Zeitschrift: Schweizerische Zeitschrift für Forstwesen = Swiss foresty journal = Journal forestier suisse

Herausgeber: Schweizerischer Forstverein

Band: 161 (2010)

Heft: 3

Artikel: Well-being and nature : policy convergence in forestry, health and rural development (essay)

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DOI: https://doi.org/10.5169/seals-1097755

Well-being and nature: policy convergence in forestry, health and rural development (essay)

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The importance of natural environments to human health was generally accepted until the early 20th century, but subsequently has been neglected. Today that traditional understanding is being rediscovered, but is now conceptualised in the language of science. For contributions in this field to have an impact today, therefore, they must be communicated in the language of medical and public health science. Concepts of well-being are now seen to be central to, and have been adopted in, policies relating to social sustainability. The emergence of lifestyle as a focus for concern both in health and sustainability is leading to convergence in policy and in practice and to the development of shared language.

Keywords: forestry policy, health, well-being, nature
doi: 10.3188/szf.2010.0062

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This paper arises from the author's experience as vice-chair of COST Action[1] E39 on Forestry and Health. Over a period of four years it became apparent that there is common ground between those who seek to address lifestyle-related health problems and those in the environmental world seeking to address the environmental consequences of contemporary lifestyles. Environmental quality is a widely-accepted determinant of health, so that the possibility of forestry to improve urban environments brings urban infrastructure and urban planning into the picture. The focus of the paper, therefore, is on well-being through contact with nature and in this context it has two themes. One is about the way that the impacts of research can be enhanced by couching cross-disciplinary research outputs in the language of the dominant paradigm. The other is to do with the convergence of social, health and forestry policy that is leading to new mandates arising in all these areas. I argue that we are in a period of flux where a number of different themes are converging on the central idea of well-being.

1 COST (Co-operation in Science and Technology) Actions are pan-European scientific networks funded through the European Science Foundation, that generally last for four years

There are many definitions of well-being. A framework of six domains has been used in Scotland (Forward Scotland 2008) to inform Government policy:

- family & relationships
- work & income
- physical & mental health
- social context
- environment
- education

In respect of social well-being Veenhoven (1998, 2008) uses four dimensions (Table 1). Other authors concentrate on particular perspectives such as economic well-being or health. What all these definitions have in common is that they are complex, so that policies that aim to improve well-being must, by necessity, involve actors from different areas of public life.

	Outer qualities	Inner qualities
Life chances	Living in a good environment	Being able to cope with life
Life results	Being of worth for the world	Enjoying life

Tab 1 *Four dimensions of well-being. Source: Veenhoven (1998) cited in Bell (2005)*

This paper is based particularly on experience in the UK. Nevertheless, experience in COST Action E39 indicates that European countries all face similar problems in public health and in taking effective action on sustainability. Between countries there were cultural differences and differences in practice that are seen to be an important learning resource.

An historical perspective on nature and health

The idea that human health is enhanced by contact with nature, indeed that people are themselves both a part of and dependent on nature, is not new. It is illustrated in the art and literature of classical times. As Simon Schama (1995) reminded us, the relationship between society and nature is "a current that flows through all the ages of Western culture".

These ideas survived the enlightenment and the age of reason relatively intact. Indeed, had Charles Darwin not seen humans as part of the natural world it is difficult to see how he could have applied his theory to human evolution. In recent modern times examples of popular culture that link well-being and happiness to association with nature are commonplace. We can see them, for example, in the late 19th and early 20th centuries in the arts and craft movement, in the images of the romantic painters, and in the outdoor teaching and performance developed in Switzerland by Dr Rollier, with his heliotherapy and by Laban in his summer dance school at Ascona.

These ideas were not confined to the elite. In the UK they were closely linked to the development of the Labour party and the wider socialist movement. In Britain in the 1930s people in factories, indeed most urban people, did not have access to the countryside, because it was largely in private ownership. This led to widespread civic protest and a famous event in April, 1932, when the people of Manchester marched into the nearby hills. Rothman (1982) gives contemporary accounts of them being met by landowners and gamekeepers, who attacked the factory workers with dogs and sticks.

One of the first acts of the new Labour government after the war was to pass legislation that reinforced rights of public access. It created our national parks, protected our best landscapes and established legal rights to existing paths and trails (Figure 1). It was this same Government that created our National Health Service.

