches to addressing broader determinants of health, there are some worrisome signs that a retreat to behavioural, lifestyle approaches is possible.

Introduction

Promoting health comprises three distinct, though potentially related sets of activities: traditional public health activities; developing healthy public policy; and delivering health care services. Public health and healthy public policy – our concern in this article – are concerned with promoting the health of the population while health care services treat individuals who are ill or at risk of being ill.

The extent to which integration of public health public policy activities is possible depends upon a variety of factors. The most important is the model of health adhered to within each jurisdiction. If health is seen as a highly individualized issue that reflects biological dispositions and risk behaviours, approaches to public health will focus on managing biomedical and behavioural risk factors (e.g., hypertension, cholesterol levels, weight, tobacco use, and diet).

In contrast, if health is seen as influenced by structural factors (e.g., the organization of society and the distribution of resources), public health will focus on health-supportive public policy such as income, employment, housing, and service provision. Since its election in 1997, the New Labour government of the UK has developed and implemented policies for addressing inequalities in health by addressing broader determinants of health. More recently however, a recent spate of policy documents on the need for Britons to modify their health-related behaviours raise concerns these approaches may detract from action to address health determinants.

We examine UK governmental statements about health, the structure and activities of public health agencies, and the relationship of public health to other arms of government activity. By doing so, we ascertain the extent to which public health preoccupations reflect the emerging theory and research concerning the determinants of population health.

Public Health Concerns in the United Kingdom

The UK has a longstanding intellectual and academic concern with inequalities in health. In 1980 the Black Report revealed that despite a generation of accessible health care, class-related health inequalities had not only been maintained but in many instances had widened (Black & Smith, 1992). The report appeared at the onset of the conservative Thatcher era and its content and recommendations were ignored for two decades. Instead, numerous policies served to widen income and health inequalities. The election of the New Labour government in 1997 saw the ongoing academic and policy concern with health inequalities translated into a government-wide effort to address health inequalities through the development of public policy. Careful documentation and analysis of these efforts is now available. These reviews illustrate how evidence combined with the political will to address broader determinants of health can translate into effective policy development and action.

From the Black Report to the Acheson Inquiry into Health Inequalities

The 1980 *Black Report* and the 1992 *Health Divide* (Townsend, Davidson, & Whitehead, 1992) described how lowest employment-level groups showed a greater likelihood of suffering from a wide range of diseases and dying prematurely from illness or injury at every stage of the life cycle. Among various interpretations available, it was concluded that the material conditions under which people live their lives -- availability of income, working conditions, and quality of available food and housing, etc. -- were the primary determinants of these findings.

Upon the 1997 change in government, the Labour government commissioned the *Acheson Commission into Inequalities in Health*. The commission considered a wide range of evidence and concluded that:

The weight of scientific evidence supports a socioeconomic explanation of health inequalities. This traces the roots of ill health to such determinants as income, education and employment as well as to the material environment and lifestyle (Acheson, 1998).

It offered recommendations across a wide range of health determinants: poverty, income, tax and benefits; education; employment; housing and environment; mobility, transport and pollution; nutrition and agriculture policy; mothers, children, and families; young people and adults of working age; older people; ethnicity; gender; and the National Health Service. The most important were: a) all policies likely to have an impact on health should be evaluated in terms of their impact on health inequalities; b) high priority should be given to the health of families with children; and c) further steps should be taken to reduce income inequalities and improve the living standards of poor households.

Government Action Plans

The government responded quickly to these recommendations. Among the major policy initiatives was the document *Reducing Health Inequalities: An Action Report* (Department of Health, 1999). The action areas are contained in Box 1.

Box 1 Reducing Health Inequalities: The UK Agenda for Action

Upon election in 1997, the UK Labour Government organized a strategy based on nine themes. Specific policies are listed to illustrate its action approach.

- *Raising living standards and tackling low income* by introducing a minimum wage and a range of tax credits and increasing benefit levels;
- *Education and early years* by introducing policies to improve educational standards, creating 'Sure Start' - preschool services in disadvantaged areas, free to those on low incomes;
- *Employment* by creating a range of welfare to work schemes for different priority groups;
- *Transport and mobility* by setting targets to reduce road traffic accidents, develop safe walking and cycling routes, and standardize concessionary fares for older people;
- *Issues for the NHS* include working in partnership with local authorities to tackle the wider determinants of health, reviewing the resource allocation formula to local healthcare agencies, developing frameworks to standardize care across the country for particular conditions, and broadening the NHS's performance framework to include fair access and improving health;
- *Building healthy communities* by investing in a range of regeneration initiatives in disadvantaged areas, including Health Action Zones
- *Housing* by changing capital financial rules to promote investment in social housing and introducing special initiatives to tackle homelessness;
- *Reducing crime* by investing in range of community-led crime prevention schemes and tackling drug misuse;
- *Public health issues* - the first-ever Minister for Public Health oversaw a range of initiatives to encourage healthy lifestyles, strengthen the public health workforce and tackle specific problems such as fluoridation of water supplies.

Source: Adapted from Benzeval, M. (2002) England, Box 12.3, p. 207, in J. Mackenbach & M. Bakker (Eds.), *Reducing Inequalities in Health: European Perspectives*. London UK: Routledge.

There are aspects of the Agenda for Action and related documents such as Opportunity for All- Tackling Poverty and Social Exclusion (1999), A New Commitment to Neighbourhood Renewal: National Strategy Action Plan (2001) and From Vision to Reality (2001) that contrast with the public health situation in Canada and the USA (Department of Health, 2004b) . There is recognition that health inequalities are a cause for serious concern not only by health departments but also the entire government.

Goals were set for the elimination of health inequalities. The 2002 Spending Review Public Service Agreement – a kind of business plan -- for the Department of Health contained the goal of “By 2010 to reduce inequalities in health outcomes by 10% as measured by infant mortality and life expectancy at birth” (UK Government, 2002) These initiatives focused on a) tackling poverty and low income; b) improving educational and employment opportunities; c) rebuilding local communities; and d) supporting vulnerable individuals and families (Oliver & Nutbeam, 2003). To facilitate action, the government set up “cross-cutting spending reviews” focused on health inequalities to be used by a number of departments to inform spending plans for 2003-2006.

Reviews of these Initiatives

A 2003 evaluation concluded that significant progress had been made in tackling health inequalities (Exworthy, Stuart, Blane, & Marmot, 2003). Evidence concerning health inequalities had been gathered, health inequalities had been placed on the policy agenda, and a diverse range of activities developed. Indicators of outcomes and policy implementation were emerging though impacts upon health status were not yet apparent. The authors concluded: “Many challenges remain but the prospects for tackling inequalities are good (p.52).

A 2005 evaluation concludes the Labour government has taken seriously the issues of poverty and social exclusion (Hills & Stewart, 2005). Evaluations of these initiatives are positive, though effects modest. Success is apparent in reducing child poverty as a result of the government’s tax and benefit reforms. But while overall poverty rates have declined, rates for working aged adults without children had reached all-time high levels by 2002-2003. Their detailed analysis of initiatives, their effects and issues raised are presented as Table.1.

TABLE 1: RECOGNITION, TARGETS, POLICIES, IMPACTS AND GAPS IN SELECTED UK POLICY AREAS

	Recognition, targets and policies	Impacts	Problems and gaps
Child poverty	Prominent reduction target. Major tax benefit reforms benefiting low-income families with children.	Fall in relative child poverty 1996-97 to 2002-03 on or close to 2004-05 target. Falls in deprivation and higher child-related spending by parents.	Still above EU average. Long way to be "best in Europe". Adult elements of family benefits price-linked.
Working-age poverty	Policy focus on worklessness, not poverty in itself. Policies aimed at employment and income at work.	Fell against absolute line, but only slight fall in relative poverty, which has increased for those without children.	Despite fall in registered unemployment many remain without income from work and dependent on price-linked benefits.
Income inequality	Reduction in overall income inequality not an aim. Focus on relative poverty for selected groups and on life chances. Income inequality monitored at EU level.	Inequality not changed greatly since 1997. Gap between incomes at the very bottom and very top has grown a little, but the gap between those near the bottom and those in the middle or near the top has fallen a little.	Incomes and earnings at very top continue to increase fastest. Some at bottom left behind through price-linked benefits or lack of take up.
Employment	Clearest initial priority. Action through New Deals and 'active' policy towards unemployed.	Lowest unemployment for 30 years, but economic inactivity falling only slowly. Jobless households still high.	Initial impact of New Deals slowed. High unemployment remains for 16- to 17-year-olds.
Education	Blair stated three priorities for government: education, education and education. Targets for school attainment. Higher spending since low point of 1999.	Positive impacts at primary level, with poorest schools improving fastest. More mixed picture at secondary level.	Large social class differences remain. Tension between improvements for all and closing gaps.
Health inequalities	Unprecedented focus of analysis: Acheson report and follow-up. However, main thrust of policy is on overall health and NHS spending.	Too early to judge, but few attributable impacts yet visible. Time trends show little evidence of narrowing gaps.	Gap between analysis and implementation.
Political participation	Aspects of constitutional reform and parts of Social Exclusion Unit agenda for neighbourhood renewal. Participation requirements in nearly all policy areas. Targets for volunteering and confidence in institutions.	Formal political participation continues to decline. Better responsiveness of providers to participation. Positive evidence on quality of involvement, and better targeting on excluded groups.	Many low-income families feel they 'have no influence at all'. Achievements have not led to excitement about participation and involvement.

Adapted from *Policies Towards Poverty, Inequality and Exclusion since 1997* (2005). London: UK Rowntree Foundation. On line at <http://www.jrf.org.uk/knowledge/findings/socialpolicy/0015.asp>.

Brewer and Shephard (2004) reached similar conclusions in their analysis of Labour's welfare reform policy of "making work pay" (Brewer & Shepard, 2004). In 2004, there are 350,000 fewer children until 16 years in household where no adult works since 1997. Child poverty rates are on track to be at levels not seen since the early 1990's.

Against the Grain: Retreating to Individualized Lifestyle Approaches

Potential roadblocks to the continuation of these initiatives need to be considered. Two recent UK thrusts have the potential to divert attention from broader policy perspectives on health.

Securing good health for the entire population. In April 2003, consultant Derek Wanless provided an analysis of how to improve the health of citizens (Wanless, 2004). The most striking aspect of the 214 page report is its emphasis upon individual behaviours. The report is sprinkled with references to "wider social costs of particular behaviours" "individuals' poor lifestyles" and "pursuing healthy lifestyles and addictions." Positive changes will be assisted by providing information, marketing healthy lifestyle choices, and by National Health Service staff. Local health authorities, community organizations, and various members of the private sectors will be engaged. The case studies presented are focused on salt consumption, obesity, falls, and physical activity.

Of concern, the Wanless report reinforces the view that individuals are responsible for their own health "[W]hile understating or neglecting entirely the impact of government policies and wider social inequalities on health status (McDonald & Scott-Samuel, 2004)." A similar critique is offered by Burstow: "It fails to offer a clear view on the central question of the balance between personal responsibility and state intervention" (Burstow, 2004). Some see the report as a tentative step towards healthy public policy (Joffe & Mindell, 2004). However, Joffe and Mindell's focus on healthy public policy is limited to reducing behavioural risk factors by supporting individuals through taxation policy, food/agriculture policy and transportation. The devolution of responsibilities to Scotland and Wales means that the Wanless report does not cover these countries. However analysis of Scottish and Welsh health documents reveals a similar emphasis upon behavioural, lifestyle oriented approaches to promoting health. (See *Improving Health in Scotland* (Scottish Executive, 2004)– *The Challenge* and *Health Challenge Wales* (Welsh Assembly Government, 2004).

Choosing health. The government white paper takes an unambiguous view that individual lifestyle choices are primary determinants of health: "Health is inextricably linked to the way people live their lives and the opportunities available to choose health in the communities where they live (Department of Health, 2004a). p. 9). The 187 page report outlines how concepts of informed choice, personalization of health issues, and organizations working together can reduce the numbers of smokers, reduce obesity and improve diet and nutrition; increase exercise; encourage sensible drinking; improve sexual and

mental health. The health education focus is apparent with sections on marketing health; food labeling, information for the public, information for the media, and working in partnership with local organizations and the private sector. The National Health Service will provide Health Trainers and Personal Health Kits to assist individuals in changing their lifestyle choices.

Scott-Samuel states: “Consistent with the Government’s consumerist, market-driven agenda for the public sector, the White Paper enthusiastically espouses health education (supporting individuals in making informed health choices) and more hesitantly, health promotion (supporting healthy choices through healthy public policies) (Scott-Samuel, 2004).” The report shows little awareness of Labour’s need to address upstream origins of poor health related to material inequalities, excessive deference to the market in trade and services, and promoting egalitarian public policies.

Campbell points out that “While there is mention of health inequalities issues, the measures proposed to address these often assume that they can be tackled through improving access to health services and through changing behaviour and ‘choices’ on a market/consumer model” (Campbell, 2004). Similarly, “Nor does the individualistic choice-based analysis of health acknowledge the social and economic determinants of health.”

In summary, public health and health policy attention in the UK is directed to addressing inequalities in health. Compared to Canada, and the USA as examples, there is a strong public policy concern with addressing the basic determinants of health. It is difficult to avoid the conclusion that “Debate on policy to inform health inequalities is alive and well in the UK” (Oliver & Nutbeam, 2003)(p.286).

Understanding the UK Approach to the Determinants of Public Health

Approaches to public health are driven by dominant political ideologies within jurisdictions. Among health professionals, the dominant approach to promoting health is primarily biomedical and behavioural. Leaving the promotion of population health to health professionals – which occurs when government policymakers show little commitment to promoting equity in health outcomes – will allow prevailing epidemiological, class, and professional biases to dominate public discourse. If we allow the dominant perspectives of the professional health communities (i.e., medicine, nursing, nutritionists, health promoters, etc.) reinforced by the beliefs and paradigmatic views of the average health researcher and service worker to determine the health approach, attention to broader determinants of health will always take a back seat. In the UK we see that ideological commitments to health equity provide a fertile soil in which policy can be developed from empirical research findings concerning broader determinants of health. The extent to which this concern can be maintained and expanded remains an open question

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Section 2:
Rhetoric vs Reality
a) People or Politics

GENERATION INEQUALITIES

Priscilla Alderson

Inequalities between older and younger generations affect health and can amplify analyses of other types of inequality (for example, Hutton 2003 on class and state, Chua 2003 on ethnicity). One dimension of the 'war on terror', for instance, is war waged by states with older populations against states with younger ones. The following examples, although described briefly, illustrate the actual or potential impact of age/generation inequalities on physical and mental health and wellbeing.

Consideration of children's needs and rights are often dismissed or silenced by opposing them to women's needs and rights or by stressing adults' generous and often lavish and responsible care for certain children. (Related arguments were once employed to dismiss women's demands for equal rights with men.) While respecting the vital importance of women's and men's rights, and adults' care for children, this article suggests that people's rights need not necessarily be in opposition to each other and that greater equality between generations could benefit all age groups.

Prenatal politics

The embryo and fetus do not have legal rights, and prenatal politics are viewed here for their potential effects on life after birth. Young people are denigrated in various ways, including when they begin to explore and express their sexuality. The denigration includes many efforts to reduce 'teenage pregnancy' rates including among young women aged 18 +, instead of to listen to young people's views about their needs and problems, and possibly to respect the decisions of young adults to become parents. Babies born to women at the age of 18 or so, in contrast to those born to women over the age of 40, are more likely:

- to be conceived without the aid of IVF, which is associated with multiple births and their higher morbidity and mortality rates;
- to avoid inheriting certain abnormalities;
- to live nearer to, and receive support from, their extended family; and
- to enjoy extra decades of contact with their grandparents and parents.

Prenatal services that encourage expectations of 'the perfect baby' contribute to a changing ethos of parenthood, away from (sometimes resigned) acceptance of less than perfect children, and towards treating future children as commodities to be selected or rejected. Intentionally or inadvertently, multimillion pound prenatal screening services raise the threshold of acceptable 'normality', the level that the fetus is expected to reach in order to

deserve to be born into human society (Paul 1992). The potential effects on the health of inter-generational relationships of such rising expectations have not been investigated.

Genetics

There are inequalities between adult generations who make reproductive genetic choices and their future/potential children who carry the risks, for example, of pre-implantation genetic diagnosis, IVF, or termination of pregnancy (Alderson 2002). Genetic manipulation and 'therapy' usually involve beings in the first days or years of life and not adult volunteers. The main use of genomics, apart from offering adults preventive-health life-style options, is to offer them personal prenatal options. Collectively, the prenatal decisions made have comparable outcomes, whether they occur in democratic states or those with explicitly eugenic government policies (Paul 1992). In India and China, medical prenatal services that enable parents to select sons produce severe difficulties for subsequent generations. Proponents of life-prolonging genetic research tend to disregard the potentially disproportionate use of the planet's limited resources by extremely old people (Bailey 2005).

Economics

Social and physical advantages of earlier parenthood are undermined by many current policies. British young parents work the longest hours in Europe, pay among the highest rents and mortgages (that benefit older house owners who paid comparatively little for their homes), pay high costs for often poor quality childcare, and repay student loans, with interest, for fees imposed by decision-makers, many of whom enjoyed years of free higher education. Two-thirds of the nation's wealth now belong to the one third of the population aged over 50 years. Many young children live in overcrowded homes, whereas many elderly and less active people have spare rooms (Qvortrup 1992). Childhood poverty continues to rise; 54% of inner London children live in poverty (Hood 2004), involving poor housing, amenities, opportunities, education and diet, which all affect health, obesity and accident records (Wilkinson 1994).

The Treasury promotes borrowing and spending now, for future generations to pay for later. The cheap-to-build (how soon to deteriorate?) and expensive-to-run Private Finance Initiative (PFI) buildings will be paid for over the next 30 years (Pollock 2004) by our children and their children. And after 30 years, private companies will retain the assets. Thus future generations will have to pay many times over - for resources we will have used, rising running costs, accumulated interest, their own immediate and future needs and, possibly, extortionate legal fees if they try to extricate themselves from these debts. How will all these economic considerations affect their health and health care?

Education

Politicians repeatedly reduce education to children's potential earning power when they become adults – dismissing crucial health-promoting and non-economic aspects of education, childhood and life itself, and diminishing childhood into a prelude valued mainly for its potential adult economic success. To equate 'success' with earning power transfers blame and responsibility for the low salaries for essential work including child care away from employers and national policies and on to people who cannot or will not qualify for higher paid careers. This blame is funnelled down to school children, with threats and accusations that those who will inevitably 'fail' do so through their own choice and fault, not because society relies on high levels of 'failed' and low paid workers. Longitudinal cohort studies aggravate this culture of blame when they define 'low aspirations' as 'not planning to go to university', instead of respecting a wide range of types of employment and aspirations.

The very long hours worked by young people studying for school exams may affect their rising reported rates of anxiety, depression, self-harm, eating problems and drug dependence. Their hard work is rarely recognised or rewarded as work, or as essential preparation for their future employment on which retired generations will depend.

Fierce competition and threatened failure within and between schools in the market of league tables undermines inclusive tolerant harmonious relationships that help to reduce disaffection, bullying and mental ill health.

The government's plans to open schools for 50 hours a week, far exceeding European working hour regulations, are unlikely to be welcomed by the high numbers of children who report in surveys being unhappy at school, or the 40% who say that they never school toilets because they are too unpleasant (Barnes and Maddocks 2002), which is not conducive to children's health or learning.

Childcare is largely planned around parents' employment rather than children's wellbeing and rights. Alone in the United Kingdom, England does not have a Children's Rights Commissioner. OFSTED sets no minimum levels of natural lighting, space for vigorous play, or time spent outside in either schools and centres for young children, despite these facilities being crucial to their wellbeing.

The rapid rise in prescription rates of the medication Ritalin, for 'hyperactivity', has occurred during the period when playtimes have been cut, playgrounds and playing fields have been sold, maths and literacy hours and other government educational policies requiring children to sit still for long periods have been introduced, the numbers of children who walk to school have fallen, and schools have installed machines selling high calorie and high additive sweets and drinks. If Ritalin is an antidote to adult-induced disorders, it is an ironic twist to identify children's behaviour as the cause rather than the result of problems in schools.

Political debts

People aged under 18 are increasingly used as political footballs. Politicians can score points without losing votes when they promise 'zero tolerance' of the 'job culture' in schools and streets. Overtly or covertly, politicians incite older generations' anger and fear about youth, while young people carry the costs of social stigma, alienation and exclusion. The police collect records of crimes committed by young people but not of most crimes committed against them. In numerous ways, state agencies and the mass media promote unhealthy and inaccurate propaganda about children and young people who can seldom seek redress or publish their own views.

Debts accumulate through short-term expedience in domestic and foreign policies, which often initiate or exacerbate many problems, ranging from lack of housing, public transport and qualified health care practitioners, to unresolved conflicts and global injustices. Wars usually involve older generations sending younger ones (including parents of young children) into the 'theatres' of battle, increasingly in urban areas, where children are at still greater risk of being injured, killed, deprived of basic necessities, forced to migrate, and of learning hatreds that fuel future wars. Britain has no coherent policy for supporting the youngest casualties of war including those who seek asylum here. The untold future costs of all these political omissions and errors mount, while current politicians and industrialists reap the profits.

Ecological debt

Our pollution and destruction, for example, of rain forests, threatened species, the ozone layer, the polar ice cap threaten 'the planet' (Hillman 2004) or, in other words, younger and future generations. The use-now pay-later ethos is replacing ancient traditions of nurturing and replenishing the world's heritage for future inheritors. Current predictions about climate change and trans-global infections have unimaginable implications for future health and healthcare that urgently require planning and prevention. Reasons for the lack of attention to them despite this urgency need to be unravelled. Do they include entrenched beliefs about relative values and the excessive valuing of present adult generations over younger and future generations? Human rights are too often defined in civil and political terms that ignore vital economic and social rights and favour rich over poor (O'Keefe and Scott-Samuel 2002) – and also favour the old over the young, when young people cannot own property, or are denied respect for their views, autonomy and reputation. Inequalities of gender, 'race', class and (dis)ability are compounded by youth. Moreover, civil rights are mainly spatial concepts, defending ownership of property and person against intrusion. Generation inequalities, however, also have to be understood in temporal terms, to see how current adult generations are removing sometimes irreplaceable resources and opportunities from younger and future generations.

Childhood and deficit

It has become fashionable to perceive childhood as deficient (Alanen and Mayall 2002), and like the sick role a time of partial exclusion until 'adult' maturity and competence are attained. This view discounts children's considerable competencies and ignores the barriers and prejudices that corral them into partly ascribed and imposed dependencies through naïve faith in adults' benign wisdom. 'Childism' is so endemic and little recognised that there is not even a word for it like sexism or racism.

Other examples of detrimental effects on children's health and wellbeing include: the high incidence of severe child abuse and neglect; the courts' refusal to listen to young children's views in decisions about the family; children being the only remaining group without legal protection from assault; the 2004 Children Act that deprives children of important freedoms and privacies; their exclusion from public spaces they once enjoyed; privatised leisure amenities, often subsidised for older people but expensive for young people and families; the advertising, food, fashion and beauty industries, which bring complicated advantages and harms.

Talk of 'ending child poverty' is meaningless as long as British politicians refuse to define poverty, and children remain in relative poverty because they depend mainly on a fraction of their parents' income. This is not necessarily to suggest a 'young-age pension', but to point out the discrepancies between old age pensions and benefits versus far smaller state payments for children. Many pensioners have completed few years of paid employment, or none. The right to a pension *after* decades of contributing to society, whether or not as taxpayers, might be complemented by the same right *before* while preparing for those decades. That might strengthen obligations and loyalties between older and younger generations, and acknowledge that children and young people and their work are highly valued in our present and future society, with practical and symbolic advantages for their health and wellbeing. The effective redressing of generation inequalities will involve listening to children and young people and working with them in many new ways.

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THE RIGHT TO HEALTH: AFRICAN MIGRANT COMMUNITIES AND HIV IN THE UK

Livingstone Musoro & Eileen O'Keefe

Introduction

At the second People's Health Assembly meeting in Ecuador in July 2005 the global campaign for the Right to Health was launched. What does the right to health mean for people in the UK? The "right to health", distinct from the right to health care, is understood by reference to the social determinants of health. This paper illustrates the significance of the right to health by reference to black African migrant communities in the UK affected by HIV. Because of barriers upstream to their right to health, their access downstream to the right to health care is put at risk. Access to healthcare by HIV+ Africans in the UK is hampered by stigma, not least within their own communities. This is made worse by chronic fear amongst those whose immigration status within the UK is unresolved. Chronic fear reduces the ability of affected communities to prevent the onward spread of HIV within and beyond their immediate communities in the UK. Global labour force movements which deplete health systems capacity in source countries together with restricted availability of anti-retroviral drugs (AVRs) reduce the likelihood of getting treatment in those countries. African migrants are crucial to the health and social care workforce in the UK. This is in itself a right to health issue. This linked set of affairs means that African migrants in the UK affected by HIV have their right to health and health care impaired. This is so with respect to communities from sub-Saharan Africa who are at the sharp end of heterosexually transmitted HIV (O'Keefe, 2004). The right to health acts upstream, while the right to health care acts downstream. The Department of Health's recently produced framework for HIV and AIDS in the African communities stays stubbornly downstream and does not engage with upstream right to health issues (Department of Health, 2005)

The Right to Health

The right to health and not just health care was acknowledged with the Universal Declaration of Human Rights. It affirms everyone's right to a standard of living adequate for health. This explicitly includes food and housing as well as medical care. In taking the standard of living as the starting point, the Declaration highlights the social determinants of health. The International Covenant on Economic, Social and Cultural Rights provides the most comprehensive article on the right to health in international human rights law (Committee on Economic, Social and Cultural Rights, 2000). Article 12.1 of the Covenant, requires States parties to recognize "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health", while article 12.2 sets out a number of "steps to be taken by the States parties ... to achieve the full realization of this right". The notion of "the highest attainable standard of health" in article 12.1 takes into account both

the individual's biological and socio-economic conditions and a state's available resources. Article 12.2 acknowledges that the right to health embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life, and in so doing, extends to the underlying determinants of health. Several regional human rights instruments also recognize the right to health, such as the European Social Charter of 1961 (art. 11) and the African Charter on Human and Peoples' Rights of 1981 (art. 16). The right to health is closely related to and dependent upon the realization of other human rights, including access to information.

