Northumbria Research Link

Citation: Day, Ann (2008) Principles and key concepts in public health practice. In: Public Health Approaches to Practice. Expanding Nursing and Health Care Practice . Nelson Thornes, pp. 21-35. ISBN 978-0748783977

Published by: Nelson Thornes

URL:

This version was downloaded from Northumbria Research Link: https://nrl.northumbria.ac.uk/id/eprint/2537/

Northumbria University has developed Northumbria Research Link (NRL) to enable users to access the University's research output. Copyright © and moral rights for items on NRL are retained by the individual author(s) and/or other copyright owners. Single copies of full items can be reproduced, displayed or performed, and given to third parties in any format or medium for personal research or study, educational, or not-for-profit purposes without prior permission or charge, provided the authors, title and full bibliographic details are given, as well as a hyperlink and/or URL to the original metadata page. The content must not be changed in any way. Full items must not be sold commercially in any format or medium without formal permission of the copyright holder. The full policy is available online: http://nrl.northumbria.ac.uk/policies.html

This document may differ from the final, published version of the research and has been made available online in accordance with publisher policies. To read and/or cite from the published version of the research, please visit the publisher's website (a subscription may be required.)

Northumbria University NEWCASTLE

University Library

2 Principles and key concepts in public health practice

Ann Day

Learning outcomes

By the end of this chapter you should be able to:

- ★ Understand the different concepts associated with public health
- ★ Describe the key principles of public health practice
- ★ Relate the principles of public health practice to individual, family, group, community and population concepts of public health
- ★ Identify the multidimensional influences on health and well-being.

Introduction

Chapter 1 showed that since New Labour came to power in 1997, public health has been high on the government's agenda (Acheson 1998; Department of Health 1997, 1999a, 1999b, 2000, 2004, 2006; Home Office 1998; Wanless 2002, 2004). Simultaneously, public health practice particularly in nursing, has gained recognition and enhanced credibility (Acheson 1998; Department of Health 1999b, 2001a, 2004, 2006; Home Office 1998). Some people might think that public health is a relatively new area of nursing practice, but nurses have always made a contribution to public health, especially nurses working in the community (Carr and Davidson 2004; Standing Nursing and Midwifery Advisory Committee 1995). Indeed the first public health nurses were the ladies sanitary inspectors, who in 1867 were working with disadvantaged mothers and their children in the slums of Salford. Over the past 140 years these practitioners have transmogrified into what we now call specialist community public health nurses (SCPHNs) (Nursing and Midwifery Council 2004). While SCPHNs remain key public health practitioners working with individuals, families and communities to tackle health inequalities, they are now part of a much wider, multidisciplinary public health practitioner workforce (Department of Health 2001b) as follows:

- **public health specialists** – a small group of people from a variety of professional backgrounds and experience, such as consultant public health nurses.

- **public health practitioners** – spend a substantial part of their time furthering health by directly working with groups and communities (examples are health visitors, school health advisers, occupational health nurses, environmental health officers, community development workers).
- **public health wider (non-specialist) workers** – including managers in the NHS and local authorities, nurses, midwives, teachers and other health workers such as health trainers.

With public health now firmly on the government agenda, all nurses are encouraged to become more involved in public health, whatever their clinical practice. Whether nursing on a neonatal unit or nursing on an older people's unit, public health is everybody's business. Public health has adapted its practice over the years to embrace contemporary public health approaches and works in collaboration with populations, but more fundamentally with the individuals, families and communities who make up those populations. The main focus of public health practice is very much concerned with improving the health of populations, preventing disease, promoting health and reducing inequalities.

The principles of public health practice

Biomedical model and social model

To understand the principles of public health practice, we need to consider the key concepts in public health and more fully understand Acheson's definition of public health: 'the science and art of preventing disease, prolonging life, promoting, protecting and improving health and well-being through the organised efforts of society' (Acheson 1988, p.16).

