Peckham in the 21st Century
The Quest for Sustainable Health Care

by Christoph Gräfe
Peckham in the 21st Century - The Quest for Sustainable Health Care

In 1926 doctors George Scott Williamson and Innes Hope Pearse started a unique medical experiment in Peckham, South-East London. Families of the area were invited to become members of The Centre which combined leisure and socialising facilities alongside a community farm and regular health status assessments. Due to a lack of funding and the implementation of the NHS in the 1950s their experiment eventually was closed down - but today their principles and findings might be more relevant than ever before.

Williamson and Pearse believed that a different approach to health care was more appropriate. Instead of treating the disease, the human should strengthen its body to resist future illnesses. Elements of their philosophy can be found in what today in known as the Sustainable Development Agenda. This paper will attempt to combine both key principles of the Peckham Experiment and the Sustainable Development Agenda to formulate an argument for a new approach to health care in the United Kingdom today. Furthermore, this project will view the Peckham principles in the context of sustainable development (SD) because the author believes, as shown later, that both concepts (Peckham and SD) translate easily and complement each other.

For this task, the reforms of the NHS as proposed by the Coalition Government and the new context of the Big Society\(^1\) are seen as opportunities. Health Care in the Britain faces a massive reorganisation under the plans set out by the Coalition Government for reforming the NHS\(^2\). This opens a rare opportunity to reset the targets and some principles of NHS operations. At the same time, this project will explore the opportunity of creating a health care system that follows the principles of sustainable development\(^3\) as set out by the Department for the Environment, Food and Rural Affairs (DEFRA).

At first, this paper will explore the definition of Primary Health Care and attempt to establish how this is still valid today. A short treatise on the NHS will follow, leading into a preliminary discussion on what aspects the present NHS does not perform well enough. This will be the discussion basis for the section following, setting out both the Peckham principles and the SD agenda for health care. The next section will look into and set the context of austerity measures, NHS reform, Big Society, but also health in the urban structure and society and health - this attempts to show what benefits a NHS focused on Peckham principles and SD agenda can offer. Lastly, a comparative diagram will emphasise and visualise the relations between the Peckham principles and the SD agenda.
# Contents

The Task of Primary Health Care  
*Requirements*  
*Core Activities*  
*Goals*  
What is the NHS?  
Identifying two Major Problems with the NHS  
The Principles of Peckham  
Theory of Positive Health by Scott Williamson  
How did The Peckham Centre work?  
The Sustainable Development Agenda for Health  
*Preventative approach*  
*Community-Based*  
*Health inequalities*  
*Good Corporate Citizenship*  
Establishing the Context  
Health in the Urban Structure  
The Relationship of Society and Health  
Health Care in the Context of NHS Reform and The Big Society  
What would a Peckham Centre look like today?  
Conclusion  
APPENDIX  
Bibliography
The Task of Primary Health Care

Before this paper can explore how health care can be reformed and transformed into providing a service that has SD at the heart of its operations it must be established what primary health care actually entails.

This section will outline the original definition of primary health care as given by the World Health Organisation (WHO). Also, for completeness, it will take a look at the requirements, activities and goals of primary health care as determined by the WHO. These will then be used to establish a status-quo which allows for critical analysis and, later, for proposing changes in the spirit of SD and the Peckham principles.

Braunack-Mayer (2007) cites from the International Conference on Primary Health Care in Alma-Ata (1978) who define primary health care as the following:

“Essential health care based on practical, scientifically sound and socially acceptable methods and technology, made universally available to individuals and families in the community through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country’s health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.”

This statement already outlines the emphasis on the individual responsibility and the community. Both items are reflected in the Peckham principles and the SD agenda (as shown below), but, arguably, not necessarily at the core of the present NHS structure.

To continue, the report lists three categories for primary health care:

**Requirements**

- be based on relevant research and experience;
- provide the full range of health services - health promotion, prevention, cure and rehabilitation - to address community needs;
- be intersectoral, involving agricultural, housing, education, public works and communication programmes, as well as health programmes;
- promote community and individual self-reliance and participation in the planning and delivery of health care;
- be supported by appropriate referral systems; and
- be provided locally by health workers who are trained to work effectively as a team and to be responsive to community needs.

**Core Activities**

- health education;
- promotion of food supply and proper nutrition;
- an adequate supply of safe water and basic sanitation;
- maternal and child health care, including family planning;
- immunisation;
- prevention and control of locally endemic diseases;
• appropriate treatment of common diseases and injuries; and
• provision of essential drugs.

**Goals**

• decreases in excess mortality of poor, marginalised nations;
• decreases in major risk factors that increase morbidity and mortality;
• sustainable health systems; and
• an integrated approach to wider social policy and community development.

When looking at the requirements and goals set out for primary health care by the WHO one must recognise that community focus and sustainability were incorporated (see highlighted items). However, while these are listed in the WHO description of primary health care, one must question to what extent these are represented and translated in modern health care systems today.

