

# Health and Sustainable Development: Agenda 21 and beyond

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## 1. Introduction

The links between health and environmental quality are nothing new. Growing awareness of those links led to the environmental health professions and indirectly to the environmental movement. But at present it is fair to say that working relationships between the environmental and the health sectors are generally limited and under-developed.

Over the last decade there has been a renewed focus on these links, and a growing body of work shows the value of cross-sectoral working, which has been fuelled in part by the integrated approach that is 'sustainable development'. Sustainable Development was originally defined as "*development that meets the needs of the present without compromising the ability of future generations to meet their own needs*". This was put on the political agenda by the 1992 UN Earth Summit. This event produced the comprehensive global action programme 'Agenda 21'. One of the key sections of this plan – Chapter 6 – specifically addressed health issues.

But there have been many other factors influencing change since 1992. Indeed in both health and environment terms this has been a decade of rapid change and this has worked against developing long-term strategies, but there have been many positive initiatives, notably the new focus on health inequalities, while the new restructuring around Primary Care Trusts certainly offers the opportunity for more 'joined-up' working between the disciplines.

It's perhaps worth considering those changes in order to see where we've come from before we look where we might go.

## 2. The Health perspective.

Much of the change in the health services started in 1991 with the *NHS and Community Care Act*, which introduced the internal market. In 1992 the *Health of the Nation* report encouraged health authorities to take on a more strategic role, namely that of maintaining and improving the health of the local population.

In 1997 the Labour Government brought further change with a new post of Minister of State for Public Health and in 1999 the White Paper, *Saving Lives: Our Healthier Nation* (OHN), which set out both to improve health and to reduce health inequalities. It aimed to prevent up to 300,000 untimely and unnecessary deaths by the year 2010 and puts more emphasis on the social and environmental determinants of health. This included work to set up health improvement programmes (HImPs) and health action zones (HAZs). In 2001 the *Shifting the Balance of Power* paper further restructured the NHS and set up the Primary Care Trusts system and reduced health authorities by about a third. Each PCT is to have its own director of public health. |

There's also been the ground-breaking work on Health Inequalities. The Acheson report – 'The Independent Inquiry into Inequalities in Health' was set up in 1997 and goes further than any other report to link poverty, health, environment and inequity. It is in many ways the best document yet produced in the UK on sustainable development.

The report suggests that “the economic and social benefits of greater equality seem to go hand in hand. The quality of the social environment is worst where financial deprivation is greatest, such as the inner cities.” It makes many recommendations, the first to which is “that as part of health impact assessment, all policies likely to have a direct or indirect effect on health should be evaluated in terms of their impact on health inequalities, and should be formulated in such a way that by favouring the less well off they will, wherever possible, reduce such inequalities”.

In November 2002 the Dept. of Health followed this up with the 'Cross-Cutting Review on Health Inequalities'. This specifically identifies environmental improvement as one of four areas where interventions are likely to bring health benefits.

### **3. The environmental perspective**

Environmental issues have also changed significantly. The 1992 UN Earth Summit took place at the end of a period when environmental awareness had risen very rapidly. Chernobyl, CFCs and the ozone layer, tropical rain forest destruction and climate change had put global issues in the media. In the mid-1990s the focus shifted to the UK, especially concerns about roads and transport with strong arguments over the impact of vehicle emissions on health. In 1998 the 'Committee On the Medical Effects of Air Pollution (COMARE)' issued its' report on 'Quantification of the medical effects of air pollution in the United Kingdom' which concluded that between 12,000 and 24,000 people might die prematurely every year as a result of air pollution. Other reports suggested that, in urban areas, road transport was the major cause of such air pollution.

The 1997 change of government also produced a new strategy for sustainable development, *A Better Quality of Life*. It includes a section of 'Better Health For All' and also refers at relevant points to '*Our Healthier Nation*'. While this remains something of an aspirational document, it is as good an example of 'joined-up thinking' as can be found anywhere in government. It includes fourteen 'headline indicators', one of which is 'expected years of healthy life'; two others (on housing and air pollution) link strongly to the health agenda.

