

The Merseyside Health Action Zone: A case study in the implementation of an area-based public health policy.

Thesis submitted in accordance with the requirements of the University of Liverpool for the degree of Doctor in Philosophy
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For my parents:

Hilary Ann Povall
(1937 – 2003)

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Abstract

Susan L Povall: The Merseyside Health Action Zone: a case study in the implementation of an area-based public health policy.

Background: Health Action Zones (HAZs) were in the vanguard of the U.K. New Labour government health policy and existed between April 1998 and March 2003. They were area-based initiatives charged with the two aims of reducing health inequalities and contributing to the modernisation of services. The HAZs were aimed at areas of deprivation and were based on partnerships between local government and the local health sector. They were subjected to a barrage of changes both internally, through changes to their focus and funding, and externally, through organisational changes within their core partner agencies.

Objective: The research examined “*What has been the experience of implementing the HAZ policy on Merseyside?*” from the perspective of those people involved with the development and delivery of the policy in Merseyside, people whose voices are rarely heard. It had the specific objectives of: a) to explore how central government interacted with the local implementation of MHAZ; b) to identify aspects of central government policy that facilitated or hindered local implementation; c) to identify what factors, if any, helped to make the horizontal relationships within the MHAZ operation work.

Methods: The research contributes to the emerging field of policy ethnography. A case study ethnographic methodology was employed, adopting the qualitative methods of observation, semi-structured interviews and documentary analysis. The empirical data was collected between October 2000 and September 2003, mostly through the interviews. An iterative, thematic analysis was used to develop the findings.

Main results: There are three key findings. Firstly, the persistent and rapid changes in the policy context had a detrimental impact on both short-term stability and the long-term security of the MHAZ. Secondly, the HAZ Way of Working, a whole systems approach, created a flexible, supportive environment for change. The HAZs had a specific set of values at their core and these values resonated with people connected with the MHAZ, releasing energy and enthusiasm. Thirdly, people are the means through which policy is implemented and change occurs.

Conclusions: The findings highlight a tension in two change management processes operating within the MHAZ: a collaborative, flexible, whole systems approach to local change and a prescriptive, burdensome, top-down attempt to force change in the public sector. They reveal two different value systems operating against each other and reflect the paradox at the heart of the New Labour Third Way. Specifically, the findings lead to the following conclusions: people operate according to a set of values and policy implementation works best when it is in line with these values; MHAZ demonstrates the potential of joining-up locally, but this joining-up does not extend vertically between the central government and local implementation; to effect the lasting change that New Labour desires it needs to bring these two together to create a supportive environment for change with a common set of values.

Key Words: U.K., New Labour, Public Health, policy, implementation, stakeholder perspectives, whole systems, change management, values.

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List of abbreviations

DoH	Department of Health
HA	Health Authority
HAZ	Health Action Zone
HLC	Healthy Living Centre
LA	Local Authority
LSP	Local Strategic Partnership
MHAZ	Merseyside Health Action Zone
NHS	National Health Service
NOF	New Opportunities Fund
PCT	Primary Care Trust
SMR	Standardised Mortality Ratio
StBoP	Shifting the Balance of Power
StHA	Strategic Health Authority

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Chapter 1

The Merseyside Health Action Zone: **Setting the scene**

[T]he complex myriad of partnerships that constituted Health Action Zones, involving hundreds of organisations and thousands of individuals, means that many different stories can be legitimately told.

(Bauld et al, 2005, p.442).

The Health Action Zones (HAZs) were announced shortly after New Labour's election victory in 1997. They were the first New Labour area-based initiative and were targeted at areas of deprivation in England. The Zones were trumpeted as 'trailblazers' and were intended to kick start changes that would help to address health inequalities and contribute to the modernisation of services. They were to form broad based partnerships to tackle the underlying determinants of health, with a partnership between the local health sector and local government at their centre.

A vital part of our vision for a fair, modern and strong health service will be Health Action Zones. They will help health service organisations, local authorities, community groups, charities and local businesses to forge innovative new partnerships – to improve health and modernise services. Frank Dobson, Secretary of State for Health (DoH, 1997b, p.1).

They will cut through red tape barriers between health and social care. They will do much more than reshape services to deliver more seamless care for patients. In Health Action Zones, the NHS will work in partnership with local government and other agencies to tackle the root causes of ill health. Alan Milburn, Health Minister (DoH, 1997c, p.1).

Originally the HAZs were proclaimed as five to seven-year initiatives that would be based on local needs. Over time, and as the New Labour agenda developed around them, their focus was changed to support National Health Service (NHS) priorities and their long term future became increasingly doubtful. HAZs were eventually brought into the mainstream when their funding was allocated to the baseline of the new local primary care agencies from April 2003. For Merseyside, this meant the disbandment of the regional focus of the HAZ work.

This thesis provides the story of the implementation and delivery of the Merseyside Health Action Zone (MHAZ). It is based on the experiences of people associated with this HAZ, and reveals the enthusiasm that can be generated when people have the opportunity to try ideas congruent with their value systems, and to work in a flexible and supportive environment. It has been an enormous privilege to be able to observe this process, and to record the voices of the people working on the frontline of the HAZ in Merseyside. It is rare to hear such voices (C. Jones, 2001). Voices that tell us what motivates and challenges public and charitable sector workers; what enthuses them and what causes stress and anxiety. A sentiment supported by the *Guardian*:

... we have constructed a mosaic of voices. They are men and women who are often talked about but heard only rarely. They are the voices of people who work in our public services – people who, in some fundamental sense, work for the public good. (Guardian, 20 March 2001, cited C. Jones, 2001, p.548)

The voices of public sector frontline staff can tell us much about the reality of working within the public sector, and the pleasures and pains of policy implementation. These voices represent neglected areas of experience that can

highlight the tensions between the rhetoric of policy and the reality of implementation. This thesis captures the voices of frontline staff involved in the implementation of a public policy, overcoming this neglect. It is time to start listening to the reality of policy implementation (C. Jones, 2001).

1.1 Giving voice to the frontline

The policy implementation literature is dominated by research assessing the general processes of policy development at the macro level, focusing on the differences between intent and outcomes (Schofield, 2004). However, there is little that explores the details of policy implementation at a local, or micro, level. Studies at this micro level provide for lessons at the macro level, looking upwards to shed light on and deepen understanding of the processes there. The emerging field of policy ethnography examines this micro level, revealing the processes involved in implementation, the direct practical issues concerning personnel and the capacity for change that can make or break policy.

Hunter (2003a) argues that there “*are serious, and often neglected, issues about whether, and how, national policy can be effectively implemented locally and what needs to be in place for this to occur*” (op. cit., p. 29). Further, he suggests that if there is to be a genuine movement towards policies to address the root causes of health inequality and deprivation then there is a need to first move away from the current linear, command-and-control models of policy implementation. Hunter and Killoran (2004) argue that “*stakeholder’s views of implementation and tackling health inequalities at local level are critical to the success of policies*” (op. cit., p.1). Stakeholder views also shed light on what frontline workers need to deliver change.

Public policy is implemented by a myriad of people. They include those in central government and the civil service who translate policy statements into policy instructions and guidelines, but most importantly they include those implementing policy on the frontline of local service delivery. The policy implementation literature does not consider how these frontline workers translate policy into action (Schofield, 2004), and yet it is these people who make policy a reality. Schofield (2004), therefore, argues that “*the researcher, by necessity, has to be interested not only in the nature of the policy, but also with those upon whom the action depends*” (ibid, p.286).

This thesis explores the implementation of the HAZ policy on Merseyside, through the experiences of those involved with the policy at different stages of the process. Frank Dobson, who as Secretary of State for Health introduced Health Action Zones, shared his reflections on the original intentions behind the initiative. The research also includes the observations of two of the national government Department of Health (DoH) civil servants responsible for implementing and supporting the HAZ policy. However, the main voices are those of the people delivering the Merseyside HAZ: those working to deliver the policy strategically across the Merseyside region, those working to deliver the policy strategically within the five districts of Merseyside, and those working in interventions in receipt of MHAZ monies; and their voices, as I note above, are too often neglected in policy analysis.

1.2 Research question and aims

The New Labour government is committed to improving equity and promoting social justice. Central to these aims is the radical reform of the public services (Blair, 2004b). This ‘modernisation’ agenda has the joint aims of raising standards of

service and improving accountability through central control and setting targets (Bevir and O'Brien, 2001; Gray, 2004), and tackling entrenched problems with complex causes through partnership working and collaboration, or 'joined-up' working (Bevir and O'Brien, 2001; Powell and Exworthy, 2001). These two facets of the New Labour project are evident in the HAZs, and so exploring the implementation of the MHAZ from the perspective of those working within or connected with it provides the opportunity to assess the impact of these processes on those working to create change.

From the outset of my connection with the Merseyside HAZ it was clear that there was an enormous amount of frustration resulting from the rapidly changing context within which the HAZs were operating. This frustration extended beyond the HAZ to others working in the public and charitable/voluntary sectors I met at conferences and seminars. But it was also clear that there was a substantial amount of enthusiasm for addressing health improvement on Merseyside, and for working in the way that MHAZ promoted. This led to the research question:

“What has been the experience of implementing the HAZ policy on Merseyside?”

This question was examined from the perspective of those people involved with the development and delivery of the policy in Merseyside, with the specific objectives of:

- a) To explore how central government interacted with the local implementation of MHAZ.
- b) To identify aspects of central government policy that facilitated or hindered local implementation.
- c) To identify what factors, if any, helped to make the horizontal relationships within the MHAZ operation work.

The research contributes to the growing field of policy ethnography. The process included observation and extensive conversation across a broad spectrum of people involved with the HAZ initiative recognising the “*importance of people as drivers of change*” (Hunter and Killoran, 2004, p.8). This took place over a number of years, tracking changes in the policy context and daily realities of implementing the HAZ on Merseyside. It reveals the value of micro level analysis, and in particular the myriad processes and dynamics which influences all policy implementation. One of the significant features of the HAZ policy is the complexity of the processes at play. This complexity can only be revealed by this type of analysis.

The HAZs represented a significant development in health policy thinking, and the high profile emphasis on reducing health inequality was greeted enthusiastically by many people. There was a marked similarity between the aims and structure of the HAZs and the values of the World Health Organization (WHO) sponsored Health For All initiative. These promote equity, participation, partnership and sustainability as the underlying principles for promoting health and wellbeing. Many of the people drawn to working in the HAZs had Health For All and health promotion backgrounds. I, too, was interested in the policy because I share a belief in these ideas as the means to generate health improvement. The Merseyside HAZ was therefore an opportunity to see how these ideas could play out in practice.

1.3 The New Labour context

The New Labour public service agenda is characterised by a push for modernisation to drive up standards and make services more equitable. Targets, monitoring and league tables have been used to compel policy change, assess progress, reinforce Ministerial priorities, target resources and complement organisational restructuring.

The pressure from this top-down change agenda has been overwhelming (Exworthy *et al*, 2002; Hunter, 2003a) and frontline staff have seen their jobs reduced to filing paperwork, with minimal contact with the clients of their services (C. Jones, 2001). This has created an enormous amount of stress and dramatically reduced job satisfaction (C. Jones, 2001; Coffey, 2004). As this thesis reveals, issues such as these became significant pressures on the MHAZ.

At the same time, various agencies within the statutory sector find themselves with a duty to work collaboratively (Exworthy *et al*, 2002) to create joined-up solutions to the complex problems of poverty, social exclusion, deprivation and health inequalities. Some of this is through area-based initiatives, such as HAZs. Partnership is not a guaranteed success, and there have been difficulties in forging partnerships where there is a lack of trust and openness, where there is uncertainty about resources and the different agencies have different structures of accountability, making joint goals difficult (Exworthy *et al*, 2002).

Health Action Zones heralded a renaissance in interest in public health and health inequalities within government. Tessa Jowell, then Minister for Public Health, commissioned an independent inquiry into inequalities in health, and a review of the Conservative public health policy *The Health of the Nation* (Hunter, 2003a). The resulting report (Acheson, 1998) and public health policy *Saving Lives: Our Healthier Nation* (DoH, 1999c), marked the New Labour commitment to tackling the underlying determinants of health, although both were criticised for their focus on medical outcomes (Exworthy, Blane and Marmot, 2003; Hunter, 2003a; Oliver and Nutbeam, 2003).

The appointment of Alan Milburn to Secretary of State for Health saw a return to the NHS at the centre of New Labour health policy. A New Labour ‘moderniser’ (Hunter, 2003a), Milburn’s focus was on the modernisation of the NHS, always an important election priority (Hunter, 2003a). This modernisation included the restructuring of the health service to bring decision making closer to, and more inclusive of, the people utilising the services. Prior to the NHS restructure local health sector administration for primary care was managed by Health Authorities (HAs). Following the reorganisation these were replaced by smaller Primary Care Trusts (PCTs). For example, in Merseyside there had been four HAs, and these were replaced by nine PCTs. The HAs had reported to regional NHS civil servants, here the North West Region NHS Executive. Similarly these organisations were disbanded and replaced by smaller Strategic Health Authorities (StHAs), in this case the Cheshire and Merseyside Strategic Health Authority. The local government organisations, Local Authorities (LAs), were not restructured in this way but underwent changes to their governance methods and duty of care for community wellbeing. As time progressed, all local statutory agencies were required to work together with the common goals of improving health, wellbeing and service provision through Local Strategic Partnerships (LSPs).

A rapid change in public sector policy has been a key feature of the New Labour approach to the modernisation of public services (Clarke, 2004). In the face of directives about national priorities, like waiting lists, frontline health workers gave little priority to health inequalities (Exworthy *et al*, 2002). This loss of visibility in public health and health inequalities caused concern amongst the public health community (Hunter, 2003a) and those working within the Health Action Zones. Kingdon (1995) suggests that the climate of government contributes to whether or

not issues remain high profile agenda items. New Labour have been criticised for reacting too readily to *Daily Mail* headlines (Toynbee, 2004a). This, and an insatiable desire for change (Blair, 2004b), have created a policy context that is never stable. This unsettled environment creates problems for the people working to implement New Labour policy changes, some of which have been brave and innovative – like Health Action Zones.

1.4 The dawn of a new area-based initiative

Frank Dobson, then Secretary of State for Health, announced the creation of Health Action Zones on 25th June 1997 at the annual conference of the NHS Confederation. He proposed

to target a special effort on a number of areas where we believe the health of local people can be improved by better integrated arrangements for treatment and care. (DoH, 1997a, p.1).

Health Action Zones were embraced as a bottom-up initiative, focused on local needs, with the remit to take risks and generate change in the delivery of local services and the quality of people's lives. They were talked up as being in the *vanguard* of New Labour policy, on the *frontline* in the war against inequalities, as *trailblazers* for change:

Health Action Zones represent the best of cross-Government working to benefit the public. They are trail blazers which will benefit thirteen million people. Frank Dobson (DoH, 1999a, p.1).

Health Action Zones are in the frontline in the Government's war on health inequalities. Tessa Jowell (DoH, 1999b, p.1).

People involved with Health Action Zones felt themselves to be at the cutting edge of policy, to be working in a high profile initiative that had brought their work into

the mainstream. As one respondent who had worked for many years in community based health improvement said she

worked in the way that HAZ works before HAZ existed, because I think HAZ is a new incarnation of a whole lot of other developmental process orientated things, but it made that approach stronger and more recognised and ... legitimated it. (Intervention, Health, 11/2002).¹

One of the ways in which this approach was legitimated was simply through the ability to talk openly about health inequalities. Another interview participant explained that under the previous Conservative governments

the only way that we were allowed to talk about health and health inequality was through the regeneration agenda. It was very much stamped on. ... The idea of health inequalities on a geographic basis, or words like poverty ... people used them privately, but you couldn't use them in any official way. (MHAZ co-ordination, 03/2003).

Health Action Zones reflect the New Labour aim of creating a more just society by modernising public services through collaboration and reducing inequality by targeting initiatives at the more deprived areas. Opportunity, responsibility and community are core New Labour values (Brown, 2004), and HAZs “*have both the opportunity and the responsibility to pioneer new ways of driving up local standards of health*” (Tessa Jowell in DoH, 1999b, p.1).

The HAZs also had the political objective of making some quick changes to systems New Labour felt had been failed by the outgoing government while more considered changes were developed and implemented. In particular, Health Action Zones were a way of getting more money into the health system in deprived areas quickly. Areas, like the East End of London, which “*wasn't getting its fair share, even under*

¹ See page 146 for an explanation of the references for quotes derived from this research.

the formula. If you assume, for this purpose, that the formula was fair” (Frank Dobson, personal communication, March 2003). The long term aim was to adjust the NHS funding allocations formula so that more money went to the NHS in areas with high concentrations of disadvantage, and this took effect in April 2003 (DoH, 2002a).

It was a way of [injecting money and releasing energy] for the areas most in need, getting things going quickly, rather than trying to get the whole machine doing it. (Frank Dobson, personal communication, March 2003).

The emphasis on collaboration was more than just a reflection of the New Labour challenge to individualism and the belief that

[p]eople are not separate economic actors competing in the marketplace of life. They are citizens of a community. We are social beings. ... People are not just competitive; they are co-operative too. They are not just interested in the welfare of themselves; they are interested in the well-being of others. (Blair, 1996, cited Bevir and O’Brien, 2001, p.537/8).

It was also a reaction to the internal market introduced to the NHS during the Thatcher Government. This had set different parts of the NHS in competition with each other, and had inhibited co-operation and stifled innovation within the system (NHSE, 1997). *“So it was partly to pump into the system ... in the areas most in need ... a co-operative approach.”* (Frank Dobson, personal communication, March 2003).

Health Action Zones were an attempt to facilitate innovation. To recognise that frontline staff are best placed to identify improvements to the services provided locally. In this sense, HAZ funding was a pot of money outside mainstream funding

that could be used to take risks and try new things, *“and it wouldn’t be so awful if it was in the Health Action Zone ...if it didn’t work”* (Frank Dobson, personal communication, March 2003).

