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

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ABSTRACT

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

1. Introduction

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

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

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

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

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

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

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

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

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

1.2. Towards a conceptual framework for healthy settings

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

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

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

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

Table 1
Interviewees—Élite key informants.

Vivian Barnekow Rasmussen (VR)	Technical Adviser, Promotion of Young People's Health, World Health Organisation Regional Office for Europe, Copenhagen, Denmark
Cordia Chu (CC)	Director, Centre for Environment & Population Health, Griffith University, Queensland, Australia (and expert in workplace health promotion and settings-related research and practice).
Len Duhl (LD)	Professor Emeritus, University of California, Berkeley, USA (and widely recognised to be one of the 'founding fathers' of Healthy Cities)
Trevor Hancock (TH)	Consultant, Ministry of Health Planning, Victoria, British Columbia, Canada (and widely recognised to be one of the 'founding fathers' of Healthy Cities).
Dominic Harrison (DH)	Deputy Regional Director of Public Health, North West Region, Department of Health, England (and centrally involved in the WHO European Health Promoting Hospitals and Regions for Health programmes).
Ilona Kickbusch (IK)	Independent Global Health Consultant, Switzerland (and formerly Director of Health Promotion for WHO and widely regarded as a key architect of the healthy settings approach)
Michel O'Neill (MO)	Professor, Faculty of Nursing, Université Laval, Québec, Canada (and Co-director of Quebec WHO Collaborating Center on the Development of Healthy Cities and Towns)
Jürgen Pelikan (JP)	Scientific Director, WHO Collaborating Centre for Health Promotion in Hospitals and Health Care, Ludwig Boltzmann Institute for the Sociology of Health and Medicine, University of Vienna, Austria
Agis Tsouros (AT)	Regional Adviser, Healthy Cities and Urban Governance, World Health Organisation Regional Office for Europe, Copenhagen, Denmark

Note: Titles/roles correct as at time of interview in 2007. Interviewees' views and comments were made in a personal and professional capacity but not formally representing their employing organisations.

open – interacting with the other settings and the wider environment – and complex (Grossman and Scala, 1993; Paton et al., 2005). Using the concept of complex adaptive systems as a framework to examine health promoting schools, Keshavarz et al. (2010) note that such systems have distributed network control; are characterised by continuous feedback, adaptation and change; exhibit emergence and unpredictability; and are 'nested'. Dooris et al. (2007) further highlight the importance of appreciating the nested nature of settings, drawing on the work of Bronfenbrenner (1979, 1994) in the field of social psychology and child development with its focus on the interconnections within the microsystem, mesosystem, exosystem, macrosystem and chronosystem.

Thirdly, the approach adopts a whole system focus (Pratt et al., 1999), using multiple, interconnected interventions and programmes to embed health within the culture and routine life of a specific setting; ensure living and working environments that promote greater health and productivity; and engage with and promote the health of the wider community (Barić, 1993). Healthy settings initiatives use a range of methods and techniques to introduce and manage change within the setting in its entirety. In geographic settings such as cities, these are drawn primarily from community development (Dooris and Heritage, 2011)—more recently informed by capacity-building and social capital theory (Nutbeam, 2008). In settings such as schools, hospitals, prisons and workplaces, they are drawn from organisational development and management theory (Grossman and Scala, 1993; Kickbusch, 2003), with a strong focus on context, leadership, quality and change. Exploring how this whole system vision can be translated into practice, Dooris (2009) has presented a model highlighting the need to balance long-term development with high-visibility project work, top-down commitment with bottom-up engagement and public health and core business agendas.

Although widely seen as an important and legitimate health promotion mechanism, the settings approach has, like Healthy Cities, attracted some critical discourse. Within their critique of the 'new public health', Petersen and Lupton (1996) argue that the ecological model of health actually involves the conceptualisation of an ever increasing number of 'environmental' risks as amenable to personal control. More specifically, Wenzel (1997) cautions against trivialising 'health promoting settings' by reducing it to delivering 'health promotion in settings'; and Baum (2002) highlights the need for initiatives to take account of wider contextual factors and to address imbalances of power and control—a theme also developed by Poland et al. (2000). An additional debate concerns the tension between conceptualisation and real-life implementation. Whitelaw et al. (2001) have formulated a typology that distinguishes different forms of settings-related practice, reflecting different analyses of the problem and solution in terms of whether the focus is more on the individual or the setting/system. Likewise, Dooris (2004), p. 56) comments that "whilst the theoretical framework guiding the work may be rooted in systems thinking…the practice is often constrained to smaller-scale project-focused work around particular issues."

2. Methodology

This paper is informed by a qualitative study conducted for a doctorate comprising a 'hybrid' of previously published work and new empirical research. This research engaged with key informants who have been active in shaping the emergence and development of healthy settings internationally, in recognition that conceptual thinking must be constantly refined and developed (Green, 2000). By engaging with visionary thinkers, leaders and policy-makers widely acknowledged to have been the architects and pilots of the settings approach, the research offered the opportunity not only for critical reflection, but also for advancing ideas and concepts articulated in the prior publications work and identifying future challenges. This paper focusses on findings related to the conceptual and practical development of the settings approach; policy and practice integration; and connecting 'outwards', 'upwards' and 'beyond health'.

