Managing public health – health dividends and good corporate citizenship

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Abstract: This paper uses the example of health service activity in part of a major UK conurbation to explore the idea of a 'health dividend' and 'good corporate citizenship'. Because of the scale of resources devoted to healthcare, healthcare providers have a duty to maximise the economic and social as well as health impact of their activities and to realise a health dividend for local communities. The paper draws on links between realising a 'health dividend' and realising a 'peace dividend from arms conversion and explores some of the tensions this creates, especially in an area characterised by significant social inequalities and deprivation.

Keywords: health dividend; peace dividend; health inequalities; social inequalities; public health; good corporate citizenship; Sandwell; UK.

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1 Introduction

Health provision is not simply about curing illness. This paper explores another big question, that of the local economic benefit from the investment that goes into the provision of health services and the health services role in supporting economic and environmental development at a local administrative level, particularly in the UK. The question of the indirect benefit to the community from the activity of the health services should apply in any political, economic or social system. Investment in health services is huge in most industrialised nations, and still relatively large in poorer countries. How that investment is made determines whether the community served is enriched or made poorer and more dependent. In the UK this has come to be described, first in terms of 'health dividend' and then as a 'corporate citizenship role'.

Choices are made all the time in local health service commissioning and delivery but often the economic consequences of these decisions are not made explicit. They may enrich the local economy, for example, by employing local people, or impoverish it, for example by investment in 'Big Pharma' products or multinational healthcare providers. There is therefore a need for public health service providers to play a role as a good corporate citizen, maximising the health benefit from investment decisions and exercising good environmental stewardship. This challenge to be the best corporate citizen on behalf of the community in which health services operate is only just beginning. In the context of the need for sustainable development and climate change there is also a growing environmental imperative for the good corporate citizen as well.

The next part of the paper accordingly contextualises the issue of public health on the basis of the recent experience of the UK. In part three, I explore the basic idea of the health dividend drawing on the experience of Sandwell in the UK West Midlands. The fourth part then looks at some of the local initiatives in Sandwell that have formed the basis of trying to encourage the management of the local health service to play the role of 'good corporate citizen'. *Although the argument uses the experience of one local administration in the UK it should be evident that the issues raised apply in principle to the management of health service provision on a much wider scale.*

2 Public health as an economic, social issue and political issue

As a public health specialist, I entered medical training at a time when technological medicine was throwing all in its wake. Advancement was accepted as linear and inevitable. Cures were anticipated for the chronic disease epidemics of the industrial world: cancer, heart disease and strokes. We would also triumph over disability although we were not so preoccupied with that. Infection was considered to have been mastered, controlled even, if not perhaps defeated (Inglis, 1983). Yet it has always been apparent to me that improving health is primarily a political, social and economic undertaking. Virchow, the great German pathologist, who became a public health reformer for his city of Berlin, said 'Medicine is a social science and politics is merely medicine on a grand scale' (Simon and Krietsch 1985).

By the end of the 1970s in the UK there was growing concern about the failures of medicine, Black published his seminal report about *Inequalities in health*, which were prevalent across civilised industrial Britain (Department of Health, 1979). A movement called 'the new public health' was taking shape, concerned with preventing the scourges of chronic disease, addressing inequalities caused by social and economic inequality (Ashton and Seymour, 1990). Globally, the World Health Organisation had declared a goal of 'health for all by the year 2000' for which the European office produced the visionary 'targets for health for all in the European region' (WHO, 1978; WHO EURO, 1985). The 1986 Ottawa Charter on health promotion set out five areas of health policy – healthy public policy, empowering individuals, developing communities, improving environments and reorienting health services to more preventive and low tech interventions (Canadian Public Health Association, 1985). It was apparent that what was collectively created by social conditions and political choices could not be individually treated and cured (Navarro, 1981). Patients were being mended, only to be sent back into the social conditions which made them ill in the first place.

In the UK, the evidence that inequalities in income were the major cause of inequalities in health continued to emerge in the 1980s through studies from Glasgow and the North of England (Phillimore et al., 1994; McCarron et al., 1994). The Health Education Council (HEC) published the *Health Divide* in 1987. This was a final defiant act before the HEC was wound up and replaced by the Health Education Authority, under more direct government control. The report, authored by Margaret Whitehead, showed the widening of inequality even in the seven years since the Black Report (Whitehead, 1987).

In 1984, a publication from the UK longitudinal survey showed that the standardised mortality ratios of unemployed men were 27% higher than for employed men. The major causes of the excess death rate were lung cancer, suicide, accidents and violence. The difference in death rates between unemployed men and employed men was getting bigger as time went by, showing that people were not becoming unemployed because they were unhealthy (Moser et al., 1987). Health concern about the impact of economic policies continued with Richard Smith's massive exploration of the health effects of unemployment (Smith, 1988).

The widening of inequalities in health was subsequently demonstrated for the country as a whole in the Office of National Statistics publication of the Decennial Census supplement in 1996 (Dreever et al., 1996; Middleton, 1996a, 2003). The conservative government, much later acknowledged that there were 'variations in health' across the country, implying in the use of the term that these were some how natural, not the result of policy and not amenable to political change (Department of Health, 1996a).

Sir Donald Acheson was commissioned by the new Labour Government in 1997, to produce a review of inequalities in health and make recommendations to reduce them (Department of Health, 1998). His analysis suggested that inequalities in income were the major cause of inequalities in health and should be addressed. His second highest priority for action was intervention to improve early years support and pre-school education for disadvantaged families. His report captured other major areas for policy development including maternal and child nutrition, providing free school fruit and increasing overall population consumption of fruit and vegetables. He was particularly scathing of the effects of the common agricultural policy, with its perverse incentives to consumption of high fat, high sugar, high meat diets. He recommended that health inequalities impact assessments should be conducted to determine the differential impact of health services interventions. Many health promotion policies had the effect of increasing inequality as they were taken up more by more educated, more demanding social groups.