This emphasis on partnerships, service modernisation, and addressing health inequalities through tackling the root causes of ill health resonates with the ideals and philosophy of the World Health Organization programmes of Health Promotion, Health For All and Healthy Cities. These are the sort of ideas that influenced Health Action Zones and came *“from all over. They are the sort of thing that people have been talking about for quite some time”* (Frank Dobson, personal communication, March 2003). But it was New Labour that allowed them to be discussed openly (Exworthy *et al*, 2002; Deacon, 2003; Oliver and Nutbeam, 2003) and that brought issues of social justice, poverty and inequality into the mainstream once more. This generated a great deal of enthusiasm for the HAZ initiative. As one respondent, working at the strategic level of the Merseyside HAZ, put it

... it was the thing about inequalities – it was such an opportunity – because I’d been trying to do it against the tide of the politics at the time, that to do this, and to do it for Merseyside ... it was like it had my name on it. (MHAZ co-ordination, 03/2003).

Sadly, over time the rapid pace of New Labour policy change dimmed the HAZ light to some degree. A new Secretary of State for Health, Alan Milburn, changed the HAZ focus from local needs to supporting the national agenda priorities of cancer, coronary heart disease, mental health, waiting lists and National Service Frameworks (NSFs, policies aimed at improving outcomes for specific areas such as cancer, coronary heart disease, older people). HAZ budgets were cut due to an under spend in the first year of the second phase. There was a centralised, time consuming,

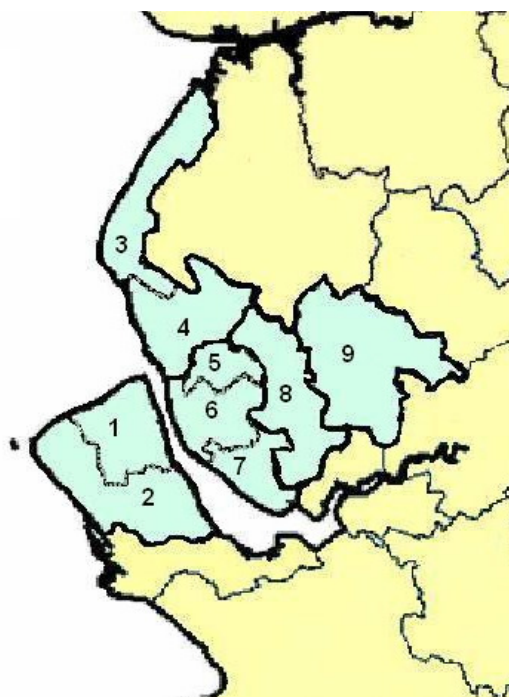
performance monitoring system imposed on the Health Action Zones. Organisational changes in the two key partners – Local Authorities and the NHS – disrupted partnerships. New partnership arrangements, such as Local Strategic Partnerships and Public Health Networks, and local authority Community Plans and NHS Health Improvement and Modernisation Programmes seemed to make Health Action Zones redundant. Most of all continual funding insecurities undermined morale.

Although announced as a five to seven year programme, HAZ funding was only guaranteed until the end of March 2002. At the eleventh hour this was extended until the end of March 2003. Again, at the last minute, it was announced that the final three years of HAZ funding would be forthcoming, but that it would go directly to Primary Care Trusts, who by now had a requirement to reduce health inequalities. Health Action Zones became unhappy places, many ‘haemorrhaging’ staff. The Merseyside HAZ managed to maintain its enthusiasm, staff and partnership through most of this, ending its Merseyside wide focus only with the enactment of the final funding changes in April 2003.

1.5 Merseyside Health Action Zone

The Merseyside HAZ was the largest and most complex of all the HAZs, covering 1.4 million people and initially having 9 strategic partners: 5 Local Authorities and 4 Health Authorities covering the districts of Liverpool, Knowsley, Sefton, St Helens, and Wirral (MHAZ, 2000). Following the NHS reorganisation which took effect at the beginning of April 2002, the four Health Authorities were replaced with nine Primary Care Trusts. Figure 1.1 shows the boundaries of these core partners.

Figure 1.1 The Merseyside Health Action Zone primary partner agencies



Local Authority	Health Authority	Primary Care Trust	Map reference
Metropolitan Borough of Knowsley	St Helens and Knowsley	Knowsley	8
Liverpool City Council	Liverpool	North Liverpool	5
		Central Liverpool	6
		South Liverpool	7
Metropolitan Borough of Sefton	Sefton	Southport and Formby	3
		South Sefton	4
Metropolitan Borough of St Helens	St Helens and Knowsley	St Helens	9
Metropolitan Borough of Wirral	Wirral	Birkenhead and Wallasey	1
		Bebington and West Wirral	2

The programme operated at two main levels. There was a regional focus to the work managed through the Steering Group, and operated through the Central Co-ordination and Support Team, headed by the MHAZ Co-ordinator. Each district also implemented a HAZ programme, and these districts had some flexibility to address

local needs within the context of the overall programme goals. Eventually each district had its own HAZ co-ordinator, and most of them managed their local programmes through a broad based partnership.

- 1. Achieving equity:**
Reducing health inequalities, promoting equality of access to services and improving equity in resource allocation.
- 2. Engaging communities:**
Involving the public in planning services and empowering service users and patients to take responsibility for their own health and decisions about care.
- 3. Working in partnership:**
Recognising that people receive services from a range of different agencies and that these services need to be co-ordinated to achieve the maximum benefit.
- 4. Engaging frontline staff:**
Involving staff in developing and implementing strategy, developing flexible and responsive organisations and encouraging and supporting innovation in service delivery.
- 5. Taking an evidence-based approach:**
Having a more structured, evidence based approach for service planning and delivery as well as clinically effective procedures and interventions.
- 6. Developing a person-centred approach to service delivery:**
Developing services around the needs of people and delivering them as close to people as appropriate.
- 7. Taking a “whole systems” approach:**
Recognising that health, social and other services are interdependent and need to be planned and organised on a whole system basis to deliver seamless care and tackle the wider determinants of health.

Box 1.1 Health Action Zone Guiding Principles

The HAZ in Merseyside aspired above all to be “*a catalyst for long term strategic change*” (MHAZ, 2000, p.4) to embed the HAZ Principles (see Box 1.1) in the work of the core partner agencies.

The Merseyside Health Action Zone is about long term fundamental changes in the way we all think about health, the ways in which we use and provide services, and the attitudes which influence the ways we interact with other professionals, other organisations, service users and groups within the wider community. (Op cit, p.38).

The Merseyside HAZ partnership had the following aims (MHAZ, 2000), reflecting the aims of the HAZ programme to reduce health inequalities by tackling the root causes of ill health and modernising health and social care services:

- A focus on outcomes and making a difference.
- Preventive long term approach to improving health and reducing inequalities.
- A coherent integrated approach – joining up policy and action.
- Learning and spreading good practice – focussing on ‘what works?’
- A participative approach involving all sections of the community.

As a second wave HAZ, the people developing the Merseyside programme were aware that the HAZs might be refocused to address national priorities. They took the pragmatic decision to emphasise the national priorities in their local programme; although cancer, coronary heart disease and stroke, and mental illness were also top priorities for the region. This meant that they had to make less of an adjustment than some of the other HAZs when the HAZs were told to focus on these national clinical priorities.

The HAZ had four specific goals (MHAZ, 2000) (see Appendix A for more detail):

1. Reduce levels of poor health through modernising and improving health and social care through, e.g., reducing inequalities of access to health care for cardio-respiratory disease, cancer, infectious disease and mental health; changing attitudes about health.
2. Promote healthy employment opportunities through, e.g., working with schools and other organisations to promote employability; improving access to employment.
3. Increase the proportion of people who have an active independent life through, e.g., providing support for people to remain in their own homes; supporting local transport initiatives.
4. Enhance quality of life through, e.g. building on the strengths of local people; supporting healthy food initiatives.

And a fifth overarching co-ordination goal of “Making it Happen”, and sharing learning (see Figure 1.2).

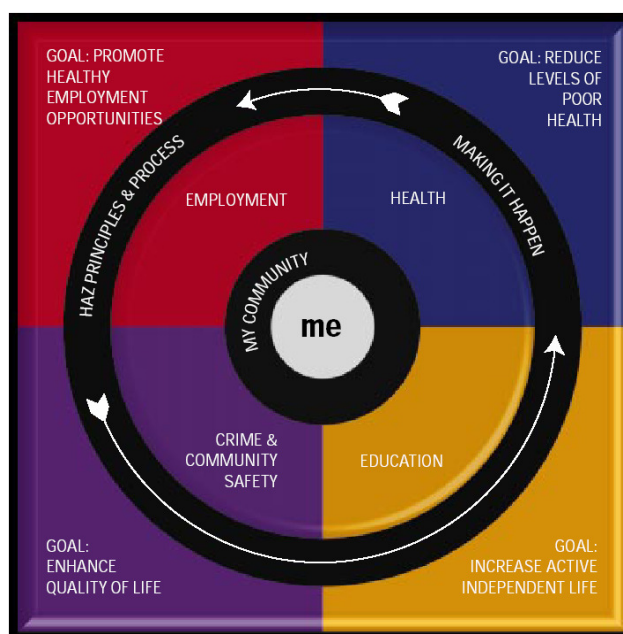


Figure 1.2 Merseyside HAZ - an integrated approach to tackling the complex problems of the poorest and most disadvantaged communities on Merseyside (Source: MHAZ, 2000, p8).

This last goal represents the work of the co-ordinators at both the regional and district levels to promote the HAZ ethos and to support people in their association with the HAZ. It was through this, the core partnerships and the funding of interventions that the people working within MHAZ hoped to ensure that “*HAZ principles become embedded in all that we do*” (MHAZ, 2000, p.38).

1.6 The research context

Many stories are starting to emerge about the Health Action Zones (HAZs) in England. The National Evaluation of HAZs have produced their final reports (Barnes *et al*, 2003; Benzeval, 2003; Mackenzie *et al*, 2003; Bauld *et al*, 2005), there are numerous local evaluations (see www.haznet.org.uk), and there is a growing literature assessing various aspects of the HAZ aims, for example: local governance (Crawshaw and Simpson, 2002); local perceptions on the impact of HAZs (Sullivan *et al*, 2004); engaging with the voluntary sector (Unwin and Westland, 2000); engaging with communities (Crawshaw *et al*, 2003; Crawshaw *et al*, 2004); organisational change (Maddock, 2002; Evans and Killoran, 2004); smoking cessation (Woods *et al*, 2003); partnership working (Asthana *et al*, 2002; Matka *et al*, 2002); as an example of an area-based initiative (Powell and Moon, 2001; Cole, 2003); policy tensions (Lannin, 2003).

In Merseyside there have been two reports assessing the impact of the HAZ regionally. The Merseyside HAZ (MHAZ) was one of eight integrated case study sites comprising one module of the National Evaluation of Health Action Zones, and there is a final report of the findings from this HAZ (Mackinnon, 2003). The MHAZ also commissioned Liverpool John Moores University to undertake a local

evaluation of its work (Springett *et al*, unpublished). The findings presented here both support and complement the findings from these two pieces of work.

Much of the literature about HAZ work has emphasised the importance of having champions and risk takers involved (Maddock, 2002; Matka *et al*, 2002; Barnes *et al*, 2003; Benzeval, 2003; Cole, 2003; Mackenzie *et al*, 2003; Evans and Killoran, 2004; Springett *et al*, unpublished). Springett *et al* (unpublished) have also touched on how people local to Merseyside have gained from working in the 'HAZ Way'. This thesis expands on this literature to show how the commitment, energy and enthusiasm of people in all parts of the delivery of the HAZ in Merseyside have been some of its lasting successes.

This chapter has presented some of the macro level concerns experienced by the HAZs. By bringing the analysis down to the micro level a more penetrating light can be shone on the consequences of these issues. Issues such as the implications of implementing policy in an unsettled environment. This type of analysis reveals things rarely discussed at the macro level. The public sector is often pilloried and the private sector held in high esteem. This research demonstrates the commitment, passion and enthusiasm released when public sector workers are given the opportunities to take risks and work in a manner congruent with their values. Policy ethnography has revealed the thoughtfulness, capacity, innovation, wisdom, intelligence and passion that exist within all levels of the public sector workforce. If more policy is based on building and sustaining those strengths and enthusiasms, just imagine what could be achieved.

The research is based on the epistemological position that health is more than the absence of illness and infirmity, and that health is generated through the complex

interaction of many physical, emotional and social factors. Although, as individuals, there are many things we can do to protect and promote our own health and the health of those around us, many of the factors that impact on health are affected by political decisions made elsewhere.

This viewpoint is not universally accepted and so it therefore follows that there are many different theories which attempt to explain the acknowledged association between social circumstances and health outcomes (illness and death), and how morbidity and mortality can be reduced and health improved. Many of these theories are presented in Chapter 3. This eclectic mix of theories is included to situate the approach taken by MHAZ within these debates and also to demonstrate how these debates are similar to those that exist about the underlying causes of poverty and inequality more generally, discussed in Chapter 4. In both cases there are arguments for a shift in emphasis at the national and international level away from the neo-liberal drive for the generation of wealth to an emphasis on universal wellbeing, and for the need for co-operation and collaboration to address the complex conditions of poverty, inequality and health inequality.

The notions of equity and justice discussed in Chapters 3 and 4 have influenced the New Labour policy process. These and theories on the development of New Labour values and approaches to implementation shed light on New Labour's social aims and describe the context within which the HAZs were operating.

1.7 Structure of the dissertation

This research is a piece of policy ethnography. This approach to examining the policy implementation process is described in more detail in the next chapter. Ethnographic methodology typically comprises the methods of observation,

interviews and documentary analysis. All of these have been used here, and their particular application is discussed in Chapter 2, along with the approach taken to data analysis, ethical considerations, reliability and validity of the results. In addition, Chapter 2 discusses the Merseyside HAZ in more detail, particularly its organisation and financial arrangements, and introduces me, the researcher, my interest in the work of the HAZ and my relationship with the people working within it.

Much has been written about health inequalities and there have been various suggestions on what the underlying causes of inequality are, and how a government might best address them. Chapter 3 presents some of these discussions. It starts with considering what is meant by 'health' and 'health inequalities'. HAZs were to improve health by addressing the underlying determinants of health. This suggests a particular understanding of health, often termed the social model, an idea that has been developed 'in exile' – largely without UK government backing. The chapter will consider how these ideas are represented in the HAZ policy, with specific examples drawn from the Merseyside programme.

Chapter 4 examines how New Labour brought these ideas 'in from the cold', and how the HAZ programme reflects the New Labour emphasis on social justice. In many ways the HAZs were the victims of a rapidly changing policy agenda. They were intended as a quick fix, an attempt to get things moving quickly. At the same time, they were an experiment in broad based partnerships for health improvement. There is a conflict between the government's need to see results, and the need for time and stability for such an initiative to build relationships and to start to show benefit. This chapter will discuss the government's changing health agenda and its early effects on the HAZs.

Chapters 5, 6 and 7 present the findings from this research. Chapter 5 gives voice to those working at the strategic level of the MHAZ: policy makers, Steering Group members, and co-ordinators of the programme regionally and in the districts. These people were the interface between the Ministers' and Government expectations of the MHAZ and the interventions who were delivering change through specific projects. As such, they were responsible for adapting the MHAZ programme to the changing circumstances within which the HAZs were trying to operate. It is at this level, then, that the main effect of this conflict was felt. The chapter tells the story of the development of the HAZ from its shaky first application for HAZ status, to its demise following the funding changes that took effect in April 2003. The chapter concludes by looking at the strengths of the strategic HAZ approach in Merseyside, particularly the way in which they have been able to promote the social model of health.

Chapter 6 presents the strengths and weaknesses of the HAZ from the perspective of people working within some of the interventions MHAZ funded at the regional level and within the districts. For these people MHAZ was usually just one source of funding and so they were able to discuss the difficulties of being on the frontline generally, and put the MHAZ initiative into that context. It is perhaps no surprise that most of them disliked the monitoring arrangements. Overwhelmingly, the people in interventions appreciated the flexibility and support that the MHAZ co-ordinators were able to offer them.

Chapter 7 pulls together the experiences of all the people included in this research to reflect on how they felt about the HAZ process. There were a small number of people who did not enjoy their part in the HAZ. However, the majority did enjoy it,

and they particularly liked the opportunities to be creative, the opportunities to connect with other people, and the opportunities to work in a different way. For some people their contact with the HAZ has been transformational. This chapter will reflect on why that was.

Chapter 8 presents a discussion of the findings. It is in these discussions that the contribution of this thesis to the literature becomes apparent. This contribution emphasises the value of listening to those on the frontline of policy implementation. The findings point to the importance of congruence in values and ways of working at the macro and micro levels of policy development and implementation. Chapter 8 continues with a reflection on how the findings relate to the theories on the links between socio-economic circumstances and health outcomes, and a personal reflection of the research process. Chapter 9 presents the conclusions from this thesis.

Chapter 2

Researching the policy process

Case studies using qualitative methods are most valuable when the question being posed requires an investigation of a real life intervention in detail, where the focus is on how and why the intervention succeeds or fails, where the general context will influence the outcome and where researchers asking the questions will have no control over events. (Keen and Packwood, 1995, p.444)

The previous chapter introduced the research presented in this thesis. This chapter will discuss the methodology and methods used to answer the research question. In addition it will provide more detail on how the HAZ was implemented in Merseyside. The chapter will also unveil me, the researcher. In the methods I have chosen to use I am very much a part of the discovery process, and as such it is important that I explain my interest in this work and give some of my background as it relates to my involvement with the HAZ.

2.1 Research approach and some definitions: Case-studies and ethnography

This research has been identified as a piece of policy ethnography. Policy ethnography (Griffiths and Hughes, 2000; Exworthy *et al*, 2002)

aims to provide detailed observational data on the organisational enactment of public policies that will complement data from larger-scale survey or interview research (Griffiths and Hughes, 2000, p.211).

Policy ethnography is a methodological approach employed to look at the detail of policy implementation by studying a single case. This piece of research fits this description well, as it is the exploration of the implementation of the HAZ policy in

Merseyside, a particular case, using ethnographic methods. The learning from this study adds detail to issues identified by the National Evaluation of Health Action Zones, and to other studies examining specific implementations of New Labour public policies. Studies in this depth also offer the opportunity to identify unanticipated lessons from the process of implementation, and that has been the situation with the Merseyside HAZ implementation.

In essence, therefore, a policy ethnography is also a case study. Like most things, the concept of a case study means different things to different people. For some it is simply the study of a single case, for others a research methodology (Verschuren, 2003; Yin, 2003). In this instance it is both the study of a case and the use of multiple methods (observation, interviews and documentary analysis) to explore the research topic. It departs from Yin's definition of a case study in that the theory model emerged from the data, and had not been defined *a priori* (Yin, 2003).

