FRANCO-BRITISH INTERREG IIIA EUROPEAN PROGRAMME

Project title:

Health and Health Behaviour in South East England and Northern France

This document reports on the Qualitative Workstream Study carried out by the University of Greenwich:

Health and Health Related Behaviour in South East England and Northern France: An investigation of the views and perceptions of residents in Kent, Medway and Nord Pas de Calais of health determinants, health status and opportunities for health improvement: a qualitative study.
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Health and Health Related Behaviour in South East England and Northern France:
An investigation of the views and perceptions of residents in Kent, Medway and Nord Pas de Calais of health determinants, health status and opportunities for health improvement: a qualitative study.

Background
The qualitative study described here is part of a wider public health project which sought to compare health related quantitative data across Kent, East Sussex and Nord Pas de Calais. The comparative quantitative data will be used to inform strategies for addressing health inequalities within the Euro region and provide opportunities for mutual learning.

The qualitative element sought to support and illuminate the findings of the wider public health project and addressed the following of its objectives:

Objective 2: To describe and compare the determinants of health among the population of Nord Pas de Calais and Kent and Medway; East Sussex, Brighton and Hove;

Objective 4: To compare health and lifestyle across the two regions;

Objective 7: To investigate how each region involves users and carers and their views in relation to access to health and social care services and levels of health;

Objective 8: To use this information to compare the effectiveness of healthcare programmes (including preventative programmes) in relation to differences in health and programme delivery between the two regions; and

Objective 9: To disseminate the results through papers, reports and conferences and the world wide web so that local people and health services can benefit.

Qualitative research can enhance quantitative research by placing quantitative data into meaningful contexts. The focus is on the meanings the participants in the study setting attach to their social world. The overall aims of the qualitative study were to explore the perceptions of residents of Kent and Medway, Surrey and Sussex and Nord Pas de Calais, of:
1) what could be done to ensure that future generations experience good health.

2) ways in which the general public could be involved in deciding or influencing public health or health care policy aimed at improving the health of the population.

Objectives:

1. To undertake a comprehensive literature review to determine what is already known about factors influencing the adoption and maintenance of health promoting and health damaging behaviour.

2. To undertake a literature review to determine what is known about the current involvement of the general public in setting public health priorities and determining public health policy.

3. To ascertain residents’ knowledge and perceptions of risks associated with health damaging and health promoting behaviours and their perceptions of the barriers to adopting a healthy lifestyle.

4. To ascertain residents’ views on major threats to the publics health.

5. To ascertain residents’ perceptions of what government organisations, the health service and the general public can do to ensure the health of future populations.

6. To examine ways in which residents are currently involved in decisions about both individual care and the organisation and delivery of health related services in general.

7. To ascertain ways in which they would like and could be involved in decisions or planning of public health related policy.

Methods

Background Information

- France has a higher life expectancy at birth compared to England
- Both countries have inequalities in health with better health in the south of the country than the north
- There are a multitude of pre-determinants which influence health inequalities
- There are a number of similarities in the make-up of both regions
Kent, Medway, Sussex, Brighton and Hove and Nord Pas de Calais have similar geographic and economic characteristics including distinct rural and urban areas, poor and affluent areas, coastal/port areas, dockyards and ex mining areas. The study was conducted on both sides of the Channel using the same methodology.

The study was undertaken in two stages.

**Stage one – literature review**

The overall objectives of the qualitative study were to undertake a comprehensive literature review to determine what has already known about factors influencing the adoption and maintenance of health promoting and health damaging behaviour. It also established what was known about the current involvement of the general public in setting public health priorities and determining public health policy.

The review on the English side incorporated relevant national and local research. This helped assimilate literature regarding lay beliefs of disease causation and health related behaviour; it then assessed the literature regarding public involvement public health policy making.

Searches were undertaken using Medline, Embase, Cinahl, PsychINFO, Social Sciences Citation index and in particular health promotion data bases. In addition manual searches using reference lists from key papers were undertaken.

Each paper, research report, book etc was read to identify the main findings/concepts reported and these details were entered into a grid. The literature was then systematically compared for common and recurring concepts or themes.

For England, a report was produced which provided an overview of what is currently known about the complexity of health related behaviour drawing out common themes across lifestyle behaviours and successful interventions (Knight and Ruston, 2005).

**Stage two – focus groups**

**Background**

In order to meet the aims and objectives of this study focus groups were used to elicit a range of views in a semi structured environment and capture a diversity of perceptions. Focus groups are unstructured or semi-structured interviews with small groups of people who interact with each and the group leader. They have the
advantage of making use of group dynamics to stimulate discussion, gain insights and generate ideas in order to pursue a topic in greater depth. Focus groups are effective as they enable data to be collected from a group of people more quickly than individual interviews; secondly the researcher is able to interact directly with the respondents to probe and clarify responses and finally, the open response format of a focus group provides an opportunity to obtain large and rich amounts of data in the respondents own words. The main disadvantage of focus groups however, is that they are limited in their generalisability to a larger population. Nevertheless focus groups can help to reveal problems and solutions from the perspective of the respondent and thereby facilitate the development of policies that are able meet identified health and health care needs.

Focus groups were selected as the primary research method because:

- They are a technique that facilitates the detailed expression of ideas and assumptions by the lay public.
- The subject area under investigation – lay beliefs about health inequalities and potential implications for the health care system – constitutes a relatively new field of research, and hence requires thorough, qualitative inquiry.
- Qualitative research sheds further light upon the quantitative data already collected and analysed because representations of health form an important part of the decision making processes surrounding health behaviour.

**Convening the Focus Groups**

The original aim was to conduct a maximum of fifteen Focus Groups on each side of the Channel; fourteen were eventually achieved on the English side. The intention was to include 6 – 12 participants in each, balanced by age, gender and ethnic status. Two pilots were conducted on the English side in order to test how effective the questions were in eliciting detailed responses from the participants.

The recruitment of participants for the focus groups involved contacting pre-existing groups. The organizer of the group was either contacted directly using the contact details found on the Parish Council website or through contacting the Parish Clerks (mainly via email) who passed us details of some pre-existing groups. The organizer passed on the contact details of the group members who had agreed to take part. This included the address so we could verify that the participants belonged to the
electoral ward we were looking at. A convenient date and venue local to the participants was then arranged and participants’ expenses were refunded.

Each participant was advised of the nature of the focus group, its purpose and practical arrangements. They were invited to sign their consent to attend and have their comments recorded and cited anonymously for the purposes of this research and publications in accordance with research governance code of practice. This project was submitted for approval by the Research Ethics Committee of the University of Greenwich.

**Focus Group content**
The focus groups aimed to be socio-economically and geographically representative of residents living in Kent, Medway and East Sussex Brighton and Hove. In order to do this the Townsend Index was used which correlated closely to the French system. Each electoral ward was assessed and placed in one of twenty groups based upon socio-economic status with group one being the most affluent, and group twenty being the most deprived. The groups were then aggregated into five tiers. Groups one to four has been placed in tier one representing the most affluent section of the population. Groups five to eight, nine to twelve, thirteen to sixteen and seventeen to twenty were then grouped into tiers two to five. The distribution of the focus groups is shown in table 1; tier 5, the most deprived tier, was over represented in the data.
Table 1
Focus group distribution using the Townsend Index

<table>
<thead>
<tr>
<th>Tier 1</th>
<th>Tier 2</th>
<th>Tier 3</th>
<th>Tier 4</th>
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<tbody>
<tr>
<td>Rainham Central</td>
<td>Grain Peninsula</td>
<td>Faversham St Ann’s</td>
<td>Sunlight Centre</td>
<td>Hastings</td>
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<tr>
<td>13/9/06 FG 10</td>
<td>4/7/06 FG 2</td>
<td>21/7/06 FG 6</td>
<td>Gillingham North</td>
<td>Tressel</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>19/6/06 FG 1</td>
<td>12/7/06 FG 4</td>
</tr>
<tr>
<td>Ash Canterbury</td>
<td>Rainham North</td>
<td>Hadlow</td>
<td>Sheerness East</td>
<td>Margate</td>
</tr>
<tr>
<td>12/11/06 FG 12</td>
<td>13/9/06 FG 11</td>
<td>16/3/07 FG 14</td>
<td>11/7/06 FG 3</td>
<td>Cliftonville West</td>
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<td></td>
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<td></td>
<td></td>
<td>18/7/06 FG 5</td>
</tr>
<tr>
<td></td>
<td>Eythorne and Shepherdswell</td>
<td>Canterbury Westgate</td>
<td>East Brighton</td>
<td></td>
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<tr>
<td></td>
<td>17/11/06 FG 13</td>
<td>8/9/06 FG 9</td>
<td>17/8/06 FG 7</td>
<td>King’s Farm</td>
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<td>24/8/06 FG 8</td>
</tr>
</tbody>
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Participants in each focus group were asked to fill out a participant questionnaire to monitor the socio-economic composition of each group to assess whether the participants in each focus group were socio-economically representative of the electoral ward in which they lived.

The focus groups were conducted along the following lines:

- Each focus group contained between 6 – 12 participants with a moderator to facilitate the discussion. An observer was also present, taking detailed notes about the proceedings. The discussion was tape recorded for later transcription.
Each focus group was structured around four questions (below) which were designed to be as simple as possible, so that all participants could become involved in the discussion. Each of the four major questions was posed orally with recourse to prompts as necessary. The prompts included two maps (reproduced below) and diagrams which aimed to stimulate both a greater understanding of the subject areas and more in depth group analysis of issues surrounding inequalities in health. The use of jargon or professional terminology was avoided both by the moderator and in the questions.

Before the general discussion commenced, each participant was asked to note down their initial responses to the questions on post-it notes, which were collected. The moderator then invited the participants to develop their initial ideas orally, discussing the themes arising as a group and encouraged the group to develop the conversation to stretch beyond the parameters of the initial thoughts.
Question One: Thoughts on areas on the map representing deprivation and life expectancy


NB – these maps do not show the North Kent coast accurately, in particular the Medway and the Isle of Sheppey and therefore they do not reflect geographical accessibility well. This was commented on by some focus groups. Since the maps were intended to be a general trigger for discussion, the Kent and Medway map was also used for E Sussex focus groups (Hastings and Brighton)

Thoughts on blue/red areas on map

“Doubt over efficiency of statistical information on chart due to migration and immigration. Areas of depression have poor health” (FG12)

“I am surprised life expectancy Isles on Sheppey” (FG3)

“Move inland, lowest expectancy around coast” (FG2,3,4) x 5

“You would think that the blue area would be more round the coastal areas than inland. I think I will be moving” (FG5)

“I am moving to Kent. They look very healthy in Kent” (FG4)
Map 2 – Kent & Medway Deprivation by Electoral Ward

Question Two: What do you think is the most important causes of inequality in health?

Question Three: What do you think is the most important things that can be done to improve the health of the nation or the population or the community that you live in?

Question Four: What can the general public do to stop becoming sick? How do you think the general public could help the government to create policies to reverse such inequalities?

Results

Literature Review
Overall the literature review was concerned with:

- Health inequalities – lay beliefs and lifestyle behaviours: a review of the sociological literature
- A history of health inequalities in the UK
- Lay health beliefs and how these affect health related behaviour
- Lay beliefs about the causes of health inequalities
- Public involvement in determining and addressing health inequalities

The key papers identified are appended to this document. The issues for discussion by focus groups were then identified as outlined below.
Focus Groups

Need more info here from tables once FG14 completed – see other document

Table 2
Summary of focus groups by Townsend Index (deprivation)

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<thead>
<tr>
<th></th>
<th>Tier 1</th>
<th>Tier 2</th>
<th>Tier 3</th>
<th>Tier 4</th>
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<tr>
<td>Less deprived</td>
<td>Focus groups 10, 12</td>
<td>Focus groups 2, 11, 13</td>
<td>Focus groups 6, 14</td>
<td>Focus groups 1, 3, 9</td>
<td>Focus groups 4, 5, 7, 8</td>
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<tr>
<td>More deprived</td>
<td>Focus groups 4, 5, 7, 8</td>
<td>Focus groups 6</td>
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Overall comment on results
The results are divided into 2 sections. Section 1 overviews general issues around focus groups, numbers, numbers of participants, age, representative of area etc.

Need comment here on overall FG stuff- draw from tables document

Section 2 is presented under four headings:

1.0 Lay perceptions of deprivation and life expectancy based on Kent and Medway maps.
2.0 Lay perceptions of the most important causes of inequality in health.
3.0 Lay perceptions of priorities to improve health locally and nationally.
4.0 Lay perceptions on what the public involvement in policy and strategy to reverse health inequality.
1.0 Lay perceptions of deprivation and life expectancy based on Kent and Medway maps

Participants were largely aware that there were areas of Kent and Medway which were deprived but had never before considered that this could affect life expectancy.

I have noticed that in Dartford there’s some red areas and this is amazing, this red area here, the size of this, but I mean I lived in Dartford and I was advised to move away from Dartford because of the pollution and because I kept getting chest infections and I can honestly say I haven’t had anything, but I was ill repeatedly in Dartford. (CHECK FG??)

Focus Group 13 participants in particular expressed surprise at pockets of low life expectancy in places (Canterbury, Deal), suggesting that this linked to social deprivation and the availability of medical services in Canterbury, and a growing elderly population in Deal, which was seen to place increasing demands on health care services. In addition, the group commented on the difference in house prices between electoral wards represented on the map, particularly commenting on differences between separate villages in the Dover area.

However, there was some discussion around the validity of the statistics presented, and how accurate they really could be in relation to a mobile population. For example, if someone moved, would they take their original life expectancy with them? Would they take on the life expectancy of the new area? One comment sums up what several participants were thinking, said in jest, yet with serious undertones:

… Choose probably Tunbridge Wells if you want to live longer. (Focus Group 3)

Others were sceptical about the accuracy of data presented on the maps, particularly with such a mobile population in some areas, who may not be represented on the electoral ward (Focus Group 5), or even for those who were born in another area:

I was born in Bromley, what use am I to the statistics? It just doesn’t make sense. (Focus Group 12).