Much human rights practice in the UK emphasises the entitlements of individuals (O'Keefe and Scott-Samuel, 2002). Health and social care workers give special weight to supporting personal autonomy. They emphasize rights that service users have to the information they need to make informed choices about their health and to lead healthier lives. In other words, in the UK the focus is downstream. The right to health and the right to health care are connected. For instance, it is more difficult to access information rights about threats to health in the immediate environment which might lead people to seek appropriate and effective contact with health services, if social and economic factors result in fear about talking honestly about the risk of infection which currently prevails in that environment. Immigration procedures, experienced by Black African migrant communities, make it hard for them to disclose positive status within their own families and friendship networks. Immigration procedures make it hard for them to challenge the stigma they face.

Immigration

In a recent report, an independent panel of expert physicians pointed out that the UK government's decision to withdraw NHS services from failed asylum seekers and others of undetermined immigration status with an inability to pay for their care as a policy to deter 'health tourism' will add to the HIV epidemic because these individuals cannot control their infection without sufficient healthcare and social support (Gazzard et al, 2005). This could lead to costly onward transmission of HIV of around £0.5 to £1 million (per single transmission case) in terms of individual health losses and treatment costs (Department of Health, 2003). The Panel recommended that: (a) HIV be reclassified as a sexually transmitted disease that warrants free medical care irrespective of immigration status, and as a first cost-effective public health measure, the Government was urged to reconsider its position on withdrawing HIV treatment to failed asylum seekers and others of undetermined immigration status who do not have an ability to pay; (b) a statutory obligation be placed on the National Asylum Support Service to consider medical reports carefully prior to dispersal; (c) asylum seekers only be dispersed to areas that can provide sufficient care and services for their needs; and (d) Government reimburse Primary Care Trusts in a timely manner. The Panel also urged the Government to "create an environment of transparency and reassurance to encourage asylum seekers and others of undetermined immigration status to volunteer for testing.....this will not be an easy task as a poor command of

English, mistrust of authority and fear of deportation can combine to create an unproductive environment and missed diagnostic opportunities.” On 5 May 2005, the Law Lords held that the European Convention on Human Rights' prohibition on inhuman treatment does not prevent deportation of people with advanced HIV/AIDS who are dependent on the anti-retroviral treatment they receive in the UK, even if this means they will die for want of such treatment abroad (IRR, 2005). If they are sent back, service provision is unlikely to be available, not least because of the depletion of the health care labour force drained from impoverished countries. The skills drain benefits the UK health care system.

African migrant workers keeping the UK healthy

Workers from abroad are not an optional add-on in the modernising NHS which suffers from decades of cuts in capacity. As seen in the table below, health and medical services receive the highest proportion of migrant specialists.

The Main Occupational Groups of Those Granted Work Permits into the UK

Occupational Group	2000-2002	2002 alone
Health and medical services	24.1%	25.1%
Computer services	17.2%	14.1%
Administration, business and management services	12.7%	12.6%
Education and cultural activities	8.4%	9.2%
Financial services	8.0%	5.7%
Hospitality, hotels, catering and other services	6.9%	11.4%
Entertainment and leisure services	5.6%	5.0%

Source: Clarke and Salt, 2003.

Source countries for work permit holders have changed significantly over recent years. From 1995 to 1998 the Old Commonwealth countries, the United States and Japan accounted for at least 53% of applications in each year. Since then, there has been a significant increase in the number of permits issued to applicants from underdeveloped countries. There are nearly 30,000 African doctors and nurses registered to work in Britain who are filling vital gaps in the NHS. In Ghana, which has a population about a 1/3 that of the UK, there are 1,500 doctors for the whole country. Likewise, many Zimbabweans who migrate into the UK are key workers in education and healthcare (Bloch, 2005). WHO researchers found that while 340 nurses graduated in Zimbabwe between 1998-2000, 382 Zimbabwean nurses joined the UK register in 2001 (Stillwell et al, 2003). Ethical guidelines issued by the UK government in 1999 on recruitment from developing countries are not stemming the flow either to the public or the private sector. The private sector is especially reliant on this flow. “In London..two-thirds of social care staff are employed in the independent sector....[where they]...earn less than their local authority counterparts..” (Robinson, 2002).

The skills drain of health care workers from impoverished to wealthy countries has been identified as a “right to health” issue (Bueno de Mesquite and Gordon, 2005). The empirical evidence on the extent of skill drain and its impact on specific African countries have begun to be documented. Mensah and colleagues see this migration as “an aspect of rapid international integration and commercialisation of health service labour markets, in the context of high levels of inequality” (p.12) (Mensah et al, 2005).

HIV in the UK

There are about 53,000 cases of HIV in the UK, and the number diagnosed is rising by about 20% a year. According to the Health Protection Agency, 6,606 new infections were diagnosed in 2003 (Boseley, 2005). Between 1990-94 HIV transmissions acquired through sex between men accounted for 7362 while 3240 new infections were acquired through heterosexual contact. This pattern has been changing rapidly with heterosexual transmission now far outstripping transmission between men. Between 2000-2003 there were 5919 reported cases of HIV acquired through sex between men while there were 10257 cases from heterosexual exposure. More than 80% of those newly diagnosed with heterosexually transmitted HIV in the UK in 2001 were from migrant communities, largely from sub-Saharan Africa. These figures only include those known to the health services. Nicoll and Hammer assert, “HIV retains a remarkable ability to expose and exploit weaknesses in societies and healthcare systems, notably through affecting marginalised groups” (Nicholl and Hamers, 2002). Comparisons between white British and Black African people with HIV in the UK, both groups which have experienced stigma and discrimination, show that getting enough money to live on and immigration status are the most pressing concerns of the latter (Weatherburn et al, 2003). Difficulties regarding economic and social rights hamper Africans affected by HIV from promoting the exercise of family members and friends’ rights to information and decision-making about their health and well-being.

Does the Framework for African communities address the right to health?

The National Strategy for Sexual Health and HIV set out the framework for support for people affected by HIV and promotion of sexual health at national and local levels (Department of Health, 2001). It identified five major aims:

- Reducing transmission of HIV and sexually transmitted diseases with timed targets of 25% reduction of new infections by 2007;
- Reducing the prevalence of undiagnosed infections by setting a national standard for accessing an HIV test;
- Reducing rates of unintended pregnancy;
- Improving health and social care for those living with HIV;
- Reducing stigma linked with HIV and STIs.

The Strategy is to be carried out through mainstreaming HIV funding and giving PCTs responsibility for commissioning services. In light of the large prevalence, the dramatic increase of new infections and the high estimated numbers of undiagnosed cases of HIV amongst the African communities, the Department of Health took pains to highlight need for a prevention strategy for African communities deemed to be “at special risk”.

The much-delayed Department of Health framework for HIV and AIDS in African communities, finally published in 2005, fails to offer proposals on healthy public policy to counter the inequalities in living standards which it notes. It describes the arrangements for access to health care of migrants infected by HIV but makes no comment about the public health and right to health issues at stake. Indeed, its bland focus on guidance for local commissioners and service providers ensures that it does not engage with the wider determinants of health that are crucial to the right to health for these populations. Action on the social determinants of health would lead to reduction in the fear and want that makes it so difficult for marginalized communities to address the need to be open about threats to their sexual health.

An immigration policy which acknowledged the dire public health consequences of punitive responses to positive status would enable African communities to be more “fully engaged”. The greater the fear about the consequences of being open about their positive status, and the more they are preoccupied by worries about immigration, the more difficult it is to prevent further transmission amongst African adults and the more difficult it is for young people to make healthy choices as they become sexually active.

Conclusion

The right to health proscribes any discrimination in access to health care and underlying determinants of health, as well as to means and entitlements for their procurement, on the grounds of health status including HIV/AIDS. The disturbing economic and social conditions experienced by asylum seekers and other African migrants in the UK jeopardises the human right to health and the right to healthcare. We agree with Mensah and colleagues’ that “the net effect of some types of health professional migration... is a perverse subsidy: a net flow of benefits from poor to rich country health services. That perverse subsidy is indefensible, contributing as it does to worsening the huge inequality in health services between the UK and developing countries..... UK health service users benefit from the services of people who would otherwise be caring for African health needs, hence compensation should be paid to remove this perverse subsidy from poor to rich” (p.30 Mensah, op cit).

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DECODING *VALUING PEOPLE*: SOCIAL POLICY FOR PEOPLE WHO ARE LEARNING DISABLED¹

Mark Burton² and Carolyn Kagan

Introduction – the contradictions of *Valuing People*

Valuing People (2001), the English policy framework for learning disability (with similar frameworks in the other UK countries,) is a bold policy initiative that accelerates the transformation from institution based services towards a person centred approach that emphasises inclusion in society. Four key principles are at the heart of the proposals: *Legal and Civil Rights, Independence, Choice and Inclusion*.

Valuing People emerged from an increasing consensus that emphasised the common human status of all learning disabled people, and the imperative of ending their segregation and congregation, but it is also located firmly within the broad social policy of the Blair government and the market model that has swept in to health and social care over the past decade. These characteristics do not sit comfortably together and have exposed some fundamental flaws in *Valuing People* that can be related to an uneasy amalgam of unvoiced neoliberal assumptions and a romanticism about learning disabled people.

Some key issues: Individualism, romanticism and voluntarism versus Politics and Economy

The utopia painted by *Valuing People* sees people making choices about activities in pleasant neighbourhoods, usually suburbs, with plentiful community resources, including schools, post offices, churches, pubs, sports facilities. They are supported in this by their own staff, whom they employ, and who work to their specification. They are likely to be in work, and to have friendships and relationships, mostly with non-disabled people. Somewhere in all this there is the notion of independence. In many ways these utopias have been helpful. They have helped us see beyond the disability, beyond individualising and disabling understandings of people, their identities and needs. They can help us see people in terms of their connections with others, as actors, with rights to belong and participate with the rest of us. But the image could be criticised as follows.

Choice is elevated to a position above other goods. People's real difficulties in making choices that are in their interests and don't restrict the freedom of

¹ Based on a workshop presented at the UK Community Psychology Conference: Exeter October 2004

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others, are elided. Those that have such a profound intellectual impairment that they can't communicate are absent from the picture. The complex health needs of many (mentioned in *Valuing People's* section on health) and the need for knowledgeable and skilled specialists, is not emphasised here, perhaps because in the rush to de-professionalise the lives of people, to save people from restrictive definition as health problems, the productive and sensitive engagement of health workers is too difficult to describe. A kind of trick takes place where the least impaired people are used to stand for all the others (which reflects the higher profile of mildly disabled self advocates), but the life circumstances of those with lesser impairments are ignored. The social dimension becomes a series of individual encounters (and the reluctance of those from the mainstream to share their lives with the impaired, unless as work, is not mentioned), collectivist solutions to social need hardly feature (co-operatives, demonstrations, cycling clubs). Meanwhile the workers, the personal support assistants, are on short term, part time, or casual contracts, probably not unionised, and undoubtedly poorly paid.

Two things are going on here. On the one hand, social inclusion is seen in a rather restricted and individualistic way, not as an integral part of a society that values and supports all its members, but as a special case, typically in a mythical middle class community. On the other hand, there is a kind of romanticism about learning disabled people, so that both significant impairments, and the personal histories that produce human damage, are not so much denied as glossed over, making the real difficulties in enabling inclusion, autonomy, good health, meaningful activity, and acceptance appear insignificant. This means that the job of delivering an adequate system of supports, or of supporting individual people, is made to seem straightforward, and therefore not one that requires significant additional investment.

Yet this approach underestimates the real need illustrated by the fact that over one third of people with learning disabilities require intensive support and/or are unable to communicate their needs in normally accepted ways. This is not to deride the overall aim of inclusion, but the point is that if this is to happen, but there needs to be a realistic assessment of the level and types of supports that are needed and the long haul involved in such a social transformation that has to work against the grain of received disablist ideology, the legacy of discrimination, abuse, and continuing material (physical and social) disadvantage. Failure to do this will lead to cynicism and a return to negative expectations.

The emphasis on Person Centred Planning illustrates the individualism and romanticism that characterises *Valuing People*. Here the perfectly sound idea that arrangements should be built around the person, rather than the person fitted into services is elevated into a kind of strategy for service reform (see Mansell & Beadle-Brown, 2004).

Our suggestion is that the dominant individualism of the wider political and economic policy contexts exerts a powerful influence on the specific policy and practice content in this field. Yet it is interesting to see the person centred

planning idea being taken up in other fields (Department of Health, 2005; Ladyman, 2004; Leadbeater, 2004), as perhaps the new 'big idea' in the endless reform of public services.

Social development: the paradox of individualisation

In some areas *Valuing People* does try to set out a programme of planned social change that goes beyond the individualistic change recipe just criticised. It is from these areas that an idea of a more adequate approach can be gleaned.

Perhaps not surprisingly it is in the chapter on Health where a more adequate approach is set out, a simultaneous strategy of working on the health care systems to enable access to services provided with a decent level of appropriateness and effectiveness to learning disabled people, together with improved co-ordination at the individual level. Here we have a system of health services that is still, despite many knocks, founded on a social model of collective and universal provision. Unlike in the case of Person Centred Planning where 'there is no such thing as society' to engage with in creating a meaningful and adequate context for inclusion, in the case of the section on *Improving health for people with learning disabilities* a different vision is sketched out that links action at the individual level with action at the level of health and other systems - because here **there is such a thing as society** - it has been created through the struggle to establish, reproduce and defend the National Health Service, to identify population needs and respond to them, not just through exhortations to individuals to lead healthy lives, but through proper social programmes that tackle inequalities and other causes of ill health. What we have here are the building blocks of a social approach to the simultaneous support and liberation of people who are learning disabled. What would be the community and societal level strategies to complement person centred approaches, just as the health inclusion agenda complements Health Action Planning? It is in some ways difficult to imagine in a society so fragmented and anti-collectivist in form. It is doubtful if there can be a learning disability-specific approach here, but rather there needs to be an integrated approach to social policy that has at its core the building of local communities and their local economies, with democratic local governance and a focus on culture rather than consumption - a different kind of utopian vision, but one that would be more in tune with the social inclusion agenda that *Valuing People* aspires to.

Such an approach would moreover need to be properly resourced. Instead the new Learning Disability Development Fund (set up to support *Valuing People*) merely recycled money withdrawn from resettlement dowries on the death of the resettled person - money that most local services thought had been transferred in perpetuity to build up the new generation of community provision.

Individual control and the consumer model: Direct payments

An interesting aspect of the contradictions of *Valuing People* can be found in the emphasis on Direct Payments (Department of Health, 2003, 2004)

By giving individuals money in lieu of social care services people have greater choice and control over their lives, and are able to make their own decisions about how their care is delivered.

(Department of Health, 2004)

To some extent direct payments were a result of the struggle of physically disabled people for control over the supports they needed. As Spandler notes (2004) there is considerable and persuasive evidence for the benefits that direct payments bring: including increased personal autonomy, emotional wellbeing, and better social opportunities (Holman & Bewley, 1999; Stainton & Boyce, 2002), but at the same time they imply the use of a poorly paid and non-unionised labour force, without the regulatory requirements (e.g. training, safety) that apply to the formalised sector. At least some of the burden of administration and management is shifted to the people who receive direct payments, or their family carers. Every time a direct payment is made, it is in effect at the expense of the infrastructure of support services, typically those in the public sector, and this piecemeal process can mean a failure to develop an effective system of social supports (O'Brien, 2001). Yet Stephen Ladyman, previously community care minister (quoted in *The Guardian*, 9 November 2004), called for a radical shift in the provision of social care with nearly all staff employed by private companies or working directly for one or more individuals.

It is unfortunate that the routine practices of so many services have been so bureaucratic and insensitive that the only response seems to be a consumerist model, but little sustained attempt has actually been made to put the people using the service in the driving seat of properly funded public services. Instead the model of consumer choice in a marketised system has been allowed to emerge as the hegemonic model of how to empower disabled people. What is needed here is an approach that combines collective responsibility, participative governance, drawing on both experiments in deliberative democracy (Abers, 2000; Fung & Olin Wright, 2003) and on critical systems methods (Midgley, 2000) with choice and control at the individual level. A necessary part of this would be to allow the services provided by local government to be selected as providers within DP schemes (not allowed under the current rigged market). Such a balanced system approach where user control is empowered at all system levels and not just that of individual consumer choice, could lead to a new co-operative approach between people whether in roles of citizen, worker or user (cf. Carpenter, 1994). Ultimately an approach like this would serve as a stronger safeguard in times of turbulence and scarcity to which disabled people are particularly vulnerable, than the neoliberal recipe of empowerment as consumers individually spending public money.

Work: romanticism and the labour market

Like direct payments, the sections of *Valuing People* that focus on work and employment are connected to policy initiatives that go beyond learning disability. The New Deal relates to a number of social groups; the long term unemployed, lone mothers and disabled people. While the rhetoric in *Valuing*

People is all about the right of learning disabled people to be employed, the policy emphasis is almost entirely on 'supply side' measures rather than on the 'demand side' measures that have been successful in increasing access to employment, for example in other European countries. So while the talk appears at first to be informed by a social model of disability, with its emphasis on removing barriers, the practice is on adapting disabled people to the few openings that there are. These features are likely to be further exacerbated in the specific case of learning disabled people. If Grover and Stewart's (1999) emphasis on the role of social policy to support the capital accumulation strategy of the state is accepted, then the argument would be that the increased participation of disabled people (including those who are learning disabled) is intended to a) reduce benefit costs, and hence taxes, and b) maintain a downward pressure on wage levels. While at the individual level, getting a proper paid job is of real importance, the aspirations of those working in the system to enable this to happen (well) for a significant number of learning disabled people may be frustrated, since the political and economic underpinnings are not neutral.

Moreover, those people who depend most on formal services will not be working, despite the availability of behavioural technology. To think otherwise is again to deny the level of impairments and to fall into the romantic trap discussed above.

Human Rights

As we saw above, *Valuing People* is based on four key principles: *Legal and Civil Rights, Independence, Choice, and Inclusion* (Department of Health, 2001 pp 30-31). There is nothing particularly wrong with these aspirations in themselves, but the selection of these and not others is interesting. The passage on legal and civil rights emphasises freedom from discrimination and the right to vote, but it says nothing about collective participation or political mobilisation.

This language of rights is persuasive, until an alternative viewpoint is presented. Díaz-Polenco (2003) among others (e.g. Pollis & Schwab, 1979) observes that the increasingly dominant model of human rights prioritises individual market choices and the option of casting a vote for one of several pro-capitalist parties, at the expense of rights to health and well being, education, political, civic and cultural participation.

In *Valuing People* the notions of what people need, and of what their rights are, have perhaps become distorted by this neoliberal shift in thinking. Nevertheless, there are glimpses of a more adequate approach. This is no less than the construction of a society that truly includes and values all its members, a society founded on both values and practices of social solidarity, a society that can only exist if the powers of privilege and capital are controlled. Do we have to wait for Person Centred Planning, Employment, and Direct Payments to fail to deliver real change, real belonging, and real respect, before we start the real work of collective social transformation to make a society that does a real job of valuing learning disabled people?

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A STRATEGY FOR SEXUAL HEALTH IN THE UK

Lisa Power

The UK has the worst sexual health in Western Europe, and the situation is continuing to deteriorate despite a clear knowledge of how it could be improved, and despite examples from nearby nations showing how it could be better managed. The primary reason for this is a lack of political will at many levels, despite strong commitment by some individuals to sexual health.

Since 1999, the UK incidence of HIV has risen by more than 10% every year, and currently more than a quarter of UK people with HIV are unaware of their serostatus. (Health Protection Agency (HPA)). Sexually transmitted infections (STIs) are also at their highest levels since records began. (HPA). Yet public and political attention focuses mainly on the demonisation of particular groups and issues related to HIV. Migrants with HIV have been used by some politicians and pressure groups as a focus for more general prejudice about immigration and asylum. A small number of high profile prosecutions for transmission of HIV under England's nineteenth century assault laws have refuelled old media myths about marauding HIV "serial transmitters" and generated further prejudice against migrants.

Despite acknowledgement by some Ministers that there is no evidence to support its effectiveness, the UK Government has repeatedly failed to state that it will rule out harsher health-screening requirements, including HIV testing, for some people applying to enter the UK. Such measures might quieten public fears and demonstrate apparent Government action on HIV (and have been used for this by other Governments), but they are unlikely to have much effect on the progress and costs of the HIV epidemic in the UK.

In a 2003 report, (Coker, 2003) Richard Coker questioned the effectiveness of screening in identifying people with HIV and raised doubts about its usefulness in achieving public health objectives. A Terence Higgins Trust (THT) investigation of health screening in Canada revealed that HIV screening had not been cost-effective, and that Conservative politicians there condemned the scheme as a failure. Aside from the practical issues, the ethical dilemmas associated with compulsory testing are many. For example, what is the definition of confidentiality within the context of compulsory screening?

To further assuage public fears about immigrants and the pressure they supposedly place on public health services, the UK Government recently limited free access to acute care in the NHS to emergency-only care for visitors, illegal residents and failed asylum seekers. While other transmissible diseases such as tuberculosis (TB) and STIs are excluded from these regulations on public health grounds, HIV is not. This is despite such treatment reducing HIV infectivity, and despite the fact that free treatment for

TB will not work for people coinfecting with HIV unless they are treated simultaneously,

Already, THT has seen pregnant women refused treatment to prevent them passing HIV to their unborn child, and people coinfecting with TB and HIV fleeing mid-course from their TB treatment because of HIV related bills. The British Association of Sexual Health & HIV (a specialist clinician body not known for a radical agenda) has condemned the change, as have the Royal College of Nursing and the Joint Council for the Welfare of Immigrants. A recent Parliamentary Health Select Committee investigation found that the regulation change was neither humane nor cost effective, while also being damaging to public health. And yet the Government's immediate response was to refuse to reconsider. Being seen to be "doing something" about illegal immigrants was a greater priority than public health or the public purse.

Critics would counter that screening for HIV and associated service restrictions are necessary to stem the tide of people whose main motivation for coming to the UK is to seek health treatment for this disease. However, data from a survey of recent arrivals to England with HIV, undertaken by the Terrence Higgins Trust, (THT,2003) showed that three-quarters of people learned of their HIV status more than nine months after entry to the UK, and over half were not diagnosed until they became unwell.

Most immigrants that we see at Terrence Higgins Trust come to the UK, not to exploit the healthcare system, but as refugees from countries in turmoil, to join family in the UK, to study or to work. In fact, the Government relaxed entry regulations in 2003 in a bid to attract highly skilled migrants to fill gaps in the UK workforce, including the NHS. As a result, there have been many welcome new arrivals from countries such as South Africa and Zimbabwe (both countries which have high HIV prevalence) and from Russia, China, Nigeria, and India (all countries with serious and fast growing HIV epidemics). Is the Government asking them to bring their skills but leave their health problems at home?

Similarly, great play has recently been made by police and the media of a small number of prosecutions of people with HIV who have passed the virus on. Proposals to prosecute for the reckless (i.e. unintentional) transmission of HIV were firmly rejected by a Home Office White Paper on Violence in 1998. Yet recently, the Crown Prosecution Service and police forces have begun to pursue such prosecutions under existing laws of grievous bodily harm (GBH) without regard to the harm that may do to public health. While a small number of people are being prosecuted, with sensationalist headlines about "AIDS killers" and "biological GBH", many more people with HIV are learning not to admit to needing help in maintaining safer sex, and to conceal sexual activity from their clinicians. People who believe they are HIV negative are lulled into a false sense of security by police pronouncements that "this means that all people with HIV will have to tell you before they have sex" and, worse, into a false sense that somehow safer sex is no longer their responsibility too. Not one specialist sexual health or HIV organisation supports the prosecution of

reckless transmission, and yet no Government Department or Minister has moved to take the situation in hand.

The reality is that these high-profile measures contribute little, if anything, to the health or the sexual wellbeing of the UK. We know what would decrease transmission of HIV and STIs, and yet as a nation we repeatedly fail to prioritise such action.

There are a small number of quite simple steps which, if taken and appropriately backed by central Government and the NHS, would begin to roll back the tide of sexual ill health, which is swamping the UK. Most of them do not cost a vast amount of money. All of them are cost-effective even where they do. All that is needed is focus and political will.

Firstly, decent and universal relationships and sex education should be a core part of the national curriculum, giving every person who grows up in the UK the basic tools to understand sex and sexual health, and to make their own choices. Good sex education delays age of first intercourse and reduces number of partners, so there is no political excuse for refusing to implement this on the grounds of morality.

Secondly, there need to be effective and focussed campaigns targeting communities at greatest risk of sexual ill health and HIV transmission, alongside a general national information campaign about the issues. Again, we know that greater understanding of the dangers of unprotected sex reduces onward transmission of STIs and HIV, as well as unintended pregnancy. We also have a better understanding of the evidence base for what works in health promotion than ever before; incorporating that and the use of needs assessment more widely into commissioning could improve effectiveness greatly.

The third plank is modernisation of sexual health services. The Government is well aware of this and has allocated funds to implement their Sexual Health Strategy. However, much of these special funds have been gradually syphoned off into the general budgets of primary-care trusts in order to pay for higher priority areas of work. (Kingdom et al, 2003/4). We know that without ring-fencing, monitoring or clear targets for sexual health, local health bodies will shy away from prioritising sexual health.

Workload in GUM clinics has doubled since 1997 and the waiting times for diagnosis and treatment have in themselves become a further spur to onward transmission. These waits for basic sexual health checks—four to six weeks in some areas—are caused far less by floods of treatment tourists than by primary-care trusts' chronic neglect of GUM services. Community based clinics, easier access, faster throughput and use of modern technology all have a part to play to combat this.

The final plank in an effective strategy would be to tackle the stigma and ignorance which continues to exist around HIV and sexual health, and to insist

that future policies on them be evidence-based rather than prejudice-based. THT has begun to work on this by asking all candidates in the recent General Election to sign up to a pledge not to perpetuate HIV-related discrimination and we will be working with the seventy signatories who were elected to drive forward challenges to prejudice.

