1 Health and health policy

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Tempting as it might be to launch into the key debates, it would seem prudent to pause for a while to consider what we mean by health and health policy. These terms are used throughout the book and are viewed in broadly social and theoretical contexts. What do we mean by this? When we talk about health in its social context we are drawing attention to the myriad of economic, social and cultural factors that influence the way we live and the health we experience. These factors influence who we are and the way we relate to each other. Let us not think of ourselves as having a single social identity, stamped on us for all time. Our identities change throughout our lives, along with our lifestyles and experiences of health. Consider, for example, the elderly couple whose diet is now restricted because of limited income and whose health is fading. Their understanding of health (their own and others) is transformed as a result of their own experiences. They do not need to be categorized. They need to be understood. So what do we mean by a theoretical context? Rather than focus upon the details of empirical research, we are seeking to uncover different approaches to health care. Health policies are consequently seen as illustrating different philosophies of life rather than as dry policy documents. It is contended throughout this volume that our views on the provision of health care often rest upon how we understand the nature of health and upon the way we regard the rights and responsibilities of the individual and the state.

Health

Let us start by taking a look at the nature of health in the broadest of senses. We should begin by recognizing that each one of us will no doubt have a different
view of health, partly because we will have different expectations of our own minds and bodies. Somebody who is actively involved in sports will surely have a different view of their health than somebody who is physically frail. The energy levels expected by young people will tend to be very different from those expected by many senior citizens. Parents with young children will often cope for many years with disturbed sleep and might have to make significant adjustments to their lifestyles to reduce the risks of chronic illness. It would seem, moreover, that our views on our own health will change as we move through the various stages of our lives. Because of this, the way we view the possession or absence of good health will probably change over time. There is, in short, a subjective element to the way we conceptualize and experience both health and illness.

Health and social functions

Health could be seen in terms of the ability of the individual to perform their social functions. Different people will have different functions. These might include raising a family, going to work, and tending to our own needs as well as the needs of others. The more our lives connect with the lives of others, the more expectations will be placed upon us. Viewed in one way, our health could be seen in terms of the ability we have or seem to have to fit in and live in accordance with the expectations placed upon us by other members of society. It should be appreciated that health and illness have serious social consequences. Good levels of health help the economic and social system to function effectively, while illness is dysfunctional for both the individual and for society. In order to minimize this dysfunction, the so-called ‘sick role’ allows people to be sick temporarily. The sick person is exempt from work and many other social obligations but also has a responsibility to seek help and to improve their health (see Aggleton 1990: 9; Daykin 2000: 115). The sick role provides individuals and society with a safety valve. It allows individuals to opt out of social obligations on a temporary basis without in any way minimizing the importance of these obligations. A person might, for example, be suffering from stress as a result of an increased workload. The sick role allows the individual to say ‘enough is enough’ and to withdraw their labour until they are healthy enough to work.

Scenario 1 Health, social circumstances and the sick role

Kyle is a 20-year-old student from a working-class and ethnic minority background. He is suffering from chronic migraines on a daily basis and is finding it difficult to keep up with his studies and to hold down his job in a local supermarket. He is expected to attend lectures and seminars four days a week and to work in the
supermarket two evenings a week and every weekend. Although his parents give him a small allowance, there are limits to what they can afford. Kyle is considering leaving university and his job. He is the only one of his peer group who has gone to university and he believes that they have an easier life claiming unemployment benefits. Kyle is aware, however, that this could have a devastating impact upon his career prospects and that his parents would be disappointed if he chose to abandon his studies.

Questions

You are a health professional working in a university health centre.

1. What kind of advice would you give to Kyle?
2. How do you think his health is being influenced by his social circumstances?
3. To what extent does Kyle need to change his circumstances in order to improve his health?
4. To what extent and in what ways could the ‘sick role’ help Kyle to deal with the multitude of expectations placed upon him?