The Acheson Report findings were taken up in considerable measure by government – or at least the ones which were consistent with the policies they were following already. The Labour Government continued to offer a supportive climate for addressing health inequalities, which developed through the *Programme of action for change on inequalities in health* programme (Department of Health, 2003). Some would say the commitments on the ground and the speeds of implementation were slow. In terms of priority, inequalities in health took a back seat – an example being that it made only chapter 13 of the National Health Service plan (Department of Health, 2000). More importantly, the priority afforded to health service reorganisations distracted from the coherent delivery of public health programmes. The Labour Government achieved massively for the public health by its reduction of unemployment. The introduction of the minimum wage was another positive in public health policy. The Labour Governments

could also claim to have introduced strongly evidence-based policies from American social experiments including 'workfare', or 'welfare to work', introduced in the UK as the 'new deal for employment'; the working families tax credit (income supplementation studies); Surestart, Surestart plus maternity grant (Oakley, 1998).

The issue in respect of these policies was about the magnitude of individual benefits being provided. The minimum wage for example, was judged to be much higher in many other European countries. The Surestart plus maternity grant was a marginal benefit – a one off payment rather than a regular income for pregnant mothers in poor circumstances. Most recently, in the UK, the Brown Government shot itself in the foot by stopping the 10% income tax banding. This had been one of those incomes redistributive taxes that helped people get out of the poverty trap – the backlash from removing it appeared to take the government completely by surprise.

In 2004, the government published its *Choosing Health* public health white paper. (Department of Health, 2004) This set priorities for public health improvement including reducing health inequalities, reducing smoking, tackling obesity through better food and fitness, improving sexual health, improving mental health and well being in the workplace and reducing drug and alcohol misuse. The health of the young and the old were priorities in all the programmes. A new initiative was the health trainer programme, designed to provide personal help and support to people who wanted to change their lifestyles. This was claimed to be a strong response to the public consultation and was modelled on the earlier successes of the stop smoking services. The white paper also identified 88 spearhead primary care trusts in the worst 25% of local government areas in England, where it was felt the most improvement was required on all these measures.

Also by 2004, the government had in train a comprehensive series of public service agreement targets, including three on reducing inequalities in health – by improving life expectancy, by reducing infant deaths and by reducing teenage pregnancy. The neighbourhood renewal fund had operated for a few years prior to this but there became an expectation that this fund would be applied by local strategic partnerships, to deliver benefits for their residents against the public service agreement target areas. Floor target action plans were required, to demonstrate how the extra investment would be applied – to bring the spearhead areas up to the minimum – the 'floor' – required so that national health inequality targets could be achieved. The public service agreement targets were set for the year 2010. This relatively short time scale led local strategic partnerships to a narrower range of activities – in many cases more *technological fixes*. For example, to improve life expectancy over five years required emphasis on stop smoking services, finding and treating people at risk of heart disease and stroke through statins and anti high blood pressure drugs. In education, there were technical fixes too – coaching students who could get from predicted grades below GSCE C grade up to grade C and above. And in crime reduction there was an emphasis on rapidly implementable policing strategies.

The period from 2002–2008 saw massive increases in health services spending in the UK – up to the average % of gross domestic product for European countries. This had been recommended through the first report by Derek Wanless in which he envisaged three scenarios for health spending. Two scenarios predicted burgeoning costs and a system unable to meet demands, the third required what he described as the 'fully engaged public'. People with more knowledge of their own health and more control over it and sources of health information would be able to form a partnership with health

services which would limit the need for cost rises. The scenario also required a massive investment in information technology both for the management of the health service and for the provision of accurate health information to the public (HM Treasury, 2002 the Wanless report 1). Wanless went on in a second report to describe the increases he saw needed in the infrastructure for public health including a massive development of the public health workforce in order to achieve the 'fully engaged scenario' (HM Treasury, 2004, 'Wanless 2'). Sadly few of these provisions have materialised – health services investment was dissipated in two reorganisations, pay rises and technological service costs. The possibility of the fully engaged public and controlled health costs appears as chimerical as ever.

In 2007, the Brown Government appointed Lord Ara Darzi, to undertake a review of health service provision which led to the *'Our National Health Service, Our Future'* review for England (Department of Health, 2008). This talked of the principles of enhanced community provision, reduced capacity in specialised hospitals, increasing standards across the board, and recognising the need for a 'staying healthy' pathway. However Darzi's review still neglected the power of enhanced community engagement towards a public 'fully engaged' in keeping themselves healthy. The agenda appeared largely individually focused with people seen as responsible for their own health, notwithstanding the incredible economic forces ranged against them and the physical and social environment creating obesity and poor health potential. The clinical service agenda also appeared largely a consumerist vision of where people will receive services whether they really need them or not.

The relatively short term focuses of the public service agreement targets and the consumerist agenda for health services of the future cannot shift the underlying causes of inequality in health which are fundamentally economic. In the UK, governments have so far only addressed inequalities in health by introducing policies which may incidentally redistribute wealth. They have been shy of an active policy of redistribution for fear of offending the new electorate of 'middle England'. Yet the international comparative research of Richard Wilkinson and others suggests that the countries with the least inequality in health and the highest life expectancy are those with the least inequalities in incomes (Wilkinson and Pickett, 2009).

This then is the context of public health practice – the pursuit of economic, environmental and social policies, which will have the most impact on health. Embracing conceptions of sustainable development, fairness in use and access to resources and pursuing these to the highest available standards of research evidence available.

3 From the peace dividend to the health dividend

The principle of the health dividend emerged over time out of thinking about another aspect of public spending, that on defence. Peace campaigners in the early 1980s were frequently challenged by powerful vested interests within the defence industry, from left and right of the political spectrum. Particularly compelling for a lay audience was the economic idea of opportunity cost. The world's military economies were damaging health even before the bombs dropped. They wasted human ingenuity, material and financial resources for destructive purposes and opportunities for world development were foregone.