To illustrate this further, the reader should ask to what extent their local health centre takes an “integrated approach to wider social policy and community development” or even “promote community self-reliance and participation in the planning and delivery of health care”. One could argue, that under the current system in the NHS such local responses and approaches are limited by the structure of the organisation.

In a later section of this paper when looking at the proposed reform of the NHS by the Coalition Government, opportunities will be considered regarding the NHS becoming more community orientated again. Also, it is worth emphasising again that both the SD agenda and the Peckham principles put such community-based community-relevant tasks as well as preventative measures as primary objectives.

The next section will give an investigation into how these principles of primary health care have been translated into a health care system. A brief look will be taken at formation of the NHS in Britain while beginning to outline structural problems the NHS faces today.
What is the NHS?

The National Health Service (NHS) was established in Britain in 1948 after 8 years of extensive proposals set out in several white papers. The William Beveridge 1942 Report outlines the principles of the new National Health Service. "A comprehensive national health service will ensure that for every citizen there is available whatever medical treatment he requires, in whatever form he requires it, domiciliary or institutionally, general, specialist or consultant, and will ensure also the provision of dental, ophthalmic and surgical appliances, nursing and midwifery and rehabilitation after accidents[6].

Before, the health care system in the United Kingdom appeared rather disorganised and as a complex mixture of private and public health services. The public sector part of the equation consisted of municipal hospitals and community health services run by local councils who were also responsible for sanitary and environmental health services. The private sector in turn generally provided private GPs, voluntary hospitals and other commercial organisations.

With the establishment of the NHS, every British citizen had access to a basic level of health care available at no cost to them. With respect to primary health care, this sector of the NHS has long seen itself disadvantaged towards the hospital sector; also, GPs found themselves not to be able to exert the same political influence as their professional counterparts in hospitals. The 1970s saw a revision of the service with primary health care receiving a rise in profile while three main problems of the NHS were tackled: professional rivalries, poor management and co-ordination, and locally poor-quality services.

However, in respect to this investigation, it is important to point out that "throughout the postwar period, at least up until the 1980s, the primary care sector was regarded as a relatively neglected area". Back then, as today, for politicians it was far more important to build new hospitals rather than improving and extending primary care services. The consequence of such mismanagement will be addressed in the context section, illustrated by the issue of overbedding in London.

In the 1990s primary health care received increasingly more attention from the political elite. Baggott (2004) suggests the installation of primary care services such as NHS Direct by the Blair administration as an example for such increased attention levels.

Another action undertaken by Labour was the move towards Primary Care Trusts. These were set up to, in theory, use the majority of the NHS budget to plan across the primary and secondary health care divide and commission services accordingly. While the intention was to put primary care in the driving cab of the health service, in reality, as Baggott (2004) emphasises, acute and specialist services remained in control of the agenda.

More detailed information on the development of the NHS and an in-depth analysis and critique can be found in Baggott (2004). The next section will, however, identify two structural shortfalls of the NHS to set the conditions for improvements of the services through and by the application of the Peckham principles and the SD agenda.
Identifying two Major Problems with the NHS

It is important to note that by no account does this paper attempt to list all the problems with the NHS. However, it is of significance to highlight two major problems with the National Health Service when using the SD agenda as an analytical tool.

The first failure of the NHS, and arguably all modern health care systems, is taking an approach which focuses on treatment rather than disease prevention. Doctors were originally distributed according to where the greatest need was (here true for the NHS) - the belief was, and sometimes still is, that by increasing numbers of doctors in an area the health problems will go away. This notion is ill-advised and by doing so one is treating the illnesses, but not the cause.

While it is clear why such an approach is used, after all illness is a visible and easily identifiable factor, it is important to understand that prevention should be at the forefront of health care provision in the interest of efficiency of the health care system, but also in the interest of the individual. Important in this context is, however, that prevention requires a holistic approach. Such an approach, is offered by the SD agenda.

Another major setback for the service is frequent reorganisation of the NHS. As shown in the previous section, one might argue that every administration in Westminster aims to shape the health service according to their visions. Whereas this may be understandable from a political viewpoint, this greatly limits the productivity and efficiency of the service in the long term.

Appleby & Harrison (2007) emphasise the significance of assessment and analytical measures in determining the achievements of budget increases, reductions or reallocations. Before trying to reform the service, attempts should be made to determine the true effectiveness and return of specific procedures within the NHS. Based on that assessment, more well-informed decisions can be made which will ultimately allow for a NHS that is fitter for the future.

In this brief section, two structural failings of the NHS were addressed. One affects the patient directly, the other limits the efficiency and effectiveness of the whole system. Both, however, ask for structural changes; and both are addressed by the SD agenda for health care and the approach to health care as outlined by the Peckham principles. The following sections will outline both agendas, starting with the Peckham principles below.
The Principles of Peckham

The next section will have a brief look at the principles that governed the Peckham Experiment, and consequently the Health Centre.