Gauging levels of health and illness

Without wishing to make us sound like machines, many people use terms like ‘worn out’ or ‘drained’ to describe being in a state of poor health. These terms conjure up an image of a person who for some reason is depleted of energy and is finding it difficult to cope. Blaxter (1990) has used the term ‘reserve’ to describe the energy we have at our disposal. While this reserve is depleted by health damaging behaviour (like smoking or excessive alcohol consumption) it can be increased through health affirming behaviour (such as exercise or a good diet). Aggleton (1990) has noted that members of the general public, those without any specific bio-medical training, tend to view health in terms of ‘the wholeness or the integrity of the person, their inner strength, and their ability to cope’ (Aggleton 1990: 13). Health can be seen in fairly functional terms in which we are deemed to be healthy if we can cope in our various roles. This does, however, differ between ages. Older people are far more likely to view their health in terms of their ability to cope and get around, while young people tend to see it more in terms of their general level of fitness (Jones 1994: 3). There are also differences between classes in the way they view health. For example, it has been shown that middle-class women tend to view health in terms of physical fitness and the exercise they take, while working-class women see it as the absence of illness and the ability to ‘get through the day’ (Aggleton 1990: 14). It is clear that what is seen as healthy for one person is not necessarily the same for another. Anybody who
deals with the health of other people needs to be aware of this. The way we describe our own health is unavoidably influenced by the expectations we have of ourselves.

Shifts over time
In addition to there being vast differences in the way that individuals view their own health, the way that health is regarded within our culture will change dramatically over time. The way we see health has changed significantly over the centuries. During the late eighteenth and early nineteenth centuries, various social commentators argued that poor health stemmed from a poor match between the individual and the environment. Lamenting the decline of a rural past, commentators warned about the corrupting influence of modern city living (Davey et al. 1995: 4–6). Poor health was also regarded as quite stylish among some sections of the artistic elite of the late eighteenth and early nineteenth centuries. It became almost fashionable to be thin and pale, to look delicate and ill. The so-called ‘tubercular look’ (associated with TB) was thought to show distinction and breeding. According to Susan Sontag (1978), the cult of thinness found in women’s fashion in the twentieth century (and now beyond) is ‘the last stronghold of the metaphors associated with the romanticising of TB in the late eighteenth and early nineteenth centuries’ (Sontag 1978: 34). Byron and the Romantic poets and scholars tended to believe that illness made a person interesting and distinctive. Poor physical and mental health gave the impression that the sufferer was sensitive to the core. Those who suffered from TB and had the money to travel became tragic symbols in the work of the Romantics. These people were freed from their daily routines and encouraged to search for meaning. Sontag claims that it allowed the Romantics to retire from the world. Indeed, the Romantics ‘invented invalidism as a pretext for leisure, and for dismissing bourgeois obligations in order to live only for one’s art’ (Sontag 1978: 36). According to this line of thought, illness can have its cultural benefits.

The negative view of health
Health can be viewed negatively (in terms of the absence of something) or positively (as possessing something). If health consists in the absence of disease, people could be seen as being healthy if they do not have a disease. This would be irrespective of how they feel and whether they considered themselves to be healthy. The problem with this view of health is that it assumes that there is a norm for all bodies. It also tends to rely upon a diagnosis being made, most probably by a member of the medical profession. If we are unaware that we have a disease or if this disease has not been diagnosed, does it mean that we are healthy? (see Aggleton 1990: 5–6). Health can also be regarded as the
absence of illness. Illness is experienced and consists in the unpleasant feelings that often accompany a disease. The problem with this view of health is that it relies exclusively upon subjective experience (see Aggleton 1990: 7–8). We should also note that illness differs from sickness. Sickness is often calculated according to the number of people seeking medical help and perhaps absence from work. Illness, on the other hand, is about how we feel. We might put up with feeling ill and thus not reach the statistics of those who are deemed to be sick (Jones 1994: 9). While not seeking to minimize the importance of disease, illness and sickness, these notions do not in themselves capture the nature of health. Indeed, these notions do little more than signify the absence of health.

The positive view of health

Health need not only be viewed as the absence of something. Positive views of health emphasize the value of things we possess. In the 1946 constitution of the World Health Organisation, for example, it was declared that health should be seen as ‘a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity’ (WHO 1946: 1). Although this is an extremely broad definition of health, it does capture the ‘positive’ dimension of health and alerts us to the need to take into account social as well as individual factors (see also Aggleton 1990: 8 and Jones 1994: 6). This positive view of health also encourages us to find ways to improve or promote good health rather than always think in terms of responding to illness or disease. For those who hold a positive view of health, health is often viewed in a holistic way. Ewles and Simnett (1985), for example, claimed that it is important to acknowledge and give due weight to the emotional, spiritual and societal factors that influence health (Ewles and Simnett 1985: 9). We might of course wish to extend this list to include numerous other things like environmental or psychological factors. Even if the lists provided are incomplete, they do show the importance of looking beyond our ailments to understand the nature of our health.