The United Nations Special Task Force report on disarmament and development was a seminal report cataloguing the complex of economic harms occurring as a result of the pervasive influence of uncontrolled military expenditure (United Nations, 1981; Sangar, 1982). Victor Sidel's landmark paper in the *Lancet*, 'destruction before detonation' captured the enormity of the gulf between spend to meet health need and spend to service the military economy. Sidel calculated that every two seconds a child died from a preventable disease and another was permanently disabled. This death and disability represented the world's failure to spend US $2. In the same two seconds, the world had spent US $50,000 on arms (Sidel, 1985). In the UK other some health professionals took up this theme arguing for redirection of military spend in the UK into depleted health services facilities (Middleton, 1988, 1992).

The campaign was dismissed as naïve by some; arguments that money not spent on one thing would then be spent on something else did not hold. The world spent more on cut flowers, and breakfast marmalade than it spent on famine relief. Nevertheless the idea of opportunity cost was a simple and compelling one which ordinary people could understand. Governments were not individuals buying marmalade. They were exercising real choices with the state's earnings – they could buy arms *or* health.

The collapse of communism and the end of the Cold War made the idea of converting arms industries for peaceful purposes a mainstream political imperative, attractive to politicians of all persuasions and led to an expectation of 'the peace dividend'. This would be the reward for disarmament – reinvestment in socially useful production and services – 'arms conversion', 'spin-off' or 'technology transfer' were terms applied for the change needed to best reapply the knowledge, science, skills and human resources of defence industries.

The peace dividend did come to fruition but more by political inaction than by design. There were macroeconomic shifts in government expenditure. Many governments (82 out of 151 surveyed by the Bonn International Centre for Conversion in 1996) had reduced military spending (Bonn, 1996). The UK was one of 24 countries cited by the UN development programme as having increased social expenditures between 1985–1995 (United Nations, 1995). But there was little planned disinvestment from defence, redirection of public investment and structured conversion of military plant, machinery, personnel and intelligence. In the absence of a planned shift, workers in the arms trade and military alike were thrown out of work and it would only be much later under the new Labour Government that employment conditions improved mainly via the expansion of the service sector.

Rationalisation of defence production also came about through acquisition and merger of arms companies. The prime example of this was the merger of Lockheed and Martin-Marietta in 1995, creating an aerospace and defence electronics giant with overall sales in 1994 totalling $22.9 billion. These rationalisations did deliver some reduction in military spend for the client government defence procurers rather than through national economic planning. For example, the US Government stood to gain $1 billion over ten years in contract efficiencies through the Lockheed-Martin merger (Bonn, 1996).

For some companies, third world arms exports were seen as a stopgap until the next great defence investment. (Quigley, 1988) Others found that the Gulf War and other interventions show-cased their 'smart weapon' developments (Quigley, 1990, New Internationalist, 1994; Silverstein, 2004). After 1996, the annual reports of the Bonn International Centre for Conversion began to report continuing but slowing trend in

reducing military spend and capability, but from 1999, they reported a shifting climate fuelled by new conflicts in the Balkans, East Asia and with the onset of the 'war on terror', the 'peace dividend' has all but been forgotten (Bonn, 1999–2003; Roche, 2000).

The arms industry presents the most florid example of an industry which damages health and needs to be redirected for health benefit. But what of health service provision itself? *It is one thing to argue for a shift from defence expenditure to health expenditure but how far does health service provision and action itself maximise the benefit to health?* From the late 1980s, Paul Field and I began to apply the search for 'spin-offs' from health service activity and for health damaging industries we needed to 'convert' to healthier production (Middleton, 1996b). We came to call this the 'health dividend'. There were industries that damaged health - what were their vested interests for health improvement? What was 'spin-off for them? Of equal significance, the everyday activity of providing health services carries with it opportunities to enrich local communities.

In 2002, the King's fund described the health dividend as the benefit to the economy and environment from health services investment decisions (Coote, 2002). Health services, in which huge sums of public money are invested, must use their funds wisely for the maximum direct economic good of the communities they serve as well for providing them with services. The health dividend is particularly necessary for disadvantaged communities where a locally provided service means a more appropriate and sensitive service, but it also means the local economy benefits and giving local people a chance for better health. It is also desirable in the context of multi-agency regeneration programmes where combined efforts may minimise waste and provide greater benefit for a given public investment.

In the summer of 1988 I became Director of Public Health in Sandwell in the UK. Sandwell is a community of some 300,000, part of the Birmingham conurbation and one of the most deprived areas in the UK reflecting a recent history of industrial decline and deprivation. I inherited a health promotion budget which was greatly under-committed and for which there seemed no firm plans. I used the opportunity to raise the level of sophistication of health promotion operations in Sandwell. No longer would we be seen as operating health education campaigns in small-scale health fairs. We would operate at the policy and partnership level and we would address major economic, environmental and social barriers to achieving better health.

One of the vehicles we established to assist us in this was the Sandwell Economic Strategies for Health group. This group was one of the earliest attempts in the UK, to move locally on the inequalities in health agenda, addressing the health inequalities where they were caused, in economic and social inequality. The activities of the group were described in an abstract for the investment in health conference in Bonn, in December 1990 – see Table 1.

The group produced a number of very long-term beneficial outcomes that are highly relevant to delivering the health dividend. The first was a scheme, following one by Jarman in St Mary's Hospital Medical School London, which put welfare rights workers into general practice (Jarman, 1985). We followed with the Sandwell service shortly after Birmingham had implemented one using Citizen's Advice Bureau (CAB) workers. In preparation for a Sandwell health action zone we expanded the level of availability of CAB workers to enable every practice in Sandwell to have access to some level of service. This service over the 13 years has enabled thousands of clients to receive their full benefits entitlements and so brought in millions of pounds to the Sandwell economy,

perhaps the most spectacular single example of the health dividend (Paris and Player, 1993; Middleton et al, 1993; Abbott and Hobby, 2000, 2002; Emanuel and Begum, 2002).

