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Social Science & Medicine 51 (2000) 1047–1059

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MEDICINE

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New Zealand children's health camps: therapeutic landscapes meet the contract state

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Abstract

This paper surveys the history and current status of children's health camps in New Zealand, and places these sites within the theoretical context of therapeutic landscapes. The first health camp was established in 1919, and the seven current camps provide respite, education and health care for approximately 4000 children each year. We analyse the health-place relations inherent in the health camp concept and suggest that the 'therapeutic landscape' idea developed by Gesler provides a useful framework to explain the development of camps as sites for enhancing child and family welfare. Specifically, we contend that changing understandings of health and children have been closely linked with changing perceptions of what is therapeutic about the camps. Survey data demonstrate that contemporary restructuring of the welfare state has recast the role of health camps and placed them in a precarious position in terms of both financial viability and public acceptability. We conclude that the current status of health camps is ambiguous given the pressures of deinstitutionalisation philosophies and the regulatory environment of formal contracts between funders and providers. © 2000 Elsevier Science Ltd. All rights reserved.

Keywords: Health camps; Therapeutic landscapes; New Zealand; Children

Introduction

New Zealand's first children's health camp was established in 1919 by Dr Elizabeth Gunn, a school doctor and former army officer. Her camp at Tura-kina, near the North Island city of Wanganui, operated for 11 years and provided much of the inspiration for similar camps that were set up around the country by enthusiastic individuals and local organisations during the 1920s. These early, volunteer-led initiatives were generally short-lived and seasonal, and it was not

until 1932 that the first permanent camp was opened. The election of the First Labour Government led to significant state involvement in the funding and regulation of the camps, and in 1937 it launched the King George V Memorial Appeal to raise funds for five permanent camps (McLintock, 1966). Thus, in less than 20 years, the children's health camp movement had evolved from a series of small-scale and localised initiatives into a national network of permanent camps supported by the state (Tennant, 1995). This support included a glowing prime ministerial endorsement:

Here the boy or girl whose health is sub-normal — below par — and who will otherwise be one of the first to fall to the approach of disease, becomes a changed being — revitalised in mental and physical

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resources, on the way to become a useful, self-reliant and prosperous citizen with memories that will help to keep him or her intensely human. Such a child returns to school and home bright-eyed and vigorous, full of the joys of life and with a health insurance policy with premiums fully paid up for years ahead (Michael Joseph Savage quoted in Woods, 1996, p. 39).

These therapeutic qualities associated with routine, instruction and rural tranquillity came to be taken for granted as the health camps movement entered its third decade. In the middle of the century it was widely accepted that the camps were national treasures whose existence symbolised New Zealand's commitment to the well-being of children and helped to 'maintain its supposed position as world leader in health and welfare' (Tennant, 1995, p. 109). Although volunteer labour and philanthropic sources of funding remained significant, the camps were closely linked to the welfare state, and their fortunes have in many ways reflected its development and demise (Tennant, 1994). They emerged at a time when central government was taking an increasing interest in children's well-being (evident in child protection legislation and the expansion of state schooling) and flourished in an era when the young were identified with the national interest (Coney, 1997). More recently, the camps' survival has been threatened by state sector reform and critiques of welfare which have left them vulnerable to both changes in funding and arguments against institutionalised health care (Boston, Dalziel & St John, 1999). Each camp must now compete with other service providers for funding, and most are experiencing financial difficulties. Nevertheless, New Zealand's seven permanent health camps remain in place, providing periods of respite, education and health care for approximately 4000 children aged 5–12 years (and a growing number of parents) each year.

An examination of health camps allows us to consider one aspect of the changing landscape of health and welfare provision in New Zealand. Reforms over the last decade have increasingly required providers of health and welfare services to compete for funding, at times resulting in a contraction of opportunities for service users (Kearns & Joseph, 2000). The central aim of this paper is *to consider the changing functions and perceptions of health camps in light of prevailing ideologies about health and children*. We demonstrate that the notion of 'therapeutic landscape' developed by Wilbert Gesler (1992) has been implicit in the history of the camps and how understandings of what is therapeutic have been socially constructed and historically contingent. A secondary aim is *to contribute to geographies of children's health care in New Zealand*. Notwithstanding recent analyses of the national children's

hospital in Auckland (Kearns & Barnett, 1998, 2000), geographies of children's health remain under-researched. More generally, Roger Cooter observes that 'the knowledge, practices and policies articulated in the name of child health and welfare are encountered only in passing in [the existing literature]' (Cooter, 1992, p. 2). The camps also shed light on the social history of medicine in New Zealand (Tennant, 1996), as their focus has shifted from initial concerns about racial fitness, malnutrition and tuberculosis to emotional well-being and, most recently, to addressing behavioural problems, child abuse and family dysfunction alongside physical ill-health.

The remainder of this paper is organised into six sections, the first of which reviews the notion of 'therapeutic landscape' as it has been developed and applied by health geographers. The second section briefly reviews our method. The third section examines the place-related qualities of health camps and their potential implications for children's well-being. Here we discuss the development of the camps and record changing perceptions of their purpose. In the fourth section we analyse the impacts of New Zealand's state sector reform on the camps' operation. We suggest that the requirement for camps to negotiate contracts in a competitive environment makes the entire network economically precarious at a time when public support is uncertain. The fifth discussion section reflects on the camps in light of the contemporary socio-cultural context. A concluding section draws the themes of the paper together and suggests that current debates over the merits of health camps are essentially spatial, concerning *where* the treatment of children 'at-risk' should take place.