The other major UK environment and health issue has been the food we eat. Food scares have pushed food and farming up the political agenda and the development of DEFRA was significant in this context. It seems certain that the overall focus on food is having at least limited health benefits, while reductions in pesticide use lower the public health risks from misuse and overuse. This in turn links to work on the Stockholm Convention which finally agreed an international phase-out of the 'dirty dozen' persistent organic pollutants (POPs), most of which are pesticides. The EU is now working on a new Chemical Regulation that will limit the production and use of persistent endocrine-disrupting chemicals, and a range of UK NGOs are seeking to turn this 'limiting of production' into a phase-out programme.

The other major concern is global climate change. The nature and extent of this change remains open to debate, but there is an overwhelming consensus that change is taking place. The impact of all this on health remain unclear and much research is under way.

One new concern, which is likely to have increasing influence in the next decade which is the concept of Environmental Justice – the idea that poorer communities suffer the additional impact of living in the worst environments. I will return to this focus on environmental inequalities later. Many UK groups are now looking at this approach and the Environment Agency has set up an Environmental Equality steering group.

It is also important to recognise that the 1990s have seen a steady expansion of local work on environmental issues. One report suggests that there has been broadly a trebling of local activity in the decade since 1992. Much of this has resulted from or been helped by local council-run Local Agenda 21 programmes, one of the most positive outcomes of Agenda 21. One sentence called on local authorities to “consult with their communities” to produce a “local Agenda 21”. This was taken up enthusiastically in the UK: by 2001 over 93% of UK councils had produced a document, with widely varying results and approaches.

Most LA21 programmes remained rooted in an environmental perspective, with some positive results including targets for waste minimisation, energy saving (often linked to fuel poverty work), and work on biodiversity and transport. However few LA21s made working links with the health sector although this is perhaps mostly due to the non-involvement of health sector organisations.

Voluntary sector networks on issues such as food and waste have also expanded, aided in part by funding from National Lottery programmes. This has further implications for change. Whereas in the 1980s most ‘environmental’ professionals were employed by national organisations, the majority are now spread throughout thousands of local projects, local councils and other organisations. This means that environmental health professionals may find more local stakeholders for new projects or programmes.

#### 4. Making the links

Several organisations have sought to strengthen links over this period. In 1996 the **Chartered Institute established a Commission on Environmental Health** to make recommendations for its future development in the United Kingdom. ‘*Agendas for Change*’ was the final report, which suggested that, while health and the environment have always been closely related, in recent years the subjects have tended to drift apart. The Commission concluded that this drifting apart needs to be reversed and hoped that ‘*Agendas For Change*’ should provide ‘a starting point for a wide ranging debate within the profession and beyond, leading to substantial reform and long-term improvements in environmental health’.

The **World Health Organisation** European regional office runs the ‘Environment and Health for Europe’ process as well as its’ work on ‘Healthy Cities. In June 1999 WHO Europe ran the ‘Third European Ministerial Conference on Environment and Health’ in London, bringing together health and environment ministers from all parts of Europe. A parallel event for NGOs and other sectoral groups was also organised. The conference focused on issues including:

- Transport Environment and Health
- Water and Health
- Children’s health and the environment
- Human health effects of climate change
- Economics, environment and health
- Local Environment and Health Implementation
- Access to information and justice in environment and health matters

There has been less follow-up on many of the key London issues than was hoped at the time of the conference. This has been for several reasons, including lack of resources but it does seem that the underlying problem is a lack of commitment to joint working.