However, we must beware of making superficial generalisations that fail to recognise differences in national culture in Europe. For example, although a survey by the Swiss Agency for the Environment, Forests and Landscape (SAEFL 1999) found that the

Fig 1 *Window sculpture in the Forest of Dean: Britain's public forests encourage public access.*

Swiss public have a technical understanding of forests that is little different to that of other European countries (Rametsteiner 1999) it is hard to envisage that a programme such as Christoph Leuthold's educational workshops (Bildungswerkstatt Bergwald)[2] in the Swiss mountain forests would be successful, or attract the necessary resources in the UK. At some fundamental level that the surveys did not identify, there is perhaps a difference in the relationships of societies with their national landscapes.

Institutional barriers to linking health and nature

In the 1930s it was not only the socialist movement that staked out its claims to the countryside. In this period nature became politicised in a particular way, and in some countries was appropriated by the far right who used landscape and nature as symbols of nationalism. After 1945, it seems that it was difficult for people to continue to promote health through nature without attracting suspicion that they were making a political point.

By the middle of the last century the really big achievements in public health, including clean water, treated sewage, mass immunisation and good

2 www.bergwald.ch (20.1.2010).

housing, were well advanced. Future advances in public health were incremental, rather than step-changes. These smaller advances were more difficult to implement and to assess, were subject to laws of diminishing returns and were less visible to policy-makers and politicians.

Following the achievements in public health the medical approach to health, one of the great achievements of our civilisation, became highly successful. So successful that its rationalist, scientific approach quickly became the dominant mindset in healthcare across the Western world. As the United Kingdom Public Health Association (UKPHA)[3] in a joint report with local government and the National Health Service reported in 2004, "preventing illness and disability, improving health and tackling health inequalities do not command the same level of political priority as the improvement of healthcare and clinical services". This is written against the background that, in a total healthcare budget of GBP 110bn, just GBP 1.9bn (1.8%) is spent on public health in the UK (HMRC 2009).

Healthcare has expanded so that today the OECD (2009) calculates that in Europe it accounts for 9% of gross domestic product (GDP), with France at 11% and Switzerland at 10.8% of GDP having the highest levels. The wider health profession enjoys unprecedented prestige and power, based on a rationalist model that frames health and the evidence of health within the rhetoric of science.

As the health sector has grown, we have seen a steady conflation of health with the institutions of health. In the UK at least 'health' and 'National Health Service' seem almost to be one and the same. What this means is that changes in healthcare practice, for example, the adoption of interventions based on health through exposure to natural places, are difficult to separate from institutional change. In much of Europe these institutions of health – not only hospitals, health centres and other centres of treatment, but also health departments, regulators and professional bodies – are in some way tied to the public sector. Politicians are accountable, so that at times health can seem to be as much a political as a medical activity. For scientists this means that if we want our research to be used and to have an impact, we need to pay attention to how that research is presented.

Healthcare professions, like any other professions, operate within particular paradigms (e.g. Bourdieu 1985, Tsouvalis 2000). To have influence in the world of healthcare one needs to speak the correct language and frame one's messages so that they fit the dominant paradigm. Reputation and credibility are important resources, since they reassure those who are investing their own reputations and credibility in acting upon research findings. The greatest weight is likely to be given to arguments that are framed in the language of mainstream, rationalist contemporary healthcare.

This is simple pragmatism. It is reinventing a language, or perhaps creating a new language, so that ideas which the health world briefly forgot, can be acted upon today. The language to use is that of science, as the institutions of health are now construed as part of the realm of science rather than culture. It is sometimes an ugly language, falling short of the poems of Wordsworth or the prose of Ruskin. Today one talks about evidence-based practice and randomised trials, for that is what gives purchase in the discourse of health. However, outside the health professions society at large is less constrained, such that health, nature and culture continue to be intertwined.

In the United Kingdom there have been a number of developments in forestry, which when they first started were considered to be outside the mainstream, but today have been adopted completely. Urban forestry was one of these innovations. The wider social agenda for forestry was another. It is only since the early 1990s that the wider governance of forestry, which nowadays is taken for granted, was introduced. Well-being is another of those areas that today seem new, but in a few years time will be perhaps a routine part of forestry.

Converging objectives in public health, social and forest policy

Issues that bring the worlds of forestry, health, social policy and wider sustainability together, include a common concern to instil changes in personal behaviour and a new understanding that environmental quality and health are closely linked (Figure 2). Whilst the objectives for each sector might differ, the practical activities necessary to meet their objectives are closely related. Forestry aims to remain relevant and deliver benefits that fit the needs of contemporary society. The health world needs to address a new set of public health problems that are framed increasingly within concepts of well-being, because 'this is what people value in life' (Carlisle & Hanlon 2008). There is also a growing acceptance that environmental management is directly linked to public health (WHO 2005). Social policy aims to address inequality, which is partly to do with well-being. Urban planning has become aware that poor living conditions, poor urban design, social deprivation and poor health all go hand in hand (e.g. Ambrose 2001). Thus, as in the 19th century, town planning and public health are once again linked, and insofar as urban forestry impacts on environmental quality in towns, it is also relevant to well-being and public health.