The definition of public health highlights several key concepts fundamental to public health, which will be unpacked and outlined. Firstly, the 'science' or biomedical model and the 'art' or social model approaches to health. While these models can be seen as two distinct models, public health nursing simultaneously takes account of both approaches. To understand the health of a community, it is essential to understand the data on mortality (death) and morbidity (ill health) for that community, which is the epidemiology of disease. **Health needs assessments** are conducted by public health practitioners to identify and assess health conditions and the health needs of a community. Here are some of the questions explored in a health needs assessment:

- How many people are in the community?
- How many are affected by a specific disease such as coronary heart disease?
- What are the ages of those affected?

Keywords

Health needs assessment
A health needs assessment is a systematic approach to determine the health issues facing a population, leading to an agreed service or intervention which is intended to improve health and reduce inequalities (Health Development Agency 2004)

- Are men and women equally affected?
- Is there a common pattern?

The data from the health needs assessment is then analysed to determine the occurrence of coronary heart disease and the effective, evidence-based interventions that should be made available to the community.

Besides this biomedical model, sometimes known as the epidemiological model, it is also important to consider the social model to fully grasp what is affecting the health and well-being of the community. For example, is there an inequality? In other words, is there a gap between the most advantaged sections of society and the least advantaged? Here are some specific questions to ask for the coronary heart disease example:

- Is there an inequality in those presenting with coronary heart disease?
- Do they live in a disadvantaged area?
- Is unemployment high?
- Is there poor accessibility to shops selling good, healthy food at reasonable prices?
- Is there good accessibility to health-care services?

A key principle of public health from a nursing perspective is to practise within an overarching framework which links the two models to give an overall picture of the health and well-being of the individuals and the whole community.

Reflective activity

Think about patients with coronary heart disease that you have nursed or cared for in some other way. Is there any commonality between them? Here are some questions you could ask:

- If they have a job, is it a skilled or unskilled job?
- What are the shops like in the neighbourhood where they live?
- Is there a nearby park or open space where people can walk without feeling afraid?

Health protection and promotion

If we think of the biomedical model and the social model of public health as an overarching framework for understanding public health practice, we can then start to think about the main principles of public health in the second part of Acheson's definition: 'preventing disease, prolonging life, promoting, protecting ... health'. These key public health principles translate into the three strands of health protection, health promotion and the maintenance or restoration of health.

Building on the example of coronary heart disease, here are some things that the public health practitioner might be involved in:

- **health protection** – working with the local community and the local authority to dissuade local shopkeepers from selling cigarettes or alcohol to under-age children
- **health promotion** – in collaboration with the local community, setting up sessions to help and support people wanting to change to a healthier lifestyle, such as stopping smoking or losing weight
- **maintaining or restoring health** – provision of screening programmes, such as blood pressure sessions, in the local community centre, the local shopping centre or other accessible places.

Wanless (2004) warned that it might be difficult to encourage some sections of society, particularly disadvantaged groups, to become 'fully engaged' with some of these activities. As a result, the government (Department of Health 2004) suggested that the delivery must be underpinned by three principles:

- **Informed choice for all** – people need to have good, reliable information so they can make choices that affect their health.
- **Personalisation of support to make healthy choices** – public health practitioners must consider the reality of people's lives when giving help and support. It makes no sense to encourage someone to go running when that person doesn't feel safe to be out and about in their local neighbourhood.
- **Partnership working to make health everybody's business** – this includes working not only in partnership with individuals and communities but also with the public, the private and voluntary sectors, the media and many other groups.

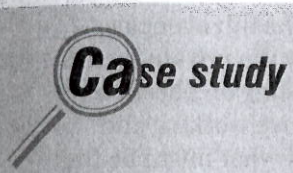
Over to you

Go to the Health Protection Agency website and see which areas of your practice have a health protection element.