1. **Study of health rather than disease**
   Peckham approached health care as much more than the mere absence of disease. Fostering growth, strength and development of the body was at the heart of the study.

2. **Holistic approach**
   Peckham took a holistic approach: physical, psychological, social and spiritual factors which combine in health were fostered through an appropriate environment.

3. **Social Club**
   For members, the Centre was more like a social and sports club than what a Health Centre is today. Yet within it, many members, particularly the parents, became aware that their health and development as personalities, and the health of their families as social units, had been greatly improved, through the unique kind of social club that becomes an all-age community.

4. **Family membership**
   Membership was based on family. Equal importance was given to whole people using the Centre both individually and as a family with as little segregation of age groups as possible.

5. **Health checks and family consultations**
   Health checks were conducted on all members of the family. Findings were related to the growth of the family and explained to the whole family together at the family consultations.

6. **Limited membership and easy access**
   Membership was largely restricted to people living within close proximity of the Centre to ensure easy access and continuity of personal association and friendships.

7. **Non-directional help**
   People were left to do and choose as they please. It showed that own initiative proved to be more effective and to produce a richer social environment than the more traditional authoritarian approach.

8. **Non-competitiveness**
   Focus was on the individual’s ability to acquire new skills and to discover latent talents. Taking part was more important than winning, particularly in the case of young children. Indeed, when initially pursuing their own individual interests children were seen to be by nature non-competitive; later, competition was a means of developing and demonstrating their skills.

9. **The building**
   The building had an important impact on the activities within it. Freedom of movement and visibility in an open-plan structure were important in promoting social cohesion, spontaneity of behaviour, and awareness of opportunities for action.

10. **Nutrition**
    A Centre Farm produced fresh organic food for the use of Centre families, especially for expectant and nursing mothers and their young children. Information on healthy nutrition was made available.

11. **Open discussion**
    Members and staff entered into an equal partnership in which there was open discussion on topical issues, both organised and spontaneous.

Most important to this paper are principles one and two; the first emphasising on preventative measure rather than treatment, and the second acquiring the holistic approach as used by SD.
While the principles of Peckham are important to this paper, one must understand their origin and their relation to the Scott Williamson's theory of positive health. His approach to health care which is outlined here was translated into a holistic approach by The Centre through his experiment at Peckham.

Theory of Positive Health by Scott Williamson

Williamson regarded the human in a holistic way; also did he not depersonalise his patients. It was essential for him to see;

the Person as a living being (an organism).

He further claimed that;

as an organism it (the person) possesses certain attributes that distinguish it from mere aggregation of bits of inorganic matter

Williamson establishes these attributes to be the following:

**UNIQUENESS**
- individuals define themselves
- medical evidence shows rejection of 'foreign' tissue when implanted/transplanted

**WHOLENESS**
- understanding the organism as a whole
- all parts are working together to ensure well-being and efficiency of the whole

**POWER OF CREATIVE GROWTH**
- every organism has its unique metabolism
- everything created for the body by the body (physical growth and renewal) is creative process

The essential item here is the belief of the trinity relationship of a person with its material, social environment and environmental conditions. Only attention to all three main factors, under the main attributes of the Theory of Positive Health lead to the ideal state of well-being, a well functioning human being. A similar concept has been established for the SD agenda. The last section will clarify the similarities of the two agendas.

In order to establish how this theoretical framework was used to operate a community health centre the next section will explore the running of the Peckham health centre.
How did The Peckham Centre work?

The Centre was the place where theory was developed and translated into practise. The building, constructed by Sir Owen with radical functionalist design principles, reflected Williamson's approach to health. Open planning, with every compartment visually merging into the other reflected, barriers were non-existent freedom the salient characteristic of the building. Facilities provided included a swimming pool, arts rooms and many other recreational provisions.

Participants had to sign up to a membership scheme. Individual memberships were not possible, the emphasis of the experiment was on the holistic approach - so it was required for the entire family to take part. In return for a modest membership fee they received periodic health overhauls and were free to use the facilities and associated events.

Williamson's holistic approach becomes visible in the following. He describes how he sees the human with its relations and its context:

“In the Centre we have not been looking [...] at any isolated group or class of individual as commonly envisaged for the purpose of present day administration. We have looked for evidence of function in that long pulsating stream of livingness in which human families fulfill their cycle of development; where husband and wife are seen as one, united in parenthood, and where the child, not regarded merely as an isolated individual, is seen as a new 'limb' or differentiating organ, arising and acting within the unity of the family - concrete and tangible evidence and sensitive indicator of the development and functioning of the whole family organism.”

Furthermore, Williamson very early identifies the significance and the primary tasks of a health centre.