A case study can be quantitative or qualitative in its approach (Verschuren, 2003; Yin, 2003), although authors usually recommend methodological triangulation to develop a rounder view of the case being researched (Keen and Packwood, 1995; Macpherson *et al*, 2000; Verschuren, 2003; Yin, 2003). Authors are usually in agreement that a case study approach is most useful when researching an intervention in a real-life context, there is a need to answer 'how' and 'why' the intervention succeeds or fails, the researcher has little or no control over the events, and the context is complex (Keen and Packwood, 1995; Macpherson *et al*, 2000; Verschuren, 2003; Yin, 2003).

Verschuren (2003) argues that there is a continuum of case study research from the purely reductionist approach through to an holistic approach. The reductionist

approach can use qualitative as well as quantitative methods, but is defined as having ‘tunnel vision’ because it examines the ‘case’ at a single point in time, detached from its physical, social and political context without taking into account its relations with other objects in the case and without looking at the functions it fulfils for the larger whole (Verschuren, 2003). Verschuren suggests that this should be referred to as ‘case research’, and that the term ‘case study’ should be reserved for a more holistic approach where the researcher is concerned with dynamics, developments and processes, examining group characteristics. In this respect case studies should employ participant observation methods, combining observation and interviews in methodological triangulation to generate ‘thick’ data (Macpherson *et al*, 2000; Verschuren, 2003). Macpherson *et al* (2000) suggest a third approach which is akin to more critical research perspectives, where the researcher seeks to create proactive partnerships with the researched through action research in order to critique values and norms and generate social change.

The different explanations of the case study echo the multiple interpretations of ‘ethnography’. Ethnography has its origins in anthropology, and involves the overt or covert participation of the researcher in the daily lives of the study group over an extended period of time (Hammersley and Atkinson, 1995). Often the term ethnography is used as a synonym for qualitative research (Chambers, 2003), but Chambers (2003) stresses the importance of the study of culture, the shared meanings of a group, as a focus for this approach. Atkinson and Hammersley (1998) (cited Flick, 2002, p.147) identify the following features of ethnographic research:

1. A strong emphasis on exploring the nature of a particular social phenomenon, rather than setting out to test hypotheses about them.

2. A tendency to work primarily with 'unstructured' data, that is data that have not been coded at the point of data collection in terms of a closed set of analytic categories.
3. Investigation of a small number of cases, perhaps just one case, in detail.
4. Analysis of the data that involves explicit interpretation of the meanings and functions of human actions, the product of which mainly takes the form of verbal descriptions and explanations, with quantification and statistical analysis playing a subordinate role at most.

Within an ethnographic approach research questions are refined and become more specific as the fieldwork and data analysis progresses (DePoy and Gitlin, 1994; Keen and Packwood, 1995), reflecting the research process described above. Ethnography - understood as an inductive process, combining observation, interviews and documentary analysis to explore a particular social phenomenon (Travers, 2001; Flick, 2002) - has been advocated for the study of government policies, especially in the health service (DePoy and Gitlin, 1994; Keen and Packwood, 1995).

The second definition of a case study given by Verschuren (2003) and ethnography as described in the previous paragraph are essentially the same methodology, although Yin (2003) argues that case studies differ from grounded theory and ethnography in that they are used to explore theory developed before the data collection begins. Policy ethnography, then, is a particular type of case study with the specific aims of exploring policy implementation in more detail. It deviates from Yin's definition of case study methodology in that theory generation is been inductive. Therefore, this research has employed ethnographic case study methodology, using the qualitative methods of observation, semi-structured interviews and documentary analysis to explore the 'dynamics, developments and processes' of the Merseyside HAZ within its wider political context.

Interpretive social science is concerned with '*what people know and how they understand their lives*' (Rubin and Rubin, 1995, p.35), recognising the time, context, complexity and particularity of the research situation. Within this holistic approach, feminist researchers have championed the personal and political within research (Ramazanoğlu and Holland, 2002; Fontana and Frey, 2003). Feminist researchers come from many different ontological and epistemological positions (Stanley and Wise, 1990; Ramazanoğlu and Holland, 2002), however what

is distinctive is the particular political positioning of theory, epistemology and ethics that enables the feminist researcher to question existing 'truths' and explore relations between knowledge and power (Ramazanoğlu and Holland, 2002, p.16).

The aim has been to develop a methodology that 'humanized' both the researcher and the researched (Rubin and Rubin, 1995), and which empowered research participants by allowing them to determine the direction of conversations (Rubin and Rubin, 1995; Fontana and Frey, 2003).

Feminist methodology argues for the production of knowledge as part of, and entwined with, the process of research (Stanley, 1990). From this perspective, research respondents are not seen as objects, and the researcher develops closer relationships with the research participants (Rubin and Rubin, 1995; Fontana and Frey, 2003). It is recognised that the research data is a product of the interaction between the researcher and the research participants (Stanley and Wise, 1990; Rubin and Rubin, 1995), and that the perspective presented in the final analysis is just one perspective and is particular to that researcher (Silverman, 2003). Stanley and Wise (1990) suggest that theory is constantly being revised in the light of the experiences of the processes of research, making it a reflexive process.

This more fluid, responsive and adaptive approach to research has influenced my own research methods. Although this research is not concerned with issues of gender and power, following Rubin and Rubin (1995) I have incorporated those aspects of the feminist approach that are relevant to the nature of this research. Feminist methodology has provided valuable support for the iterative nature of theory generation employed here. Moreover, it influenced my decision to adopt a more conversational interview style, reflecting the importance of the participants as the owners of the knowledge shared in these meetings. Finally, it stresses the importance of the researcher reflecting on the research process to be conscious of how the data gathered is as much an expression of the researcher's own interests and values as it is the information shared by the research participant.

2.2 Writing style

A note on the writing style employed within this dissertation. Alongside differing epistemological positions, there are associated debates about appropriate means for presenting research findings. The positivist view that the researcher should be as close to an inert research tool as possible, requires the researcher's voice to be removed from the text, and so the writing assumes a passive voice (DePoy and Gitlin, 1994). This style of writing has also been used in presenting qualitative research in order to gain credibility in the wider scientific community (Richardson, 2003). Richardson (2003) argues that this passive, science influenced writing is boring, precisely because it does not contain the researcher's voice. There are many types of research design within the naturalistic approach, and consequently there is no universal format for writing (DePoy and Gitlin, 1994). However, naturalistic reporting reflects the complexity of the research area, and the researcher's role within

it, often including reflexive passages throughout the text. Such ‘confessional reporting’ can be overdone, but it helps to raise awareness of the difficulties inherent in research (Fontana and Frey, 2003). Feminist researchers champion the use of reflexivity in writing:

“[t]hus, to a greater or lesser extent, researchers incorporate their personal experiences and standpoints in their research by starting with a story about themselves, explaining their personal connection to the project, or by using personal knowledge to help them in the research process.” (Ellis and Bochner, 2003, p.212)

I have adopted this approach in this dissertation. Whilst I have not been fully ‘embedded’ in the field, I am conscious of the ways in which my research approach may have influenced the data collected and that I have a particular perspective on health inequalities and approaches to tackle them. I discuss this later in this chapter.

Richardson (2003) advocates the use of different writing genres for representing the complexity of the interaction between the researcher and the researched and the data they generate together. Silverman (2003) cautions against using inappropriate methods, and argues for the need to be clear about the purpose of a piece of research. I am not a poet, and creative writing would be inappropriate for representing the findings from this piece of research. There will be some autobiographical and reflexive passages, and in these I will talk in the first person. Otherwise, I will adopt a more traditional writing style.

2.3 My interest in Health Action Zones

At this juncture I should explain my interest in Health Action Zones and the perspective from which I approached this research. In an earlier incarnation, I had

worked as an IT analyst/programmer and had been fortunate to have had the opportunity to live and work in Belgium, the USA and Australia, as well as my country of origin, Britain. I also had working visits to the Netherlands, Germany, Singapore and Hong Kong. I love to travel, and I have enjoyed visits to many other parts of the world, a highlight being Nepal. I am blessed with friends from many different cultural backgrounds and over time I became aware of the degree to which people's experiences and opportunities differ, and how this is reflected in health outcomes – especially within the USA. I began to see how culture and politics shape both societal and individual values and structures. The world is becoming increasingly homogenised, but I gained a greater respect and affection for difference. I also began to see how different countries and cultures address issues of poverty.

I returned to the UK because I wanted to change my career and engage with something that contributed in some way to creating a more just and equitable society. I undertook a BA honours degree in 'Health' at Liverpool John Moores University, where the degree programme is underpinned by the World Health Organization definition of health as "*a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity*" (WHO, 1948). This degree course examined health from a multidisciplinary perspective, and challenged the view of health as simply the absence of disease. I developed two clear strands of interest in my studies there: health as a cultural construction, and the political and economic influences on the distribution of ill health both within and between countries. It was this interest in the political influences on health inequalities and equity that led to my application for the studentship at the University of Liverpool, advertised as an opportunity to explore current health policy and health inequalities within the context of the Merseyside Health Action Zone.

I have been fortunate to have had many wonderful opportunities in my life, but I know that there are many people whose opportunities are limited from the moment they are born. I have in my earlier life in IT worked alongside a child protection agency in one of the most deprived parts of the USA. The town was dull, with most of the shops out of business and boarded up, and there was a high incidence of drug use and drug related violence. I heard stories about the lives of the people there that would make anybody's blood run cold. I saw the cumulative negative effect that working in those circumstances had on the people working in that agency. By contrast, the adjacent town was noticeably affluent, with white picket fences and thriving businesses. This close proximity of affluence and poverty demonstrates the localised nature of deprivation. It means the causes of deprivation can be quite specific, and are often complex. I believe that quantitative research methods can describe such complexity, but to understand the experience of it necessitates qualitative research approaches.

DePoy and Gitlin (1994) argue that the purpose of data collection in qualitative research is

... to obtain information that incrementally leads to the investigator's ability to reveal a story, a set of descriptive principles or understandings, hypotheses, or theories. (DePoy and Gitlin, 1994, p.227).

It is my intention to reveal a story as this dissertation unfolds. Borrowing from feminist theory, the research process itself is a learning experience where the researcher and the researched are co-creators of the knowledge produced and it is important to recognise that the researcher's understandings are as "*temporally, intellectually, politically and emotionally grounded*" (Stanley and Wise, 1990, p.23) as those of the researched. As such, this is as much my story as it is that of the

people associated with Merseyside HAZ. It is an unpicking of knowledge gained where our stories have interacted. I have evolved as a researcher during this process, and the context within which Health Action Zones have been working has changed quickly and dramatically. One senior member of the Merseyside HAZ team told me that our interview was '*like a therapy session*' because it gave her some space to reflect on the achievements of MHAZ in stressful and difficult circumstances.

From the start, my association with the people of the Merseyside HAZ has been a welcoming, friendly, generous and supportive one. My mother became very ill and died during this period of research, which was enormously difficult for me, especially as my father and I were the most immediate of her support network. I received a great deal of support from the Merseyside HAZ team. From a research perspective, this helped to strengthen my relationships with them. It also lengthened the period of my empirical research, which meant that I was able to observe and reflect on much more of the Merseyside HAZ lifespan than I would otherwise have done. This close working relationship could have limited my ability to maintain critical distance. I discuss this in detail in Chapter 8, but I was able to put some emotional distance between myself and the people of the MHAZ by being based at the University, and through rigorous questioning by my university supervisor, peer review, and reflection on my role in the research.

2.4 The Eternal Loop: Developing the research question

My research position was jointly funded by the Merseyside Health Action Zone and the University of Liverpool as part of encouraging a broad collaboration between the HAZ and other organisations and institutions within Merseyside. The HAZ co-funded three postgraduate research posts, two at Liverpool John Moores University

and one at the University of Liverpool. All three students were given *carte blanche* to decide what aspect of the HAZ we would like to research. We were given three months to familiarise ourselves with the HAZ and to choose our topics for research.

In addition to our academic supervision, all three research students were jointly supervised by the Monitoring and Evaluation Co-ordinator at the HAZ, through monthly meetings. When this person took a leave of absence, this role was taken on by the Merseyside HAZ Co-ordinator. This regular supervision at the HAZ not only aided our familiarisation with the work of the HAZ, but also allowed us to observe changes in the HAZ over time. This, our participation in HAZ events, presentations of our research to people connected to HAZ and public health in Merseyside, and general access to the HAZ office helped to create good, friendly working relationships with the core HAZ team, the district HAZ Co-ordinators and others connected with HAZ.

Following the resignation of the Monitoring and Evaluation Co-ordinator, we were not so closely supervised and I spent less time in the MHAZ office, which meant that my contact with the people working there was therefore much less. However the support I received from the HAZ team during my mother's illness, and my collaboration with Marie Armitage on a paper for the Health Equity Network all helped me to reconnect with the HAZ and make me feel a part of the HAZ process, albeit loosely. The friendliness and openness of all people connected with the HAZ, and the ease with which I have been able to access them, is, I feel, a reflection of not only the people, but also the philosophy of the Merseyside Health Action Zone and their enthusiasm for it.

My colleagues at Liverpool John Moores University had to work to tight timeframes to produce research proposals and documentation for ethics committees. I had the luxury of a less structured approach to my research development. This gave me a longer period of time to observe and feel my way into my research topic before having to formalise my data collection methods. This is typical of research using participant observation and ethnographic methods. Whyte (1984) argues that the initial stages of ethnographic research need to be about exploring the field, making contacts and connections and building relationships, helping to establish trust (Fontana and Frey, 2003). DePoy and Gitlin (1994) and Flick (2002) suggest that these early stages enable broad observations to describe what is seen, which are followed by a narrower focus to discover the meaning of the phenomenon under investigation.

I have stated earlier how on starting my research with Merseyside HAZ, it became almost immediately apparent to me that there were a lot of top-down pressures on the HAZ such as the cuts in funding, changing priorities, and time consuming continual requests for information and a resource heavy performance monitoring system. I wondered how this would affect the ability of the HAZ to deliver a programme based on local needs, engaging both communities and frontline staff. I was also interested in the extent to which such an area-based initiative would be able to address health inequalities and modernise services in the context of wider social and political constraints.

As my data collection continued, it became apparent that people were key to the implementation process as ‘makers’ and ‘breakers’ of opportunities, and that the chance to build good working relationships had also been important in the operation

of the Merseyside HAZ. Another key finding was how important it was for people, especially in the statutory sector, to have the opportunity to take risks and to do things differently. These emerging findings have since been corroborated at a ‘stakeholder’ event (which I took part in) hosted by Jane Springett and colleagues as part of their evaluation of the MHAZ. There, in an exercise to identify the key lessons learned from MHAZ, the four items voted most important were (Springett *et al*, unpublished, pp.68/9):

- People are both makers and breakers. It’s about managing relationships.
- Importance of support structures.
- Think beyond the obvious.
- Take a flexible approach.

As I gathered my data, observed the patterns emerging and undertook an initial analysis of the early information I had gathered, my interest developed from trying to understand the tensions between local work and central demands to recognising the ‘personal’ in public policy implementation. People are the means through which policy is implemented, and I wanted to understand what helped and hindered the capacity, or even desire, of individuals and groups to do that. As this is a New Labour policy initiative, the New Labour political agenda and approach to public service provision became part of the context within which the policy was being implemented. It was clear that New Labour had both created a policy context that created stress, and developed opportunities for collective working that people enjoyed. This research then became an exploration of the experiences of the people involved in the implementation of a New Labour public policy, with particular emphasis on those aspects of the HAZ implementation in Merseyside that generated stress and enthusiasm.

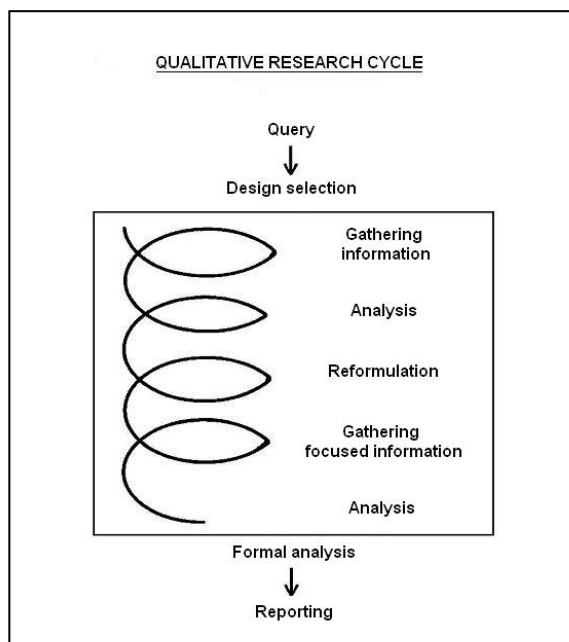


Figure 2.1 The qualitative research cycle
(Source: Depoy and Gitlin, 1994, p.186)

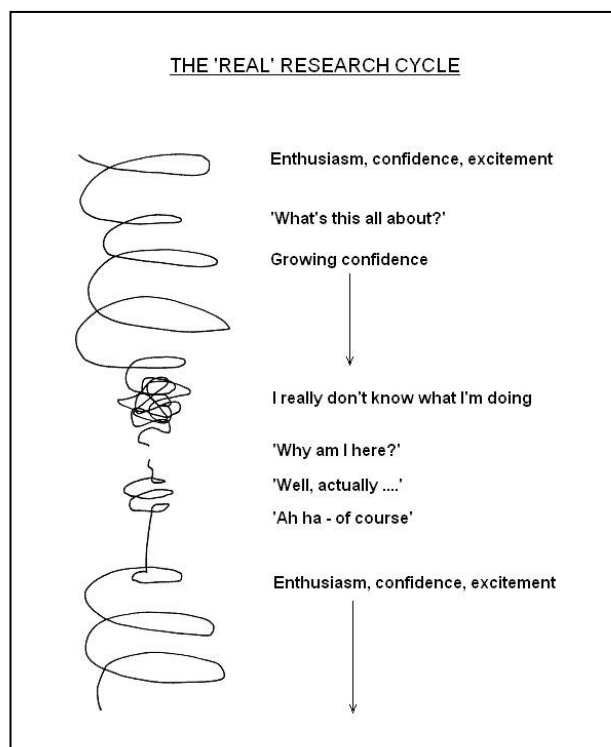


Figure 2.2 'The real research cycle'

This unfolding of the research focus alongside the data collection has been described by DePoy and Gitlin (1994) as an iterative process, represented in Figure 2.1 as a spiral. This diagram is a useful representation of the process of qualitative research. However, in my experience, the research process is much less orderly. There are periods of uncertainty, periods of certainty and confidence, periods of confusion and times when nothing visible happens. But at all times the work is progressing, if slowly². Figure 2.2 is a pictorial representation of this process.