Therapeutic landscapes

Health and healing have long been associated with particular places, and in the 1990s geographers have devoted increased attention to the therapeutic processes and qualities attributed to various settings at different times (Williams, 1999). The most prominent contributor to this research direction is Wilbert Gesler, who developed the notion of 'therapeutic landscape' (Gesler, 1992) and subsequently analysed settings which, for environmental, individual and societal reasons, are considered to have restorative qualities (Gesler, 1993, 1996, 1998). His analysis of 'landscapes associated with treatment or healing' (1992, pp. 735–736) sees landscape as more than the traditional interaction between physical and human processes. Rather, he seeks to recognise pluralistic qualities of landscape, drawing upon the 'new' cultural geography which views landscape as a text which may be read for what

it says about both the human mind and social structures.

Gesler contends that modern health care systems often fail to provide the therapeutic landscapes in which physical and mental healing can occur. Indeed, '[f]ew people mention hospitals when asked to name therapeutic places' (Gesler, 1993, p. 171). While hospitals may indeed be more closely associated with *illness* than *health* in the minds of many, it is useful to note that in small town New Zealand public hospitals are often cherished community institutions (Kearns & Joseph, 1997). This link between health and specific places in the built environment has been down-played during the recent health reforms, however. Policy-makers have increasingly justified the closure of smaller hospitals with the argument that 'we' cannot afford to be sentimental and must 'invest in procedures, not bricks and mortar' (Coster, 1999). While the therapeutic qualities of contemporary medical landscapes may be open to debate, Gesler (1993) asserts that much can be learnt from places which established reputations for healing, such as Epidauros in Greece.

Epidauros functioned as a healing place during the 1000 years in which it was home to a sanctuary dedicated to Asclepius, a Greek demi-god and renowned physician. It was located in a scenic, elevated environment near fresh water springs, and was some distance from the nearest city. It thus combined tranquillity, beauty and remoteness, three qualities later found in many of the spa towns which emerged in Europe and North America (Gesler, 1993). Both the sanctuary's physical surroundings and its buildings contributed to a therapeutic landscape with a strong sense of place (see Ley, 1981).

Gesler's analysis leads him to conclude that nature may foster mental and physical well-being, that a degree of isolation from the stress of everyday life may improve health, and that the design of the built environment is important for patient and practitioner alike. Such thinking has recently led to minor modifications in hospital design. According to Gesler, if contemporary biomedical facilities were to take these factors more seriously, and engender a sense of place, they would be able to provide more humane, efficacious and cost-effective treatment.

Belief in the healing powers of nature — of fresh air, clean waters, wild herbs and magnificent scenery — is widespread and has a long history (Kevan, 1993). Drawing on the cultural ecology tradition, Gesler (1992) observes that mineral springs, for example, have been ascribed restorative powers since at least the times of the Ancient Greeks. Further, those springs which have been developed into spas have typically been situated in naturally beautiful settings such as Bath, England (Gesler, 1998) or in small towns promoted as unpolluted and free from the pressures of

urban life such as Hot Springs, South Dakota (Geores, 1998). While the country and the city have been thought of in complex and often contradictory ways throughout history (Williams, 1973), rural places have frequently been constructed as therapeutic in opposition to urban places as sites of physical and moral decay (Marx, 1986). Indeed, late nineteenth century perceptions of industrial cities as unwholesome and unhealthy contributed to the development of rural summer camps for children in North America (Thurber & Malinowski, 1999).

Our review of therapeutic landscape ideas has thus far dealt, at least implicitly, with concepts drawn from two scholarly domains. First, from *cultural ecology*, we have the notion of nature as healer and a consideration of human–environment relations. Second, from the *humanistic tradition*, ideas such as sense of place and symbolic landscape have informed ideas about the therapeutic properties of isolation and psychological attachment to place. Gesler (1992) draws on a third scholarly tradition which arguably has received less attention from those seeking to apply the therapeutic landscape idea to case studies (but see Geores, 1998; Frazier & Scarpaci, 1998). This domain might variously be regarded as materialism, structuralism or political economy (Cosgrove, 1987) and, within cultural geography, it is concerned with power, resistance, ideology and historical contingency (Jackson, 1989). We contend that these ideas can help explain how the status of a health care concept and site (the children's health camp) can change markedly over a relatively short period of time.

A brief elaboration on such ideas is warranted. Elite groups have frequently sought not only to dominate but also to assimilate other peoples and their practices (Sibley, 1995). Contingent upon specific spatio-temporal circumstances, power *over* others can be manifested in the power *to* re-socialise and re-educate through moving people from one place to another. The widespread use of residential schools for 'Indian' children in Canada provides a good example of this process (Comeau & Santin, 1995). However, just as individuals might resist participating in such purportedly therapeutic sites and practices, so too their promoters may resist challenges to their legitimacy through vigorous self-promotion, attempting to discredit alternatives and making changes to their practices in light of prevailing ideologies and beliefs. This pattern has certainly been true in the case of some psychiatric hospitals which have resisted closure by portraying themselves as highly therapeutic settings. In New Zealand, the example of Tokanui Hospital opening a Maori unit, complete with use of *te reo* (Maori language) and traditional healing practices, is illustrative. This move, however, occupied a short and final chapter in the history of the now closed hospital. Resistance, in this

case, succumbed to the prevailing philosophy of deinstitutionalisation and ideology of restructuring (Joseph & Kearns, 1996).