## **5. Agenda 21, Chapter 6: an action plan for health and sustainability?**

One of the drivers for the integration of Environment and Health within the overarching theme of sustainable development has been the UN Agenda 21 action plan, agreed by governments at the 1992 UN Earth Summit. The opening paragraph of Agenda 21 states:

*“ Health ultimately depends on the ability to manage successfully the interaction between the physical, spiritual, biological and economic/social environment. Sound development is not possible without a healthy population; yet most development activities affect the environment to some degree, which in turn causes or exacerbate many health problems.”*

Chapter 6 specifically addresses health issues, with five key target areas:

- a. Meeting primary health care needs, particularly in rural areas.
- b. Control of communicable diseases
- c. Protecting vulnerable groups
- d. Meeting the urban health challenge
- e. Reducing health risks from environmental pollution

All these issues relate directly to environmental health priorities. Given that the UK has a fully-developed national health service it is not surprising that the majority of the issues in Chapter 6 have been tackled. The introduction of Primary Care Trusts brings the UK very much in line with the underlying thrust of Agenda 21, as does work on Health Inequalities.

### **a. Meeting primary health care needs, particularly in rural areas.**

The prime objective, of ‘meeting the basic health needs’ has been met, with the proviso that there are worrying differences in accessibility to health services in rural areas, and that the public is very concerned about many aspects of rural and urban health service delivery. Health indicators show clearly that people living in rural areas tend to slightly better health than urban dwellers. This is linked to overall poverty figures for the UK, and conceals pockets of rural poverty and ill-health.

### **b. Control of communicable diseases**

The anthrax-related events in the wake of September 11<sup>th</sup> 2001 have given a new focus to work on communicable diseases in the UK and one (bio-terrorism) that was not covered in Agenda 21. The Government published ‘*Getting Ahead of the Curve – A strategy for combating infectious diseases*’ in March 2002. This set out a blueprint for a new agency, the National Infection Control and Health Protection Agency which will co-ordinate systems and work with Regional Directors of Public Health.

Even though the UK is free of many of the diseases highlighted in Agenda 21, tackling diseases such as the AIDS / HIV pandemic and malaria and childhood diarrhoea require global support. UK development assistance has risen since Rio but is still a very long way from the international target of 0.7% of GDP called for at Rio. The UK has also significantly failed to “contain the resurgence of tuberculosis” in London and other major cities. This highlights the need for increased spending to improve environmental health and to continue to tackle poverty.

### **c. Protecting vulnerable groups**

This section stresses that specific emphasis on vulnerable groups, “*particularly infants, youth, women, indigenous people and the very poor*” as a prerequisite for sustainable development. This can again be seen as primarily an issue for developing countries. However the UK has poverty, albeit not as absolute; there are vulnerable elderly people (and numbers are rising), and the health impacts are clear in areas such as fuel poverty and early deaths every winter.

#### **d. Meeting the urban health challenge**

The ‘urban health challenge’ set out in Chapter 6 was very optimistic, calling for an improvement of “10 to 40%” in health indicators by the year 2000. The UK has tackled this issue, albeit in a piecemeal way. Many urban regeneration programmes have specifically tackled health issues. Other work has been supported by the WHO European Healthy Cities programme. A number of UK cities are actively involved in this programme.

#### **e Reducing health risks from environmental pollution**

This section of Agenda 21 identifies thirteen key pollution issues, all of which are tackled to some extent in the UK, some through health and safety work, other through the Environment Agency and through ongoing research.

### **6. Work by the key agencies**

Work on environment and health issues is now being done through a range of agencies. This means there are more stakeholders and also more potential partners for new programmes. There have been many reports and initiatives from groups in both disciplines over the last decade, from Friends of the Earth to the Kings’ Fund. The key agencies currently include:

- **The National Health Service**

The NHS is the largest organisation in the country with around a million employees and spending about £7 billion on goods and services: about £500 million is spent on food, providing over 300 million meals for patients, staff and visitors.

Given the sheer size of the organisation, it is not surprising that the NHS has been slow to embrace sustainability. However the benefits of environmental interventions on public health are well charted, and it is therefore disappointing that so little has been done to maximise the mutual benefits of improving internal environmental performance and public health. For instance NHS trusts produce over 100,000 tonnes of clinical wastes each year and GPs, dentists and others produce more than this again. Disposing of such wastes costs from £180 - £320 per tonne, so investment in a waste minimisation strategy is likely to pay real dividends.