Audio-recorded semi-structured élite telephone interviews were used to collect data. The value of interviewing to access experience and perceptions and gain in-depth insight and meaning – both verifying and constructing theory – is well documented (Seidman, 2006). As the purpose of the research was not only to validate existing concepts and ideas, but also contribute to their further development, interviewing was felt to be the most appropriate data collection method. Acknowledging the need for interviews to be concise yet sufficiently open to access perspectives and generate new thinking, semi-structured interviews were chosen (Gillham, 2005). The value of élite interviewing is widely recognized (Marshall and Rossman, 2006), the choice of method reflecting a concern to access the unique knowledge, experience and expertise of individuals selected for their international standing and influence.

Expert sampling (Trochim, 2006) was used to select informants. Care was taken to ensure that interviewees would, collectively, be

Table 2
Summary of categories and themes emerging from interviews.

Categories and themes
Conceptual and practical development of the settings approach
• Ottawa Conference and Charter for Health Promotion
• Roles and influences of WHO and individuals
• Common principles and/or features drawing on insights from different disciplines, but no widely shared overall theory
• Ecological, salutogenic and wider determinants focus
• Emergence of Healthy Cities and extension of approach to other settings
• Management and organisational theory and systems focus—but limited engagement from practice
• Appreciation of commonalities and differences between settings programmes
• Underdevelopment of theory, due in part to lack of research and funding for research
• Emergence of theory from practice
Integrating the settings approach in policy and practice
• Successful embedding through multi-sectoral ownership and policy impact
• Variation between cultures, countries and regions
• Increased impact of approach on topic-based programmes and strategies
• Challenge of embedding the approach within 'medically-based' public health
• Challenge of developing networking as a means of enabling diffusion and embedding of approach
• Failure of WHO and other international agencies to provide continued support after initiation
• Failure to capture, articulate and capitalise on the richness of the approach
• Failure to become integrated into the commissioning process and performance management systems
Connecting 'outwards'
• Limited joint working and connectedness
• Relationship between joining up at theoretical, programme management and operational levels
• Role and history of Healthy Cities as a tool/mechanism to encourage links
• Role of WHO at global and regional levels
• Challenge of different settings operating within context of different systems
• Challenge of different personalities and mindsets
• Challenge of limited resources and potential for confusion
• Opportunity to bring different settings together to share successes, identify common challenges and build partnerships
Connecting 'upwards'
• Settings approach can't do everything, but can make a significant difference to everyday life
• Settings approach addresses determinants of health
• Settings approach should connect upwards through taking on an advocacy role
Connecting 'beyond health'
• Value of encouraging collaboration between agendas to maximise synergy and harnessing commonalities
• Value of encouraging collaboration between agendas to reduce burden on settings
• Settings approach includes focus on sustainable development
• Risk of undermining the power of 'health' to build consensus and mobilise
• Challenge of different mindsets and personalities
• Challenge of territorialism and conflict within systems
• Failure of Bangkok Charter to understand or articulate links
• Importance of being open to opportunities and being flexible and appropriate to context
• Need to ensure that linkage points are contemporary
• Value of understanding global/local links and how globalisation/sustainable development are reflected in everyday life

able to provide a rich world-wide reflection on settings-based health promotion—both generically and in relation to key globally-recognised settings such as cities, hospitals, schools and workplaces. Potential interviewees were contacted to introduce the study and request participation, and the interview schedule was designed and trialled. Whilst normal ethics procedures were followed for obtaining informed consent and ensuring secure data storage, it was recognised that the nature of the research meant that findings would be more meaningful with attributed data. All nine of those approached agreed to participate in the study (see Table 1), confirmed their willingness to allow data attribution and subsequently approved transcripts for use within the thesis and subsequent publications.

Following transcription, data analysis was undertaken to generate categories and themes and enable coding—thereby facilitating the accurate conceptualisation of the data (Marshall and Rossman, 2006). The process followed Bowling (2002), combining 'coding down' and 'coding up'—as categorisation was informed by the interview schedule (which was derived from the themes emerging from the body of published work but also included open questions). Findings are presented below with illustrative quotations (see also Table 2 for summary of categories and themes).

Reflecting on the study design and implementation, it inevitably proved necessary to set boundaries and be pragmatic about what was feasible and achievable within the constraints of time and resources. The decision to explore views and perspectives of an élite sample of 'movers and shakers' within the field of healthy settings proved to be successful in examining, testing and enabling the further development of concepts and ideas contained in my body of publications. Furthermore, the data and resulting discussion provide a firm basis for subsequent research to be carried out in ways that extend the sample and broaden the range of methods. However, it must be acknowledged that the perceptions and insights of these élite informants are likely to be markedly different from those that would have been gleaned from conducting research with a broader cross-section of stakeholders including local policy-makers and practitioners involved in designing and implementing settings programmes 'on the ground' (Richards, 1996).