Gesler's discussion of the materialist tradition focuses our attention on historical contingency, which highlights 'the importance of past events that shape the social context of phenomena such as health care delivery' (1992, p. 740). He draws on ideas developed by Allan Pred (1983, 1984) who conceptualises place as neither imbued with intrinsic qualities (e.g. 'a spa is natural and therefore good for health') nor static (e.g. 'once a hospital, always a site of care and cure'). Rather, Pred sees place as historically contingent and always in a state of 'becoming'. In other words, historical events and manifestations of ideologies have tangible legacies in the environment, and these, in turn, impact upon, and are transformed by, present-day routines and situated social practices. In the words of Pred:

Place is therefore a process whereby the reproduction of social and cultural forms, the formation of biographies, and the transformation of nature ceaselessly become one another at the same time that time-space activities and power relations ceaselessly become one another (1984, p. 282).

By way of example, effective community opposition to national health reforms in Hokianga, New Zealand can be attributed in large part to the socio-cultural milieu of the district in the early 1990s. Whereas other rural communities lost health care services at this time, Hokianga did not: strong local belief in the value of free community clinics had been built up over 50 years of use, and was reinforced by collective regard for the pioneer doctor who had established the service, providing a strong foundation for successful resistance. While individuals made a difference, resistance was a communal act and contingent on a community-of-interest having a stake in the past, and valuing a collective tradition of free and accessible health care (Kearns, 1998).

In light of the forgoing survey, we suggest that the three strands of the 'therapeutic landscape' idea — nature (via cultural ecology), meaning (via humanism) and context (via structural considerations) — provide a useful framework for analysing the historical development of children's health camps in New Zealand. However, it is the last of these strands (context) which we emphasise in the remainder of this paper. Specifically, we contend that evolving understandings of the purpose of health camps have correlated with changing perceptions of the camp environment: as concerns about children and their health have shifted over time so too have the elements of camp life considered therapeutic.

Method

This project employed a mixed methodology. First, a critical review of secondary sources was undertaken. Health camps have occupied a rather modest niche within New Zealand's health and welfare sector, however, and relatively few studies of them have been undertaken. This paper therefore relies heavily on Margaret Tennant's comprehensive *Children's Health, the Nation's Wealth: A History of Children's Health Camps* (1994) for historical background. We seek to bring a new theoretical perspective to the existing historical analysis by examining it in light of recent geographical scholarship on therapeutic landscapes, and to supplement its insights by reflecting on the challenges the camps are currently facing. Second, we undertook a survey of the managers of the seven children's health camps in New Zealand. A nine-item questionnaire was sent out in August 1999 and responses from all seven managers were subsequently received via post or email. These responses were subjected to a thematic analysis that informs the latter part of the paper. These data reveal trends in delivery and funding arrangements from the perspectives of 'insiders' who daily encounter the challenge of sustaining and re-interpreting the health camp tradition. Third, a key informant interview was undertaken by telephone with the Executive Director of the New Zealand Children's Health Camp Board in September, 1999. This contact yielded both important information (e.g. unpublished evaluation material) and support for our project, including a request to camp managers that they respond to our questionnaire in a timely fashion.

Children's health camps

Children's health camps were established in New Zealand at a time when the well-being and development of children were issues which ranked highly on the public agenda. Concerns about childhood malnutrition and the susceptibility of the young to diseases such as tuberculosis coincided with 'a whole cluster of ideas about national efficiency, racial fitness and the threat of an effete urban life' (Tennant, 1994, p. 20). In this context there was a growing preoccupation with personal health which was clearly reflected in the organisation of the first camps.

From 1919 Dr Elizabeth Gunn ran a series of health camps under canvas for children aged 5–13 years. Her camps offered large meals, fresh air, sunshine and gentle exercise, and their success was measured on the weigh-scales: '[s]econd helpings of food were encouraged — fattening "malnutrits" was a key rationale for the camps' (Woods, 1996, p. 61; see also Gesler, 2000). At the same time children were instilled with skills for

'healthy living' ranging from teeth-brushing to table manners and it was hoped that campers would 'return to home and school as proselytes for the habits they had learned during their stay' (Tennant, 1994, p. 4). Although the name 'health camp' was chosen in part for reasons of public acceptability (it down-played any connotation of parental failure and distanced the camps from stigmatised state institutions such as industrial schools), it is clear that the early camps were genuinely intended to promote children's health. The question may then be asked: what elements of these camps were considered therapeutic, and why?