What this diagram lacks is a third dimension to the research process which is the context within which the research is conducted. This is the complex interaction of the personal and professional lives of participants, including the researcher, with the equally complex social and political environment within which the intervention is working. This affected data collection in two ways: firstly, in my access to people in terms of finding convenient times to meet; secondly, in the information they shared with me in our conversations, not all of which was pertinent to the research question, and some of which was very personal.

As I have said, my own story extended the period of research, which allowed me to observe the HAZ process over a longer period of time. During this time the pressures on the HAZ team were constantly changing, and the HAZ team's reaction to these changes also changed over time. In essence, I was able to observe the HAZ process through a panoramic window, rather than a picture window. This extended period 'in the field' enriched my opportunities for observation (Flick, 2002).

² Back (2002) has written an enormously reassuring paper describing this process and offering advice for PhD Students on what to expect.

2.5 The Merseyside Health Action Zone organisational structure

Chapter 1 introduced the Merseyside HAZ and its partnership structure. It was a joint endeavour between the Local Authorities and the NHS in five districts: Knowsley, Liverpool, St Helens, Sefton and Wirral. Figure 2.3 is a representation of the complex organisational structure of MHAZ as it was at the end of the Merseyside wide element of the HAZ in March 2003. From the beginning of MHAZ until March 2002 the North West NHS Executive had performance monitoring responsibilities for MHAZ, and the Central DoH HAZ team in Leeds had frequent direct contact with the MHAZ Co-ordination Team. Following the implementation of the DoH policy, *Shifting the Balance of Power* (DoH, 2001) in April 2002, the Central HAZ Team took a less immediate role, and the newly created Cheshire and Merseyside Strategic Health Authority (StHA) assumed responsibility for performance management of MHAZ.

The MHAZ Policy Group consisted of the chief executives of the Local Authorities and non-executive members of the Health Authorities (PCTs following the NHS reorganisation). The inclusion of this group in the hierarchy was as much a tactical measure as it was to provide a system of governance for the Merseyside programme. It ensured that the work of HAZ remained visible to local politicians and decision makers. The MHAZ meetings were attached to regular pan-Merseyside meetings for the chief executives of the Local Authorities. These regional meetings post-dated the establishment of MHAZ, and a member of the MHAZ Steering Group suggests that they were in part influenced by the development of HAZ:

I think in a number of ways the establishment of the Health Action Zone was a spur to the recognition of how easy it was [to work in partnership].
(Strategic, Local Authority, 04/2002).

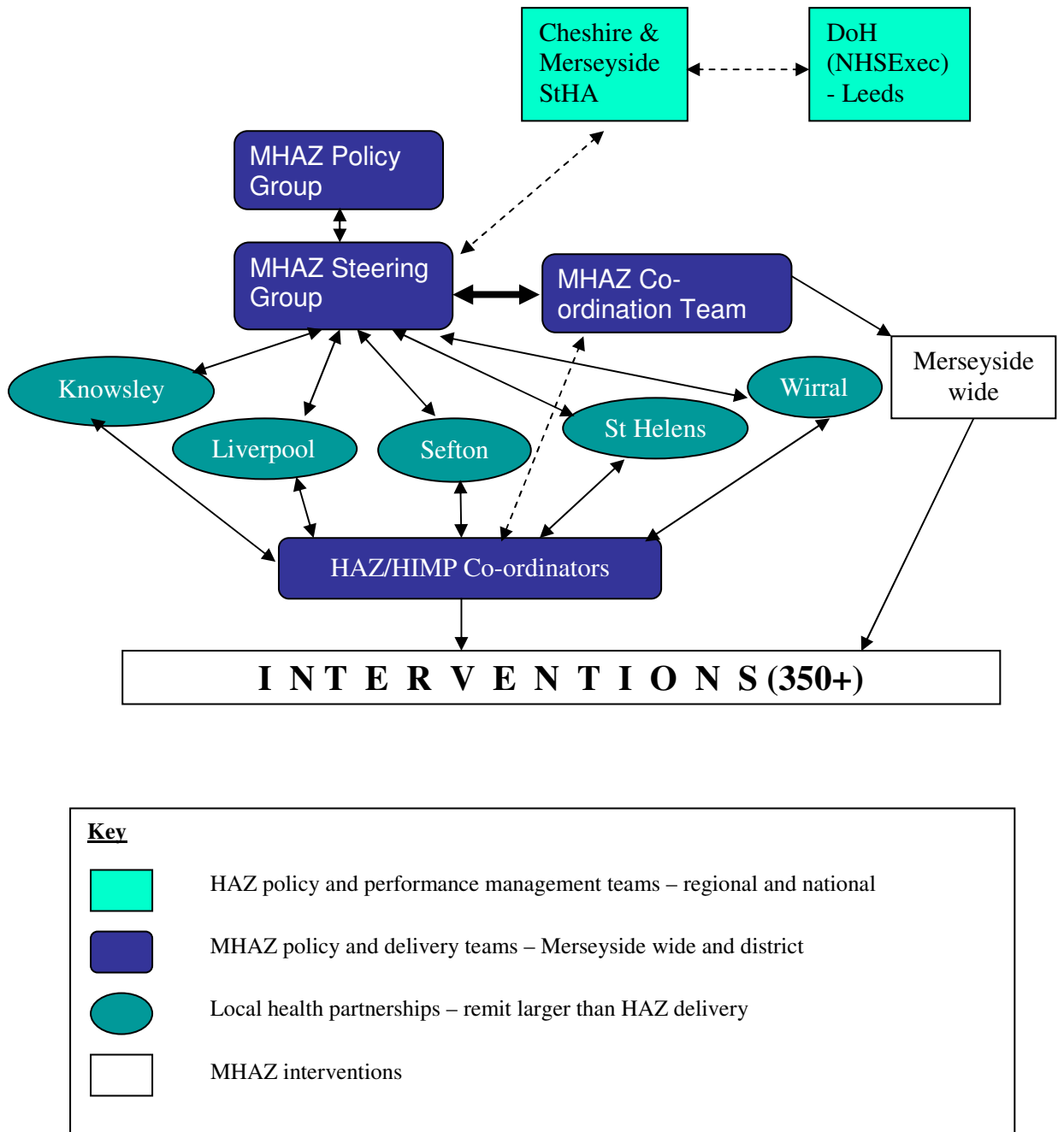


Figure 2.3 Merseyside HAZ Organisational Structure, March 2003

The HAZ Policy Group meetings formed the first part of pan-Merseyside meetings. The meetings were deliberately staged in the Liverpool Health Authority (the host organisation for the Merseyside HAZ) to facilitate interaction between the two

statutory sector bodies. This Policy Group authorised the HAZ programme on an annual basis, and the interim meetings were used to present particular aspects of the HAZ work, as well as to provide an overview of progress. Some saw the role of this group as simply one of rubber stamping the HAZ programme, for others the political activity of engaging with these high ranking officials in the statutory sector was immensely important.

In these pan-Merseyside meetings, each of the local authority chief executives had assumed a lead role for one aspect of Merseyside development, for example employment, economic regeneration, health, and so on. The Chief Executive with lead responsibility for health became co-chair of the MHAZ Steering Group. Before the NHS reorganisation the second co-chair of the Steering Group was the Chief Executive of the Liverpool Health Authority, and afterwards the Chief Executive of the Central Liverpool PCT (which took over as host of MHAZ). The other members of the Steering Group were senior officers from all the partnership agencies. The Steering Group was responsible for the “*development, implementation, evaluation, monitoring and financial accountability of the HAZ programme*” (MHAZ, 2000, p.45). There was also a wider reference group, and these organisations were included through various working groups, and on local health partnerships (See Appendix B).

The Merseyside HAZ Co-ordinator was line managed by the chairs of the Steering Group. She had responsibility for the work of the Merseyside HAZ Co-ordination Team. This team consisted of a core group of people who were together from late 1999 till March 2003. These were the MHAZ Co-ordinator, her personal assistant, the Communications and Involvement Manager and the Finance Manager. There

were others who left before the end of the programme: an administrator and the Monitoring and Evaluation Co-ordinator; and three more who joined part-way through and stayed till the end: Information Management Officer, Finance Information Management Officer, Secretary/Administrator.

Each district also had a HAZ co-ordinator who reported to a local health partnership. The structure of these partnerships varied by district, and some were more successful than others. Equally, the positions of the district HAZ co-ordinators varied considerably. In one district the function of the HAZ co-ordinator was just one aspect of that person's job, in another the HAZ co-ordinator headed a small team responsible for the programme.

The core partnership remained strong throughout the life of the Merseyside focus of the programme. The funding for the Merseyside HAZ came from the core HAZ funding and additional HAZ related monies (HAZ Deprivation Uplift) paid directly to the participating Health Authorities. The decision was taken to pool both sources of HAZ funding, and then to devolve this combined HAZ funding down to the 5 partner districts of Merseyside: Knowsley, Liverpool, St Helens, Sefton and Wirral, using an agreed formula, retaining some funding for the Merseyside wide programme. This allowed more freedom to develop local programmes relevant to the dominant issues in those areas. The Merseyside wide programme addressed issues that were relevant to the region as a whole and also to encourage the sharing of information between the districts. All the core partners made an additional financial contribution that contributed to the costs of the Merseyside Co-ordination Team, and their activities.

The particular details of how the HAZ was implemented in Merseyside and the details of the programme will be looked at more closely in Chapter 5.

2.6 Data collection and analysis

The methods used for data collection were largely self evident. My connection with MHAZ provided me with a rare opportunity for the observation of an unfolding policy process. As a jointly funded and supervised research student, I had free access to the MHAZ Co-ordination Team. This facilitated the development of good working relationships, fostering mutual respect and trust. My extended connection with the team meant that I had privileged access to the general discussions about the changing pressures on them over time. They also acted as ‘gatekeepers’ (Silverman, 2001) to the rest of the HAZ and MHAZ organisation and intervention community, both through direct contact (providing names and addresses) and indirect contact (through access to individuals at presentations, seminars and conferences). I was not completely immersed in the field, I worked mainly from my office in the University of Liverpool, however it was a feature of this research that people associated with MHAZ were very willing to talk about their involvement with and experiences of the programme.

DePoy and Gitlin (1994) have identified three possible strategies for data collection generally: watching and listening; asking; obtaining and examining materials. These are a close fit with Denzin’s list above, and form a useful framework for identifying the methods used for data collection here.

- *Watching and listening:* The close working relationship with the MHAZ co-ordination teams provided the opportunity to be an observer of the HAZ policy process in various ways: supervision, participation in working groups, seminars,

conferences, and general observations and conversations within the MHAZ working environments.

- *Asking*: A large part of the data gathered through direct conversation has come from semi-structured interviews. However there were other opportunities to obtain data through asking, such as informal conversations at conferences and workshops, feedback from presentations for the Merseyside HAZ community, at HAZ conferences, discussions with other people researching the HAZs, and in lectures given to undergraduates.
- *Obtaining and examining materials*: The review of documents and literature, including the reports from the National Evaluation of the Health Action Zones, local HAZ evaluation, MHAZ documents, and the academic literature about HAZ and related areas.

I have also kept a research diary, and I have chosen to provide my supervisors with regular updates on my progress, which I have called Status Reports (an example is given in Appendix C). In addition to working on my PhD, I have also been involved with a number of projects and groups that have facilitated my understanding of the wider health, health inequality, and political issues which would have impacted on the Merseyside HAZ: Liverpool Black Roots Summer School, Vice-Chair for a social enterprise project based in Toxteth, Politics of Health Group (POHG), two projects with the Liverpool Yemeni Arabic Community, module convenor for the International Health Module of the Masters in Community Health programme at the Liverpool School of Tropical Medicine 2002, various ad-hoc teaching work.

2.6.1 Observation and documentary analysis

Denzin suggests that participant observation

...simultaneously combines document analysis, interviewing of respondents and informants, direct participation and observation, and introspection (Denzin in Flick, 2002, p.139).

These methods of data collection are similar to those already identified for qualitative case studies (Verschuren, 2003) and ethnography (DePoy and Gitlin, 1994; Keen and Packwood, 1995). So, it is clear that Denzin is describing a participant observation methodology. As given above, the data collection methods employed in this research combined observation, documentary analysis and semi-structured interviews.

As with Denzin's definition above, there was an element of direct participation in my association with MHAZ. I was invited to two internal meetings, one a meeting of the Evaluation Working Group, and the other a meeting to discuss how best to manage the data emerging from the interventions. The original intention for this second meeting was that I would attend regular meetings and be part of the decision making for that group. I felt this was inappropriate for my position as observer. I was not invited to any further meetings.

I also participated in meeting with and training some of the MHAZ Fellows (six to 12 month research grants), internal seminars as a speaker, MHAZ hosted conferences, the MHAZ Open Day as a stall holder, and external conferences, both HAZ related and broader. Nevertheless, I did not participate as a working member of the MHAZ programme, and I did not observe any partnership meetings. In this sense I was not completely immersed in the operation of the MHAZ, and so, although accorded the opportunity for close observation of the implementation processes, I was not a participant observer of the MHAZ implementation.

Most of the data derived from documentary analysis comes from documents in the public domain: HAZ and broader related literature, MHAZ reports, press cuttings, local HAZ documentation, and so on. Some less public material was shared with me, particularly relating to discussions at the end of the MHAZ regional programme, and I had extensive discussions about this with some of the central co-ordination team members. I also had access to the unpublished internal evaluation conducted by Springett *et al* (unpublished). Although I asked for and was granted permission to read the minutes from Steering Group meetings, this was a task that I did not undertake.

The data from my observation and documentary analysis provided information on the context within which the MHAZ was operating. It gave me a sense of the stress and enthusiasm people were feeling, and the recognition that these feelings were widely spread within the MHAZ and the HAZs more generally. These aspects of the data collection covered the whole of my connection with the MHAZ. The interview data relates to a particular 12 month period within the three years I was associated with the MHAZ. This was the period of greatest instability, and was also at the end of the life of the regional programme. The interview data adds depth to my observations and reading. As such it forms the bulk of the data presented in the findings chapters.

2.6.2 *Semi-structured interviews*

Because I was interested in the implementation of the HAZ in Merseyside, I felt it was important to capture the voices and stories of as wide a selection of people from the HAZ organisation and delivery as possible. Flick (2002) suggests that the choice of a sampling framework is a decision between width and depth in data collection. I wanted to capture the experiences of people from as many of these different layers of

the MHAZ organisation (Figure 2.3) as possible. The MHAZ structure was large incorporating a broad reference group (Appendix B). It would have been impossible for me to interview representatives from all these organisations. As the research was looking at the implementation of the HAZ, I decided to limit my interviews to people on the frontline of MHAZ work: members of the Merseyside HAZ Steering Group and Co-ordination Team, the local HAZ co-ordinators and a sample of interventions. The five districts were represented through members on the Steering Group, as well as through the district co-ordinators and interventions. The two co-Chairs of the Merseyside HAZ Steering Group also sat on the Merseyside HAZ Policy Group, and one of the prior members of the Steering Group I interviewed now works at the Strategic Health Authority. Through these three people I also gained a small insight into the way MHAZ was perceived in these parts of the management structure.

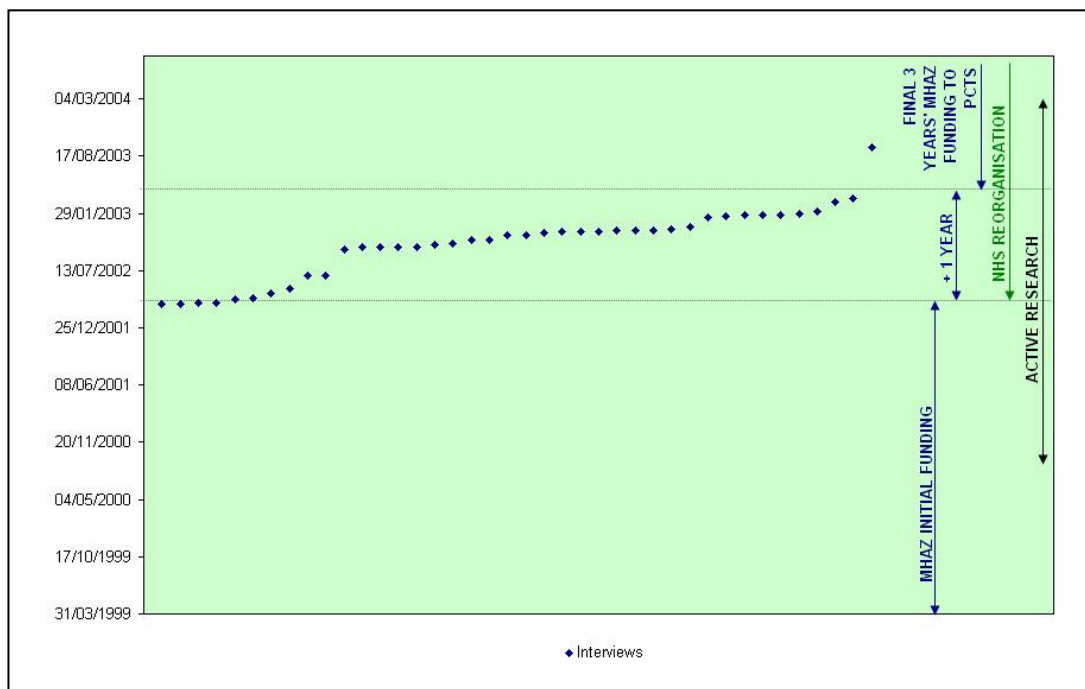


Figure 2.4 Timing of the interviews

In total, I conducted 37 formal semi-structured interviews over a twelve-month period between 18th March 2002 and 11th March 2003, and one in September 2003 (see Figure 2.4 above). Of these, half were at the strategic or co-ordination level (Steering Group, co-ordination team and individuals, past members of both, and the HAZ Policy Team at the NHS Executive in Leeds), and half were with organisations or individuals that were in receipt of HAZ money (interventions – statutory sector and community/voluntary groups). The interviews lasted between 30 minutes and three hours, with a mean time of 69 minutes and just over half taking between 55 and 80 minutes, with a total of 45 hours of interview recordings. Table 2.1 provides a summary of these interviews (my interview with Frank Dobson, former Secretary of State for Health, in March 2003 is not included in these numbers).