3 www.ukpha.org.uk (20.1.2010)

Fig 2 *Extensive areas of Bluebells (hyacinthoides non-scripta) are unique to the British Isles and make excellent natural habitat for young people.*

Throughout Europe there is recognition that sustainability will continue to elude us unless lifestyles change. Even in Switzerland, a country that many people in the UK might see as a leader in sustainable development, the Swiss Federal Statistical Office (SFSO 2008) recently stated that "Switzerland's lifestyle is not sustainable, because we use more than our fair share of global resources".

The common theme around which policy convergence is taking place is well-being as part of sustainability. At UNCED's Rio Earth Summit in 1992, almost all the world adopted the principles of sustainable development. In forestry we had our own Forest Principles, which led to around 270 Proposals for Action, most of them predicated on concepts of dependency, injustice and poverty, which seemed of little relevance to forestry in Europe.

Of the three pillars of sustainability – society, economics and environment – I suggest that those working in forestry in Western countries had difficulty understanding what the social pillar meant. How did principles and actions, that were designed with the developing world in mind, apply to European forests and to European society? Society in European countries does not depend on forests for its survival, or face displacement from forests by corrupt politicians. Indeed, most countries in Europe have long traditions of managing forests for community benefit. So over a period of years Europe has had to lay out a set of forestry principles to suit its own circumstances.[4] Once it set itself that task it was inevitable that well-being would emerge as one of its core principles.

After that slow start what we are seeing now is a rapid growth in well-being-related outdoor and forest projects in Europe. These projects are diverse and in some cases, for example, children's play or forest tourism, might not appear to be related to health at first.

A shared interest in changing behaviour and lifestyle

If we look more widely at sustainable development, perhaps foresters are not the only ones perplexed by the social aspects. In local and regional government, despite all the enthusiasm engendered by UNCED's Agenda 21, we saw few policies or fresh approaches that defined and advanced the new agenda of social sustainability. It has taken years for governments to understand that sustainable development will not come about unless we change the way we live our lives to use fewer natural resources. Thus, we now see a growing rhetoric of behaviour change and policymakers from different sectors adopting similar approaches of making targeted interventions to change the behaviour of particular groups. For example, in the UK the National Institute for Clinical Excellence (NICE 2007) has recently issued guidance on interventions to change public behaviour to benefit health. This focus on behaviour has led to an interest across government in social marketing, which essentially is a combination of social science with marketing techniques for non-commercial purposes. Typically, it identifies and targets particular social groups and develops campaigns specific to them. This is familiar territory to public health practitioners, where there is a wide recognition that lifestyles are problematic; this is illustrated in the familiar campaigns to reduce smoking, raise awareness of cancer and most recently to encourage physical activity in children.

At the same time that concern about lifestyle-related disease has come to the fore, there has been an increasing recognition that the medical revolution has entered its mature phase. It faces the same law of diminishing returns that came into play in public health; society is spending more and more to achieve increasingly smaller health gains.

Social policy and forestry

In the UK it is possible to argue that forest policy does not really exist. Forestry is too small and unimportant to be a discrete area of policy. What forest policymakers do is to take key policies from other parts of government and interpret them in terms of the contribution that forests can make. We see this especially in the field of land-use policy and the Common Agricultural Policy where forests are in the frame, because of their environmental and economic value, not because forests have their own policies. However, it also applies in other policy fields, including social policy.

4 The European forestry process is led by the Ministerial Conference for the Protection of Forest in Europe (MCPFE)

A particularly important development, at least in the UK, has been the emergence in wider social policy of a strong narrative of social inclusion and environmental justice. The policy objective is that all parts of society should have equal access to the benefits available to society at large. Poor people, people from minority groups and people facing disadvantage should have equal access to benefits such as access to forests and to the countryside. This has become an important theme in UK forestry policy and has led to specific strategies relating to social diversity and to targeting people that might at one time have been overlooked.

Social exclusion, of course, is also a central concern in health. There is a clear understanding that poor people and people in deprived localities have poorer health outcomes than people who live in high quality environments. Urban forestry is completely relevant here, since it is poor urban environments where these problems are greatest.