“[The Peckham Health Centre] is not that assemblage of Clinics conveniently congregated for the carrying out of medical desiderata, such as early diagnosis, minor therapy, prevention of disease, etc., which it is becoming fashionable to call a 'Health' Centre. It is a locus in society from which the cultivation of the
family - living cell or unit of society - can proceed, and from which the family sustained in its growth and development, can spontaneously evolve as part of a larger whole - a live organismal society.\[^{23}\]

While it presented a place for Williamson to undertake his experiment and assess his participants, it also provided the space in which his participants interacted. The Centre was “the first experimental station in human biology. It asks the question - what circumstances will sustain human being in their capacity for full function (i.e. for health); and what orientation will such fully functioning entities give to human living (i.e. to society)?”\[^{24}\]

This science of Williamson was visionary for its time, and some 70 years later it still remains only that. It is time to look again at his findings and discover ways that will take his principles from theory to practise. The next section will expand on the Sustainable Development Agenda for Health which can offer a gateway for Peckham principles to be incorporated in the health care system.
The Sustainable Development Agenda for Health

This section aims to give a short insight into the SD agenda using the UK government Sustainable Development framework. In the following, recommendations for a health care system which follows this agenda will be stated (provided by the SDC) and connections will be drawn to the Peckham principles. This will allow to sketch a future health care system which has sustainability and Peckham principles at its core.

Sustainable Development Framework for the United Kingdom. Graphic from:

The five guiding principles set out in this framework allow for a comprehensive understanding of sustainable development, as well as a holistic analysis of problems that call for a sustainable development solution. By investigating impacts and relations to environment, society, economy, governance and knowledge it is thought to allow for solutions which enable sustainability.

With regard to health, the complexity of the issue requires a holistic approach. It is not sufficient to increase the NHS budget when negative health feedback mechanisms exist elsewhere. The SDC defines this approach as such: “Promoting wellbeing for all; focusing on preventing illness; valuing the human resources involved in health and care; promoting low-carbon living; and judging success in terms of medium and long-term effects on society, the environment and the economy. [...] the concept of preventative and public health must be expanded beyond the current narrow definition of ill health prevention by the NHS.”

Furthermore, the SDC extends its reform program with concrete proposals in several areas within state control. Some are listed below, more can be found in the document Sustainable development: The key to tackling health inequalities, published by the SDC.

Policy recommendations for sustainable development in health care

Economy focus on finding synergistic outcomes for both health inequalities and other environmental sustainability issues (such as carbon reduction) when using public resources
potential climate change impacts to be taken into account when planning for health inequality reduction

**Transport**
growth in walking and cycling
targeting road-traffic pollution. focus on transport mode shifts

**Green Spaces**
NHS should recognise benefits of contact with natural environment,
taking active role in promoting this in local community and owned estates
increased investment in creation of quality green spaces, especially in deprived areas

**Built Environment**
planning system adapted to reflect requirement for meaningful positive health impact
recognition of impact of improving deprived areas -> reducing crime,
encouraging increased footfall, more attractive, more social contact,
heightened sense of security

To provide truly sustainable health care - sustainable both in the sense of SD and in providing high-standard health care now and in the future - demands a shift in treatment approach. It must be noted that “in the developed world, healthcare services tend to be highly resource-intensive”\(^{28}\). However, in line with the Peckham principles, the Sustainable Development Commission (SDC) points to the fact that “an approach to healthcare which [...] favours community-based primary care and embraces the principles of good corporate citizenship, can help to address the root causes of inequalities and thus in the long term lower the resource intensity of healthcare”\(^{30}\).

**Preventative approach**

A health care system built along those lines should be able to perform better with fewer financial resources. One important factor to create such a system is placing emphasis on preventative care, rather than treatment. ‘Amidst the old-established disciplines, medicine alone has been concerned both with the basic knowledge of biology and its application to the individual, and it is perhaps surprising to find that the cultivation of health, as distinct from cure and prevention of disease, should not have emerged earlier. [...] Prevention is no more the anticipatory cure.’\(^{30}\) This view is essential to the Peckham approach which was explained earlier. In addition, both the SD agenda and Peckham call for strong involvement of the individual and the community to identify possible health hazards and increase resistance.

The SDC describes this in the following. “For a preventative approach [...] to take root, ownership for health issues must be spread beyond health professionals and indeed, at times, even beyond the public sector e.g. private sector workplace transport schemes and health advice.”\(^{30}\) Again, one can see similarities to Peckham. Health must be established as a holistic concept, not just as the absence of illness - it requires a healthy body, healthy mind and social interaction for a strong, thriving human being.

**Community-Based**

Essential to the Peckham method and also recognised in the SD agenda is the concentration on the locality, the focus on the community and the individuals the health service is serving. The SDC clarifies: ‘When it comes to a sustainable health system, there is a strong case for increasing community-based treatment services. ‘Care closer to home’ implies less distance to travel and fewer barriers to
equal access, and is a robust model for ensuring long term viability of the health system. Much high-carbon hospital care can be undertaken in community settings, reducing the NHS’s carbon footprint."  

Weinstein (1988) refers back to the point of budget constrains and prevention in the context of a community-based priority health care system. He emphasises that by returning focus to the community, and demanding more responsibility from the individual massive resources could be saved while creating a higher level of health service. “If we are ever to attain the goal of healthier cities tomorrow we need to drastically change health priorities today. We need to shift our spending from higher technology to lower technology treatment and from treatment to prevention. More responsibility must be placed upon citizens themselves, but with appropriate support services and incentives.”  