The children's health camp movement emerged at a time when issues of 'race' and 'national fitness' were prominent on the political agenda of many industrial nations. The Boer War (1899–1902) had led to considerable concern about the high numbers of unfit men in Britain and the 'racial deterioration' this was deemed to signify. World War I confirmed that New Zealand men were also in poor physical condition, with only 34% of conscripts found to be completely fit (Tennant, 1994, p. 23). Increased intervention in the lives of children was one response to such revelations: improving child health was seen as essential if the degeneration of the national physique was to be arrested, and the generation lost at war was to be replaced. Healthy children were a key to 'the progress of the race' and the continuation of imperial capitalism.

The character of the first camps was clearly contingent on this post-war milieu, with considerable emphasis being placed on creating children who were physically robust and accustomed to military discipline (Tennant, 1991). To this end camp life was strictly regimented with early-morning bugle calls, discipline enforced through corporal punishment, and activities such as marching, saluting the flag, and silent sunbathing (Woods, 1996). As Tennant observes, the camps' implicit task 'was to produce the standardised New Zealand child, sturdy in body and mind, deferential to authority and amenable to routine' (1994, pp. 57–58).

While early twentieth century militarism clearly shaped the camps, they were also influenced by the eugenics movement (see Radford, 1991). Drawing on ideas about competition between human 'races', eugenicists contended that heredity determined the quality of society, and bemoaned the supposed proliferation of 'degenerates' such as the poor, unemployed and disabled. The Plunket Society, another New Zealand institution which sought to promote child health, was founded by Frederic Truby King, 'an extremely vocal eugenicist who was an advocate of racial improvement through selective breeding' (Tennant, 1994, pp. 23–24). King was not strictly hereditarian in outlook, however, and believed that environmental improvements and proper health care could improve racial quality. The eugenics movement in New Zealand was characterised

by such ambiguities: its Social Darwinism was modified by recognition of the links between health and environment and a belief that the dictates of heredity could be modified, particularly in children (Tennant, 1994). Such thinking was supportive of the health camps movement, and in the 1930s organisations with explicit eugenicist concerns, such as the Christchurch Sunlight League, ran their own camps.

In addition to mirroring social and political concerns, early camps were organised to combat specific health problems such as tuberculosis and malnutrition. The 'tuberculin test' revealed that large numbers of children were infected by the bacillus which caused pulmonary tuberculosis, and a key public health challenge was to ensure that the disease did not develop in later life by strengthening the resistance of the 'pre-tuberculosis' child. The term 'pre-tuberculosis' came to refer not only to infected children, however, but also to those who were pale, underweight or in poor physical condition. As Linda Bryder has observed, it 'became an extremely useful category, to categorize that amorphous mass of sickly, undernourished children' (1992, p. 75).

Tuberculosis was widely regarded as a disease of civilization, and its treatment was deemed to require a 'return to nature' (Bryder, 1992). Such thinking was influential in the establishment of open-air schools, in which doors and windows were placed on all sides of the classroom. The therapeutic qualities of fresh air were extolled throughout Western Europe (Gesler, 2000), and open-air schools, were viewed as 'preventative medicine' (Bryder, 1992). By the early 1920s these ideas reached New Zealand, where the first health camps used tents with the sides rolled up to allow maximum air circulation. Elizabeth Gunn had visited Europe and Britain, and was well aware of open-air schools. Despite later claims regarding the New Zealand camps' distinctiveness, they clearly borrowed from overseas examples (Tennant, 1995).

Bryder (1992) has suggested that, in Britain, the emphasis placed on the healing powers of fresh air allowed public health officials to down-play the importance of food in improving child health. Substantial school meals were expensive, and there were financial advantages in 'relegating food to a position of secondary importance to fresh air in the treatment of malnutrition' (Bryder, 1992, p. 72). In the case of New Zealand's early health camps, however, considerable emphasis was placed on providing large meals and recording the 'mass poundage' gained by children. Vigorous exercise was discouraged, lest the campers burn off too many calories, and there was no apparent recognition of the health risks inherent in over-eating:

Food, and its consumption in vast quantities and ritualised manner, was a major preoccupation of

the health camps. The object of what appears in retrospect to be institutionalised gluttony was weight gain as a hedge against tuberculosis. A 'well-rounded' child was the ideal of the day... (Tennant, 1994, pp. 49, 52).

Food, then, played a key role in the early health camps. However, their organisation also reflected strong contemporary beliefs in the therapeutic qualities of nature, and of sunlight in particular. Children attending Elizabeth Gunn's camps were forced to sunbath naked, and in complete silence, for 90 minutes each day. Sunlight treatment ('heliotherapy') had been pioneered in Scandinavia, and was heralded as a cure for various childhood ailments, including tuberculosis (Dow, 1995). It attracted a strong following and a quasi-scientific status in other Western nations, and remarkable health benefits were attributed to direct contact with sunlight (Kevan, 1993). An advocate of summer camps for boys in North America characterised daily sunbathing as 'a potent means of storing up health and strength' (Talbot, 1905, p. 6167), while similar ideas were promoted in New Zealand by 'Sunlight Leagues' whose members operated numerous health camps during the 1930s. Although such thinking may seem anachronistic in today's melanoma-conscious society, it is interesting to note periodic public debates between those who emphasise the harmful effects of sunlight and those who assert its potential benefit in terms of vitamin D levels (e.g. *New Zealand Herald*, 16 November 1999).