Another cross-cutting concept that has its roots in Europe is social capital. Dating from 1916, and later developed by Pierre Bourdieu in 1972, Robert Putnam's writing has been particularly influential. Writing about small businesses in Northern Italy (1993) he ascribed the economic success of the region to the network of relationships and collaborations in which they all engaged. The idea became an important part of European rural development policy. In his later writing (2000) he used the concept of social capital to argue that personal and collective well-being was linked to the networks and relationships in which people and communities participate. Again, the idea was taken up by policymakers and has become an important objective in social policy in Europe. In the UK, for example, one of the purposes of our social forestry projects is to build social capital in rural and in inner-city communities.

A further point on convergence is to do with the gradual adoption of ideas about forests as a service, rather than simply as places of production. Across Europe we see policies and projects to encourage use of the forests, to use forests to support rural development policy, to promote forests in the landscape and as places for recreation and to encourage the establishment of trees and woodlands as part of the fabric of our cities. In many countries these activities fall outside the mandate of the forestry profession and require partnerships and collaboration with other authorities.

So, on many fronts, there has been convergence between policies for public health and for the outdoors. Projects to support volunteering, to establish art in forests, to encourage children and families to walk or collect berries and mushrooms, to promote cycling and camping, to educate children outdoors (Figure 3), to plant street trees and create woodlands in industrial and urban landscapes, can all be seen as a contribution to public health.

Contributing to health through forestry research and practice

One can make a case that forestry is a traditional activity. It has long timescales and the profession of forestry requires a careful approach, since following short-term changes in fashion can impact on the long-term outcomes of forest management.

Despite the constant innovations in medicine and surgery, the health profession is also risk averse. Whatever a practitioner's personal character, in professional practice there is an inherent conservatism, since the consequences of a wrong decision can be serious. So, health professionals are reluctant to make changes, unless they are convinced that the benefits make change worthwhile.

So, decision-makers in both worlds have the same needs: to know (i) that they have a mandate to take a particular course of action; (ii) that it is legitimate and appropriate for them to do so; and (iii) that the risks are known and manageable. Research can help address these concerns.

One should not fall into the trap of believing that health research is inherently different to forestry research. It is not uncommon in forestry to have just one or a few sites to research and frequently there are limited possibilities to make generalisations from specific observations. One might feel, therefore, that forestry research is unlikely to be considered as strong evidence in comparison with health research. It is true that in some fields, particularly intervention trials, health researchers are used to degrees of control and replication that would usually be unaffordable or difficult to justify in forestry. Nevertheless, there are large areas of health research, for example, in public health and in palliative care, where funds are constrained. Another common debate is to do with the weight that can be placed on qualitative research, which is often highly localised and cannot be generalised.

Prof. Muir Gray, head of evidence in the department for health in England, states that it is not the case that health research outputs need to be quantitative (personal comment). If quantitative data is available, then, as in forestry, it is important that it is used, but a large amount of health research is necessarily an investigation into subjective experience. Qualitative research is common and is readily accepted, if it is rigorous and well designed.

Scientific rigour, good design and care in the claims made are historic attributes of forest research and need not concern us. Of more concern, is that a persuasive case is unlikely when research is restricted to one-off interventions. Can we demonstrate the effects of going for a walk, not once, but a hundred times, by hundreds of people, rather than just small samples? There seems to be little alternative to longitudinal studies that yield data from time

Fig 3 *Even without a controlled experiment most people would say that the day in the forest has been good for those children.*

series, covering a wide range of sites and involving large numbers of people.

An obvious source of such data is activities that are underway or planned as part of forest management. Exploiting this data source on a pan-European scale would require common approaches to evaluation, so that analyses of datasets are compatible. The aim would be to establish a body of work from what is currently a collection of unrelated activities. There is a parallel need to develop a process for sharing information about methods. For example Geographical Information Systems (GIS) are likely to be a powerful tool, whilst new technology, such as the ability to track mobile phones, opens new possibilities for spatial research.

This is not just a research agenda. Across Europe public authorities are spending money on outdoor access projects of different kinds. Are we exploiting this activity as a resource for learning and research? My own research in the UK illustrates a typical cycle. A proposal is developed and submitted; the funding is won; the project runs for its allotted time and then it finishes, often with little attempt at evaluation. The following year another project is put forward and so on. This failure to learn and develop operational practice based on shared experience surely applies to Europe as a whole. Are we missing opportunities to develop an evidence base from our operational activities? I suspect that, because they are not classed as research, their value for delivering research data and 'evidence' is overlooked.