Place and health

Participants related geographical deprivation and inequalities represented on the map to a variety of issues. Main factors arising were place (coastal, urban, rural);
changing nature of place (socio-economic), including loss of traditional industry or tourism function; and access to services (education, healthcare, local amenities such as shops) arising from location.

The majority (8 of 13 focus groups) explicitly commented on coastal areas, and all but one expressed surprise that these areas were generally deprived. They generally related this deprivation to poverty. The following quotes illustrate what the groups were thinking:

I was surprised at the high incidence of the blue areas and that the low life expectancy is mainly on coastal areas - that was my first thoughts. (Focus Group 2)

Participants across the range of focus groups (for example 2, 4, 5) expressed surprise that coastal areas were categorised as deprived, mentioning fresh sea air as health giving, and as places where, people used to go to get better. (Focus Group 2)

However, other participants saw that coastal areas and lower life expectancies were part of a wider cycle of socio-economic decline, albeit on a very local basis:

No, it's because it's areas of deprivation. Somebody who lives in those areas has a long history of unemployment and deprivation; also, when you look at the coast, it's where you have had people who have been dumped on the coast haven't you? (Focus Group 9)

No. Whoever did the chart, they picked the areas where you would expect it to be like that. Although how in Cliftonville West we can live 'till 87, and just two miles down the coast in Margate, you can live to '72… (Focus Group 12).

Several of the focus groups commented that there could be a link between (urban) industrialisation and health expectancy, raising concerns around pollution and chemicals arising from factories as well as overcrowding and rushed urban lifestyles (Focus Groups 2, 3, 6, 8, 9, 10, 12,13). Coal mines and dock areas were also viewed as important to health status:

...That can't be good for you, coal dust. (Focus Group 3)

Well I know two people, family-related, that suffered from the dockyard with asbestosis. I mean if that dockyard hadn’t been there, and if they hadn’t have
worked in the dockyard, they wouldn’t have got that would they? (Focus Group 10)

Well one of the social factors here, specific to this ward, is it's an ex-mining community and there’s obviously a lot of respiratory disease here. (Focus Group 13).

Some focus groups commented on the rural / urban health differences:

One of the things you notice in the general trend, is that it seems to be that the lower life expectancies are more around the built-up areas and the urbanised areas, rather than the more rural areas in the country. It seems that somehow people have a better quality of life, regarding health. (Focus Group 4)

All these blue areas - a lot of the blue areas are country aren't they? The countryside. The green areas are like a lot of the towns and things. So living in the country must be better for you. (Focus Group 10)

Does that mean that these blue areas - because this blue area is mainly in the country, that these people are having real fresh air and more exercise, because they live in the country? (Focus Group 10)

Again, just that you are better off to live inland in the country basically, away from the pollution of industry. (Focus Group 13).

But:

I am not sure because you would sort of think that actually some rural areas - traditionally their health services aren’t that brilliant. There are some risk factors again in living in rural areas. (Focus Group 11)

Better health in rural areas was linked to better environmental conditions, such as less pollution and less fast food outlets, but also perceived better health care services operating under less pressure than urban areas (Focus Group 4).
Other participants linked health to social issues, such as variation in education standards across the region, and how this might have a wider impact on health status, such as diet and accessing better employment. For example,

...you come out to a village like ours where there is a lower standard of living, people - they are not rich people out here - so the children don’t learn quite so easily, so it says, in low socioeconomic areas, and that is just one argument that they put forward - that without education you don’t have a lot of money, you don’t eat properly, you eat takeaways and it can affect you in health. (Focus Group 2)

...and maybe our understanding isn’t as grand as, you know, as some people’s, and maybe we have not all had excellent education delivered to us - it’s true, so therefore it’s about perception and understanding and knowing what is available to you, knowing what your rights are, and knowing when to ask the right questions about health. Also it’s not really a very empowered place, so people tend to think ‘well what can I do about it?’ They don’t go out there and say, ‘We want a doctor’s surgery, and we want it right here and we want it now!’ They will just sit back and accept what is going on. (Focus Group 4)

Changing nature of place and health
Others perceived the change as part of a wider national picture, with England generally losing its predominant industries:

That is why most of this is going downhill - it's not all about government funding - it's more about private sector… actually there was no money at all in the area in the first place. (Focus Group 5)

Also particularly around Dover which, you know, we know well, is because of the unemployment because the closure of the pits ?? - all of those were mining areas, the pits closed, the ferry closed. There’s high unemployment around the Dover area which of course has made them areas of deprivation and as Margaret said we know around the Sheppey area there is high unemployment again from the sense of there’s less there’s dock work and they end up… the industrialisation has created a lot of… (Focus Group 9)
Well there seems to be more blue inland away from the coast - it seems to be a more healthier area. But then again it could be again economics - if they are living in a community away from the coast, away from all the … what shall I say? … all the industry and that, it seems to be healthier people. (Focus Group 13).

You find also some of that is linked to the sorts of industries that is there, because Sheerness has a steelworks, Sheppey Central has the pollution areas and they have lots of docks; and up Dartford and Rochester, that’s naval works - there’s a lot of asbestos from there. They have got very low… and that will probably skew the figures; then you have got coalmining in the areas, you have got the docks in Dover. In Margate - I don't go over to Margate - I don't know those particular wards particularly well - I don’t know why that would be specific…. That may not be industry-related, that may be related to something else. (Focus Group 13).

Participants largely linked the changing nature of place to loss of traditional industry or function. Having such a large coastline, much traditional industry in Kent in particular was based here and presents particular challenges.

Yeah, but remember there was docks there wasn’t there? I know they closed a long time ago, and I am not quite sure what the main industry is now, Sheppey, but I bet it's not really helping. (Focus Group 1)

Yeah it makes sense. You can see, they are all… first of all most of them are industrial areas which are run down - nearly all of them actually - and you have got the dock area around Dover, parts of that is… and then if you come to Folkestone, another run-down area. (Focus Group 9)

The changing nature of docks also featured across some focus groups. One participant commented that:

...Because you have got all the boats and that coming in and that, and you get more germs and that. Because my other half, he works down there and he comes back home black, and he’s like ‘Oh, I shouldn’t really work down there in that.’ (Focus Group 3)
Also we have lost on the fishing… because places like Hastings, Deal, even Margate had a good fishing industry at one time. Fishing has gone and there I think comes a European directive where no one is allowed to get so much catch other than ‘x’ amount of fish. (Focus Group 5)

Many participants identified particular ex-seaside resorts as having become new locations for housing deprived households, both local and as out-migration from London. Comments were made about areas having become dependent on benefit-dependent homeless households in bed and breakfast accommodation (such as Cliftonville West, Margate, Thanet) (Focus Groups 9, 12) and participants suggested that:

They are people on benefits, that is right, and they are not going to live so long are they? (Focus Group 12).

The loss of the traditional English seaside – and a total change in the local community (Focus Groups 5, 12) – was seen to be caused largely by hoteliers having to find new sources of income

It's not good living within sea air! It's because of the bed and breakfast classes, because it's a migrant population. Well, in Ramsgate, it always struck me that a lot of the mothers who came into school were slightly depressed, they were down, and they didn’t... (Focus Group 12).

Some regretted the demise of the traditional Kent seaside resort, with participants reporting how generations of their family had holidayed in places such as Margate and Ramsgate, suggesting that then these areas were, “humming, it was buzzing” (Focus Group 5) until cheaper foreign holidays took over, particularly from the 1970s. Some participants particularly in tiers 4 and 5 suggested that a constant influx of shorter term benefit claimants into the ex-hotels led to decline and growing complacency:

So of course a lot of them had to take down the ‘Hotel’ sign because they were no longer actually being what they should be, which is accommodation for somebody looking for somewhere to stay for bed and breakfast or an evening meal. So a lot of the big houses which are now multiple occupation were hotels, that then became benefit places which then finally have crumbled down. (Focus Group 5)

…it has completely changed the area. (Focus Group 5)
Well because you get young pregnant girls, you get ones who have been in trouble and inner cities have dumped them on the coast to manage by themselves. They get involved in drug taking with various unsavoury people. And also, as far as I understand it, a lot of people with mental health problems - they are dumped on the coast to look after themselves. (Focus Group 9)

There were also many comments across focus groups about an increase in immigrants, although it was unclear as to whether this related to asylum seekers, refugees or economic migrants per se. Places such as Dover were seen to have become rapidly deprived as a result of asylum seekers (Focus Group 1, 8)

Eight focus groups made comments about deprivation and lower life expectancy being related to immigration (generally but not necessarily related to the coastal areas). There were many comments made across the range of focus groups about how immigrants were generally seen to have caused a decline in local health. Comments ranged from:

- It's like aliens coming in bringing all their diseases … you don't know what you are brushing by, what diseases they have got in their country so that has definitely got to have something to do with all of this. (Focus Group 3)

- Well they are all bringing their germs in over here aren't they? …I mean they come in, they are not treated, they are not checked, and they come in with all sorts. (Focus Group 8)

- …the red areas seem to be traditionally run-down and poor areas, and they are not now being helped by a growing immigrant population, who are bringing, as we said, their health problems with them. (Focus Group 12)

- Well obviously because they have come from possibly a country where their Health Service hasn't been as good as ours and they have brought… TB has come back into the country again because … And so obviously, like these areas, there's going to be more of a health problem because of this - they've have had lack of healthcare in their own country, so their fitness and their standard of health is going to be low, so it will make the area more deprived, and their resources for the health centres and everything… there will be more
of a demand with the costs and everything for the health areas - it will be
more for those areas. (Focus Group 12)

Participants reported that many in-coming communities tended to congregate in
already deprived areas, which cost less. This accelerated the decline, and placed
additional pressure on already stretched services, causing problems for the
traditional community.

... obviously if you have got cheaper housing somewhere, then obviously the
people who haven’t got the money i.e. a lot of foreign people that have come
to this country (who) move to the cheaper areas. (Focus Group 5)

This cycle of decline was seen as difficult to escape.

And it takes a long time for the circle of unemployment, depression, ill-health
starts… it takes a long time for people to break that circle, to become
knowledgeable. (Focus Group 12)

Many participants across focus groups commented on the changing nature of place,
and decline setting in, leading to lower life expectancies (for example, Focus Group
5). The decline and onset of deprivation was seen to be multi-causal and led to a lack
of service provision as vulnerable groups (such as children and the elderly) made up
a disproportionate percentage of the evolving community (Focus Group 5).

Areas with high levels of unemployment and low wages were seen to give rise to
elevated levels of stress, which was seen to have a knock on effect on negative
health behaviour as coping mechanisms (see later section). For example,

So your kids smoke and you don’t eat properly. (Focus Group 8).

Yes, or on benefits and they don’t look after their children as well as they
could. (Focus Group 5)

And if they haven’t been in work for so many years, they have got into a
routine, so it doesn’t matter what time you get up in the morning, it doesn’t
matter what time you go out, it doesn’t matter where the kids are… you just
stroll through the day, so there is no structure. (Focus Group 5)
Although this was countered:

Well I am unemployed and a single parent and I have got structure to my life.
(Focus Group 5)

And when you have a high-benefit area, there is a lower standard of living because people can’t (access things to help them because they are labelled)
(Focus Group 5)

Many focus groups suggested that this general decline was due to general environmental decline, family breakdown and a decline of social capital (although this term in itself was not used), leading to far wider decline in health due to apathy setting in. One focus group commented that:

… but if people are going to have lack of pride of their own environment, where they live, then maybe they are going to have a lack of respect for their bodies too, and not bother to eat and drink the right things and that’s going to affect their health; maybe they haven’t got much money either because they are maybe unemployed or on benefits. (Focus Group 5)

Generally the community role was seen to be largely redundant (focus group 9) and socio–economic decline was also perceived to affect behaviour. It was difficult to tease out whether this was viewed as a cause or effect, with a decline in social capital:

Everybody goes inside their house now, closes their front door and that’s it. They don't look out for other people. (Focus Group 5)

If it's a scruffy area, you might feel pretty scruffy (Focus Group 11)

Some focus groups blamed the general socio-economic decline on lack of government funding for issues ranging from housing and education to health care (Focus Group 5), as well as wasted in National Health Service spending (which is addressed more fully elsewhere in this report). Others saw the general decline in behaviour as due to benefit dependency or drug taking (Focus Group 5).

Conversely some participants recognised that higher income also had an effect, particularly because sufficient finance gave people the opportunity to move and improve their life chances (Focus Group 13). In addition, the following comments were made:
You will find a lot of people congregate to Sittingbourne, Maidstone and Canterbury where they seem to have more money and they have probably come down from London and started buying houses down there, so they are well-oiled, they might have better jobs, and a better lifestyle, go to the gym and all that sort of thing, you know. (Focus Group 8)

But a lot of this, especially around Cliftonville West, where there’s a lot higher life expectancy - it’s probably fairly affluent people have come to live in all these retirement flats. (Focus Group 12).

Participants noted that cheaper areas to live tended to lack wider facilities and access to facilities, which was seen to limit choice. This included decent shops for fresh food (Focus Groups 9, 11) and access to leisure activities for exercise (Focus Group 11). Overall, living in a deprived geographical area was seen to have a major health impact:

Well because you can't have things that other people have, you can't buy the right sort of food, or you are not able to motivate yourself to get the right sort of food or look after yourself properly or your children properly. (Focus Group 12).

A lot of the perceptions were about other peoples' behaviour, particularly those seen as being highly deprived or benefit recipients (notably second and third generation). Some of this attitude may have come form the media, and certainly recent policy had influenced what some participants were thinking. For example,

…what is amazing, what Blair came out with the other week which seemed horrendous - there was a programme on Radio 4 where a lot of people educated…. were really - although it sounds horrendous, he was right, because these people said they could literally identify the children before they were born, because of the parents of the people who were going to have the problem. (Focus Group 9).