In the inter-war years exposure to fresh air and the sun's rays were seen to offer benefits beyond mere restoration of physical well-being. A moralistic view of child health prevailed (Tennant, 1994), and some viewed encounters with nature as a way of treating the diseases associated with urban life, and also as a way of promoting orderly, well-mannered behaviour in the young. The moral status of children has long been subject to debate in Western societies (Valentine, 1996), and at least some early twentieth century observers associated outdoor life with moral improvement in the young (Thurber & Malinowski, 1999). In the contemporary English context, Valentine (1997) observes that the countryside is still imagined as an ideal place in which to grow up — an environment in which the innocence of children can be protected. However, this dominant conception is contested as rural communities and lifestyles are perceived to be under increasing pressure from negative (predominantly urban) influences.

Prior to World War II, health camps were primarily intended to improve the physical well-being of children. While many organisers were also cognizant of behavioural and family problems, some actively sought to exclude 'troublemakers' and chil-

dren from families deemed undeserving or unlikely to continue health camp routines (Tennant, 1994). From the 1950s, however, the *raison d'être* of the camps began to change. There was a greater recognition of behavioural problems and a desire to assist children from dysfunctional families. Such changes can be linked to post-war acceptance of the child as a 'psychological being' as well as to a decrease in the physical disorders which had earlier precipitated many health camp stays. Accordingly, camp directors introduced programmes to cater for the 'nervous, solitary and emotionally troubled among their clientele' (Tennant, 1994, p. 6).

The trend towards catering for a wide range of problems accelerated in the 1980s and 1990s, as the seven permanent health camps (see Fig. 1) responded to issues such as low self-esteem and child abuse, and admitted children from extremely difficult or problematic backgrounds. As one manager noted in response to our survey, health camps are increasingly dealing with children whose problems are 'social in nature, as opposed to strictly health-related'. This said, many such children come from poverty-stricken homes, and it is notable that physical conditions associated with poverty, including malnutrition and tuberculosis, are re-appearing in campers as well as in the wider population (National Health Committee, 1998). In addition, several respondents noted that their camps are increasingly being perceived as 'front-line' providers of paediatric mental health services.

The camp staff have responded to the diverse needs of the children referred to them with a mixture of old and new initiatives. They continue to provide free medical treatment, regular meals and schooling, as well as 'self-care routines' (relating to washing and dressing, for example) which children can take home with them. In addition they have developed specific programmes for dealing with emotional problems and behavioural disorders, and — in marked contrast to the past — 'New Image' courses which help children to *lose* weight. The average length of stay is 5–6 weeks for those in a standard programme and 1 week for those who require respite care. Children are referred to camp by public health nurses, and, less often, by school principals, social workers and general practitioners (Dumble, 1999). The emphasis on routine has been relaxed, and, as Tennant concludes, '[t]he atmosphere is now more likely to be compared with a small-scale Outward Bound or self-development course than the modified convalescent home of the mid-century' (1994, p. 260). Despite these changes, the development of the 'contract state' in New Zealand, together with anti-institutional sentiment, has called into question the capacity of camps to continue to provide therapeutic places for children in need.

The impacts of the contract state

While health camps have historically been supported by a mix of public and private funds, the balance of responsibility has gradually shifted towards the state. As Table 1 shows, the bulk of present funding comes from the state purchaser of health services, the Health Funding Authority (HFA). The balance is derived

from charitable donations, parental contributions and contracts with other state agencies. Health stamps — special postage stamps which, since 1929, have been sold during an annual appeal to support the camps — no longer represent a major source of funds.

During the tenure of the National (conservative) government 1990–99, considerable emphasis was placed on efficiency, contestability and accountability