Health inequalities

Increased levels of responsibility will also offer the opportunity to tackle what has become known as health inequalities. Again, both SD agenda and Peckham draw attention to individual responsibility. The SDC enforces a less authoritarian style when it comes to dealing with the chronically sick. These people are not only the most frequent users of the system, they are at the same time the most vulnerable. Their proposal calls for “enabling people with existing long term conditions to take care of themselves (as) a new and more sustainable approach to health service delivery. It puts individuals in charge of their own health care and reduces health inequalities.”

A second group which suffers from health inequalities can be found in the low income group. Despite the original intention of the NHS, to provide health care at no cost to the user, people with limited earnings will have to rely on cheaper alternatives for food and drink, but also these groups tend to be more reluctant to live a healthy lifestyle. This inequality gap must be bridged when a lower cost health system and a more equal society are desired. The SDC notes that “if people in lower socio-economic groups enjoyed the same level of health as those in higher groups, there would be fewer people leading unhealthy lives and requiring healthcare. This would help to reduce healthcare costs and the carbon footprint of the NHS, and save money for treating unavoidable illness and tackling the causes of health inequalities.”

Two more issues are of significance here. Knowledge about health issues must be prioritised; the SDC envisages “the development of school health services [as] pivotal to the health and wellbeing of the school community, and could help to spread knowledge about public, as well as personal, health issues.” Peckham solved this issue by involving individuals and a community in the centre; increased interaction and involvement in decision-making indirectly built-up health knowledge.

Nevertheless, concentrating on the original intentions and tasks of primary health care, as described above, will reduce a number of problems the health system is facing today while incorporating SD and Peckham principles. After all, “universal access to primary care is associated with reduced inequalities in health outcomes and the quantity and quality of primary care is associated with lower and better use of hospitals.”

Good Corporate Citizenship

As mentioned before, the SD agenda offers a holistic approach to problems of society; therefore, one must see beyond one system and understand the whole. In concrete terms, this means the SD agenda can work only within the NHS, however, it would be much more beneficial to the NHS and society as a whole when SD principles govern all matters within state control. For this purpose, and to act as a role model, the SDC has identified the NHS as organisation to follow the model of good corporate citizenship (see graphic on left). Through this, “NHS organisations can embrace sustainable development and tackle health inequalities by making sure they are having a positive impact on the determinants of health through their day-to-day business.”
Establishing the Context

So far, this paper has focused on the NHS as the present health care system for the United Kingdom, the Peckham experiment and its principles and the Sustainable Development Agenda for health. The previous section has also attempted to outline connections between Peckham and the SD agenda, as these share more similarities than differences.

The next part of this paper is to give a limited account of the extent of health care within a societal system. First, the urban living environment in which an increasing percentage of the world is found and which poses its own threats to health will be looked at.

Following will be a short insight into the relationship between society, societal structures and health. To conclude, the present context of the NHS reform as proposed by the Coalition Government will be defined before finishing with a brief account about what a Peckham Health Centre could look like today.

Health in the Urban Structure

There are arguments claiming that with increasing urbanisation, general health conditions decline. The obvious task is to find ways to minimise these health risks and limit their effects. The causes are obvious; the density of the urban structure leads to increased air pollution, at the same time a greater number of people are vulnerable to a specific health risk. As McMichael (2001) claims “in several respects, urbanisation has become both socially and ecologically somewhat dysfunctional. This situation poses risks to the sustainability of good health”.

In 1875 Benjamin Ward Richardson proposed an urban structure which incorporated health knowledge of the time into city planning. Richardson suggested Hygenia, a city structure which left enough space for humans to flourish with open spaces to reduce air pollution, a significant problem of the time. However, while his concept was very ahead of its time, it is also impractical as it saw town structures limited to approximately 100k people.

Nevertheless, Weinstein (1980) believes that “Hygenia, while probably never attainable, is a worthwhile goal”. Also, the SD agenda offers a similar construct when it takes into account the various external factors influencing human well-being and health state. Weinstein continues to set out the problem of present health care systems. In his view, they are more about sickness planning, rather than health keeping.

The Kings Trust believes that the recognition of the immediate environment and social circumstances directly influence the human health. This connection has been recognised by the government; as the aim of strengthening the role of local authorities, which will enable an inter-sectoral approach at local level to improving health. It has to be recognised that policies on housing, crime and education all have impacts on health. This holistic approach is reflected in the SD agenda and implementation of this agenda will help tackle all these problems at once.

