

# The practice nurse and the healthy city

**B**y the year 2000 the urban population of the world will exceed three billion, and almost 50% will live in cities with populations of more than one million ... in Europe that figure is 75%. For most of us the quality of the urban setting will play a major role in determining our health.

Throughout the world cities are at many different stages of development. Some new cities are still being established while old cities continue to grow or to be remodelled. In other parts of the world, once-great cities are in a state of crisis and rapid decline.

However, despite prophecies that cities are doomed, for many of us they remain the focus for dreams of utopia — or at least the good life — and young people continue to flock to them.

The familiar trends of growth and decay in cities have coincided with changes in traditional social structures: the decline of the three-generation family living in one place, and the changing expectations and status of women, marriage, work and retirement.

Interest in greening post-industrial cities has become a major phenomenon, and concern about the world's ecology, particularly in relation to pollution, is now at the top of the political agenda. If the planet is to survive, city dwellers must modify their habits as consumers.

There's a need to broaden our social view of health in the urban setting as the nature of medical problems changes. Although the appearance of AIDS has reminded us that

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**The year 2000 presents a challenge to health workers everywhere, and especially those in urban areas. Dr John Ashton offers advice on how cities can achieve the WHO goal of Health for All and the implications for practice nurses.**

eternal vigilance against infectious disease is vital, infectious diseases have largely given way to heart disease, stroke, cancer, accidents and suicide as manifestations of a life style that's out of step with our evolution.

We evolved as hunter-gatherers with an active physical life, supportive social networks and a very different type of nutrition from that of today.

## CHANGING ERAS OF PUBLIC HEALTH

Between 1840 and 1970, three distinct eras of public health can be identified. We are now in the early stage of a fourth era, coming to be known as the 'New Public Health'. It involves a fundamental reappraisal of what has gone before.

### 1840-1880: Environmental health

Industrialization led to the rapid growth of cities and resulted in masses of people living in insanitary, overcrowded conditions. Liverpool's first Medical Officer of Health, William Henry Duncan, found in a survey taken in the 1830s that one-quarter of the population was living in squalid, earth-floored, windowless cellar dwellings with upwards of 16 people in a room.

Under such conditions epidemics of typhus, typhoid, cholera, measles,

pneumonia and tuberculosis thrived. The public health response that developed was based on building construction regulation and provision of safe water, food and sanitation.

This was backed up by law, and enforced by the Medical Officers of Health (MOHs) and their sanitary inspectors. Analysis of the epidemic curves of deaths during this period shows the impact of these environmental measures.

### 1880 to 1930: Personal prevention

As the worst of the living conditions were tackled it was possible to develop personal prevention measures beginning with immunization and vaccination. School health services, personal social services and family planning clinics were to follow.

Family planning had a strong impact: spacing children more widely reduced maternal mortality, and smaller families meant less competition among siblings for scarce family resources, thus improving the nutrition and health of children.

### 1930 to 1974: The treatment era

Before about 1930 there were few treatments that had any effect. Between 1930 and 1974, beginning with insulin and the sulphonamides, there was an explosion of new treatments, which continues today.

However, we have become more aware of the limits to treatment, and more alert to side-effects. The induced dependence of more than 5% of adults on benzodiazepines underlines the dangers of looking for magic bullets to cope with daily frustrations.

We now recognize that health is usually gained and lost in everyday life and that medical care is only one

factor among many. However, medical care is particularly important for those with chronic conditions.

**THE NEW PUBLIC HEALTH AND HEALTHY CITIES**

What is emerging as the New Public Health is actually the rediscovery of the importance of the environment and a healthy criticism and appraisal of personal prevention and treatment. It seeks a synthesis of all three, based on a better informed public and an awareness that the social, economic, psychological and physical environments all need to be examined in the face of modern threats to health.

The world oil crisis in 1973 forced governments to reconsider their emphasis on hospital-based medical care. The World Health Organization strategy of Health For All By the Year 2000 offers a new approach to achieving health. The Healthy Cities Project is one way in which that strategy is coming to life.

**HEALTH FOR ALL BY THE YEAR 2000**

WHO's strategy is to ensure that by the year 2000 'all people in all countries should have at least such a level of health that they are capable of working productively and participating actively in the social life of the community in which they live'. The emphasis is on:

- the promotion of life styles conducive to health
- the prevention of preventable conditions
- rehabilitation and appropriate health services

Health for All has been separated into 38 targets to be achieved by the year 2000. They cover specific causes of death and disability, life styles, environments, and the research, teaching and services needed to promote better health (see chart).

Since the Health For All policy was adopted in 1981, it has been recognized that health promotion must go far beyond health education, and into policies and politics that support healthy environments and healthy choices.