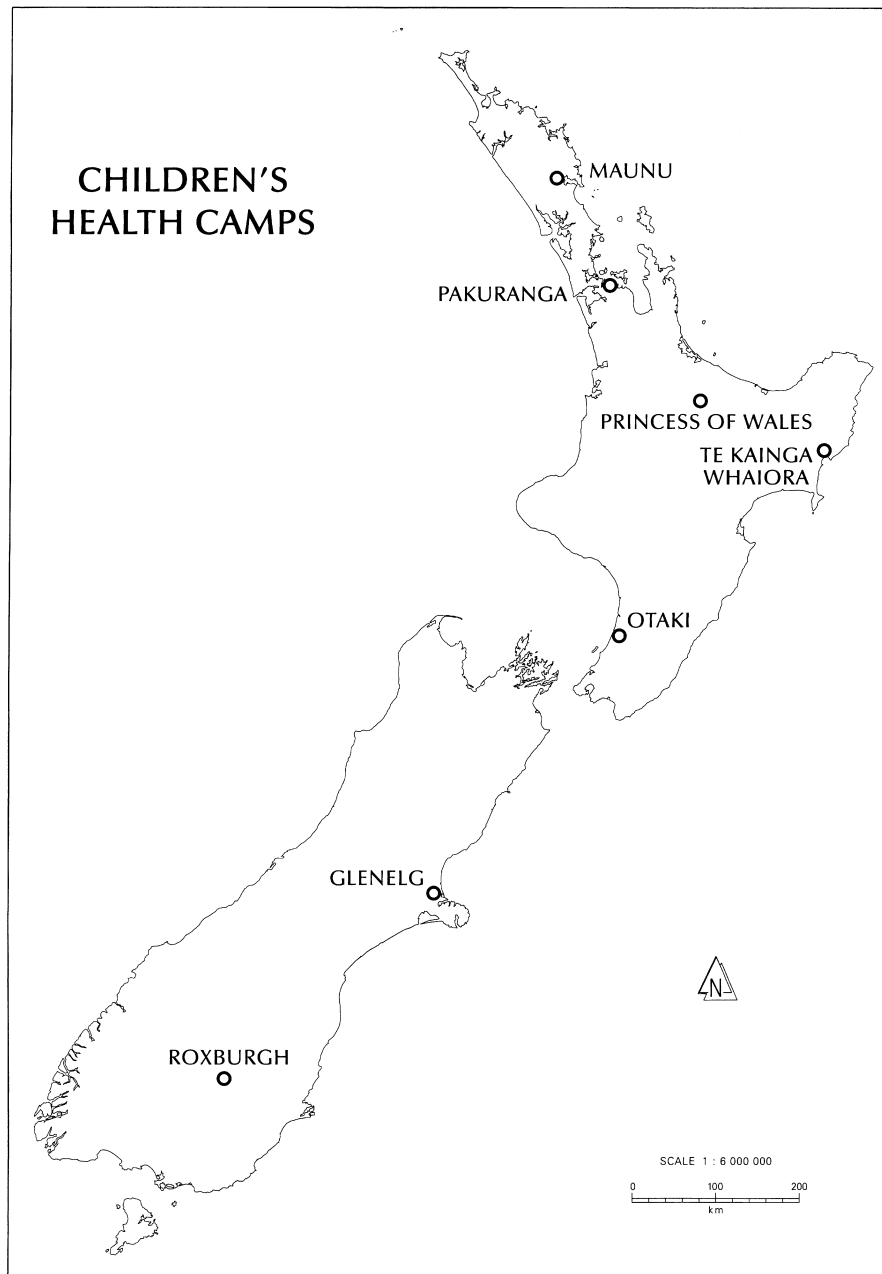


Fig. 1. Location of children's health camps, 1999.

within New Zealand's public sector (Clark, 1997). Competition among health care providers was encouraged through the separation of funding and provision, echoing international trends towards the creation of internal markets for public welfare services (Barnett & Barnett, 1999; Pinch, 1997). Contractual arrangements now regulate the provision of public health care in New Zealand, reflecting what commentators have characterised as the emergence of the 'contract state', a form of de facto privatisation (Kirkpatrick & Lucio, 1996).

The introduction of competitive contracting into New Zealand's social services strongly reflects a neo-liberal faith in the inherent efficiency of markets, but does not necessarily signal a retreat from governmental 'intervention' (Lewis & Moran, 1998). Rather, a new form of governance has been inscribed on the landscape. Those responsible for the delivery of health services are not only professionally, but also financially accountable for their actions. As Nikolas Rose has observed, '[t]ransforming activities — operating on a patient, educating a student, providing a social work interview for a client — into cash terms establishes new relations of power' (1996, p. 54). The managers of children's health camps, like other providers of health and welfare services in New Zealand, must now operate according to an array of targets, indicators and performance measures which 'govern their conduct while according them a certain autonomy of decision-making power and responsibility for their actions' (Rose, 1996, p. 57).

For health camps, the 1990s involved a shift from direct funding by the Department of Health to competitive contracting with health authorities. Even prior to this shift, reductions in funding had led the New Zealand Children's Health Camp Board (NZCHCB) and the Public Service Association (the union representing health camp workers) to question the New Zealand government's commitment to child health (*New Zealand Herald* 28 October 1991). Further, while subsidies for doctor visits

were increased, places of respite (e.g. Department of Social Welfare residential homes and adolescent psychiatric units) were down-sized, signalling a move to deinstitutionalise child health and welfare services and thus an implicit threat to the health camps.

In the contracting environment of the nineties, the camps' contracts can be fixed for a set period (as was the case from 1990 to 1996), while they are required to compete with other charitable organisations such as CCS (formerly the Crippled Children's Society) and the Cancer Society for the philanthropic dollar to meet the shortfall in their operating expenses. These circumstances led to questions being raised in the media about the financial viability of the camps, many of which have incurred significant losses, despite the fact that improving child health is a stated government priority (*Dominion*, 9 December 1995).

This situation led to a plea to central government for financial assistance by the NZCHCB in February 1996. This plea was rejected on the grounds that while their services were well-regarded, the Regional Health Authorities (RHAs, predecessors to the centralised HFA) were choosing to put more money into home-based care programmes. The advice from the Associate Minister of Health was to lobby the RHAs and to consider cutting services (*Dominion*, 19 February 1996). The NZCHCB subsequently debated selling the valuable real estate occupied by the Pakuranga Health Camp in suburban Auckland as part of their asset management programme. (*New Zealand Herald*, 20 August 1998). While all seven health camps have remained open, they have been under considerable pressure to reduce services and defer maintenance (*New Zealand Doctor*, 13 November 1996). More recently, the Otaki Health Camp is reported to have had no increase in funding since 1990 and, to cope, the management has sold several of its buildings. In justifying the frozen funding, the Health Funding Authority said the camps 'were not a priority because there are more effective ways of helping children and

Table 1
Characteristics of New Zealand health camps^a

Health camp	Location	Children accommodated 1998	HFA (state) funding as percentage of total
Otaki	Otaki	633	95
Princess of Wales	Rotorua	511	'Principal source'
Roxburgh	Roxburgh	420	85
Pakuranga	Auckland	408	95
Maunu	Whangarei	300	87
Te Kainga Whaiora	Gisborne	260	90
Glenelg	Christchurch	237	88

^a Source: Children's Health Camp Board, and Health Camp Managers Survey, 1999.

families at risk' (*New Zealand Herald* 3 February 1999).