Especially in urban areas, the present system of investing heavily in high technology treatment facilities does not represent the most efficient and effective way to keep the population healthy. Also, the approach to health care hinders maximum efficiency. Gatrell (2009) describes a discrepancy in health care service in pharmacies between rural and urban areas: “The inner-city pharmacy was characterised as a ‘fortress’, encased in iron bars and razor wire, in which health-giving advice was negligible”. In return, the rural pharmacy is described as a “small and old-fashioned ‘haven’, free from the surveillant eye of security cameras, and operating with a low turnover. Here, advice-giving was much more frequent and the conversations were informal and wide-ranging”. This example identifies another problem factor for high standard health care in the urban structure. The city lacks tightly knit social relationships; therefore it is the task of the primary health care system to provide what society has decided to trade in for the urban lifestyle.
To tackle the health care problems in urban centres, the NHS, for example, invests heavily in "high cost, high technology treatment resources such as hospitals and kidney dialysis units". Weinstein (1980) claims that this is a too great percentage of the health budget. Already 1993 practitioners argued that there are far too many hospital beds in the British Capital - a trend that has not been reversed yet.

Weinstein (1980) continues to argue that small scale measures for health care provision have increasingly been neglected in budgeting. He draws out principles that are represented in the Peckham idea, and today also in the sustainability agenda in regards to health care. He states "too little is spent on lower technology and lower cost treatment resources like neighbourhood clinics and paramedical personnel. Little systematic use is made of low cost, low technology, preventative effort to involve volunteers and citizens in the health system".

At the same time, the Kings Trust draws attention to the results of the Total Place project which give opportunity to take a place-based approach to tackle local health care issues among other responsibilities for public services. To some extent, this approach had been taken by the Peckham Centre and is also reflected in its principles. At the core of such an approach lies the fundamental understanding of the the complex interrelationships health issues have.
The Relationship of Society and Health

A significant factor which is commonly neglected when looking at health is the effect of social factors and relationships. Instead, a connection is established between health and wealth. Marmot and Wilkinson (2006) point out that "although there is a robust relationship between income and health within all developed societies among the 25 to 30 richest countries, there is no relation between GNP per capita and death rates. The fact that income and health are related within developed societies but not between them suggests that health among the most affluent countries is a reflection of social position and relative income, rather than of exposure to differences in living standards alone."  

Elaborating on this thought, Marmot and Wilkinson (2006) continue to suggest that "mortality and morbidity rates may be two, three or even four times as high among poorer compared to richer people, or among people who are more socially isolated compared to people with strong social ties." Therefore, it is not only, or not necessarily the financial status that determines health status in this context; arguably, a greater effect has the social context of the individual and its social connections.

One must not forget that the human is a social animal and is therefore dependent on social relations. Marmot and Wilkinson (2006) emphasise that humans act as reflective beings and are therefore dependent on social relationships for their well-being. "It is because we are so sensitive to the eyes of others that pride and shame, acceptance and rejection, social inclusion or exclusion have such powerful influences on stress." This means that when Peckham enforces social interaction it actively tackles health inequalities. The importance of preventative action is once again symbolised.

Gatrell (2009) joins in by noting that "social isolation and lack of engagement in local community life contribute to poor health and even early death". He refers to the importance of social networks - "the social connections and relations [...] with friends and family [as] a predictor of all-cause, and cause-specific, mortality or of poor health".

As shown earlier, it is not about the individual per se but the social environment which greatly determines health conditions. Marmot and Wilkinson (2006) make a striking claim. They call to ignore occupational hazards simply because "much larger proportions of population are exposed to the hazards of low social status, weak social affiliations, and stress in early life". Instead of treating island health issues for isolated groups. A real change could be made by Peckham-like health centres situated in communities; each one individually sensitive and adaptive to community needs with the overall aim of improving health.
Health Care in the Context of NHS Reform and The Big Society

This section aims to outline briefly what implications the proposed changes by the Coalition Government may have on the health care system. Further critical analysis will be offered regarding the reform of the health care system.

The release of a White Paper for NHS reform is an indication for the willingness of the present administration to reorganise the health care system. The exposed objective of this reform is to make the NHS more efficient and increase value for money by reducing managerial levels within the organisation. At the same time, GPs will be given responsibility for local health budgets all with the aim to make the NHS more accountable to its users.

However, the process of reforming such a vital and extensive organisation like the NHS has its dangers. Appleby & Harrison (2007) suggest that especially when reforming the health system caution should be taken. They claim as “the impact of new policies is hard to predict, there should be more extensive use of pilots or experiments, before new ideas are put into effect.” With reference to the past Labour administration they continue “The present government has initiated pilots in some areas but has often pressed on with national programmes before the results of the pilots have become available. And in many areas it has introduced policies without any ex ante evaluation.”

As a Guardian editorial suggested lately, “Health service: The change remains the same.” The Coalition Government has pushed forward with ideas that aim to reform the entirety of the NHS at an unprecedented scale. However, no trials have been initiated to determine the impact that the removal of manager layers will have; at the same time, GPs will effectively be required to take charge of their own finances and allocation of resources.