Evidence-based approaches to policy and practice

A recent development that started in healthcare, but is now extending into other areas of public life, is the use of evidence-based methodologies using systematic reviews.

Systematic review differs to traditional literature reviews in that the reviewer enters the literature to answer a specific question rather than to gain a broad understanding of an academic field. The reviewer works to a predetermined protocol setting out the nature of the literature that will be accepted as valid evidence. Forming the question and establishing the protocols is time consuming. The aim is that the output from a systematic review is replicable, so that another reviewer with the same question and applying the same protocols should come to the same conclusions. As the volume of accessible systematic reviews builds up it becomes possible to see where there is good evidence and where further research is needed. So the process is also valuable as a disinterested method for identifying research priorities.

There has been rapid growth in these approaches, driven by a need to make sense of the high volumes of research and analysis that researchers today have to cope with. The Cochrane collaboration in health that began in Oxford in the UK is now a worldwide process and is among the most cited information sources in medical literature. The Campbell collaboration in humanities and social science is more recent, but also attracts support from across the world. Most recently there is an emerging interest in these approaches in the fields of environmental science (including forestry) and education. The Centre for Evidence-Based Conservation at Bangor University outlines procedures for systematic review in conservation sciences (Pullin & Stewart 2006).

The outputs from these collaborations are available to scientists of all disciplines in any part of the world, and as the approach spreads, it seems likely to become an important resource for cross-disciplinary research and also for science in less developed countries. Note that the approach has its roots in logical positivism, so that one of the questions these collaborations face is how to draw on qualitative and constructionist research whose outputs are not readily quantified or codified.

A proposal for collaboration

The developments that I touch on in this paper apply to a varying degree across Europe. Is there a need for the forestry sector across Europe to collaborate? Is there an opportunity to make better use of practice to inform research? Rather than establish separate research projects, can we not develop common systems of evaluation and objective-setting that will allow us to make greater use of existing activities as a source of research data, whilst applying common systems of evaluation as a means of synthesising information from this data? This is common practice in mensuration and forest planning, yet is much less so in socio-economics.

One possibility might be to establish a facility that will mirror the Cochrane Collaboration as a depository for evidence in the field of forest and environmental science. There are possibilities for European collaboration with funding available within the EU Research Framework, in which Switzerland participates.

One of the issues that was identified in COST E39, is that research which relates forest and environmental science to health and well-being takes place across many disciplines and in several languages. Therefore, it is not seen as a united body of work, which means that its impact and the contribution of individual research papers, is reduced. Closer collaboration would help address this problem. ■

Received: 7 July 2009, accepted (with review): 8 December 2009

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Natur und Wohlbefinden: eine Annäherung von Wald-, Gesundheits- und ländlicher Entwicklungspolitik (Essay)

Die Bedeutung der natürlichen Umwelt für das Wohlbefinden war bis ins frühe 20. Jahrhundert allgemein anerkannt, wurde aber später vernachlässigt. Heute wird das traditionelle Verständnis wieder entdeckt und in die Wissenschaft transferiert. Damit die Erkenntnisse eine Wirkung entfalten können, müssen sie in die Sprache der Medizin und des Gesundheitswesens übersetzt werden. Der Begriff des Wohlbefindens wird heute als zentraler Aspekt der sozialen Nachhaltigkeit akzeptiert und hat in den relevanten Politikbereichen Eingang gefunden. Der gesunde Lebensstil als Schwerpunktthema sowohl im Gesundheits- als auch im Umweltbereich führt zu einer Annäherung der beiden Bereiche in Politik und Praxis und zur Entwicklung einer gemeinsamen Sprache.

Le bien-être et la nature: convergence des politiques de la gestion forestière, de la santé et du développement rural (essai)

L'importance de l'environnement naturel pour la santé était reconnue jusqu'au début du XXe siècle et a été négligée depuis. Ces connaissances traditionnelles sont redécouvertes aujourd'hui et conceptualisées d'une manière scientifique. Pour obtenir un impact, ces contributions doivent aujourd'hui être communiquées dans le langage de la médecine et de la santé publique. Le concept du bien-être est devenu central et, en conséquence, a été adopté dans les politiques concernant la durabilité sociale. L'apparition du concept de «style de vie» aussi bien dans le domaine de la santé que celui de l'environnement a amené à une convergence des politiques et pratiques de ces secteurs ainsi qu'au développement d'un langage commun.