The growing epidemics of HIV and sexual ill health in the UK are a tragedy, albeit a much smaller one than that of Africa or Asia. They are a tragedy because we have the knowledge and the skills to stop them growing and to reduce them. But as long as sexual health is not a local NHS priority, and as long as the Government of the UK allows politically populist measures to those that are proven to reduce onward transmission, the UK will continue to suffer unintended and unnecessarily poor sexual health.

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HOW DOES LITERACY AFFECT HEALTH? – A CASE STUDY

Elsbeth Hosie and Kate Burton

Introduction

'There is no one obvious reason why poor literacy per se should be associated with poorer health, but far more adults with poor literacy experience poverty and social disadvantage throughout their lifetime in comparison with adults who have good literacy'. (Bynner, 1999)

It is estimated that 23% of the Scottish population have difficulty in reading, writing and using everyday maths. Whilst an additional 31% need information to be expressed in clear simple terms (Scottish Executive, 2000). People with low literacy and numeracy skills are more likely to experience poverty, unemployment and poor health. In addition low literacy levels affect people's ability to function at work and in society in general (Department for Education, 1999). This article explores the impact that low levels of literacy and numeracy skills have on health and illustrates how this issue might be tackled locally through the example of the Literacy and Health Project, a project taking place in Northwest Edinburgh Local Healthcare Co-operative (NWEHCC), which started in 2003.

Literacy Links to Health

The links between low literacy skills and health inequalities have been well documented, for example Bynner and Parsons (Bynner and Parsons, 1977) questioned 17,000 people born in 1958 in England and Wales on their literacy, numeracy, health, mental outlook and jobs. Significant differences were evident, in mental health and health related practices, between those with higher and lower literacy levels. More recent data has shown that those with low levels of literacy and numeracy skills are, at age 26, four times more likely to report poor general health than those with the highest levels of literacy and numeracy attainment and there is a similar inverse relationship between literacy and numeracy skills and depression (Acheson, 1988). This association has been confirmed by Canadian research, which looked at both self-reported and objective indicators and found that 'low literacy levels have a major negative impact on health'. Current available evidence suggests (Scottish Executive, op cit) that around 800,000 adults in Scotland have very low literacy and numeracy skills, and there are three factors which are strongly associated with a low level of these skills:

- Having left education at 16 or earlier
- Being on a low income
- Being in a manual social class group

Other factors include:

- Living in an economically disadvantaged area
- Being over the age of 55
- Having a health problem or disability affecting learning, speech, sight or hearing
- Gender – women performed less well than men on numeracy tasks

Literacy is not just about being able to read, write and count. It affects the ability to seek, understand and assimilate information and instructions and the ability to relate and apply new information. It affects self confidence and self-esteem which underpin individual's willingness to question, discuss, and where necessary, challenge information particularly from those in positions of authority. A study in Ireland found that patients reported painful associations and feelings of shame and fear caused by their low literacy levels added an extra burden on top of their illness (National Adult Literacy Agency, 2002).

Within the Health Service it is not standard procedure for health practitioners to read through written information such as consent forms, instructions for medication or information leaflets with patients. However, when it is considered that 1 in 4 adults in Scotland struggle with reading basic information and another quarter need information set out in simple, clear English, it is recognised that much written health information is not fully comprehensible for a large sector of the population. For example, only half of 44 sets of information leaflets in England and Wales on abortion were of 'standard readability' jeopardising the ability of 'most women... to make an informed decision about abortion method.' (Wong et al, 2002). Patients' embarrassment when asked to fill in forms, difficulties posed by consent forms and appointment slips and confusion caused by medical terminology, hospital signage and complex information leaflets - are all factors found by patients to restrict participation in their health care. (Wong, op cit; Scottish Executive, 2003; Perrin, 1998)

Literacy Links to Health

Direct effect on health	Indirect effects on health
<p>People with limited literacy skills may find it difficult to:</p> <ul style="list-style-type: none"> • Understand and use health information such as instructions for medication, food labels and safety warnings • Access services which support their health needs • Keep appointments • Find their way through the complicated health system • Interact with health care providers • Seek appropriate medical attention. While some people with limited literacy skills may use health services more frequently, others often wait until the health problem reaches crisis point. 	<p>People with limited literacy skills are more likely to live in poverty, and may:</p> <ul style="list-style-type: none"> • Lack access to good food • Live in low quality housing • Work in unsafe environments • Experience isolation and social exclusion • Encounter high stress in daily living and suffer from low self-esteem • Experience more barriers to healthy living, such as being active, healthy eating and not smoking • Experience barriers to healthy living, affecting development in childhood and adolescence.

Scottish Response

In response to the low adult literacy and numeracy levels in Scotland the Scottish Executive in 2000 appointed an Adult Literacy Team with a remit “to provide a focus for the development of national policy and strategy on adult literacy and numeracy”. In 2001 the Adult Literacy and Numeracy in Scotland Report (Scottish Executive, 2000) was launched, this sets out a national strategy, recognising that ‘the raising of adult literacy and numeracy levels is acutely important to the wide variety of Scottish Executive policies that promote social justice, health, economic development and lifelong learning’. The report defines literacy and numeracy as:

‘The ability to read, write and use numeracy, to handle information, to express ideas and opinions, to make decisions and solve problems, as family members, workers, citizens and lifelong learners.’

This approach recognises that literacy and numeracy are not discrete skills but rather rooted in different contexts of people’s lives, such as workplaces, schools and doctors’ surgeries. The provision of literacy and numeracy learning opportunities aims to develop people’s ability to perform effectively in the various situations they meet, building on their existing knowledge and

skills and developing the understanding, confidence and self esteem to engage with the different contexts they meet in their daily lives.

An initial £24m over 3 years was invested in a national programme to assist 80,000 people develop their literacy and numeracy skills, set up a national training framework, and provide a free, quality literacy and numeracy service, at least doubling the existing capacity. The funding is administered through local Community Learning Partnerships to ensure a multi-sectoral approach. Learning Connections at Communities Scotland is responsible for supporting the implementation of this policy and for the development of a quality service.

NWELHCC Health and Literacy Project

In response to the Scottish report the Edinburgh Community Learning Partnership allocated funding to establish a Health and Literacy Project in Primary Care. This project was established in Northwest Edinburgh Local Healthcare Co-operative (NWELHCC) in 2003.

NWELHCC is responsible for providing high quality healthcare to the population of Northwest Edinburgh within available resources in addition to improving the health of the population and addressing health inequalities. NW LHCC is the largest in the Lothian Primary Care Trust area, with a population of just under 140,000. It covers a geographically wide and diverse area, from the rural communities around Kirkliston, Ratho and South Queensferry, to the city-centre areas stretching from Cramond and Corstorphine through Muirhouse, Pilton and Granton to Stockbridge and Canonmills. Included are areas of relative affluence, as well as areas of significant deprivation and health inequality, particularly in the North Edinburgh Social Inclusion Partnership (SIP).

The aims of the Health and Literacy Project are:

- To raise awareness of literacy difficulties and the problems these pose for people trying to access health care
- To highlight issues of effective communication within health settings
- To work with individual learners and small groups referred by health professionals
- To work alongside health professionals offering literacy support in health promotion and health education programmes.

The project works alongside health visitors, midwives, GPs, CPNs, learning disability teams and anyone who has close enough contact with patients or clients to recognise that they may benefit from some literacy support. A literacy referral system has been developed so that anyone in NWELHCC can refer a client to the project. As staff become more aware of this service, and become more confident about raising the subject of literacy with clients, referrals are increasing and coming from a wider range of health workers.

The project works with:

- **Individual learners** – it is important that new learners feel comfortable and that they say what it is they want to learn and how they want to do it. For some learners this means one-to-one support, sometimes starting in their own homes. For example, a pregnant woman had difficulty understanding all the written information given to her at antenatal visits. Once her midwife picked up on this and asked if she would like some help with her reading, she worked with a tutor, finding out more about her stage of pregnancy and how she could prepare for her baby. By focusing on her individual interests and working at her own pace, the mother understood more about her health care and felt more able to make decisions about childbirth and caring for her baby. It was all very relevant to her situation, so her motivation to learn was high. After the birth of her baby, she continues her literacy work, looking at child development and possible future career opportunities for herself. The initial referral from her midwife, and the intensive one-to-one support from the health and literacy project, has helped to break her cycle of exclusion.
- **Learning groups** – working alongside other people with similar interests is well recognised as a positive learning experience. The project is currently working with a range of groups, offering literacy support to those in the group who would like it, so that everyone is able to take a full part in activities. These groups include, cooking, healthy eating, driving theory and getting ready for college. Participating in these groups, increases confidence, helps address health inequalities and reduces isolation as well as improving communication and literacy skills.
- **Raising awareness** – The project has been involved in a NHS Lothian Health Inequalities Seminar and at a recent NWELHCC wide Protected Learning Time event, ran two workshops on effective communication and using forum theatre to highlight literacy issues within primary care settings. Participants had the opportunity to explore alternative approaches to communicating with patients effectively so ensuring their health needs could be met.

If you would like to more about literacy links to health, please contact elspeth@clanedinburgh.org or jo@clanedinburgh.org at the Health and Literacy Project Pennywell Resource Centre, Pennywell Road, Edinburgh, EH4 4PJ. Telephone 0131 537 4230

Conclusion

This article has explored the impact that low literacy levels have on health. It provides a starting point for further discussion on how to improve health through improving literacy and numeracy skills, and demonstrates why this is an important issue to be taken forward by NHS Lothian given its current commitment to tackling health inequalities and health improvement.

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THE HEALTH AND HEALTH CARE NEEDS OF LESBIAN, GAY, BISEXUAL AND TRANSGENDER PEOPLE

Julie Fish

Rhetoric and (the absence of) policy in the health of lesbian, gay, bisexual and transgender people

Since its election in 1997, New Labour has demonstrated its commitment to tackling health inequalities through a range of policy initiatives. The link between the social, political, cultural and economic disadvantage in people's life circumstances and poor health outcomes has been targeted through a number of health strategies. Yet, despite the particular relevance of a social and political model of health, lesbians, gay men, bisexuals and transgendered people (LGBT) are completely overlooked in health policy documents. In its rhetoric about current flagship policies - *Creating a Patient-led NHS* (2005) and *Choosing Health* (2004) - the government has pledged its commitment to sustaining an ethos of fairness and equity and to the achievement of good health for everyone. Furthermore, it is committed to providing information and practical support to improve emotional wellbeing and access to services. However, these goals are impossible to achieve for LGBT people when they are not even recognised as users of health services. Their opportunity for the fundamental human right of good health is thereby curtailed.

Addressing institutional heterosexism

The history of LGBT health has not been benign; being LGB was considered a mental disorder until 1974 and it was not until 1993 that homosexuality was removed from the International Classification of Diseases. Although being transgendered does not constitute a mental disorder under the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), in order to gain access to sex reassignment surgery, transgendered people must meet its criteria. Moreover, a plethora of legislation has perpetuated the characterisation of LGBT as sick people, most notably Section 28 of the Local Government Act, repealed in 2003, which specifically linked homosexuality with disease. These discriminatory attitudes are reflected in the practices of some health care professionals. Some doctors continue to state publicly that LGBT are deviant, sick or abnormal and a number fail to extend the ethos of high quality non-judgmental care to LGBT patients. There is also some evidence that doctors allow their views to influence their professional relationships. Consultants have refused to have nurses or junior doctors on their team because they were believed to be a lesbian or gay man and LGBT doctors fear that their career would be jeopardised if their sexual orientation became known. A recent report by the British Medical Association (British Medical Association, 2005) found that while 76% of LGBT doctors thought it was important to be

'out' at work, only 39% had disclosed to close work colleagues. If doctors, who are in relatively powerful positions in health care hierarchies are reluctant to 'come out', it is likely that users of services will remain closeted; this will have consequences for the care they receive.

Conducting research to reduce health and social inequalities

In order to improve the health of LGBT people and reduce health and social inequalities, policy makers need access to comprehensive research. Studies among LGBT populations in the UK have largely been undertaken without governmental support or finance. A systematic review of LGBT health research in MEDLINE, the largest health database, found that only 0.1% of research articles related to LGBT populations (Boehmer, 2002). Conducting research among LGBT populations presents a number of challenges, not least because they are a dispersed and hidden population. Moreover, most population-based surveys do not routinely collect data about sexual identity. Some researchers have been reluctant to include questions out of fear that heterosexual respondents would be alienated by them, others define LGBT issues as marginal to the health concerns of the population as a whole. By failing to include LGBT people in their studies, researchers are perpetuating health inequalities. These gaps in the evidence base mean that there are insufficient data to influence health policy and inform relevant health education for LGBT people.

Researchers and policy makers are often unclear about the socio-demographic characteristics of LGBT communities. Contrary to popular stereotypes of a young, upwardly mobile homogenous group with large disposable incomes, LGBT people are as diverse as the heterosexual population. They vary by age, 'race' and ethnicity, education, income, employment and disability; they include prisoners, asylum seekers, homeless people and people in poverty. They are also assumed to be too small a population to be worthy of study; however, a recent population-based study found that approximately 5 percent of both men and women reported same-sex relationships (Johnson et al, 2001). Improved research techniques have encouraged disclosure; for women, this represented a three-fold increase in reporting same-sex behaviour over a ten year period.

Identifying the physical, social and mental health needs of LGBT communities

Notwithstanding these provisos, a growing body of research suggests that LGBT people experience significant health inequalities. Despite their similar experiences of heterosexist oppression, social conditions impact upon LGBT health in different ways. LGBT health needs include cancer, mental health, eating disorders, suicide and self harm, problem drinking and substance misuse, sexual health and HIV, homophobic bullying in schools, physical attack and harassment, domestic violence and parenting. This brief overview identifies some of the salient issues for LGBT and seeks to indicate the heterogeneity of their health concerns.

Lesbians may have specific health risks including an increased susceptibility for breast cancer, polycystic ovarian syndrome and cardio-vascular disease. Lesbians' risk factors for breast cancer include: a reduced likelihood of having children; in addition, they have an increased likelihood of delaying childbirth, alcohol consumption and being overweight. Lesbians have reported higher rates of breast cancer than heterosexual women. Furthermore, lesbians are typically assumed to be at low risk for cervical cancer. The risk for cervical abnormalities may differ depending upon number of partners, sexual frequency, and particular behaviours in which women have engaged. There is also some evidence to suggest that lesbians who have never had sex with men have developed cervical abnormalities. In addition to sexual behaviour, tobacco use may contribute to lesbians' risk for cervical cancer because studies have shown that they are more likely to smoke than heterosexual women.

Increasing trends in suicide among young men have become a public health priority, but young gay men are not recognised as being at particular risk. Studies have shown that young gay and bisexual men may be up to seven times more likely to attempt suicide than their heterosexual counterparts. In a recent study conducted on behalf of Mind (King et al, 2003), lesbians and gay men reported more psychological distress than heterosexuals despite similar levels of social support and quality of physical health. Confusion about the open expression of their sexual identity in society has led a number of lesbian and bisexual women to consider self harm; bisexual women are the most likely to have done so. Bisexual men were more likely to have recently used recreational drugs and bisexual women were more likely to recount negative reactions from mental health professionals when being open about their sexual identity.

The experience of social and political marginalisation places many transgendered people at risk of depression, suicide and self harm and alcohol abuse. Discrimination against transgendered people has included the refusal of care such as smear tests, breaches of their confidentiality and the practice of placing transsexual women who have completed sex-reassignment surgery on male wards. One US study found that male to female (MTF) transsexuals have the highest rate of HIV infection of any risk group.

While the incidence of HIV is increasing among gay men in the UK, there has not been a corresponding increase in resources dedicated to them. In the early stages of HIV health promotion, the use of condoms was encouraged for all instances of anal intercourse between men. Current advice recognises that HIV transmission can be reduced if men have unprotected anal intercourse (UAI) only with partners of the same HIV status. There has thus been a shift from condom use at all times to condom use for sero-discordant UAI - where one partner is HIV negative and one is HIV positive. The numbers of men reporting unprotected anal intercourse has increased and knowledge of their current HIV status is therefore key to making decisions about UAI; testing for non-clinical purposes is needed if men are to know their HIV status. Yet

uptake of testing among gay men is not high: community samples suggest that up to 50 per cent of gay men have never been tested and few gay men discuss safer sex with their GP.

For the past two decades, research has suggested that gay men are at greater risk for eating disorders when compared to both heterosexual men and lesbians. Gay men are more likely to engage in recurrent binge eating and purging; but while they share similar levels of body dissatisfaction to heterosexual women, there are also key differences. Rather than being solely concerned with body weight, gay men's body dissatisfaction is related to both the composition and appearance of their bodies (Yelland and Tiggemann, 2003). Some gay men also believe that increased muscularity can offer protection from physical attack. Given the continued incidence of homophobia-fuelled hate crimes this belief may be based on fears or experiences of violent attack.

Violence against lesbians and gay men has only recently become the focus of public policy following the introduction of the Crime and Disorder Act 1998 and the publication in 2000 of guidelines by the Association of Chief Police Officers to identify and combat homophobic crime. Homophobic crime is recognised as having a devastating effect on the quality of life of its victims and can be particularly difficult to come to terms with. Prior to the introduction of the legislation, there had been no systematic recording of homophobic hate crimes in the UK. A national survey documented a high prevalence of homophobic incidents: 67% of men and 64% of women reported being a victim (Wake et al, 1999). The most common incidents were verbal abuse, threats and intimidation and physical assault, but they also included sexual assault and rape, arson and blackmail.

Addressing the barriers to health care for LGBT communities

Improving the accessibility and appropriateness of mainstream health services presents a considerable challenge to the NHS. Findings from international studies have revealed two main issues, which act as barriers to LGBT access to health care. First, there is a lack of knowledge and understanding due to insufficient training and information about LGBT health needs. LGBT people have been refused care and their symptoms have been misdiagnosed. Not surprisingly, LGBT have been found to be less satisfied with the care they have received than their heterosexual counterparts. Second, heterosexist assumptions act as a deterrent to LGBT self-disclosure: recent media reports have drawn attention to the reluctance of LGBT patients to reveal their sexual identities to their doctor because they are afraid of a hostile reaction. These issues mean that LGBT people use health services less frequently or less effectively than they might otherwise do. For example, a UK national study found that lesbians were less likely to attend for smear tests, less likely to practise regular breast self-examination and more likely to report bad experiences of health care than heterosexual women in similar studies (Fish and Anthony, in press).

Strategies for the development of inclusive health policy

Devolution has had a positive impact for the health of LGBT in Scotland where the NHS has taken a lead in commissioning research and instituting an agenda for change (Pringle, 2003). The initiative has led to an audit of current provision of LGBT targeted services, the establishment of demonstration projects and the sharing of innovative practice. A number of other initiatives are underway in other parts of the UK to complement this work: health and social care needs assessments are being undertaken in a number of cities to identify local issues and to target the effective delivery of services. What is lacking, however, is the inclusion of LGBT health concerns in public health strategy. Experience in the US has demonstrated that inclusion in *Healthy People 2010* – the federal government's health policy – is needed for LGBT health to be taken seriously. Without equal access to health care and equal consideration of their health needs, health equity cannot be achieved for LGBT people in the UK.

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ENSURING ACCESS TO NHS CARE FOR ASYLUM SEEKERS

Sally Hargreaves, Judith Cook, Jane Shenton and Hermela Chassme

There has been considerable discussion around how best to provide for the health care of asylum seekers and refugees in the UK (Burnett and Peel, 2001; BMA, 2003). Although in recent years statutory services have developed considerably in order to respond to the various needs of this group, needs remain and there has been criticism over recent government policies towards this group (Mayor of London, 2004; Refugee Council, 2004). Medical professionals have increasingly voiced their concerns that it is the asylum process itself that impinges detrimentally on the mental and physical health of this group and their ability to access appropriate health care (Burnett and Peel; BMA op cit).

In April 2004 Médecins Sans Frontières (MSF) carried out an assessment into the impact of one such policy - Section 55 of the Nationality, Immigration and Asylum Act 2002 – which allows for the denial of state support (benefits and accommodation) to asylum seekers judged to be late in lodging their initial asylum claim. In February 2004, the GLA stated that Section 55 was causing unprecedented hardship among a particularly vulnerable group, and “forcing up to 10,000 asylum seekers a year into destitution” (Mayor of London, op cit). In the absence of any information on the health impact of this, we assessed the ability of asylum seeking groups affected by Section 55 to access health care and thus the impact that Section 55 was having on their health and wellbeing.

MSF conducted a number of comprehensive medical assessments at the request of the Refugee Council in Brixton, London, which was struggling to engage enough GPs in the area for this purpose. These medical assessments were undertaken to accompany the request of asylum seekers, made destitute under Section 55, for reconsideration for accommodation and subsistence support by the authorities.

46 medical assessments were done in total (20 men; 26 women; average age 32 years). A range of nationalities presented to the service, the majority of whom had little or no English and required an interpreter. Most (33) said they were completely alone in the UK. While only 5 of 46 reported having slept in the street, doorsteps or parks in the past week, most had only precarious shelter – the floors of churches or mosques, of a stranger they had met, or a friend or relative. Most said that they were reliant on food from community centres, the Refugee Council, friends and relatives, and from begging.

42 of 46 individuals reported traumatic experiences in their country of origin. These included imprisonment, rape, threats of rape, beatings, or witnessing

the killing of family members. Such horrific stories appeared to us to go against the stated purpose of Section 55 as targeting individuals not making genuine asylum claims.

Destitution was clearly detrimental to the health of the individuals we saw. All reported a deterioration in health since arrival in the UK –including mental health problems and complaints related to stress, poor diet and poor sleeping conditions. Five had symptoms of post traumatic stress. 21 of 46 reported that they felt depressed, of whom 11 had considered self harm and two had made suicide attempts since being in the UK. Individuals told the MSF doctor that they felt afraid of being on the streets, especially the women, and angry at having to beg. Many said they felt hopeless.

Despite the fact that all of these individuals are entitled to full NHS care during the time that they claim asylum, only one had registered with a GP as a permanent patient, although 21 of 46 had seen a GP at some point (either a one-off visit, or when in emergency accommodation). Our medical assessments determined that 32 of 46 required referral to a GP. One required referral to A&E, and four required referral to other secondary services. 15 needed referral to the Bicultural Team of mental health workers at the Refugee Council, three of whom were likely to need assessment by the Medical Foundation for the Care of Victims of Torture. These referrals were facilitated with support from the Refugee Council's Health Access Advisor. Almost half the individuals (22) required help to fill out an HC1/HC2 form for free prescriptions.

Clearly this group needed considerable support in accessing health-care services. When asked about problems they had previously faced in getting a GP, 11 of 34 who responded said they were told by a GP that they couldn't register because they had no permanent address. Other replies included not understanding the system and how to get a GP, and being told by a GP that the surgery was full. One GP stated that the individual was not entitled to free primary care.

These experiences are consistent with a recent survey from the Refugee Council, which found that of 130 organisations consulted, 62.1% reported that they saw clients who had difficulty accessing primary care services. In addition, 66% reported seeing clients with health problems as a result of being made destitute as a result of Section 55 legislation (Refugee Council, op cit). This group is known to have specific health needs which are exacerbated by poverty and poor access to services (Burnett and Peel; BMA ; op cit).

It appears that the Section 55 policy is on its way out. As a result of a Court of Appeal ruling in June this year, which found that the human rights of three destitute asylum seekers had been breached (Article 3, European Convention on Human Rights), the UK Government has been forced to change its policy on section 55, so that it operates more humanely. While the Government has indicated that it intends to challenge this ruling in the House of Lords, basic levels of support are for the moment being reinstated. This has led to a drop in

numbers of individuals made destitute under Section 55 presenting to the service in Brixton.

However, we remain concerned about the impact of recent government initiatives to restrict access to free NHS care for 'overseas visitors', which specifically include failed asylum seekers, individuals who are refused political asylum (Department of Health, 2003). How best to deal with this group is currently much debated in the UK as the general election approaches, forming a particular focus of the UK Government's controversial 5-year immigration strategy announced earlier this year (HM Government, 2005). As of April, 2004, NHS hospitals are obliged to withdraw all free secondary health care (except in cases that are deemed immediately necessary or life threatening) to failed asylum seekers presenting to services (Department of Health, op cit). While treatment of certain infectious diseases will remain free, HIV/AIDS care is not exempt, so is now chargeable. In addition, proposals now under discussion (Department of Health, 2004) seek to withdraw access to free primary health-care services for this group.

Based on our experiences above, and of previous work with failed asylum seekers specifically (MSF, 2004) we are concerned that these changes will have a detrimental effect on the health of failed asylum seekers and their ability to seek appropriate medical care, as many will be unable to pay. Decision making as to who is and who isn't entitled runs the risk of being arbitrary and may impact on migrants such as asylum seekers and refugees, who may already face barriers to care but who are fully entitled to use services (Hargreaves et al, 2005). We recommend that the potential impact of any such policies on the health and medical needs of vulnerable migrant groups should be explored and assessed before any future legislative changes are considered.

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Rhetoric vs Reality

b) The Health Care Sector

THE NHS AS PART OF GLOBAL HEALTH

Sunanda Ray

A Global Health Watch is essential at this time to protect the health of the poorest people in the world, to ensure their equitable access to health care. The questions health activists have to consider are:

- How can the vision of healthcare as a right survive the global move towards market driven health services?
- How can international links be used to support health services for poorer communities, rather than propping up systems for elites in cities? True exchange should not mean transfer of market principles from rich to poor.

From the perspective of the NHS in Britain, the first point is that the NHS must publicly acknowledge the debt it owes to developing countries from which it draws its skilled labour. The people in those countries deserve compensation for this loss of human resources. In addition, black and minority ethnic [BME] people within Britain are worthy of recognition for the contribution they have made to keeping the NHS afloat since the 50s, instead of being made to feel second class. Finally, health workers in the NHS must see themselves as part of an interdependent world, where communication and cooperation is crucial to respond to the dangers we face collectively in the face of diseases like SARS and avian flu, as well as the impact of climate change on the movement of so-called tropical diseases such as malaria, cholera and dysentery.

