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SPECIAL SECTION

The past, present and future of health geography: An exchange with three long standing participants in the Geographies of Health and Wellbeing Research Group

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Abstract

This article traces the past, present and future of health geography through the career journeys of three notable academics, Sarah Curtis (SC), Julia Jones (JJ) and Graham Moon (GM). All three of these scholars have had entanglements with the Geographies of Health and Wellbeing Research Group (GHWRG) of the Royal Geographical Society (with the Institute of British Geographers) (RGS-IBG) throughout their careers, enabling them to shape health geography into the contemporary sub-discipline that we know today. GHWRG has, for the last 50 years, offered a lively and supportive network for all those interested in the geographies of health and health care, medical geography and all other areas of scholarship related to health and wellbeing that engage with geographical concerns.

KEYWORDS

career, health geography, interview, legacy, research network

Sarah Curtis is an Emeritus Professor in the Department of Geography at the University of Durham. She is an internationally recognised specialist in the geographies of health and wellbeing, with particular interest in the socio-geographical processes that are associated with health inequalities. Throughout her career, her work in population health geography has made a significant impact in fields beyond the discipline, including public health and health care planning. Sarah retired in 2016 and continues to carry out collaborative research with colleagues at Durham University and with the Centre for Research in Environment Society and Health at the University of Edinburgh, where she is Honorary Professor. Sarah served as Chair of the GHWRG during 1996–1999.

Julia Jones is Professor of Public Involvement and Health in the Centre for Research in Public Health and Community Care at the University of Hertfordshire. Her background is in health geography, having undertaken a PhD which explored the geography of mental health reforms in Britain and Italy. Julia's work is impactful, interdisciplinary and international. She has strong partnerships with local community groups and organisations, including NHS Trusts, local authorities and charitable organisations. Julia is currently a co-investigator on a multi-million-euro Horizon Europe grant, Bootstrap,

which seeks to initiate health and social policy and practice change designed to reduce the harmful effects of digitalisation on mental health. Julia was involved in organising GHWRG's first, 'Young Researchers in the Geography of Health' conference in 1994. Since then, the conference has become highly successful, influential and increasingly international, known as the 'Emerging and New Researchers in the Geographies of Health & Impairment' conference.

Graham Moon is Emeritus Professor of Human Geography within the School of Geography and Environmental Science at the University of Southampton. His research focuses on health geography, with a particular concern for the difference that place makes to health-related behaviours (smoking, drinking and diet) and mental health service use. Graham has inspired more than a generation of students to love and engage with this field of research, having led and developed the teaching of health and wellbeing geographies at the Universities of Southampton and Portsmouth. He is the founding editor of *Health & Place*, the top-ranking international health geography journal, where, through his stewardship, he has continually supported both undergraduates and early career researchers to engage in debates in the field. Graham was Secretary before becoming the Chair of GHWRG in 1992. The group was rebranded from the Medical Geography Study Group to the Geographies of Health Research Group in 1994 under Graham's leadership.

Current members of the GHWRG invited comments from each academic contributor, all of whom have long-standing connections with the GHWRG. They were asked to complete a brief questionnaire about their perspectives on the changes in the sub-disciplines in which they have specialised throughout their careers, their involvement in the research group, the United Kingdom's (UK) influence on the sub-discipline, and the future of geographical scholarship on health and wellbeing. This paper follows on from a small tradition of interview-style papers in geography (including Featherstone, 2020; Grosz et al., 2017; Stenning, 2013; and Sturm and Bauch, 2010). Members of the research group recorded the exchanges and considered how they reflect on the role of the GHWRG in the development of this field of research and application of knowledge over time. Our aim here is to communicate the importance of sub-disciplinary research groups, and in the case of the GHWRG, its pivotal role in the production of and influence on geographical knowledge on health and wellbeing.