Health and well-being of people and communities

The phrase 'improving health and well-being' is another key public health concept and fundamental to public health practice. The idea is as old as civilisation itself. The Romans focused on the health and well-being of their populations, with sophisticated, safe water supplies and latrines back in 3000 BC. Aristotle in 384 BC used the Greek word *eudamonia*, 'the well-being of the whole person'. Twenty-four centuries later, public health policy and public health practice encompass not only the well-being of the whole person as an individual, but also that person's family, the community where they live and the population or society they belong to.

In public health terms, 'well-being' means being concerned with people's health within a holistic interpretation of health; that is, incorporating the physical, mental, emotional and social aspects of health. This well-being of the individual cannot be seen in isolation, but is interconnected with and interdependent on their family, community, population and the policies and systems that operate not only at a national level, but also at a local level. These seemingly disparate yet connected areas can have beneficial or harmful effects on a person's health and well-being.



Oliver twist

Read this extract from the *Guardian* (18 September 2006) then answer the questions.

Parents and head in school dinner talks

Two mothers who handed out fast food to school children in a backlash against a school's healthy eating policy will meet the school's headteacher today in [an] attempt to resolve the row.

Julie Critchlow and Sam Walker have been accused of undermining the Jamie Oliver inspired crusade against junk food in schools by handing out burgers, fish and chips, and fizzy drinks through the fence at Rawmarsh Comprehensive School, in Rotherham, South Yorkshire.

They say they are giving children what they want after the school brought in a new healthy menu and banned pupils from going to local takeaways.

But they also insist that they favour healthy eating, pointing out that they have also handed out jacket potatoes and salad sandwiches.

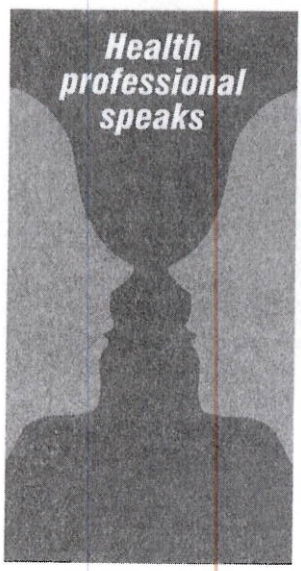
- What are your thoughts on what the two mothers did?
- What do you think about the school bringing in a new healthy menu?
- What might be the long-term holistic outcomes for the children's health and well-being?

Collaboration and partnership

The final part of Acheson's definition, 'through the organised efforts of society', refers to collaborative working with communities and multidisciplinary agencies to achieve better health and well-being. The idea is that the community itself needs to participate actively in determining the main issues affecting its health and well-being. This means that the community and people in the community need to feel empowered and confident enough to articulate their issues. This can often be a problem in disadvantaged areas where some people may feel that they have no control over their lives and can do nothing to affect what happens to them. This is known as an external locus of control (Rotter 1966). A locus of control is the extent to which individuals

believe they can control events that affect them. People who have an internal locus of control believe that they have some control over their lives and therefore have some self-confidence and self-esteem. An important principle of public health practice is to work closely with people and communities, helping to build up their confidence so they can take an active role in decision-making processes that affect their community and work effectively with professionals.

However, a community's ideas about what it needs might differ from the professional agencies' ideas about what it needs. For example, a community might think that their biggest problem is concern about drug misuse or crime in the area, and the related concern about letting their children move about freely. But the agencies – health agencies, local authorities, voluntary organisations and latterly the private sector – may be influenced by the government agenda focusing on obesity as a major public health problem. The key to collaborative working and partnerships is to reach a common understanding of what might be the priorities and how best to tackle them. Chapter 7 discusses partnership working in more detail.



Health visitor

As a local community development worker and a health visitor, I had been given a remit based on the government's Respect Agenda to set up a parenting programme to try and prevent children becoming the 'juvenile delinquents' of the future. But when I asked the mothers what they wanted, they said they wanted to feel good – they wanted to be pampered. So I used part of the funding to set up some aromatherapy, beauty and manicure sessions. Every mother who came along could choose three sessions of whatever she wanted. In time the group became quite a close-knit group and continued to meet, even though the funding for feel-good sessions had run out. They started to share among themselves the problems they'd been having as parents. We heard each other's stories and discussed things that we found had worked and things that hadn't worked, and in our own we way developed a parenting programme based on the mothers' strategies to cope with difficult parenting situations.