The second was the aspiration to expand local occupational health services to serve small businesses. This led to the adoption by Sandwell health authority of an occupational health business plan to fund new posts covered by income to be attracted by the new services. Over ten years these services have become 'Workwell' small business health services, funded by health and regeneration authorities and producing substantial health and employment benefits in the Sandwell and Black Country area (Workwell, 2003).

Table 1 Sandwell Economic Strategies for Health group

Sandwell Economic Strategies for Health group

The Sandwell Economic strategies for Health Group addresses a range of issues around economic development, employment, income, the environment and their effects of health. These include:

Local evidence on the effects of poverty and deprivation on health

Sandwell's industrial past has left large tracts of derelict land, extensive surface pollution, mining subsidence which makes industrial and residential land reclamation difficult. The poor environment is both unattractive to new industry and directly related to poor potential for health. Healthy city planning including greening the environment is therefore essential for health, and for wealth.

Discussion of the need for an anti-poverty strategy

Studies of anti-health and pro-health vested interests in the local economy: to promote a dialogue with these industries and explore support for positive health interests and products. These studies are the Sandwell tobacco retail employment survey and the Sandwell food industry study.

The Health Authority is a major employer and is therefore looking to develop healthy work policies

The Health Authority is a major purchaser and local buying strategies are being explored.

The Health Authority is a major innovator and currently a number of products to aid the handicapped are in the prototype stage or in small – scale production. Local manufacturers are being sought to produce and market these.

The Sandwell Economic Strategies for health group – attempts to promote health from its roots – in the methods of production, in the goods and in the social circumstances of the products. This is an essential start point for health promotion.

3.1 The food industry

Our approach to promoting consumption of healthy food began with traditional health education methods, schools work, campaigning, and publicity. But over time we have progressively sought to address structural problems of access to healthy food and wider public policies needed to enable people to eat healthily.

Since 1988, Sandwell has conducted a major drive on healthy eating in schools, a programme of health education, combined with a poster competition produced a range of high quality materials. There was extensive engagement of staff groups such as dieticians, community nurses and the community dental service. Individual healthy eating advice has remained a key activity for the oral health promotion service and the community dietetic service. There was an expansion of community dietetic services in the early 1990s funded through additional community funds made available as part of 'building a healthy Birmingham' proposals (West Midlands Regional Health Authority, 1989). The community dietetic service developed work with the schools meals services and produced the first obesity management protocol/clinical policy and developed children's dietetic services, but these services were highly orientated towards individual advice and education and a clinical interventionist approach to the patient/client presenting.

There was little prospect of mass population diet change in Sandwell and no capacity for these services to address structural barriers to the production of healthy food. In parallel, therefore, we developed a number of initiatives, which sought to engage economic interests in food production and retail. We needed to widen the interest of public policy makers in the need for better nutrition and show them the scope for public health and local economic benefit.

The food industry offered the prospect of a real health dividend. The health lobby and the food industry could share objectives for changed manufacture, greater job creation and marketing of new healthier food products. We commissioned the West Midlands Enterprise Board, which had a track record in food industry research, to ask how many people the food industry employed, what it made, and whether there was scope for more healthy food production? Could it provide the 'value added' to make healthy food more attractive to the industry and to the public and create more jobs as a spin off (Maton et al, 1989, 1992; Middleton, 1996b).

The principal findings of the food study were that the food industry was under represented as an employer in Sandwell at approximately 4% compared with the West Midlands at 12% and a UK national rate of 14%. If we were interested in reducing the harmful effects of unemployment on health we need look no further than simply encouraging more food industry employment in the area. The study pointed to a number of areas for food policy development – support for the food industry and employment, researching food access and the local retail scene and alternative local economic vehicles for delivering healthy food. There was scope for more job creation in food manufacture, in specialist minority ethnic food production, in cooperatives supporting local retailers in purchasing healthy food items, in food cooperatives for local supply of fruit and vegetables, and there were opportunities for economic support for the local food industry – a suggestion that a food park might be attractive as had been developed – small manufacturers could come together in the same industrial estate and share some common services, marketing, packaging, distribution for example.

The food industry locally was keenly aware of the interest in healthy food and did see diversifying their product range as an opportunity to create high 'value added' merchandise. The study also marked our first excursion into what would come to be called the 'food desert'. A subset analysis from the research looked at the need for support to retailers and the inaccessibility of healthy and affordably healthy food. Kevin Maton's 'healthy shopping basket' (Maton et al., 1989) mirrored other research by the London Food Commission and the then Manchester polytechnic about accessibility and affordability of food (Food Policy Unit, 1984; Lang and Cole-Hamilton, 1986). But it also predated by a long way more sophisticated analysis by Donkin et al, which developed a geographical information system methodology for identifying the food deserts (Donkin et al., 1999). Following the analysis of food deserts in Sandwell we moved forward to create with local retailers the eatwell programme, through which they have been helped to supply fruit and vegetables at low cost and good quality in over 40 shops locally (Eatwell, 2010: http://www.webwell.org.uk/For-Everyone/Shopwell.htm).

For thirteen years multi-disciplinary food policy groups have explored creating a 'sustainable food system' in Sandwell with an attempt to partner health and regeneration. We have moved from traditional health promotion initiatives, such as five [portions of fruit and vegetables] a day which is designed to modify food choice based on education about 'healthy eating', to understanding the links between food choices, which are linked to cost and availability of food, taste, social attitudes and culture to a wider development of food policy. (Sandwell food network, 2010: www.Sandwellfood network.org) There is now a clear body of evidence locally and nationally demonstrating the limitations on healthy diet due to cost and to availability. Sandwell has contributed significantly to the national evidence base (Department of Health, 1996b; Lang and Raynor, 2002; National Heart Forum, 2004, Middleton, 2009).