The view that health consists in something we possess is gaining prominence in policy documents in Britain and elsewhere. The Black Report of 1980 recognized that we need to consider factors other than freedom from pain or discomfort and that we should give due credence to the importance of vigour, well-being and engagement with our communities (Black 1980). Policy documents often recognize that health is not simply the absence of disease but also the presence of physical, mental and emotional well-being (see for example NHS Scotland 2000: 16). It is argued that improving these dimensions of health can enhance quality of life (Scottish Office 1999). Health policy documents in the United States and in New Zealand have stated that good health should be seen in terms of increasing life expectancy and quality of life (US Department
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of Health and Human Services 2000; Ministry of Health 2006). Policy makers have started to recognize that helping people to come to grips with the nature and importance of well-being can improve levels of health. Rather than see health in terms of the absence of illness, it can be viewed as a dynamic force that can be influenced by circumstances, lifestyle choices, beliefs, culture and environment. It has been argued that quality of life depends upon having the opportunity to make choices and to gain satisfaction from living. Health can indeed be seen as a resource that gives people the ability to manage or change their lives (Health and Welfare Canada 1986). Viewed in this way, the pursuit of good health becomes an aspiration. This is a far cry from the negative view of health with its emphasis upon the problems we experience rather than the potential we have.

The bio-medical model of health

There are two main models that we can use to discuss issues of health. These are known as the bio-medical and the social models of health. The bio-medical model of health gained prominence during the nineteenth century and still holds considerable power. It looks for ways to identify the cause of an illness and seems to assume that illnesses can be classified and treated in an objective way. The individual is indeed objectified and individual health is recorded in case histories. The bio-medical model of health is anchored in provable facts, derived from rigorous procedures. It is concerned with the internal workings of the body and it presumes that our state of health is a biological fact. The model rests upon the belief that it is possible to diagnose a person’s health by taking note of the symptoms and that experts are needed to define and manage our health (Armstrong 1986: 47; Gillespie and Gerhardt 1995: 82–3; Senior and Viveash 1998: 10). The bio-medical model of health tends to view health in terms of freedom from a clinically ascertainable disease (Black 1980). One of the main problems with this approach is that it can lead to prioritizing the treatment of short-term acute illnesses rather than long-term chronic conditions. It can likewise serve to funnel resources into expensive cures for diseases while virtually ignoring relatively inexpensive health promotion programmes (US Department of Health and Human Services 2003). As the bio-medical model of health deals with identifiable illnesses, it is felt that it is possible to identify and gauge the results of medical intervention.

There are a number of problems associated with the bio-medical view of health. In particular, it rests upon a limited view of knowledge and it subjects too many aspects of life to medical measurements. The bio-medical model assumes that medical knowledge is scientific and objective. This knowledge is thought to enable those who possess it to understand the human body, the causes of an illness and the benefits of intervention. What this fails to take into account is that this form of medical knowledge has been created by a small
minority and is merely one interpretation of health and illness (Senior and Viveash 1998: 13). It could be argued that members of the medical profession have a vested interest in promoting an overly medical view of life and in diagnosing normal changes in the life cycle as periods of illness. With the backing of drug companies and limited by the time available for consultation, medics often rely upon using drugs to treat rather than concentrate upon promoting better health and preventing illness (Senior and Viveash 1998: 14–15). This bio-medical model of health tends to categorize people according to the illnesses they experience.