1 | REFLECTING ON HEALTH GEOGRAPHY: DEFINITIONS AND JOURNEYS

We asked each contributor for their thoughts on what 'health geography' represents for them. Sarah reflected on how she describes the sub-discipline to people outside of the community:

SC: If am asked, by people I meet from outside the health geography community, what is my field of academic expertise, I tell them I specialise in health geography, and they often seem intrigued to know what this is. My usual 'brief, plain language answer' is that 'health geography is about how places matter for health'. They often want to know more, so I would usually say that I study 'how the kind of places we are in, as well as our own individual characteristics, can be important for our mental and physical health'. I do not usually complicate matters by mentioning that the focus of health geography includes 'places' and 'spaces', but this seems to me an important additional point (especially given the increasing significance for health of 'virtual' as well as 'real' spaces). [...] Several influential reviews of health geography have influenced my thinking.[1] There are also clear links to ideas beyond health geography about the 'wider determinants' of health.[2]

Graham drew on the definition he had used when launching the journal *Health and Place*:

GM: So, for me, health geography is about the 'differences in health and health-related experiences between places, the social, cultural and political processes shaping the contexts for health, the health-related experience of health care provision, the development of health care for places, and the innovative methodologies and theories underpinning the study of these issues'. It's a rather long-winded and all-encompassing definition that, in practice, I frequently reduce to 'the difference that place makes to health' and append 'and wellbeing' to the end. I do, however, rather like its all-encompassing aspect – [it] can include many topics and approaches from geospatial to non-representational theory, produced by those who self-identify as health geographers and by those who do not, but happen to have 'health' topics as their focus; membership of a geography department or possession of a geography degree are certainly not defining qualities. [...] The inclusive, diverse and welcoming nature of health geography is as much a testament to the generally collegiate nature of those who practise it as it is to the quality and insights that arise from their publications.

Graham went on to reflect further about his relationship with health geography,

> Though the above may represent what health geography means to me personally, I'm also aware that it has had a rather more utilitarian meaning associated with distancing from 'medical geography'. I too was once taken with this distinction, which positioned health geography as new, progressive, theorised, methodologically plural, critical and concerned for a broadly defined notion of health. Without any shadow of doubt, these attributes are still fundamental but, as I explored,[3] I don't think it's any longer the case, if it ever was, that health geography represents something that exists as a contrast to past medical geographies. Rather, I would argue, we have seen an inevitable evolution with health geography simply becoming the preferred label for the eclectic, wide-ranging and often highly impactful research that we do.

For both Sarah and Graham, health geography represents the varied and differentiated relationships between health and place, which are shaped by socio-cultural, economic and environmental processes.

For our contributors, there is a sense of pride in the identity of becoming a 'health geographer', as Julia told us: 'I am immensely proud to be a health geographer and still describe myself as such, even though I have moved into a different (but highly related) research area, that of applied health and care research. It is wonderful to know that the health geography community is as vibrant as ever'. All three of our contributors reflected on their debuts into the field, with varied journeys to the sub-discipline. Both Sarah and Julia started out in the field by undertaking PhD projects that were situated in health geography.

JJ: I first started working in the field of health geography as a PhD student at the University of Sheffield in the 1990s. My doctoral research was a cross-national comparative study that explored the evolving geographies of deinstitutionalisation in Britain and Italy from the 1950s onwards. My research adopted a place-based approach, with a focus on local experiences of mental health reforms in two places – Sheffield and Verona (Italy) – in order to explore the process of implementation of national mental health polices at the local scale.[4] I was fortunate to receive ESRC and ERASMUS funding for my PhD studentship, which enabled me to spend seven months in Italy whilst conducting my international fieldwork.