The very nature of a market economy in health care means that labour moves from poor areas to rich ones as skilled professionals seek to better themselves and their families. In many African countries declining national incomes and investment in essential services mean that professionals find it harder to get their kids educated to levels where they can compete in international job markets. Conditions of work within their own health services become more frustrating with drug and equipment shortages. Morale drops as it becomes harder to get job satisfaction from seeing patients get better. The HIV epidemic makes all of this harder. Modern communications technology means that professionals are able to access information about work in rich countries more quickly, apply for vacancies on-line and move out. So, although these professionals themselves may not be poor, it is true that increasing poverty in Africa encourages migration.

The briefing from Save the Children Fund and Medact, *Whose charity? Africa's aid to the NHS* (SCF 2005) demonstrates how African countries are effectively bailing out the NHS in Britain as it faces financial difficulties while trying to provide quality care and meet targets (Coombes 2005). Ghana is one country. The NHS receives similar aid from other countries in the region such as Malawi, Zimbabwe and South Africa. Meanwhile, governments do not dare bring in taxation levels needed to pay the real cost of health care for ageing populations, increased availability of high technology interventions, high cost

drugs, and higher public expectations. Meanwhile, legal migrants contribute \$4.5billion more in taxes in Britain than they consume in services (New Internationalist 2005)

Inequalities in health

<p>In Britain</p> <ul style="list-style-type: none"> • 1 child in every 150 dies before the age of 5 • Average per capita spend on health is £927 	<p>In Ghana</p> <ul style="list-style-type: none"> • 1 child in 10 dies before the age of 5 • Average per capita spend on health is £6 <p>...but</p>
<ul style="list-style-type: none"> • Britain has saved £ 65 million in training costs by recruiting Ghanaian doctors since 1998 • By 2008 will need 25 000 more doctors and 250 000 more nurses than 1997 	<ul style="list-style-type: none"> • Ghana has lost £35 million of its training investment in health professionals

Save the Children/Med Act June2005

Developing country health services are also markets, so need a level of advancement to maintain these, at least for the urban elite. Evidence of the market are that drugs and equipment often cost more in real and relative terms in poor countries, because deals cannot be done with companies on bulk purchasing and so on.

The following examples show how drugs costs even in middle income countries can cripple health services:

“The South Korean government is again on a collision course with the medical profession after it enforced restrictive prescribing practices on doctors in a bid to cut a \$3bn (£2bn) debt.” *BMJ 2001*

“Czech medical goods distributors have stopped delivering to several hospitals because of the hospitals’ mounting debts...The Association of Large Distributors is refusing to continue regular deliveries of drugs and other supplies to six hospitals that together owe its members £6.6m...Czech Association of Doctors, blamed the artificially high price of drugs for the crisis” *BMJ 2002*

The beneficiaries of the profits of these drug companies are mainly in rich countries such as Britain. Most countries in Africa do not have the infrastructure to manufacture medicines from scratch. Health activism is essential to draw attention to the impact of drug company profits on healthcare for poor people, but also need to be alert to industry using activism as an excuse to withdraw funding from public interest projects such as the search for vaccines for HIV, malaria and so on.

Many of the solutions proposed for compensating developing countries for brain drain are market solutions based on “trickle down”. In India and the Philippines, there are schemes for supporting training institutions so that more professionals are trained to compensate for those who continue to leave. International links between medical schools support educational exchanges and visiting lectureships. Many of these are short-term and mainly benefit the elite populations in cities. Medical tourism whereby patients travel to India or South Africa for surgery to avoid waiting lists or for cosmetic surgery is already successful but cannot form the basis for a country’s health service. For the hospitals concerned, quality standards are improved, surgeons are motivated to stay because of higher income and employment is created for others. Most of these benefits stay predominantly within the private sector. The question we have to keep asking is how these schemes benefit the poorest communities in labour-donor countries. Simply investing in training for medical schools will not address inequitable access to health care. In many African countries with thriving medical schools in the 1980s there were difficulties in persuading health personnel to work in rural areas even though this was where the greatest need lay. Many took up training in health professions as a way to better themselves and their families, to provide secure incomes and futures for their children. For health professionals to focus on areas of deprivation they need considerable motivation, rewards and incentives to compensate for loss of earning in the private sector.

Many in Britain justify recruitment of health workers from developing countries by the hard currency they earn that is sent home as remittances. Again this benefits individual families but is not usually reinvested in health services. Health workers who attend for professional training return to their country of origin better trained and able to contribute, but may then be too specialised to work in rural areas. They tend also to replicate the systems from specialised training and may focus on medical technology that is not affordable for the majority.

For international links to adequately contribute towards health care programmes for developing countries that donate health professionals to Britain, compensation and restitution schemes must emphasise as a principle benefit for poorer communities rather than the rich. This needs an active learning approach that recognises the contribution of all parties involved in the exchange. Research in NHS settings can be extended to support health systems in developing countries but must support of principles of equity of access. Joint ownership and projects between NHS institutions and health services for poorer communities can genuinely support skills transfer and knowledge share between health workers. Diaspora colleagues working in Britain provide a resource that should be included in the dialogue, supported to be part of the solution, especially in training and mentoring. Some of this networking is already taking place through BME associations in the NHS, working through community partnerships and university links. In return, NHS staff who have spent sabbaticals in developing countries have improved their practical skills and knowledge, taken on more critical problem solving approaches to management, and give higher value to the principles of the

NHS. In particular they witness nurse-led systems that are only just developing in Britain, and experience working examples of multidisciplinary approaches to health care, with patient participation and community facilitation.

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EVOLUTION OF INDEPENDENT SECTOR TREATMENT CENTRES AND THEIR IMPACT ON THE NHS

Sally Ruane

Initially a response to concerns about capacity constraints within the NHS and public dissatisfaction with waiting times, Diagnostic and Treatment Centres (DTCs) are now seen by government as an element of competition essential for more efficient NHS trusts. They were announced as policy in *The NHS Plan* of July 2000 (Cm 4818). They were described as part of a programme of capital investment which, in partnership with the private sector, would reshape services to increase the numbers of elective operations since they would focus exclusively on short stay or day case elective surgery, unhindered by the vicissitudes of emergency care (Cm 4818:44). Initially, 20 DTCs were to be set up, 8 fully operational by the end of 2004 and treating around 200,000 patients per year. They reappeared in *Delivering the NHS Plan* (DH, 2002a) as part of the government's 'choices for patients' and 'plurality and diversity' agenda. Specific mention was made of private sector DTCs, contracted competitively by the Department of Health to offer 'free' surgery to NHS patients. By January 2005, the function of DTCs was to 'spearhead diversity and choice', provide extra capacity to reduce waiting times, to 'stimulate innovative models of service delivery and drive up productivity' (DH, 2005:3). Eighty were envisaged for December 2005, forming a vital plank in the government's ambition to give every patient a choice among four or five providers by that date. Thirty four of these are expected to be owned and run by the independent sector.

Although NHS consultants feared this development would lead to deskilling, there are strong clinical arguments in favour of the delivery of cold surgery and related procedures under a more specialised and focused 'Fordist' approach. The policy's consequences under consideration in this piece relate to the mode of its implementation, specifically the privileges afforded to private providers. DTCs have been described as 'diagnosis' or 'diagnostic' and treatment centres; some centres are now referred to merely as 'treatment centres' and independent units can be referred to as ITCs (independent treatment centres) or ISTCs (independent sector treatment centres) or IS schemes. In this piece, DTCs shall be taken to refer to centres regardless of ownership; ITCs shall refer to private or independent centres.

The initiative is adapted from models of provision found elsewhere, such as the US 'Surgi Centres' and relates to the NHS in England. The centres, which can be based within existing facilities, in a separate fixed geographical location or as mobile clinics travelling between hospitals, are characterised by exclusive focus upon day case or short stay scheduled care and relatively low risk cases. They specialise in types of surgery that have historically experienced the highest waiting times: notably cataract removal and hip and

knee replacements. The first NHS unit was being piloted at the Central Middlesex Hospital in 1999. In 2003, around 45 NHS DTCs were open or planned and were expected to offer 150,000 extra operations per year by 2005 (DH, 2003). At the same time, around 25 IS centres - 11 local schemes and 8 chains - were envisaged to offer over 100,000 operations per year by the same 2005 target (DH, 2003:2) in a £2 billion initiative. The first ITCs were fully operational by October 2004; all preferred bidders were based overseas, emphasising the Department's determination to ensure these independent units add to capacity.

The Department of Health claims the DTCs have already had a substantial impact. By January 2005, some 106,000 patients had been treated in NHS DTCs and around 16,000 had been treated in ISTCs mostly for cataract removal (DH, 2005:6). NHS waiting lists had declined between April 2003 and October 2004 by 144,000, whilst the numbers of those waiting 6 months or more had dropped by 126,000 (DH, 2005:7). Waiting times for cataract surgery have reduced to three months; whilst the traditional NHS providers are performing on average 5 cataract procedures a day, private mobile clinics can do 39. Similarly, Ravenscourt Park NHS DTC reduced hip replacement waiting times from 204 days (2002) to 30 days (2003) (Ward, 2004). Moreover, substantial reductions in lengths of stay are evident in some units such as the Sheffield Orthopaedic Centre, which has designed a new hip and knee replacement care pathways to achieve a patient stay of 5 rather than the previous 12-14 days.

Despite their apparently shared purpose, NHS-run units must be distinguished from IS-owned centres in order to understand the implications of this policy. This is because of the operation of the reformed financial flows within the NHS (DH, 2002b), which provides for payment by results and, connected to this, the imposition of a market framework in which the commissioning bodies, Primary Care Trusts (PCTs) are obliged from April 2005 to purchase health care from a range of providers.

This comparatively recent commitment to diversity for NHS patients and a belief in the value of individualised choice within the NHS appear skewed towards the private sector. The new market in healthcare - far more radical than the 'internal' market operating during John Major's term in office (1991-1997) - requires PCTs to contract for health care with a variety of providers, including local and non-local NHS hospitals, Foundation Trusts, and public and private sector DTCs. Procedures are in time to attract a standard tariff to ensure that competition is based upon quality not price and where a provider 'underperforms' - i.e. fails to deliver the anticipated number of procedures, money is withdrawn by the PCT. Providers who offer health care above the tariff cost will lose money; those who can provide at below tariff cost will for the first time not be required to return surpluses to a central pool but will be able to retain and reinvest them. Thus any provider which underperforms or which is unable to attract sufficient custom from purchasers faces a major threat to its survival.

Within this framework, the ITCs potentially pose a major threat to the continuing viability of some NHS services and in some respects independent schemes enjoy contrived market advantages. First, early disclosures confirmed that the prices paid for ITC procedures are significantly higher than those stipulated by the NHS tariff scheme and this was justified as necessary given market entry costs and the salaries of staff being brought in from abroad (DH, 2002c:6; Carvel, 2003; see also Sturcke, 2004). Although the Department believes ITC contract prices will conform to NHS tariffs in the medium to long term, it is not clear when this will be.

Second, some contracts are negotiated at a national level by the Department of Health and *guarantee* a given provider a certain income and volume of activity or share of the market typically over a five year period. The Department stipulates (DH, 2002c:5) that PCTs will be responsible for ensuring that this commissioned activity is used and paid for. While some contracts are negotiated nationally but have to be paid for locally, squeezing local NHS budgets, others are paid for nationally and PCTs can use them locally at nil cost to themselves. In this context, the pressure on PCTs to utilise this 'free good' rather than commissioning care from local NHS providers is enormous given budget pressures. One newspaper report claimed that GPs had been offered incentives to refer patients to private companies. Allegedly, health officials were planning to offer GPs extra cash to encourage patients to choose a particular private treatment centre - Care UK Afrox because the Department of Health had agreed a £98m 5-year contract for more than 5,000 operations. The cash incentive came in the form of the Department paying for the treatment rather than the local PCT. Most patients had opted to go to the local NHS hospital and many patients could not go to the hip and knee replacement unit because there were no back up facilities in the event of complications. GPs were said to be furious at this 'unethical' pressure (Revill and Hinsliff, 2005). Other quality problems have emerged, such as the infamous £90 million contract with Alliance Medical for 120,000 MRI scans which is centrally funded (Ward, 2004).

Third, the preference given by the government to the private sector can also be seen in decisions to transfer work away from NHS units to ITCs even where there are no waiting list problems. Unison reported in 2003 that up to 50% of Oxford Eye Hospital's cataract work was to be transferred to a national chain of ITCs at a cost of £1-2 million lost revenue out of a total turnover of £5 million, despite its beacon status for achievement in cataract surgery (Unison, 2003). The retired chairman disclosed that SW Oxfordshire PCT was refused the right to withdraw from a cataract surgery contract when it realised the contract would seriously damage the viability of Oxford's eye hospital. He claimed that the PCT had been bullied into signing the contract by Thames Valley Strategic Health Authority who were themselves coming under heavy pressure from the Department (Carvel, 2005a).

According to Ward (2004), some NHS DTCs are in danger of collapsing since the extent of government use of private centres has left NHS DTCs with spare capacity. In fact, the original Middlesex pilot unit could itself be under threat

since it is performing several thousand procedures fewer than it has capacity for and its income does not at present cover its overheads. And Ravenscourt Park Hospital, set up at a cost of £14 million in 2002, is predicted to incur losses of £37 million by 2010 because of high running costs and low numbers of referred patients (with only 35% of its beds required) as a result of cash shortages at local PCTs (Mulholland, 2005). Another treatment centre is in deficit to the tune of £9m. Indeed, the extra capacity created by the DTCs is such that funding shortages could now usurp capacity as the chief cause of treatment delays (Ward, 2004). NHS Elect, set up to represent them, warns that if NHS DTCs lose out over next 3 years or so, they will probably have to withdraw from the market (Ward, 2004).

The way in which the policy has been unfolding has met with strong protest from key interest groups. In a *Health Service Journal* survey of PCT and hospital trust chief executives, 73% believed ITCs represented poor value for money; 37% claimed the scheme was enforced by bullying from the Department; and 79% that their organisations were being required to take fewer patients or forgo expected growth to make room for the anticipated expansion of the private sector (HSJ, 2005). Overall, chief executives believed the requirement to contract 'up to 15%' of elective surgery from ITCs jeopardised NHS services and risked destabilising the local health economy. Some NHS wards are closing as a result. The 'prescriptive' nature of this policy gives the lie to the government's claim to be devolving decision making to the local NHS. The BMA has adopted a critical policy stance, claiming that ITCs diminish continuity of care and divert public funds from services to private profits (BMA, 2004). Instead, NHS capacity should be extended. The NHS Confederation (2005) has expressed increasingly strong reservations about the policy's implementation, specifically, that centralised decision-making has sometimes located ITCs where they are not needed and is undermining the local NHS because of the consequent removal of large amounts of elective work from NHS hospitals.

Despite evidence that, given funding constraints, some extra private sector capacity appears to have been unnecessary and that the use of ITCs has undermined the efforts of planners and led to wasted resources, the new Secretary of State for Health has reaffirmed earlier announcements that the role of ITCs is to be doubled. This second round of contracting raises the ITC contribution to 11% of elective surgery for NHS patients (Carvel, 2005b) by 2008. The Department of Health has said the aim is to create 'a sustainable independent sector provider market which can offer innovation, increased capacity and compete with the existing NHS providers' (Hencke and Carvel, 2005). A departmental spokesman has admitted that this is not about capacity, it is about patient choice in a vibrant market and this now appears as an ideological smokescreen for the deepening privatisation of the NHS.

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GATS, PRIVATISATION AND HEALTH¹

Sarah Sexton

Introduction

I've been asked to talk about the World Trade Organisation's international agreement on services (other agreements cover goods or products) – the General Agreement on Trade in Services – and its connections to privatisation of health care services in the countries of the North.

Most of what I have learnt in the past few years is based on the work of many colleagues around the world in the areas of health, international trade policy, and privatisation.¹ What I have done is just to try to understand it -- the GATS agreement is simple but complex and without legal precedent -- and bring their various knowledges together. I put together a briefing paper, *Trading Health Care Away? GATS, Public Services and Privatisation*,² from which (and drawing on subsequent developments) I will today make four points:

1. A public service -- that is, one provided and/or paid for out of the public purse -- need not be privatised or sold off for it to come under GATS rules.
2. GATS is just one of several mechanisms to liberalise public services and services in general; it's not the only one. We need to consider GATS in the context of all these mechanisms, not in isolation from them.
3. The liberalisation of *other* services -- not health care or medical services -- may have a grave impact on health care services.
4. GATS is not at present significantly affecting health care services -- but it has a serious potential to affect people's health, the determinants of health: what keeps us away from using health care services.

The UK and the National Health Service

The UK is a good example of these points. Its National Health Service (NHS) was established in 1948 when the government introduced various health and welfare reforms in response to working class agitation and mobilisation -- a health system seemed a better option than a Russian Revolution.³

The UK's health service is paid for out of general taxation -- there isn't a particular tax for health or social insurance as in Germany or The Netherlands. Even the *Financial Times* newspaper, a supporter of free-market economics, considers general taxation to be the most economical, the most

¹ This article is based on a presentation given at an international congress "Service Without Borders? Privatisation, GATS and the Consequences for Women", organised by the Attac Women's Network and held in Cologne, Germany from 9-11 May 2003. See also The Corner House: <http://www.thecornerhouse.org.uk>

efficient, the least bureaucratic and even the fairest way to fund the bulk of health care.

The services the NHS provides have been free at the point of delivery and provided on the basis of need -- are you sick? -- not on the basis of ability to pay -- have you got the money?

The NHS employs 1.2 million people, making it the UK's largest single employer and the world's third largest employer.⁴ "People", however, is, depending on your perspective, a gender-neutral word or a masculine-assuming word (the people are understood to be men) or a women-hiding word (most of the "people" are in fact women). ("Refugees" is another such word: by far the majority of the world's refugees are women and children.)

The NHS is the biggest single employer of women in Europe.⁵ Six out of 10 health workers are women; 8 in 10 non-medical staff are women -- and non-medical staff account for more than one million 'people' working in the NHS. Some 87% of nurses (and allied health professionals) are women, while 86% of administrative and clerical staff.⁶ One quarter of NHS workers have dependent children.⁷

And what proportion of the top jobs in the NHS are held by women? Less than 20% of those in charge of hospital trusts are women. What about medical staff? Less than one-third of doctors are women. Women are perceived as good at running the community, mental health and disability units, while men handle the acute medicine and teaching jobs better.⁸ Women do the cleaning and the laundry -- the lowest paying jobs.⁹

One quarter of doctors and nurses working in the NHS qualified outside of Britain in countries such as Spain, Scandinavia, the Philippines, Australia, New Zealand, China or South Africa. Nelson Mandela has appealed to Britain to stop "leaching" his country's health workers. (People moving from one country to another to provide a service is a key issue in GATS and a pertinent one for health services.¹⁰)

Women come into contact with the health service far more than men do, as they often seek care not only for themselves but also for their children, relatives and the elderly.

UK Privatisation and the "Privatisation" of the NHS

The NHS has been held up for decades as a model to be emulated around the world. Despite being underfunded and overworked, particularly over the last two decades, it still provides high-quality health care to most of the people in Britain more cheaply and more efficiently than almost any other medical system in the world (according to the Organisation for Economic Cooperation and Development, OECD).

But now it is the mechanisms for dismantling it as a public service that are being exported around the world.

The UK in general is a model of privatisation.¹¹ Over the past two decades and more, various public entities and services – telephones, water, gas, electricity and railways – have been outrightly sold off:

But selling off the NHS? That would be politically unacceptable, especially given the general popularity of the NHS and its entrenched public nature.

Instead, successive governments have taken the back-door approach. Just like structural adjustment programmes in the countries of the South, the process has been called "reform" and "modernisation" (many of those working within the NHS believe that reform is needed, but have a different interpretation of what is needed) rather than commercialisation or privatisation. The process seems ad hoc, fragmented, gradual and covert.

A first step has simply been to undermine confidence in public services by ensuring that there is unrelenting criticism in the media of the NHS. Other steps have been to:

- require the NHS to contract out its services, particularly support services such as cleaning, catering, laundry, administration and laboratory analysis, to private firms rather than to provide them themselves. The NHS pays for these services, but no longer provides them.
- separate the buildings from the service provided in them, and bring in the private sector to build and/or run the buildings. The UK government's Private Finance Initiative (PFI) has been the main mechanism for this.¹² If the process can be called a "public-private partnership" or PPP, that's even better and politically more acceptable, because the term suggests a public dimension to the arrangement rather than one that is controlled by private interests.
- introduce internal markets: separating the purchaser of the health service (a general practitioner sending a patient to a hospital for a scan or specialist check up) from the provider of the health service (the hospital).
- introduce commercial accounting systems and private financing. As David Hall of the Public Services International Research Unit points out, "The introduction of business accounting ... may be a change as significant as that of private ownership itself".¹³
- allocate resources on the basis of an individual patient's health *risks* rather than a population's health *needs*.
- introduce user charges and private insurance.¹⁴

The UK is now embarking on a system in which taxpayers, via public money, pay for the provision of health care, but it is the private, for-profit¹⁵ sector that owns and manages the infrastructure and operates the services. Nearly half of all UK tax revenue now goes to profit-making companies.¹⁶

What have been the impacts of this "reform"? Dirty wards, dirty sheets, unmet performance standards, lower pay and poorer working conditions, especially for women.

In the first 15 hospitals built by the for-profit sector in the UK under the Private Finance Initiative, the number of hospital beds has been reduced by one-third. Private money is now funding the largest hospital building programme in Britain for 30 years -- and the programme is in effect being paid for by the largest service closure programme in the history of the NHS. These new hospitals are smart and modern, but tend to be on the edge of town centres; patients invariably need their own transport to get to them, thus adding to the expenses that poorer people in particular face.

In general, for-profit health care tends to be more expensive and less efficient than public health care, and not necessarily of higher quality. Private health care is never cheaper or more comprehensive than state or public care. The rhetoric about the private sector serves to obscure the fact that, in many respects, this process is not really about providing better or quicker health care services: it is about the for-profit sector capturing public money and wealthier individuals' money.

Privatisation of a health care system means that the public system has less money and fewer staff as health care workers are attracted by better pay and working conditions elsewhere. The private sector caters for wealthier people, who also tend to be healthier people -- the public sector has to help the rest: the poor, elderly and children who often most need health care and have the least money.

A market-based approach to health not only drives up the cost of health care but also changes the services that do get provided. Neither the public or private sector end up providing preventative health care services, for instance: the private hospital sector is not interested in what makes people ill (the insurance sector might be but only so as to avoid patients), while the public sector hasn't got the money to provide such services. A market-based approach promises that good health can be bought and sold in the marketplace. It can't.

Who takes care of those who can't afford the health care services, or for whom health care is no longer provided? You know the answer by now.

GATS and Privatisation

What have these processes to do with the World Trade Organisation's services agreement, GATS? When I was first learning about GATS and health, I discovered that those who had been contending with these health issues for several years disagreed as to what was the main problem. The GATS agreement itself? Or privatisation in general? Or economic liberalisation? Or deregulation? Or that the for-profit entities aiming to gain access to the service markets in other countries by means of GATS would be "foreign"? (A key challenge when tackling "globalisation" is to find ways of

discussing the relevant issues without adding to or unwittingly supporting the growing racism and prejudice that surrounds us all and that all these processes have both fuelled and exploited.)

Health researcher Meri Koivusalo maintains that GATS, indeed all the World Trade Organisation agreements, is not really about trade barriers *between* nations, nor about conflicting interests between North and South, but about "the various incentives and mechanisms which deal with the respective rights, responsibilities and capacities of the private and public sector."¹⁷ Under GATS, governments can still regulate -- but GATS itself is about regulating governments.

What has been happening to the NHS in the UK over the past two decades illustrates the points I mentioned at the beginning of this talk about GATS and privatisation.

1. **A public service -- that is, one provided and/or paid for out of the public purse -- need not be privatised or sold off for it to come under GATS rules.** The NHS, a public service, has not been privatised as such or sold off, yet much of it *is* subject to competition and provided by for-profit interests -- privatised in effect. Ask the majority of people in the UK, however, and they would say that the NHS is still a public service that has not been privatised.

Public services are theoretically exempt from GATS. But if a public service *competes* with another, presumably non-public, service, then it probably comes under GATS rules. Even WTO officials concede this.¹⁸ Thus if a government contracts out any part of its public services, such as cleaning or catering, or if private (either for-profit or voluntary) companies supply services that are also provided by the government (for instance, if private hospitals exist alongside state ones, or if there is a mixture of public and private funding), then those services could be judged by a WTO dispute panel as *not* being a government service and thus subject to GATS rather than exempt from it, that is, subject to competition from operators from abroad.¹⁹

Under the North American Free Trade Agreement (NAFTA), US for-profit hospitals argued that the user fees charged by the Canadian public health system to patients were commercial charges and that denying US companies entry to the Canadian health market was a denial of the right of US companies to profit from that market. European trade officials, moreover, have emphatically reassured WTO members that an exemption for governmental services in the European Union Treaty has offered them no protection at all in practice.²⁰

Many trade unions and others are therefore calling for public services to be clearly and categorically exempt from GATS -- and for such services to be defined as those "in the public interest".

2. **GATS is just one of several mechanisms that companies, via their national governments, could use to liberalise services.** GATS was

not instrumental in any of the UK's health privatisation. It had nothing to do with it. The government managed quite nicely on its own, thank you.

In other countries, World Bank and IMF programmes have done the job of cutting back and redirecting public spending and of introducing user fees so as to create health markets.²¹

Elsewhere, bilateral agreements between two countries or regional agreements between several countries (such as the North American Free Trade Agreement between the US, Canada and Mexico) have required countries to liberalise their services -- and the liberalisation of services required under some bilateral agreements goes far deeper than that contained in the GATS rules.²² In April 2003, for instance, the United States urged Japan to take steps to accept greater foreign entry into high-quality medical services under a bilateral initiative to promote Japan's inward foreign direct investment.