The social model of health

The social model of health rejects the neutrality and scientific pretensions of the bio-medical model and regards reliance upon the scientific method as merely one way to measure health. The social model of health acknowledges that health and illness are created socially and that the health we experience relates to the way society is organized. According to this view, health has an historical, cultural and social context and cannot be understood unless we appreciate this (Gillespie and Gerhardt 1995: 82–3). Whereas people who believe that we are isolated and autonomous individuals might believe that it is possible to change our circumstances and make rational choices about our lives regardless of our backgrounds, those who believe that we are social creatures and that our health has a social context understand that any autonomy we might have can be undermined by poor health (Black and Mooney 2002: 197). Government agencies have recognized that health has a social context and that a range of social factors will influence the health we experience. Policy makers in Scotland recognize that our physical and mental well-being will be influenced by the work we do, our housing, the education we receive and the environment in which we live (Scottish Office 1999). In Canada, it has been acknowledged that biology, lifestyle, health care organizations and our social and physical environments will have significant impacts upon our health (Health and Welfare Canada 1986). The Department of Health in Northern Ireland has argued that poor health is often caused and made worse by poverty, unemployment, low educational attainment, poor sense of community, environment, conditions under which we live and work and the lifestyles we lead (DHSSPS 2002: 38). It would appear from the above that the social model of health has an increasing amount of support among policy makers.

There might, of course, be a cynical reason for this. The social model of health allows far more room for policy makers to intervene and tinker with the nation’s health. By tracing our health to social factors, they attempt to convince us that we need an active state to intervene to regulate this broader social context and that this intervention will help to improve general levels of health. Even if we agree with this general assertion, it is important that we are
aware of its political dimension. Campaigns designed to heighten awareness of the social context of health are political in themselves in that they often challenge the power base of the medical hierarchy. As we will see when dealing with professionalism (Chapter 9), nurses have been particularly important in promoting a patient-centred approach to health care that takes into account the broader social context. We should be aware, moreover, that the conflict between the bio-medical and social models of health is played out at times within teams of health care workers and that those engaged in health care may well be able to locate themselves in one camp or another (see Box 1.1). Although the social model of health is appealing to those who wish to use the state to reform the economic and social system, it is likely to be seen as less attractive to those who want to free the individual from the influence of an interventionist and intrusive state.

**Box 1.1 Health professionals and the social model of health**

As we have seen the social model of health recognizes that our health will be influenced by our social circumstances. This model of health is gaining greater credence among health care professionals. Doctors have become increasingly aware of the importance of social, economic and cultural factors in the development of conditions and in tackling health problems. This has allowed doctors to understand and respond to the impact of adverse social conditions upon the health of their patients (see Willems et al. 2005). The nursing profession has a long tradition of holistic practice and it is noted that an increasing number of nursing departments have moved away from a bio-medical approach and have adopted a holistic approach to health care (see Thompson and Hammer 2007). A distinction is sometimes drawn between ‘cure’ and ‘care’. Although we might associate ‘cure’ with physicians and ‘care’ with nurses, it has been argued that these two values should be viewed along a continuum and that all health care workers should aspire to combine ‘cure’ and ‘care’ in their practice. Rather than attempt to set a balance between ‘cure’ and ‘care’ in the abstract, commentators have argued that the balance should shift along the continuum depending upon the particular needs of each patient. This would mean that the relative importance of ‘cure’ and ‘care’ would vary between cases (see Baumann et al. 1998).

**The bio-medical model of disability**

One of the key ways to understand the differences between the bio-medical and social models of health is to examine how these models can be applied to a specific area. Consider, for example, different approaches to disability. The
bio-medical model of disability regards it as an illness. It portrays people with disabilities as problems and attempts to exert control over their lives. Using the bio-medical model, it is assumed that if we could treat all forms of illness we could do away with disability. This rests upon and reinforces the belief that disabled people are both ill and inferior (Marks 1999: 59 and Drake 1999: 10–11). Traditional views of disability portray people with disabilities as having medical problems that place a limit upon what they can do (BMA 2007: 3). It has been argued that the bio-medical model of disability pays far too much attention to the ‘impairments’ of people with disabilities and that this creates obstacles to their full participation in society. It is believed by some that society’s attitude and reaction to impairments and illness creates real barriers for disabled people (Scottish Parliament 2006). Bury (1996) argues that the medical model of disability is used to protect the existing system. By treating people with disabilities as sick and in need of medical intervention, it gives enormous power to medical practitioners. Disabled activists claim that the disabled rather than medical practitioners should be in charge of the rehabilitation process (Bury 1996: 26). It should be appreciated that the bio-medical view of disability creates an extremely narrow and potentially dangerous view of disability. Apart from anything else, it disempowers people with disabilities and seems to leave them at the mercy of medical judgement rather than as citizens with a range of different needs.