“First, the crisis-driven nature of health care reform is certain to continue and the media will retain its role in driving the political agenda. Secondly, there is likely to be greater disquiet about the implications of the revival of the internal market in England, resulting in a more centralised and regulated approach than currently envisaged. [...] There will also be increasing pressures to focus on health rather than health care. These will arise within Government - in an effort to reduce health service costs in the future - and be bolstered by campaigners from outside Government concerned about public health issues. Finally, the governance of health care - as in other areas of British Government policy-making - is likely to be dominated by a similar disregard for constructive criticism.”

While the proposals can enable greater responsibility and accountability as set out in the Government’s Big Society, it remains questionable to what extent GPs are really wanting to be allocated that responsibility, as the Kings Trust points out. After all, they went to medical school and their job has always been to treat sick people. All of a sudden they will be faced with managerial tasks and financial decisions for which almost none of them are trained for.

Busfield (2000) states, no holistic approach in policy making with respect to the health care system has been taken. She points to the lack of health implications analysis, indicating that the problem gets amplified because “[...] governments often give little attention to the health implications of many other public policies”. Therefore, one may see great need for taking on a new policy strategy.

One must now ask the question where Peckham and the SD agenda for health fit into this picture. First of all, the SD agenda does offer a holistic approach to health care as desired by Busfield (2000). Additionally, increased information flow about NHS performance alongside giving more power to the lower levels of the organisation can be viewed as positive contributions towards the good governance element of the SD agenda in the UK. However, one should not forget about the accomplishments already made by increasing carbon awareness in NHS trusts.

At the same time, one must become aware of the principles and results of the Peckham Experiment. These principles offer a holistic approach to health care while conserving financial resources. Arguably, initial investment for building up more health centre structure will be substantial, however, with the
Peckham method primary health care is able to significantly reduce the need to send people onwards to resource intensive secondary health care.

Referring to Appleby & Harrison's argument of not trialling health care policy before implementation, one must recognise that Peckham has gone through an extensive trial period already. Societal circumstances may have changed since the original experiment was undertaken, however, the belief of this paper is that the principles are robust and the approach holistic enough to allow for adoption to modern times.
What would a Peckham Centre look like today?

Before this paper draws to a close, it may be of interest to explore at this point how a health centre following the Peckham could look like today. Stallibrass (1989) describes how a Peckham Centre-like institution could look like today.

One must recognise that when the Peckham experiment was originally established, different structural circumstances were in existence. Through their experiment, Drs Scott Williamson and Innes H. Pearse provided health care to the lower classes for the first time on a regular and consistent basis. Their experiment filled a gap; by offering preventative health care and health advise. Today circumstances are distinctly different.

Peckham Centres today must translate the Peckham philosophy into the present time context, however, “people's basic needs do not change but their circumstances have changed”64. Stallibrass (1989) adds:

“The Peckham Biologists were successful in producing a situation in which a stable and health-promoting community could grow because, firstly, their hypothesis of the nature of health and of the conditions in which it can flourish turned out to be largely correct and, as good scientists, they modified it when necessary in the light of the facts that emerged during the course of the experiment.”65

In the original experiment, scientists were at hand and modified the situation according to their belief when necessary - this control mechanism is not at hand anymore. Setting up something similar without the watchful eye of Williamson and Pearse today would be doomed for failure, according to Stallibrass (1989).66 According to Stallibrass (1989), today a health centre according to Peckham principles must be run by a group/community of families or individuals who believe and embrace the findings of the original experiment.67

In the spirit of the Big Society and the SD agenda, it is about finding groups of people “who are enthusiastic for the idea of creating a Centre on ‘Peckham’ lines for their own use”68. Believing in the responsible citizen can see the development of a Peckham Health Centre 2.0.

The Coalition’s idea for a Big Society can set the right policy context, however, it cannot force the development of social enterprise. By promoting and raising awareness for a SD approach to policy, in this context for health care, allows for more people becoming aware of the situation. With the looming reform of the NHS, another useful step-stone is laid in establishing Peckham principles in modern day health care. By giving local GPs more power in shaping local health care provision, the ‘conversion’ of professionals towards the Peckham principles could greatly aid the development of such centres.

In the end, what is needed is a group of people “who regard such a community as an ideally healthy environment to understand fully the nature of the conditions in which it can grow and to create and maintain such conditions for themselves”69. It may be disappointing to see that a Peckham community cannot be created on the drawing board, that is has to grow by itself. However, this is in the spirit of both Peckham and the SD agenda. Williamson called this ‘power of creative growth’, the SD agenda calls this ‘good citizenship’.

This paper believes that present policy developments (NHS reform, Big Society, SD agenda) are certainly favourable towards the Peckham idea. They allow for the translation of the principles into a modern context, at the same time, they are supportive of community action.