3. Findings

3.1. Conceptual and practical development of the settings approach

Reflecting on the emergence and development of healthy settings, those interviewed noted the centrality of the Ottawa Conference and Charter and pointed to the pivotal role of both WHO and key individuals (many of them among the interviewees). Whilst rejecting the idea of a clear theoretical framework underpinning the settings approach, they highlighted the contribution of a range of disciplines (e.g. ecology, politics, management science, social psychology) to wider conceptual developments taking place in the early 1980s. In particular, they perceived the shift towards an ecological model, the increased focus on salutogenesis and the growing emphasis on wider health determinants as having helped shape the settings approach and generate a theory of social change:

> [The holistic concept] was the key element, because originally we were looking at medicine in a very linear way, so by doing this, we broke that pattern. When you suddenly discover that education has something to do with health – environment, transport and so on – you have a very different model of what health is. (LD)

> [The settings approach] needs to take account of both the pathogenic and salutogenic aspects of organisations. (JP)

> [One component] is to do with determinants…The theoretical and factual understanding that health is largely shaped by factors beyond the health care sector, I think that…underpins the settings-based approach. (TH)

The establishment of Healthy Cities was understood to be an expression of and response to these wider conceptual developments—and a catalyst for the subsequent focus on different sectors and the development of a range of settings programmes:

> Healthy Cities, it wasn't labelled [as a setting] at first but it was a trigger point. (MO)

A number of those interviewed reflected that the conceptual ideas guiding these wider settings programmes drew extensively on management and organisational theory. Dominic Harrison suggested that the strong focus on systems thinking and framing of challenges around whole systems – concerned with how the whole institutional capacity of organisations could be marshalled as a 'public health agency' – was more consistent with the European social democracy model than neo-liberalism. There was also an acknowledgement that developments in theory and practice need to appreciate both commonalities and differences:

> A hospital is not a city, it is an organisation and not a political unit…This meant that we needed to combine health promotion with the methods for organisational change…It was necessary to make a distinction between organisations and communities and villages and so on, which are different. And they use community development, which is parallel to organisational development and different, although there are similarities too. (JP)

In considering the relationship between theory and practice, there was a general agreement that theoretical work was underdeveloped, due in part to funding constraints, and that it had generally emerged from practice:

> There is nearly no comparative systematic research…which hinders the development of an empirically-founded theory…

> Even within single settings, theoretical work is not so well developed, because not many people are into theoretical work, but instead most into keeping their setting up practically and doing interventions. And there's not much money to develop a more theoretical and scientific perspective—there are very few big multi-site studies, not for hospitals, schools, cities. (JP)

> The theory and the analysis of the various aspects of the settings approach followed the emergence—it came out of practice. (AT)

Some interviewees also observed that lack of engagement with wider theoretical influences – much of it outside of the traditional public health arena – had led to a tendency for initiatives to remain project-based rather than develop a whole system approach to change:

> I think that…people have been trying to implement [the approach] without going back to…[management science] literature. This did have the consequence that some of the health promoting settings projects have been about doing health promotion in a setting. (IK)

3.2. Integrating the settings approach in policy and practice

All interviewees pointed to examples of successful integration in policy and practice at national and local levels—highlighting the importance of multi-sectoral ownership beyond the 'health' sector, particularly within local government:

> The settings approach and movement survived and thrived, because it found supporters in politicians and decision makers in several sectors and in different professional environments…it managed to spread the interest and legitimacy across a much wider spectrum of policy-makers. (AT)

> It tends to be more settings-based in local governments [because they] tend to think in terms of neighbourhoods, schools and so on. (TH)

Policy and practice integration was seen to be stronger for certain settings. Work with schools was highlighted as a particular success, with explicit cross-agency leadership and buy-in at a European level and examples of national cross-government commitment:

> The setting up the joint initiative between the Council of Europe, WHO and the European Commission in 1991 made a crucial mark for us in developing Health Promoting Schools. (VR)

> [In Austria] Health Promoting Schools was run jointly by the Ministry of Education and the Ministry of Health. (IK)

Similarly, interviewees felt that the private sector had understood the value of the settings approach and actively applied it to workplace health, using health promotion as a mechanism for enhancing productivity:

> I think that Healthy Workplaces is the most successful [setting] of all…There's a different kind of demand – which means you can use health promotion not as an end in itself, but as a modern means of solving old problems of labour, of production. (JP)

Reflecting on policy integration, Jürgen Pelikan and Cordia Chu pointed to wide geographical variations arising from political and cultural factors:

> In countries like Italy and Ireland, the settings approach is more accepted within health policy—whereas in many other countries, the political environment is not well prepared for that. (JP)

> I think the settings approach was picked up by the Asian community because it makes sense to them and sits with their ideology…It works much better than the individual approach about behavioural change…Even without support, it didn't go away but flourished. (CC)