SC: My involvement in health geography began with my PhD research on access to health care experienced by older people living in small towns and villages in Kent.[5] I was studying in what was then the Urban and Regional Studies Unit at the University of Kent at Canterbury (UKC). UKC has a long-standing and leading track record of research relating to public policy, so from the outset I was made aware of what we now think of as the potential 'policy impact' of research in health geography. Also, the Urban and Regional Studies Unit had a strongly interdisciplinary perspective, still evident in the UKC School of Social Policy, Sociology and Social Research, so I learned at an early stage how geography can connect with other disciplines. My early postdoctoral posts included assisting research at the Personal Social Services Research Unit[6] on development of socio-geographical indicators relevant to allocation of the Rate Support Grant in England.[7] Later, in the Department of Geography at Queen Mary, University of London, I was managing a survey of health inequalities between two socio-economically diverse areas of London.[8] This project, as well as the inspiration of David Smith's work on social justice[9] made me very aware of socio-geographical inequalities in health. Thus, I have always been connected to ongoing debates about socio-geographical dimensions of inequality in health and wellbeing and how research in health geography can be brought to bear on these issues.

Graham's journey to health geography was a little different. He initially saw himself as a political geographer, yet his research on the local state and provision of services in suburbia led him to question health and primary care provision:

GM: I had no exposure to health geography in my undergraduate degree or during the first 18 months of my PhD. I saw myself as a political geographer and my PhD focus was on the local state (an of-its-time concept from the late 1970s and early 1980s) and its role in the provision of public services in suburbia. As part of this work, I examined the impact of urban morphology, social geography, and political control on the distribution of road repairs (potholes!) and leisure services. Discussion in supervisions speculated on what would be the case when political control was less local and less democratic—as was the case with health care. Consequently, I completed a third case-study chapter, on primary care provision. Influences on this choice, beyond a casual reading of my GP father's journals and the nature of NHS

governance at the time, were papers on the geography of primary care by Paul Knox[10] and by David Phillips[11] that were central to the then emerging interest in geographies of health care as opposed to the focus on disease ecology that had previously dominated in medical geography. I read widely in this literature and this reading was relevant to subsequent post-doc positions where I focussed on community responses to mental health care and homelessness provision in a UK parallel to the North American work of Michael Dear and Martin Taylor.[12] So, in essence, I came into health geography through a concern with who benefitted from and who opposed different forms of health care provision. I can very precisely recall the moment when that interest in health geography shifted to my main, almost exclusive focus (though there were a few subsequent lapses). I was sat at the departmental typewriter turning my primary care thesis chapter into a conference paper when Kelvyn Jones, then relatively recently appointed to Geography at Portsmouth, asked me to collaborate on Health, disease and society.[13] We went on to have a long and fruitful collaboration and that text set out the broad concern with health that was a key element of the mid-1980s shift to health geography in the UK.

Each contributor has added greatly to the discipline and their work is testament to the developments, changes and continuities within health geographies. The discipline was known for its initial reliance on quantitative methodologies and concerns:

GM: For health geographers, the focus was on the pattern or spread of disease or on the distribution of health care provision. Qualitative method had not received the attention that it now has, and quantitative studies were limited by computing and based largely on surveys as access to large national and international datasets was rare. Conceptually, ideas like the ecological fallacy and the modifiable areal unit were transferring to health geography, but otherwise there was little overt 'theory' in the sub-discipline beyond general sub-Marxian welfarist concern to uncover inequality in health care research.

The UK context is important to this emergence, as Graham describes:

GM: In the early 1980s we in the UK had only just rediscovered health inequality in the quasi-supressed Black Report of 1980 and, with only marginal changes, the NHS was organised in much the same way as it had been since its inception. AIDS was an emerging disease but otherwise pandemics were a thing of the past in more developed counties. Over 40% of the UK population smoked tobacco. For health geographers, the focus was on the pattern or spread of disease or on the distribution of health care provision.

Sarah made related comments, discussing the ways health geography in the UK has been uniquely shaped by the national context of health care.