Participants recognised that socioeconomic deprivation was cyclical and difficult to escape.

… people’s knowledge of how you look after children and the facilities that they have in their homes, and how they are able to use the facilities that are offered them … Obviously the areas which are high in unemployment, so that
causes social problems …it causes problems within the home if people are long-term unemployed or long-term sick; they become stuck in a rut and it's hard to get out so they - some of them more often than not spiral down rather than rise up above things, and it causes ongoing problems. (Focus Group 12).

Participants suggested that this cycle of decline was aggravated by reduced parental support, a poor attitude toward education and one participant reported that, “you can work as hard as you like - but you won't shift them. That's the way they like it and that's the way they will do it” (Focus Group 12).

Access to services

The issue of place, location and access raised several comments and foci for discussion. Some of the focus groups have been convened on islands in Kent (for example Focus Group 3) and felt that factors like a new bridge linking them to the mainland had had a major effect on people's health, due in part to reduced stress from easier mobility. Others in more deprived areas (such as Focus Group 4) suggested that General Practitioners would not wish to locate nearby. Such comments across various focus groups related to residents’ access to services, but also access to residents, such as by a General Practitioner.

Why it has an effect? It's a really complex question. Because I think that lower income groups probably have more difficulties getting access to decent medical facilities. For example we can look at our parish here, and one of the big issues is transport to doctors - it's very, very difficult for a lot of people to get to decent medical services, and I would imagine that applies to quite a few of these areas. (Focus Group 13).

No, I sort of go back to what I said before, like here, if it's transport issues… and something we haven’t touched on there is actually the quality of the services that are available as well, and I would imagine that some of the - for example, GP services in some of the red areas, probably are pretty poor in comparison with GP services in the blue areas. But that in turn may be a reflection of the sort of economic depression in those areas. I think you might see that GPs are a bit choosy when they decide where they are going to go and practice. (Focus Group 13).
Concerns were also raised about the quality of some services, distance of travel to Accident and Emergency services and maternity units, as well as the number of services provided in some areas, together with potential costs and transport availability in getting there (Focus Group 3, 4, 6, 9, 11). Participants commented about the extra services a more deprived area such as theirs would need because they suffered a multitude of needs over and above other less deprived areas, notably the perceived number of immigrants (who would need more time with a health care practitioner due to language barriers) (Focus Group 4, 6, 8), and people with mental health problems due to unemployment (Focus Group 4, 6, 9), as well as alcoholics and people taking drugs in the area (Focus Group 4). As one participant reported:

I think we have a high percentage of lots of vulnerable people and not just one group, so I think therefore the demands are higher. (Focus Group 4)

When we lived in another area that was as I say a much poorer area, I would say (the National Heath Service) wasn’t nearly as good as it is here. (Focus Group 9).

2.0 Lay perceptions of the most important causes of inequality in health

Participants across the range of Focus Groups acknowledged both structural and behavioural explanations for health inequalities. Participants were asked first individually to write down, and then via group discussion, to rank the list of health determinants they were provided with, based on Dahlgren and Whitehead (1991). This following table represents the group response across the focus groups.
Table 3
Numerical ranking of health determinants

<table>
<thead>
<tr>
<th>ISSUE</th>
<th>RANKING (1 = most important, 5 = least important)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual lifestyle factors</td>
<td>FG4, FG8, FG11</td>
</tr>
<tr>
<td></td>
<td>FG10</td>
</tr>
<tr>
<td></td>
<td>FG1, FG5, FG12, FG9</td>
</tr>
<tr>
<td></td>
<td>FG3, FG6, FG2</td>
</tr>
<tr>
<td>Living and working conditions</td>
<td>FG9, FG10</td>
</tr>
<tr>
<td></td>
<td>FG1, FG3, FG4, FG5, FG11</td>
</tr>
<tr>
<td></td>
<td>FG6, FG8, FG2</td>
</tr>
<tr>
<td></td>
<td>FG12</td>
</tr>
<tr>
<td>General socio-economic, cultural and</td>
<td>FG1, FG2, FG3, FG5, FG6, FG12</td>
</tr>
<tr>
<td>environmental</td>
<td>FG8, FG9</td>
</tr>
<tr>
<td></td>
<td>FG4</td>
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<tr>
<td></td>
<td>Joint 4 &amp; 5</td>
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<tr>
<td></td>
<td>FG11</td>
</tr>
<tr>
<td>Social and community networks</td>
<td>FG2</td>
</tr>
<tr>
<td></td>
<td>FG1, FG10, FG4</td>
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<tr>
<td></td>
<td>FG3, FG6, FG8, FG12</td>
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<tr>
<td></td>
<td>Joint 4 &amp; 5</td>
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<td>FG11, FG5, FG9</td>
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<tr>
<td>Age, sex and constitutional factors</td>
<td>FG6, FG12</td>
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<tr>
<td></td>
<td>FG3, FG10, FG11</td>
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<td>FG8, FG2</td>
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<td></td>
<td>Joint 4 &amp; 5</td>
</tr>
<tr>
<td></td>
<td>FG5, FG9</td>
</tr>
</tbody>
</table>

Comments
FG’s 7 : data missing from tape
FG 13 : no agreement made

The highest number of focus groups placed **general socioeconomic, cultural and environmental** first, reasons including for the following reasons:

It's the general socioeconomic, cultural and environmental conditions. So it's like - it's the foundation to all of these. If you, in your culture… if certain things aren’t available or are available, or certain pressures or anything along
those lines... environmental - obviously if you are next to a huge radioactive
dump or something, that is going to determine problems and everything along
those lines. If you are in a place with nice fresh air and good,
uncontaminated soil, it's going to be a healthy thing. (Focus Group 5)

Because the socioeconomic factors, basically the more or less money you
have depends on everything else - like it gives you more choice, or it gives
you places so you can live. So that is the most important because it causes
everything else (from the time you were born). (Focus Group 6)

**Individual lifestyle factors** were rated second, but were the most commonly
discussed issues across all focus groups. Participants saw lifestyle issues as
including, “Smoking and drinking. And no exercise. Drugs. Obesity.” (Focus Group
12); sexual health was only raised a couple of times across the range of focus
groups. Lifestyle factors appeared to be raised more in lower tiers than higher tiers:

Number 1 which we felt was the most important was individual lifestyle factors
because everybody has a choice and obviously you can't make people do
what they don't want to do. So they have a choice where they live to a certain
extent, and a choice to where they work and what they do for a living. (Focus
Group 4)

Some suggested that everyone had a choice in – and responsibility for – their own
health:

It's about choice - it's about choosing where you want to live, choosing what
you do for a living, and choosing what you are going to eat … Everyone has
that individual control over their lives don't they? And some of us choose to
say - it's part of my decision-making to eat those biscuits. (Focus Group 4)

People are not being taught so much to take responsibility for themselves
really at all sorts of different ages - they are just not doing it (Focus Group
12).

Although others suggested that the situation was not so clear cut:

Personaly I don't. I think that - I think there is just a low awareness really,
and I don't think you always... you just do stuff, you don't actually think about
things, you know, you are reacting to a situation, so something might have happened and you will react in a certain way, so you might not sit back and think ‘Um, what are my choices?’ You are just going to do that, you know, and then think oh boy, I should have done that (at a later date). So I think it’s about… I suppose a feeling of chaos and panic - you know, we live in a poor environment and you don’t tend to sit back and think what am I going to do now? You just react. So there’s less processing of thoughts and choices. (Focus Group 4)

Because the socioeconomic factors, basically the more or less money you have depends on everything else - like it gives you more choice or it gives you places so you can live. So that is the most important because it causes everything else. (Focus Group 6)

… it can start off with an informed choice, or a lack, kind of, of informed choice. I haven’t quite squared it up in my head, but I think that policy might be a kind of central problem, with regards to making a choice. So if you were poorly educated, where you had a poor diet, you have poor mental health - then you might not be in such a good place to make such a good choice. So if you didn’t know a lot about cheap tricks with chicken broth and fresh vegetables … And if you didn’t know that going for a walk or something is as good as going to the gym, then you might kind of not choose to make that activity or eat well. So it’s kind of a combination of informed choice and poverty, but poverty not necessarily being financial. (Focus Group 11)

Two focus groups rated **living and working conditions** as the most important health determinant, with changing patterns of employment affecting health in specific areas. However, there was no overall priority correlation between specific areas and occupational diseases identified:

Working conditions are serious, because many people, especially in this area have died from asbestosis. (Focus Group 2)

Well one of the social factors here, specific to this ward, is it’s an ex-mining community and there’s obviously a lot of respiratory disease here. But that is specific to this area. (Focus Group 13).

Most people … are not in a position to choose their career, they are desperate for a job. (Focus Group 5)
Even people now in the modern day, working in the call centre - I mean the stress that they have now is tremendous, and the targets they have to work to and everything. (Focus Group 9)

Participants linked employment status to health. Major sources of employment had been mining, the dockyards and tourism, each of which had declined over time. Many participants related health status to occupational exposure to hazardous practices and substances, such as asbestosis from the dockyards (Focus Group 2) and highly industrial areas suffering an excess of pollution (Focus Group 4). Poor working conditions were related to poor health, seen to derive from a lack of choice in the employment market:

Because if you have poor conditions, your health suffers. If you have a good, clean environment then your health is going to be better - you have more of a chance … Also you want to go to work because you are happy there - and being happy helps your health. (Focus Group 3)

…most people … are not in a position to choose their career, they are desperate for a job. (Focus Group 5)

Well not maybe current, but in the past, miners’ families - people working in steel, factory environments - it goes on your occupation, whether you are going to pick up other illnesses and ailments really. So you are exposing yourself into something of the higher risk - be it 10/20/30 years down the line - you are more likely to need more hospital/GP services for the investigations that have got to be carried out. (Focus Group 13).

Manual work (requiring lower educational status) was generally seen as more likely to give rise to accidents, but higher status jobs were seen to present their own forms of occupational stress as were new forms of employment, such as ‘call centres’ and pressure to meet targets (for example, Focus Group 9). Women were particularly seen to be under pressure in creating a work-life balance (for example, Focus Group 6).

Participants suggested that changing patterns of employment affected health in specific areas e.g. dockyards/mines. However, participants also reported a general trend toward new styles of employment such information technology superseding
traditional manual industries. This was seen to engender new forms of employment related ill-health, notably stress, largely due to loss of power for employees:

Even today, working conditions for people are not say conducive to health, and factory working is piece work, so you have got a lot of stress going on … And repetitive work. … And travelling backwards and forwards to and from the office, you know. I mean out in rural areas like this, the car is essential and you have got to get up at 4/5 o'clock in the morning to get on the motorways to get up to town. (Focus Group 2)

Well because working conditions… now I mean obviously not so much the labour-intensified work, but obviously the stress levels in work now where you are… No job is secure whereas a man could start work, or a young lad or a person start work say 20 or 30 years ago and possibly be in that job until the day he retired - there is no job security now. (Focus Group 12).

Living conditions were seen as an important health determinant in some focus groups. Discussions were concerned with the rise in property prices, forcing both parents to have to work (Focus Group 12), which was seen to have an impact on family life, such as the time to cook and share a family meal (Focus Group 12). Other focus groups also commented on environmental conditions affecting health, such as cold and damp (Focus Group 11, 12), overcrowding, facilities and general quality (Focus Group 11). As a result, some suggested that, “Housing is one of the biggest contributors isn’t it to poor health”? (Focus Group 9). This was compounded by the fact that area regeneration was not seen to cover health, and that participants saw health being dealt with as a separate issue (for example, Focus Group 4).

**Age, sex and constitutional factors** were rated as second lowest, although nine focus groups explicitly commented on the importance of genetics in pre-determining health. For example,

… I think if it's in the genes and it's passed down through the generations in the family; it doesn’t matter what social class you are in, you can have that particular disease, so therefore really I don't think it matters whether you are a hard worker or whether you sit down in an office. (Focus Group 3)
Whilst many participants were fatalistic about their genes, others saw knowledge of family health histories as potentially beneficial and this knowledge gave them some power to be able to make changes to their own health, based on their own individual knowledge, but also relevant screening services from the NHS (Focus Groups 4, 8). Others reported that they maintained their own health damaging behaviours, such as smoking, because they had examples of family members who lived to a late age even when smoking.

… if you have got the knowledge and you know that there’s blood pressure problems in your family, heart attacks in your family, then your individual lifestyle choices should be governed shouldn’t they? You know, so you’d say I shouldn’t smoke because the last three generations of my family have died of lung cancer. (Focus Group 4)

But normal things like blood pressure, I could have kept it down more if I hadn’t ate so much and smoked so much. So a lot of it is down (to the individual)… (Focus Group 8)

Which again would help, if the Health Service took onboard what you may be prone to from your background, to screen it better. (Focus Group 8)

Some health damaging behaviours – notably smoking – were perceived as coping mechanisms:

It's probably because it's a quick fix for stress. To have a cigarette… I have smoked since I was 16 and people that have smoked… (And I still smoke because) … It keeps me calm and it's an enjoyment. I could never stop unless they said I was dying - and even then… (LAUGHS). But my mum, she smoked all her life and she had seven children, so it can't be smoking because she died at nearly 90 something - nearly 92 and it wasn’t cancer that killed her. And I know another lady, just to give you an example, another lady near where my parents lived - she was about 55/60, she had never drunk, never smoked, had her own business, and I think it must have been 10 years ago she had a heart attack and is now taken everywhere in a wheelchair.