It is apparent that for people to eat more healthily requires healthier growing, healthier processing, access to affordable food, education and information, consumer understanding and expectations and cultural change or accommodation. There is no simple local or national magic bullet that can be fired to create healthier eating. Partnerships are needed at all administrative levels from global to local, in production, processing, retailing; in promoting healthier commercial and institutional catering, and healthier eating in the home. All the available magic bullets need to be kept in the armoury.

This 20 year development of healthy food strategy in Sandwell demonstrates two facets of the health dividend. Firstly, the potential to diversify for the food industry to contribute to a healthier economy, for job creation, more sustainable industry and healthier food. Secondly, this research and the lobby which followed were mounted by the health service and show how local health service investment can be used to promote local health and the local economy. The health service has invested in local food services, food cooperatives, community agriculture and local people have benefited in terms of income and access to healthy fresh food produced at affordable prices. So their health should be improved directly and indirectly. Local people have also exercised democratic involvement in a health-promoting venture. Despite much talk about public involvement in health there are relatively few examples of giving people clear and practical opportunities to take part, to learn and to benefit.

3.2 Retail tobacco

The food industry is clearly one that 'we can do business with', and have to as everyone needs food. On the other hand, we are asking 'Big Tobacco' to go out of business – or find something else to do – something they have signally failed to do so far.

In Sandwell, like most other areas nationally and internationally, we do not have tobacco manufacture so our interests in this context are purely about tobacco retail. We wanted to understand the nature and importance of cigarette sales to the Sandwell economy. Did it really create jobs? A study sought information about the number of people employed in tobacco sales, the income generated, the total turnover and profit levels. This study estimated that Sandwell's market for tobacco products was between £36.4 million and £41.6 million per year in 1989. Around £4,500 was spent per hour on tobacco products in Sandwell. For each smoking related death £70,000 was spent on tobacco. Sandwell retailers made between £1.27 million and £1.45 million in 1989, with an average overall profit margin of 3.5%. About one third of all tobacco sales were attributable to single outlet, locally owned retailers. Dependence on tobacco sales differed according to outlet type. For newsagents, tobacco accounted for 32% of sales but less than 10% of profits. Between 300–400 whole time equivalents in Sandwell's retail sector were estimated to be dependent on tobacco sales at this time. We judged these jobs would not be lost in the event of further tobacco sales decline, because we had evidence that jobs were increasing in the sector as tobacco sales were going down. In addition virtually any other goods sold by retailers could be shown to have a higher profit margin. The study supported other work that suggested the tobacco lobby had greatly over stated the economic need for cigarette sales. Tobacco jobs in Sandwell were much lower than the industry's own claims suggested. They claimed that nationally 180,000 retail sales jobs were dependent in tobacco sales. Our study suggested a figure of more like 40,000 (Press et al., 1990; Middleton, 1996b).

Our discussions in the UK with the Tobacco Worker's Union illustrated that their concerns about the nature of global manufacture were not dissimilar to those in other industries. *Just in time* and *just enough* methods of manufacture are making skilled workers superfluous. Machines take in measured volumes of raw materials delivered by 34 ton truck, create the product and then ship it out. Storage of raw materials and finished products is kept to an absolute minimum. Workers are taken on no-salary contracts as and when needed, just enough and just in time. The tobacco industry can switch production on and off as it needs. The Southampton British American Tobacco plant, for example, had been created purely for the supply of cigarettes for China. Later it was to transpire that the plant supplied cigarettes for Andorra, one of the smallest countries in Europe. The purpose of this rouse was the expected re-importation/traffik of cigarettes back into Britain with duty avoided. (Joosens and Raw, 2000) The European tobacco subsidy has also been a continuing blight on European health policy. Tobacco industry spokesman briefed the trade unions on why the tobacco advertising bans should be contested leading to a clandestine collusion of workers and bosses and the resultant lobby was able to fight and delay advertising bans. There are clearly *real politik* and real economic issues at play that the health services remain somewhat innocent of.

Some of the trade unionists in the tobacco industry did recognise the need for collective defence of their jobs and skills against the prospect of job cuts, on the back of increased mechanisation or reduced cigarette consumption. A number had wanted to pursue the idea of skills audits and alternative plans for groups of workers. But sadly the

impetus for this with this particular group of workers was not as strong as it had been for some of the armaments workers involved in the peace dividend and conversion debates of the 1980s.

For retailers, while tobacco itself did not yield large profits, customers often bought other items after entering a shop to buy tobacco. This 'traffic building' was considered to be very important. But our research concluded that anti-smoking initiatives could be employed without adversely affecting the local economy. Many retailers would be willing to reduce their reliance on tobacco sales if alternative product lines could be established. Health authorities could work with retailers to help them achieve this goal. A major new factor since 1989 was the impact of smuggled imported cigarettes from Europe. The findings were reported in Saxon and Middleton (2001).

Overall we have been less successful in turning health dividend aspirations into action through our tobacco control work although two good examples stand out where local health service investment in health promotion is directed towards Sandwell service deliverers. We have funded an extensive programme of trading standards officers' test purchasing for cigarette sales to under 16s (Saxon et al., 1997).

Health educational programmes and tobacco control programmes which result in reduced tobacco consumption and spend, have been shown to be beneficial to local economies. This is because virtually any other items purchased provide a retailer with higher return. For every smoking quitter about a £1000 extra is generated for the local economy according to research conducted in the West Midlands (Field and Broome, 2003).

3.3 Manufacturing and people centred design

The final formal example of how thinking about the peace dividend has been carried over into thinking about the health dividend is the experience of inclusive design. The cue for this came from an earlier workers movement, the Lucas aerospace shop, Stewards Combine in the UK (Wainright and Elliot 1982). In the mid 1970s the Combine had pulled off the remarkable feat of uniting shop stewards in manual and skilled technical trades across 150 sites of Lucas aerospace UK, to fight threatened job losses due to cuts in defence spending. They surveyed their membership and produced over 150 ideas for products that could be made using their skills and equipment. Quite by accident all the products turned out to be socially useful and environmentally sound. They fell into five broad categories:

- renewable energy production: wave and wind power
- energy efficiency products including enhanced battery power
- telechirics: remote access technology to undertake tasks in dirty and dangerous conditions
- healthcare products: the domestic ventilator, efficient new generation kidney machines
- transport ideas: the road rail bus.