Area/Organisation	Policy Team	Steering Grp		Co-ord Teams	Interventions		Total
		LA	NHS		LA/NHS	Other	
Knowsley HAZ		1		1 (LA)	2	1	5
Liverpool HAZ			1	1 (NHS)	1	3	6
Sefton HAZ		1	1	1 (LA)	1	1	5
St Helens HAZ				1 (LA)	2	2	5
Wirral HAZ		1		1 (NHS)	2		4
Merseyside HAZ				4	1	2	7
HAZ Team, Leeds	2						2
Other *			1	2			3
Total	2	3	3	11	9	9	37

* Three people who were associated directly with Merseyside HAZ but who now have other jobs.

Table 2.1: Summary of interviews within the HAZ organisational structure

I spread the interviews evenly between the various districts, between LA and NHS representatives on the Steering Group, and between statutory sector and voluntary sector interventions. The ‘other’ row on the table shows people interviewed who had been directly associated with MHAZ at a strategic level, but who had moved to other jobs at the time of interview.

Different sampling techniques were used for the two broad groups of people. I used a purposive sample to identify people at the strategic or co-ordination level. Some of these individuals were obvious, such as the local co-ordinators, long serving members of the central co-ordination team, and chairs of the steering group. Others I had met at events, such as the people from the central HAZ team in Leeds.

The HAZ intervention group was largely self-selected. There have been over 350 HAZ funded interventions, covering many types of approach to health improvement, from specific jobs within the statutory sector to art and theatre programmes within communities. To respect the role of the district co-ordinators as gatekeepers to their intervention communities I used a snowball sampling approach to identify people from the interventions to interview.

I asked each of the five local HAZ co-ordinators to nominate individuals from 2 organisations for me to interview. (I actually chose to interview 3 from each district). Each of the co-ordinators was willing to do this, but they each responded differently. In Wirral I was given two names as requested, with contact details. In Liverpool and Sefton I received a short list of interventions to choose from, with contact details. In Knowsley I was given the complete list of current interventions to choose from, and then the co-ordinator made contact with them on my behalf. In St Helens I was asked for a pro-forma letter about my research that could be shared with the interventions. This resulted in eight offers for interviews, and I selected 4 people from these contacts. At the Merseyside level, I chose one intervention that I already knew, one that had been recommended by a member of the central co-ordination team, and one was self-selected through St Helens. Often the individuals I

spoke to had had money from HAZ for more than one intervention, and HAZ was rarely their sole source of funding.

One of the drawbacks of this snowball approach is the probable tendency for people to suggest successful interventions, or for those with a good relationship with the HAZ to put themselves forward for interview. This would obviously cause the findings to be biased in favour of the Merseyside HAZ, which is a potential limitation to the findings. I did have sufficient flexibility in my choices to be able to balance the interventions between the statutory and non-statutory sectors. I did find that all the interview participants were willing to reflect on both the positive and negative aspects of their relationship with the HAZ in Merseyside.

In most cases I had sent the interview participants a letter introducing myself and outlining my areas of interest and topics for discussion (see Appendix D for an example). These letters differed slightly depending on whom I was sending them to, to reflect the role they fulfilled with MHAZ and whether or not I already knew them. The style of interviewing evolved over time and varied with the interview participant. I found that my opening question on the interview guide (see Appendix E) often resulted in a long narrative about people's connections with HAZ and/or their projects. With some additional prompting and questioning, the questions on the interview guide were often answered without needing to go through them one at a time. However, I always reviewed the interview guide at the end of the meeting, and sometimes I shared it with the interview participant during the meeting. Where people were very busy, or I felt the least powerful participant, I did follow the interview guide more strictly.

This conversational style of interviewing is championed by Rubin and Rubin (1995) and developed as I gained in confidence as an interviewer.

In qualitative interviewing, the researcher is not neutral, distant, or emotionally uninvolved. He or she forms a relationship with the interviewee, and that relationship is likely to be involving. The researcher's empathy, sensitivity, humour, and sincerity are important tools for the research. The researcher is asking for a lot of openness from the interviewees; he or she is unlikely to get that openness by being closed and impersonal. (Rubin and Rubin, 1995, p.12).

Flick (2002) identifies several different types of semi-structured interviews. In this context the interviews were a combination of two approaches, the expert and narrative interview. In an expert interview the person is of interest because of their knowledge about a situation. They are not of interest because of themselves, per se, but as representatives of a particular group or institution. Expert interviews, therefore, need to be tightly controlled to ensure that the subject matter is restricted to the topic of interest. My interviews naturally evolved into much more fluid interactions. This is much more similar to narrative interviews (Flick, 2002), only the interview participants were being asked to be experts on the nature of their work rather than experts on themselves, and the interviews were limited in time.

The narrative interview is typical of the qualitative approach of allowing interviews to be responsive to the holistic way in which experiences are made (Flick, 2002). In particular the interviews are examples of Rubin and Rubin's (1995) hybrid model between an interpretive approach and feminist interview methods. Here it is argued that interviewers are not neutral and should not dominate the interview process, knowledge in interviews is situational and conditional, and that although it is possible to look for common themes across cases, it is important not to lose sight of

the specific. Rubin and Rubin (1995) accept the notion of gentleness and reciprocity in the interviewing relationship, but argue that is not necessary to become lasting friends with the participants. Fontana and Frey (2003) stress that it is important for the interviewer to show their human side, and be prepared to share information about themselves, although Rubin and Rubin (1995) caution that the researcher should not share more than they are comfortable with, but cannot then expect the participant to share more than this themselves. With these points in mind, I did often share non-confidential information or my own perspectives on things during the interviews, and encouraged a conversation rather than a rigid fact finding interview. This seemed to help people relax, and one respondent said it made the interview less daunting.

The people I interviewed included a national politician, civil servants in the NHS Executive, senior officers in the local statutory bodies, administrative staff, and professionals within the public and voluntary sectors. I had to present myself differently in these different contexts. In all cases I endeavoured to be friendly and approachable, but some interviews required me to adopt a more professional role, and others a more encouraging and reassuring position. In the early interviews, the main problems were my nerves and inexperience. Thankfully I already knew the first few interview participants. In later interviews I had to assess how to present myself as the interview began. This adaptable approach reflects the observation of Rubin and Rubin (1995) that interviews may be taken over by the interviewee, are affected by the interviewer's personality, moods, and so on, and as such are invented anew each time.

Presenting yourself correctly is essential for establishing rapport and gaining trust within the interview (Fontana and Frey, 2003). On the whole I developed a good

rapport with the participants. On one occasion this did not happen and the interview data was very thin. On another occasion I encountered a deeply distressed person who felt unsupported by their external management team. On that occasion the interview produced little information to contribute to the research question, but lasted for three hours – time I was happy to share as I felt it helped that person to talk about their successes and problems. At the end I was challenged ... “I’ve done this for you, what will you do for me?”. In this instance I was able to help by alerting the local HAZ co-ordinator to the person’s problems, and they were able to take steps to help them. There were times when I felt challenged and even tested on my political standpoint. I met people who were frustrated, anxious, confident, happy and empowered. Each interview required me to renegotiate my position as researcher, and all of them offered me the opportunity to develop my research skills.

2.6.3 Data Analysis: Themes, coding and writing

The level of transcription is determined by the type of analysis to be used (Ryan and Bernard, 2003), and this depends on the purpose of the research (Silverman, 2003). I chose not to transcribe all these interviews in full, but rather to take detailed handwritten notes, and fully transcribe those interviews or sections of interviews that were richest in data (Rubin and Rubin, 1995; Lapadat, 2000; Flick, 2002). Transcription is an integral part of the research analysis as it requires repeated listening to the recordings (Silverman, 2003), helping to identify broad themes in the data. The recordings were made using a digital recorder. These recordings were then copied to the computer where they were easily accessible. Although the transcriptions were largely handwritten, I marked the text with timings from the digital recording,

making it easy to find sections of the interview for verbatim transcription or to listen to certain sections again.

As said above, the research question emerged from the data collection. Like this, analysis is “*contextual and arises from the situation*” (DePoy and Gitlin, 1994, p.267). Typically with ethnographic research coding is done at the end of data collection (Flick, 2002). However, some analysis occurs throughout the process of research (Miles and Huberman, 1994). Several authors identify various phases of data analysis (Miles and Huberman, 1994; Rubin and Rubin, 1995; Flick, 2002; Ryan and Bernard, 2003). DePoy and Gitlin (1994) suggest four stages to on-going analysis:

1. Inductive reasoning – to put the data in a wider context
2. Category development – emerging from fieldwork and interactions.
3. Taxonomic analysis – grouping of categories according to similarities.
4. Themes and meanings – go beyond the obvious and develop a complex understanding of the data.

Ryan and Bernard (2003) suggest a first stage of ‘sampling’ to identify categories and concepts for further coding. I performed a quick analysis of the first seven interviews to identify any categories that were emerging. These were consistent with the findings from my observations at that stage and were verified in a seminar given as part of the MHAZ *Sharing the Learning* series in 2002 (Povall, 2002). Constant reflection on the data coming from the remaining interviews supported these findings, but also identified some differences between the groups of people taking part. This assisted in the transcription of interviews by limiting the data selected for detailed analysis.

The transcripts of interviews were combined with field notes and reflection to identify more concrete categories, using a grounded theory approach (Flick, 2002; Ryan and Bernard, 2003). I read through all the transcripts and field observations, without taking any notes, to identify dominant concepts (Rubin and Rubin, 1995). I followed this with a second reading creating typed notes identifying key points within these concepts from each interview. I then developed final categories from these notes through a cut-and-paste approach within Microsoft Word. In the final stage of this analysis, I transcribed the categories onto index cards and post-it notes to help group these categories into themes and develop the links between them (Miles and Huberman, 1994).

The writing and reflection process is also part of data analysis (Richardson, 2003). This helped to identify more complex themes and meanings. At one stage in the final writing-up process I felt I needed to change the focus of my dissertation slightly. As a result I revisited my earlier analysis and did a second analysis on some of the data. The categories, themes and connections proved to be consistent throughout this analysis, providing some internal validity to the findings.

From my observation and interview data it became clear that there two largely different perspectives on the HAZ in Merseyside. The strategic implementation of the MHAZ had to deal with the stressors on the HAZ programmes, from funding issues and changes in focus to agency reorganisations and disrupted partnerships. It was also at this level that the whole systems approach to change was implemented. The primary focus of those involved at this level (DoH civil servants, partnership members, and co-ordinators) was the operation of the HAZ initiative. They could

talk about the impact of the pressures emanating from central government and the excitement of working in new ways to address health and health inequalities.

In contrast, the interventions in receipt of HAZ monies were focussed on delivering their own programmes. For most of these people the HAZ was just one source of funding out of many. Their connection to the MHAZ was limited and contextualised by their relationships with their other funders. At this level people could talk about the difficulties of funding, performance monitoring, and such, in a broader context. They could compare their connections with the HAZ to their experiences of other initiatives, past and present, and reflect on those things that HAZ did well or not so well.

These two perspectives on the HAZ in Merseyside provided the focus for the first two findings chapters, Chapters 5 and 6. The last findings chapter, Chapter 7, presents the themes that arose from all the interviews, the common experiences of those at the strategic level and in the interventions. Taken together, these findings reflect the human experience of being involved with the MHAZ. They talk about the importance of people, as individuals and collectively, in delivering change. And they talk about the value that people derive from working in certain ways and feeling connected within a network and within a broader change process.

2.7 Ethical considerations

The ethical considerations for qualitative research are concerned with the researched as partners in the production of knowledge. Issues centre on gaining access to individuals and organisations in a way that promotes trust and respects the individuals concerned (Buchanan *et al*, 1988).

I was fortunate not to have any difficulty in accessing either the organisation of MHAZ or people whom I wished to interview. My position as a student partly funded by HAZ would certainly have helped me gain access to members of the MHAZ Steering Group and the co-ordination teams. For others, though, their readiness to talk with me is, I suspect, a reflection of the perceived value of the Health Action Zone in Merseyside. One respondent said that she wanted to be interviewed because she felt it was important that success of HAZ was told. Certainly in St Helens, where people volunteered to be interviewed, I was contacted by eight individuals who wished to be part of my research. Everybody that I approached was willing to take part and offered further assistance if necessary.

However, I recognise that it is important to protect individuals and to preserve their anonymity. Christians (2000) has argued that professional ethical codes can be reduced to four issues: informed consent, deception, confidentiality, accuracy. The aim of informed consent is to protect respondents from harm (Fine *et al*, 2000). I did not use a written informed consent procedure, requiring the signature of the interview participant. Rather I stressed the confidentiality of their responses in the both the letter I sent confirming the interview and at the beginning of the interview process. Here, I explained the nature of my research to each respondent and stressed that the interview would be confidential and anonymous.

By assuring confidentiality I was promising not to share the raw interview data, which I did not, even when requested to do so. Recognising that the interview participants were the owners of the data they shared, and might not want some of their views published, even anonymously, in the public domain, I offered to send them summaries of our conversations for them to review. I did not do this due to

personal circumstances, and I recognise that using this information without their consent goes against preferred practice. I have made every effort to maintain the anonymity of the quotes used as evidence in the findings chapters. I have not attributed the quotes and have generalised their positions within MHAZ as far as is possible, although potentially some of the participants may be recognisable due to their particular roles in the MHAZ organisational structure.

The accuracy of my findings has been verified in a number of ways. Firstly, in the first two years of our studentships, the MHAZ postgraduate students were encouraged to host seminars to disseminate our work to people associated with the HAZ (Povall, 2001b; Povall, 2002). Both of these events were well attended and generated many interesting questions and suggestions from the audience. In addition to these presentations, I also gave an oral presentation during a one-day conference entitled *Learning from Health Action Zones* (Povall, 2001a). Again I received comments and positive feedback from those present. I have also been in contact with members of the National HAZ Evaluation Team and another postgraduate student who worked with two other HAZs (Lannin, 2003). Discussions with these contacts have also allowed me to test out and verify my findings at different stages during my research. I also gave feedback in some interviews, as part of the conversation, this allowed for a different point of view to emerge.

2.8 'Trustworthiness'

It is one of the limitations of qualitative research that it is not easily generalisable to situations other than the one being investigated. Any qualitative research is time, place and people dependent (Buchanan *et al*, 1988). Similarly the statistical techniques used to assure reliability and validity in quantitative research cannot be

used with qualitative methods. Instead, a number of different approaches can be used to allow confidence in the validity of the data, and credibility and rigour of the methods of data collection (DePoy and Gitlin, 1994; Flick 2002). These are:

- i. Triangulation: the use of several methods to collect data.
- ii. Saturation: prolonged engagement in the field, in order to collect sufficient data to fully describe the phenomenon. This is not always possible with limited time and resources. In such a case a compromise would be to sample the total cycle of the phenomenon.
- iii. Member checks: check the findings with the informants.
- iv. Reflexivity: the researcher should reflect on the research process to identify possible bias and personal perspectives. This should flow through analysis and reporting.
- v. Audit trail: ensure that there is documentation to describe the key moments in ones thinking.
- vi. Peer debriefing.

All of these approaches have been used in this research. Triangulation is discussed in more detail below. I have kept a research journal, notes of ideas and notes from meetings with my supervisors, all of which represent an audit trail of the research process. An extended time in the field has exposed me to more of the HAZ policy cycle than I perhaps originally intended. It has also allowed me to interview people from a broad spectrum within the HAZ organisational structure. The findings have been reviewed with the informants and other people within HAZs through presentations. In addition, as part of my PhD supervision, I have given presentations to my peers at Liverpool University. All of these things assure the credibility and validity of my findings.

2.8.1 *Triangulation*

The three strategies for data collection suggested by DePoy and Gitlin may be used independently or in combination, but collecting data using more than one strategy can generate a broader understanding of the research situation, and is referred to as *methodological triangulation* (DePoy and Gitlin 1994; Flick 2002). Denzin (cited Flick 2002, p.226) has identified four types of triangulation:

1. *Data triangulation* – collection of data using the same methods, but at different times, in different places and from different people.
2. *Investigator triangulation* – using different observers or researchers to minimise personal biases.
3. *Theory triangulation* – approaching the research question from a number of different theoretical perspectives.
4. *Methodological triangulation* – combining different methods or different subscales within methods.

Triangulation was originally conceived as a strategy for validating the results from different methods, but has moved to an emphasis of enriching the results and overcoming the limitations inherent within the different methods (Flick, 2002). This research has had the opportunity to combine two of these four types of triangulation. The methodological triangulation has been discussed above. In addition to this, the spread of interviews and observations over a broad spectrum of people, and over a time frame that saw many external pressures on the Merseyside HAZ, has afforded an opportunity for data triangulation.

The NHS reorganisation and the funding difficulties MHAZ experienced had implications for the interviews I conducted. Not so much in the people I was able to talk to, but in terms of their perceptions and the information they shared. I spoke to

some of these people before the reorganisation, and some after. At various times during that twelve-month period the funding for the programme was in doubt. This was not something I could share with the groups and individuals at the intervention level, but was something that coloured the interviews with people at the strategic level of Merseyside HAZ. However, this breadth of experience of Merseyside HAZ has enabled me to explore the HAZ as an evolving process and to look at it from several different perspectives.

Finally, although there is no investigator triangulation within the research, there have been several pieces of research that look at HAZs generally and at Merseyside HAZ particularly. The findings from these research projects are remarkably similar, and help to build a bigger picture of the processes involved. These contribute to theoretical triangulation.

2.9 Reflection on the data collection process

The Merseyside HAZ has been working in a context of almost continual change since its creation in 1999. This makes it difficult to isolate what is HAZ from the more general changes occurring in the broader context within which HAZ is situated. When I first started working with the HAZ, I was fresh from an undergraduate degree that had encouraged me to be critical of policy and academic writing. I expected to find a programme that was unable to challenge the political, social and organisational structures that dominated debates about health and which influenced the health outcomes in society. In short, I believe that health is much more a product of social, environmental, economic and political processes than it is a product of health services. I wondered to what degree a small programme like HAZ would be

able to succeed within a political and economic system that seems to generate health inequality.

