the leisure review
an independent view for the leisure industry

Why isn't health listening?

Following a series of articles in *The Leisure Review* on the politics of the promotion of physical activity, Carl Bennett follows up the debate on the relationship between the health and leisure sectors, warning that you might not like what he has to say.

Without harking back to recent editorials too much, it is probably useful for us to consider the potential role physical activity (note the careful use of the words 'physical activity'. Not sport. Not leisure. Not culture) can play in improving health.

"The scientific evidence is compelling", said the chief medical officer (CMO) in his opening preamble for At Least Five Times a Week (DH: 2004). This significant document continued to cite the many benefits being active can claim and how physical activity is likely to improve the health outcomes for so many clinical conditions (more than 21 different conditions cited). All wonderful stuff. But wonderful from who's perspective? Why was this document written? Who's language was it written in?

"If we are going to be entrusted, over and above the clinical model, over and above the drugs and clinical interventions that have been proven to work, we need to do things differently."

William Bird's efforts to portray a comparison between drugs and the potential physical activity has to impact on health reflect an approach that has been around for years (see Jerry Morris, who originally coined the analogy, and his 1949 'bus driver/conductor' review). So why is it that the offer placed on the doorsteps of NHS (health) organisations fails to be picked up, developed and delivered? Is not physical activity the snake oil described by the CMO, Jerry Morris, William Bird and Charlie Foster…?

Well. Here is my take. Some may not agree with what I am about to say but I am a realist and an experienced health practitioner who happened to have an early career working in the sport and leisure sector.

It all comes down to language. Simple. Here endeth the sermon.

If only it were that simple.

The use of clinical terms and the growing use of acronyms in the NHS has encouraged a language all of its own. If you are outside of this environment your language may be viewed as ill-informed or even just wrong. Therefore, what you have to say, or offer, has no use to the person you are trying to engage unless you use the appropriate language. The language of the NHS can be seen as difficult a language to crack as Japanese, which, according to the Foreign Services Institute, is officially the most difficult language to learn.

Experience has taught me that the clinical side of the NHS (doctors and nurses) are a hierarchial bunch. Have you noted that when a doctor becomes a consultant he or she takes the title 'Mr' or 'Mrs'? Hmmm. Language. Hierarchy. Difference. Then you have the tiers. While this government is doing its best to tear out the innards of the media-hyped management bulge, it is clear that the landscape of personnel structures within the NHS at the local level is different in each geographic area of the country. This is because different areas have different needs and priorities. This causes much confusion when I talk to providers. "Why is it," they ask, "in Wigan they have lots of NHS money for physical activity yet in Cumbria we have so little?" "Priorities," I reply. Priorities.

There is another reason: legacy. Not the Olympic thing: regeneration. The various regeneration themes have left a legacy in areas where the greatest ground was to be made on the more affluent areas around the country. Invest more cash in those areas where people die earlier than others. This is how you address inequalities at the national level and in many instances it worked. However, inequalities still exist. Regeneration left a legacy for organisations who deliver physical activity to tune into, a legacy that has enabled the growth in the value (currency) of the physical activity offer. This legacy also developed

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'champions', champions for the physical activity theme area.

The past 20 years or so have proven that those areas who received Single Regeneration Budget and Health Action Zone resource over a number of years have far better established and embedded physical activity structures than the areas that did not. This legacy has paid dividends for the likes of myself and others who came into the field of health during these times. Therefore there is an element of inequality regarding the potential physical activity has to offer across the geography of the UK.

However, if you're in an area where SRB and HAZ was limited or non-existent you do not have a reason for doing nothing. Not placing energy in developing your priorities to help meet current and future need is not acceptable. The emerging health and wellbeing boards will address that in future. Reshape or be reshaped.

To understand the local health priorities is not a difficult feat. Just download the local public health annual reports from the past two years or so. The health priorities will jump right off the pages. The joint strategic needs assessment will contain some of the 'joint' priorities that you can also tune into.

Here lies the real issue. Remember, I wrote earlier that you might not like what you are about to hear. Well here it is: the Big One.

We need to change.

There. I said it. Change. Ouch.

We need to change. We need to respond to the challenges and strategic drivers if we are ever going to get a slice of the health action and cash. If we are going to be entrusted, over and above the clinical model, over and above the drugs and clinical interventions that have been proven to work, we need to do things differently. Doing what we have always done will not suffice in the future. Not addressing our language issues will not get us to where we need to be. Not addressing the shape and programming of our services or offers to meet strategic agendas will not get us to where we need to be. Not addressing the specific training needs of staff, those we expect to work with those the health sector would like to entrust us with, will not help you get to where you need to be.

Understanding different languages is simply good communication. Communicating your offers to those who are inactive is a good start. This population will need the knowledge and skills you are required to have to work with the health sector. If we start with a common objective and then agree a common track to get there we will be partly en route. The objective has to be the collective improvement of the health of our communities. If we are to do this in line with our health partners we need to be talking the same language. They are unlikely to change. That means we must. It is down to us. It is down to you.

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