In addition, the Combine espoused the principles of democracy in work, restoring rights of workers, combining the interests of worker and user, combining the interests of blue

and white-collar workers. And most of all, creating goods, which were socially useful and environmental protecting.

The Lucas ideas were never implemented through the company and eventually political decisions were taken which shored up Lucas defence contracts for a few years as jobs disappeared by natural wastage. However a number of Combine members formed a movement of alternative product development which thrived through the 1980s. Most prominent among the Lucas shop stewards movement was Mike Cooley whose book, *Architect or Bee?* was a key work about human-centred design and uses of technology (Cooley, 1987).

Human-centred design is a movement for design which meets the needs of people; involves people in the process of design; seeks to produce equipment, aids and adaptations/goods and services which meet their needs more successfully; and offers the potential for disabled people to play a full and satisfying role in an enriched society (Norman, 1998; Middleton, 2005; Middleton et al., 2005a, 2005b; 2006; Chesters et al., 2005).

Here we will focus on user-centred design and the issue of disabilities. The contradiction here is captured by the arguments of the peace dividend supporters, that 'we can land a tornado bomber in the dark in high winds using infra – red blind landing technology. All we offer a blind man is a stick.'

In parallel with the aspiration for more socially useful products, a small caucus of designers have been promoting user-centred design. They have tried to address mass production problems that prevent disabled people getting inexpensive and appropriate equipment they need. In the past designers and manufacturers have failed people with disabilities. The obstacles to users having a say in the design of goods include the professional arrogance: health and care workers think they know best what disabled people need; ignorance of design as a professional discipline; a shortage of designers sympathetic to the needs of disabled people; the neglect of disabled users rights and aspirations for aesthetically pleasing equipment. All these reflect the essential absence of professionals in healthcare and design and the inability of professionals to listen to the clients/users.

Today, there are five principles on which inclusive design for disabled people is founded:

- technology should serve people not people serving technology
- disabled people are made disabled by services that have been designed to exclude them and to make them dependent
- disabled people should be involved in design to bring their insights to make better products
- that better design for disabled people is better design for all
- that manufacturing systems must be adapted through better design so that goods are not custom made for disabled people, but are adaptable through modular construction for different consumer needs.

However, there are also powerful economic and political forces at play creating barriers as well. These include the lack of economic power of disabled people and the limited market for disabled needs. The lack of suitable equipment on the market confirms the

lack of market opportunity for manufacturers and there is nothing to buy. No choice means no spend, no new markets, so no economic gain for marketing and manufacturers. There are also insufficient legal pressures either to design better to meet disability needs or individuality, to reduce discrimination and exclusion; there is only precarious grant aid for disability access and advocacy groups and for social businesses working in the field.

A Sandwell health action zone was set up in April 1998. It was one of the first wave of English health action zones charged with tackling health inequalities and creating innovative new models of health and social care. One principle we have sought to apply in Sandwell HAZ is to make the public money work for Sandwell people – providing jobs in health-related employment, developing skills and training for local people. A local agency for health and economic development was a leading edge HAZ innovation project. It has three elements – to develop social businesses in the health and social care field; the Sandwell inclusive design partnership and alternative economic systems including time money and credit unions. The Time Bank enables people to trade services such as child and elder care which are less valued in the orthodox economy. These three strands are seen as complementary. Local people can provide and benefit from services through social businesses or local exchange. Disabled people can be involved in all these initiatives. The inclusive design partnership (SIDP) would link local disabled people, manufacturers, designers and academic departments. The interest of economic development agencies like advantage West Midlands and the European union offers the possibility of further funding and a more sustainable future.

Product ideas developed with service users included a new toilet assistance rail – the first new design of help for disabled people using a domestic toilet, for over thirty years; a new fabric constructed cot side for use with domestic beds is also the first attempt at an aesthetically pleasing and functional cot side for the home; and a three-position handle for a walking stick designed to meet different needs for people with arthritis and other deformities but also we hope meeting a need in the wider walking and rambling markets. The latter two of these products have now gained patents for the Sandwell PCT and are going into production in the West Midlands. If these succeed, they will demonstrate an aspiration of ours that is again an example of the health dividend. By securing patents from NHS sponsored ideas we will be able to reinvest fees from licensing arrangements for further use for care of patients.

One of the outcomes for the inclusive design strand was the creation of MEDILINK West Midlands. This agency links companies with technical expertise in different manufacturing processes and services with health service professionals and others with ideas for new products. Medilink was launched in 2003 and already has over 200 companies signed up as members. Different areas of the health service in the West Midlands are leading on different aspects of medical and healthcare technology development, for example, on infection control, orthopaedic devices and information technology applications.

There is massive scope for what is called SMART Housing. The benefits of the approach are for inclusive design and for sustainability. For example, a room where the lights come on when there are people in it obviates the need for light switches which some disabled people can't use, but it also saves energy.

SMART Housing can assist and promote community care – non-intrusive sensors on the kettle or a toilet seat can promote assurance that an elderly person is active – without the need for costly and intrusive caring professionals. There are a range of assistive

devices coming into increasing service use under the catch-all banner of 'telecare' – they include better community alarms, smoke detectors, fall detectors and so on. Early evaluation suggests telecare is extremely economically beneficial in preventing needs for residential and hospital care and enabling independent living by otherwise vulnerable older people.

There is currently considerable interest from the economic development agencies of most regions in the potential for development of medical technologies. This interest tends to be focused on high tech and new medical innovation. The lead time for such technologies to be tested, piloted, patented and licensed is extending. It is likely to get longer still as the clinical trialing and health technology appraisal and acceptance by bodies such as the UK National Institute for Clinical Excellence start to play a more prominent and controlling role.