Over time I have been impressed with the enthusiasm almost all the people I have met have had for HAZs. This, and my close working relationship with the Merseyside HAZ might have led to the desire to present them in good light. However, the enthusiasm of those involved with MHAZ has been a finding of the Merseyside component of the National Evaluation of HAZs (Mackinnon, 2003), and the local evaluation of MHAZ (Springett *et al*, unpublished). In fact Springett *et al*

adopted an attitude of healthy scepticism with respect to many positive reports that formed part of the performance management regime, and which also comprised a large part of the National Evaluation Report, and have tried to give voice to the different concerns within the system. (Springett *et al*, unpublished, p.5).

They concluded:

What emerges from the various sources of evidence is a tremendous enthusiasm and commitment to the HAZ at all levels amongst those directly involved in some way. For example, there was only one dominantly negative response in all the 106 questionnaires received. (Springett *et al*, unpublished, p.44)

There is genuinely an enormous degree of good will for the HAZ initiative. This positive feeling is a feature of the experiences of people working in the policy development arena, the strategic delivery and the HAZ funded interventions.

It is worth noting, however, that no research is completely objective. Qualitative research always has a high degree of subjectivity in the findings, and feminist research suggests that this sort of ethnographic study is by its nature highly subjective (Stanley and Wise, 1990). In order to minimise this, or to be explicit

about this, it is important for the researcher's voice to be evident within the discussion (Fine *et al*, 2000). Peer review, academic supervision and reflexivity have been valuable in identifying these areas of potential bias. In addition, situating the findings with similar findings and in the context of wider academic and policy debate adds credibility to them.

2.10 Summary

This research is an example of policy ethnography, a case study employing ethnographic methodology to uncover the detailed experience of implementing a particular policy in a particular place. In this instance, the ethnography considers the implementation of the New Labour Health Action Zone policy initiative in Merseyside, the largest and most complex of the implementation sites. A broad range of voices have been captured through observation and, predominantly, semi-structured interviews. The data have been analysed using a grounded theory approach, generating the themes and categories presented in the findings chapters, Chapters 5, 6 and 7.

The next two chapters discuss the theoretical debates leading up to the development of the HAZ policy and some of the early findings of the National Evaluation of HAZs, which together form the backdrop to the research reported here. The next chapter, Chapter 3, considers different perspectives on health and explanations for health inequalities. Reducing health inequalities was one of the two main aims of the HAZs. As such the theories relating to this are important for reflecting on how New Labour proposed to address health inequalities and the expectations of those who were drawn to work within the HAZ organisations.

Chapter 3

Ideas in exile: The principles of health for all

There was also the “sleeper effect” of evidence produced in a “cold climate”, which at the time may seem to have little or no immediate impact, but was stored and used when a more favourable political climate develops. (Whitehead *et al*, 2004, p.819)

This chapter considers theories about health and health inequalities. They are relevant to the Health Action Zones in that people familiar with these theories have been drawn to work within the Zones, and as such these theories have informed the way the policy has been put into operation. The HAZ Principles themselves reflect many of these definitions and debates. The bringing together of this set of values with people used to working according to those values has contributed to the enthusiasm observed for the HAZs. This is particularly relevant in Merseyside where there has been a long history of partnership working and community development and Liverpool has been part of the World Health Organisation’s Healthy Cities programme for 15 years.

Health inequalities were largely ignored under the Conservative governments preceding New Labour because the issue did not fit with their values (Baggott, 2000; Macintyre *et al*, 2001; Petticrew *et al*, 2004; Whitehead *et al*, 2004). However, much of the evidence for health inequalities and the debates about their causes were generated during this time (Petticrew *et al*, 2004; Whitehead *et al*, 2004). In this way they were ideas developed in exile, or in a ‘cold climate’.

Kingdon (1995) argues that policy action results from the opening of a policy window when the three streams of problem, policy and politics come together. By this he means that a problem has been identified, there are policy options available to address the problem, and there is the political will to do so. Nutbeam (2004) has argued that “*policy is most likely to be evidence-based if scientifically plausible evidence is available and accessible at the time it is needed*” (op. cit., p.138). This evidence comes from what Kingdon describes as the ‘policy primeval soup’: ideas that have been developed, promoted and gradually accepted by academics, researchers and career civil servants, sometimes over many years (Kingdon, 1995).

The evidence and debates about health inequalities which developed in exile during the Tory years were the ‘policy soup’ from which New Labour drew when developing their policies to address health inequalities. There is a large and growing body of literature about the nature, possible causes and approaches to reducing health inequalities³. It would be impossible to review all the literature here. Instead key ideas will be presented as they relate to the development and goals of HAZs.

3.1 Definitions of health inequalities

The term ‘health inequalities’ has no clear or universal definition. At the core of all the various definitions is an understanding that health inequalities are differences in health outcome (morbidity and mortality) by previously defined social groupings (such as social class, occupation, sex, age, educational attainment, ethnicity) both within and between countries (Townsend and Davidson, 1992). For some people these variations represent the ‘natural’ distribution of differences within a population,

³ For example: Introduction to Acheson (1998); Evans *et al* (2001); Graham (2000b); Hofrichter (2003); Raphael (2001a); Townsend, Davidson and Whitehead (1992); Wilkinson (1996); Wilkinson and Marmot (2003).

and so for such people the term is simply descriptive as nothing can be done to alter this 'natural' state (Townsend and Davidson, 1992). However, the term is generally understood to refer to the distribution of health outcomes that are socially and/or economically determined (Townsend and Davidson, 1992; Baggott, 2000; Exworthy *et al*, 2002; Graham, 2004), although it can be difficult to disentangle the natural and social causes of health status (Townsend and Davidson, 1992).

Health inequality and health inequity are often used interchangeably (Baggott, 2000; Graham, 2004). But some authors suggest that health inequality is a descriptive term with no moral judgement made about the differences described (Baggott, 2000; Oliver and Nutbeam, 2003; Graham, 2004), whereas health inequities are inequalities that are unfair and unjust (Whitehead, 1992a; Baggott, 2000; Oliver and Nutbeam, 2003; Graham, 2004), and implicit in this definition is the understanding that socio-political values have an impact on the distribution of health outcomes within a society (Graham, 2004).

The identification of health inequities requires moral judgements based on particular theories of justice and society, and beliefs concerning the origins of health inequalities (Baggott, 2000; Gwatkin, 2000; Kawachi *et al*, 2002; Oliver and Nutbeam, 2003). Therefore, determining which health inequalities are also health inequities is not wholly an objective process (Kawachi *et al*, 2002). Oliver and Nutbeam (2003) argue that there is therefore a need for a clear ethical framework to determine which inequalities are inequitable and therefore require action to redress the balance. They suggest that New Labour has no clear ethical framework for its health inequalities agenda, and in fact New Labour define all health inequalities as intrinsically unjust and unfair (Graham, 2004). Kawachi *et al* (2002) conclude that

most socio-economic conditions that have been shown to have a negative influence on health outcomes are unfair.

3.2 Definitions of health

Intrinsic to the discussions about health inequalities is an understanding of the word 'health'. For some this is synonymous with 'ill health', for others it encompasses more holistic and positive concepts of health and wellbeing. Health is a contested concept (Seedhouse, 1986; Duggan, 2002; Hunter, 2003b), its definition changes between groups, across societies and over time (Townsend and Davidson, 1992). On the one hand it is often equated with the absence of disease, and this has been the dominant definition in the West over the 20th century. The Cartesian split between body and mind in the 17th century freed the body for scientific evaluation (Aggleton, 1990). Increasingly the body came to be viewed as a machine and as medical science advanced the understanding of how the body functions has been reduced down to the molecular level. By the end of the 20th century, the causes of ill-health have become localised in the patient's body, with the belief that these can be detected by science, and treated with drugs or by surgery - rarely are people treated as a whole as they were in earlier forms of health care (Aggleton, 1990).

When health is equated with the absence of illness, especially in professional and political circles, health improvement is pursued through sickness and/or disability alleviation. This view of health is generally termed the 'medical' model. Using this model, health improvement is achieved by curing or preventing disease through medical intervention, by mediating for disability, and by attempting to encourage people to adopt 'healthier' lifestyles. In fact, research suggests that only between 10 and 30 percent of the differences in health outcomes are attributable to differences in

health-related behaviours across socio-economic groups (Graham, 2000a). Similarly it has been estimated that improvements in medical care have only contributed about one fifth of the 30 years increased life expectancy during the twentieth-century in the USA and UK (Davey Smith, 1999; Hunter, 2003b).

The word 'health' is derived from the Anglo-Saxon word 'hael' meaning 'whole', incorporating a sense that health is more than the sum of healthy body parts (Townsend and Davidson, 1992; Naidoo and Wills, 2000). This is similar to the meaning of health in some African cultures where health means Life, encompassing a sense of vitality (Povall *et al*, 2000), and the ecological approach to health in other traditional cultures (Deloria, 1994).

This more holistic model of health as an expression of vigour, harmony, wellbeing and engagement with one's social context (Townsend and Davidson, 1992; Hunter, 2003b) is reflected in the World Health Organization definition of health as "*a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity*" (WHO, 1948), and its embodiment in the principles of Health For All and health promotion. Hunter (2003b) suggests that most Western holistic definitions of health stem from this WHO definition, although it has been criticised as being naïve and unrealistic. However, this definition does demonstrate the complex, holistic nature of health (Tones, 1996; Hunter, 2003b).

This 'social model' suggests that health is a product of an individual's or group's social, economic, psychological and physical circumstances. Figures 3.1 and 3.2 are two well known models of health utilising this perspective (Duggan, 2002).

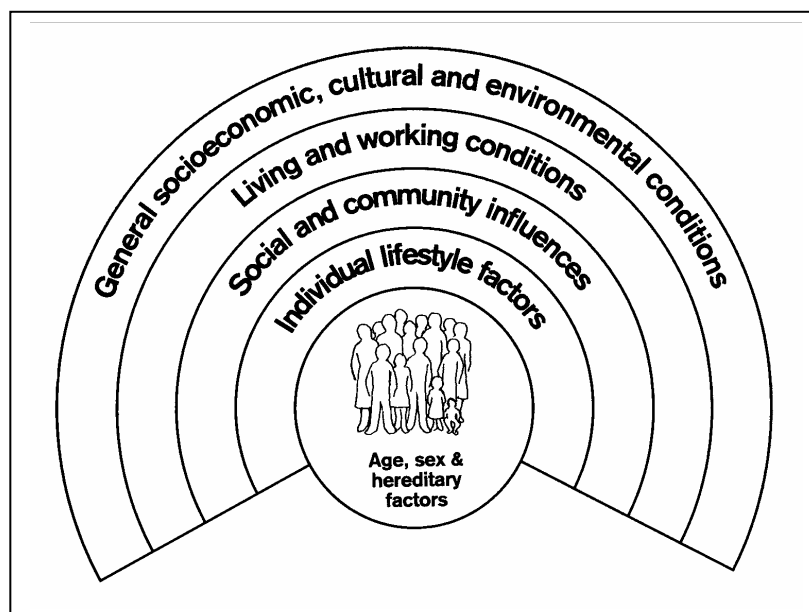


Figure 3.1 A conceptual model of the main determinants of health – layers of influence. (Source: Dahlgren and Whitehead, 1991, cited Whitehead, 1995, p.23).

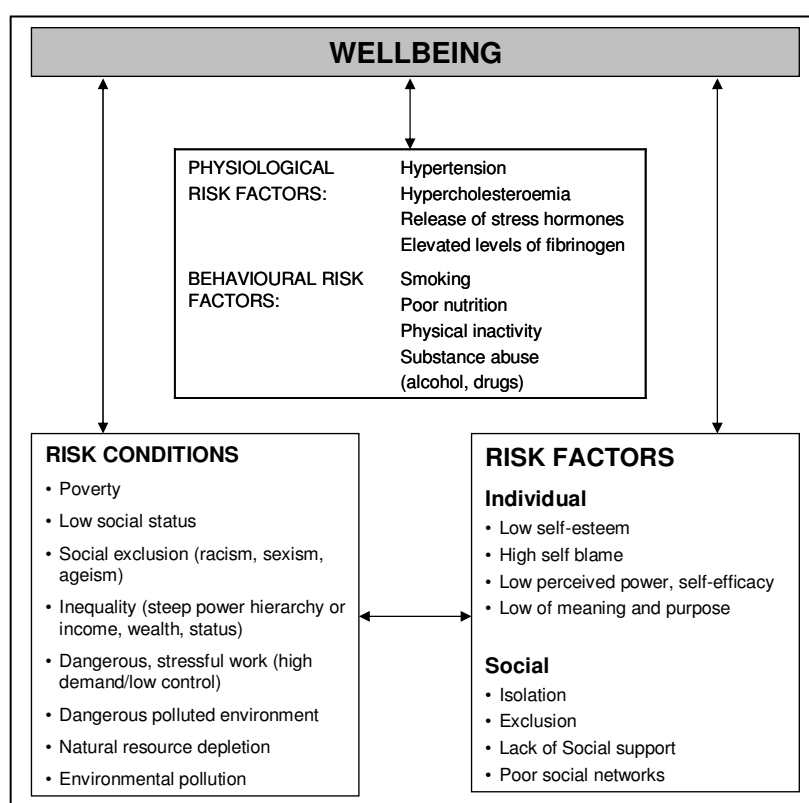


Figure 3.2 Socio-ecological model of health (Source: Labonte, 1998, cited Duggan, 2002, p.95)

The Dahlgren and Whitehead model in Figure 3.1 represents the different determinants of health as layers of influence on an individual. These layers are interconnected, as

individual lifestyles are embedded in social and community networks and in living and working conditions, which in turn are related to the wider cultural and socioeconomic environment (Acheson, 1998, p.6).

In Figure 3.2, ‘risk conditions’ are those living and working conditions that are affected by political and economic decisions (Duggan, 2002). These conditions increase the chance of illness and the likelihood that someone will engage in health damaging behaviours (‘risk factors’). These determinants, or root causes, of health and ill-health are complex (Whitehead, 1992b; Hunter, 2003b), and show how from the perspective of the social model of health, health improvement can be achieved by addressing the socio-economic conditions under which people live, as well as by behaviour modification and providing adequate health care services.

HAZs were intended to improve health and reduce health inequalities by addressing these ‘root causes’ of ill health. To do so necessarily requires action in many arenas and at many levels. Therefore the HAZs were intended to be broad partnerships based around a central collaboration between the health and local government sectors. It is also why they strove for a whole systems approach to change, which recognises the interdependence of many of the factors above.

For the remainder of this dissertation, unless otherwise stated, the use of the term ‘health’ will imply the social model of health, and ‘health inequalities’ will refer to those differences in health outcome that are influenced by socio-economic conditions. HAZs are the focus of this dissertation, and as they are a piece of New

Labour policy, I will follow New Labour rhetoric and define health inequalities as differences that are fundamentally unfair and unjust.

3.3 Putting health inequalities on the map

The relationship between socio-economic position and health has been noted as far back as ancient China, Greece and Egypt (Graham, 2000a). In 19th century Britain, William Farr documented the differences in mortality rates between richer and poorer areas, and this contributed to the drive for public health reform (Baggott, 2000). This early public health movement was concerned with the sanitary conditions of the poor, and it was through the efforts of these policy entrepreneurs that for example, clean water was provided, sewers were laid, and housing was improved (Baggott, 2000; Webster and French, 2002; Szreter and Woolcock, 2004). Over time, this focus on the environmental links to health outcomes lessened as medical science improved and health care came to dominate the health agenda (Baggott, 2000; Webster and French, 2002).

New approaches to health policy began to emerge in the 1970s in the UK and elsewhere (Baggott, 2000; Hunter, 2003b). These reflected concerns in the cost of health care provision and the growing belief that improving population health could not be achieved through medical and hospital services on their own (Hunter, 2003b). In 1976 the UK Labour government published a document titled *Prevention and Health: Everybody's Business*, which identified inequalities in health status as one of the key areas for future intervention (Baggott, 2000). This stemmed from the growing pressure from people working in the health services who were aware of the gap in health status in Britain, and the recognition that health status in the UK was not improving as quickly as it was in other wealthy countries (Townsend *et al*, 1992).

The Labour government set up a Research Working Group to consider the evidence for health inequalities, both national and international, and to make recommendations for policy interventions. The Working Group was chaired by Sir Douglas Black, and the report resulting from this work became known as the Black Report.

The Black Report concluded that socio-economic factors affect health and favour the better-off, and that therefore much of the problem of health inequalities lay beyond the scope of the NHS (Townsend *et al*, 1992). A disagreement about how to fund the recommendations of the report led to a delay in its release (Berridge, 2003). This meant that the report was finally presented to the new Conservative government in 1980, where it met with a decidedly cool reception (Townsend *et al*, 1992; Berridge, 2003). Not only was the conclusion that material deprivation contributed to health inequalities not consistent with Tory ideology (Baggott, 2000; Berridge, 2003), but the cost of the recommendations was unaffordable at a time of economic crisis (Oliver and Nutbeam, 2003). It has been argued that if the report had been submitted to the Labour party, they too would have found the cost of implementing the recommendations problematic (Klein, 2003). Nevertheless, Patrick Jenkin, then Secretary of State for Social Services (which included Health), was advised to publish the report in a way that distanced its conclusions from the government (Berridge, 2003). This apparent suppression of the report

led to an enormous growth of research interest in this area, the growth of networks of researchers, a kind of underground culture of inequalities research and debate which continued throughout the 80s and early 90s. (Berridge, 2003, p.12).

It also raised interest amongst the trades unions and “*quite exceptional efforts were made by bodies connected with the health and welfare services to bring the evidence*

and arguments in the report to a wide audience” (Townsend *et al*, 1992, p.4). The Labour Party were encouraged to take an interest in the report (Townsend *et al*, 1992), and passed a resolution that the next Labour Government would give priority to implementing the report’s recommendations (Townsend *et al*, 1992; Oliver and Nutbeam, 2003). In addition they recognised that many of the report’s recommendations could be initiated by Local Authorities and so encouraged local Labour representatives to implement them (Townsend *et al*, 1992). Some local authority representatives have reported that the New Labour health inequalities agenda amounted to a rebranding of work they had been trying to do for some time (Exworthy *et al*, 2002).