A recent report by the King's Fund, “Claiming the Health Dividend”, suggests that the NHS could save millions of pounds and improve thousands of people's lives every year by investing in local communities and more sustainable practices. The report calls on the NHS to use its’ unparalleled purchasing power more effectively to promote better health, and also to invest in tackling unemployment, boosting local business, reducing the amount of waste they produce and making their buildings more energy-efficient. It suggests that if they do, they will reap multiple benefits later on.

Change is coming: in April 2002 NHS Estates issued “The new environmental strategy for the National Health Service”, a report on “Sustainable Development in the NHS”, and materials for use by Trusts. The Environmental Strategy calls for the introduction and achievement of:

- Environmental appraisal
- Environmental Management systems
- Environmental performance management”

This is not just about good practice. The NHS is covered by the Environmental Protection Act 1990 and some Health Trusts have already fallen foul of this, notably in regard to waste management, and are now being advised to recognise both the ‘Polluter Pays’ Principle and the Precautionary Principle, which seems appropriate, given that it is at the core of public health work.

- **The Chartered Institute of Environmental Health (CIEH)**

The CIEH has been at the centre of many debates about better linkages between the two disciplines of health and environment. Nationally and internationally the CIEH has worked to ensure health and sustainability issues were considered together, notably through the ‘Agendas for Change’ report. However the environmental health profession is under pressure to tackle difficult issues on limited and even declining resources, leading to a focus on the primary agenda of enforcement and regulation and have had to ignore opportunities to take a more strategic role in sustainable development and to develop cross-disciplinary working. These points are looked at in the recent joint CIEH / Health Development Agency project on “Environmental Health 2012” which sought to develop and set out a new vision.

- **The Environment Agency**

The Environment Agency (EA) was set up as a non-departmental public body in 1996. Most of the Agency’s work with regard to the protection of the environment also has an impact on health and it is this impact that determines the setting of standards and actions required with regard to the environment. The Agency is also now developing work on Environmental Equality.

- **The European Union**

Health policy is so high on national political agendas that most governments have generally resisted the EU ‘interfering’ with it and therefore in the past the EU has not developed public health policy. Until the Treaty of Maastricht was ratified in 1993 there was no legal basis for EU health policy. The Treaty states that *“The community shall contribute towards ensuring a high level of human health protection by encouraging co-operation between member states and, if necessary lending support to their action. “*

There is now a new programme on public health which came into effect in January 2003. The new programme has three ‘Strands of Action:-

1. Improving information for the development of public health
2. Reacting rapidly to health threats
3. Tackling health determinants through health promotion and disease prevention.

## **7. The key processes**

Any work on environment and health must, if it is to be successful and recognised, fit in with and link to other ongoing processes. Several of these offer opportunities for joint working; indeed many actively require such partnership.

- **Health and Local Strategic Partnerships**

Just as the Health Service has been reorganised, so local government has changed. The Local Government Act 2000 which introduced the concept of Community Strategies for every local council to improve local service delivery through a Local Strategic Partnership (LSP) which includes all sectors of society.

LSPs are central to delivering integrated local services and most are including PCTs. The NHS plan suggests that PCTs will in time take a lead role:

- “in ensuring alignment between Health Improvement Programmes, Primary Care Trust plans and Community Strategies and Neighbourhood Renewal Strategies;
- in ensuring that health input to local strategic partnerships from all key stakeholders in the local health community is properly co-ordinated;”

A 2002 report, ‘Community Strategies and Health Improvement’ by the HDA sets out a range of ways to develop practice and shows how selected local authorities and health trusts are going forward together. There is however evidence that suggests that some PCTs that are joining their LSPs are not playing a very active role.

- **Health and Regeneration**

The need to regenerate poorer communities has been a central part of government policy for over twenty years. One theme for some of that work has been to improve the health of the people living in those areas. Relatively little work exists to show the health benefits of regeneration work. The ground-breaking Stepney Health Gain Project project reported major health improvements from a major housing redevelopment: the overall the rate of Illness Days fell from 37 per hundred (over one in three) to five per hundred (one in twenty) – a seven fold improvement. To date little other work exists: the lack of resources for the necessary base line studies may be one problem.