The financial stress experienced by health camps over the last decade has been contingent on the particular institutional and budgetary arrangements prevailing within New Zealand's health care sector (Barnett & Barnett, 1997). Camp managers responding to our survey reported a variety of difficulties in their relationships with funding agencies. Four of the seven respondents highlighted the funder's concern to assess tangible 'outcomes' of the camps' activities. This preoccupation with outcomes reflects the new public sector ethos of accountability and efficiency, as well as a perceived need to ensure that providers fulfil their contracts. Yet, as one manager noted, it is difficult to assess the long-term benefits of a short-term stay at camp, given the many individual and social factors which interact to influence a child's well-being. Indeed, as a recent evaluation of health camps concluded

... studies of camp outcomes have not been able to produce statistically significant evidence proving long-term health gain ... analyses are not only limited by lack of data, but complicated by other factors such as the non-health related potential gains from attending, [the] multifactorial nature of the health problems and associated services and agencies, and the potential gain for those other than the child, e.g. family members, classmates (Dumble, 1999, p. 6).

Other problems cited by our respondents included 'establishing working relationships with funding agency personnel in a constantly changing health sector', 'having insufficient funds to recruit and retain suitable staff', and 'uncertainty concerning future funding'.

At the same time as they have experienced financial difficulties, health camps have been challenged by those opposed to institutional health care. There is a widespread disdain for institutions replete with implications of excessive infrastructural costs and high levels of social control. It has been contended by some that health camps come between children and their families, and do little to improve the homes to which campers must ultimately return (e.g. Human Rights Commission and Youth Law Project, 1988). Such arguments have contributed to the camps' funding problems, as health and welfare professionals have, in turn, questioned their effectiveness. In the words of one RHA spokesperson:

The needs of at-risk children are not best served by putting them in a holiday camp for six weeks, then sending them back home. ... [W]e give \$2 million to health camps in the North Health region, and we think there are better ways to spend the money.

For that much we could have probably 30 more field workers out there actually relating to families in their homes (cited in Woods, 1996, p. 65).

Camp managers and supporters have resisted such criticism by re-asserting the camps' therapeutic qualities in brochures and other publicity material. Indeed, the RHA spokesperson cited above was ultimately persuaded by the NZCHCB of the camps' benefits and released \$250,000 in funding for a case management service (B. Cunningham, pers. comm., 2000). Several of the respondents to our survey claimed that 'all aspects' of camp life are therapeutic, although particular emphasis was placed on the value of providing children with 'time out' from stressful situations and family problems. In other words, short-term removal from difficult circumstances offers potential health benefits. This contention has been endorsed by camp users themselves, with a recent evaluation stating that: '... the very process of removing the child from their environment has been reported to be one of the programme's strengths by both the children and their caregivers' (Dumble, 1999, p. 14). In his response to our survey, one camp manager urged us to consider Maslow's (1954) hierarchy of needs, asserting that a child could best learn to improve his or her own health when living 'in an environment that ensures s/he is safe, warm, wanted, well clothed, stimulated, has consistent and recognised boundaries/expectations and has positive interaction with others'. Two respondents discussed the therapeutic qualities of their camps' secluded, natural environments, invoking ideas from cultural ecology which Gesler (1992) draws on when observing widespread belief in the healing powers of nature. In addition, camps are continuing to impart 'life skills' and 'coping strategies' which children may take away with them. A recent and targeted example of such activity was in the aftermath of major floods in the Hokianga district in early 1999. A special stay at Maunu Health Camp was arranged for Hokianga children during which '... the children were able to work through the emotional impact of the flooding using art, murals, stories, carving and carpentry' (Hauora Hokianga, 1999).

Discussion: placing health camps in context

In the shift in preoccupation from sunlight and body weight to coping skills and strategies, we observe health camps seeking to re-legitimate themselves in changed (and historically contingent) circumstances. In the era of collective concern for welfare which began soon after the establishment of the first camps, prescriptive attitudes regarding the nature of healthy bodies prevailed. Now, 60 years later, the *zeitgeist* in

New Zealand has moved towards neoliberal individualism (Kelsey, 1995). To resist irrelevance, antiquation and closure, the health camp movement has increasingly emphasised the individual through a focus on personal skills and strategies.

Pred's (1984) analysis of historical contingency and the 'becoming' of places can assist us in explaining the tenacity of health camps. Not only have they been part of the time geographies of everyday life for thousands of children each year, but in addition, those New Zealanders without first hand knowledge of a health camp are likely to be familiar with them by virtue of the health stamp tradition. The routinised activity of using (if not collecting) health stamps over the last 70 years has generated a strongly positive collective regard for health camps as part of the national heritage (Dumble, 1999). Together, these practices have provided the foundation for a powerful (if thus far latent) resistance to the possible closure of the camps.