SC: 'British' health geography has probably been heavily influenced by the organisation of health care in this country. The National Health Service (although it is it currently looking very 'fragile' under the pressures of the COVID pandemic) is an internationally exceptional feature of the setting within which British research in health geography is carried out. For example, in terms of research focused on health inequalities, it is probably easier here than in many other countries to be able to study similar health-related information for members of the population in all parts of the country. We also have very long-standing records relating to the British population from sources such as the population census, and, unlike many other national census programmes, ours has been collecting information on individual's health for several decades, which are now being linked to administrative records from sources such as the NHS to expand the richness of the data. We have various longitudinal surveys (perhaps most notably the Understanding Society Survey), which are also very valuable for the kind of research that interests GHWRG. Also, British research in mapping disease incidence and prevalence geographically has a very long pedigree so this perspective is very 'ingrained' in our thinking (dating back, for example to John Snow's[14] work on the cholera epidemic in London). (However, it has been pointed out[15] that some of the earliest work of this type was conducted in other parts of Europe and the USA.)

Although British health geography is known for its engagement with theoretical debates (GM), the discipline is known for a diversity of approaches to questions regarding health, wellbeing and place. Graham Moon provided a concise rundown of the conceptual and methodological developments in health geography as he sees them. They can be viewed in Figure 1.

Although the discipline has gone through substantial changes, the term health geography still resonates today for the contributors. The inclusion of 'wellbeing' is seen to broaden the conceptual net to new concerns and issues.

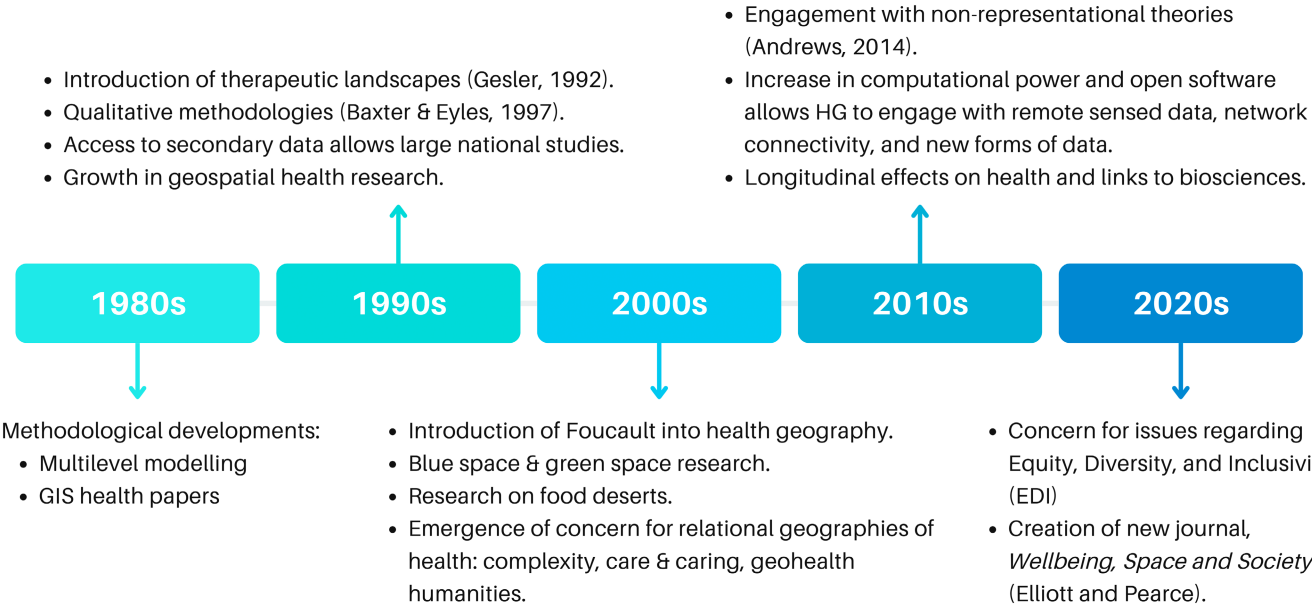

FIGURE 1 Timeline of developments in health geography (Andrews, 2014; Baxter & Elyes, 1997; Gesler, 1992).