A further observation was the increased impact of the approach on topic-based work. Recognising the complexity of many current challenges, Dominic Harrison emphasised the necessity of adopting a systems-based approach within the context of neo-liberal economies, whilst Len Duhl and others expressed optimism that the reach and influence of healthy settings thinking is extending beyond programmes explicitly carrying the settings 'label':

> I think it is influencing work on current topics. That's the part that's been really revolutionary because now…people really will talk about this holistic approach rather than a linear approach. (LD)

Interviewees also identified barriers to policy and practice integration, the first relating to the dominance of 'medically-oriented' public health and the difficulty of gaining ownership and support:

> When public health is integrated within the health care system…it's harder to sell healthy public policy, health promotion and settings-based approaches because the tendency is to medicalise and individualise. (TH)

A second concerned networking as a means of enabling the effective integration and spread of the settings approach. Whilst actively promoted by WHO and other lead agencies, there was concern that networking has been developed without adequate ongoing support or sufficient understanding of how to maximise impact and ensure sustainability across diverse settings and in different political and cultural contexts:

> The approach initiated by WHO was to have a charter and develop a network…[But] there are very different development patterns for different kinds of settings and in different nation states. It would be very interesting…to see how social innovation has been organised for settings-based health promotion…[Also] it's a problem that both the EU and WHO are hesitant to support networks continuously, so in Health Promoting Hospitals we are forming an international association to make our network somewhat more independent and self sustained. (JP)

> The triggering role of WHO has been very useful, but…they had sometimes unrealistic expectations either about their collaborating centres or other entities, and in some cases, they were trying to control even if they had no power. (MO)

More generally, interviewees highlighted the gap between theory, policy and practice, and pointed to the failure to articulate the richness of the approach, develop a robust evidence base and effectively embed it within commissioning and performance management processes.

3.3. Connecting 'outwards'

Reflecting on connections between different settings programmes, there was a strong consensus that initiatives had not always worked well together and were often not effectively joined-up—as illustrated by Trevor Hancock:

> You have a Healthy Schools programme over here, a Healthy Workplace programme over there and a Healthy Cities programme over there. (TH)

Whilst there was agreement that co-ordination between programmes and networks made 'common sense' at a theoretical and policy level, some interviewees pointed to pragmatic difficulties at strategic and operational levels:

> They were all new movements that were striving to establish themselves in different areas, in different sectors with different professional groups, enjoying a lot of acceptability of their own as they grew. And although the principles were very similar, in practical terms, it was always difficult to connect them, it always looked a bit complicated. (AT)

In relation to the emergence of settings programmes within the WHO European Region, Agis Tsouros and Ilona Kickbusch highlighted the role of Healthy Cities in triggering and nurturing these—also noting the subsequent divergence and siloing that has occurred:

> When I was still [at WHO], we did try to engage the Healthy Cities that they also had Health Promoting Schools, Health Promoting Hospitals etc…In fact, Health Promoting Hospitals grew out of Healthy Cities…and then became a separate project with a separate network. The longer this has gone on, the more jealously people have guarded their settings boundaries. (IK)

Moreover, nearly all interviewees highlighted the role of Healthy Cities as a natural mechanism to facilitate connections between settings. However, the overriding sense was that this had not generally been translated into practice:

> It was often said that 'a Healthy City should be a city of healthy settings'—it's well understood that this should have been the case, and although it happened in some cases, it did not really happen in any major and seriously strategic kind of way. (AT)

However, cultural and geographic variation was again noted—with positive examples being given of Healthy Cities and Communities serving as macro-level contexts for organisation-based settings initiatives:

> In British Columbia, we've identified Healthy Communities as a core public health programme—and within Healthy Communities are Healthy Schools, Healthy Workplaces, Healthy Care Facilities. (TH)

> The 'ecological model'…shows that every setting plays a part within the larger whole…Within Asia…the emphasis on Healthy Schools, Healthy Marketplaces or whatever is seen as a part of the Healthy Cities agenda. (CC)

Interviewees reflected on WHO's role in encouraging connectedness between settings. At the global level, there was a sense that Ilona Kickbusch's pioneering work had been followed by a lack of commitment and momentum, symbolised by the dissolution of a dedicated health promotion division:

> I don't see that WHO have done enough to link up different settings. There were three to four years of complete loss of leadership and intention in WHO in Geneva. (CC)

However, it was noted that some WHO regional offices had encouraged a more 'joined-up' approach through an integrated organisational structure for settings programmes:

> Some WHO regions [such as Pan-America, the Western Pacific and South-East Asia] did create opportunities [for joining up between settings]. This was because settings were all put under one umbrella, under the responsibility of one person. In WHO Euro, this was never the case. Its programmes grew in their own different ways with different people at senior programmatic level. (AT)

Michel O'Neill introduced a note of caution, suggesting that such integration can actually put more pressure on people and detract from the effective work of any one setting:

> I know the work of PAHO, and it's the same sub-group that's working on Healthy Schools and Healthy Communities. I see the same potential risk there, with groups and networks getting confused by all those settings people trying to work all the settings together…Theoretically it seems nice, but practically it makes me more nervous. (MO)

Interviewees identified several further barriers to 'joining up' between settings—including the complexity caused by programmes operating within the context of different types and levels of political system, and the impact of different personalities and mindsets:

> You're usually looking at different ministries dealing with different areas, and they tend not to be that joined-up. (TH)

> It's not only projects, it's also individuals who won't work together…My European experience was about personalities who weren't willing to do anything together, so it's not always easy! (IK)

More optimistically, there was also a focus on opportunities to bring together key players representing different settings to reflect on progress, address challenges and build partnerships.

3.4. Connecting 'upwards'

In relation to connecting 'upwards' to ensure action on the overarching determinants of health, interviewees asserted the importance of valuing the role of the settings approach in promoting health in the places that people live their lives:

> You should be conscious of what's going on in the big picture but your work at your own level, I think it's quite appropriate—because trying to change the whole world at one time is quite a big job! (MO)

Linked to this, a number of people emphasised that, if practised appropriately, the settings approach *is* determinants-focussed, through thinking holistically, highlighting underpinning risk conditions, changing environments and enabling empowerment:

> If a settings approach is done properly, then it does address the determinants of health—it changes people's working environments, it changes the way work is organised, it empowers them as patients or as school children or as teachers…The big issues always reflect themselves in people's everyday lives and unless you provide a political space for empowerment – which is essentially what the settings do – you're not really doing health promotion. (IK)

> Many [public health] programmes focus on risk factors, which tend to be embodied in individuals. But the question is "what are the risk conditions that generate those risk factors or risk behaviours?" An intervention in those risk conditions is likely to be much more effective, more ethically sound—and require a settings- or systems-based approach. (DH)

Developing this further, Vivian Rasmussen and Ilona Kickbusch discussed how the approach could and should connect upwards through taking on an advocacy role—providing examples of how Healthy Cities and Health Promoting Schools have been able to exert influence through becoming integrated within local government associations and informing national policy.

3.5. Connecting 'beyond health'

In terms of connecting 'beyond health', interviewees emphasised the value of ensuring collaboration with parallel agendas in order to maximise synergy. Whilst recognising the tendency for people to guard their own programme, they highlighted the importance of avoiding disconnected parallel programmes:

> We all know that schools are over-burdened with initiatives …and we need to speak with the same tongue and join up! (VR)

> I think something we're really bad at but need to be a lot better at is avoiding 'multiple silo' programmes, so you don't go into the community with a Safe Community project this week, a Sustainable Community project the next week and then come in with Healthy Cities! (TH)

A number of barriers were also identified, primarily relating to different personalities and mindsets and the 'in-built' territorialism within different organisations and systems:

> It was more or less impossible within WHO to create a joint programme between Healthy Cities and Safe Communities…Again, some very forceful personalities…you just couldn't do it. (IK)

> Ilona tried hard in Europe to bring [parallel programmes like Healthy Cities and Sustainable Cities] together, but it's hard because everybody wants their own programme. (LD)

Many of those interviewed emphasised engagement with fields such as Investment for Health[1] and sustainable development, stressing the importance of being open to new opportunities and appropriate to context, thereby maximising potential leverage:

> I think that Healthy Cities very smartly did connect with Agenda 21[2] and sustainable development…and integrated them visibly in its strategies and plans…we were able to position ourselves as key advocates of health in the context of Agenda 21. (AT)

> In Indonesia, we've been asked to help set up a centre of excellence for sustainable development…Healthy Cities is seen as the Health Department's agenda, so we're looking at the idea of eco-cities, sustainable and healthy cities. (CC)

Related to this was recognition that linkage points must be contemporary. This might necessitate engaging with emerging agendas such as wellbeing and corporate social responsibility, and potentially working in contexts where 'health' is no longer the dominant agenda or mindset:

[1] Investment for Health (Ziglio et al., 2000) provides an analytical framework for examining links between health, economic and social development, and the consequent political, environmental, social and financial opportunities and barriers to the promotion of the health of the population.

[2] Agenda 21 (United Nations, 1993), an action plan for sustainable development for the 21st century, was a key output of the Rio 'Earth Summit' on Environment and Development held in 1992.

> Labels like Agenda 21 sometimes don't mean a thing to people in communities. Likewise, Health for All 2000 has gone, it's passé. (CC)

> From my perspective of the hospital…health promotion first had to relate to and demonstrate its contribution to quality. Now…health promotion has to show how it can align with sustainability…And I think the new concept…will be Corporate social responsibility and how health promotion can make its contribution…even though I don't think that the Bangkok Charter itself makes the link. (JP)

One important opportunity highlighted was the development of greater understanding of how globalisation and sustainable development are reflected in everyday life—and therefore in settings. Agis Tsouros argued that Healthy Cities has responded appropriately, positioning health within the context of cities as engines in economic and social development, whilst others reiterated the importance of identifying global/local links and re-examining the nature of settings, whilst starting 'where people are at'.