Therefore rather than look to the high tech end of development there is an opportunity to get the mass produced aesthetically pleasing aids and adaptations for daily living up to standard, improving disabled peoples lives, making profit for more manufacturers and providing jobs. There remains massive opportunity for the refinement and improvement of existing equipment, for user-centred equipment and for aesthetic design enhancement of existing aids, adaptations and services. This area of development also offers the possibility to create new modular forms of product which are more versatile and adaptable for different needs and are inexpensive to produce and to buy.

Mass production of modular systems of common everyday items remains the large potential area for meeting the needs of people of differing abilities with different problems and needs. The time is right for an extended movement for inclusive design. We will be bidding to economic development agencies to invest more heavily in the innovative potential of the health and care systems. We need to harness the discipline of design to enable the best aesthetic and production solutions to come forward. Health services redevelopment can include opportunities for technological and service innovation- science parks attached to hospital sites for example.

We have the potential to be the architect of a better more inclusive society rather than the bee slaving to the preordained order (Cooley, 1987). This remains largely an aspiration, which will take years to deliver; but it has become the potential rather than the fanciful, an idea rather than an ideal. Disabled people deserve better, but we will all be the richer if we seek to achieve it. This idea that by meeting the needs of disabled people we enrich our entire community, both on the social level but also through providing economic benefit has been called the 'inclusion dividend'.

4 Becoming the good corporate citizen

The King's Fund (Coote, 2002) described the health dividend as the benefit to the economy and environment from health services investment decisions. They developed this theme further with the Health Development Agency, through the report, *Good corporate citizenship and the NHS: a regional mapping* (Jochelson et al., 2003). This report highlighted work done in the West Midlands by Field and Broome, looking at the economic impact of health service spend in the region (Field and Broome, 2003).

The major spin-off from health services activity is local employment. Pay budgets are the largest components of NHS spend so anything which enables money to go into

local residents pockets has greater chance of being recycled reinforcing a local multiplier effect. This can be achieved in a number of ways – most important of which is to train a local workforce, particularly in deprived areas. Secondly, offering incentives to keep health service staff living in the area they serve and providing incentives for newly appointed staff to relocate to the area if they are newly appointed. The health service also has a key role to play in developing occupational health services for small business, developing an innovation and intellectual property function to meet needs through health technologies but especially through aids and adaptations for independent living; this is a huge growth market still to be tapped into and could be particularly strong in traditional manufacturing areas to regenerate manufacturing potential. Health services can be involved in a dialogue with the local food industry which offers the potential for expansion of local food production, creation of more food related jobs and diversification towards healthier diets. The health service is a major landowner, and their strategic decision about locating facilities has the potential to act as a focus for regeneration of local centres.

These ideas echo the aspirations I had had for the Sandwell health action zone that I set out in the 1997 annual public health report, *A new deal for health in Sandwell* (Middleton, 1997). In this I repeated the earlier Sandwell economic strategies for health group objectives and set out a role for the health services as a local employer and trainer, a landowner, a buyer of goods and services, innovator and provider of occupational health services. I also used the opportunity of this public health report to reproduce a New Economics Foundation report about community enterprise (New Economics Foundation, 1997).

An example familiar to workers in community economics is that of how health service investment, in this case, in the form of staff salaries, tends to disappear immediately from poor inner city areas such as Sandwell. £26 million from Sandwell hospital salary budget went to people with non-Sandwell addresses, in 1997. The money was not spent by health service workers on the Sandwell council tax to be reinvested for Sandwell services; it was not spent in Sandwell shops supporting local businesses and keeping alive local communities. It was 'exported' to the leafy shires around the conurbation where the health services professionals and managers chose to live (Middleton, 2002).

The first and most obvious area of good corporate citizenship is the role of the health services as an employer and trainer. This can be especially important with local disadvantaged groups. We have devised workforce development plans that will enable local people to get on to a ladder of health service employment as health care assistants with a range of NVQ qualifications. We have supported the previous youth training schemes to the extent that from my small department alone five young people have found their way into formal statutory sector employment. Our peer education project which began in 1995, trained an average of 90 young people per year between 1996–2000 and subsequently smaller numbers, but with schools adopting their own peer mentoring schemes (Middleton, 1997, 2005; Sandwell MBC, 2002).

We have trained lay health workers from the South Asian community to work for us as sessional health workers since 1995. We have also trained a pool of 60 interpreters to provide interpreter services for us through the Sandwell integrated language and communications service. Our commitment to user involvement has seen mental health

service users, learning disability clients, and physically disabled people find roles in the mental health and learning disabilities commissioning boards.

Indirectly we have commissioned services from numerous community enterprises over the years; these have been providers of locally sensitive services and major employers of local people. A Local Housing Association's care and repair service is the provider of our repairs on prescription packages of home improvement. This housing association went on to set up a house proud scheme, a dedicated Home Improvement Agency (HIA) with powers to match private equity contributions with statutory grants to enable better housing repairs to take place. *Smethwick Energy Action Limited* (SEAL) is a long standing community enterprise which has specialised in energy efficiency housing measures and is the major independent contractor for the Sandwell warm zone initiative. A *Falls prevention collaborative*: the HAZ projects handypersons scheme, repairs on prescription, and home hazards prevention have come together with police and fire home security services, social services and primary care workers with older people. The Warley leisure assisted self-build project *has provided homes for* ten families and 24 clients with learning disabilities. *The community build is a traditional timber frame build to high standards of energy and environmental efficiency and a model for future projects.* The community building was completed in September 2003 and is now fully operational as a purpose-built community centre for the voluntary project. Warley leisure have now rebranded themselves as 'options for life' and continue to provide a dynamic range of services for and with families affected by learning disabilities.