A new 'citizen' model of involvement has been devised which encourages active involvement and gives a 'voice' as well as 'choice' (Department of Health 2006) and ownership of services for the community. Known as 'social enterprise', the model is based on members of the community influencing the planning, design and delivery of health-care services and also being part-owners alongside patients, staff and other organisations, including private and commercial organisations.

Evidence base

For further information on community empowerment, read Graney, A. (2002) Effectiveness and community empowerment. In: *Public Health in Policy and Practice* (ed. Cowley, S.). Ballière Tindall, London.
To read more on social enterprise go to the King's Fund website and read the working paper 'Social enterprise and community-based care' by Richard Lewis, Peter Hunt and David Carson.
Also go to the Department of Health website and search for 'social enterprise'.

Working with inequalities

A key concept of public health practice is working with individuals and communities to reduce inequalities in health. Wanless (2004) issued this warning:

> Persistent socio-economic inequalities in the UK, combined with a greater severity of market failures affecting lower socio-economic groups, seem to have contributed to significant inequalities in health outcomes which, unless tackled, will present a significant barrier to many in society becoming 'fully engaged'.

Health experiences differ between different social and economic groups, geographical areas, genders, cultures and ethnic communities. These inequalities in health in the UK are widening, despite a general improvement in the health of the nation over the past 30 years. The stark reality of this means that in 1997–1999 the life expectancy at birth for a man in a professional occupation was 7.4 years higher than for a man in an unskilled manual occupation (Office for National Statistics 2005). Similarly, in 1999–2001 Glasgow City was the local authority with the lowest life expectancy at birth for both males and females. Male life expectancy was 68.7, 10 years less than for North Dorset local authority at 79.3.

A thorough understanding of the causes of these inequalities is vital for anyone who wishes to work in the field of public health. Dahlgren and Whitehead (1991) explored the interaction of complex, multidimensional influences that affect people's health. They produced a now famous 'rainbow' model which highlights the main determinants of health and helps us understand how inequalities occur (Figure 2.1).

Age, sex and constitutional factors

When Dahlgren and Whitehead produced their rainbow model, it was thought that the factors at the centre of the model were fixed characteristics and could not be changed. However, with the tremendous advances in genetic technology, this situation may be changing. A person in the centre is born at a certain time, either male or female, of a

