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# Expert voices for change: Bridging the silos—towards healthy and sustainable settings for the 21st century

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ABSTRACT

The settings approach to health promotion, first advocated in the 1986 Ottawa Charter for Health Promotion, was introduced as an expression of the 'new public health', generating both acclaim and critical discourse. Reflecting an ecological model, a systems perspective and whole system thinking, the approach has been applied in a wide range of geographical and organisational contexts. This paper reports on a qualitative study undertaken through in-depth interviews with key individuals widely acknowledged to have been the architects and pilots of the settings movement. Exploring the development of the settings approach, policy and practice integration, and connectedness 'outwards', 'upwards' and 'beyond health', it concludes that the settings approach has much to offer—but will only realise its potential impact on the wellbeing of people, places and the planet if it builds bridges between silos and reconfigures itself for the globalised 21st century.



## 1. Introduction

This paper focuses on healthy settings theory, policy and practice—outlining the emergence and evolution of the settings approach, proposing a conceptual framework, and reporting on and discussing findings from a qualitative study undertaken with 'élite' individuals centrally involved internationally in designing and guiding the development of healthy settings programmes.

### 1.1. The settings approach to health promotion: emergence and development

Since its inception in the 1980s, the settings approach to health promotion has taken root worldwide, firing the imagination of professionals, politicians and citizens. The approach was advocated in the Ottawa Charter for Health Promotion (WHO, 1986). With a strong focus on creating supportive environments for health, the Charter described health promotion as the process of enabling people to increase control over and improve their health—and contended that "health is created and lived by people within the settings of their everyday life; where they learn, work, play and love" (p. 3).

Sub-titled "The Move Towards a New Public Health," the Ottawa Charter placed health promotion within the context of public health history and encapsulated broader conceptual thinking (e.g. LaFramboise, 1973; Lalonde, 1974; McKeown, 1976) through presenting an holistic socio-ecological model of health and reflecting a salutogenic focus (Antonovsky, 1987, 1996). Whilst commentators such as Ashton and Seymour (1988) viewed the 'new public health' enthusiastically, seeing its strong focus on healthy public policy and supportive environments as a means "to avoid the trap of blaming the victim" (p. 21), others were more critical. Armstrong (1993) contended that it extended surveillance through demanding individual responses to reduce dangers arising from economic and social activity. Similarly, Petersen and Lupton (1996) cautioned against an unproblematic and liberating interpretation, arguing that – through its role in the multiplication and moralisation of risk – the 'new public health' "can be seen as but the most recent of a series of regimes of power and knowledge that are oriented to the regulation and surveillance of individual bodies and the social body as a whole" (p. 3). Central to their argument was an alignment of the 'new public health' with neo-liberalism and an analysis that "while the new public health may draw on a 'postmodernist' type of rhetoric in its claims, it remains at heart a conventionally modernist enterprise" (p. 8).

As Kickbusch (1996, p. 5) reflects, the Charter resulted in the settings approach becoming the starting point for WHO's lead health promotion programmes, with a commitment to "shifting the focus from the deficit model of disease to the health potentials inherent in the social and institutional settings of everyday life…[and] pioneer[ing] strategies that strengthened both sense of place and sense of self." Subsequent international health promotion conferences provided further legitimacy and focus

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for the settings approach: for example, the Sundsvall Statement argued that "a call for the creation of supportive environments is a practical proposal for public health action at the local level, with a focus on settings for health that allow for broad community involvement and control" (WHO, 1991, p. 4); and the Jakarta Declaration (WHO, 1997, p. 3) asserted that settings for health provide an important infrastructure for health promotion and that "comprehensive approaches to health development are the most effective… particular settings offer practical opportunities for the implementation of comprehensive strategies."

Widely regarded as the first settings programme, Healthy Cities was launched by WHO in 1987 with the aim of translating WHO rhetoric "off the shelves and into the streets of European cities" (Ashton, 1988, p. 1232). Whilst Kickbusch (2003) suggests that its integrative multi-sectoral partnership model echoes Giddens (1991) and his call to move beyond a vertical silo approach to policy and politics, Healthy Cities – with its focus on city-level governance – has also been understood as a means of WHO bypassing national government resistent to the principles of the Ottawa Charter (Hanlon et al., 2012). Dooris (1988, p.7) explored similar ideas, questioning whether its local focus could achieve meaningful progress in the context of unsupportive national policy and suggesting that it risked embodying the "depoliticised politics of WHO."