**Targets for 'Health For All' by the year 2000 in Europe**

**Targets 1-12: Health For All**

- |   |   |
|---|---|
| 1. Equity in health   | 6. Increased life expectation at birth  |
| 2. Adding years to life   | 7. Reduced infant mortality             |
| 3. Better opportunities for the disabled  | 8. Reduced maternal mortality           |
| 4. Reducing disease and disability  | 9. Combating disease of the circulation |
| 5. Eliminating measles, polio, neonatal tetanus, congenital rubella, diphtheria, congenital syphilis and indigenous malaria | 10. Combating cancer                    |
|   | 11. Reducing accidents                  |
|   | 12. Stopping the increase in suicide    |

**Targets 13-17: Life styles conducive to Health For All**

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|--|--|
| 13. Developing healthy public policies                       | 16. Promoting positive health behaviour  |
| 14. Developing social support systems                        | 17. Decreasing health-damaging behaviour |
| 15. Improving knowledge and motivation for healthy behaviour |  |

**Targets 18-25: Producing healthy environments**

- |   |  |
|---|--|
| 18. Policies for healthy environments                         | 22. Improving food safety                        |
| 19. Monitoring, assessment and control of environmental risks | 23. Protecting against hazardous wastes          |
| 20. Controlling water pollution                               | 24. Improving housing conditions                 |
| 21. Protecting against air pollution                          | 25. Protecting against work-related health risks |

**Targets 26-31: Providing appropriate care**

- |   |                                       |
|---|---------------------------------------|
| 26. A healthcare system based on primary healthcare | 28. Re-orienting primary medical care |
| 27. Distribution of resources according to need     | 29. Developing teamwork               |
|   | 30. Co-ordinating services            |
|   | 31. Ensuring quality of services      |

**Targets 32-38: Support for health development**

- |   |   |
|---|---|
| 32. Developing a research base for Health For All | 35. Health information systems                |
| 33. Implementing policies for Health For All      | 36. Training and deployment of staff          |
| 34. Management and delivery of resources          | 37. Education of people in non-health sectors |
|   | 38. Assessment of health technologies         |

A well-informed and participating public is essential and professionals must learn to share some of their knowledge and power. The necessary style has been described as being 'on tap not on top'.

The concept of primary healthcare that goes along with this differs from that of general practice or even primary medical care, in recognizing that diverse groups of people have an impact on the health of others and are therefore primary health workers. These include supermarket managers who market healthy food, water companies who should supply wholesome water, and taxi-drivers who prohibit smoking in their cabs.

Medically trained workers need to support health initiatives, campaigning wherever and whenever necessary. It is from this perspective that practice nurses should consider the implications of Health For All.

**HEALTHY CITIES**

The Healthy Cities Project, a project first promoted by the European office of the World Health Organization in 1985, sprang from the ideas of many. The original intention was to bring together representatives from a few European cities to collaborate in the development of urban health promotion initiatives.

By doing that, it would be possible to promote models of good practice that could be copied or developed by other municipal administrations.

Agreeing on the precise nature of the healthy city is not easy to achieve. Certainly a healthy city is more than one with good health services. One technique for encouraging fresh ways of looking at health in the city is through scenarios workshops.

This method can also be used to explore diverse visions of a healthy city, and work towards a consensus. The thinking behind this is that although plans that take account of constraints are always necessary, to create a healthier future we must start with ideas and a clear vision — those who start with 'realism' will never have vision.

For most of recorded history cities have been unhealthy places to live,

especially for poorer citizens. Mortality rates and general health varied according to social class, with the poor suffering most.

It is not surprising that such poor conditions inspired thinkers to imagine urban utopias as a stimulus to change. Nor is it surprising that visions of the future should have influenced the town planner Ebenezer Howard, who developed the first 'garden city' suburbs in the United Kingdom at the end of the 1800s as a solution to slums.

Many technical interventions of the recent past, such as housing estates and new towns, tower-blocks and fully-planned environments, are failures. Prospective residents were not consulted about housing plans and one of their most precious assets for health — their network of family and friends — was often destroyed in the process.

The Healthy Cities Project centres on five areas:

- Developing a variety of models of good practice for cities. These may range from major environmental

action to programmes designed to support individual life style changes, but all incorporate the key principles of health promotion.

- Monitoring and researching the effectiveness of models of good practice on health in cities.

- Disseminating ideas and sharing experiences between collaborating cities and other interested cities.

- Mutual support, collaboration and learning, and cultural exchange between towns and cities of Europe.

Healthy city initiatives did not begin with the Healthy Cities Project. The community gardens movement in North America is a good example of an ecologically orientated initiative arising from within communities — it fits very well into the philosophy of Health For All.