She was agile.. (Focus Group 3)

Lack of jobs and decent [parents] leads to abuse of alcohol and smoking and in turn bad health. (Focus Group 4)
Social and community networks generally ranked as lowest perceived health determinants, with the suggestion that, “Community networks don’t exist any more”. (Focus Group 5) and that, “Nobody has got time for anyone any more”. (Focus Group 8). But, on probing, social and community networks were seen as important across all age groups:

…If you didn’t have a social network there would be no point in living basically because you need a social life. (Focus Group 3)

Social and community networks, because that was about influence. If you have got lots of friends who smoke cannabis and take drugs all day, then the likelihood is that you are going to too. If you are hanging around with people who don't find that socially acceptable, then it's unlikely that you are going to do that because you are with your peers. (Focus Group 4)

However, despite this being rated as the least important health determinant, other comments in this part of the focus group discussion suggested that many in fact saw social and community networks as extremely important in determining health status at a very local level. For example,

I think from the point of older people, they can feel very lonely and neglected and I think with all the different things they have got for the older people now, it has made a difference … (because) … it keeps their minds occupied for one thing and they don’t get so depressed. (Focus Group 3)

Valued community groups in the local community included social groups for older people and computer classes (Focus Group 3). A large part of the value of such groups was the potential for developing social networks across all age groups:

This is a community service, and they have got this community service which they have got ordinary type people and they are run by voluntary helpers … and I was very impressed - they do two sittings for lunch a day at £3.50 a time; I thought my attitude to that is you can’t get it anywhere else. (Focus Group 12).

The other thing is getting out and being with people. (Focus Group 12).
Social and community networks … are important because if you feel part of a community and you have got friends and stuff, then your self-esteem won’t. … (suffer) …. you will be more encouraged to kind of ‘put yourself out there’ as it were, get involved with other services, meet people, get stuck into stuff, have a good time and that will lift your mental health and that will increase your chances of really getting stuck into other things … (Focus Group 11)

Perhaps the following comment provides insight into why social and community networks were rated lowest in this study:

Politicians are obsessed with this idea of community … but I mean - who amongst us here is a community leader? (Focus Group 9)

This idea that you have a community that is all talking to each other is not very true in many places is it? (Focus Group 9)

**Attempts to rate health determinants as a group**

Overall there was a lot of discussion around ranking health determinants, and one focus group could not reach any agreement:

It's very difficult to put these in order isn’t it? … It is (most agree), because they are all vital aren’t they? (Focus Group 10)

I think we are mixing up what happens to the individual and what happens to a group, and statistically it’s irrelevant whether one individual has a hereditary problem or not, so what counts statistically for a group? Why does one group have a higher life expectancy than another group? (Focus Group 13).

I think it’s clear that we don’t agree - I don’t think anybody would ever agree on this … Essentially this is a highly political question, and that is probably what the divisions reflect. I mean it's political and philosophical … So we don’t agree. (Focus Group 13).

I think actually that there are many different causes rather than just one … people with low IQs aren’t necessarily able are they to realise the implications or how to feed their children properly. (Focus Group 2)
So if you were poorly educated, where you had a poor diet, you have poor mental health - then you might not be in such a good place to make such a good choice … (about diet and exercise) … So it's kind of a combination of informed choice and poverty, but poverty not necessarily being financial. (Focus Group 11)

Some participants felt that many factors – not just one – determined health (Focus Group 2). These included level of knowledge, understanding – including implications of current behaviour on future health, access to health care, peer influence (Focus Group 2) Several groups suggested that:

Everything is important (to health). (Focus Group 3)

You can’t have one without the other and they are both immediate to everybody’s lives - they are immediate, and this is a bit more of a bigger picture. (Focus Group 5)

A range of comments were received on views as to ranking the above health determinants and how participants viewed health inequalities. Some of these are presented below.

**Choice in health behaviour?**

The issue of ‘choice’ was raised in many Focus Group discussions.

When they talk about choice and the reasons why we have choice… you often feel you have no choice. (Focus Group 9)

And a lot of people are not actually taught about healthy eating and things like that. There is no education about it, therefore people don’t know. What people don’t know, they don’t know, it's not their fault but they don’t understand… (Focus Group 4)

Many participants linked health to income, both for preventative factors including a good diet, living environment, but also in being able to access a range of options in health care. Essentially, a higher income was seen to provide choices. Generally income (poverty) was the second most highly discussed issue across all focus
groups and was raised slightly more as a health determinant in higher than lower tier focus groups:

If you have got it, you can stay healthy because you can pay to have health. If you haven’t got no money, you stay ill don’t ya? (Focus Group 1)

(For people living in poverty) … there is just a low awareness really, … you just do stuff, you don’t actually think about things, you know, you are reacting to a situation, … so you might not sit back and think ‘Um, what are my choices?’ … So I think it’s about… a feeling of chaos and panic - you know, we live in a poor environment and you don’t tend to sit back and think what am I going to do now? You just react. So there’s less processing of thoughts and choices. (Focus Group 4)

Participants suggested that income had an effect on choice both for individuals and for groups of people:

They used to say money can’t buy you happiness, but this day and age it’s proving them wrong - it buys anything. (Focus Group 7)
And it's also I think to do with your disposable income - I mean if you are more affluent, you can afford better food and that sort of thing… And your occupations are less likely to be dangerous or hazardous. (Focus Group 13).

I have ‘level of wealth’ because it leads to everything else. Like if you are richer, you can afford better education or you can afford private healthcare or you can afford private healthcare or you can afford to live closer to a hospital; those options which you obviously don’t have, if you don’t have as much money. (Focus Group 6)

The perception of health is worse in a poorer community with less emphasis on the understanding and the importance of health. (Focus Group 4)

If there’s lots of people on a low income living in one area, then it is cheaper to buy convenience foods and fast foods and not fresh fruit and veg … And then because that all happens in one area, then you don’t get local shops that provide any… like if you go to the local shop …, you can’t buy brown bread … And if you don’t have a car, if you can't afford to run a car, then you can’t get to a supermarket … and you can’t bulk buy because you haven’t got enough money each week to bulk buy. (Focus Group 11)
However, not everyone saw available finance as the only part of the puzzle:

No, I don't think it's just down to money, but I think that's part of it. (Focus Group 10)

Stress was seen to be caused by a combination of factors, including minimum wages and unemployment, leading to health damaging behaviours such as smoking and a poor diet:

It's probably because it's a quick fix for stress. To have a cigarette… I have smoked since I was 16 and people that have smoked… (Focus Group 3)

…When you get a lot of stress, what you do is you start smoking don't you? You can see them down the town, sort of walking around aimlessly and stuff like that. (Focus Group 8).

**Addressing damaging lifestyle health behaviours**

Diet was raised time and time again across Focus Groups, emerging as perhaps the key perceived health issue overall. For example,

I have got the most important as poor eating habits … Well I just think that out of all your health, that is what brings your health down - too much fat, you get obesity. I mean if you get too fat, you can't exercise. It causes so many problems and I think a lot of people suffer from that … basically to be able to afford and have decent food. I think that is the beginnings of everything isn't it? (Focus Group 10)

Overall, advertising was seen as a major problem in encouraging good health behaviour. Some referred to ‘supermarket psychology’ and being ‘conned’ in to buying fast food’ (Focus Group 1). Generally it was felt that lower income groups were more susceptible to such marketing:

it's about poverty, having to feed your family on an extremely low budget; it's also this psychology that is bombarded at you. If you go to a supermarket, you walk into the healthy food first, you know, but you are so busy walking into the supermarket, you are less likely to pick that up. Also it's been proven that we are more attracted to red, so if you look at all the fast foods and the stuff that is really bad for you, everything is red. (Focus Group 1)
It's about income and nutritional knowledge which is really what we are talking about. If you have got a limited income, whether you are a single person like me or an unmarried mother or family or elderly people living on a pension and trying to make ends meet… (Focus Group 5)

Lower income groups were seen to be further penalised due to the cost of healthier food – notably organic food (Focus Group 6 and 13) – and the growth of the supermarket (Focus Group 1). There was a perception amongst some participants that it was difficult to access fresh foods as supermarkets had taken over, “destroying the local markets”. Others felt that it was difficult for people living alone to cater for themselves, and that they were pressured into buying in bulk, when traditionally they could have sourced a single chop from a local butcher. (Focus Group 7, 13).

Many participants expressed concern over the lack of cooking skills, which they perceived had declined in recent generations. Many related this to their own wartime experiences of growing their own foods and surviving on rations, regretting the current increase in obesity. This was seen to have many causes, but overall due to a changing culture of preparing and eating food.

I think you might be getting into what we regard as a second generation of defrosters … You know, you might be getting to the stage where you are 23 and your mum got everything out of a box, because she was kind of living in the Fifties and boxes were newly exciting, and those kinds of skills from grandma are a bit lost.. (Focus Group 11).

This was seen to be due to a combination of factors, including a perceived increase in leisure time for some (Focus Group 1) but also an increase in more working hours, particularly by women.

If you are depressed you won’t cook - especially when you are the person who is doing everything. You think oh, not again and the last thing you do want to do, is sometimes when you get home from work is cook a meal because you then have to do the washing, the ironing, sit down, spend time with your child, do their homework and there just isn’t… You know, people who (work) 9 am - 5 pm - there just isn’t enough hours in the day … And yet
the food, the food actually is adding to the depression. People get caught up in that, they get caught up in a cycle don’t they? (Focus Group 1)

There are so many distractions nowadays, people are… not just perhaps with mums going to work, but whatever their children are involved with… so people’s lives are just hectic … Yeah, everything, the whole culture has changed. And life is more stressful because we have more choice. (Focus Group 6)

Many participants noted that diet did not exist in isolation, and that other factors also needed to be addressed:

But I think it's not just the cooking, it's learning the concept of providing for yourself and providing for your kids and your family, it's the whole process. (Focus Group 7)

I think there has been an erosion of some of the skills. I think the awareness of like healthy choice is probably higher than it ever has been and I think it's about how people choose to pick up that message, whatever it may be. And I think it's the lack of skills that mean that there isn't really an interface to connect the awareness to the practical application. (Focus Group 11)

The range of focus groups saw a need to challenge diet through education – both in and out of schools – from the earliest age, and with appropriate interventions at different life stages. As one participant reported, it was too late by the teenage years (Focus Group 11). (“There’s so many types of education - it's not just being at school, it's not just academic” (Focus Group 12).) Participants generally saw education as a way forward in counteracting poor nutrition not just knowledge about healthier food, but also re-learning practical skills in cooking, budgeting and so on (Focus Group 1). Part of this was seen as a task for schools, but also as a wider societal function to be delivered by other organisations, generally the voluntary sector.

Some focus groups – notably Focus Group 6 – has substantial discussion about the need to change the whole culture of food. This was seen to include advertising, convenience foods, school food (including reducing ‘choice’ given to children, which in some instances was seen as detrimental to health) and a need for working mothers to have paid leave to look after their children at critical points to enable
health promoting behaviours to be reinforced, learning from older communities who still possessed cooking skills.

When probed on what might be done to encourage people to change their lifestyles, such as take more exercise, a dichotomous view emerged and comments varied from:

It's up to the individual. (Focus Group 7)

Of course, if you don't use your car so much, you exercise. (Focus Group 7)

Or does it reflect also the lack of sporting facilities around here? We haven't got many swimming pools around here (Focus Group 13)

You have your countryside for walking and running. (Focus Group 13)

Some Focus Groups believed that simple increases in general daily activity and generally keeping busy – not just formal exercise – could pay dividends in improving emotional health:

… get out and do something every day, because if you do one little thing, it leads to another thing, it leads to another thing and then you feel better in yourself and your health will improve, I am sure. Not your physical health, but your mental health. (Focus Group 12).

Drug and alcohol abuse were also seen as health damaging behaviours, with effects in both the individual and wider community through anti-social behaviour. Again, marketing was perceived as a major problem in terms of alcohol sales, and participants saw the increase in alcohol consumption as a longer term health damaging behaviour. Others suggested that drug abuse had overtaken alcohol abuse as a health determinant, both to the user, but also due to the effect on the wider community, perceived crime levels and fear of crime:

… there is a major drug problem in this town, which is causing so much crime obviously as well. It obviously goes hand in hand …Fear of crime, fear of being attacked. There's a high percentage of antisocial behaviour around here - fighting - and a lot of driving while under the influence of drugs as well. (Focus Group 4)
On probing as to whether some adults were perceived as more prone to drug addiction, participants suggested that the situation was becoming out of control, and that the government has in a sense ‘encouraged; the situation as part of the benefit culture: I think it's getting to a stage where it's everywhere. (Focus Group 3).

However, others reported that problems of drug addiction and its consequences were being successfully addressed at very local level. For example,

(We used to find a lot of used needles) ... drug addicts would have been reusing needles, sharing needles and increasing the risk of health problems etc. Now they have got a (needle exchange) clinic on their doorstep, there’s really not a lot of that going on. So that is one instance where you could say that things have improved. OK, you haven't got them all off drugs, but at least they are using clean needles and they are not sharing their needles and they are not spreading disease such as HepB etc and AIDS around - HIV. (Focus Group 4)

Overall, the need for sustainable health changing policies, not just financial poverty reduction, was seen as paramount:

Yes, I think so, as long as it's not just pushing money at them which can then get for example spent on cigarettes. It's a matter of intelligent support, directed support. (Focus Group 6)

**Access to the NHS**

NHS provision was generally seen as good across the region, but problems were identified as including access due to finance, transport, quality of some services locally, knowledge of services and advocacy (Focus Groups 2, 4, 6, 13). Even though the National Health Service (NHS) was free at the point of delivery, participants argued that health care inequalities remained. Participants generally felt that issues such as waiting times presented inequalities (Focus Groups 1,2,3), some admitting that they had opted for private health care in order to reduce waiting times (Focus Group 2), although other participants were very happy with the NHS (Focus Groups1, 2). A dichotomous view emerged in how participants felt the NHS operated:

I think the other thing is lack of National Health facilities. I mean when we were young, we could go to the dentist - it didn’t cost us anything. Now, try and find a National Health dentist, opticians. I have to say I think old Nye
Bevan would turn in his grave - he would - when he sees what has happened to the National Health. (Focus Group 7)

I think it's marvellous the way my doctor's surgery has turned itself around. (Focus Group 7)

Despite the fact that the Health Service gets enormous criticism and in many cases justifiably so, I wonder how many of us around this room would be here now, if it weren't for the National Health Service - I certainly wouldn't have been here … You can criticise it as much as you like - it costs us, it's not free, we are all paying for it, so all our money has gone into this, but it's a wonderful service. (Focus Group 12).