The social model of disability

The social model of disability attempts to undermine this imbalance of power and advance the view that disability is not a medical problem but one stemming from material and cultural forces. Indeed, the idea of disability could be seen as oppressive and one that can be used to erect barriers to sections of the community. The idea of disability could be seen as something imposed from above on top of any impairment. It might also serve to exclude some sections of the community from full participation in economic, political and social life (Barnes and Mercer 1996: 6–7). It has been argued that disability should be distinguished from impairment and ill-health and be seen as ‘disadvantage experienced by an individual . . . resulting from barriers to independent living or educational, employment or other opportunities . . . that impact on people with impairments and/or ill health’ (Prime Ministers Strategy Unit 2005: 8). According to the BMA (2007), people are not disabled by impairments but by society and by the way that activities and opportunities are organized. People with disabilities are urged to take control of their situation and challenge the disabling barriers created by society (BMA 2007: 3–4). This view of disability recognizes that social attitudes need to be challenged and that social facilities and opportunities need to be made accessible to people with diverse needs.
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The more we view disability as an illness, the more likely we are to find ways to quarantine those with disabilities from those without.

The social model of disability sets out to undermine self-blame and self-hate among people with disabilities and urges us to value the abilities rather than the disabilities of people. People with disabilities can often find themselves isolated from the mainstream of society. It has been noted that up to 20 per cent of disabled people find themselves cut off from activities they enjoy and that they are more likely than people without disabilities to live in poverty, have fewer educational qualifications, to be out of work and be subject to prejudice and abuse (Prime Ministers Strategy Unit 2005: 5–6). Governments across the world have come to recognize the importance of empowering people with disabilities. In the United States, the Department of Health and Human Services has argued that attention should be placed upon improving the relationship between people with disabilities and their environments (US Department of Health and Human Services 2005: v). In Canada, approaches to disability stress the importance of facilitating independent living, social networks and inclusion in the life of the community (Health Canada 2007). The Ministry of Health in New Zealand approaches disability as part of its commitment to human rights. It is argued that we must tackle the barriers that disable people and that human rights must apply to all people (Ministry of Health 2001: 3). The social model of disability and of health in general does indeed encourage us to challenge oppression and discrimination on a number of levels and to recognize that the labels handed out by the medical establishment can be dangerous and can be used to marginalize significant sections of the community.

Scenario 2  Models of disability

John is a 25-year-old man who has had to use a wheelchair since his motor cycle accident in his teens. Following his accident, he lost his partner and his job. His social circle has shrunk and he has become increasingly depressed. John’s physical health has also deteriorated. He has almost doubled his body weight and he now smokes habitually.

Questions

You are a health care professional working in a local day centre, which John uses two days a week.

1  Why is it important to distinguish between John’s illness and his disability?
2  What could be done to improve John’s health?
Health policy

Having looked at some of the general features of health and illness, we now move on to consider the broad dimensions of health policy. Once again, the aim is to create some foundations rather than to define all forms of health policy or to provide a comprehensive list of everything health policies embrace. Health policy is one of the means by which the state can intervene to direct or provide for the health care needs of the nation. As we will see, the extent of this intervention differs greatly between countries and the question of how far the state should intervene is subject to a great deal of debate. What could be called the social policy perspective on health is concerned primarily with the role of the state in the provision of health care. It looks at what the state does, how policies are made, the historical development of state provision and at the various demands for reform. It seeks to determine the appropriate role of the state, the way in which health is organized and combines such disciplines as ethics, politics and economics (Lloyd 2001: 164–5). It should be appreciated at the outset that health policy is often developed as part of a broad package of social policies. If the government assumes some responsibility for tackling poor health, it makes sense that this is done in conjunction with other social policy initiatives in such areas as housing, unemployment, poverty reduction and education. In Ireland, for example, health policy is closely linked with other policy areas such as economic development, employment and urban regeneration (DHSSPS 2002). It is often the case that agencies or ministries are called upon to work together to deal with health problems. In New Zealand, for example, the Ministry of Health and the Ministry of Social Development work together on those social projects that have a bearing on health (Ministry of Health 2006). It must surely be the case that treating health in isolation would fail to give due attention to the broader social factors influencing our health. For example, somebody might be suffering from depression as a result of being made redundant and feeling trapped in poor housing or a deprived area. We would suggest that no amount of medication could improve matters long-term for this person and that providing them with opportunities for meaningful work and personal development would probably have a greater impact.