> I am trying to look at 21st century settings…of our everyday life—I've mentioned supermarkets, shopping malls…Whilst the traditional 'boundaried' settings are ever critical…much of 21st century global society is about these 'unboundaried' settings or healthscapes…For local communities, globalisation…affects healthy settings very locally…exchange between the settings is absolutely critical…[and] settings projects need to be much more active in addressing what I call 'unbounded public health'. (IK)

> We need to recognise the linkages to globalisation challenges…We need to think globally, act locally and make our way through the turbulence. With more communication and skill, perhaps we can seize the opportunities offered by globalisation and promote settings work. (CC)

> If you're doing it right, you get local expressions of local concern…Sustainability yes, but probably expressed as transportation options or urban design or parks or water quality. (TH)

4. Discussion

4.1. Overview

The findings reveal a range of insights concerning settings-related theory, policy and practice. Reflecting the literature discussed earlier in this paper, interviewees were clear that the settings approach had no one overarching 'theory'—echoing arguments made in relation to health promotion as a whole (McQueen, 2007). Whilst appreciating the distinctiveness of different settings, they highlighted common features of the approach as applied in these varying contexts—emphasising how its holistic, ecological and systems-based focus had been informed by wider multi-disciplinary conceptual developments. In contrast to Petersen and Lupton (1996), interviewees largely viewed healthy settings as a progressive force, with Dominic Harrison suggesting that the approach had challenged the neo-liberal individualistic and reductionist model of public health and health promotion. Likewise, they countered the critique that settings initiatives risk losing sight of wider influences on health (Baum, 2002) by emphasising that, when practised in a way that is true to its theoretical roots, the approach is explicitly determinants-focused.

With regard to integrating the settings approach within policy and practice, those interviewed felt that the settings 'idea' and approach has to some extent become explicitly embedded in international-, national- and local-level level policy across sectors, thereby contributing to the pursuit of 'health in all policies' (Kickbusch, 2010), which builds on the Ottawa Charter's Healthy Public Policy focus. Again, interviewees saw this as progressive, echoing Kickbusch (2007) in her discussion of the expansion of health governance and the deterritorialisation of health. Within this, she explicitly rejects the critique that the 'new public health' represents the privatisation of risk (Petersen, 1996), arguing that this is narrowly "rooted in the paradigm of control and discipline, rather than in the paradigm of reflexive modernity" (p. 156).

However, the findings also point to substantial variation between regions and countries, due largely to perceived political and cultural differences. Variation was also noted between types of setting. Health Promoting Schools and Healthy Workplaces were seen to have been particularly successful (Barnekow Rasmussen, 2005; Chu et al., 2000) and whilst acknowledging advances made by Health Promoting Hospitals (Pelikan, 2007), those interviewed felt that the approach had become more firmly embedded in local government than in medical public health. Recognising that the settings approach requires 'political' commitment to improving whole system health (Kickbusch, 2003), this supports earlier observations that the healthy settings approach tends to be "more easily understood by the community members and political decision makers than by members of the 'health' professions…because they are closer to the 'logic' of everyday life, than to a professional perspective" (Kickbusch, 1996, p. 6)—and has obvious resonance within England as public health transfers into local authorities (Department of Health, 2011). Similarly, interviewees supported arguments that the evidence base for healthy settings is underdeveloped (Dooris, 2005; Dooris et al., 2007) and saw this as an inhibiting factor for its assimilation into policy and practice. The importance of collaborating centres and networks was also stressed, alongside recognition that more attention needs to be paid to how they enable the spread of innovation in contrasting settings and regions, as well as to exploring issues of power, control and durability of funding. Furthermore, it was recognised that effective policy and practice integration may mean that the healthy settings 'label' will not be explicit, but instead that the ecological systems perspective of the approach is applied within topic-focussed programmes or adapted to inform area-based programmes, as explored by Dooris (2009).

In terms of connecting 'outwards', the findings suggest a widespread recognition that there is an inherent logic in 'joining up' settings, which is supported by the wider health promotion and healthy settings literature suggesting that health promotion in general (McQueen, 2007) and healthy settings in particular (Dooris et al., 2007) must embrace complexity and appreciate wholeness and interconnectedness. Specifically, Healthy Cities was seen to provide a connecting context and framework. As observed in the early days of settings developments (Dooris, 1993, p. 9), "Healthy Cities provides…an holistic approach… ⊀ schools, hospitals, prisons, workplaces and homes cannot simply be listed as settings alongside 'cities': cities include within them each of these settings—and the richness of the Healthy Cities vision lies in facilitating an integrated approach to promoting health." Whilst the relationship of systems theory to complexity has been questioned (McQueen, 2007), it has also been argued that systems thinking allows one to "do justice to the complexity of health" (Naaldenberg et al., 2010)—and the positioning of settings as complex systems (Dooris et al., 2007; Keshavarz et al., 2010) explicitly requires an appreciation of the inter-relationships that exist. In the literature, the conceptual and