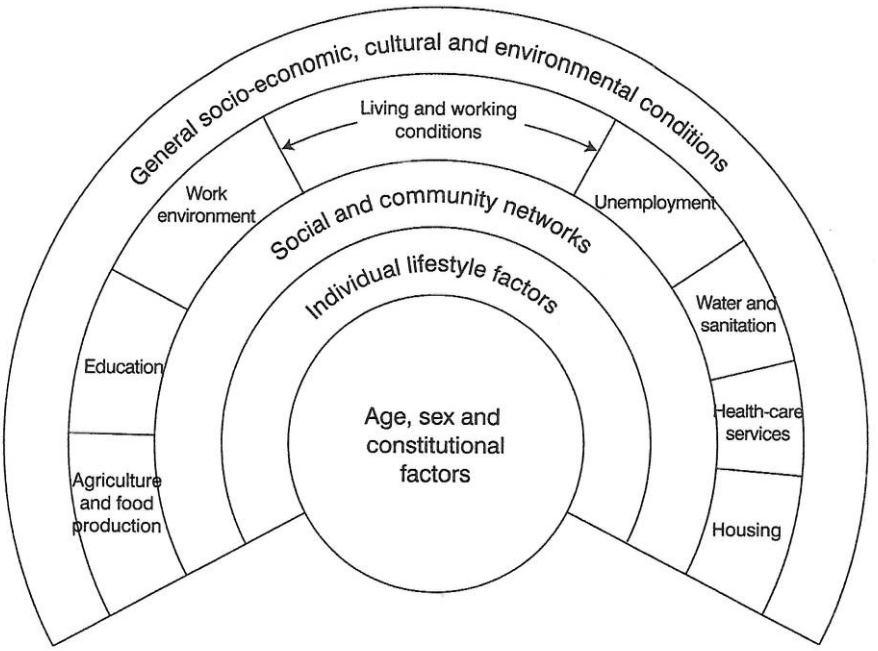


Figure 2.1 Determinants of health. Reprinted, with permission, from Dahlgren and Whitehead (1991)

particular ethnic group and may have inherited genetic factors that may affect aspects of their health and development. Also, they may have been subject to smoking, alcohol or drug misuse in utero.

Individual lifestyle factors

In the next layer of the model, the choices the person makes about their lifestyle as they grow into adulthood can have a positive or negative effect on their health. For example, if they drink heavily, smoke, eat unhealthy foods and take little or no exercise, they will be affecting their health in a detrimental way and they will be predisposed to coronary heart disease.

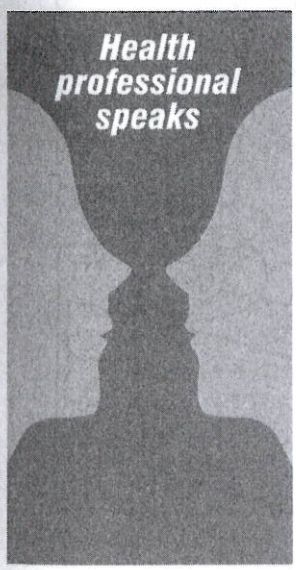
Social and community networks

Within current government policy, this layer of the rainbow model is seen as vitally important for the health and well-being of a person, their family and their community. Having friends, relatives, friendly neighbours and feeling safe in the community are thought to provide people with a sense of belonging and a feeling that a supportive network is close at hand. This social capital encourages trust and reciprocity in the community; it is a key public health concept (page 31). Public health practitioners can work with local communities to support them in determining their community needs; for example, the community could decide that a priority is to find a place where children can play safely.

Living and working conditions

The living and working conditions layer of the rainbow model relates to some of the most important influences on the health of individuals and communities; it focuses on the local economy and the conditions in which people live and work. Many issues may be beyond the control of individuals and communities and some may influence their health in a detrimental way. For example, communities may live in food deserts, where it is difficult to buy good, healthy food at reasonable prices. Poor public transport links may affect access to good food, jobs, education, health services and social care. It is a sad irony that disadvantaged people often do not access health and care services, although they would actually benefit more than the worried well, who make frequent access. This inverse care law (Tudor-Hart 1971) is not just about physical accessibility, but also about the availability of good health and social care services plus the welcome given to disadvantaged people when they do access these services.

Moreover, an area may have poor educational facilities. Poor educational facilities seldom attract better teachers and this may affect the educational attainment of children. Education and skills are thought to be essential for escaping a lifetime of disadvantage. The fundamental ethos underpinning the government's Sure Start programme is that an early start to education, together with childcare, health and family support services, encourages a child's learning and will help them avoid a life of disadvantage. Housing may be poor, damp and without basic heating. Unemployment may be a key issue, with the closure of local factories that employed the community. Or a person may be in low-paid employment with poor conditions. Separately or combined, all these factors can affect people's physical, mental and emotional health.



Health visitor

I am an experienced health visitor and I used to run a free parents and tots session at the local community hall. I was very upset when I found out that the local council wanted to close the hall. Over the five years when I ran the sessions, I noticed there was much less post-natal depression and generally fewer mental health problems. The local council said it had to close the hall as it was 'unsafe' but there was going to be a 'bigger and much smarter' building where it would put together health, social care and education professionals. The planners put it three kilometres from the old community hall and there was no regular bus service. It was not on the way to the local shops, schools or any other amenities. The parents and tots sessions at the new hall ceased after six months as nobody went along.