Other examples include Rails to Trails in the United States and Susstrans in the United Kingdom — these are community organizations which convert disused railway tracks to cycle

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**Figure 1.** *The facilities at Peckham Health Centre in the 1930s, demonstrating a range of community-led initiatives.*

Welfare and Educational	
antenatal clinic	sports clubs and recreational clubs
postnatal clinic	keep-fit and gymnastic classes
birth control clinic	adult cultural education
infant welfare clinic	music, debates, drama, any event desired by members
care of the toddler	citizens advice bureau
nursery school	holiday organizations
immunization service	outings and expeditions
schoolchildren's medical examinations	the bar
vocational guidance	billiards
sex instruction for adolescents	dancing
girls' and boys' clubs	social gatherings
youth centres	
Therapeutic	
marriage advice bureau	social worker
mothers' clinic	hospital follow-up overhaul
child guidance clinic	rehabilitation clinic
poor man's lawyer	

completed. Summary evaluations are scrutinized by the steering committee and modifications made to future courses. The steering committee recognized the need for longer term evaluation which examines the impact of the courses on nursing practice.

Enquiries about courses should be addressed to Sian Davies at the Marie Curie Memorial Foundation, 28 Belgrave Square, London SW1X 8QG.

**The Marie Curie Memorial Foundation** is a comprehensive cancer charity that has four main areas of operation:

- The provision of nursing and welfare services for cancer patients in their own homes.
- The provision of residential homes for the medical and nursing care of cancer patients.
- A Research Institute that undertakes research into the cellular mechanisms that cause cancer.

■ An Education Department that offers professional education courses and conferences throughout the UK.

The Education Department offers update seminars on cancer research and treatments, and courses in cancer nursing, palliative care, occupational health and teaching cancer nursing.

In addition, there are more experiential workshops in communication, counselling and bereavement for nursing and other staff caring for cancer patients.

## PUBLIC HEALTH

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and walking routes. In the South Bronx, New York, GLIE farms have ridden the wave of health foods and products by establishing a highly successful community business, growing herbs and selling them to hotels and restaurants from a base in derelict industrial land within a community demoralized by unemployment, crime and drug abuse.

Similar tales of urban regeneration are emerging from elsewhere in North America. It is important to bear in mind the comparison between community-driven initiatives such as these, and traditional government initiatives. What is needed for the new initiatives is the active support of various agencies within a city.

If we ask what would be healthy practice nursing in a healthy city, we

might get some uncomfortable answers. The reorientation of medical care towards health promotion and prevention is a central part of the Health For All strategy, yet most health centres are still described as sickness centres and most health workers as sickness workers. The 38 targets provide a chance to turn things on their head and make plans to promote and maintain health rather than just to treat sickness.

### COMMUNITY-LED INITIATIVES

Some clues to the type of practice which could emerge are provided from the Peckham Pioneer Health Centre in South London in the 1930s. Peckham as a health rather than a disease centre was based on supporting health

through a democratic partnership between staff and public. It achieved its goals through a variety of non-medical means (see Figure 1, p.378).

Community-led initiatives such as these are likely to be a part of any initiatives in primary care similar to those of Healthy Cities.

There is a limit to what can be done at the local level to improve health. The importance of the Healthy Cities approach is that by starting with a global vision of health and then focussing on local, individual and group action, change can be generated from the bottom up. Such change is likely to be both powerful and durable.

### FURTHER READING

*The new public health* by John Ashton and Howard Seymour. Open University Press, 1988.

## LETTERS

### CLEANSING OF WOUNDS

I was surprised to read in 'Open Wounds 3' (*Practice Nurse*, October 1989, p.222) that "superficial wounds should be cleaned thoroughly with 0.5% chlorhexidine". Research (e.g. 'Best performer', *Nursing Times* 6 April 1988, p.53) has shown that the only safe cleansing lotion is physiological isotonic saline. Chlorhexidine is toxic to new capillary network; it supports the growth of *Pseudomonas*, and its bactericidal activity is reduced in the presence of blood.

**Christine Nice**

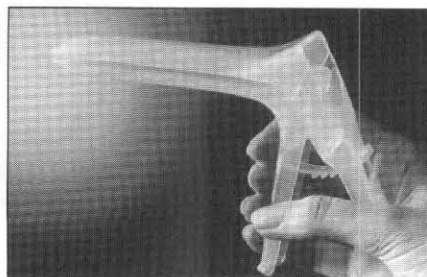
*Practice Nurse, Dartford*

● *I have no reason to dispute that physiological isotonic saline is ideal*

*for wound cleansing, but in my opinion 0.5% chlorhexidine is an excellent skin cleanser for the minor wounds the practice nurse is likely to meet in the treatment room. Wounds are normally dressed when the bleeding has ceased, and problems with Pseudomonas infection in the general practice treatment room are uncommon.*

**Kenneth Scott**

We should like to receive letters from you, on any subject about which you feel strongly. They should be typed double-spaced, marked 'for publication' and signed. Send them to the Editor, *Practice Nurse*, Reed Healthcare Communications Ltd, Friary Court, 13-21 High Street, Guildford GU1 3DX.



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