GM: Mainly because I have always seen it as wide-ranging, inclusive and capable of pretty much anything, adding 'well-being' to the group name seems a sensible way of extending still more! What I find most exciting about health geography is that its wide-ranging nature means that novel, interesting ideas are always turning up and it's practised for the most part by nice, kind, sharing people.

2 | INTERDISCIPLINARY HEALTH RESEARCH

Sarah Curtis eloquently explained the value of (health) geography to interdisciplinary conversations, and how this contributes to the strength of this field of research, creating opportunities for collaborative and innovative perspectives on the underlying causes of variation among different populations and individuals.

Sarah Curtis explained her perspective on the value of (health) geography to interdisciplinary conversations, commenting that:

SC: I think that, because geography is fundamentally concerned with interactions between human populations and their physical environment, geographers are very well placed to engage in interdisciplinary research with academic specialists in fields including medicine, sociology, economics, anthropology and environmental sciences.

Julia Jones' career trajectory is a testament to the ways in which health geographers are equipped and able to work with a diversity of disciplines, organisations, sectors and stakeholders. She told us that:

JJ: I strongly believe that health geographers have much to contribute to interdisciplinary conversations and research that focuses on improving people's health and wellbeing and, importantly, that strives to reduce health inequalities in society.

Julia's PhD experience was interdisciplinary from the beginning and she described the learning curve she went on during her time conducting fieldwork:

JJ: This was a life-changing experience; I was hosted by the Department of Geography at the University of Verona and the Department of Public Health, Section of Psychiatry and Clinical Psychology, which also managed one of the three mental health services in Verona. My fieldwork in Verona involved spending time in the local mental health services

and conducting interviews with mental health professionals, service users and local town planners. This experience was a steep learning curve so early in my research career, but extremely valuable in terms of learning about 'real-world' research and also conducting research in another language (I had the great opportunity to learn Italian whilst doing my PhD). My doctoral research provided an important introduction to applied health research and working across health disciplines. It was an extremely beneficial research experience that opened up exciting career opportunities following on from my PhD.

After her PhD, she continued her international collaborations. Julia described her geographical contributions to research teams, bringing a spatial perspective to teams based in psychiatry.

JJ: Four years after completing my PhD, I applied for, and was awarded, a Marie Curie Postdoctoral Fellowship that took me back to Italy for two years. It was an amazing learning experience to work across disciplines in the Section of Psychiatry and Clinical Psychology, Department of Public Health at the University of Verona. I was part of a research unit composed of mental health professionals (psychiatrists, psychologists and nurses) and social scientists (health economists, sociologists and statisticians). During my Fellowship, I learned so much from my colleagues about applied mental health research, health economics, systematic literature reviews, writing for publication and service user and carer involvement. I felt valued as the only health geographer in the team, encouraged to bring a geographical 'lens' to the interdisciplinary research in mental health that we conducted together during my Fellowship. The contribution of health geography to mental health was also acknowledged by my psychiatry colleagues at Verona and I was invited to write an editorial about 'The geography of mental health' for an Italian social psychiatry journal *Epidemiologia e Psichiatria Sociale*.[16]

Julia now works as a Professor in Public Involvement and Health. Although she does have other health geography colleagues, her research centre is fundamentally interdisciplinary.

JJ: I work in an interdisciplinary research centre, with other social scientists, clinical academics and people with lived experience (service users, carers and members of the public). I am delighted to add that there are fellow health geographers working alongside me, both in my research centre and externally, across health and care organisations including local authorities, third sector organisations and the NHS. This demonstrates the array of career opportunities for health geographers to work across disciplines and sectors, contributing our unique geographical perspectives and research expertise to addressing the complex health, wellbeing and care challenges experienced by citizens, communities and society as a whole.