Socio-economic, cultural and environmental conditions

The final layer is for the overarching political strategies that dictate policy, economic and environmental issues and that partly influence our views on culture, ethnicity and gender. The strategies depend on which political ideology is current. So, as explained in Chapter 1, New Labour governments have introduced a huge array of policies that focus on community involvement to improve public health in the UK.

Reflective activity

Study Figure 2.2 and think about the children growing up in this environment.

- What might be some of the risks they are susceptible to?
- What might be some of the influences within the family that the children are subjected to that might be harmful to their health and well-being?
- What sort of issues within the community might this family be struggling to cope with that could potentially affect their long-term health and well-being?

Figure 2.2 Reflect on this environment

Strengthening communities through social capital

Here is how the World Health Organization (1998) has defined social capital:

> Social capital represents the degree of social cohesion in communities. It refers to the processes between people that establish networks, norms and social trust, and facilitate(s) coordination and cooperation for mutual benefit.

Social capital is thought to encourage social cohesion and increase the likelihood of individuals and communities being socially included rather than excluded through, for example, disadvantage and unemployment. Employment is thought to be a key impetus that gives a sense of well-being, participation and a social network of friends or colleagues. As Puttnam (2003) suggests, social capital has positive economic effects and these economic effects have a knock-on effect in that a thriving local economy will encourage social capital by providing jobs.

The Health Development Agency (2004) suggested that social capital has four key elements:

- **social resources** – such as informal arrangements between neighbours or within a faith community
- **collective resources** – such as self-help groups, credit unions and community safety schemes
- **economic resources** – such as levels of employment and access to green, open spaces
- **cultural resources** – such as libraries, arts centres and local schools.

Reflective activity

Social capital is an important public health concept that is thought to have positive effects on health and well-being. Look at this quotation from Robert Puttnam (2003), the great exponent of social capital: 'We are social animals: for example there is the extraordinary statistic that if you presently do not belong to any group, joining a club or society of some kind halves the risk that you will die in the next year.'

- What do you think about this statement?
- What might be some of the challenges facing the family in the cartoon on page 30 if they wanted to join a group?

Social capital remains a challenge, particularly in some disadvantaged areas, where social exclusion is rife. Social exclusion has been described as 'what can happen when individuals or areas face a combination of linked problems such as unemployment, discrimination, poor skills, low incomes, poor housing, high crime, bad health and family breakdown' (Social Exclusion Unit 2004). Lone parents and their children are a

particular group who can face social exclusion. According to the Office for National Statistics (2005), in 2003 a quarter of all children in the UK lived with one parent, and 43 per cent of those parents were not in employment.

Jan and Jade

Jan, aged 18, lives in a one-bedroom council flat in a disadvantaged inner-city area with her daughter Jade, aged 2. She can't get a job as she hasn't any qualifications and she has no one who can look after Jade. Jan was at school studying for her GCSEs when she became pregnant. She'd been having a difficult time at home, not getting on with her mother, who'd taken up with Jed, 10 years younger than her mum. Jed gave Jan the creeps, especially when he suggested that he'd moved in to be closer to Jan, not her mother.

Jan started to bunk off school and hang about with a few people older than her who'd left school a couple of years before. She got pregnant. The school didn't seem very interested but Jan was given some home tuition. Jan didn't like spending too much time at home because Jed was there. She left home and ended up in a place for young mums and babies. Eventually she got a council flat. She finds it very difficult living on benefits. She wants to buy Jade things like nice clothes and healthy food but she can't afford them. Jan can buy a packet of custard cream biscuits for the same price as one apple and Jade seems much happier with custard creams. Jan knows that she shouldn't smoke, but she thinks it helps her cope with her loneliness and boredom.

- From a public health perspective, what could have been done to avoid Jan becoming socially excluded?
- What can the public health practitioner do to enable Jan and Jade to become socially included?