We need to look at all these mechanisms and interests to see how they intersect with GATS. We need to explore how government actions, such as those in the UK, can, albeit unwittingly, bring health care services under the GATS umbrella. We need to be aware of other processes that are privatising health care.

What GATS does do, however, is to entrench privatisation and make it irreversible, possibly permanent.²³ As the WTO Secretariat has said, GATS has the effect of "protecting liberalisation policies, regardless of their underlying rationale, from slippages and reversals".²⁴

I would like to inject, however, a word of warning and a note about context. The corporations and countries that support and use the rules of the World Trade Organisation as they are currently written, interpreted and implemented are powerful. But ordinary people affected by their policies and actions are powerful, too. We should take care not to give "the powers that be" any more power, for instance, by stating baldly that the GATS commitments are irreversible or that they automatically mean a rush of foreign investment. We need also to look at context.

For instance, Sierra Leone is the only country that has listed all its health service categories as covered by GATS -- and yet US hospital chains or insurance companies do not seem to be dashing into the country. Companies are interested in high-cost commercial care, in patients who can pay for services, and in countries that have public money that could be directed their way. If they don't see how they can make a profit out of a service, they will not be rushing in to provide it, even if it has been listed under GATS.

Another example. The British government sold off the national railways some years ago. One of the many new companies thus created, RailTrack, maintains the track -- the railway or railroad itself --

throughout the country; other companies run the trains. But in 2002, RailTrack went bankrupt (despite millions of public money being poured into it), and the British government effectively renationalised it. It is now run as a not-for-profit company. Britain has actually broken GATS rules -- because the EU has listed maintenance of rail track under GATS as open to competition.²⁵ But as far as I'm aware, no country has lodged a complaint with the WTO about this, either because no company based outside of Britain was involved in maintaining the tracks -- or because there's no money to be made in Britain's railways so why bother.

3. The liberalisation of *other* services -- not health care or medical services -- may have a grave impact on health care services.

So far, GATS has not -- as yet -- been used by countries or companies to privatise health care services and open them up to foreign competition. What's listed under GATS as subject to liberalisation is more or less what was already liberalised when the Agreement was signed in 1994. Moreover, health care services are "trailing behind other sectors" in the rate that they are being listed under GATS as open to competition.²⁶

In the current stage of the GATS renegotiations,²⁷ health care services would not seem to be an issue, although it is difficult to tell given that the negotiations between government representatives are taking place behind closed doors (but in close consultation with corporate lobbyists) and are not disclosed to the public.

But the liberalisation of *other* services under GATS may in fact have a grave impact on health care services.

Consider all the services (according to a GATS schedule) used in a hospital, especially one that contracts out some of its operations:²⁸

- *Business* services:
 - medical, dental, midwives, nurses, paramedics
 - data processing
 - research and development in natural and social sciences
 - technical testing and analysis
 - placement and supply of personnel
 - maintenance, cleaning
- *Construction related* services
- *Education* services (teaching hospitals)
- *Environmental* services: sanitation, refuse, and waste disposal
- *Financial* services: health insurance, lending, and asset management
- *Health related & social* services:
 - hospital
 - other human health
 - social services
 - ambulance

- residential facilities, convalescent, rest homes, disabled care
- *Tourism related:* catering

If a government has committed data processing under the GATS "Business services" classification, does that include data processing in a hospital? What about all the invoicing and payments, a growing and probably lucrative area given that so many different services are being provided by different companies?

What about the financial services a hospital needs or that patients rely on? It has not been health care companies lobbying for GATS since its inception, but financial service companies -- banks, insurance companies, credit card companies, investment companies, pension funds (and telecommunication companies). They are the most organised sector in the GATS arena; they know what they want from the Agreement and from the renegotiations. Where can a hospital go to borrow money to maintain its buildings but to the private financial markets if a government does not have, or will not provide, the money?

A significant part of financial services is insurance services, and in the context of health and social services, it is health insurance service that is at issue. In sum, the liberalisation of other services, particularly financial services, might well affect health care services.

4. **GATS is not at present significantly affecting health care services -- but it has a serious potential to affect people's health, the determinants of health: what keeps us away from using health care services.** A whole range of services and the regulations governing them directly and indirectly affect people's ability to stay healthy and to remain uninjured. Many are subject to liberalisation under GATS. I'll mention just three:

- *environmental and water services.*

If people -- not "people"; who does the cooking and cleaning? -- are excluded from access to clean water and to sanitation because they can't afford it, theirs and everyone's health suffers. The privatisation of water and sewage supply typically leads to an increase in prices, which forces people to collect their water from untreated sources. Children in particular are more prone to water-borne infections and diseases. Over two million people, mostly children, die each year from diarrhoeal diseases related to lack of access to clean water. Yet in the current round of GATS negotiations, the EU is trying to get water services classified under GATS and to persuade countries to open up their water supply to competition.

Water is also essential for agriculture. Who grows the food in small subsistence plots that feeds most of the world's people and that never

enters national, let alone international, statistics because it is consumed directly or traded locally?

- *pollution restrictions.*
Emission limits or bans on what power generators or manufacturers can put into the air could be considered as barriers to trade, as could restrictions on the distribution of alcohol, tobacco and firearms.
- a whole host of *occupational and workplace health* and safety regulations, aimed at preventing accidents at work could possibly be challenged if, in practice, they created a barrier to a company outside the country providing a service.

To conclude: Health is a fundamental human right, but trade policies are negotiable.

Notes and references

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- 6 "Women Bear The Brunt of PFI [Private Finance Initiative] in the NHS", Centre for Public Services, Sheffield, UK. www.centre.public.org.uk
- 7 "Beyond Workplace Nurseries", Second Annual NHS Childcare Conference, London 12 February 2003, www.doh.gov.uk
- 8 "Top of the NHS is no place for women", *The Guardian*, 16 April 2001.
- 9 op. cit. 5.

- [10](#) For an exploration of these issues, particularly concerning developing countries, see David Woodward, "Trading Health for Profit: The Implications of the GATS and Trade in Health Services for Health in Developing Countries", March 2003, www.ukglobalhealth.org (Health and Trade) and www.twinside.org.sg in. See also Corner House Briefing 23, op. cit. 2, Box 6
- [11](#) For analysis and description of the processes, see Dexter Whitfield, *Public Services or Corporate Welfare? Rethinking the Nation State in the Global Economy*, Pluto Books, London 2001. See also Centre for Public Services, www.centre.public.org.uk.
- [12](#) For extensive research, analysis and critique of how the Private Finance Initiative operates within the health service, see the articles of Allyson Pollock and colleagues in the British Medical Journal, www.bmj.com
- [13](#) David Hall, *Globalisation, Privatisation and Health care -- A Preliminary Report*, Public Services International Research Unit, Greenwich, January 2001, p.17, website: www.psir.org.
- [14](#) For more details of all these mechanisms, see Corner House Briefing 23, op. cit. 2, Box 10, and Dexter Whitfield, op. cit. 11.
- [15](#) Note that the "private" sector can also include the non-profit or voluntary sector. In many "developing" countries, it is this sector that provides many health care services, particularly in places where structural adjustment programmes have required public or state sector cut-backs.
- [16](#) Calculated by Allyson Pollock from 1999 data.
- [17](#) Meri Koivusalo, *World Trade Organisation and Trade-Creep in Health and Social Policies*, GASPP Occasional Paper 4, 1999, Helsinki, 1999, website: www.stakes.fi/gaspp
- [18](#) Although GATS encompasses all services, many civil servants and government ministers state that it makes an exception for public services -- those "supplied in the exercise of governmental authority" (Article I.3b) -- such as health care, education or utilities. But GATS defines government services so narrowly -- "any service which is supplied neither on a commercial basis, nor in competition with one or more service suppliers" (Article I.3c) -- that the exception would probably be meaningless if one country were to challenge another country's public services at the WTO dispute panel as contravening GATS. The meaning or interpretation of this exemption is unlikely to be clarified other than by a dispute panel. Moreover, the WTO's Council for Trade in Services commented in November 1999 that exceptions provided in Article I.3 needed to be "interpreted narrowly" when applied to health services. Council minutes are used by dispute panels to interpret WTO agreements. See "GATS and Public Service Systems: The GATS 'Governmental Authority' Exclusion", discussion paper from international branch of the Ministry of Employment and Investment, Government of British Columbia, Canada, 2 April 2001, website: www.ei.gov.bc.ca or members.iinet.net.au/~jenks/GATS_BC2001.html; and Krajewski, M., "Public Services and the Scope of GATS", Center for International Environmental Law, Geneva, May 2001, website: www.ciel.org
- [19](#) Many government and WTO officials frequently state that the GATS rules do not apply to a country's services unless a government has specifically decided to list or "schedule" them under GATS as being open to competition from entities based in another country; they claim that GATS is a "bottom-up" agreement rather than a "top-down" one. This is only partially true.

Some GATS obligations do not apply to a service unless a country has scheduled the service, market access and national treatment being the main ones. Other obligations, however, apply directly and automatically to all WTO members for *all* services: most-favoured-nation and transparency. One rule on domestic regulation (Article VI.4) may also apply to all services (the Agreement's wording is unclear). Moreover, the assertion that a country can "choose" what services to include under GATS assumes that it has sufficient knowledge and understanding of the complex Agreement and domestic legislation (something that dispute panels have indicated that neither the EU or Canada had concerning, respectively, the distribution of bananas and the manufacture of automobiles), and that it is not pressured or enticed by other countries to list services in return for concessions in other WTO agreements.

20 See Ellen Gould, "The WTO General Agreement on Trade in Services: Separating WTO *Fact* from *Fiction*", Council of Canadians, website: www.canadians.org.

In theory, the US could take Britain to the WTO disputes panel if the British government or any other body refused a US multinational permission to buy a British NHS hospital that had been financed through the Private Finance Initiative.

The Canadian province of Alberta plans to allow private, for-profit hospitals to provide services previously provided only by public hospitals. If any of these private entities are based outside Canada (and a US-based company could use NAFTA to gain access), Alberta would be obliged to extend the same rights to every other "like" foreign provider under the GATS most-favoured nation rule. This is despite the fact that Canada had not made any commitments under GATS to liberalise professional, health or social services. See Sanger, M., *Reckless Abandon: Canada, the GATS and the Future of Health Care*, Canadian Centre for Policy Alternatives, February 2001, website: www.policyalternatives.ca

21 See Corner House Briefing 23, op. cit. 2, Box 7.

22 See Corner House Briefing 23, op. cit. 2, Box 12

23 A country can alter a commitment it has listed in its GATS schedule, but has to wait three years after it has listed the commitment or service before it can do so. The country also has to negotiate a substitute commitment to open up another service area to competition as compensation in a way that satisfies all other WTO members.

24 WTO Secretariat, "Recent Developments in Services Trade", 9 February 1999, S/C/W/94, website: docsonline.wto.org, quoted in Ellen Gould, "The 2001 GATS Negotiations: The Political Challenge Ahead", The Alliance for Democracy, March 2001, website: www.thealliancefordemocracy.org

25 This point made by Canadian GATS researcher Ellen Gould, 1 July 2002, as follows: "The renationalisation of RailTrack [the privatised company that maintained the railway track but did not run the trains] by Britain was a violation of the EC's GATS commitments. While the EC did not make commitments in rail transport per se, it did commit under maintenance and construction of rail lines under its construction commitments, and these are services carried out by RailTrack."

26 WTO Secretariat, "Health and Social Services: Background Note by the Secretariat S/C/W50", 18 September 1998.

27 The GATS agreement came into effect in 1995. Since then, various Annexes have been negotiated and added to it. One GATS clause (Article XIX), however, mandates that the Agreement should be renegotiated several times so as to achieve more liberalisation, and that the first round of such renegotiations should begin within five years of GATS coming into effect, that is, the year 2000. WTO members thus began renegotiations in February 2000 to change or clarify some of the rules and to persuade each other to list more of their services under GATS. In November 2001, WTO member states decided to link the GATS renegotiations to renegotiation of other WTO agreements (the Doha Round); as of September 2005, these renegotiations are largely stalled. For more information, see www.s2bnetwork.org

28 This point is drawn from the analysis of Professor Jane Kelsey, University of Auckland in New Zealand, from her presentation, "Deregulation of public services & the GATS" at the University of London School of Public Policy, 5 February 2003.

PLANNING HEALTH CARE FOR THE DYFI VALLEY – A CASE STUDY

Nicola Ruck

Introduction

This is a story of a hospital in one of the most rural, thinly populated parts of Britain. The hospital serves the Dyfi Valley in Mid Wales, within the devolved NHS Wales run by the Welsh Assembly Government. Hospital services for the Dyfi Valley have declined since the 1980s and in 2005 there is a crisis of confidence so that many local people believe that the remaining hospital may close, despite assurances from the Local Health Board that it will not. This paper discusses the questions:

- Why are people worried that the hospital will close?
- Does the planning process allow consultation?
- How can staffing difficulties be solved?

The story centres on Bro Ddyfi Community Hospital in Machynlleth, Powys, directly managed by the Powys Local Health Board. The services being provided are:

- Minor Injuries Unit
- Outpatient clinics in various specialities
- Clinical services, including physiotherapy, OT, dietetics, radiology
- Consultant beds for Elderly and Elderly Mentally Infirm
- GP/Consultant acute and rehabilitation beds
- Maternity services including normal deliveries
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There are ten Community Hospitals and no District General Hospitals in Powys. In the Dyfi Valley, local geography and history are both key to understanding the present crisis.

People and Geography - 40 miles to see a doctor

The catchment area of Machynlleth Community Hospital is the town of Machynlleth and surrounding Dyfi Valley, which is mainly in Powys but also includes rural areas of Gwynedd to the north and Ceredigion to the south. The population of Machynlleth town is about 2000 and surrounding rural districts 10-11,000.

With only 1 person to every 5 hectares, Powys is the most sparsely populated county in England and Wales. 4% of the Welsh population live in the county, which covers 25% of Wales. Powys also has a higher proportion of elderly people than the rest of the UK. In Machynlleth 28% of the population is over 65 years of age and numbers of working age are going down as younger

people leave to find jobs (Powys LHB, 2005). Holiday visitors each year number about 10 times the resident population.

The Dyfi Valley is a "Communities First" area, defined as in need of support because of poor access to services. There is difficult geographical access to services, poor public transport, restricted employment opportunities, and substantial levels of poverty.

The area is a network of small towns 20-30 miles apart, filled in with small villages, hilly farmland and mountains. The Dyfi river valley is in a wide plain that floods several times each winter and closes the direct route from the north to the nearest District General Hospital (DGH) in Aberystwyth. If the Minor Injuries Unit in Machynlleth is closed, it is a 30-40 mile round trip for treatment in Aberystwyth or Dolgellau. If the valley is flooded, people from the north of the catchment area have an extra 10 miles to Machynlleth and out of hours an 80 miles round trip to Aberystwyth.

History - Too many plans and no action

There used to be two hospitals in Machynlleth managed by the Powys Health Care NHS Trust. The first was originally a workhouse, then became a Red Cross Hospital in 1917, then the Chest Hospital, and is now the Bro Ddyfi Community Hospital (Wyn Davies, 1984). GPs in Machynlleth are a crucial part of the Community Hospital provision and currently provide their own out of hours service.

The second hospital was the Machynlleth and Corris Cottage Hospital, built in 1935 and paid for entirely by one penny subscriptions of quarrymen from a local slate quarry. This hospital was closed in 1995 despite the NHS Trust saying it would not be. It is now run by a Charitable Trust as a Care Centre used by Social Services and others. The memory of this closure is very strong in the Valley and makes people determined not to accept the new Board's assurances about non-closure of Bro Ddfyi without evidence of action on the ground.

A nationwide change took place in 1997 when political devolution created NHS Wales. Priority was given to access to integrated health and social care services, responsive to the needs of Welsh people. The Welsh Assembly Government identified the following as priority aims:

- promoting independence and intermediate care services
- supporting people at home in the community
- preventing avoidable admissions
- accelerating departure from hospital
- relieving pressures on the acute sector

The policy for Dyfi Valley patients reflects these aims: their acute care is provided in a DGH out of the county, and then they should be transferred back to Machynlleth for rehabilitation and home care if needed.

The next planned change was in 2000, when Powys Health Care NHS Trust completed a Community Hospitals Review, which aimed to balance the need for geographical spread with clinically viable services, and proposals were approved in 2001. For Machynlleth's hospital, the plan proposed reduced bed numbers, flexible use of generic medical beds, retention of the minor injury unit and greater co-operation with three neighbouring hospitals. However, this plan was not implemented in Machynlleth, although it was in other hospitals, and no investment was made in the Community Hospital (1).

Then in 2003 Powys Local Health Board was created by the merger of Powys Health Care NHS Trust, and part of Dyfed/Powys Health Authority. An effect of this reorganisation on the Dyfi Valley is a discontinuity in the services - the new managers were not in place pre-2003 and do not have a history of working with the community through an important period. However, the Board did not forget the neglect of Bro Ddyfi Hospital, and in 2004 a plan to improve the Hospital was prepared as the first step in the Welsh Assembly capital planning process (Powys LHB 2004). The Strategic Outline Case has now been presented to Cardiff for capital funds to improve the hospital, with a large number of options that have not yet been costed and assessed in detail (1). A decision from the Assembly is expected in July 2005.

In summary, since 1995 there has been one hospital closure, two management reorganisations, one planned investment in Bro Ddyfi Hospital that never came off, and now a plan that is far from implementation.

In the meantime, staff shortages have resulted in reduced and sometimes cancelled services. The Minor Injury Unit has had to be closed on at least 4 occasions during 2004-05 "due to staffing difficulties" (1), the number of rehabilitation beds has gone down and part of the hospital is unused. Patients who could have been treated locally have had to transfer to neighbouring District General Hospitals, causing problems for visiting carers. The Health Board report that: "on approximately 10 occasions since June 2004 there have been delays in transfer of patients from District General Hospitals back to Machynlleth". This is because of fewer beds open in Machynlleth, leading to problems at the DGH and problems for patients who spend longer at a distance from relatives and friends.

More positively, a new X ray Unit has been equipped and a consultant physician appointed. The hospital staff and GPs continue to provide a much appreciated service as far as they can.

From the community point of view there has been a reduction in hospital services since 1995 and little input to the plans for Powys services since then. Planning goes on but it has not yet benefitted Dyfi Valley's hospital. There have been consultations with the Community Health Council, the Health Forum, the Patients' Panel and Town Council, but there is unease because of the visible signs of continuing decline in the hospital. Local councillors and others are not reassured by statements that the "hospital will not close" when this has been said before, and plans have been shelved before.

In April 2005, about 300 people turned up for a public meeting with the Chairman of the Local Health Board. He assured the community that there was no plan to close the hospital, but did not clarify at all how local views and needs could become part of health service plans. The Assembly Government process of approving capital projects was portrayed as distant and out of local hands.

Staffing services - available according to need

"Services should be available to all and allocated according to individual need" is a quotation from Powys Health Board's stated principles, and is fundamental to the original principles of the British NHS. What does this mean for services in a rural area? People in the Dyfi Valley feel strongly that it is vital to have the minor injury services and recovery and social care beds locally. Having to travel 80 miles, or even 40, to have a wound dealt with is seen as very unfair and potentially dangerous. Minor injuries services are also seen as important for the large numbers of holiday visitors.

The CHC and the Patients' Panel have proposed that the following services should be available locally:

- 28-30 beds for flexible use
- Social care beds
- Clinical services such as X ray, endoscopy, physiotherapy
- GP cover of beds
- Encourage home births for normal deliveries and Aberystwyth Hospital

The Town Council have added:

- Adequate bed capacity to facilitate recovery following treatment in a DGH
- Outpatient clinics at Machynlleth, or transport to nearest OPD
- Qualified paramedic/nurse always available for Minor Injuries out of hours.

One crucially important factor in providing these services is the staff. Staff shortages have led to reductions in services, especially 24 hour cover. Why are there difficulties in staffing? The NHS could be considered the best health service in the world: why is it difficult for it to staff a rural hospital? Local people do not accept staff shortage as a justification for closing an essential service as this comment at the public meeting shows: "A business does not close if one person is off sick".

On the face of it, devolution to Wales should have made services more appropriate to rural areas, but has it contributed to the problem? Maybe, although staff shortages are a problem throughout the NHS, not just in rural Wales. Since the splitting of the NHS into purchasers and providers there has been no central human resource planning and so no national staffing strategy to reduce shortages.

But the local situation, as a deprived area far from main transport links, also affects recruitment and retention of staff. The Health Board run recruitment drives but have to cover a county 120 by 60 miles, with similar problems throughout. Powys is a Training Health Board offering development opportunities for staff, and has been successful in recruiting new senior medical staff in the past year, but nursing shortages continue. The Health Board hope that the return of the post of Matron from 2004 will make jobs in Powys Community hospitals more attractive. The Town Council has been accused by the Health Board of putting off job applicants by publicising fears that the Hospital may close. There is therefore an urgent need for agreement on a plan for services to be provided, for investment and renovation to start, and for community/Health Board to cooperate over a recruitment drive.

The Health Board should, as agreed at the public meeting, set up an improved system of sharing information and receiving comments from the Dyfi Valley population. They also should make common cause with local organisations such as Communities First, and Ecodyfi who are experienced in promoting the area to attract jobs. The Dyfi Valley has enormous strengths as a place to live, such as low pollution, sea and mountain activities, environmental projects and natural beauty.

Collaboration - feet in the same soil

"Service provision should be a collaborative approach with the local authority, voluntary sector, independent sector, users and carers."

This is from the 2005 Powys Strategic Outline Case (1), and refers to services for adult mental health, but it surely applies to all services. Collaboration in providing services is unlikely to work unless there is also collaboration in planning them. Collaboration in promoting health services jobs is also vital. There is an active community in the Dyfi Valley with clear proposals for their hospital that have geography and history to back them up. NHS Wales needs to change its planning system to make it rooted in the same soil.

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Rhetoric vs Reality

c) Beyond Health Care

HEALTH AND ECONOMIC POLICY

Peter Draper

Ten years ago, the *British Medical Journal* published a main editorial about health and economic policy that I co-wrote with Hugo Crombie. Its central message is well conveyed by its subtitle - *The health sector should be contributing to the development of economic policy.*

The occasion of the publication of the UK HEALTH WATCH report presents an opportunity first to look at what seemed to be key issues concerning health and economic policy a decade ago, and second, to ask 'Where are we now?'. In addition to my own observations*, John Appleby, chief economist of the King's Fund, kindly comments below. Let us begin by reviewing the key points of the original editorial (BMJ 1 July 1995, pp1-2).

After noting that in 1986 a major WHO publication had legitimised and promoted action by the health sector to collaborate with other sectors to achieve health goals - intersectoral action - and having commented on the fairly wide acceptance of the idea at least in public health circles, the editorial made its central point.

"But what about macroeconomic policy, which largely determines widening differences in incomes, high unemployment, and poverty levels - and all the damage to health that they cause? Should the health sector remain silent because this part of the environment is not essentially medical? Or should the health sector be pointing out the health implications of economic policies?"

The editorial went on to suggest that critical perspectives of macroeconomic analysis and policy from the health sector that were shared with social and environmental commentators were particularly relevant. Estimates of economic 'growth', particularly Gross Domestic Product, were seen as seriously flawed, for instance in relation to costs to people's health and environmental costs such as pollution of different kinds. (These days, climate change would certainly have been instanced for its massive environmental and health costs already and looming.) The Brundtland report and the concept of sustainable development was discussed briefly - and approvingly.

The conclusion was to suggest four ways in which the health sector might contribute to the development of macroeconomic policy. The first suggestion, that the health costs of "socioeconomic inequalities, unemployment, poverty, and crime can be brought to policymakers' attention whenever possible" seems to have occurred frequently except in relation to crime. Health impact assessments have almost certainly greatly helped to produce results, albeit smaller and slower than many of us would like.

* Dr Hugo Crombie was abroad and unable to collaborate in this review

The fourth proposal was that the health sector should “*promote wider understanding* of the many positive implications for public health of environmentally sustainable development” (emphasis added). My own feeling is that so far the health sector in Britain - apart from good but isolated efforts - has not got to grips with this kind of ‘economic-environmental-health education’, not even about climate change. Today, there is certainly no posse of relatively independent Medical Officers of Health (or equivalent institution) clearly and publicly warning and educating about this group of important public health problems.

Perhaps we can hope that the work the Sustainable Development Commission is doing with the NHS (among other organisations) will help the NHS to become an environmentally sound organisation and thus enable appropriate parts of the NHS later to speak out about health and sustainable development from the strong base of a model organisation that practices what it preaches. However, before we get too carried away, we have to remember that the NHS is fast being broken up and commercialised, as will become even more clearly apparent in the coming months.

My main observation, however, is that the *context* for the health sector to contribute to the development of macroeconomic and microeconomic policy has significantly worsened over this last decade. In this period, big corporations and their umbrella organisations have widely succeeded in becoming - as the euphemism goes - ‘government partners’ in ways that have certainly not been mirrored by the health or environmental sectors also being accepted as ‘government partners’. Furthermore, corporations have multiplied and grown bigger and stronger - and their tentacles have developed to encircle not only national governments but their grip has tightened on key international organisations, notably, the World Bank, the IMF, the World Trade Organisation, the European Union Commission and, not least, on WHO.

The core of the problem is that health and environmental aspects of business activity are still treated as ‘externalities’ in corporate and conventional economic reckoning despite years of informed criticism particularly from individual new/Green/alternative economists and from organisations such as the *New Economics Foundation*. Furthermore, as Joel Bakan, a distinguished Canadian law professor, spells out in his recent and highly acclaimed book *The Corporation*, executives of corporations are legally bound to treat externalities as ‘other people’s problems’ whenever possible, whether they concern workers’ health or the environment. The bottom line is not financial success with social responsibility but ‘shareholder value’ in cash terms.

The current law governing executives’ responsibilities is so important that it is worth quoting in some detail from Joel Bakan’s report of his interview with Milton Friedman, the economics Nobel laureate and one of the world’s most influential economists.