practical value of developing a more joined-up approach has been discussed from a number of perspectives. Galea et al. (2000) propose that smaller 'elemental' settings such as schools, workplaces and hospitals should be viewed as operating within larger 'contextual' settings such as cities or islands—and that real health benefits accrue when effective action is taken at both levels. Poland et al. (2000) and Dooris (2004) present a further rationale for connectedness based on the fact that people live their lives across a range of contexts, that there can be synergistic effects between settings, and that a problem manifest in one setting may have its roots in another (for example, bullying in schools may have its roots in a local neighbourhood). However, appreciating that programmes tend to operate at different levels within different political systems and that such a joined-up approach can serve to create confusion and over-extend limited resources, some interviewees were concerned about the potential negative impacts of increased connectedness, and unsurprised that that this 'theory' and vision has not been widely translated into practice.

In relation to connecting 'upwards', those interviewed suggested that the holistic, empowering and determinants-based focus of the settings approach is in itself politically radical and important in addressing inequalities—a finding reinforced by the Commission on Social Determinants of Health (2008), which endorsed the approach and urged a stronger focus on evaluating health equity impacts. Whilst acknowledging the danger of 'taking on the world', interviewees echoing themes addressed by St Leger (1997) and Dooris (2004, 2006a) in emphasising the importance of retaining an awareness of the 'bigger picture'—giving examples of how settings programmes have effectively developed advocacy and lobbying roles to achieve national and international-level leverage.

With regard to connecting 'beyond health', most people recognised theoretical and practical motivations for joining up agendas and felt particularly that a focus on sustainable development has become integral to the settings approach. Whilst Michel O'Neill cautioned about the risk of losing focus and reducing capacity to mobilise around health, others supported the wider literature (Bentley, 2007; Davis and Cooke, 2007; Dooris, 1999, 2004), suggesting that it is important to avoid 'multiple silo' programmes, to be flexible enough to let go of particular labels, and to harness commonalities and exploit synergies with parallel agendas and movements. The importance of further exploring the meaning of globalisation for healthy settings and of finding contemporary linkage points was also highlighted. This appreciation of the need to broaden the horizons of public health and forge links across professions, disciplines and sectors can be seen as a natural expression of the so-called 'deterritorialisation of health' (Kickbusch, 2007) and of an ecological model, which Rayner and Lang (2012) suggest not only theorises complexity but necessitates addressing 21st century transitions and reconnecting with the "interplay of large-scale forces and trends" (p. 324).

Responding to these research findings, I would suggest that there are two key challenges: to build bridges and enhance synergy between settings programmes and networks; and to reconfigure the settings approach for the globalised 21st century.

4.2. Building bridges and enhancing synergy between settings programmes and networks

In building bridges and enhancing synergy, there are several inter-related tasks:

First, we need to make explicit opportunities and barriers to connecting between settings. This will mean drawing on relevant theoretical work (e.g. Bronfenbrenner (1979, 1994)) and researching and revealing the political and practical reasons why Healthy Cities has generally failed to provide a strategic or operational framework for connecting settings programmes. In addressing these challenges, it will be important to elucidate different approaches to network development, increasing understanding of how social innovations can effectively spread.

Second, recognizing that certain WHO regions have facilitated a more co-ordinated and integrated approach (WHO, 2002, 2005a; Pan American Health Organization (PAHO)), we need to map and explore different approaches being taken in different parts of the world. There is a need for research that analyses and enhances understanding of cultural and organisational factors influencing levels of connectedness. This would offer the potential to engage with settings programmes and other connection points (e.g. Investment for Health and Development) to advocate a more joined-up approach and build a systematic global documentation and exchange system.

Third, we need to find opportunities to bring different settings programmes and networks together to reflect on and share experience and learning. This offers the potential to build understanding across settings, develop synergy, harness resources and identify common challenges and opportunities.

Fourth, we need to consider our expectations of WHO. Despite having played a pivotal role in initiating and establishing "networks of commitment and diffusion" (Kickbusch, 2003, p. 385), WHO's record in facilitating co-ordination between settings and building on its catalytic role to nurture and provide ongoing support is questionable—an observation that can be understood in part by engaging with the critical discourse about the nature of WHO as an entity (e.g. Navarro (1984), Petersen and Lupton (1996), Strong (1986)). It is therefore important to consider engaging with other international agencies and – building on the experience of Health Promoting Hospitals (Pelikan, 2007) – explore alternative means of establishing sustainable infrastructures to support networking and the spread of innovation within and between settings (Abrahamson and Rosenkopf, 1997; Broesskamp-Stone, 2004; Costongs and Springett, 1997).