Keywords

Upstream
Upstream public health practice focuses on preventive measures, tackling the root causes of ill health. It brings a wide range of benefits in an attempt to improve health

Downstream
Downstream public health practice focuses on tackling existing health problems. It brings a narrower range of benefits with direct effects for the individual

Upstream and downstream health strategies

A well-known analogy considers public health strategies as either **upstream** or **downstream** on a river (Acheson 1998). Acheson talked about upstream causes of ill health such as poverty and social exclusion. Upstream strategies to combat these inequalities are policies which lead to health interventions to prevent the development of avoidable diseases and improve the health of individuals and communities. A good example is the recent smoking ban in restaurants and pubs in the UK. Meanwhile, downstream on the river, smoking, unhealthy diets and lack of exercise are all causes of ill health. Downstream strategies focus on individual lifestyle factors and interventions to treat preventable disease such as support for people to help them quit smoking and classes that teach people to cook healthy food.

Over to you

Recent public health policies (Department of Health 2004) have been criticised for laying too much emphasis on the individual's responsibility for health. Several complex factors influence our health, and we may have little influence over some factors. The UK Public Health Association (2004) produced a critical analysis of *Choosing Health*. Read this extract from the UKPHA analysis and work out your own views on the subject.

The relevance of choice in public health

We welcome the recognition given in the White Paper to the legitimate role of government in creating healthier environments and shifting social norms in order to support individuals and protect the health of vulnerable groups. However, we fundamentally disagree with the portrayal of personal choice as the key issue for improved public health and the focus within the White Paper on individuals as consumers, and not as citizens.

What does choice mean in public health? Public health is principally about organising society for the good of the population's health; at this level of concern, it is no more a matter of individual choice than the weather.

Many individuals cannot choose whether or not they have sufficient income to live in warm safe housing and eat healthy food. They cannot choose to walk or cycle when both pedestrian and cycle routes are often neither safe nor pleasant and dominated by the needs of the car. Those who suffer the worst health inequalities cannot choose to enjoy the benefits of local safe green spaces to pursue healthy outdoor activities or to breathe clean fresh air.

Even when choice can be exercised, consumer decisions are profoundly affected and influenced by the powerful and all pervasive impact of the advertising and promotional activities of the food and drink industry, which is driven by the need to increase sales and maximize shareholder value rather than to promote the public's health.

Conclusion

Public health is a key part of health provision in the twenty-first century. It is the business of every nurse and health-care practitioner, whether they work in an A & E department or a surgical unit. Public health practice is not only concerned with individual people, but also with the families and groups they belong to, the communities where they live, and the population or society they are part of. Public health's main concern is to improve the health and well-being of people by preventing disease, by promoting health and by striving to reduce inequalities. Moreover, public health practice does not happen in isolation. The ethos underpinning public health practice is one of partnership and collaboration with

other agencies, but more importantly, with the individuals, groups and communities who need the public health interventions.

Rapid recap

Check your progress so far by working through each of the following questions.

1. What are the main principles of public health practice?
2. What is meant by a community?
3. How might a public health practitioner gather information about the health of a community?
4. How can the area where a family lives affect the family's health?

If you have difficulty understanding more than one of the questions, read through the section again to refresh your understanding before moving on.

References

Acheson, D. (1988) *Public Health in England: The Report of the Committee of Inquiry into the Future Development of the Public Health Function.* HMSO, London.

Acheson, D. (1998) *Independent Inquiry into Inequality in Health: Report*. HMSO, London.

Carr, S. and Davidson, A. (2004) Public health nursing: developing practice. *Practice Development in Health Care*, **3**(2) 101–112.

Dahlgren, G. and Whitehead, M. (1991) *Policies and Strategies to Promote Social Equity in Health*. Institute of Future Studies, Stockholm.

Department of Health (1997) *The New NHS: Modern, Dependable*. HMSO, London.

Department of Health (1999a) *Saving Lives: Our Healthier Nation*. HMSO, London.