The development of the Sandwell Independent Living Centre, and its user-led and owned company, Ideal for All has been one of the most substantial of our programmes to support local enterprise. A painstaking process of community consultation began in 1995 looking at locations, company models, involvement and services to be provided. The independent living centre company was set up in 1996 and funding from the capital challenge initiative was successfully bid for the building commenced on the site of the former Malthouse high rise blocks in 1998, and the building was commissioned in 1999. From a small enterprise with social service and health grants of around £300k, Ideal for All now has an income stream of over £1 million per year and is being looked at as a model of best practice by other independent living centres around the country. Ideal for All was highly commended in the Office of the Deputy Prime-Minister's award for urban regeneration at an urban summit in Birmingham in 2002 and the Office of Public Management good governance award in 2007.

A second area of corporate citizenship is the health services as a landowner including involvement in urban regeneration. The Neptune health park is an example of how multi-agency regeneration can bring about better solutions than individual agency solutions. As part of a nationally funded City Challenge programme there was a commitment to re-housing some local general practitioners in the Black Country Family practice on a site more central to town centre of the town of Tipton. Hospital outpatient and diagnostic services, a pharmacy, an optician, the Tipton Citizen's advice bureau, a community enterprise service and a community health information service all came into the centre. When it became apparent that a major new health facility was to be built near the town centre, the cooperative society, one of the UK's large retailers, reviewed its plans to pull out of Tipton and built a new store. A community centre, extensive new housing developments, an environment centre and new schools within walking distance all then contributed to the further regeneration of the town.

However, when the City Challenge programme finished the impetus was lost and further development did not take place. The lessons for the long term nature of regeneration plans needs to be learned, and hopefully is being, with the ten year, new deal for communities initiative. Neptune sadly was built to the standards of public buildings – cheapest not best – and is already in need of renovation. But the concept is still an important one and should not be lost (Middleton, 2002).

The Right Care Right Here programme is developing major hospital and community reprovision for the Sandwell and Western Birmingham area. It offers further opportunity to deliver a real health dividend, combining health developments with the 'urban living' housing market renewal area and the building schools for the future programme. The programme is providing new jobs in health and social care and developing skills. Community interest clauses are being set in new build contracts and it is hoped that a new science park will be developed adjacent the new hospital in Smethwick.

A third area of corporate citizenship is that of the health services as an innovator. Inclusive design development has already been described. In addition we have over ten years experience of developing multi-media packages for health promotion. In 1993, we commissioned Jubilee Arts, a major local community arts organisation to create for us what was then a little used medium, a multi-media compact disc with materials compiled by local young people about sex and HIV. It was called 'sex get serious'. It involved over 200 young people in its generation and it has been used extensively as a health promotion tool to the present day. Three years later we commissioned 'ease the wheeze', a multimedia programme on asthma. We have commissioned two further multimedia packages – 'buzz' on drugs and a smoking prevention CD (Jubilee Arts, 1993, 1997, 1999). In parallel with this we have commissioned other community arts projects as a vehicle for community learning about health. We have part funded successive development stages of 'the public' facility in West Bromwich. This is the largest lottery funded voluntary project in the UK and opened in the summer of 2008. (www.Thepublic.com). The facility will offer further opportunities to link health promotion innovation with community arts and employment opportunities. We are also renewing our interests in the power of the arts and media to improve health through a new strategy for the arts and health in Sandwell.

Fourthly we can consider corporate citizenship in terms of the health services as a purchaser of local goods and services. Buying local is not as straightforward as it sounds: all resource procurement is subject to audit scrutiny for securing value for money to the taxpayer. European rules apply also. The idea has not yet become established that there may be an additional dividend to be gained for the population you serve if you are able to buy local, and that other benefits may accrue such as reduced environmental costs of transport.

Nevertheless within the existing rules, our supplies organisations over the years have contributed to local buying initiatives. They have been regular contributors to the economic development organisations' meet the buyer exhibitions for local companies. 'Think local' began in the mid 90s as a local services directory and has been used by our purchasers as a reference for particular commissions and have invited local companies to tender where appropriate. This has now evolved into the much stronger initiative, '*Find it in Sandwell'* which has a strong website and regular 'trade fairs' for buyers to meet local providers (www.finditinsandwell.co.uk).

Finally, we can note our corporate citizenship role in terms of work on occupational health services. Sandwell health authority was committed to provision of occupational health services for major employers when I was appointed in 1988. However, we gave this a quantum leap by getting the health authority to agree a business plan in 1992, which enabled the department to invest in additional personnel and take on more local companies work with income generated. This process was expanded still further with health action zone funding in 1998. Over 40 companies benefited annually from the programme. The Workwell service has now been further developed through regeneration zone funding for a Black Country wide service. The 2002 public health report gave a dramatic examples of how this investment was been good for business- a company in Wednesbury threatened with closure because it had not got its insurance for health and safety was helped by Workwell to conform with requirements, stay in business and protect 100 jobs (Middleton, 2002). The Workwell programme continues to evolve within a major programme of support to workers, employers and employment agencies in Sandwell (Sandwell PCT, 2009).

5 Conclusions

In the post 9/11 and post credit crunch world we face severe environmental, economic and security risks which will massively impact on the public's health (Middleton, 2008). These challenges make it imperative for the health services decision makers to behave with the highest standards of environmental and economic corporate responsibility. The health system is one of the biggest investments our society makes for the collective good. We cannot waste resources, or worse, damage our environment. And we must do all in our power to create a health literate, self reliant and fully engaged community.

Here I have described the evolution of the 'health dividend' out of the peace dividend. Both began with efforts to demonstrate less harmful alternative goods and services which could come out of health-damaging industries and provide greater social, environmental and health benefit. The need for an organisation like the NHS in the UK to exercise its responsibility as a good corporate citizen exactly parallels the aspirations of arms conversion campaigners not just to see a technical transformation of their industries for better socially useful production, but to see greater participation by users and producers of goods and services, to see greater democracy and involvement and sharing of benefits. The health service can indirectly improve the health of the people it serves through claiming the health dividend – as a major employer, a major landowner, as an innovator, as a purchaser of goods and services and as an expert resource in occupational health.

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