A lot of perceived problems with the NHS were related to service user abuse as well as (unnecessary) bureaucracy:

… and I feel (personally myself) that the Health Service is very much abused, and I think there are too many bloody chiefs and not enough Indians. (Focus Group 7)

We have too many administrators now in the health business pushing paper about which in my view is unnecessary but the government, the hierarchy seem to think it is necessary, but God knows why! Why do they need to push paper about? The doctor knows what he is doing, the specialist knows what he is doing, let him get on and do it! (Focus Group 2, similar comment in Focus Group 4))

Some described the inequalities they saw as part of a 'post code lottery' of care and many related inequalities to issues of access. The following quote useful sums up what many participants were thinking:

… I personally think that location has got to be one of the main factors (including) the quality of a particular practice … (it)... could be the financial aspects ...(or) … public transport which makes it more difficult for me to go to the doctor's - they are far less willing to come and see me because of the distance that they travel and the costs with it - so location has to be a very strong thing. There is also the fact that certain locations are just unhealthy -
you know, the industrial areas have got more pollutants in the air and so on. (Focus Group 13).

Access was seen to be both physical access, around issues such as location and transport (as well as cost of transport) but also due to the particular practitioner and access to further services that this person provided or facilitated (for example Focus Groups 2, 6, 10, 11). Local hospitals were seen as, “All right for basics” (Focus Group 10), although not necessarily satisfactory for more specialist treatment. Similarly, participants’ treatment within the NHS system has raised some concerns about quality and equality of care: “some (doctors) are pretty good but it's so patchy - you know, it's kind of pot luck whether you get a decent GP or not” (Focus Group 13). with suggestions that some patients may be excluded from services as they may be deemed too expensive to treat within the local budget.

Several participants were also concerned about the possibility of infection from hospitals (Focus Group 2), something that has been in the media a lot. Some related this to a lack of practical skills (including the loss of the matron) and an excess of bureaucracy by an over-population of administrators distanced from the medical process.

**Poverty and low morale: escaping the cycle of deprivation?**

Many participants perceived barriers to accessing services.

… people come into the centre and they will say this or they will say that and I will say ‘Why don't you contact this person, or contact this agency and see if they can help you, or this organisation?’ But even once they have got the information, actually empowering that person to take that step… you know, there's a lot of barriers between actually saying to someone ‘Go and see this person’ to them actually doing it. (Focus Group 4)

The barriers being:

Confidence, a fear of being judged; there is a lot of stigma around living in this area in social housing … Their own personal education … Yeah, so I think there are definitely barriers there, it's definitely around confidence … And how you feel about yourself and how you perceive yourself. ‘Well who cares about me anyway? Why should I bother if I have got this wrong with me, or that wrong with me? I will be dead soon anyway’ - and that is just a miserable
outlook that someone might have, and ‘Why should I look after me? No one else really cares.’ ... It's not only that, It's morale as well. (Focus Group 4)

Actually, being able to actually explain I think sometimes but if you have got ... a lot of the people who... (a) the doctor can't understand you, or the doctor can’t understand ... and if you can’t understand the doctor it makes a lot of difference, so it can be that we have got a lot of doctors who are coming in from other countries, that although they may be fine and they may be qualified, but to talk to them sometimes is very difficult because you actually can’t understand what they are saying (to you, or what you are saying to them). (Focus Group 10)

Participants also reported that gaining and maintaining motivation about trying to change was challenging, because things because the results were so far away, plans so likely to change over a period of years, and it was difficult to gain and initiative and to keep that initiative going both for individuals and communities. (Focus Group 4). Participants also reported feeling powerless in the face of government to be able to make any changes. (Focus Group 7).

3.0 Lay perceptions of priorities to improve health locally and nationally

You have got to go back to basics and start with the basics. (Focus Group 12).

There was a general feeling that (primary) schools had become more important than the home / family in education around health, so this was the place to start delivering health education and promotion. This stemmed from a variety of perceived reasons, including parents working longer hour. Comments included:

re-educating people from a young age, maybe like in primary schools ... about how to live healthier and stuff, so that they carry it into their adult lives. (Focus Group 1)

Well if say a child comes from a poor area, they haven't really much idea have they? But if they go to a school and they are taught about decent community living and all that sort of thing, I think it would make a lot of difference to the child. (Focus Group 3)
When we were kids … you didn’t have a morning or an afternoon when there wasn’t a sports period or a dance period or netball or something included in it. That is not in the spirit of people now. (Focus Group 10)

…better education about how to make better informed lifestyle choices earlier on, and sort of clear examples of how the things that you do might impact on your health later. (Focus Group 11)

Yeah, I don’t think education necessarily means school exclusively - health education comes in lots of different forms … Advertising. I think there needs to be more healthy, or health-related advertising on TV. (Focus Group 6)

**Improvements to school and community education, including practical skills**

The groups generally favoured the forthcoming ban on smoking in public places, some questioning why it needed to take so long to introduce such legislation when other parts of the UK had already introduced it. The role of the government was seen as paramount here.

Many recognised the ‘celebrity role’ in delivering health messages, suggesting that the media had enormous influence in health behaviour. Recent media coverage of school dinners for example has clearly had an impact on the groups’ thinking. One participant commented that

get celebrity backing because everybody is obsessed with what the celebrity does so it’s a good way to sort of get messages across to people, because we have tried to get other messages over and it’s never worked (Focus Group 1).

Another took a more ‘hands on’ approach in identifying how they had tackled their “most awful school dinner situation” as well as introducing a Breakfast Club (Focus Group 10) through a combination of health promotion and health education, which were seen to tackle diet, but also help improve behaviour.

Food was considered the most important of the lifestyle behaviours in determining health. Issues discussed by participants included participants’ own experience of food, perceptions about other people’s diet and nutrition – including issues such as available skills in preparing healthy meals, and the effort people were willing or able to put into preparing their own food at home. There appeared a constant tension
between ‘traditional’ home cooking and pre-prepared convenience meals and / or fast foods.

There was frustration around contradictory messages around health promoting food and the advertising of fast food, with confusion around mixed messages. For example,

Well I feel one of the most important things is to have some say in the media presentation, because this is influencing everybody under their very roof - wherever it is - bedroom or whatever, and it's the most insidious business all together to my mind. (Focus Group 9)

we should stop advertisements and use TV to educate more. (Focus Group 2)

selling only health-giving foods in our supermarkets, not the junk we are subject to now and the stuff that hits you from our supermarkets is too overpowering and most of it is junk anyway, and junk is going to give you bad health (and also) … to live positively means the best, or respecting yourself and your body and your community and your neighbour and yourself (Focus Group 5)

… every foodstuff is packaged and it's function is to make money for a corporation which in turn will pay dividends to its shareholders, and a grandchild's wellbeing is much less important than the pension funds of whoever happens to have their pension money invested in the company. (Focus Group 5)

Just take all the adverts away, that will work … They wouldn’t do it, but take all the crisps off the shelves; take all those bad things off, take all the sugar out of all the stuff … They could make it like more healthier. (Focus Group 8)

There was a divide amongst whether participants (or other people) had time to cook amongst competing time requirements. Comments were about the ready availability of fast food outlets and general pre-packaged foodstuffs, reducing time needed to prepare meals, but also of the perceived effort in preparation:

You know, with people’s lifestyles… … the people who produce the food in the family - they don’t have time to spend three or four hours a day in the kitchen. (Focus Group 11)
Well, what I am saying is, there’s a lot of factors working against (us adopting a healthier lifestyle), that are purely economic, yes. (Focus Group 13).

No, but the youngsters of today, they buy things that they can just chuck in the microwave and that is it. (Focus Group 13).

Addressing other lifestyle issues
The food, tobacco and alcohol industries was viewed as being immensely powerful in determining lifestyle behaviour. Packaging and advertising were seen as priority, with “greed by fat cats and manufacturers in trying to sort of flog things to us which aren't for our own good, but how you address that, I don’t know”. (Focus Group 13). Participants linked lifestyle behaviours around food, smoking, exercise and drug and alcohol abuse as key in determining health. Sexual behaviour only featured in very few of the focus group discussions. This was perhaps due to the massive media attention other lifestyle issues have recently received.

Some participants said that they smoked, but found a variety of reasons why not to stop, even when they knew it was health damaging:

Well smoking is an addiction, so set that aside.. I think generally.. it's difficult isn't it? Young people, they do get much, much more information about what is good for you and what is bad for you, but actually I think that it's human nature to think well it's never going to happen to me, and you just carry on in the way.. until something shows you… And I actually feel quite healthy - I don’t do anything healthy but I feel quite healthy, I am not ill or anything. So I think you do what you get away with. (Focus Group 11)

No, I think that (smoking) is a social issue more than anything else. It's peer pressure. Sometimes you are strong enough to stand it and sometimes you are not. (Focus Group 10)

Similar comments were raised in respect of taking regular exercise, or even being more active day to day. Peer group pressure and local support were seen as key. On probing as to what might prevent people taking exercise, participants reported that:

Well the thing is, I would rather do it in a little group, do you know what I mean? Not sort of like with young people, with my own age group and I think
that would make my breathing better and stuff like that … (delivered by) local, local communities. Not these big flashy leisure centres that we can't afford. Just go up the church and have a little group, you know what I mean? (Focus Group 8)

I would like free access to swimming pools because we love swimming and we have to pay to get in, so I would like the Government to make free access to local swimming pools … I would like to go to a gym, but it's far too expensive for me. I would love to go a gym. I used to go… (Focus Group 7)

…I keep meaning to join a gym. It's not that accessible. You have to pay quite a lot of money as well, and if you just get one improvement in health, it can lead to others - it can have a domino effect (Focus Group 11)

**Reinforcing a sense of individual responsibility**

Comments in the focus groups suggested that participants were generally aware of their own health damaging behaviour such as diet, smoking and a lack of exercise. In addition, many focus groups also provided perceptions of other people’s health damaging behaviours. A dichotomous view emerged as to whether health damaging behaviours and healthy lifestyles were an individual’s responsibility, or something that the government or local community group could help address.

Generally many participants were aware of what they could do to take more responsibility for their own health, such as improving their diet, taking more exercise and stopping smoking. However, even with this knowledge, many participants that they did not put this knowledge into action, and also were not able to identify many methods of helping promote health more widely in the community:

But we know all this don't we? But it is hard to stop… (Focus Group 8)

A lot of it really is down to individuals … It's your willpower… you say 'Right I am not going to do that anymore.' (Focus Group 8)

I was going to say that it's very difficult because actually those people that know what is good and what are healthier ways to live, don't do it. (Focus Group 11)
Some participants suggested that knowledge in itself was not sufficient, and that other health promoting mechanisms needed to be readily available and appropriate to local need:

I don’t really think health education is much of a success. I mean most of us are educated as to what is good for us and what is bad for us and we still (do the wrong things) … (Focus Group 13)

Others reported that smoking related illness and death was down to luck:

With regard to the cancer carrying on in families, you have either got the gene or you haven’t. (Focus Group 6)

Some groups were pessimistic about the potential for positive changes in health behaviour:

You can’t see how there is any end to it can you? It just going to escalate on and on and on - eventually it will just finish and you will come to a full stop. (Focus Group 3)

As a result, issues were discussed around which participants felt they could help improve their own health. One issues arising was that of adopting a “positive mental attitude … sick people … get on far better than those who whinge and whinge about it.” (Focus Group 2).

Such an attitude was seen to pay dividends:

… once you get the self-respect… it’s the same as if you walk into a room and you are full of positive energy, and you are thinking positive; positiveness will come out. No matter how frustrated you feel inside, the positive will come out and that’s the balance, that is what we need to find. (Focus Group 5)

Other factors were however seen to be out or people’s hands. Stress was seen as a major contributor to poor health. Participants saw this as multi-causal and related it to low income, but also children and the changing working world. It was also seen as related to the local environment, and pockets of deprivation within otherwise affluent areas were seen to compound it:
... we live in a little pocket in Medway (and Sheerness comes into this as well) because when their dockyard closed there was nothing - we are living in this little pocket of - in some places, total deprivation. You look at some of the houses in the back streets of Gillingham and people living in basement flats in really poor conditions, it's damp, you know ... I think that is what makes it worse. I think you only have to walk two or three streets further down and they become much nicer and much better, so that is that sharp contrast. (Focus Group 1)

Stress at work – and a general increase in, and irregularity of working hours – was seen to lead to lack of time to adopt a healthier lifestyle, such as regular exercise, ability to prepare food.

It just feels that I don’t always take the time to stop I guess, I kind of always try and do something and then when I get tired and worn out and I can’t do it, then I get frustrated and then I get upset and angry and I sort of think some more breaks would help with that, and I would probably enjoy my life better and I would get on with people at work better, if I took the time away from work that I am probably due. (Focus Group 11)

Local, targeted initiatives

Participants commented on a range of local initiatives they had found helpful in addressing health inequalities. Some regretted the demise of local orchards in favour of cheaper fruit imports (for example Focus Group 13). Others discussed local initiatives that helped counteract the loss of local markets for fresh fruit and vegetables, but commented that these also had their limitations. Focus Group 1 suggested that ‘Local Roots’ was a project providing fresh vegetables, but:

One of the reasons that that fell apart was because it was aimed at the poorer people to give them access to fresh fruit and vegetables, but it wasn’t the poorer people that were coming in for the … but it failed completely for people that it was meant to reach (Focus Group 1).