Graham echoed the interdisciplinary potentials of health geography, with great confidence in the skillset of geographers to contribute to teams:

GM: For me, health geography brings a sensitivity about place to interdisciplinary discussion. As a health geographer I have always found it easy to talk and collaborate with other parts of geography and also with other disciplines that do health research. [...] Beyond Geography, my main links have been with social epidemiology. I even co-authored an introductory text on that topic drawing on a decade teaching it to nurses. In fact, reflecting on the world beyond Geography, I realise that I spent the majority of my career based outside of academic geography in a multidisciplinary social science department where I was appointed as a sociologist/methodologist. Health inequality was and is a universal topic; all the other disciplines with which I have been associated have seen geographical health inequality and the ways that it can be studied as valid study topics. Nowhere exemplifies this better than *Health and Place*. I set the journal up from within health geography and it has been, and remains, a top outlet for health geography research. But the clear majority of its papers are not from people who would ever self-identify as card-carrying health geographers or even geographers.

Sarah Curtis discussed the importance of working across sectors. In particular, she spoke of the ways health geographers can contribute to health-related policy.

SC: I have engaged in numerous collaborations with a range of non-academic agencies concerned with health policy and practice, and I am sure that I have learned as least as much from them as they may have done from me! Such

collaborations are not 'one way'; health geographers can gather very valuable insights from these interactions, as well as communicating useful research findings to policy makers.

For all our contributors, health geography is understood as a discipline that is strongly placed to add to interdisciplinary conversations and developments in health, public health, health and social care policy, and wellbeing.

3 | THE IMPORTANCE OF GHWRG

For all our contributors, the GHWRG has been a highly significant part of their journeys. Graham reflected on his 40-year relationship with the research group and his time as Chair, before Sarah Curtis took the role.

GM: I've been involved with the Group since the mid-1980s. I was Secretary and then Chair of the Group in the first part of the 1990s succeeding David Phillips. Sarah Curtis followed me as Chair. It was a productive period that saw the name change to Geographies of Health, the start of the ENRGHI meetings and the foundation of *Health and Place*. The name change reflected the view that health was a better representation of the wider interests of the group and in tune with the changing emphasis in wider health policy. We had a vote and became 'Geographies of ...' to avoid abbreviation confusion with historical geography. I dropped off the Committee around 2000 due to other pressures but made a brief reappearance in the early 2010s. I'm very happy with the addition of wellbeing to the focus as it reflects the direction of travel of the membership and, as with the change from medical to health, the wider policy environment. I can't presently envision further evolution but who knows what will come round the corner in the next 20–30 years.

SC: Thinking back, the GHWRG has been an immensely valuable source of knowledge support for me over my whole career, especially in the ways that it enables researchers at different career stages and with diverse geographical expertise to connect and interact. I also think that the development of the ENRGHI programme has been a very positive step. Thinking ahead, it seems to me that given the increasingly challenging professional environment for early and mid-career academics, the GHWRG should make support for these groups a priority and consult with them about what they need to sustain them as they build their careers, and how those of us at later career stages can work with them in helpful ways.

Julia reflected on the value of the research group in the early days of her career, boosting her confidence and supporting her with attending her first international conference:

JJ: I am extremely grateful for the support and encouragement, I received at the start of my academic career from the GHWRG, that gave me the confidence to 'spread my wings' as an early career researcher. As a PhD student, I was encouraged by members of the GHWRG to attend my first international conference (in Vancouver, it was amazing!), write my first article (for *Health and Place*) and to jointly organise the first 'Young Researchers in the Geography of Health' conference, in 1994, with my geography PhD friends, Dr Judith Bush and Dr Dawn Thompson. It is wonderful to know that the renamed conference 'Emerging and New Researchers in the Geographies of Health and Impairment' (ENRGHI) is still going strong, providing great opportunities for networking, peer support and personal development for the new generation of health geographers.

Clearly, GHWRG has shaped (and been shaped by) the career journeys of the contributors. The comments above also reflect the conceptual and methodological developments of the discipline itself.