In these ways, the development of ideas about health inequalities and their causes and possible solutions to them, happened in exile but informed local action. They were prominent in academic discourse, and work to address them was happening close to the ground, but *“the issue was not a serious policy concern during most of the 18 year life-span of the successive Conservative Governments”* (Oliver and Nutbeam, 2003, p.281). However, the authors of the Independent Inquiry into Inequalities in Health Report (the Acheson Report) note that the Black Report was influential internationally and informed the development of the WHO Health For All policy (Acheson, 1998).

3.4 Health For All

Health For All (HFA) was adopted by the member states of the WHO in 1977 in recognition that large numbers of people did not have an acceptable standard of health (Parish, 1995; Tones, 1996; Pappas and Moss, 2001). It was launched at the Alma-Ata Conference in the Soviet Union in 1978, with the Alma-Ata Declaration

(WHO, 1978). At the heart of this declaration was the recognition that social justice and equity are pre-requisites for health, and that “*health is primarily about politics*” (Kelly and Charlton, 1995, p.80). These ideas became influential at the local level, and in Britain this was spearheaded by the adoption of a Health For All framework by the Mersey Regional Health Authority in 1984 (Ashton, 1992), reflecting Liverpool’s history of being at the cutting edge of public health developments (Green, 1992).

The discipline of health promotion developed in the WHO alongside Health For All, from the recognition that health education on its own would not be sufficient to radically improve health (Parish, 1995; Tones, 1996). Tones (1996) describes health promotion as “*a kind of militant wing of HFA2000*” (ibid, p.10). The member states of the European region of the WHO adopted the 38 targets of Health For All in 1984 (Kickbush, 2003). This helped to give this broader approach to health promotion legitimacy and contributed to the positive political environment that led to the Ottawa Charter for Health Promotion (Tones, 1996; Kickbush, 2003).

According to the Ottawa Charter (1986), health promotion is “*the process of enabling people to increase control over, and to improve, their health*” (Ottawa Charter, 1986, p.1). Health is “*seen as a resource for everyday life, not the objective of living*” (Ottawa Charter, 1986, p.1). The purpose of health promotion is to advocate, enable and mediate for health and wellbeing, and is built upon the principles of building healthy public policy, creating supportive environments, strengthening community action, developing personal skills, and reorienting health services towards prevention.

Despite the adoption of a Health For All strategy by many countries, progress towards new national policies based on the principles of Health For All was slow (Ashton, 1992). The Health For All process was relaunched in 1995, recognising the limited success of the policy to that date (Pappas and Moss, 2001; WHO, n.d.). The relaunched policy re-affirmed the principles of Health For All in response to accelerated global change and new thinking (WHO, 1998). It recognised poverty as the greatest threat to health, and that new responses were needed to tackle emerging challenges such as: demographic shifts - urbanisation, ageing, increase in chronic diseases; social, behavioural, biological changes – sedentary lifestyles, increasing levels of violence, increasing disease resistance to drug treatments; transnational factors – global economic policies and processes, environmental degradation.

Similarly, The Jakarta Declaration on Health Promotion in the 21st Century (Jakarta Declaration, 1997) was a restatement of the principles of the Ottawa Charter in the light of the new Health For All process. The Jakarta Declaration (1997) states the new priorities for health promotion in the 21st century as: social responsibility; increased investments for health development; to consolidate and expand partnerships for health; increased community capacity and individual empowerment; and to secure an infrastructure for health promotion. This latter priority promoted settings, such as schools, hospitals, workplaces, universities and prisons, as sites for health promotion (Tones, 1996; Dooris, 2004). These ‘healthy settings’ were to afford an opportunity to put the principles of Health For All and the Ottawa Charter into action (Tones, 1996; Johnson and Baum, 2001; Kickbush, 2003; Dooris, 2004).

Perhaps the best known example of WHO endorsed health settings is the Healthy Cities initiative (Tones, 1996; Kelly and Killoran, 2003; Kickbush, 2003; Dooris,

2004). Liverpool was amongst the first eleven WHO sponsored Healthy Cities (Liverpool Healthy City 2000, 1997), and John Ashton and others working from Liverpool were influential in the European Healthy Cities project (Ashton, 1992; Green, 1992). The Healthy City projects

advocated partnership and network-based approaches of change management to allow creation of political commitment, generate visibility for health issues, embark on institutional change, and create space for innovative health action. (Kickbush, 2003, p.386).

Healthy City work is based on the principles of Health For All, defined as equity, intersectoral collaboration, community participation, and sustainable development (Naidoo and Wills, 2000; UKHFAN, n.d.). These two functions of the healthy settings approach combine to form a ‘whole systems’ approach to health improvement (Dooris, 2004).

The Healthy Cities concepts helped to shape the development of the HAZ policy (MHAZ, 2000), and the HAZ Principles reflect the aims of Health For All (see Box 1.1 in Chapter 1). In Merseyside, it was clear that the Liverpool Healthy City work directly influenced the development of the HAZ programme. One participant in this research who worked closely with the Healthy City project in Liverpool explained:

I think being able to input the experiences that we’d had in Liverpool around joint working on public health, the development of the City Health Plan, etc, helped to lay some of the foundations for the HAZ. Because it’s the same ... Health For All, Healthy Cities. (MHAZ co-ordination, 03/2002).

Although, almost inevitably, the local focus of the Liverpool Healthy City project has been lost in the development of the HAZ, the MHAZ has been beneficial in that “*the Health For All way of working has expanded right across Merseyside*” (op. cit.).

This settings approach to health development, and particularly the emphasis on healthy public policy⁴ and intersectoral work, reflected the need to tackle health improvement and health inequalities from a broad base, as discussed earlier. To be successful health promotion needs to be part of the core values of an organisation and the people involved need to be committed to the process (Johnson and Baum, 2001). Just as health promotion remains a contested concept (Tones, 1996), so health promotion has been undertaken differently in various settings (Johnson and Baum, 2001). Consequently, such settings based health promotion projects have had mixed results (Baum and Cooke, 1992; Duhl, 1992; Dooris, 2004).

The Ottawa Charter promoted a holistic socio-ecological model of health (Dooris, 2004), where the focus is on health generation and not disease alleviation (Kickbush, 2003). However, Kickbush (2003) concedes that the tendency has been to fall back to health education methods of trying to change individual behaviours (smoking, exercise, diet, and so on). This tension between health care provision and health promotion has been evident throughout the life of the HAZs. In part it reflects the fact that different models of health are competing with each other. The socio-economic model of health might now be widely accepted, but it is not always widely acted upon.

3.5 An area of 'special need'

All these ideas about health and health inequalities formed the policy primeval soup (Kingdon, 1995) that influenced the development of Health Action Zones. They also explain some of the initial enthusiasm for HAZs as for many people working within the HAZs had been trying to implement these ideas for years but without a

⁴ "Healthy public policies improve the conditions under which people live..." (Milio, 2001, p.622)

supportive context. With the New Labour government these ideas received government backing and financial support for the first time. Health Action Zones were aimed at areas of special need, where complex socio-economic conditions combined in a manner that limited opportunities and had a detrimental impact on health for parts of the population.

Merseyside has a long history of deprivation. Both Liverpool and Wirral were mentioned as areas needing special attention in the seminal Black Report, published in 1980 (Townsend and Davidson, 1992). In the intervening years the area has received a great deal of special funding, apparently to little effect:

For twenty years, rescue funds have flooded in from local government, from Westminster, from Europe. Countless schemes have been set up and dismantled, two-year plans and five-year plans, regeneration projects like Objective 1 ... Snazzy offices have been opened, glossy brochures printed up, and many solemn-faced men in suits have waxed fat in the process. The whole area could be renamed Quango City. When Tom thinks of the money that has been pumped into Liverpool 8 over the years, he gags. "There's been about six billion so far, spread over the last four decades, and here we are today, still living in shit." (Cohn, 1999, cited Chatterton and Bradley, 2000, p.98).

During this time the Thatcher government deregulated the labour market, and there was a corresponding rapid increase in unemployment between 1979 and 1985 (Burström *et al*, 2000). In addition there has been a shift away from manufacturing to service industries, which has particularly affected employment amongst men in the unskilled manual work social groups (Graham, 2000a). Figure 3.3 shows the variation in long term unemployment and those who have never worked across electoral wards in the five Merseyside districts, based on 2001 Census data. It can be

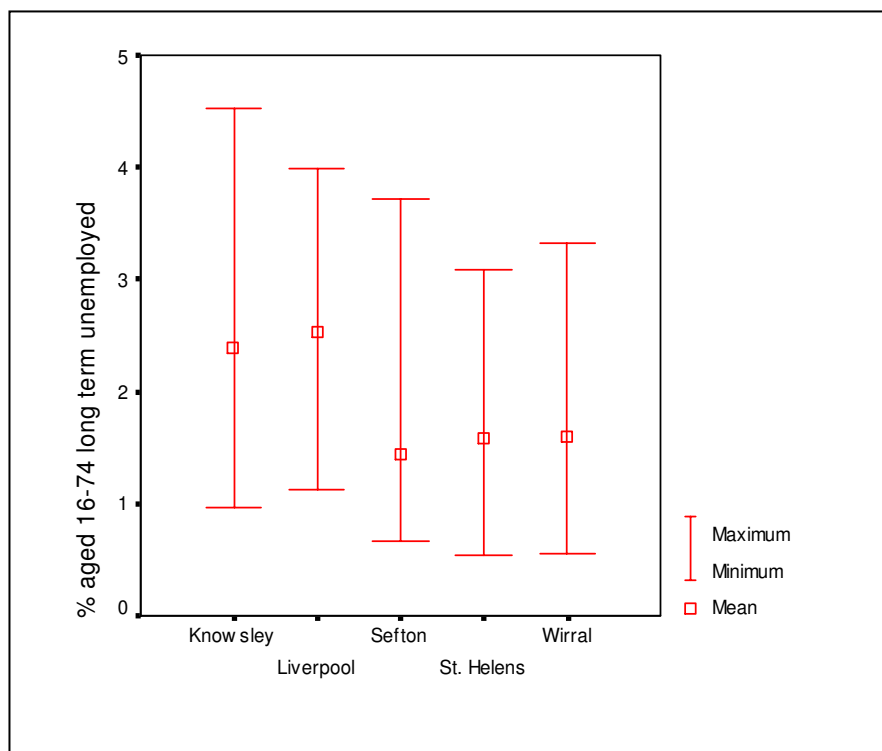
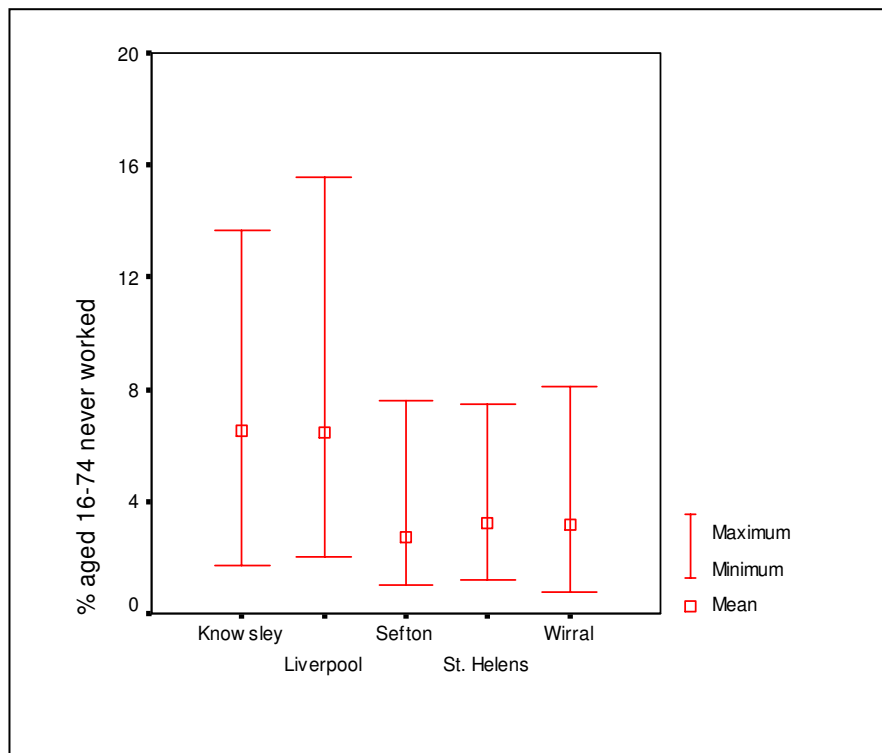


Figure 3.3 Percentage of 16-74 year olds across Merseyside electoral wards who have been in long term unemployment or who have never worked (Source: 2001 Census data (ONS, 2004a))

seen that Liverpool and Knowsley are particularly disadvantaged in this respect. One of the consequences of this change in employment patterns is the outwards migration of people from these deprived areas as they seek employment elsewhere (Shaw *et al*, 2000).

Population levels in these post-industrial areas have been declining steadily over the last few decades as a result of these moves (Graham, 2000a). For example the North West and North East regions have seen a population fall of 1.7% and 2.8% respectively between 1991 and 2001 (ONS, 2004b). At the same time the population in the East, South West, London, and the South East of England have seen a 5% increase in their populations (ONS, 2004b). It is the more able, more affluent people who leave, and they are replaced by poorer people, so the net effect is a widening of the gap between rich and poor areas, deepening levels of deprivation (Shaw *et al*, 2000). This pattern occurs regionally as well as nationally (and internationally!), so that within the North West, although the population of Merseyside is expected to continue to decline, that of Cheshire is expected to increase (NWPHT, 2003).

Local Authority District	1971	1981	1991	2001	Change 1971-2001 (000's)	Percentage Change 1971-2001
Merseyside	1,656.5	1,522.2	1,449.7	1,362.0	-294.5	-18%
Knowsley	194.1	174.0	156.9	150.5	-43.6	-22%
Liverpool	610.1	517.0	480.7	439.5	-170.6	-30%
St Helens	189.0	190.2	180.9	176.8	-12.2	-6%
Sefton	307.5	300.4	295.2	283.0	-24.5	-8%
Wirral	355.8	340.6	336.0	312.3	-43.5	-12%

Table 3.1 Population in thousands for the Census Years 1971 – 2001 by LA (Source: LHA, 1999, p.8 and 2001 census data (ONS, 2004a)).

Table 3.1 shows the changes in population of the Merseyside districts since 1971. The decline in population is neither even nor consistent across the five districts. It is

no surprise, given the above analysis, that Liverpool and Knowsley have experienced the greatest losses of population.

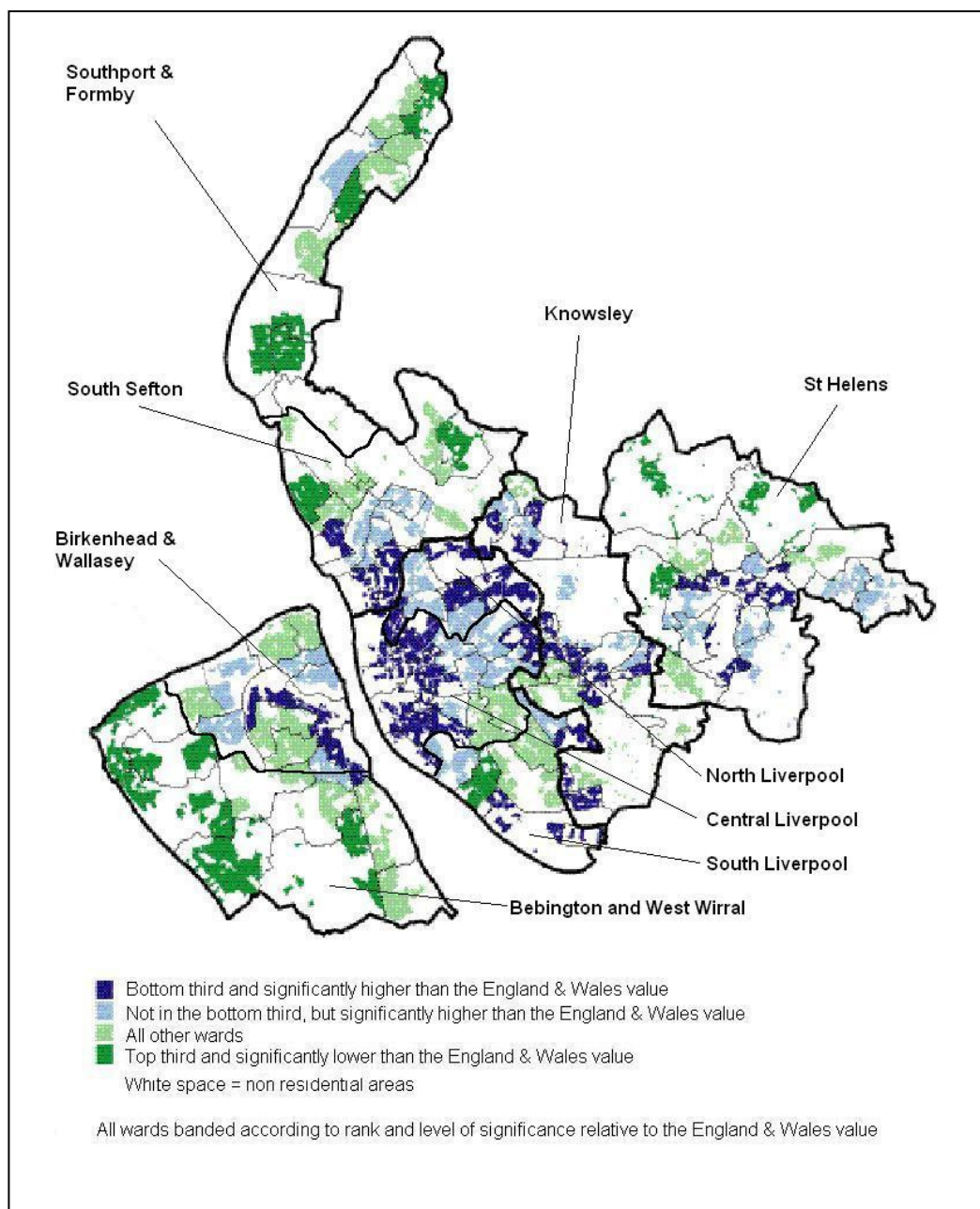
Table 3.2 demonstrates how the five Merseyside districts rank out of all the 354 English districts using various analyses of the Indices of Multiple Deprivation for 2000. All of them are within the 100 most deprived districts in all measures, but once again Liverpool and Knowsley fare the worst.