'Friedman thinks that corporations are good for society (and that too much government is bad). He recoils, however, at the idea that corporations should try to *do* good for society. "A corporation is the property of its stockholders," he told me. "Its interests are the interests of its stockholders. Now, beyond that should it spend the stockholders' money for purposes which it regards as socially responsible but which it cannot connect to its bottom line? The answer I would say is no." There is but one "social responsibility" for corporate executives, Friedman believes: they must make as much money as possible for their shareholders. This is a moral imperative. Executives who choose social and environmental goals over profits - who try to act morally - are, in fact, immoral.

'There is, however, one instance when corporate social responsibility can be tolerated, according to Friedman - when it is insincere. The executive who treats social and environmental values as means to maximise shareholders' wealth - not as ends in themselves - commits no wrong. It's like "putting a good-looking girl in front of an automobile to sell an automobile," he told me. "That's not in order to promote pulchritude. That's in order to sell cars." Good intentions, like good-looking girls, can sell goods. It's true. Friedman acknowledges, that this purely strategic view of social responsibility reduces lofty ideals to "hypocritical window dressing." But hypocrisy is virtuous when it serves the bottom line. Moral virtue is immoral when it does not.' (P34)

It is this basic legal structure of corporations, that some informed critics call amoral, immoral or even psychopathic, that lies behind the various corporate campaigns to ruthlessly deregulate business despite massive and worldwide problems ranging from appalling sweatshops in China to the United States, to profoundly hazardous working conditions and various kinds of serious pollution.

Just in day-to-day terms in Britain, think, for example, of the many times that a Confederation for British Industry (CBI) spokesperson (usually Digby Jones) appears on the BBC's *Today* program complaining of the burden of regulations on industry whereas no-one ever seems to be interviewed about the many health, safety and environmental horrors for which regulations - reasonable but tough regulations - are vital. The typical corporate complaint of this kind is not about a specific and manifestly unreasonable regulation but about 'the burden of regulations'. And think too of the drip, drip of tabloid ridicule of regulations such as the lies about the mythical European 'straight banana' requirement.

Finally, if one considers the seedcorn of policies, it is salutary to reflect on the publications and broadcasts that promote new or early thinking about policy and those that come from or influence thinktanks, thus spreading to policymakers inside and outside government. It is still a very rare event to see in the national media a discussion of macroeconomic policy that shows environmental awareness let alone an associated public health understanding. It does happen occasionally, for instance in articles by Caroline Lucas, the Green MEP, and Colin Hines (author of *Localization: A*

Global Manifesto) in the economics pages of the *Guardian* from time to time, but there are still far too many deserts, for example in the *Independent*, the *New Statesman* or in Will Hutton's 'ecoblind' economics columns in the *Observer* - journals that in today's troubled world should be regularly enlightening us on these issues.

To end with a modest proposal about discussions in the responsible media, maybe we should all be suggesting to relevant editors and producers topics, evidence and suitable authors whenever an occasion presents itself. A serious 'not for publication' letter with a constructive idea - written on paper with an impressive letterhead to a named editor, for example - usually seems to get a serious reply and occasionally a tangible result.

John Appleby

Draper and Crombie's 1995 BMJ editorial tends to focus on the desirability of measuring the health consequences of non-health care economic policy - but why not be more ambitious? All public policy and private activity generates multiple types of outcomes (usually only measured in monetary terms). Education does not just produce 'education', but health too. As we know, all other things being equal, there is a link between health and a person's educational attainment. Roads may facilitate travel, but they can also have a negative impact on health (long recognised by government transport policymakers who have pioneered the measurement of the health externalities of their main interest - roads, rail and other means of travel).

At the extreme, why measure GDP (and its sectoral components) in terms of money? Why not also measure economic output in terms of quality adjusted life years? Indeed, the King's Fund has previously suggested that if the 2005 Budget can estimate the environmental impact of taxation and other Budget measures, then why not attempt the same for health?

This may all seem far-fetched, but over the decade since Draper and Crombie first wrote their editorial, the notion of health impact assessments (HIAs) has developed with the broad aim of assessing the health consequences of non-health care policy. The aim of HIAs (and the main thesis of Draper and Crombie's editorial) is ultimately to provide a more comprehensive set of information concerning the size and range of outcomes different policies and economic activities may have on the population's health. Armed with this information, policymakers could then start to make policy to improve the volume and distribution of health outwith health care (and possibly at less cost).

There are two obvious problems with this alternative measurement of economic activity and government policy outcomes. The first is largely technical; how should this sort of information be generated and in what detail? How, for example, do we measure the health consequences not just of the education system, but also of different ways of organising education? HIA is

not a precise science - primarily due to the lack of data on the relationships between the policy or activity being subject to the HIA and possible health consequences.

The second problem is directly concerned with economics and is about the problems of prioritising. Even if the appropriate health consequences information could be amassed, how does it actually inform a policy decision? The problem here is that not all human activity is solely devoted to the generation of health - no matter how much public health colleagues would like it to be! We don't just desire the health consequences of urban regeneration, we want urban regeneration for the employment it brings too. But the multiple outcomes of policy can be in conflict and trade offs are required; how much health should be sacrificed for a new road (or a road in one place and not another), for example?

Nevertheless, the thrust of Draper and Crombie's views are surely correct and, despite the difficulties we note, should not let the inability to attain the best be the enemy of the merely good.

IMPROVING HEALTH - WORKING FOR SUSTAINABILITY

Alan Cunningham

Sustainable Development has been defined as 'Human development and achieving human potential require economic activity that is socially and environmentally sustainable in this and future generations' (Canadian Public Health Association). This paper suggests that health improvement will be poor or negative and that health inequalities will continue to grow unless health is linked to sustainable development and unless an appropriate planning and organisational framework supports both health improvement and development. Such a framework, which is here described as a 'Sustainable Communities Networking Resource' may be derived from the work of the World Health Organisation and would address the wider determinants of health.

Creating a Sustainable Communities Networking Resource - A framework, structure and resource for use in working for local sustainable development and for health improvement.

The resource would include linked categories to inform and support action, networking and resourcing for sustainable development and for health improvement. These are categories in which poverty, development, environment and health can best be considered together. (These categories have been selected from the United Nations Agreement on the Environment as confirmed by the Rio and Johannesburg summits and from work on health including 'Health21' WHO Europe). The Resource would;

1. *Support health promotion and the attainment of full health potential for all.*

It would include available initiatives of the Primary Care Trusts and the Department of Health but also voluntary sector and other activities, which are compatible with the WHO Policy Framework, 'Health21'

'Sound development is not possible without a healthy population; yet most developmental activities affect the environment to some degree, which in turn causes or exacerbate many health problems. The health sector cannot meet basic needs and objectives on its own; it is dependent on social, economic and spiritual development,' (WHO Regional Office for Europe, 1999)

2. Support Anti-Poverty Programmes.

This would include existing Anti-Poverty Programmes e.g. ensuring full take up of available benefits, also the support of minorities who may be particularly vulnerable to poverty.

It would support other rights based programmes e.g. the demand for an adequate minimum wage, as well as other sustainability based programmes e.g. LETTS Schemes, Time Banks.

3. Support for access to cheap and nutritious food as well as providing support for access to information on nutrition

It would support the work of public bodies such as the Food Standards Agency and the Department of Health but it would also support the work of non-governmental organisations such as Sustain and the Soil Association

4. Provides social support

It would support networks and networking such as in Liverpool, the Community Network. It would also provide access to social skills training and social skill resources

5. Support Sustainable Transport

It would support walking, cycling and public transport use.

6. Support people in employment

It would support the work of trade unions and it would provide access to employment advice

7. Support the Unemployed

It would provide appropriate advice and also provide access to information on employment

8. Support People at Key Transitions

For instance it would support people when they leave school, marry, become unemployed, or retire

9. Support Mothers and Children

For instance it would support the work of the government's Sure Start programme

10. Support for the addicted and for their families**11. Support in reducing stress**

It will support building a social framework and offer a range of strategies to reduce stress

12. *Help to focus on unsustainable patterns of production and consumption*

It will therefore encourage changes in unsustainable consumption patterns. It will support local co-operatives and publicise material on ethical consumption and on fair trade initiatives

13. *Support activities aimed at the promotion of food security and, where appropriate, food self-sufficiency within the context of sustainable agriculture.*

It will support, for instance, food co-operatives, farmers markets, and allotment schemes

14. *Support for access to cheap and low risk credit*

It will support for instance Credit Unions

15. *Support sustainable energy use*

16. *Support for access to sustainable housing*

It will promote sustainable housing use

17. *Support for sustainable agriculture and for rural development*

It will support the application of the Ecological Footprint concept. Ecological Footprint Analysis measures the amount of renewable and non-renewable ecologically productive land area required to support the resource demands and absorb the wastes of a given population or specific activities. (Ecological Footprint)

18. *Support for the conservation of biological diversity including maritime diversity and for opposition to deforestation*

It will support local nature reserves, forest projects, community forests, wildlife trusts etc and parks. It will support recycling and action to reduce pollution, it will support the application of the ecological footprint concept. It will identify access to green spaces as being of positive benefit for health.

19. *Support the promotion of education, public awareness and training to achieve ecological and development understanding and sustainable living*

It will publicise local and Internet opportunities for such training and it will provide access to appropriate information and resources. It will provide access to the experience of cultural diversity and to differing worldviews.

20. *Support the widest possible access to and use of information for decision-making (including local demographic information and area profiles).*

In sustainable development, everyone is a user and provider of information considered in the broad sense

21. Support public and community engagement in the planning process

It will support a level of community engagement in the planning process, which is compatible with and not less than that supported by WHO Health21 and UN Action21

Improving Health - Working for Sustainability - Comments

The International Policy Framework for Health and Sustainability (Health21/Action21)

The British Government has made a commitment to reduce inequalities and to work for health improvement and it has endorsed the Declaration of the World Health Organisation (WHO), which underlies the WHO's Health-for-All Initiative, for the twenty-first century. This Initiative was re-affirmed at the Fifty-first World Health Assembly in May 1998. The Declaration forms the basis also of the European Policy framework, 'Health21'. Health21 supports a very broad view of health and of the determinants of health. The underlying principles of 'Health21' as of 'Health for All' are: equity, sustainability, health promotion, intersectoral action, community involvement, supportive environments and international action. (WHO Regional Office for Europe) Health21 suggests the need for participation in all decision making affecting health, the need for accountability for health and for everything, which affects health and of the need to think always about the long term effects or outcomes of anything, which affects health.

These principles are also substantially the same principles of The United Nations Agreement on the Environment (Rio and Johannesburg Summits)- 'Agenda21' or 'Action21'. Action21 outlines policies and a programme of action for sustainable development. The first principle of the Rio Declaration on Environment is that human health is the centre of concern for sustainable development. Improving health therefore goes hand in hand with sustainable development.

Health21 and Action21 are intended for anyone who is concerned with health improvement or with sustainable lifestyles, they are not just directed at senior policy makers

Current UK Performance in Health Improvement and Sustainable Development

The Publication in 2004 of the revised Multiple Deprivation Indicators based on the 2001 census suggest that there has been no improvement in health for some populations and that health inequalities have also increased. A recent report in the British Medical Journal shortly before the 2005 general election also suggests that health inequalities are increasing. (Shaw et al, 2005)

At the same time British society is characterised by an increasingly harsh urban/rural split. British towns and cities without exception impose an unsustainable 'ecological footprint' (Ecological Footprint) on their own countryside and on the developing world.

Health inequalities and the lack of sustainable development certainly reflect a lack of resources, they also reflect the way resources are used.

Planning for Health and for Sustainable Development

Health and development are likely to be influenced by the procedures, systems and methodologies used in public policy determination and application. They will also to be affected by the perceptions, values and understanding of those who are involved in the public policy process. This includes a wide variety of public sector agencies as well as firms, professions, trade unions, churches and other non-governmental agencies. Government is dependent on a wide variety of interests and it has to accommodate their perceptions values and priorities in implementing the policy process.

The recognition of factors and agents, which impact upon health and sustainable development, is in part a function of organisation as is the success or otherwise of the policy framework suggested by the WHO, and by the United Nations. The principles and strategies of Health21/ Action21 could be applied more extensively and more effectively with appropriate organisational support.

Agis Tsouros, Head of the WHO European Centre for Urban Health has stated:

Frameworks for action on health improvement and on socially and environmentally sustainable development are necessary because uncoordinated action, uncoordinated development is having increasing adverse effects on people as it is on the planet.....The key recommendations on health in Agenda 21 relate to developing municipal health plans, using local health profiles and strengthening city networks for health...'. (WHO Regional Office for Europe, 1997)

The WHO document 'City planning for health and sustainable development' (op cit) provides a model for urban planning, which is rooted in the recommendations of 'Agenda21', the European Sustainable Cities & Towns Campaign, the European Commission and the Healthy Cities Network as well as the WHO (Europe.) This document provides a planning model, which is rooted in the use of local health profiles, strengthened city networks for health, a model which is participative and sustainable'

Health Improvement and action on inequalities is likely to be limited or marginal unless it is based on this model. It is not sufficient to argue for an increase in resources for health unless a proper planning process supports health improvement and development. If real improvement is to take place there is a need to check that a proper planning process is taking place and that it is compatible with the WHO Planning Model outlined in the above document.

The Case for Creating an Extended Framework to Support Information, Resourcing and Action for Health Improvement and for Sustainable Development

Whilst Governments rightly move to support the interests of vulnerable groups such as the poor and the health deprived, Government action may be ineffective or inefficient. The public sector is chronically under resourced, the public budgetary process is inefficient. Public agencies have to operate within areas, which are often inappropriate for service provision and which may be too big. As mentioned previously Government has to deal with outside interests with differing values and which may not understand the issues. Public sector interests also differ and are not well coordinated. There is a need to address these issues if Health Improvement is to be effective. This provides a justification for the proposed structure framework.

The Social Determinants of Health

Recent work on the social determinants of health (Wilkinson and Marmot, 2003) also supports the case for a structure framework to support health improvement at every level. This work identifies the relationship between health and the social determinants of health. It draws attention to available evidence.

Categories identified within the social determinants of health included:

- The social gradient - people's social and economic circumstances affect their health throughout life.
- Stress - stress harms health.
- Early life - the effects of early life last a lifetime.
- Social exclusion - social exclusion creates misery and costs lives
- Work - stress in the workplace increases the risk of disease.
- Unemployment - job security increases health, well-being and job satisfaction.
- Social support - friendship, good social relations and strong supportive networks improve health at home, at work & in the community.
- Addiction - individuals turn to alcohol, drugs and tobacco and suffer from their use, but the wider social setting influences use.
- Food - healthy food is a political issue.
- Transport - healthy transport means reduced driving and encouraging more walking and cycling, backed up by better public transport.

Although intended as a guide to policy this document identifies a number of areas where action at every level including the local could make a difference in working for health improvement

There is a case for creating an extended framework to support the spread of information, resourcing and action for health improvement and for sustainable development. Such a framework could be derived from Health21 and from Action21. The framework could inform at every level from the community

network to the national NGO about health and about sustainable development. Policymaking and implementation would be more accountable. The framework would point to information, resources and organisations available in a number of policy categories.

Conclusion

In Britain health improvement has been limited and health inequalities have widened. There is little evidence of sustainable development. However, the WHO Initiative Health21 and the United Nations Agreement on the Environment. Action21 have been used to create a planning model for health and sustainable development. The use of this model or something similar is required for health improvement, just increasing resources is not enough. Health21 and Action21 suggest the need to create an extended structure framework to support the spread of information, resourcing and action for health improvement and for sustainable development.

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HUMAN RIGHTS AND HEALTH IN THE UK

Fiona Haigh

Against a background, by no means limited to the United Kingdom, in which human rights are frequently construed as, at best, formal commitments and, at worst, cumbersome obstructions, it is perhaps worth emphasising that human rights are not a pick and mix assortment of luxury entitlements, but the very foundation of democratic societies. As such, their violation affects not just the individual concerned, but society as a whole; we exclude one person from their enjoyment at the risk of excluding all of us. (Gil-Robles, 2005)

The relationship between human rights and health is a reciprocal one. Health related programmes, policies and actions may have a negative or positive impact on people's rights. Conversely human rights infringements affect people's health. Some health effects are obvious, such as when people are tortured or imprisoned under inhumane conditions. However there are less obvious effects, which are at times more far reaching. Examples of this include the long-term effects of torture on victims and family (Dawes, 1990); the impact on women's and children's health due to discrimination against women (Cook, 1995); the impact of the fear of racism on health (Karlsen and Nazroo, 2004)).

Article 12 of the International Covenant of Economic Social and Cultural Rights guarantees the "right of everyone to the enjoyment of the highest attainable standard of physical and mental health" (ICESCR 1976). But the relationship between human rights and health is much more than the right to health. Nearly every article of every human rights document can be understood to have clear implications for health (Mann et al. 1994, 577). There is also increasing evidence that the level of respect for human rights independently and decisively influences health (International Federation of Red Cross etc, 2000).

Human rights can mean different things to different people, in this context human rights refers to rights which are guaranteed by human rights law; this can take the form of treaties, customary international law, bodies of principles and other sources of law (United Nations, 2001). Some of these obligations are legally enforceable whereas as others have to rely mainly on the force of political pressure, embarrassment and moral imperative⁵. There are several widely accepted defining features of human rights.

⁵ Some rights can be restricted in certain circumstances. The Siracusa principles outline the situation where it is considered legitimate to restrict a right (UNECOSOC 1985):

1. the restriction is provided for and carried out in accordance with the law,
2. the restriction is in the interest of a legitimate objective of general interest,
3. the restriction is strictly necessary in a democratic society to achieve the objective,
4. there are no less intrusive and restrictive means available to reach the same goal, and
5. the restriction is not imposed arbitrarily, i.e. in an unreasonable or otherwise discriminatory manner.

- Human rights are universal
- Non discrimination as a core component
- Human rights are indivisible, interrelated and interdependent
- Human rights focus on the relationship between individuals and states
- Human rights involve freedoms from and freedoms to (positive and negative obligations)

A human rights approach emphasises the need to address the underlying societal level causes of ill health as well as the symptoms. By linking health to human rights we can move away from a discourse of needs to one of obligations. States have obligations to respect, protect and fulfil human rights. This paper provides an outline of how the UK is measuring up in terms of human rights and health.

The UK, Human Rights and Health

The extent to which the UK fulfils its human rights obligations is intrinsically related to health. In a sense, a country that respects protects and fulfils human rights is a country that respects, protects and fulfils health. The UK has ratified a number of International Human Rights conventions. In addition to this in 1998 The UK Human Rights Act came into force. So at first glance it appears that the UK takes its Human Rights obligations very seriously which should also bode well for health. Nevertheless the European Human Rights Commissioner commented in his recent report on the UK human rights situation “that I was struck, however, by the frequency with which I heard calls for the need to rebalance rights protection, which, it was argued, had shifted too far in favour of the individual to the detriment of the community”(Gil-Robles, op cit). There is a new catch phrase called “rights and responsibilities” (White, 2005). It is implied that having rights is linked to being a responsible member of society so that people who fail to act as a responsible member of society (for example nuisance neighbours) can lose their rights to things such as homes, a fair trial and the right not to be discriminated against. This undermines the whole concept of the universality of human rights.

Infringements

The following section provides some examples of how infringements of rights are affecting health.

Detaining terrorists

In a ruling of December last year, the House of Lords declared the indefinite detention without charge of foreigners suspected of involvement in international terrorism under powers requiring a derogation from the European Convention on Human Rights to be discriminatory and disproportionate in nature and incompatible with the rights guaranteed by the Convention (Judgements, 2004). Indefinite detention without

Some rights are however non derogable. These rights can never be derogated even in times of war. These are usually seen to include the right to life, freedom from torture, freedom from enslavement or servitude and freedom of thought conscience and religion.

even knowing what you are being charged with has had obvious impacts on the health of detainees. For example, Gil-Robles reported that a number of detainees had been shifted to psychiatric institutions (Gil-Robles, op cit).

Although the Court of Appeal has managed to put a stop to this rights infringement, the new Prevention of Terrorism Act 2005 allows for further restrictions of individual's rights such as right to liberty. There is a concern that the executive is trying to avoid scrutiny by the judiciary. Gil-Robles commented, "Substituting 'obligation' for 'penalty' and 'controlled person' for 'suspect' only thinly disguises the fact that control orders are intended to substitute the ordinary criminal justice system with a parallel system run by the executive" (Gil-Robles, op cit).

Asylum seekers

It's estimated that around 25 000 asylum seekers were detained under the Immigration Act in 2004 (Amnesty International, 2005). For some, this detention potentially infringes on a range of rights such as freedom from arbitrary detention, right to control by a court of legality of that detention, right to be informed of reasons for detention, right to communicate with family and outside world and access to medical care. Asylum seekers are often particularly vulnerable people, having suffered from torture and abuse in the countries they are fleeing from.

Cuts to legal aid has meant that unaccompanied children, immigration detainees, people with mental health needs, torture survivors and trafficked women are increasingly unable to access adequate legal representation (Asylum Aid, 2005). There are particular concerns around the detention of children and infringements of the Convention on the Rights of the Child. There are reports of mental distress, feelings of demoralisation, isolation, boredom, depression and self harm (1;10).

ASBOs and young people

The use of Anti-Social behaviour Orders (ASBOs) has also been criticised (Gil-Robles, op cit; Hibbert, 2005) although the judiciary have found them to be in line with UK human rights obligations. There a particular concerns especially in relation to young people such as 'naming and shaming' and also the criminalisation of what are essentially non criminal acts (Gil-Robles, op cit). There is an obvious risk here that already vulnerable people are becoming further stigmatised and isolated from communities. Infringement of an ASBO can result in up to a five year custodial sentence for behaviours that in themselves aren't criminal (this can include things such as being sarcastic, being drunk, associating with certain people or being in a certain area). There are also distressing examples of ASBOs being given out for what are essentially health problems- alcoholism, mental health problems, attempted suicide and depression (Statewatch, 2005).

Similar to asylum seekers, young people in Britain are also at risk of criminalisation and detention. More than 50% of ASBOs are given to young people. The United Kingdom has amongst the highest rates of juvenile

detention in Western Europe. This is although around 80% of young people given custodial sentences reoffend within two years. During custody the average time spent in education in Young Offenders Institutions in 2003 was a mere 7.1 hours a week (Hansard, Written Answers to Questions, 25th March 2004). Helen Seaford (Seaford, 2001) describes attitudes to children:

The child moves through Whitehall growing and shrinking like Alice: in the Department of Health she is a small potential victim, at the Treasury and Department of Education a growing but silent unit of investment, but at the Home Office a huge and threatening job.

By taking a punitive approach to anti-social behaviour the root causes are ignored. These root causes are also determinants of health.

Torture

The right not to be tortured is generally considered to be a non derogable right (for example see *Chahal vs UK* 1996). However, in recent times there has been a move in the UK to accept evidence that has been obtained through torture. This evidence would normally be inadmissible not just due to the risk of false confessions but also because it generally accepted to be illegal as well as morally wrong. The UK government has taken the stance that it will not rule out evidence obtained through torture unless it has been carried out by UK agents. In other words torture is condoned as long as we don't get our hands dirty. But as Gil-Roberts states "torture is torture whoever does it, judicial proceedings are judicial proceedings, whatever their purpose – the former can never be admissible in the latter" (Gil-Robes, op cit).

The UK has also said it would consider returning terrorism suspects to countries where they may be tortured if that country gives assurances that they will not be tortured. There is doubt whether diplomatic assurances are an adequate safeguard against torture (Human rights Watch, 2004).

Other countries

The failure of the UK to fulfill its human rights obligations also has impacts on health beyond the UK's borders. For example, the illegal war in Iraq has had huge health costs in Iraq (Roberts et al). The policy of hiring medical staff from other countries is also affecting the right to health of health system users in these countries (Bueno de Mesquita and Gordon, 2005)

Positives

Although this report emphasises infringements of rights that are affecting health, there are also positives. The UK Human Rights Act provides people with the opportunity for seeking redress for infringements. The Race Relations (Amendment) Act 2000 has placed a general duty on specified public authorities to work towards the elimination of unlawful discrimination and to promote equality of opportunity and good relations between persons of different racial groups in carrying out their functions. The new Disability Discrimination Act 2005 has extended protection for people living with

disabilities. There are plans to set up a human rights commission that will be able to carry out its own investigations and make recommendations.

Conclusion

Currently in the UK people's health is being negatively affected by human rights infringements. The people most affected belong to the already vulnerable groups in our society. However, although infringements of rights negatively affect health the vice versa is also true. If we promote rights we will in turn positively impact on the wider determinants of health and directly on health itself. We need to make clear the links between politics, policies and their implementation and human rights and health to identify not only potential infringements but also opportunities to take advantage of the synergistic relationship between health and human rights.

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Section 3:

Strategies for Action

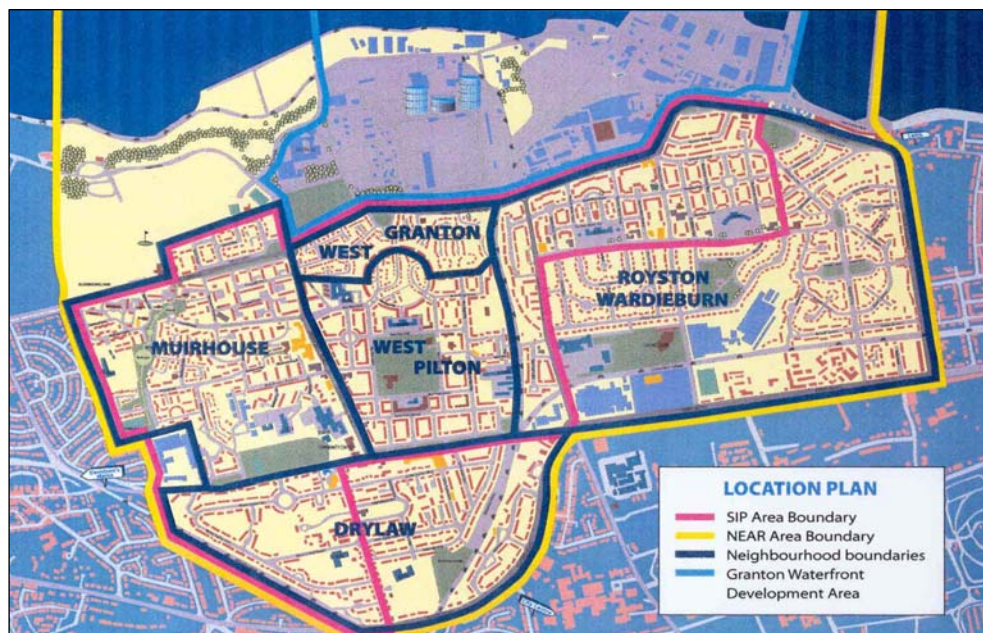
COMMUNITY LED – SUPPORTING AND DEVELOPING HEALTHY COMMUNITIES

Kate Burton

Nationally, there is a strong commitment by the Scottish Executive to engage with people and communities in all aspects of their health (physical, social and mental) and health care, including health improvement. The Health Challenge document, in its section on Communities, sets out how the Executive plans to empower and support communities to be involved in developing initiatives and solutions to improve health and tackle health inequalities.