4 | LOOKING FORWARD

All our contributors looked forward to the future of health geography. They identified four dimensions that are key to the discipline's longevity:

1. *Conceptual innovation*: Health geographers have a unique, conceptual understanding of the interrelationships between health and place. This geographical perspective has much to offer public health research and the health and care policy arena, with renewed attention on place-based approaches to identify, understand and find solutions to address health and care challenges experienced by local communities living in a particular place (JJ).
2. *Evolving interests and concerns*: The contributors see future research being interested in: (a) longitudinal studies of area effects and commercial determinants research (GM, SC), (b) virtual and digital geographies of health (SC), (c) one-health studies and bio-social sciences, which offer new possibilities as do genomic geographies (GM), (d) the ongoing experience of the COVID-19 pandemic (GM, SC), (e) non-human and ethical health geographies (SC), (f) and the links between health, climate change and wider planetary sustainability (GM).
3. *Methodological developments*: In our research training as health geographers, we learn about the range of research designs, methodologies and methods (quantitative, qualitative and mixed methods). We also have the opportunity to do empirical research from the outset, rather than desk-based research (such as a literature review), which is the extent of research training in some other health disciplines (JJ). We are perhaps seeing a growing 'separation' between health geography using qualitative, locally focused research, geospatial research and statistical research examining 'big data' for large populations. However, it is interesting to think more about how they can 'connect' to help us understand the processes we observe (SC).
4. *Early career researchers*: The future lies in the hands of the current PhD researchers and post docs. They will shape what health geography does. New priorities, some yet unheralded, will emerge with time alongside some continuities and some rediscoveries. It is anticipated that there will be some discovery scholarship as well as replication research. Equally, GM hopes that we maintain a healthy mix of theoretical engagement, methodological rigour and policy relevance.
5. *Equitable, diverse, and inclusive research*: 'I've always seen health geography as an inclusive, diverse and welcoming label [...], and we should be ensuring that our scholarship and its practice becomes more equitable, diverse and inclusive' (GM).

5 | CONCLUSIONS

Whilst we acknowledge that the reflections recorded above may not be representative of views held across the discipline (or by all members of the GHWRG), it is interesting to note the themes that have emerged from their thinking, to revisit past concerns within the geographies of health and medicine, and to reflect on how the sub-discipline has shifted and evolved. How we understand and imagine the foci and boundaries of 'health geography', the definitions and concepts enrolled within, has important consequences on how geographic debates and discussions about 'health' unfold. As the introduction to this special issue reflects, as geographers, we must be aware of, and pay critical consideration to, how geographical knowledge is produced and the type of networks that shape and enable certain ideas, approaches and themes to become established. Above all, the reflections here serve to convey a sense of both the vibrancy and value of geographic contributions to the study of health and wellbeing.

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DATA AVAILABILITY STATEMENT

Data sharing is not applicable to this article as no datasets were generated or analysed during the current study.

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ENDNOTES

[1] Examples include: Gatrell (2002); Gesler (2003); Jones and Moon (1987); Kearns and Gesler (1998); Meade et al. (1988); Parr (2008).

[2] E.g. Dahlgren and Whitehead (2021).

[3] Kearns and Moon (2002).

[4] See Jones (2000).

[5] See Curtis (1980).

[6] https://www.pssru.ac.uk/.

[7] Bebbington and Davies (1983); Curtis and Bebbington (2004).

[8] Curtis (1987); Curtis and Woods (1983).

[9] Smith (1994).

[10] Knox (1978).

[11] Joseph and Phillips (1984).

[12] Taylor and Dear (1981).

[13] Jones and Moon (1987).

[14] In 1854, the physician John Snow was able to demonstrate a link between cholera and contaminated water through mapping death rates associated the disease. He published an essay, On the Mode of Communication of Cholera (Snow, 1855).

[15] Meade et al. (1988, p. 19).

[16] Jones (2001).

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