Despite these reflections, it is clear that what started as a small WHO-led European project rapidly grew into a global movement, achieving lasting acclaim (Ashton and Seymour, 1988; de Leeuw, 2009). However, as a key application of the 'new public health', Healthy Cities has likewise been the focus of critical commentary with writers reflecting on the tension between Healthy Cities as an idea, experiment and social movement and Healthy Cities as a WHO-led programme. Davies and Kelly (1993) contend that Healthy Cities as a movement is essentially post-modern, built on an aesthetic and moral view of health. This, though, sits in tension with how Healthy Cities has been led and managed, which reflects a modernist belief in technical and scientific principles as a means of defining and solving problems. Echoing earlier critiques of Health for All (Navarro, 1984; Strong, 1986), Baum (1993) takes this further, suggesting that Healthy Cities' close affiliation to bureaucracies makes its claim to be a social movement problematic because the institutions and practices it seeks to change may compromise its ability to bring about that change. Petersen and Lupton (1996) extend their critique of the 'new public health' by focusing on Healthy Cities – arguing that its advocates "have made no effort to rethink the concept of the city itself" (p. 145) and that WHO's leadership has inevitably infused it with a modernist technocratic model. Whilst acknowledging its expansion beyond a top-down WHO-led programme to involve many cities drawing on its ideas and principles, they postulate that whilst reflecting a degree of 'bottom-up' development, national and international networks tend to "reinforce the control of knowledge and resources in the hands of experts, administrators and politicians" (p. 132). Countering these critiques, Baum (2002) argues that Healthy Cities initiatives are rarely based solely on rational processes, encouraging "visions, expressions of the 'soul' of cities and people's emotional responses" (p. 487).

Drawing on the experience of Healthy Cities, developments took place in Europe within settings such as schools, hospitals, prisons and universities (Barnekow Rasmussen, 2005; Pelikan, 2007; Gatherer et al., 2005; Tsouros et al., 1998). In each of these initiatives, the overarching aim was to encourage all parts of the organisation to work together to improve the health of the entire setting (Kickbusch, 2003). As with Healthy Cities, these developments have catalysed action in many parts of the world—often within the context of WHO-led programmes: for example, Healthy Islands and Healthy Marketplaces developed in the Western Pacific (Galea et al., 2000; WHO, 2004); and a Healthy District programme was established in South-East Asia (WHO, 2002). More widely, the approach has infused public health and health promotion strategy at national, regional and local levels—and inspired a diversity of settings-related work with its own direction and momentum.

### 1.2. Towards a conceptual framework for healthy settings

As Mullen et al. (1995) note, health promotion has long appreciated the value of using settings such as channels for reaching defined populations. However, as intimated above, the settings approach is now widely understood to go beyond this instrumental focus on implementing interventions within a setting—embracing an understanding that "place and context are themselves important and modifiable determinants of health and wellbeing" (Dooris et al., 2007, p. 328). Green et al. (2000) highlight the need to acknowledge pre-existing social relations and power structures and the reciprocal determinism between structure and agency—suggesting that settings are "arenas of sustained interaction with pre-existing structures, policies, characteristics, institutional values, and both formal and informal social sanctions on behaviours" (p. 23). As Green and Tones (2010) highlight, this view resonates with a post-modern conceptualisation of organisations, with an appreciation of the need for complex multi-level responses necessitating that the ethos and activities of a setting combine synergistically to improve health and wellbeing.

Whilst it is important to appreciate variation within and between categories of settings, and to be aware of the dangers of creating an artificial consensus (Green et al., 2000), it is also apparent that increased clarity of conceptualization can strengthen practice, policy, research and evaluation. The literature does not suggest the emergence of an overarching 'theory', instead pointing to the integration of wider theoretical perspectives underpinning health promotion with insights from a range of disciplines (Green et al., 2000; Kickbusch, 2003). However, it is possible to propose a conceptual framework for the settings approach—underpinned by values such as equity, participation and partnership, and focused on three key characteristics (Dooris, 2005).

Firstly, it adopts an ecological model (Stokols, 1996). It appreciates that health is a multi-layered and multi-component concept involving inter-related physical, mental, 'spiritual' and social dimensions of wellbeing—and that it is determined by a complex interaction of factors operating at personal, organisational and environmental (physical, social, political, economic and cultural) levels. It moves beyond focusing solely on pathogenesis towards salutogenesis (Antonovsky, 1987, 1996), concerned with what creates health and makes people flourish; it reflects a public health perspective by focussing on populations within particular contexts; and it represents a shift of focus away from a reductionist emphasis on single health problems, risk factors and linear causality towards an holistic view, concerned to develop supportive contexts within the places that people live their lives. Furthermore, Lang and Rayner (2012) argue that a 21st century ecological model of public health must take account of material, biological, cultural and social dimensions of existence, and address human health within the context of ecosystem health.

Secondly, reflecting this ecological model and drawing on insights from management science, organisational theory and other disciplines, the approach views settings as complex systems. This systems perspective acknowledges interconnectedness and synergy between different components and recognizes that settings do not function as 'trivial machines', but are both