This article will explore the value of a community led approach, to tackle health inequalities, using the example of a community health plan developed in the North Edinburgh Social Inclusion Partnership (SIP) area.

Neighbourhood Location Plan



The Power of Communities

So often the power of communities is ignored by planners, policy officers and social scientists when new projects or strategies are being developed to tackle the issues faced by disadvantaged geographical communities and communities of interest “*community can be based on identity and interest as well as locality*” (1). Frequently services or resources are parachuted into communities because they have worked successfully elsewhere rather than because they are what communities want or need to improve their health and well being. Communities are extremely powerful, they have expert

knowledge, gained through years of experience, about the issues that effect them. When empowered and encouraged, through a community development approach, communities can collectively articulate their needs and what they require to meet those needs (Adams et al 2002) To use this approach effectively communities require informal and formal opportunities to discuss with service planners and developers their needs and interests. There is no blueprint for how this process should be implemented however it is possible to identify a number of stages that are usually present in a community led approach (1).

- Mapping local stakeholders including citywide organisations, neighbourhood forums, community groups, statutory services;
- Needs assessment, involving members of the community;
- Strategy development, working with the community to set short and long term objectives;
- Working with the community to obtain resources;
- Project and service development to address priorities;
- Organisational change, encouraging mainstream service providers to change their services to reflect demands of the community.

The emerging local Community Health Partnerships and Community Planning Partnerships will have the opportunity, in the future, to support a community led approach thereby making the crucial connection between community and organisational development and will also play a key role in managing the tension between central priorities and local interests.

Our Health Matters! - The North Edinburgh SIP Health Plan

The power of a community led approach can be illustrated by using the example of Our Health Matters! (available at www.near.org.uk) The North Edinburgh SIP is an area of high levels of deprivation and unemployment, many of those in employment are in low paid semi-skilled or unskilled work and there is a high incidence of chronic ill health and premature mortality with people living in the area three times more likely, than the Edinburgh average, to suffer from cancer, coronary heart disease or ischaemic heart disease. The SIP partners vision for North Edinburgh is to create a healthy sustainable community and as part of the process to realise this vision, in 1997, it was decided to develop a health plan for the local area. To develop the health plan, a planning and implementation group was formed; this comprised members of the local community, voluntary organisations, local authority, the Health Board, primary care and GP's. Traditionally a group such as this would have developed a health plan around disease such as coronary heart disease, or lifestyle topics such as smoking, however the group was keen that the health plan reflected the needs and concerns of the local community. The group undertook a widescale community consultation exercise involving both focus group discussion and questionnaires. Through this process the community identified seven major issues which were having a negative impact on their health:

- Stress
- Life circumstances e.g. lack of money, poor housing etc.
- Access to services
- Lifestyle issues e.g. alcohol, violence, physical activity
- Loss and bereavement
- Isolation and loneliness experienced by older people
- Food poverty e.g. access to cheap, healthy food

These seven themes formed the priorities of Our Health Matters! the North Edinburgh SIP's Health Plan. Action on these priorities has been achieved by; the bending of some mainstream budgets, Health Improvement Fund (HIF) and a successful £1 million bid to the New Opportunities Fund (NOF) for a Healthy Living Centre, for example:

Community Issues	Action	Funding
Stress	Young person's counselling and mental health service at local High School	Primary Care Investment Fund
Life circumstances	Health Impact Assessment on SIP's Housing Strategy Welfare rights service in two GP practices Fuel poverty project	SNAP NOF NOF
Alcohol	Individual and group support for those effected by alcohol misuse (including carers and family members)	HIF/NOF
Food Poverty	Milk Token Initiative providing milk, books, saving account and fruit in exchange for milk tokens	HIF
Physical Activity	Move It offering a range of physical activity opportunities in local community venues	HIF/NOF

The monitoring of Our Health Matters! has demonstrated that participation, in the initiatives established to meet the plans' priorities, has exceeded original expectations. Participants report that the activities have had a positive impact on their health and well-being, increasing their levels of confidence, skills and abilities and enabling them to become more active in their community; *“this has changed my life and given me a reason for getting out of bed I used to feel really down and don't anymore.”*

Our Health Matters! is just one example of a community led approach and is often held up as an example of best practice in developing a community led approach to improving health. The Health Challenge document recognises that the communities in which people live have a considerable influence on health and that by enabling those communities to take a shared responsibility for their own health and work together will bring about health improvement. But will this improvement be sustainable? Or, are these community based interventions, such as Our Health Matters! papering over the cracks and keeping people happy in their poverty? Frequently community led activity is a short term solution to what is a longer term problem. The impact that poverty and disadvantage is having on the health of many living in Scotland's most disadvantaged communities is not going to be addressed through physical activity, healthy eating or smoking cessation initiatives. For example what real impact would such initiatives have on the health of a fifteen year-old living in Shettleston today (Scotland's most deprived council ward) who has only a 55% chance of living beyond the age of sixty-five (Black 1994).

What is required, to significantly address inequalities in health and complement a community led approach – which strengthens individuals and communities, is macro-economic and cultural change, which tackles the root cause of inequality along with improving access to essential facilities and services (NHS Scotland 2004). In addition, Scottish and UK government policies should be assessed for their impact on tackling health inequalities and improving health and a Scottish strategy, demonstrating a long-term commitment to tackling poverty and disadvantage should be established. Such recommendations for tackling health inequalities aren't new; they have been around for many years for example in 1987 in *The Health Divide* (Benzeval et al 2005) Sir Donald Acheson is quoted as saying

... to specialists in public health the most attractive points of initial attack (for reducing inequalities in health) are health promotion initiatives to reduce risk factors such as smoking, poor diet and physical inactivity, there is a limit to the extent to which some improvements are likely to occur in the absence of a strategy to change the circumstances in which these risks arise, by reducing deprivation and improving the physical environment.

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A COMMUNITY CHALLENGE TO INDUSTRY - INDUSTRIAL POLLUTION AROUND TEESIDE

Paul Munster and Carole Zagrovich

Background

Grangetown lies approximately four miles east of Middlesbrough, on the south bank of the River Tees. The area suffers from measurable levels of disadvantage and is listed number 9 in the Governments' Index of Multiple Deprivation Register that details levels of deprivation in the worst affected districts of the country. Once a small rural community, at the foot of the Cleveland Hills, the population rose dramatically due to the rapid growth of the iron & steel industry and later the petro-chemical and ship building industries.

Over the years the area has suffered drastically from the decline in these industries and the workers and their families, who once flocked to the area to share its prosperity, now suffer from high unemployment and associated problems.

Analysis, from a number of sources, reveals multiple levels of disadvantage in Grangetown, including the **highest record of recipients on benefit** in the Borough at **61%** and one of the **highest levels of male unemployment** in the Borough at **16.1%**. It was recently reported that over 40% of the population of Grangetown had poor levels of **literacy and numeracy**. There is grave concern amongst communities that young people are growing up in a 'culture of dependency on benefits'. There is a significant number of families experiencing unemployment spanning three generations and the multiple levels of deprivation lead people to resign themselves to a poor standard of living and to scale down their hopes and aspirations.

The local environment is scarred and contaminated by industry and the feelings of despair are added to by the physical decay of housing estates. Beauty spots, such as the Cleveland Hills, are scattered with huge electricity pylons, many of which are situated directly in gardens and play areas. Homes are within short distances of huge chemical sites with the nearest to Grangetown housing 20 operational chemical plants. Nearby Redcar, three miles from Grangetown, has one of the country's highest air pollution readings, for an urban area, (Regional Quality of Life Report). **Death rates are 13% higher in Teesside** than the England average with cancer as the major single cause (Tees Health Authority Report 2000-2003).

Environmental deprivation

"Industry has polluted the air, the land, the water and the people for decades. But the attitude of the companies is that they will only change if legislation forces them. Our community pays too much – my father died of emphysema." **Dave Binns (local resident)**

Toxic alarms sound twice weekly and night flaring (visible for 30 miles around) makes the ground shake. All local residents are warned about what to do if there is a toxic incident at the Wilton Chemical Complex, which only serves to heighten feelings of anxiety.

“As a kid I remember seeing a yellow gas drifting across the school field towards my classroom. Another time a fire at a plastics warehouse took 200 firemen to put out. It was a dark as night. Like the end of the world.” **Dean Axford (local resident)**

“I’ll never forget the morning I drew the curtains and there was a dark cloud of pollution whispering around the cliff tops into Staithes harbour. I knew it wasn’t storm clouds and then my sister who lives in Dormanstown rang up. She said there’s been an incident at Wilton and she’d been told to stay indoors. She was panicking, but trying not to distress her little boy who was in the house. Her home, like all the others at Dormanstown was engulfed in a black cloud.” **Anonymous local resident**

IMPACT ⁶

It is well documented that people experiencing the severest economic deprivation also suffer the most from poor environmental conditions such as air pollution, traffic fumes, poor housing and lack of transport. However, there are often many barriers to overcome before disadvantaged communities can begin to engage in environmental action. Typically, environmentalism has been seen as the preserve of the ‘worthy’ and wealthy, while poverty is a major determinant of environmental degradation, and has insidious effects on communities, cutting people’s confidence, self-worth and willingness to participate, and even leading to alienation and anti-social reactions.

Impact is the name of a local environmental community group formed by residents concerned about the levels of pollution and deprivation in our area brought about by the chemical and steel industry on our doorstep. The group was formally constituted in January 2003 with the support of Friends of the Earth. Its aims are to make individuals more engaged in democratic processes that influence the quality of the environment, and change their personal lifestyles to improve their local and global environment. It also aims to influence companies at the Wilton Chemical Complex to become more responsive to local community needs for environmental improvements. Friends of the Earth employed a Community Development officer in Teesside to work with them and help to empower them to challenge the authorities and companies involved.

⁶ www.impact-teesside.org

Since its inception Impact has gained considerable respect with the Local Authority and in particular the Environment Agency. They were instrumental in setting up a local Environmental Forum with them to which representatives of industry attend as well as other community groups in the Teesside area. In January 2005 a Global expert in the fight against industrial pollution gave a presentation to the forum and spoke about the need for improved monitoring at the Wilton Complex. The Local Authority and industry listened and appeared encouraged to take steps to improve the situation.

Impact has shown that with constant badgering and by being a thorn in the side of industry and local authority we can make a difference. But we are by no means complacent enough to think that, left to their own devices, things will get better on their own. Impact has now taken on their own environmental development officer and will shortly be moving into their own premises close to the offices of the local authority. There's still a lot of work to be done but gradually we are making an Impact.

VICTORY FOR MCLIBEL TWO AGAINST UK GOVERNMENT - VERDICT OF EUROPEAN COURT

CAMPAIGNERS CELEBRATE 20 YRS OF GROWING PROTESTS AGAINST MCWORLD

Helen Steel and Dave Morris, McLibel Support Campaign / London Greenpeace⁷

Update - Feb 2005

On 15th February, the European Court of Human Rights in Strasbourg declared that the mammoth McLibel case was in breach of the right to a fair trial and right to freedom of expression. The McLibel 2, Helen Steel and Dave Morris, held a press Conference outside McDonald's in The Strand, Central London - chosen to mark 20 years of growing protests against McDonald's since the first ever 'Day of Action against McDonald's' on Jan 19th 1985, when London Greenpeace protested outside that store.

McDonald's Corporation had launched libel proceedings in an unsuccessful attempt to prevent the distribution of leaflets criticising the company. The McLibel trial became the longest case in English legal history, lasting 314 days, in which the McLibel 2 represented themselves against McDonald's. The trial and a 23-day appeal in 1999 resulted in a mixed verdict in which damning rulings were made against McDonald's core business practices (see below). The case was described by commentators at the end of the trial as *'the worst Corporate PR disaster in history'*. Despite the rulings, no sanctions were ordered against McDonald's, yet the McLibel 2 were outrageously ordered to pay the company £40,000 damages.

The McLibel 2 refused to pay a single penny and instead launched legal proceedings against the UK government in Sept 2000. The European Court ruling on 15th February stated that there had been an unacceptable inequality of arms with McDonald's during the trial, and that the lack of procedural fairness and equality gave rise to a breach of the right to freedom of expression. They also said that the award of £40,000 damages to McDonald's was disproportionate. The court also recognised that there was a "strong public interest in enabling campaign groups and individuals outside the mainstream to contribute to the public debate by disseminating information and ideas on matters of general public interest such as health and the environment".

'Having largely beaten McDonald's, and won some damning judgements

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against them in our trial, we have now exposed the notoriously oppressive and unfair UK laws. We hope that this will result in greater public scrutiny and criticism of powerful organisations whose practices have a detrimental effect on society and the environment. The McLibel campaign and the world-wide distribution of millions of anti-McDonald's leaflets had already proved that determined and widespread grass roots protests and defiance can undermine those who try to silence their critics, and also render oppressive laws unworkable. The continually growing opposition to McDonald's and all it stands for is a vindication of all the efforts of those around the world who have been exposing and challenging the corporation's business practices' - Helen Steel and Dave Morris

McLibel Background

The McDonald's Corporation issued writs against the McLibel 2 on 20th Sept 1990 alleging they had been libelled in the London Greenpeace factsheet "What's Wrong With McDonald's? Everything they don't want you to know". The corporation currently has an annual turnover of \$40billion, and a marketing budget of over \$2billion. The trial began on 28th June 1994, the company spending an estimated £10m on legal costs.

On June 19th 1997, after a trial lasting 314 days (the longest trial ever in England), Mr Justice Bell ruled that McDonald's marketing has **"pretended to a positive nutritional benefit which their food (high in fat & salt etc) did not match"**; that McDonald's **"exploit children"** with their advertising strategy; are **"culpably responsible for animal cruelty"**; and **"pay low wages, helping to depress wages in the catering trade."** On March 31st 1999 the Court of Appeal, after a 23-day hearing, added to those damning findings ruling that it was fair comment to say that McDonald's employees worldwide **"do badly in terms of pay and conditions"**, and true that **"if one eats enough McDonald's food, one's diet may well become high in fat etc., with the very real risk of heart disease."**

The global campaign against McDonald's, and all they stand for, continues to grow

Food is central to our everyday lives, yet we have virtually no control over its production and distribution. The food industry is dominated by multinational companies who for their own profits exploit consumers, workers, the world's natural resources and billions of farmed animals. The way we eat, and even the way we think about food is being manipulated by these powerful institutions and their sophisticated marketing campaigns.

To understand the reality behind the propaganda, we can focus on McDonald's - one of the most powerful, influential and well-known global companies. The corporation was founded 50 years ago, in 1955. Despite its strenuous marketing efforts, McDonald's is widely despised, and its 'reputation' - along with that of the food industry in general - continues to sink

ever further.

Every year there is a Worldwide Anti-McDonald's Day on Saturday October 16th [UN World Food Day] - a protest against the promotion of junk food, the unethical targeting of children, exploitation of workers, animal cruelty, damage to the environment and the global domination of corporations over our lives. Launched in the UK in 1985 by London Greenpeace, the October 16th international protests have continued to grow.

In 1999, the only year in which we systematically monitored where the protests took place, we recorded 425 protests and pickets in 345 towns in 23 countries: Argentina, Australia, Austria, Belgium, Canada, England, Finland, France, Germany, Ireland, Italy, Malta, Mexico, Netherlands, New Zealand, Portugal, Romania, Scotland, South Africa, Sweden, Switzerland, Taiwan, USA. **In 2000** there were widespread and large protests throughout Italy - at one store in Rome 300 demonstrators succeeded in getting it closed for the day.

In 2002 for the first time, McDonald's workers joined in the Day of Action - there were walkouts and other forms of protests in many countries co-ordinated by McDonald's Workers Resistance (an international network of McDonald's workers - see www.mwr.org.uk).

Over 3 million 'What's Wrong With McDonald's?' leaflets have now been handed out in the UK alone since 1990, and are now distributed worldwide in over 27 languages. And global opposition to McDonald's has also continued to grow over the last few years:

- many determined **residents' campaigns** against new stores, including a successful 552-day occupation of a proposed McDonald's site by residents of Hinchley Wood, S.E. England, campaigns against drive-thrus in Canada, and protest blockades in Voronezh (S. Russia)
- mass anti-McDonald's **protests by French farmers**, including a 30,000-strong demo
- **efforts by McDonald's workers to organise** together to stand up to their bosses (egg in the UK, France, Russia and Canada), including the creation of the McDonald's Workers Resistance <http://mwr.org.uk>
- a global upsurge of concern over the **alarming increase in obesity**, heart disease and a range of other serious health problems in industrialised countries. McDonald's identified as a main culprit. This has included a lawsuit against US junk food corporations McDonald's, KFC, Burger King, and Wendys on behalf of millions of customers misled by the systematic and **unethical promotion of unhealthy food products**
- there has been growing pressure for **bans and restrictions on advertising to children**, controversies over McDonald's sponsorship of the UN Children's Fund, and over their involvement in schools and

hospitals

- an ongoing international scandal over **extreme labour exploitation in China** for the production of McDonald's 'happy meal' toys
- McDonald's USA sued and forced to apologise and pay out millions of dollars for **deceiving their customers** by not revealing beef extract was a content of their supposedly vegetarian french fries
- growing concern throughout Europe, Japan, Australia, US and Canada about **the threat to human health posed by beef-related diseases** (such as BSE) and genetically-modified animal feed
- **food poisoning scandals in South America** (Argentina and Chile)
- protests against McDonald's **mass use of refrigeration chemicals** linked to global warming
- controversies over McDonald's **hypocritical 'concern'** over animal cruelty & general corporate responsibility
- McDonald's increasingly identified by a wide range of protestors worldwide as a **symbol of modern capitalism**
- recent **falls in their global profits** and corporate closure of many stores, with US Executives admitting that recent years have been the "most challenging" in McDonald's 49-year history.
- **the McLibel trial**, dubbed *'the worst Corporate PR disaster in history'*, continues to create bad publicity.

What's wrong with Mcdonald's?

McDonald's spend over \$2 billion every year worldwide on advertising and promotions, trying to cultivate an image of being a 'caring' and 'green' company that is also a fun place to eat. Children are lured in - dragging their parents behind them - with the promise of toys and other gimmicks. But behind the smiling face of Ronald McDonald lies the reality: McDonald's only interest is money, making profits from whoever and whatever they can, just like all multinationals. The company's sales are now \$40 billion a year. The continual worldwide expansion of fast food chains means more uniformity, less choice and the undermining of local communities.

Promoting unhealthy food

McDonald's promote their food as 'nutritious', but the reality is that it is processed junk food - high in fat, sugar and salt, and low in fibre and vitamins. A diet of this type is linked with a greater risk of heart disease, cancer, diabetes and other diseases. Their food also contains many chemical additives, some of which may cause ill health, and hyperactivity in children.

Modern intensive farming and production methods are geared to maximising profits, resulting in the widespread use of chemicals and unhealthy practices that also affect people's health (e.g. BSE and food poisoning).

Exploiting workers

Workers in the fast food industry are paid low wages. Pressure to keep profits high and wage costs low results in understaffing, so staff have to work harder and faster. As a consequence, accidents (particularly burns) are common. The majority of employees are people who have few job options and so have no alternative to being bossed around and exploited - and they're compelled to 'smile' too! Not surprisingly staff turnover at McDonald's is high, making it virtually impossible to unionise and fight for a better deal. This suits McDonald's who have always been opposed to workers' rights and Unions. Pay and conditions are even worse for the workers toiling in sweatshops in China to produce McDonald's 'happy meal' toys.

Damaging the environment

Every year McDonald's use over a million tons of unnecessary plastic and paper packaging, the production of which requires environmentally damaging chemicals and degradation of forests. Most of the packaging ends up littering our streets or polluting the land buried in landfill sites. The heavy use of chemicals in modern agriculture and effluent from intensive farming cause pollution of land and water, harming wildlife, plants and the soil.

Causing cruelty to animals

The menus of the burger chains are based on the torture and murder of millions of animals. Most are intensively farmed, with no access to fresh air and sunshine, and no freedom of movement. Their short lives are cruel and their deaths are barbaric - 'humane slaughter' is a myth. We have the choice to eat meat or not, but the billions of animals slaughtered for food each year have no choice at all.

Robbing the poor

The demands made by multinationals for cheap food supplies result in the exploitation of agricultural workers throughout the world. Vast areas of land in poor countries are used for cash crops or for cattle ranching, or to grow grain to feed animals to be eaten in the West. This is at the expense of local food needs. McDonald's continually promote meat products, encouraging people to eat meat more often, which wastes more and more food resources. 7 million tons of grain fed to livestock produces only 1 million tons of meat and by-products. On a plant-based diet and with land shared fairly, almost every region could be self-sufficient in food.

What you can do

Food is central to our everyday lives, yet we have virtually no control over its production and distribution. The way we eat, and even the way we think about food is being manipulated by these powerful institutions and their sophisticated marketing campaigns. But despite strenuous marketing efforts, McDonald's is widely despised, and its 'reputation' and that of the food

industry in general - continues to sink ever further.

Every year on 16th October there is the World Day of Action against McDonald's and all they stand for - with pickets and demonstrations all over the world. Together we can fight back against the institutions that currently control our lives and our planet, and we can create a better society without exploitation or oppression. Workers can and do organise together to fight for their rights and dignity. People are increasingly aware of the need to think seriously about the food we and our children eat. Environmental and animal rights protests and campaigns are growing everywhere. People in poor countries are organising themselves to stand up to multinationals and banks which dominate the world's economy. Why not join in the struggle for a better world? Talk to friends and family, neighbours and workmates about these issues. Please copy and circulate this leaflet as widely as you can.

www.mcspotlight.org

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CHOOSING HEALTH? PRIORITIES FOR A FOOD AND HEALTH ACTION PLAN

Lynne A Kennedy, Modi Mwatsama, Simon Capewell and Debbie Fox.

“Access to a safe, healthy diet is one of the most important public health actions that a country can take to improve health and increase economic gain”. (WHO, 1999)

Introduction

During the last century life expectancy in the UK, as in most Western industrialised societies, has increased dramatically. Whilst on the whole this is perceived to be a good thing, we as a nation also bare the negative consequences of that era. Longevity coupled with the legacy of Industrialisation have both contributed to the increased burden of chronic or non-communicable disease. A substantial proportion of premature mortality and morbidity experienced is caused by cancers, cardiovascular disease (CVD) and their complications or co-morbidities (DoH, 1999; Wanless, 2003; WHO, 2002). So whilst we live longer, these diseases either kill us prematurely or leave us in poor health for longer.

There is considerable, and convincing, epidemiological evidence supporting the link between diet and the major chronic diseases. Work by Bingham (1991) estimated that dietary factors account for a staggering 30% of the combined risk of premature death caused by cancer and coronary heart disease in England. More recent work (eg Unal et al, 2004) and current policy (DoH, 2000; 2004) statements suggest around 25% of all premature deaths could be prevented by improvements to diet. These estimates are supported by findings in national and international studies (COMA, 1984; DH, 1991; 1994; 1998; 2000a; 2000; 2000c; WCRF 1997; WHO, 1990; 1998; 2004) which all conclude that diet is a *major* contributor to ill health and premature mortality.

Each year, over 25,000 adults in the UK die of CVD or related illness with a further 32,000 deaths caused by cancer (DoH, 1999; Peterson et al, 2003). These figures place the UK as one of the worst countries in Europe for premature mortality and morbidity. Overweight and obesity have been identified as major risk factors for CVD and other chronic diseases, and have become the most widespread nutritional disorders in Western society now reaching epidemic proportions (WHO, 1998; 2002; 2003; 2004). Despite major social and economic improvements during the 20th Century, social variation in patterns of food consumption and nutritional status can still be found in the UK (FSA 2002; 2003; 2004). Low income households and more socially deprived neighbourhoods experience the burden of diet related ill-health

disproportionately to their more wealthy affluent neighbours. Consequently poor diet is a major contributor to social inequalities (James et al, 1997).

Whilst for individuals the health consequences are dire, for the UK as a whole diet-related ill health represents considerable social and economic problems. Although precise figures are unavailable, reputable sources claim these costs are substantial. For example:

- the estimated cost to the NHS of diet-related ill health is somewhere in the region of £2 billion each year (Press, 2004).
- CHD alone costs the UK health care system around £1.7bn. each year and a further £3.5 billion per annum is lost to the economy through informal care, absenteeism and lost productivity (BHF, 2004);
- the National Audit Office (2001) warns if current trends for obesity persist, by 2010 the annual cost of treating obesity, alone, will rise to £3.6bn.

Given the enormity of these costs, and the social and economic burden of diet-related ill health, it is no surprise that issues relating to diet are high on the policy agenda.

Policy context

There is a consensus, nationally and internationally, that diet-related ill health is a major threat to public health and also a social and economic burden to society. Considerable effort and funding are invested in public health to try and minimise this threat and the effects on society. The WHO Global Strategy on Diet, Physical Activity and Health (WHO, 2004a), Food and Health Action Plan for Europe (WHO, 2004b) and the Countrywide Integrated Non-Communicable Diseases Intervention (CINDI) Strategy, to prevent chronic disease in Europe (WHO, 2004c), all advocate the adoption of population-wide prevention-based strategies to tackle chronic disease as the major causes of premature death and morbidity worldwide. This policy framework gives the go-ahead for professionals to prioritise services and determine action required at regional and local level against which progress towards these targets is monitored.