Department of Health (1999b) *Making a Difference: Strengthening the Nursing, Midwifery and Health Visiting Contribution to Health and Health Care*. HMSO, London.

Department of Health (2000) *The NHS Plan*. HMSO, London.

Department of Health (2001a) *Health Visitor Practice Development pack*. HMSO, London.

Department of Health (2001b) *Report of the Chief Medical Officer's Project to Strengthen the Public Health Function.* HMSO, London.

Department of Health (2004) *Choosing Health: Making Healthier Choices Easier*. HMSO, London.

Department of Health (2006) *Our Health, Our Care, Our Say*. HMSO, London.

Graney, A. (2002) Effectiveness and community empowerment. In: *Public Health in Policy and Practice* (ed. Cowley, S.). Ballière Tindall, London.

Health Development Agency (2004) *Health Needs Assessment*. HDA, London.

Home Office. (1998) *Supporting Families: A Consultation Document.* HMSO, London.

Nursing and Midwifery Council (2004) *Standards of Proficiency for Specialist Community Public Health Nurses*. NMC, London.

Office for National Statistics. (2005) Census 2001 profiles. www.statistics.gov.uk/census 2001/profiles/printV/00CH.asp, accessed 27 February 2006.

Puttnam, R. (2003) Social capital. Lecture given at the Royal Society.

Rotter, J. (1966) Generalized expectancies for internal versus external control of reinforcements. *Psychological Monographs*, **80**, no. 609.

Social Exclusion Unit (2004) *Breaking the Cycle: Taking Stock of Progress and Priorities for the Future*. Office of the Deputy Prime Minister, London.

Standing Nursing and Midwifery Advisory Committee (1995) *Making it Happen*. Department of Health, London.

Tudor-Hart, J. (1971) The inverse care law. *Lancet*, **1**, 405–412.

United Kingdom Public Health Association (2004) *Choosing Health or Losing Health?* UKPHA, London.

Wanless, D. (2002) *Securing Our Future Health*. HM Treasury, London.

Wanless, D. (2004) *Securing Good Health for the Whole Population*. HMSO, London.

World Health Organization (1998) *Health Promotion Glossary*. WHO, Geneva.

Public Health Approaches to Practice

Edited by Jan Mitcheson

Nelson Thornes

Text © Liz Berry, Patricia Bond, Susan M. Carr, Ann Day, Jane Goodman-Brown, Mary Gottwald, Scott Harrison, Jan Mitcheson, Ivy O'Neil, Sue Rouse and Yvonne Wilkinson 2008
Illustrations © Nelson Thornes Ltd 2008

The rights of Liz Berry, Patricia Bond, Susan M. Carr, Ann Day, Jane Goodman-Brown, Mary Gottwald, Scott Harrison, Jan Mitcheson, Ivy O'Neil, Sue Rouse and Yvonne Wilkinson to be identified as authors of this work has been asserted by them in accordance with the Copyright, Designs and Patents Act 1988.

All rights reserved. No part of this publication may be reproduced or transmitted in any form or by any means, electronic or mechanical, including photocopy, recording or any information storage and retrieval system, without permission in writing from the publisher or under licence from the Copyright Licensing Agency Limited, of Saffron House, 6–10 Kirby Street, London EC1N 8TS.

Any person who commits any unauthorised act in relation to this publication may be liable to criminal prosecution and civil claims for damages.

Published in 2008 by:
Nelson Thornes Ltd
Delta Place
27 Bath Road
CHELTENHAM
GL53 7TH
United Kingdom

08 09 10 11 12 / 10 9 8 7 6 5 4 3 2 1

A catalogue record for this book is available from the British Library

ISBN 978 0 7487 8397 7

Illustrations by GreenGate Publishing Services and Angela Lumley
Page make-up by GreenGate Publishing Services, Tonbridge, Kent

Printed and bound in Slovenia by Korotan

NORTHUMBRIA UNIVERSITY
LIBRARY
1313839
ITEM No. 2006702882
CLASS No. 610.734 PUB