Other participants in this focus group said that they were not even aware of the project’s existence.
Other projects suggested included a gardening project for children to help in several areas including an active use of time, learning about longer term responsibility and food production:

It might take a generation to get to, you know… but it’s all about preventative stuff. It might not work with this generation but in the future… (Focus Group 1)

Some participants were disappointed as to social changes which had led to fewer children playing in parks due to fear of crime, which was seen to encourage less active and more passive lifestyles. This was also linked to a lack of social capital (although participants did not themselves use this term)

… more communication .. And feedback from each other, which I think has always been important, but now lacks - the lack of community spirit is no longer prevalent in my way of thinking (Focus Group 2)

There isn’t a community element. (Focus Group 5)

Other ideas for local initiatives included:

… a local kind of skills exchange, so if someone in your community is good at soup, and someone in your community is good at like exercising on the cheap, then being able to share that knowledge and those experiences might be quite a good way to promote healthy living. (Focus Group 11)

But due to a lack of social capital, many suggested that this behaviour may be seen as suspicious and therefore lacked confidence to try to instigate something, suggesting a lack of platform to get something started.

Being part of a group was seen as a real help in improving health, whether as a person experiencing a given illness or as a carer seeking support.

I think if somebody organised something it might be a bit better. You get a bit lazy don’t you? If somebody came along and said ‘Right….’ (Focus Group 8)

You do need to have other people that are doing the same as you, that you can pick up the phone, you know…You are no longer an island. (Focus Group 2)
Although there was also a need to help ensure that people who could most benefit from such services had the confidence to join. Focus Group 4 for example (one of the more deprived groups), suggested that it was important to ensure that people across all age groups were helped with confidence to join in, the first stage in empowerment. A moral need (not necessarily religious) was seen as an important starting point. Focus Group 6 suggested that what was key was for people to become less selfish and reach out to others, particularly in giving their time to others.

Such groups needed resource support, yet also noted that government funding may come with conditions attached which may undermine the very status of the group:

… this group could actually become a charity - a charitable trust, but then you have got to go - you have got to have books, you have got to have every tiny little nth degree - calibrated - they want to know what you are doing and why, and in the end you think I don’t want to be bothered with all that - we want to be informed and do what we want we do when we want to do it … And let everybody decide what they want to do, rather than be sort of told by somebody up here, well you should be doing this because we have given you this money.’ We don’t want that. (Focus Group 2)

Investment in health services

Participants saw that health services were both proactive and reactive, and that both local authorities and the NHS had a role to play in addressing health inequalities. Participants appeared to appreciate the NHS role over and above the local authority role. Both of these statutory organisations were generally seen as remote, bureaucratic and in some senses self-serving. In addition, participants also suggested that most people would not be prepared to pay more taxation for these public services.

But it is to do with the people who live in our part of the world. There’s nothing invested in public…. They want to keep their money, they don’t want to spend it on public service. I have lived here all my life and I know what it’s like - they are mean. (Focus Group 9)

Local authorities were perceived as having some potential to deliver better health promoting services, although participants also recognised that they had funding constraints on what they could deliver.
Well, I can only speak about what we have tried to do. I mean when we have tried to get free swimming and use of the leisure centres, it all comes back to they are now privately run - they all are aren’t they? And it’s money and the council tax payers don’t want to pay it. I mean we can all have a wish list and say ‘Do this’ but in reality people object to the amount of council tax they pay now. I haven’t got the answer, but in my view, if only the power was as near to the people as possible and you had the money to do the things that are needed to fund a better lifestyle, that is the answer. (Focus Group 9)

Not necessarily the schools - it could be councils if you like - anybody locally and that. So clubs, sports clubs, that type of thing. I mean years ago I was involved in boys’ football quite a lot and the grounds are gradually disappearing and being built on. I mean you have got an example of Pump Lane School - they sold the bottom section of their school and there’s houses now built there. What chance have the youngsters today, your new Beckhams and your Owens, your Flintoffs - there’s not a lot of chance going for them these days I don’t think. Then they all worry about why they congregate outside Rainham station or up Parkwood or various places. (Focus Group 10)

On probing as to whether they would appreciate the opportunity for further participation in the running of public sector services, most participants suggested that they would. However, a view also emerged that most people would not be willing or able to commit time to such participation, and these views emerged from personal experience of other local committees. For example,

What does concern me - I am talking also from where I live - I am on the committee (and only about 40 of 563 people turned up to the AGM) … And it was all us older ones there, you know, and that is what does concern me. It does seem that younger people don’t want to participate in any of these community health services or any of that. The Publication Patient Involvement Panel locally - God, when we go to those meetings, I am the only member of the public there - it’s appalling, and that is where all of the hospital situation - for hospitals right across the area have discussed… and what is going on, and they are so old. I mean I am old, but they are old-old sitting around me, you know? (Focus Group 9)
Well have these clubs, try and get them up and running. I mean I have tried it in the past with various things and you might as well talk to that brick wall to be honest. (Focus Group 10)

Many participants argued that employment itself was beneficial to health as encouraging a more active lifestyle than those on benefits were perceived as having. It keeps your brain ticking over doesn’t it? … It gives you something to get up for and go out and do … It’s respect for yourself … You wouldn’t get up every morning would you? … You have got to have respect for yourself; nobody else can give you that, only yourself. (Focus Group 10)

Several focus groups raised comments around how they perceived a benefit dependent community to behave, and suggested that government policy had encouraged benefit dependency (for example Focus Group 3). Other groups suggested that this might be because house prices were so expensive locally that it left individuals with little choices. This in itself was seen to have engendered a new form of benefit dependency that had created a culture that was very hard to escape:

Some of these children … know they are never going to work, they know they are never going to get a job, they know they are going to get on benefits; they know - it's in them, ingrained in them … These young girls with all these young families now - I mean they could be educated, but they are not, they are educated the wrong way. They get straight down the road and they get handouts, straight away. When I was a little 'un, if you turned down three jobs, your benefits were stopped … Why are we giving everything for nothing? … Some people want something for nothing in this world. You have got to earn what you want. (Focus Group 10)

**Let hospitals decide where money is spent**

Generally participants were happy with the NHS locally, although some have concerns over access, ‘post code lottery’ conditions and so on, as previously outlined. Many observations were made in respect of how and where available money was being spent.

There’s never going to be enough money - no matter how much they put into the National Health, there will never be enough money, really, in all honesty
... I don't think (the government) should take more tax (for the NHS) but they should spend it in better ways. (Focus Group 11)

Look at all the money they are putting into the Health Service, and what good has it done? (Focus Group 13).

Participants saw a lot of this waste as having the potential to be redirected toward more efficient management, more front line practitioners and less administrators, less bureaucracy and generally tightening up on all functions.

I think we should cut down on the many administrators because there are more and more and more people organising things - you know, what are the end results? We could save money on all these committees and I know it's old-fashioned, but going back to your matron which they are trying to do aren't they? More discipline in the hospitals and that leads to hygiene doesn't it? (Focus Group 12).

Yes, it's the little managers who are running around - there are too many of them - they are too expensive. (Focus Group 12).

Overall, Focus Group 4 summed up a lot of what the groups were thinking was needed:

More funding.
More training.
Education.
More education.
Prevention, not cure.
Less bureaucracy. (Focus Group 4)

**Local government role**

Although the local government role did not feature as highly as the NHS role in this study, participants made comments about what could be done at local level to intervene. Comments ranged from interventions arising from loss of major industry locally, to provision of more affordable housing, to taking on a more appropriate workforce who were sensitive to local need (for example, Focus Group 1).
4.0 Lay perceptions on public involvement in policy and strategy to reverse health inequality

Much of this material has already been covered in section 3 above, particularly in respect of people taking more responsibility for their own health. Focus Group 1 suggested that people tended to deny their own health damaging behaviours. This went hand in hand with taking even small steps toward more socially responsible behaviours, which could have a snowballing effect:

But in the end a lot of our health, the state of our health is up to us isn’t it? You know, how we live and what we do and whether we bother to go to the doctor’s if we think something is wrong. (Focus Group 1)

When probed on whether more proactive individuals could affect policy making, some were sceptical:

At the end of the day I found it always boils down to like resources and money and what they can do at that time, or ‘we will look at that in the future.’ That is what I have found, me personally. (Focus Group 1)

Yeah. I have kind of lost heart in it actually, and sometimes I just don’t even bother finding out what is going on because I think well what is the point? They are looking after themselves again - they haven’t changed much so… (Focus Group 1)

… local government have lost contact with the people it’s supposed to serve. I mean they are there to serve the community, give the best services and make sure that the services are the best that we can get for our money, but they don’t listen to what we have to say. But then, on the other side of the coin, how many people actually get off their backsides and go and vote? (Focus Group 1)

Participants suggested that health behaviour was a partnership relationship between individuals and the government:

I think it has to be a two way thing. I think individuals have responsibility, local authorities have responsibility and national government has responsibility. But people get all confused - we have become very
dependent… we are a very dependent culture, and I think that is where the confusion lies … But I don’t think it's confusion as much as I think it's because we haven't got the power they have. But when you try to put... when we have tried, we have been ignored and in the end you get so used to being not-listened-to, that you just give up … your little voice is not going to be heard over millions of voices. (Focus Group 1)

Some participants reported that it was actually local community groups that had provided the real impetus for change. One of the key features was reported as being a revi

val of social capital (although that term was not in itself used by any participants). Making an initial effort for example to get communication going again in a local community – through a local community group – was seen to provide the foundation for further advocacy. For example, the Medway Credit Union was seen to have addresses a lot of mental health problems and stress as a local need in helping people with financial worries (Focus Group 1).

Individuals reported that they had personally taken the initiative for local projects. For example:

It's a very small local thing, doing what you believe in and things like that, like I believe in recycling so everything gets recycled in my house and I believe in caring for people, so I speak to everybody and it's just about doing those small things, and then you get a group of people who are quite like-minded and that is when you can push things forward (Focus Group 1)

Such initiatives were seen to Replace what used to always be there naturally, you know, and if people are working to a community-based model, then that is where it's getting people involved. (Focus Group 1)

…get together and do something. Singularly you can’t do anything. You need a lot of people, you need other big voices to keep on and on and on. (Focus Group 2)

A dichotomous response emerged, even within focus groups, as to whether the public could really make change. For example:

But they will not give us the money for research … they cannot budge the government into letting us go forward doing the research, and the reason is
this government are worried we are going to sue the lot of them … we are like an angst in the cornfield shouting at the government - they don’t want to hear us - they just don’t, so you cannot change anything, no matter how big your lobby is.

I don't agree, I don’t agree with that. I am not saying that you are going to change the world, but we can make inroads but you have got to keep on until you are a bloody nuisance basically and until they have had enough of you, and that is the only way … unfortunately, that is what you have got to do these days. (Focus Group 2)

Generally, change was seen to be needed from the general public, local government and the NHS working together. Focus Group 3 suggested that the local council held primary responsibility for promoting health locally. There was discussion again about who held primary responsibility to health, with some participants maintaining it was a personal responsibility:

Well they were saying about people's health issues and saying it's their own responsibility. Alcoholics have to deal with their own illness - if they choose to drink, that is their choice - the NHS ain’t going to supply for it any more.

But what happens when that person hasn’t received treatment, has a head injury or concussion from falling over from being drunk, and then attacks someone in your community and nearly half kills them? (Focus Group 4)

There was a general view held by participants that the public had to approach the public sector in the right way to make changes, but that a petition in itself was insufficient and that more active steps also needed to be taken. The very process of starting to become active in campaigning and meeting with other like-minded people was seen to have a snowballing and empowering effect. This became particularly clear when the community started to mobilise around a specific issue of local interest. For example,

Well I am actually active in a campaign at the moment; I am not going to say what it is, because it is political and we are empowering ourselves to do something about the state of something, and basically unless people take the actual initiative and say to themselves, actually yeah you know, if we do actually get together, if we do actually talk to people, if we do actually change the way that we are, we can prevent this, we can stop it, we can actually put a
proper government into power, we can have everything working in balance how we want it to, but at the moment, the way things are and the way people are, there’s just not enough people to empower themselves. (Focus Group 5)

Part of me does think that yeah, because I know that you could really get into it and make… you know, spend a lot of time writing letters and all sorts of things and at the end of the day, would you make a difference? I think all of us could make… if everybody made a step, then you could make a difference, but you could… you know, on the other hand, you could spent a lot of time and energy and get nowhere at all. (Focus Group 6)

On probing, participants felt that they were powerless alone, but meeting with and working with others in the community – perhaps with those who were already active in campaigning – provided an enormous boost to their confidence. Many comments were made from the more deprived Focus Groups.

They need to be helped by people in the community who may be slightly better at speaking out on their behalf. (Focus Group 5)

I mean I actually make posters, I make hand-outs, I make DVDs and I just give them out free to people - I don’t charge people anything for it. You can organise - you know… groups such as this, you can speak openly to people, you can write a seminar about problems in our area, you could organise street schemes like somebody said earlier. (Focus Group 5)

Yeah, well I am part of a community group. Sometimes they just think you are just being busybodies but you are not. (Focus Group 5)

The structure has got to be there for the community to survive - that is the important thing. You need to have a structure. (Focus Group 5)

**The value of local projects**

Some focus groups were able to point to specific examples of local community groups. Focus Group 5 identified a local children’s growing club, which was seen to benefit the children involved, but also to provide a ‘feel good’ factor to the adults involved. It was argued to be a useful activity both to entertain children, but also in a wider public health role of encouraging healthier eating as children learned how
foods grew (“we are planting carrots, radishes, beetroot, lettuce”. (Focus Group 5). The advantages were seen as being that children could see something grow, that they began to appreciate that food came from somewhere other than a supermarket shelf and that it started to get children interested in small scale local projects.