In the UK, the relationship between health and what people eat or drink has remained at the heart of public health policy for several decades (DHSS, 1977; DoH, 1984; DH, 1992; 1997; 2004). The recent public health White Paper *Choosing Health: Making Healthier Choices Easier* (DoH, 2004) clearly acknowledges that what people eat has a significant influence on health and wellbeing; this is reinforced by the delivery plans outlined in *Choosing Health: Choosing a Better Diet* (DoH 2005); is endorsed further by the National Service Frameworks (NSF), produced for CHD and Diabetes (DoH 2000, 2001), and The Cancer Plan (DoH, 2002), which all stipulate how NHS bodies should work with local authorities to develop effective programmes to promote healthy eating and reduce overweight and obesity (DoH 2000, 2001, 2000).

Choosing Health: Choosing a Better Diet (DoH 2005)***

Choosing Health, makes it clear that government intends to improve public health by continuing the emphasis on individual healthy lifestyles. National and community level prevention initiatives are seen as the way forward in changing undesirable dietary behaviour. Government has pledged financial support for community 5-a-day initiatives in deprived communities, and from 2006 a higher proportion of Primary Care Trusts will be expected to provide support for Community Food Initiatives such as healthy cookery clubs and food cooperatives to encourage fruit and vegetable consumption (DoH, 2005). *Choosing Health* (DoH, 2004), acknowledges the need for more effective ways to prevent ill health and premature death and the need to work outside the traditional medical model and, as part of the usual consultation process, invited comments and suggestions as to how this might be achieved.

Choosing Health: Choosing a Better Diet (DoH 2005): Perceptions on the priorities for a national food and health action plan

The remaining section represents a summary of the response written by the authors of this chapter to the above national consultation. Whilst this represents the views of the authors drawing upon their individual and collective academic, policy and clinical expertise, it is designed to stimulate thought and debate around the key policy areas for food and health.

Credit where credit is due: development of a national food and health action plan to improve dietary trends and public health, especially amongst disadvantaged groups, is to be commended. *Choosing Health: choosing a better diet* has many good points for example:

- Setting population guidelines and targets on reducing population energy intake of total fat;
- Acknowledging the need to tackle the increased burden of diet related ill health and premature mortality experienced by lower socio-economic groups;
- setting goals for improving consumer information and the quality of that information.

Nonetheless, the proposals as they stand do not go nearly far enough, and lays government open to criticism and doubt as to their commitment to tackle the bigger issues relating to diet and health. It fails to adequately address the political and economic tensions between (a) food supply, (b) public health and consumer, and (c) environment and community. The proposals have several crucial omissions, namely:

- The need for **cross-departmental food and health policy** and for the development of a new minister for food and health (with responsibility for food *from farm to plate*).
- The glaringly obvious omission to address the health and economic impact of international trade agreements – ie **the negative impact of the**

Common Agricultural Policy (CAP) on diet, Public Health and national and local food economies:

- Whilst the proposal identifies the food industry as a key influence in efforts to promote healthier food culture, the food industry interests (economic) have priority over public interests (health). This is outrageous and morally unacceptable. More radical action is required in order to **address current 'barriers to healthy eating' resulting from the actions of food production, manufacturing and retail sectors**. Whilst it is acknowledged that individuals have a responsibility for their own health and therefore factors that influence this ie 'Diet', this is clearly not the only determinant of health. The government has a RESPONSIBILITY to regulate in circumstances where the interests of individuals and society are affected.

What can be done? Recommendations⁸

The rest of this paper summarises priorities and actions for a Food and Health Action Plan that could REALLY do what government says it wants to do to improve the economic health and wellbeing of its' citizens, and the country as a whole.

1. The Food Standards Agency (FSA) should have responsibility for definitions such as 'low fat' and 'low salt';
 - The recommended daily allowances (RDA) for fat needs to move from the current harmful level (90 gm in adults, and 35% of energy intake) to the much healthier traditional Chinese and Japanese levels: 50 gm men, 45 gm women, and 25gm in 11 year old children. (these still represent approximately 25% of daily energy intake);
 - Likewise for salt, the RDA should be set at 3gm per day in adults, 2gm per day in older children, in line with scientific evidence.
2. Action is required at environmental and policy levels, additional strategies are therefore needed, particularly cross-departmental collaboration involving DEFRA, Department of Health (DoH) and FSA on establishing guidelines and standards for food provision, particularly within schools.
3. The Departments of Education has a clear responsibility to provide safe, affordable and healthy nutrition during school hours, this requires:
 - National overhaul of school meals;

⁸ Recommendations for change are taken from a more detailed paper written in response to Choosing Health: Choosing a Better Diet, Written by Lynne Kennedy, S Capewell, M Mwatsama on behalf of (i) the Division of Public Health the University of Liverpool and (ii) the Heart of Mersey Community Prevention Programme.

- Minimum standards for all foods and drinks provided by school shops and vending machines to offer a range of healthier choices.
4. The greatest inequalities in food and health occur in communities where income is low and too many people are dependent on lower priced items. Providing expensive healthier options will not address these inequalities in health.
 - An obvious solution is a fat-tax, with cross-subsidisation of healthy options such as fresh fruit, vegetables and fish;
 - The proposed fat tax would generate a useful budget to compensate those few small businesses/ other stakeholders with convincing financial losses;
 - Establish 'fat audits' to monitor the fate of salt and fat removed from certain products. Otherwise these damaging compounds will simply be quietly transferred into other products, especially foods aimed at vulnerable groups (for instance, cheaper foods and cheaper brands often contain MORE fat or salt or both).
 5. The FSA could and should advise government and OFCOM on legislation to effectively BAN advertising unhealthy foods during TV slots watched by children OR families.
 6. Involvement of the food industry is paramount. In its current form however, it is doubtful that their involvement will result in sufficient cooperation and change to have any impact on diet and public health. there needs to be:
 - Honest and transparent debates about the role of the food industry in promoting and or encouraging excess food consumption and dietary imbalance (for e.g. include more explicit and transparent processes for identifying commercial interests on expert committee levels etc.);
 - Action involving the food industry will require greater willingness on behalf of the food industry to acknowledge their *responsibility* in promoting and protecting public health;
 - In particular, the food industry needs to acknowledge how current food production methods contribute to the social, economic and environmental burden of diet related ill health. The draft proposals currently reflect excessive concern about potential loss of profits by industrial stakeholders. They have generally proved very adaptable;
 - It is naive to expect the food industry to share the same priority for public health; their business is to sell food, and a lot of it, in order to make profits. Lessons should be drawn from the experiences of the anti-tobacco campaign to strengthen negotiations with the food industry; positive 'levers' for change need to be identified; stricter targets and timescales introduced – on the back of increased consumer support for healthier food

culture; backed up by long term action to tighten regulation where voluntary codes have failed;

- Food and health issues are high on both public and policy agenda: this is a timely opportunity for government to develop a broader, comprehensive strategy to influence and improve dietary trends; but as the evidence suggests, action based on the traditional (biomedical) approach, i.e. emphasis on individual responsibility, will not be effective in bringing about the changes required for improvements in population health; evidence and opinion suggests that **an action plan based on the social or ecological model of health are required**;
 - Because the food and retail industries are demonstrably very responsive to market changes a period of just 18 months is recommended to demonstrate their support to a food and health action plan. Thereafter, LEGISLATION should then ensure that children, families and vulnerable groups get no misleading messages about healthy food;
 - Government should make opportunities to publicly praise companies and stakeholders which demonstrate rapid positive change.
7. The delivery aspects of implementing the National Food and health Action Plan need to be assessed – opportunities for skill mix – including ‘skilling up’ and involving Lay Food and Health Workers – should be explored.
 8. Welfare assistance: proposals to provide families on low income with financial assistance to buy milk, fresh fruit and vegetables should be developed. Such assistance need to be sensitive to avoid stigma therefore subsidies are preferable to benefits.
 9. Improving nutrition in pregnancy and early years is hindered by the promotion of harmful infant formula and weaning foods by the food industry.
 - More effort needs to be made to sign up UK hospitals to the UNICEF Baby Friendly initiative; workplaces should provide support for mother breast feeding eg provide clean, pleasant breast feeding areas other than the toilet or cloak room areas. Support services such as dedicated telephone lines and community role models should be recruited
 - The National Health School Standard and The National School Fruit Scheme should be extended to include nurseries;
 - Basic nutrition training should be introduced for all those working with young children – nursery nurses, child minders, play groups leaders etc.
 10. The NHS is a major purchaser of food supplies, one of the largest in the UK, and therefore has a unique opportunity to influence food production and food supply in hospitals and in NHS workplaces.

- Instead of involving 'popular chefs' an overhaul of existing food provision is required to provide patients and staff safe, affordable, palatable, health, socio-cultural acceptable foods;
- Genuine incentives to encourage NHS staff to eat healthy meals are required, this could be done by providing heavily subsidised foods to encourage healthy eating;
- Train all NHS staff in basic nutrition skills in order to effectively deliver action to improve the diet of and nutrition of the population it services;
- The NHS should establish better links with and make more use of community nutrition assistants, who are trained to work with local communities.

11. Health Impact Assessment (HIA) is needed to calculate the social and economic burden to public health of former policy decisions. For instance, the problems of food deserts resulting from the rapid development of out of town retailing; the concentration of a small number of food retailers and their impact on food retailing and on local communities. The impact on social exclusion should also be examined.

The authors recognise that not all the above recommendations can be implemented at once. Nonetheless, we feel, if such priorities were implemented, it would lead to the establishment of **genuine priorities** to redress imbalances in the availability and affordability of food in local communities, thereby helping to achieve healthier dietary trends.

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BIOGRAPHIES OF CONTRIBUTORS TO UK HEALTH WATCH

Priscilla Alderson is Professor of Childhood Studies at Social Science Research Unit, Institute of Education, University of London. Her research interests include children's rights and their views about their health and education services, research ethics, and participative research methods. Recent projects: 'Cross currents in ethics and genetics at the millennium,' 1999-2001, on health practitioners' views about practical ethical dilemmas posed in their daily work by the 'new genetics'; 'Children (aged 3-12 years) as partners in their diabetes care', 2003-04; 'foretelling futures: dilemmas in neonatal neurology', 2002-4. Details on <http://www.ioe.ac.uk/ssru>. A research programme is being planned about equity between generations.

Professor John Appleby is the chief economist of the King's Fund, London. He has worked as an economist in the NHS in Birmingham and London and as a Senior Lecturer in health economics at the University of Birmingham and the University of East Anglia

Clare Bamba is a Lecturer in Public Health Policy. She is interested in the interactions of policy, politics and health inequalities, particularly in terms of class and gender. She has been on the POHG steering group since 2002 and is co-author of the PoHG discussion paper Towards a Politics of Health. She is also a trade union official.

Evan Bates is currently Director of Corporate Services at The Royal Hospitals in Belfast, and a member of the Employment Services Board for West Belfast and Greater Shankill. After graduating with a degree in economics, his other main areas of work have been within the public service in Papua New Guinea, and the National Health Service in England.

Kate Burton is the Public Health Practitioner for Northwest Edinburgh Local Healthcare Co-operative (NWLHCC). Kate is responsible for leading work to tackle health inequalities and improve the health of the local population. She has been involved in establishing and co-ordinating a number of innovative projects across Edinburgh and Lothian including health and literacy initiatives and welfare rights services in GP practices. Prior to joining NWLHCC Kate was the Co-ordinator of the Pilton Community Health Project, a well established voluntary organisation that used a community development approach to tackle health inequalities.

Mark Burton is visiting professor of human services at the Research Institute for Health and Social Change at Manchester Metropolitan University. He is also a senior manager in a large integrated learning disability service with responsibilities for both health and social care. He has research and practice interests in social policy, community and liberation social psychology and in disability studies and he is active in international solidarity movements.

Toba Bryant, PhD, is a post-doctoral fellow at the Centre for Research on Inner City Health at St. Michael's Hospital in Toronto and an Associate of the Centre for Urban and Community Studies at the University of Toronto. She has published numerous book chapters and articles on policy change, housing and health within a population health perspective, and women's health and quality of life. Dr. Bryant has served as a consultant to Health Canada and the Wellesley Central Health Corporation on urban health issues.

Simon Capewell, Professor Clinical Epidemiology, Department of Public Health, The University of Liverpool. Professor Capewell has published widely in the field of Clinical Epidemiology with an emphasis on CVD prevention. He is currently, amongst other things, Research Director for the Heart of Mersey CVD Community Prevention Programme, which aims to reduce heart health inequalities across the County.

Hermela T. Chassme has been working with refugees and asylum seekers for the last 5 years. Currently she is working at the Refugee Council as Health Access and Development Worker. Her responsibilities include helping refugees and asylum seekers to access health services, advocating on their behalf along with lobbying on policies that affect these groups. Hermela graduated in 2000 with an Honours Degree in Health Sciences and Management and at present she is doing her master's degree in Public Health and Health Promotion at South Bank University.

Dr Judith Cook is a general practitioner whose work has included primary care for refugees and asylum seekers, GP consultations and medico-legal reports for the Medical Foundation for the Care for Victims of Torture and posts with Médecins du Monde in post-conflict situations in Afghanistan and Liberia. She is involved in Medact's work on the health of refugees and asylum seekers in the UK. In 2004 she worked with Médecins Sans Frontières during a broad assessment of health and medical needs of vulnerable immigrant groups in the UK.

Alan Cunningham is interested in the interrelationships between health, sustainability, social justice and quality of life. Alan has previously worked as an administrator in Further Education, where he qualified in Public Administration. After taking early retirement Alan sought to develop an earlier interest in the local applications of national and international policies. He is particularly interested in the possibility of using networks to empower communities and to support public health and local sustainability. He is a member of the Executive of the NorthWest Branch of UKPHA.

Other interests include; travel walking, indigenous peoples, comparative cultures, world music and islands.

Dr Peter Draper is a public health graduate who now freelances as a health policy consultant. He was formerly the founder and director of the Unit for the Study of Health Policy at Guy's Hospital Medical School which brought together public health, economics and sociological disciplines.

Dr Julie Fish is Senior Lecturer and Research Fellow in Social Work at De Montfort University, Leicester, UK. She conducted the first UK national *Lesbians and Health Care Survey* and has published several academic papers on lesbians' health behaviour and risk perceptions. She is currently researching a book for Palgrave entitled *Heterosexism in Health and Social Care*. She is involved in a number of initiatives and research projects, both locally and nationally, in LGBT health.

Debbie Fox is a research associate and lead for education and training in Health Impact Assessment at the University of Liverpool. Debbie has a plethora of different life experiences, in journalism and research, as a nurse and midwife, and as a Community Health Councillor and advocate for the National Child Birth Trust. She has also worked with women from ethnic minority groups and with young men to develop their literacy skills. She is passionate about, community involvement in HIA and health politics. She is a co-author of the PoHG discussion paper *Towards a Politics of Health*, and treasurer of PoHG.

Fiona Haigh is currently working in IMPACT, the International Health Impact Assessment Consortium, at the University of Liverpool carrying out Health Impact Assessments (HIA). Before joining IMPACT, Fiona spent the last five years living in Germany during which she completed a masters in public health at the University of Bielefeld. Fiona has also completed bachelors in law and social sciences at Waikato University in New Zealand and in 1998 was admitted to the bar as a barrister and solicitor. Her main research interests are HIA, health and human rights and interdisciplinary research and education.

Sally Hargreaves is a former medical editor and journalist. She began work with the aid organisation Medecins Sans Frontieres in 2001 focusing on the health needs of refugees in the UK and globally, which involving living and working in Nigeria, Uzbekistan, and Turkmenistan. She is now a Research Fellow at the International Health Unit, Hammersmith Hospital and Imperial College, researching issues around health-care access for vulnerable migrant groups in the UK. s.hargreaves@imperial.ac.uk

Elsbeth Hosie is literacy development worker and tutor with the NHS/CLAN Health and Literacy Project and part of the team who set up this new project, raising awareness of literacy links to health. With a degree in Sociology and a masters in Community and Adult Education, Elspeth has over 10 years experience in tutoring adult learners, particularly those who have no or few qualifications, encouraging them back to learning and helping them to realise their potential. This work also involved writing learning materials for adult learners as part of an EU funded Adult Returners Key Skills Programme. Elspeth is currently working on a Scottish Executive funded research project examining the impact the health and literacy project has had on health staff and learners.

Carolyn Kagan is Professor of Community Social Psychology at Manchester Metropolitan University where she is the Director of the Research Institute for

Health and Social Change. Her work includes participatory evaluation research with those marginalised in different ways by the social system, and she has worked for many years supporting service developments and citizen advocacy projects involving people with learning difficulties. She has a particular interest in the inclusion of disabled people in community life.

Lynne Kennedy has been employed by The University of Liverpool, Department of Public Health since 1994, where she is a Lecturer in Public Health Nutrition with responsibilities for undergraduate and postgraduate teaching and research in public health and health promotion. She has recently completed her PhD which examines Lay involvement in strategies to ameliorate social inequalities in diet and health. She has been actively involved and has published work relating to Food Policy and Food Poverty since 1990. She serves as a member of several local community and NHS task forces, where she aims to represent the public health needs of socially disadvantaged communities to redress social determinants of health. Lynne has been a member of POHG since its origins in 2002.

Paul Munster MSc has lived in Redcar for 20 years. He has worked for ICI R&D on the Wilton Complex for 14 years. He completed his Masters degree in environmental decision making in 2002 and is currently employed as an Environmental development officer for Impact.

Livingstone Musoro, London Metropolitan University, Human Rights & Social Justice Research Institute, Ladbroke House, 62-66 Highbury Grove, London N5 2AD, UK E-mail: l.musoro@londonmet.ac.uk, lmusoro@yahoo.com Ph: 00 44 20 7133 5095. Livingstone is an economist who has worked in Africa and the UK. He is currently carrying out research on HIV with migrant African communities in England. His research interests are on the intersections of globalization, migration, skills drain, HIV and socio-economic determinants of health in relation to African migrant communities in the UK.

Modi Mwatsama is the Food and Health Manager, Heart of Mersey Community Prevention Programme, Merseyside. Modi has a Masters in Public Health Nutrition and before her current post she worked previously for the British Heart Foundation on Food and health matters. She was joint author of a recent publication on Food Poverty by the BHF and is interested in promoting equity and health for communities.

Eileen O'Keefe, London Metropolitan University, Department of Applied Social Sciences, Ladbroke House, 62-66 Highbury Grove, London N5 2AD, UK. E-mail: e.okeefe@londonmet.ac.uk. Eileen is Academic Leader for Health Research. She works on health equity, globalization, participatory health impact assessment and human rights. A founder member of POHG, she is a member of the Community Development Forum of the London Health Commission.

Lisa Power is the Corporate Head of Policy and Public Affairs for Terrence Higgins Trust, the UK's leading HIV charity. THT, in addition to providing information and services for people with HIV across England and Wales,

campaigns for the legal and social rights of people with HIV and for greater public understanding of HIV and sexual health. Lisa is co-author of a range of policy reports and speaks regularly on discrimination, migration, health policy and the law and other related issues.

Dennis Raphael, PhD, is an Associate Professor at the School of Health Policy and Management at York University in Toronto, Canada. The most recent of over 120 publications have focused on the health effects of income inequality and poverty, the quality of life of communities and individuals, and the impact of government decisions on citizens' health and wellbeing. He is editor of "Social Determinants of Health: Canadian Perspectives" published by Canadian Scholars Press. He is also co-editor of "Staying Alive: Critical Perspectives on Health, Illness, and Health Care" which will appear February 2006, published by Canadian Scholars' Press.

Martin Rathfelder is the director of the Socialist Health Association, for half his working week. The rest of the time he works for South Manchester Law Centre and is election agent for Sir Gerald Kaufman. He was formerly the Welfare Rights Officer at Manchester Royal Infirmary and has long experience in advice organisations working to ensure that poor and disabled people got the benefits they were entitled to. He is the author of a number of books about the Welfare State and is a member of his local PCT Patients Forum.

Dr Sunanda Ray is a member of the Faculty of Public Health who has worked in Zimbabwe since 1983 and currently works for Brighton and Hove City PCT. She is also a founder member of the Zimbabwe Association of Doctors for Human Rights, which is affiliated to the International Federation of Health and Human Rights [IFHHRO]. Her publications range from Communicable diseases and HIV to sexual health, gender and behaviour change in scientific journals and in popular media. Her main interest is in getting research into action.

Dr Sally Ruane is a member of the Health Policy Research Unit at De Montfort University, Leicester. She has published work on the private finance initiative in health, UK anti-privatisation politics and the role of think-tanks in generating health policy ideas. Her current research interests include public-private partnerships and the role of the EU in health policy.

Nicola Ruck has worked for the British National Health Service, for government health services in low income countries, and for the Nuffield Institute for Health, Leeds, teaching primary health care policy and health management. She is a member of the Politics of Health Group and first joined in the 1970s. She has published on community participation in health and action research. She has experience of health promotion and human resource development and held long term posts in Afghanistan, India, Pakistan, Egypt, and South Africa. She now works freelance on health services management, uses NHS Wales services and lives in the Dyfi Valley.

Alex Scott-Samuel graduated in medicine at the University of Liverpool in 1971, and took his Master's in public health in 1976. From 1978-94 he was Consultant in Public Health with Liverpool Health Authority. Since 1994 he has been Senior Lecturer in Public Health at Liverpool University, where he also directs Liverpool Public Health Observatory; IMPACT, the International Health Impact Assessment Consortium; and EQUAL, the Equity in Health Research and Development Unit. His chief research interests are in health politics and policy, health inequalities, the health impact of patriarchy, and health impact assessment. He leads the health promotion module on the Liverpool MPH course.

Sarah Sexton is a director of The Corner House, a not for profit organisation that aims to support democratic and community movements for environmental and social justice. As part of its solidarity work, The Corner House carries out analyses, research and advocacy with the aim of linking issues, of stimulating informed discussion and strategic thought on critical environmental and social concerns, and of encouraging broad alliances to tackle them.

www.thecornerhouse.org.uk

Jane Shenton is Programmes Officer at Médecins Sans Frontières UK. Jane Shenton, Médecins Sans Frontières, 3rd Floor, 67-74 Saffron Hill, London EC1N 8QX, UK jane.shenton@london.msf.org

Helen Steel, 40, and **Dave Morris**, 51 are activists from North London. They became known as the 'McLibel Two' when accused by the McDonald's of libelling the global corporation in a campaigning leaflet distributed outside company stores. They defended themselves in what became the longest ever English trial, and one of the most notorious - described as 'the worst corporate PR disaster in history'. Both have returned to local community activism. For more information, go to www.mcspotlight.org.

Peter Townsend is Centennial Professor of International Social Policy (and was in 2002 Acting Director of the Centre for the Study of Human Rights) at the London School of Economics. He is also Emeritus Professor of Social Policy in the University of Bristol. He has been at the forefront of poverty and health inequalities studies since the 1950s. As well as challenging the philosophical and theoretical constructs of poverty, he has also been instrumental in the development of new methods of measuring and defining poverty and inequality in the United Kingdom and around the world.

Richard Wilkinson. After several years of manual work Richard trained in economic history and then social epidemiology. He worked briefly in the National Health Service before taking up research on the social determinants of health. He is now Professor of Social Epidemiology at the University of Nottingham Medical School and visiting professor at University College London. As well as an interest in what society tells us about health, he is also interested in what health tells us about society. His latest book is "The Impact of Inequality: how to make sick societies healthier".

Carole Zagrovic has worked with communities across Teesside and Cleveland for over 25 years. She has developed innovative and creative ways to involve communities in addressing difficult social, economic and environmental problems, such as youth disaffection and crime; unemployment; poverty, health & pollution; inequality, ethnicity and gender. Recently she completed a pilot study for Friends of the Earth into Environmental Justice issues. In recognition of her work, she successfully gained a training place with the economic, social and cultural organisation Dignity International to study human rights in Portugal in 2003. Having recently completed her OU Social Science studies she is now studying Environment and International Development.

The Politics of Health Group Charter

September 2005

Creating the circumstances in which people can sustain their health and live fulfilling lives is one of the most important political responsibilities. Politicians and policy makers must place at the heart of their work the development of policy that improves health and narrows the health gap between rich and poor.

Conditions to promote health are one of 'the' fundamental human rights and it is our collective responsibility to reduce poverty, inequality, social exclusion, exploitation, violence and injustice, which are the roots of ill health and premature death. The Politics of Health group holds that the following are the essential basis for promoting everyone's health

- 1. Full acknowledgement of the fundamental importance of all rights relating to health***
- 2. Governments' committed responsibility to strive for equitable social, economic and environmental conditions in which the health of all can thrive***
- 3. Governments' active responsibility to prioritise the health of their populations in the formulation of all policy and intervention strategies***
- 4. People's fundamental right to be informed and engaged, individually and collectively, in the development, delivery and review of policies and interventions aimed at sustaining and developing their health***
- 5. Economic policy that prioritises health and sustainable development as two interrelated and mutually enhancing fundamental goals***
- 6. People's right to be supported in developing loving and respectful relationships***
- 7. Everyone's right to the highest attainable standard of (7) health regardless of class, race, culture, religion or belief system, physical or mental ability, age or sexual orientation***
- 8. Governments' fundamental responsibility to ensure universal, equitable access to high quality health care, education and other services according to people's needs and not their ability to pay***
- 9. Everyone's right to just, safe and favourable conditions of work, balanced and compatible with a rewarding life***
- 10. Everyone's right to an income that provides the material means to a standard of living adequate for health and wellbeing***
- 11. People's right to a home that is safe, warm, dry, secure and affordable***
- 12. Safety, peace and security***
- 13. Everyone's right to food that is safe, nourishing, affordable and widely available, and is produced in ways that do not exploit others or degrade the planet***
- 14. Transport that is safe and affordable by all, with transport policies that encourage fuel economy and a cleaner environment***
- 15. People's rights to clean air, water and land, free from dangerous pollution, radiation and other environmental hazards, with safe disposal of waste***
- 16. People's rights to health education and the information, support and resources that enable them to promote health and to counter the causes of ill health***