"Many of us may find it impossible to create the circumstances in which a health-promoting community similar to the Centre can evolve, but if, in our work as parents, nursery teachers, play leaders, students of human development, and planners, legislators and administrators of every kind, we can keep the Peckham Biologists’ discoveries firmly in mind, and so can work with nature instead of against her, we shall be on the right track. Among other things, we shall make it easier for the young to develop their faculty for ‘autonomy’ and as a result we may be instrumental in swelling to an effective majority the number of people who feel a responsibility for their environment and who realise that they are dependent for their health and happiness on the welfare of the whole biosphere - on the health of the planet Earth.”70
Conclusion

This paper believes that in the present climate of budget constraints and political reform a great opportunity is available to define new priorities for the NHS.

As shown above, the SD agenda in conjunction with the Peckham principles offer a combined holistic approach to health care which enables the NHS in Britain to return to its original task as primary health care provider (as defined by the WHO), allows for a more holistic way of tackling health issues (as these are almost entirely embedded in society) while delivering value for money by reducing need for resource intensive secondary health care treatments.

Also, one may need to recognise that while spending cuts as proposed by the government at the moment may deal with the budget deficit, significant reductions in public service expenditure may also have a lasting negative effect.

Such intelligent savings can be offered by shifting NHS performance measures towards SD and Peckham principles. This paper attempts to show that by allowing SD and Peckham to govern the health care system at its heart, in the future significant savings could be made in the health care system. By strengthening social relations and defining the holistic approach in society, financial resources can be used more efficiently as they are targeted more efficiently.

Lastly, the NHS also has a responsibility to society beyond providing excellent health care. It is the belief of the SDC and this paper that the NHS must act as a role model for British firms and society when it comes to actively applying the SD agenda. The SDC writes that

“NHS organisations can show the wider public sector - indeed, all sectors, how to embrace sustainable development and tackle the determinants of health inequalities through their day-to-day business - an approach known as ‘good corporate citizenship’. Successful outcomes have been demonstrated, for example through employment programmes, local food procurement and GP referral to time banks.”

A time that requires changes does not necessarily have to be a time of fear and reservation. For the NHS, this can be the first time for major reform since its creation in 1948. The concepts outlines in this paper have been applied and proven before. Now can be the time to enable them on a wider scale with far reaching consequences for the whole public sector and the future of Britain. A more sustainable future can be enabled. For the health care system the SD agenda and Peckham can take the health care system in Britain into the 21st century.
APPENDIX

This section aims to draw out the similarities between the Peckham Principles and the Sustainable Development Agenda. It desires to show one agenda translates into the other an vice-versa; at the same time, they enrich each other.

The Peckham Principles

The sustainable development agenda believes that an ideal state for future development is only found when economic, social and environmental factors are prioritised equally. One factor cannot be outplayed against another.

- Wholeness approach to health < Holistic Approach
- Uniqueness approach to health < One Planet Living
- Power of creative growth < Good Citizenship

Both agendas focus on the holistic approach to problem solving

Individual responsibility lies at the heart of both agendas while emphasising the need for the greater picture

Trinity of factors - all with equal consideration to find balanced state - ideal state at the centre
Bibliography


All Web links working as of 17th September 2010

1 http://www.thebig society.co.uk/

2 Plans announced in Parliament on 12 July 2010. Also see: http://www.dh.gov.uk/en/MediaCentre/Pressreleases/DH_117360


5 Ibid. p.357f.


8 Ibid., p.79

9 Ibid., p.79

10 Ibid., p.95

11 Ibid., p.95

12 Ibid., p.94

13 Ibid., p.95

14 Ibid., p.367

15 Ibid., p.367

16 Ibid., p.367

17 Ibid., p.138

18 http://www.thephf.org/phfpeckham.html


20 http://www.thephf.org/building.html

21 Ibid.


23 Ibid., p.292


25 This section was derived using the Sustainable Development Framework for the UK as published by DEFRA and SDC Health Inequalities Document


27 Ibid.

28 Ibid., p.6


31 Ibid., p.52


34 Ibid., p.6
35 Ibid., p.52
36 Ibid., p.52
37 Ibid., p.54
40 Ibid., p.71
41 Ibid., p.71
42 http://www.kingsfund.org.uk/blog/public_health_why.html
43 Ibid.
46 http://www.bmj.com/cgi/content/abstract/306/6883/979
47 Ibid.
48 http://www.localleadership.gov.uk/totalplace/about/faqs/#what - Total Place is an ambitious initiative that will consider how a ‘whole area’ approach to public services can lead to better services at less cost. The impact of the economic downturn means all of the public sector needs to find new and more efficient ways to serve the public.
49 http://www.kingsfund.org.uk/blog/public_health_why.html
51 Ibid., p.343
52 Ibid., p.343
53 Ibid., p.344f
55 Ibid.
61 http://www.thebig society.co.uk/
62 http://www.kingsfund.org.uk/blog/ten_challenging.html
65 Ibid., p.258f
66 Ibid., p.259
67 Ibid., p.259f
68 Ibid., p.259
69 Ibid., p.260
70 Ibid., p. 261
71 from Health Inequalities document by the SDC (http://www.sd-commission.org.uk/publications/downloads/health_inequalities.pdf), p.8
72 http://www.oneplanetliving.org/index.html