The Government now has a National Strategy for Neighbourhood Renewal. This goes much further than previous government work in making the case for integrated regeneration. It highlights the role of the Department of Health in narrowing the health gap between socio-economic groups, and between the most deprived areas and the rest of the country. Targets for health outcomes from regeneration are now being set.

- **Environmental Epidemiology**

One of the major issues concerning links between quality of the environment and impacts on human health is simply evidence. There is an urgent need for more and better Environmental Epidemiology. Over the last ten years knowledge in this field has expanded substantially. Universities such as Southampton, Imperial College and the London School of Hygiene and Tropical Medicine have developed substantial experience in exploring these links, while more and more studies have refined methodologies and ways of working. The COMARE report on air pollution and transport was a defining moment in the transport debate in 1998.

Much Environmental Epidemiology is not concerned with what are usually seen by the public as 'environmental issues' but broader issues about human beings and their surroundings. However matters such as food and access to facilities are increasingly central to the development of local strategies for sustainable development, and it may well be that a reassessment of what is and is not 'environmental' is under way as a result of the focus on sustainability. It is certainly the case that environmental epidemiological studies have provided the core evidence base for developing work in the UK on Environmental Justice.

- **Healthy Living Centres**

The shape and style of voluntary initiatives has changed markedly during the last decade, due in no small part to the National Lottery. This has funded many health-focused schemes through the Community Fund. This Fund was supplemented more recently by the New Opportunities Fund (NOF) which funds local projects in line with national guidelines. One innovative approach to public health that has emerged from this process is the Healthy Living Centre initiative. It was launched in January 1999 with a budget of £300 million to develop a network of Healthy Living Centres across the UK-wide.

- **The WHO Healthy Cities Programme.**

The 'urban health challenge' set out in Chapter 6 of Agenda 21 called on local authorities to "*develop and implement municipal and local health plans*". This work was boosted in 1997 by Habitat II, the major international conference on sustainable cities and human settlements run by the United Nations Centre for Human Settlements (UNCHS). The Action Plan arising from this event makes many links between urban development and health.

Many of the advances in this field have been due to the WHO's Healthy Cities Programme. This is a long-term international development project that aims to "*place health high on the agenda of decision makers in the cities of Europe, and to promote comprehensive local strategies for health and sustainable development based on the principles and objectives of the strategy for health for all for the twenty first century and Local Agenda 21*". UK cities include Belfast and Glasgow, both of which have large well-funded programmes

- **Health Impact and Environmental Impact Assessment**

Both HIA and EIA have moved forward rapidly over the last few years, with a number of innovative approaches. It is however unfortunately the case that, despite recommendations by the CIEH, the BMA and others the two processes are still being developed in parallel rather than in an integrated manner.

## **8. Getting from here to there: bridging the divide**

The arrival of PCTs and the DoH review of Health Inequalities suggests a 'new public health agenda'. Some have seen this as moving towards creating better links between public health and sustainable development and any analysis of the goals of sustainable development, of environmental health, and of public health show an overwhelming similarity.

Despite this operational links remain weak and fragmented. One obvious reason is that people in both fields are under-resourced and under pressure to carry out core tasks and to run basic

regulatory systems. Yet there is more to be tackled. Public health can still be massively improved (the UK is well outside the top ten of countries with highest life expectancy) and much of the work, especially in poorer areas, continues to be broadly environmental.

The Stepney Health Gain project shows the undoubted health benefits of well-planned regeneration. The impact of traffic-generated air pollution has become clearer during this last decade planning and the recent work on health improvement from traffic reduction in Oxford suggests that environmental planning will have a role to play in tackling that, while less car use will certainly have role to play in increasing walking and cycling and thus cardio-vascular health.