Another example was a local community café (Focus Group 6). This was seen to help promote more responsible individual attitudes toward health, as well as helping develop confidence and building social capital in the local community. However, there were also comments to the effect that so few people still knew of the café’s existence, and it was unclear why. Those involved found it an enormous boost locally to public health, and one participant observed that, “If we had this going on all over the country, then things would happen wouldn’t they?” (Focus Group 6).

Belonging to any type of local community group, so not being passive, but active in daily life, was seen to have an effect on mental health too, because:

- We are not sitting in front of a television watching things all day. (Focus Group 13).

- I do think keeping busy is… ‘use it or lose it’ - that is what they say, don’t they? (Focus Group 13).

- The person with a serious illness can always find someone worse off than them, you know, by mixing and talking with other people, so a lot of it is.. it's also a communication. (Focus Group 13).

**Decline of social capital**

Several focus groups reported a decline in social capital (although they did not use the specific term) as being a key factor in the decline of public health. Outcomes of this decline were seen to be a lack of social interaction, lack of time, preoccupation with other issues (Focus Group 8). An increase in social capital could help to create change:

- So therefore, if we want to change anything, we have got to change it within what we live, but whether we can influence other people - I suppose if we influence our own children and our own children then make friends with somebody who doesn’t eat something that is quite good, then they might eat something and then they will
be a fitter person or will go [out with them]. It's this ownership thing and what we can do to perhaps change what we see in our own circle. (Focus Group 10)

Empowerment in public decision making?

Various views emerged as to how the participants felt they were able to become involved in the decision making process. Some felt completely powerless, even though they had made and effort to attend meetings (“They are still going to do what they are going to do” (Focus Group 8), and this compounded the disappointment and feeling of powerlessness further (“I don’t see why they ask; it depresses you because (the local council) ask, and then ignore” (Focus Group 8).

Some groups felt they had no voice at all, others felt that they had an enormous voice – but no overall pattern emerged based on area, status, mainly appeared to be due to individual personalities within the group.

I think you can do all sorts of things. I know that in my family when something went wrong, we had a problem, we went to the Social Services, we wrote to the MP, we wrote to the Head of Social Services, we wrote to the local doctor, we wrote to everyone and we got it sorted, so I do think that you CAN change things. But whether you can change things as a whole, or whether you can just change it (locally).

Well I think you can change things (2 people agree).

I don’t think as individuals we can.

... Yeah, it's got to be done in groups.

You have got to be strong.

I don’t think individual… You can like you were saying - for an individual… like within your own cell, but he is talking about across-the-board aren't you?

(Focus Group 10)

On probing as to whether participants felt empowered to be able to change decision making in the NHS, it was generally felt that there was no real forum. It was suggested that no one is accountable to such a course of action (Focus Group 10) but that such forums existed for complaints against existing – rather than proposed – services provided. This was usefully summed up by the following quote:
But if you want to change something, that’s not the same as having a problem, is it?

But if you want to actually say ‘I don’t think that you are doing that correctly and it ought to be done that way; - yeah, I think I could do that because I would go straight… I’d write enough letters to MPs and people like that - right to the top - I wouldn’t bother with anybody … because it’s not the same as having a problem. It’s actually seeing and thinking to yourself, they are wasting money, I need to get that altered, so I am going to really start a clean slate.

In this respect, the general public were not aware of where to go or who to approach if they wanted to change something.

If you have got a complaint, yes because you have got a definite complaint and they have a complaints procedure. They have to have one by the law now, so that would be there. But if you want to change something…

Therefore something that could be helpful would be to,

… have a great big sign up in every single hospital, all over every ward and everything like that - you know, if you see something that will save money; if you see something that can help somebody have a better life through changing it, write to this person or telephone this number (Focus Group 10)

**Putting knowledge into action: taking personal responsibility for health**

You can’t tell other people what to do, can you? The government can advise by giving information out, but I don’t think you can actually do anything (Focus Group 10)

I think people take responsibility for themselves in things like walking… not getting in the car to go and get a newspaper if the newspaper shop is five minutes away - walk there. That would be much better - that would make a lot of difference to young people. (Focus Group 9)
Making a start on reducing health inequalities locally

A variety of attitudes emerged. Some participants commented on how they felt they had been able to make a difference. A general view emerged that there was a point to trying to change things. Some participants suggested that the starting point was talking to people already known in the NHS and local government, with the overall purpose of encouraging greater equality, albeit on a limited basis: “And I disagree that it’s just up to the local councils and the NHS, but I agree that I might question what difference I could make” (Focus Group 11).

One problem seemed to be that:

… health policy is such a small part of the wider government policy … if I can vote on different policies because I voted for a party that’s now building policies; if I have more control and more voice in the policy making programme, and if I felt that I could better influence how policies were made, regardless of who is in power at the time, then I perhaps would feel that my efforts would make all the difference - through lobbying groups and things I think. It’s about getting the volume of people behind you, not people as individuals or it’s very difficult to make those strategic changes to policy. (Focus Group 11)

On probing as to how one might start a campaign locally, participants suggested that they might contact their local councillor, attending meetings, making timely and relevant complaints through the existing channels: “you know, there’s a lot more notice taken than people reckon; maybe they are not very good at feeding back what we are going to do with that” (Focus Group 11). The priority issue to address was to ensure that, “you can prove your case”. (Focus Group 11).

The overall theme emerging was to be positive:

All this whinging - this is a whinging society now, it’s terrible. Get on and improve it! … you have got to get people to get off their backsides and do things. (Focus Group 12).

Summary: simple solutions to a complex problem?
I really don’t think there’s any simple answer to any way that the inequalities can be reduced. I mean if everybody was in the same place, if everybody had the same doctor, if everybody has the same access, then you are starting to reduce inequalities of course - but that is not a possibility is it? I don’t think it is possible …

or

There’s things we can do to help each other to stop people becoming sick. Realistically there, the list is almost endless …

So if you inform yourself of sort of good hygiene and health practice, and then educate your children and try and influence other members of the community to follow those precepts, then you - gosh, you have got it cracked!

It's so simple - why don't we do it? (Focus Group 13).

Conclusions and recommendations
References


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<thead>
<tr>
<th>Author</th>
<th>Year</th>
<th>Research</th>
<th>Summary</th>
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</table>
| Blaxter & Patterson | 1982 | A wide-ranging study into the health related behaviour of working class mothers                                                                                                                            | • The concept of ‘good’ food first emerged  
• Food shopping is limited to the range of foods available in small local shops and mobile shops                                                                                      |
| Blaxter & Patterson | 1983 | An investigation into the meaning of food to two generations and their attitudes towards the diets of their children or grandchildren                                                                           | • Older generation: ‘goodness’ was found in hot, simple and natural food with ‘meat’ and soup being the most common sources of ‘goodness’  
• Younger generation: had more varied beliefs about ‘goodness’ with less emphasis on meat and more on milk                                                                 |
| Pill            | 1983 | A study of mothers’ awareness of the links between food and health                                                                                                                                        | • Half the women did not perceive diet as relevant to the causation of illness yet the majority of these women considered food essential to keeping their families healthy  
• Most common definition of ‘Good’ food was fresh food  
• Half the ‘fatalistic’ mothers defined ‘good food’ as ‘cooked food’, placing a high value on ‘good’ meat  
‘Lifestyle’ mothers did not
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<th>Author</th>
<th>Year</th>
<th>Title</th>
<th>Sample</th>
<th>Findings</th>
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</table>
| Williams | 1983 | An investigation into the diet of an elderly sample, and its relationship with exercise and virtue | 70 people aged >60 divided by social class                                                       | • Beliefs about food need to be interpreted in the broader context of health beliefs and practices  
• Food was bound up with the relation of parent and child and marriage and widowhood.  
• The logic of health food was tied up with corresponding ideas about health activity  
• Beliefs were influenced by the history through which the participants had lived  
• All middle class women/the vast majority of working class women saw diet as essential to maintaining health  
• Fresh food was emphasised by both groups as essential to a ‘good’ diet  
• Middle class women placed great emphasis on the need for a balanced diet high in fibre but low in fat and carbohydrates  
• The working class groups placed greater emphasis on the need to have substantial meals that contained meat and two vegetables  
• Diet was seen as a major element in maintaining health. |
and health between middle-class and working-class households

Sample: A small number of households from social classes I/II and IV/V

- Concepts such as ‘good’, ‘bad’, ‘healthy’ and ‘unhealthy’ food differed by class
- Definitions of ‘balanced diet’, ‘square meal’ and ‘proper meal’ differed between the social classes
- Patterns of food consumption also differed

Backett & Alexander 1991 Research into health related beliefs and behaviour of young children (4-12 years old)

Sample: Interviews with 54 children aged 4-12 of middle class couples

- The children were well informed about foods conventionally deemed to be ‘healthy’ and ‘unhealthy’
- However, questions about food preferences and the effects of certain foods revealed contradiction and confusion
- Children were more aware of the negative effects of ‘unhealthy’ foods rather than the positive effects of ‘healthy’ food

Ross 1995 A study of schoolchildren’s food choices and preferences

Sample: 46 11 year olds (the entire year group)

- Food choice was not determined by the health attributes of food but by values of preference, play, socialisation and convenience
- Healthy foods were associated with the concept of a proper meal and homemade food
Keane 1997  An analysis of how people view healthy eating information

Sample: 134 interviews with men and women from a range of classes, ages and ethnicities

- General information concerning healthy diet was not seen as applicable to an individual’s own situation
- There was a tendency to homogenise information sources, with the perception that information from interfering external sources which had little understanding of real life
- The media was seen as an unreliable source
- Personal experience and knowledge was seen as the most reliable information source

Turner et al 1997  A comparison between UK and Greek children of attitudes about dietary fat and health

Sample: 4 focus groups in each country with children aged 10-11

- Perceptions about fat and health were very similar
- The majority of children were able to explain the relationship between fat and health in general terms but had little understanding about the function of fat in the body

Watt & Sheiham 1997  A study of young people’s perception of food

Sample: 81 13/14 year old children selected at random

- Many young people classify foods into either ‘healthy’ or ‘fast’ foods
- Acceptability of foods differed between adults and young people
<table>
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<tr>
<th>Authors</th>
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<th>Sample</th>
<th>Findings</th>
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<tbody>
<tr>
<td>Johnson</td>
<td>1998</td>
<td>An exploration of fruit and vegetable consumption in elderly people</td>
<td>445 people aged &gt;65 were randomly selected</td>
<td>Only 37% (urban participants) and 51% (rural participants) ate the recommended five-a-day fruit and vegetables</td>
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<tr>
<td>Chowdhury et al</td>
<td>2000</td>
<td>An investigation of the food beliefs and practices of British Bangladeshis with diabetes</td>
<td>40 first generation adult immigrants</td>
<td>Food were not selected in terms of Western notions of food values, Strong religious restrictions and ethnic customs influence food choice, Binary classification systems (e.g. strong/weak) have replaced the 'hot/cold' classification of South Asia, The importance of dietary balance to health was recognised</td>
</tr>
<tr>
<td>Noble et al</td>
<td>2001</td>
<td>An exploration of children’s perceptions of the healthiness of foods served at school and how these relate to their preferences</td>
<td>123 9-11 year old children selected randomly</td>
<td>Children were found to have a clear perception of healthiness and good nutritional knowledge, But, the relationship between food/nutrients and health was rarely evident and there was difficulty in identifying invisible fat</td>
</tr>
<tr>
<td>Hill et al</td>
<td>2002</td>
<td>A study to understand why consumers choose or</td>
<td></td>
<td>Purchase of such products was influenced by health</td>
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reject reduced fat foods  
Sample: 90 consumers interviewed at locations chosen for their socio-economic characteristics  

- The sensory properties and trust in such products needs attention  
- Socio-economic status and gender differences were apparent in relation to parental control over food and children’s nutritional knowledge  
- The children’s young age was reflected in their food-health and food-nutrient associations  
- Concrete food classifications were identified  

Hart et al 2002  
A study to assess the nutritional knowledge and understanding of primary school children (7-11 years)  
Sample: 23 focus groups of children separated by age, gender and socio-economic status  

- Influences included access to fruit and vegetables in childhood, aptitude in the kitchen, experiences of food throughout their lifespan, concern with self-image and life course transitions  

Blane et al 2003  
Research exploring influences on dietary choice in early old age  
Sample: 31 people aged 67-77  

- Both external and internal barriers were observed  
- A demand for interventions focusing upon behavioural techniques rather than fact transmission was uncovered  

Hart et al 2003  
A study to assess parental perspectives on promoting healthy diet amongst primary school children  
Sample: 41 parents in 7
• Focus groups separated by socio-economic status

White 2003

An investigation into the knowledge, attitudes and beliefs of families to identify the barriers into eating ‘five-a-day’ fruit and vegetables

Sample: 1 focus group consisting of low income rural families

• Parental empowerment and realistic definitions of behaviour to tackle children’s weight issues were identified as key targets

• The main barriers were lack of availability, low-income, transport problems and lack of cooking skills
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<tr>
<th>Author</th>
<th>Year</th>
<th>Research</th>
<th>Summary</th>
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</table>
| Helman           | 1978 | Describes folk models of illness in an ‘ordinary’ English suburban community in London. | • It is possible to develop a folk classificatory system distinguishing between the subjectively hot and cold illnesses.  
• GPs have reinforced many aspects of folk models of causation for colds/fevers/chills as they give diagnoses that ‘make sense’ in terms of reference to the folk model.  
• Catching a cold seen as losing the battle against the environment – therefore colds are avoidable and the individual’s responsibility.  
• Fevers enter the body at their own volition and are therefore uncontrollable with no responsibility subjugated upon the victim. |
| Blaxter and Paterson | 1982 | An exploration of the hypothesis that perceptions of health experiences might, in poor socioeconomic experiences, create attitudes of apathy towards health that are | • Many lay notions of cause were factually inaccurate; however there was a complexity and subtlety of thinking across generations about the aetiology of disease.  
• Older women were more
transmitted through generations.

Sample: 58 3 generational working class families likely to ascribe disease to stress and neglect.