The importance of partnerships

Although the state is one of the main players in the development of health policy, we should recognize that health care is often formulated and delivered through partnerships with a variety of groups in the community. The Department of Health in Britain recognizes and embraces partnerships. In the consultation exercise that fed into Choosing Health (2006b), the Department of Health worked with key stakeholders from the NHS, local government, the
business community, the media, faith groups and the voluntary sector (DH 2006b). The NHS in Scotland is involved in a series of important partnerships, where the government and community organizations work together to identify the origins and possible solutions to poverty, poor educational attainment and poor health (NHS Scotland 2000: 4). In Northern Ireland, partnerships have been created between government departments, public bodies, local communities, voluntary groups and district councils (DHSSPS 2002: 7). In the United States, the Department of Health and Human Services has a number of strategic partnerships with non-federal organizations, especially in the field of health promotion. The structure of these partnerships allow for the Department of Health and Human Services to coordinate community initiatives rather than assume direct responsibility for providing health care (US Department of Health and Human Services 2007a). This illustrates, among other things, how the development of health policy and the delivery of health initiatives often involve a process of negotiation with key stakeholders, each of which may well have its own agenda to defend and to promote. This can make the development of health policy a rather messy affair.

Implementing health policy

It might be tempting to believe that governments with a clear majority of seats in their parliament have a free hand in making policy and in implementing their ideas as intended. But the barriers to making and implementing policy are numerous. Policy is not necessarily made in a methodical manner, where problems are identified objectively and alternative solutions are considered, monitored and evaluated. More often than not, policy is made in an incremental way by a variety of groups vying for influence and support (Palfrey 2000: 33–6). Not all groups, of course, have equal power. Within the British health system, for example, the British Medical Association (which represents the interests of doctors) will tend to have a greater influence on health policy than the Royal College of Nursing, which represents the interests of nurses (see Cameron 1999: 123–4 and 132–3). This does not mean that political and medical elites will always have their own way, as policies are not always implemented in the way intended by policy makers. Policies generally have to be implemented by people lower down the hierarchy than those who made the policies. Although policy makers might want their policies to be implemented as designed, this would rely upon a rigid command structure in which objectives and tasks were clearly defined and in which the support of the main actors (doctors, nurses, managers, etc.) for the policy initiatives of the organization could be guaranteed. What this fails to take into account is the existence of diversity within organizations and that the consequences of attempting to apply a policy are not always clear at the outset. It has been noted that a considerable amount of discretion is used in implementing policy, especially...
by the so-called ‘street level bureaucrats’ who tend to be the human face of the organization because of their contact with the public. These street level bureaucrats include nurses in health care and teachers in education (Palfrey 2000: 42–6). Governments might be able to set the agenda and design policy frameworks, but this does not guarantee success in initiating change. Without the support of key stakeholders, policies can be sabotaged.

**Conclusion**

This is a book about health rather than about illness. We do not in any detailed way account for the rise or prevalence of certain illnesses nor are we interested in concentrating upon the weaknesses of any particular health care system. Instead, we want to make sense of health and of at least some of the issues that policy makers have to face. By comparing different health care systems, it is hoped that we can come to understand possible solutions and, when coupled with some understanding of theoretical perspectives, start to think about the implications of different approaches to health policy. We recognize at the outset that health care should be concerned not only with repairing us when we are ill but also with capturing our hearts and minds. Throughout the volume you will see signs of a commitment to finding ways to address social problems and to enhance health and well-being. The issues we discuss will allow us to investigate the relationship between health and society and the impact of the economic and social climate upon health and the availability of health care. We will see that there is rarely if ever only one solution and we hope that we have left enough room in the debates for you to develop your own perspectives on health care and upon the responsibilities of both the government and the individual. By delving into the social and political context of health care, we hope to show how each of us has the power to make a difference, however small, to the health and well-being of our communities.