Fifth, in building connections, joint strategies must be formulated to enable what Ilona Kickbusch in her interview termed "political space for empowerment", and to 'connect upwards' ensuring that this empowerment is linked to effective advocacy. The importance of advocacy has long been argued in relation to Healthy Cities (Ashton, 1988) and, more recently, it has been stressed that "the effectiveness of healthy settings initiatives must also be judged in terms of…their successful advocacy for macro-level social, economic and political change" (Dooris et al., 2007, pp. 344–345).

4.3. Reconfiguring the settings approach for the globalised 21st century

In reconfiguring the settings approach for the 21st century, there are five main tasks:

First, in order to ensure that the settings approach responds to societal changes and addresses inequalities, we need to extend its reach into non-traditional, non-institutional settings (Galbally, 1987; Green et al., 2000). Kickbusch (2007), pp. 156–157) has reflected on this challenge with reference to the notion of reflexive modernity and the 'risk society' (Beck, 1992; Giddens, 1991), suggesting that "If health is everywhere, every place or setting in society can support or endanger health."

Second, we need to consider how globalisation is manifested in everyday life and what 'think global, act local' means within and across different settings. Drawing on the work of Appadurai (1996), Kickbusch (2006) has highlighted the significance of unboundaried 'healthscapes' and the ever-expanding influence

of global forces on settings of everyday life. In this regard, global media based on rapidly evolving technologies offer both opportunities and challenges, creating new understandings of 'community' through virtual settings and changing the nature of existing settings through their ever-extending influence (de Leeuw, 2000). Whilst this may require us to 'redefine' settings in ways that acknowledge their increasingly permeable boundaries (Poland et al., 2000) and question the continued relevance of place-based definitions based on "spatial, temporal and cultural domains of face-to-face interaction" (Wenzel, 1997), it will also be crucial to reassert the centrality of the 'local' and the importance of 'place'.

Third, we need to explore how the settings approach can be applied to 21st century topics. It is now widely recognised that obesity and many other issues are essentially complex and that any intervention must be systems-based (Butland et al., 2007) and adopt an ecological perspective (Rayner and Lang, 2012). As well as extracting evidence about the effectiveness of the settings approach from topic-focussed reviews (Jackson et al., 2006), it will be important to use topics such as obesity as entry points, mapping the potential for work within and across settings to impact on the complex of multiple determinants, drivers and processes; and to harness learning from the systems-based settings approach and from complexity theory (Dooris et al., 2007).

Fourth, we need to acknowledge and further build connections beyond health to parallel agendas such as wellbeing and sustainable development (Kickbusch, 2012) – and claim the territory that the Bangkok Charter (WHO, 2005b) failed to stake for healthy settings as a springboard for corporate social responsibility (Dooris, 2006a). The essentially interconnected nature of human and ecosystem health and of public health and sustainable development is becoming ever more apparent in our globalised world, with increasing arguments being made for the alignment of different policy drivers and related actions (Rayner and Lang, 2012). In the light of this, those working at all levels within healthy settings need to be proactive in forging alliances—daring to "risk letting go of the explicit language of health…[and] in doing so release the energy to facilitate the innovative and creative change that can lead to sustainable system-level wellbeing" (Dooris, 2006b, p. 5). In so doing, it will be necessary to reaffirm the whole system ecological perspective that underpins the settings approach—thereby asserting the importance of an 'ecological habitus' orientation (Poland et al., 2011) and introducing a natural focus on the interconnections between the health of people and planet (Poland and Dooris, 2010).

5. Conclusion

This paper has introduced the settings approach to health promotion and public health, and presented and discussed findings from a qualitative research study undertaken with an élite set of individuals pivotal to the global emergence and evolution of healthy settings.

In 1986, the Ottawa Charter (WHO, 1986, p. 3) introduced the 'new public health' and boldly asserted "health is created and lived by people within the settings of their everyday life; where they learn, work, play and love." It thus served as a catalyst to the development of the settings approach, kick-starting a journey that has embraced and influenced contexts as diverse as regions, cities, islands, workplaces, schools, hospitals, prisons and universities. More than a quarter of a century on, it is evident that the approach has inspired individuals, communities and organisations, and made an important contribution to sustainable health and wellbeing—its continuing presence and 'reinvention' being something to celebrate.

However, it is also clear that the journey is not yet over. The research findings point to excellent examples of theory being translated effectively into policy and practice and of connectedness 'outwards', 'upwards' and 'beyond health'. However, they also suggest that much remains to be done. Paradoxically, as we face up to today's complex global challenges such as climate change, resource depletion, ecosystem collapse and continued inequalities, it becomes ever more crucial to reassert the centrality of the 'local' and the importance of 'place' (Poland et al., 2011)—and ever more necessary to span and strengthen synergy across disciplines and boundaries (Brown et al., 2010). In this context, the settings approach has much to offer—but will only realise its potential impact on the wellbeing of people, places and the planet if it adopts a truly ecological approach (Rayner and Lang, 2012), building bridges between different programmes and networks and daring to reconfigure itself for the globalised 21st century.

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