- Heredity was given much more weight among the lay participants than among the medical profession, and normal degeneration of the body less weight.

- The younger generation were more likely to profligate about the cause of disease.

Pill and Stott 1982 Interviewed young Welsh working class women concerning their ideas about illness causation.

- At least half the sample held fatalistic views about illness causation. These women were only prepared to accept the concept of blame under very restricted circumstances involving direct risk taking.

- The remainder of the sample were prepared to recognise that individual behaviour has some part to play in illness causation but they were more likely to accept that neglect of oneself could reduce resistance to illness.

- The success of health promotion schemes depends on how far the notion of individual responsibility for one’s own health is acceptable to the general public.

Blaxter 1983 Analysed the concept of ‘Categories’ of cause can be
disease and its causes, as perceived by a group of Scottish middle aged women brought up in poor social circumstances.

- Lay models of causal processes were frequently scientifically inaccurate in detail but were not in principle unscientific and unsophisticated.
- Cause was perceived to be multifactorial and mind and body were not differentiated.

Cornwell 1984 Examines commonsense ideas and theories about health, illness and health services in a group of families in East London.

Sample: 15 men and 9 women - 'typical' working class people

- An examination of health beliefs using an ethnographic approach can take into account the influence of structural and cultural elements.
- Distinguished between public and private causes of illness.
- Public theories of the causes of illness draw attention to aspects of experience, ideas and values that people believe are acceptable to doctors and compatible with a medical point of view.
- Medically unacceptable and incompatible opinions and values are stated in private accounts of causes of illness.

Pill and Stott 1985 Explores working class Welsh mothers’ attitudes to health, concepts of causation and

- Replaced the dichotomy of ‘fatalists’ and ‘lifestylers’ with a Salience of Lifestyle Index (SLI) to assess the extent to
responsibility for illness. which women in the sample were committed to the idea that day to day choices in diet, exercise and personal habits carried implications for further health.

- Those women that scored higher on the SLI were significantly more likely to exhibit healthier behaviours.
- 20% of mothers rejected the idea of blame completely, 39% were prepared to accept it under very restricted circumstances involving direct risk taking and 41% acknowledged the role of individual habits. There is an association between the amount of formal education and willingness to accept the relevance of lifestyle and personal responsibility for health. Those that score higher on the SLI were more likely to exhibit the type of health behaviours generally thought to be appropriate.

Calnan and Johnson 1985 Explores the relationship between social class and health beliefs and perceived vulnerability to disease

- The concept of personal vulnerability was shown to be problematic with theories of vulnerability similar for both classes
- Feelings of vulnerability can be stratified into five
and 30 from classes IV and V categories: resusceptibility (respondents thought themselves vulnerable because they had previously suffered from a bout of it), symptomatic, heredity, related behaviour and direct experience

- Social, economic and environmental factors were not mentioned as variables explaining vulnerability by the women

Calnan 1987 Examined lay theories about disease causation for heart disease, depression, arthritis and cancer. Compared the beliefs of women from social classes I and II with those from social classes IV and V.

- Lay theories are complex and sophisticated and parallel modern scientific theories.
- People hold specific theories about a range of different diseases.

Blaxter 1990 A population level health and lifestyle survey.

- There is general lay agreement that health is dependent on behaviour and in one’s own hands.
- Beliefs about health as a general concept and disease must be distinguished.
- Higher educational or social class groups, and the young are more likely to mention both ‘voluntary’ behaviours and factors outside the
individuals control.

- Those in the poorest circumstances and environments very rarely attribute their ill-health to their situation and have learned to blame their own behaviour.
- ‘Inequalities in health’ are not seen as issues relevant to people’s lives.

Davison et al 1992  An investigation into the popular culture of prophylactic behaviour in South Wales

Sample: 180 adults of both sexes and a range of socio-economic circumstances

- The everyday cultural practice of ‘lay epidemiology' is involved in accounting for illness misfortune and in assessing the potential benefits of prophylactic behaviour change
- Older generations were more likely to hold fatalistic attitudes towards illness causation

Blaxter 1993  An investigation into concepts of blame and illness responsibility among middle aged Scottish women from social classes IV and V.

- Illness was primarily one's own responsibility.
- Class inequalities were not dwelt upon because the participants were conscious of the environmental perils of the past which have been largely eradicated.
- Participants often held an equilibrium of ideas which might seem opposed.
Papadopoulos 1999  An investigation into the health and illness beliefs of Greek Cypriots living in London.

- Stress was considered to be the primary cause of ill health.
- Ill health was also reported to be linked to poverty.
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<th>Author</th>
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<tbody>
<tr>
<td>Backett &amp;</td>
<td>1991</td>
<td>Research into health related beliefs and behaviour of young children (4-12 years old)</td>
<td>- Physical activity was considered to promote fitness and health</td>
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<tr>
<td>Alexander</td>
<td></td>
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<td>- Photographs of sedentary activities were judged to be unhealthy because they were physically inactive</td>
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<td></td>
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<td></td>
<td>- Public accounts of healthy activities contrasted with private accounts of their own lives</td>
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<td></td>
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<td>- It was easier for the children to think of healthy behaviour than unhealthy behaviour</td>
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<td>Stead et al</td>
<td>1997</td>
<td>An investigation of older people’s perceptions of aging and physical activity</td>
<td>- Older people are unlikely to engage in exercise for its own sake or for health reasons</td>
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<td></td>
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<td></td>
<td>- The social aspect of exercise was deemed to be its most attractive feature</td>
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<tr>
<td>Johnson</td>
<td>2000</td>
<td>An examination of the degree to which there are distinctive ethnic barriers to exercise and other</td>
<td>- Some explanations for not exercising are specific to religion, gender or generation – indicating that a homogenous</td>
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physical activity amongst communities of South Asian origin living in England

Sample: 22 focus groups comprised of British Asians

- The communities were well-informed and well motivated and took advantage of local facilities

Mulvihill 2000

A study examining factors influencing children’s involvement in physical activity

Sample: 60 children aged 5-11 (paired interviews) and 38 parents (interviewed in groups)

- Involvement was influenced by perceived enjoyment and social and cultural aspects
- Engagement in physical activity was less enthusiastic among some of the older girls

Flintoff & Scraton 2001

A study assessing 15 year old girls’ attitudes towards physical activity and physical education

Sample: 21 15 year old girls

- Contrary to concerns about girls' ‘dropout’ from physical activity and perceived lack of interest, the participants were involved in a wide range of physical activities and defined themselves as active
- They appeared to be positively influenced by contemporary discourses about the benefit of
Clayton & Ruston 2003 An exploration of women’s’ beliefs about exercise in relation to key messages about physical inactivity and coronary heart disease

Sample: 50 women with heart related problems and 33 women without

- Women related to exercise primarily in terms of losing weight, looking good, staying mobile and keeping fit
- Moderate physical activity was deemed most effective – activity inherent in women’s domestic lives provided this
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<tr>
<th>Author</th>
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<td>Mullen</td>
<td>1992</td>
<td>An analysis of health behaviour and work context among men</td>
<td>• Participants saw tobacco as a means of coping with pressure at work</td>
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<td>• Tobacco was used at certain times as a self-given reward</td>
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<td>Sample: 70 Glaswegian men</td>
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<td>Allbutt et al</td>
<td>1995</td>
<td>A study examining the social image of smoking among young people</td>
<td>• Smoking was a social and group activity</td>
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<td>• It was a behaviour which young people held contradictory and ambivalent attitudes</td>
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<td></td>
<td></td>
<td>• Smokers viewed their own behaviour and that of others differently</td>
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<td></td>
<td></td>
<td></td>
<td>• For many smokers, smoking was part of their social and cultural worlds e.g. the focus of specific concerns such as weight loss</td>
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<tr>
<td>Amos et al</td>
<td>1997</td>
<td>An exploration of smoking behaviour self image and ideal image amongst young people</td>
<td>• Smokers (male in particular) embraced certain dimensions of self- and aspirational image of which druggy, tough and tarty are signifiers</td>
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affluent and deprived areas in Scotland (Age: 12-13 and 15-16)

Michell 1997 A study investigating young people's perceptions of peer groups and smoking
Sample: 36 11 year olds and 40 13 year olds monitored over 2 years

- Different groups of pupils smoke for different reasons which are related to pecking order and group membership
- Smoking was associated with three major groups: the top-status girls, the low-status pupils and the troublemakers

Michell & Amos 1997 An investigation exploring the interrelationships between smoking, peer group structure and gender
Sample: 40 13 year old girls and 36 11 year old girls in West Scotland

- Smoking behaviour is shaped by gender
- Hierarchical peer group structure was closely related to smoking behaviour
- Only a small number of girls fitted the stereotype of the young female smoker with poor social skills and low self esteem
- Girls at the top of the social pecking order were most likely to smoke

Lucas & Lloyd 1999 An investigation of girls' smoking and group identity
Sample: 33 focus groups with girls in

- Any understanding of smoking among girls needs to incorporate the dynamic of girls' membership in groups of never, experimental and
Porcellato et al 1999 A study investigating primary schoolchildren's perceptions of smoking

Sample: 50 4-8 year olds

- The children possessed negative attitudes and beliefs about smoking
- They had yet to establish regular smoking behaviour
- They had a broad understanding of the nature of smoking

Stead et al 2001 Research to explain why smoking is associated with place of residence

Sample: 8 focus groups selected according to age, gender and smoking status in Glaswegian disadvantaged communities

- A stressful environment, strong community norms, isolation from wider social norms and limited opportunity for recreation foster smoking and undermine cessation
- Support network and identity encourage rather than challenge smoking

Wiltshire et al 2001 A study to understand the behaviour and attitudes related to smoking and contraband tobacco in socially deprived areas

Sample: 50 male and 50 female participants

- Most smokers wanted to quit but felt unable to because of the importance of smoking in their daily routine
- Contraband tobacco was viewed positively as a service and attitudes were unlikely to change
aged 25-40 in two Scottish deprived communities until government did more to help smoking cessation

Parry et al 2002 A exploration of how smoking among older smokers with a smoking related illness is influenced by the wider cultural context of smoking

Sample: 22 current smokers with arterial disease aged 65-84

- Participants view of smoking as a socially acceptable behaviour of their youth had undergone significant change
- Some Participants continued to associate smoking with their participation in social activities, others smoked at home alone and associated smoking with increased levels of isolation in their lives.

Bancroft et al 2003 An examination of disadvantaged smokers' perceptions of habit and addiction

Sample: 50 male and 50 female participants aged 25-40 in two Scottish deprived communities

- Daily contexts which smokers inhabit either constrain or facilitate smoking behaviour
- Gender differences in smoking behaviour were related to the different daily contexts which men and women inhabit
- Influences on smoking were closely related to circumstances of socio-economic deprivation

Copeland 2003 An exploration of the problems faced by young women in

- Smoking in this group is a socially and culturally ingrained behaviour
disadvantaged circumstances if they want to give up smoking

Sample: 18 female smokers aged 18-40 living in areas of deprivation in Scotland

- It is a coping mechanism
- Guilt was the overriding emotion associated with their smoking behaviour
- There was a sense of hopelessness associated with attempting to quit smoking
- Most participants were highly motivated to give up smoking but reluctant to receive help from their GPs
- Smokers and health care workers had different beliefs about effective cessation techniques

Grimshaw et al 2003 A survey to explore attitudes and experience of young smokers’ attempts to quit, use of cessation services, barriers to access and nicotine replacement therapy

Sample: 15-19 year olds from both deprived and affluent areas (Postal survey with depth interviews and focus group validation)

- Teenage smoking is characterised by optimism about quitting despite the failure of many quit attempts, lack of regard for existing services and barriers to uptake
MacFadyen et al 2003 An investigation into student perceptions of smoking images in youth magazines

Sample: 12 focus groups with 17-18 year olds

- Imagery was perceived to be attractive, sociable and reassuring
- It supported young people’s perceptions of smoking and reinforced their smoker identities
- It had the potential to be more powerful than advertising imagery

Pilnick & Coleman 2003 An investigation into patients responses to GP advice about giving up smoking

- Patients resisted linking their current medical problems with smoking through justification and minimisation of the associated risks

Wiltshire 2003 Smokers perceptions and experiences of quitting

Sample: 50 males and 50 females in two Scottish areas of disadvantage

- While many smokers wanted to quit they used their understanding of addiction and habit to illustrate the difficulties
- Addiction was referred to through accounts of anticipated withdrawal symptoms
- Accounts of the difficulties of cessation drew upon habitual usage and routine aspects of daily life
- Stressful times perpetuated tobacco use and made cessation
Bush et al 2005 A study to understand the influences on smoking behaviour in Bangladeshi and Pakistani communities in the UK

- 87 men and 54 women aged 18-80 from Bangladeshi and Pakistani communities
- Smoking behaviour was influenced by four dominant inter-related themes: gender, age, religion and tradition
- Some culturally specific contexts for smoking behaviour were identified, but there were also strong similarities with white people – especially among younger adults

Hughes & Carpenter (USA) 2005 Global literature review assessing the feasibility of smoking reduction

- Few daily smokers spontaneously reduce
- Among those who try to stop smoking and relapse, it is unclear whether reduced smoking is maintained
- Nicotine replacement can induce long-term smoking reduction in those not interested in cessation
- Some compensatory smoking occurs with reduction but declines in exposure levels still occur

- NRT viewed with scepticism
- Relapses more likely
Wiltshire et al 2005

Explores Young Scottish smokers’ experiences and attitudes towards smoking and their understandings of the ways in which this transitional period impacts upon their smoking behaviour.

Sample: 49 interviews with 16-19 year old friendship pairs

- Smoking was perceived to be a marker of an acceptable identity in new and familiar contexts.
- Smoking restrictions at work/home/within educational settings moderated consumption.
- Extending smoke-free policies to all workplaces would impact upon the transition from social to regular smoking amongst older adolescents.