It seems to be clearly in the interests of both disciplines to improve the linkages between them. The question is 'how?'. I would suggest there are at least six ways that we need to do this:

### **1. Develop better joint evaluation systems**

Environmental or regeneration projects rarely take the time (or have the resources or capacity) to evaluate their work for health gains. In any case many of these may be long-term outcomes: very few have clear health-related outputs. Similarly the environmental impacts of health work can also be assessed. But while the methodologies exist, too often the resources are not there. There is a need for better cross-disciplinary work on identifying and agreeing outputs, outcomes and relevant evaluation criteria. Including criteria that will show the broader impacts of work in one discipline may help show practitioners on the other side the benefits of co-operation.

### **2. Understand differences in professional perspective.**

There is concern amongst professionals about joint working. Most workers have more than enough within their work area to keep them busy. People seeking to work in both disciplines may find it hard to build working relationships in either. There are also differences in approach and language between health and environment staff. At the root of this may be the way the environmental sector has developed from a voluntary perspective, rooted in urgency about the collapse of planetary ecosystems. We need to recognise these differences, to understand the knowledge gaps that result and to develop joint training programmes.

### **3. Keep greening the NHS**

As the Kings' Fund 'Health Dividend' report state, there "has never been a better time to build a more sustainable health service."

Good public and environmental health programmes can make a real contribution to the NHS simply by preventing illness and freeing up beds in hospitals. The NHS itself could play an active part in making this happen. There is of course heavy pressure from short-term targets and reorganisation, but the benefits of such a strategy will pay off in many different ways.

### **4. Develop the new local agenda - Public Health and Sustainability**

The requirement that each PCT should have a 'public health network' under the Director of Public Health, provides a new structure within which public health can be developed. At the same time the 'new agenda' for local government of integrated and improving local services, delivered under the guidance of a Local Strategic Partnership offers new opportunities to deliver and integrate public health with work on local sustainability. There is a need to share ideas and experiences as this work develops.

## 5. Integrate spatial planning and health development

'Unhealthy places' don't just happen: poor design has played its part along with pollution, economic deprivation etc. The recent Government 'Sustainable Communities' plan highlights the need for '*A safe and healthy local environment with well-designed public and green space*', for '*Good quality local public services, including education and training opportunities, health care and community facilities, especially for leisure;*' and for '*A sense of place*'. This opens the ways for joint working between environmental health and planning professionals. It is also the basis for better links between Health Impact and Environmental Impact Assessments.

## 6. Tackle Inequalities Together

Recent years has seen a new focus on 'environmental justice' issues in the UK. This phrase originated in the USA where it developed out of recognitions that communities suffering the worst pollution and most disproportionate environmental and health impacts were overwhelmingly poor black and Hispanic communities. This work has led to an greatly increased involvement of those ethnic groups in environmental action, and also led to action at a national level with the signing of a 'Presidential order on Environmental Justice' designed to ensure that communities did not suffer from excessive pollution on grounds of race or ethnicity.

Environmental justice work in the UK has developed with a broader focus on all aspects of poverty and the environment. Informal links between a few practitioners in health, environment and academic networks has developed an initial base of case studies and a UK Environmental Justice Network is now under development.

The implications of this for work on Environment and Health are likely to be significant. A new focus on enabling and empowering local communities is likely to bring environmental issues into communities with poor health problems, and public participation in environmental action may be extended well beyond the 'usual suspects' both locally and nationally. All this will of course link to the 2002 Health Inequalities review. Developing and implementing strategies to tackle environmental inequalities alongside health inequalities is a challenge that the environmental and sustainability sectors need to face up to now.

**In conclusion**, perhaps the most important lesson of the last ten years is that joint working is feasible and that it delivers. The information and understanding have developed steadily; both the obstacles and the opportunities are that much clearer; the potential benefits have been set out in detail, both in terms of better public health and sustainable development. All that is needed now is the will, commitment and resources to develop pilot projects into common practice.

It should be clear to us all that sustainable development will never be achieved without good public health, while good public health requires healthy and safe environments, an end to poverty and strong civil society.