As part of the process of recreating themselves as therapeutic landscapes for the 1990s, health camps are developing new services which extend beyond their physical boundaries and reduce the perceived barriers between home and institution. The camps provide both residential and off-site programmes for parents, and staff are developing 'wrap-around' services which involve case managers supporting and advocating for families and children with (broadly-defined) health needs. This individualised, family-focused care contrasts markedly with that provided in the early camps where children were consciously (if temporarily) isolated from their families and treated in a standardised, regimented fashion.

At the same time as children's health camps have developed new services, questions have been raised about the effectiveness of existing alternatives to institutional care. One manager responding to our survey noted that many young clients had already 'run the gauntlet' of home- and school-based services, with little to show for it. In this context he suggested it would be 'most unwise' to cease funding the camps in favour of (often short-term and small-scale) community projects of dubious efficacy. If alternative care is indeed failing large numbers of children, it can be argued that health camps remain a valuable option in the contemporary landscape of child and family welfare in New Zealand. In the words of the executive director of the NZCHCB '... without health camps, there is nothing between the unhealthy child and a hospital' (*New Zealand Herald* 21 July 1993).

Certainly there is a growing demand for places at health camps, as socio-economic problems such as unemployment, poverty and inadequate housing place pressure on many families and impact negatively on child health (National Health Committee, 1998). Whereas North American children may be sent by

their parents to summer camps which serve largely recreational functions (Thurber & Malinowski, 1999), New Zealand's health camps operate year-round to assist those chronically ill and troubled children referred to them in growing numbers by public health nurses, general practitioners, welfare agencies and school principals. Ironically, then, health camps find their services to be in greatest demand at the same time as their future is threatened by funding arrangements and opposition to institutionalised health care.

Conclusion

In the course of the last eight decades health camps have responded to changing concerns about children and their health, seeking to provide therapeutic residential settings for campers. In the 1990s, however, their place in New Zealand's welfare landscape has been threatened by the need for each camp's management to negotiate a contract with a health funding agency, and by opposition to institutionalised health care in general. Unlike many psychiatric institutions and small rural hospitals in New Zealand, however, health camps have not been closed. They remain as 'curious hybrids' — neither state agencies nor private charities (Woods, 1996) — which operate despite the fact that institutional environments are increasingly cast as non-therapeutic.

It is clear that, at least among experts, the home is re-emerging the preferred site for a range of interventions ranging from maternity care to the promotion of child health to palliative care (Abel & Kearns, 1991). In this context, the future of the health camps appears far from certain. Relegitimation through a focus on life skills as well as appeals to government have been the camps' key strategies of resistance. Public regard remains largely untested, although we suggest that it may be high given evidence that health camps have been imprinted on the collective consciousness of New Zealanders. This certainly appears to be the case in areas adjacent to camp locations. For example, 'over the years, the identity of the cluster of concrete buildings sitting snugly on the rise above Half Moon Bay has endeared itself to the Pakuranga community' (*New Zealand Herald* 3 February 1999). Manifestations of such endearment include local organisations donating new equipment and a women's club ensuring that children whose birthdays occur while they are at the camp receive a card and a cake. However, any expectation of widespread protest following a possible future closure announcement may be ill-founded, however, given the raft of closures and down-sizings which have already occurred in New Zealand in the 1990s (Le Heron & Pawson, 1996).

Ultimately the debate over the utility of health

camps is a *spatial* one concerning *where* 'at-risk' children are best treated. Managers insist that the camps are being reinvented as contemporary therapeutic landscapes with an emphasis on coping strategies and life skills. In terms of recent scholarship applying the therapeutic landscape idea, health camps are of interest as they are 'invented places' (Anderson & Gale, 1992). Farmers' paddocks were converted into health camps by means of demarcation, new ownership, an arrangement of buildings and highly routinised practices. In this sense, the generalised healthy qualities often attributed to rural areas (several of which have since been engulfed by suburban expansion) were given more therapeutic specificity through their designation as health camps. An important, if ethically challenging, extension of this work would be exploring perceptions of the health camp experience with their youthful users. Further research might also examine more closely the discourses employed in constructing the child in literature associated with health camps. Explorations linking place with the themes of governmentality, risk and medicalisation from a Foucauldian perspective (see Peterson & Bunton, 1997) may prove especially fruitful in extending this work.

Our application of the therapeutic landscape concept has allowed us to identify how health camps as places of respite and health promotion have evolved according to historically contingent conditions. We have identified ideas of power, resistance, ideology and historical contingency which have previously been under-explored in studies of therapeutic landscapes. Our present discussion has at best partially embraced these concepts but it is presented with the intention that others exploring therapeutic landscapes may embrace the collision of health (care) beliefs, social practices and the materiality of everyday life.

Acknowledgements

This research was supported by a grant from the University of Auckland Research Committee. We are grateful for the assistance of Mr R. Turner of the Children's Health Camps Board and comments from three anonymous referees. We also appreciate Wil Gesler's helpful suggestions on an earlier draft of this paper, which was presented at the New Zealand Geographical Society Conference, Palmerston North, July 1999.

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