Local Authority	Rank of average score	Rank of average rank	Rank of extent	Rank of concentration	Rank of income scale	Rank of employment scale
Knowsley	2	6	5	3	36	28
Liverpool	3	5	7	2	2	2
Sefton	74	85	45	43	27	16
St Helens	40	36	38	42	61	43
Wirral	56	70	57	9	14	7

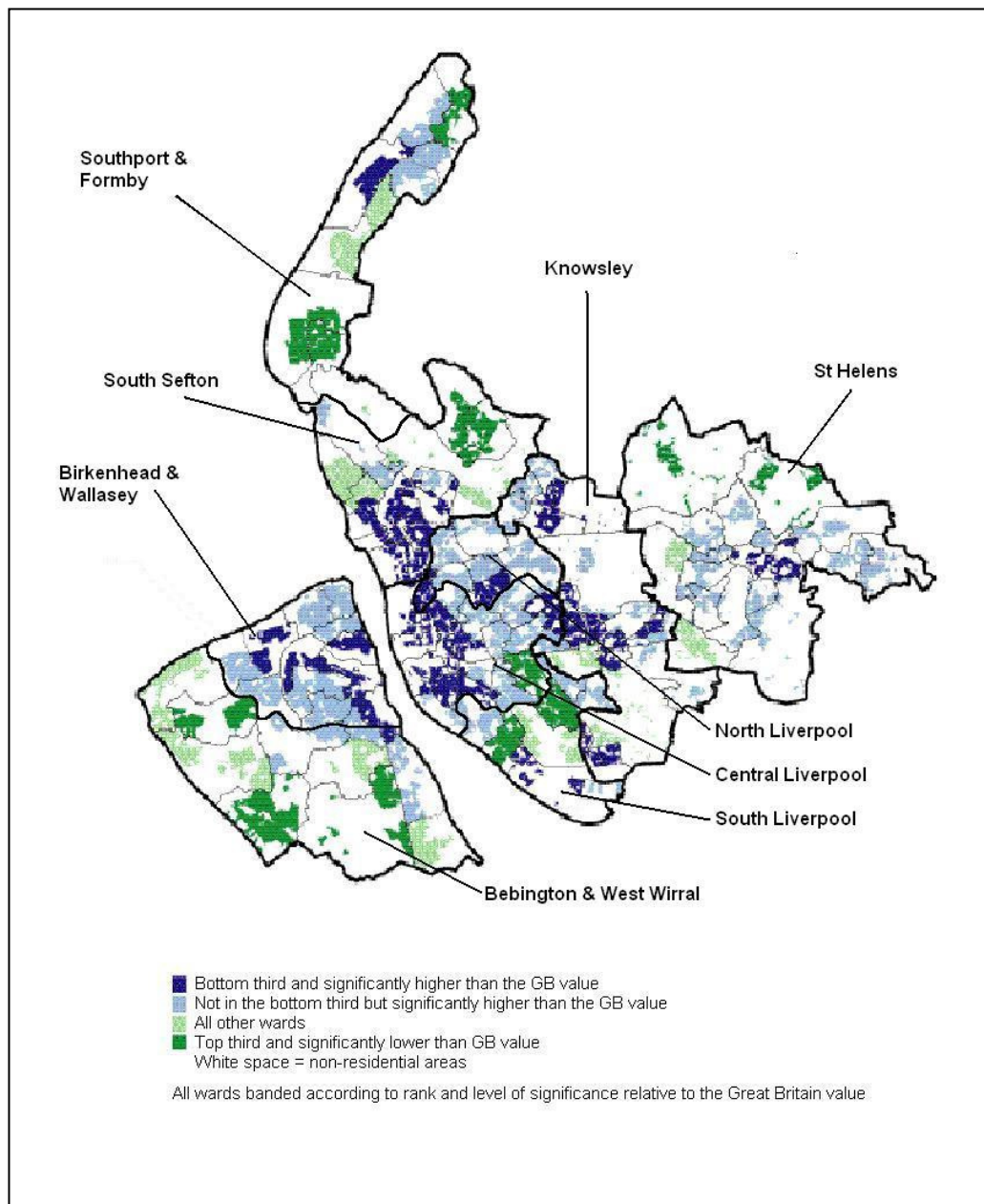
Table 3.2 District level summaries of the Index of Multiple Deprivation 2000 (rank out of 354 districts) (ONS, 2004a)

The ‘rank of concentration’ measure shows that Wirral has some areas of extreme deprivation. But as can be seen from Maps 3.1 and 3.2 these areas of deprivation are juxtaposed with areas of affluence. This is true for all the districts, but especially so for Wirral. Map 3.1 shows standardised mortality ratios⁵ (SMRs) for all causes of death by ward in the Merseyside area for years 1994-1996, Map 3.2 shows the unemployment rates across Merseyside wards at December 1998 (MHAZ, 2000). The correlation between high unemployment and high mortality is clear from these two maps.

⁵ SMRs are a relative measure of death rates. The average for, in this case, England and Wales is represented by 100%. Ratios of less than 100% represent death rates below the average, and ratios of more than 100% represent death rates above average.



Map 3.1 Merseyside SMRs for all causes of death by ward, age 0-74, years 1994-1996, relative to the England and Wales Value. (Adapted from: MHAZ, 2000, p.16)



Map 3.2 Merseyside unemployment rates at December 1998 by ward (Proportion of economically active people who are claiming unemployment related benefits) (Adapted from: MHAZ, 2000, p.17)

Comparing the two maps it can be seen that the highest death rates largely occur in those areas associated with economic decline: Liverpool, Birkenhead, Bootle (South Sefton), Knowsley and St Helens. Also, each district has some areas with high death rates and some with low death rates, and that sometimes areas in the two extremes are adjacent to each other. This suggests that although socio-economic conditions are related to health outcomes, that relationship is quite specific to the conditions of particular areas (Marmot, 1999; Marmot, 2005). The current Primary Care Trust boundaries have been superimposed on these maps, and this shows the diverse characteristics of each of the PCT populations. The highest death rates are concentrated in particular areas, with Knowsley, North and Central Liverpool, and Birkenhead and Wallasey PCTs faring the worst. This is most clear from the data in Figure 3.4.

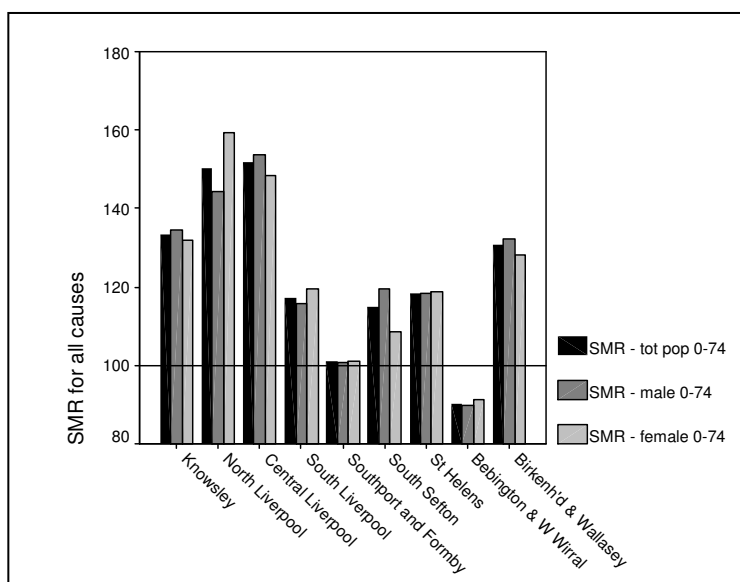


Figure 3.4 Merseyside PCTs: SMRs for all causes of death, ages 0-74, years 1998-2002, relative to England and Wales value (100%) (Source: NWPHO, 2004)

It can be seen that although there is a four year difference in the data represented in Map 3.1 and Figure 3.4, the patterns of mortality are the same, with North and Central Liverpool PCTs having the highest mortality rates (roughly 50% higher than the average for England and Wales), and Bebington and West Wirral PCT having the lowest (roughly 10% lower than the average for England and Wales). These patterns in mortality reflect the patterns of deprivation discussed earlier.

As we have seen, it is now widely accepted that socio-economic conditions, especially those of poverty, are inextricably linked to ill-health (Acheson, 1998; Baum, 1999; Black, 2000; Szreter and Woolcock, 2004). The data above demonstrates the wide variations in these socio-economic determinants, or “root causes” of health and ill-health, supporting the earlier assertions that the HAZ remit of tackling health inequalities by addressing the root causes of ill-health requires action on many different fronts. By the time the HAZ initiative was announced there was a clear understanding in the Merseyside region that many of its socio-economic problems, including appalling health outcomes, were due to a wide range of socio-economic determinants.

The first part of this chapter has demonstrated the associations between socio-economic circumstances and health. The precise ways in which socio-economic circumstances, and particularly those of deprivation, affect health outcomes are hotly contested areas. The most dominant of these debates are presented in the remainder of the chapter. Although the focus is on health inequalities there are also lessons about service modernisation, the second aim of HAZs.

There has been a great deal of research done into the links between socio-economic conditions and health outcomes, and illuminating examples exist from both national

and cross-national studies. However, where possible, examples will be given from Merseyside to highlight why Merseyside needed a Health Action Zone, and what has been done in MHAZ to engage with particular approaches to health improvement.

3.6 What are the underlying causes of health inequalities?

The literature around the root causes of health and health inequalities suggest a number of factors combine to generate health and ill-health. Figure 3.1 above presents these factors as layers of influence, working from the individual outwards. The following sections look at some of the factors that have been identified as working within these layers. Although socio-economic conditions are usually discussed in relation to their impact on individual health, there is also a place effect in the distribution of health inequalities (Graham, 2000a; Kawachi *et al*, 2002; Marmot, 2005).

HAZs are initiatives with an area focus on reducing health inequalities and modernising services. Within that area-based remit they employ a number of strategies to address these aims. The MHAZ worked at the individual, institutional, district and regional levels. There were specific interventions designed to address particular issues for individuals, such as stress reduction, smoking cessation, diet, exercise, and empowerment. There were other interventions that sought to address multiple factors in an individual's life through multidisciplinary teams, or by interdisciplinary action. Community based action included support for Healthy Living Centres (another New Labour initiative to address health and health inequalities), the creation of an Eco House and promoting connections between young and old members of a community. The strategic partnerships in the districts and at the Merseyside level ensured a co-ordinated approach to addressing problems

in particular areas, and they also raised awareness of the issues within statutory organisations.

There is a heated debate within the community of people who support the social model of health about the ways in which social and economic conditions affect health (Szreter and Woolcock, 2004). There are two main camps of opinion: those that argue that it is the material conditions associated with deprivation that affect health directly; and those that argue that it is the psychological consequences of living in a divided society that affect health, through the physiological responses to stress.

These two aspects recur throughout the discussions about the causes of health inequalities and what can be done to address them at both the individual and area levels of influence on health. They need not be mutually exclusive, although the various proponents often feel that they are (Szreter and Woolcock, 2004). However, there are no clear pathways between socio-economic conditions and health outcomes (Graham, 2000a; Szreter and Woolcock, 2004).

3.6.1 *Individual level influences on health*

Graham (2000a) identifies three subgroups of individual influences on health: behavioural, material and psychosocial. There is also a growing interest in how these may interact over a person's lifecourse, *in utero* to the present (Lynch *et al*, 1997; Joshi *et al*, 2000; Kawachi *et al*, 2002), and this perspective is also considered.

Behavioural factors are health-related habits and routines like smoking, leisure activities and diet. The traditional emphasis on the use of health education to encourage people to change their behaviours has been criticised for not taking into

account how a person's choices and ability to change can be constrained by the social, economic and environmental conditions in which they live (Seedhouse, 1986; Beattie, 1993; Gillespie and Gerhardt, 1995; Kickbush, 2003). Behavioural factors display a strong socio-economic gradient, ranging step-wise across socio-economic groups with the poorest groups exhibiting more health damaging behaviours (Lynch *et al*, 1997; Marmot *et al*, 1997; Jarvis and Wardle, 1999; Graham, 2000a; Kawachi *et al*, 2002).

Figure 3.5 shows the social gradient in life expectancy across occupational class. The social gradient suggests that it is not the conditions of absolute poverty which contribute to health inequalities, but conditions that vary across socio-economic groups (Kawachi *et al*, 2002; Wilkinson and Marmot, 2003).

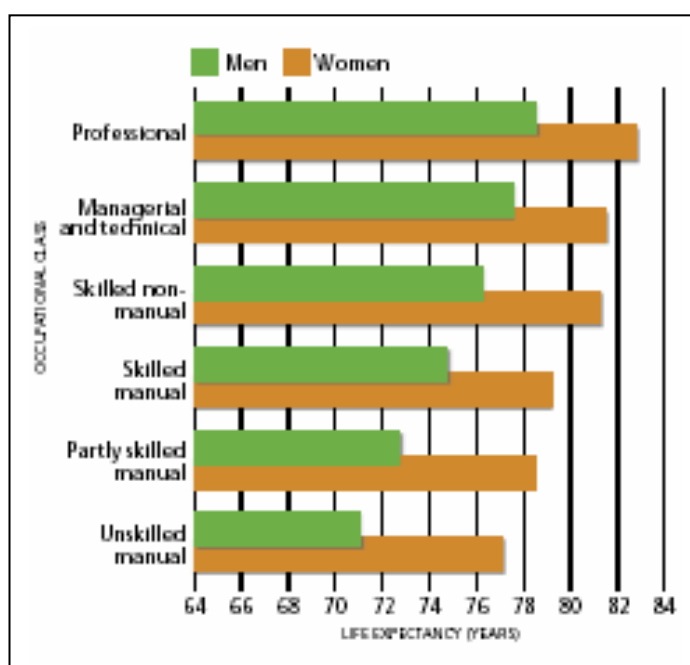


Figure 3.5 Occupational class differences in life expectancy, England and Wales, 1997-1999 (Source: Wilkinson and Marmot, 2003, p.10)

Jarvis and Wardle (1999) have revealed how smoking prevalence varies with socio-economic group, and that quit rates also show a social gradient. They suggest several factors that might influence a person's ability to quit smoking: social norms, e.g. more people smoking in the social environment; lower expectation of health problems resulting from smoking; nicotine dependence increases with deprivation as people smoke more cigarettes and smoke more of each cigarette; smoking can be used to manage stressful circumstances (Jarvis and Wardle, 1999).

Another lifestyle issue often identified as important for health is diet. At one MHAZ sponsored conference a doctor spoke of the difficulty in trying to persuade parents to feed their children a balanced meal: chips are cheap and filling, and a child is quickly hungry again after a plate of salad. The Merseyside HAZ has funded a number of food programmes, and food forums to join these different food interventions together in the districts. They also employed a Healthy Eating Co-ordinator, and through her the Fruit in School programme was piloted in Merseyside. Some areas are known to be 'food deserts' where it is difficult to access affordable, healthy food of good quality. In some of these areas MHAZ supported GPs who sold fruit at cost in their surgeries. The Health Eating Co-ordinator also liaised with companies in the food industry, such as Brake Brothers, to encourage them to reduce the amount of fat and salt in their products. In these ways, and others, MHAZ tried to help make healthy eating more affordable and acceptable.

The complexity of the influences on whether or not people make healthy lifestyle choices point to the importance of material and psychosocial circumstances in facilitating or discouraging particular behaviours. Material factors include the quality of the home, neighbourhood and workplace environments, together with

living standards secured through earnings, benefits and other income (Graham, 2000a). As above, access to tangible material conditions increases with socio-economic position (Kawachi *et al*, 2002).

The Merseyside HAZ co-funded several interventions designed to address the material circumstances in which people live and work, some of which are: projects to address issues of fuel poverty, especially amongst the elderly; support to people to become self employed in a particularly deprived area with few employment opportunities; the Merseyside Racial Harassment Prevention Unit which provides security cameras for people suffering racial abuse.

There have been a number of studies which suggest that it is the psychosocial effects of material deprivation that best explain the links between socio-economic circumstances and ill health (Marmot *et al*, 1997; Marmot, 1999; Wilkinson 1996 and 1999).

To feel depressed, cheated, bitter, desperate, vulnerable, frightened, angry, worried about debts or job and housing insecurity; to feel devalued, useless, helpless, uncared for, hopeless, isolated, anxious and a failure: these feelings can dominate people's whole experience of life ...It is the social feelings which matter, not exposure to a supposedly toxic material environment. (Wilkinson, 1996, p.215).

The psychosocial elements of material disadvantage relate to how a person experiences their position in society (Graham, 2000a). One of the ways in which social position may relate to health outcomes is through the stress that results from living in difficult material circumstances (Brunner and Marmot, 1999; Wilkinson, 1999; Kawachi *et al*, 2002; Wilkinson and Marmot, 2003).

Animal and human studies suggest that stress results from a person's relative

position in the social hierarchy, and that this is a consequence of the lack of control a person may feel they have over their environment (Marmot *et al*, 1997; Brunner and Marmot, 1999; Wilkinson, 1999; Graham, 2000a; Wilkinson and Marmot, 2003). Jones and Novak (1999) have argued that in Britain at least, poverty has long been seen as a moral as well as a socio-economic condition. They argue that there is a long tradition stretching back over two hundred years or more whereby the poor are deemed to be morally inferior to the rich and that this deeply layered perspective does damage to the poor's sense of wellbeing. Brunner and Marmot (1999) argue that several physiological changes occur when a person experiences long periods of stress, and that these are the link between the social environment and health outcomes. One of these physiological changes is the suppression of the immune system, and Evans *et al* (2000) have found a social gradient in immune response by social class, age and sex.

There is a well established body of evidence linking social support and positive health (Whitehead, 1995; Szreter and Woolcock, 2004). Loneliness and a lack of social interaction have been linked with higher levels of stress and suppressed immune response (Glaser, 2005). Relaxation therapies can boost immune function (Glaser, 2005) and, together with psychological support, have been shown to help prevent the spread of cancer following surgery to remove the primary tumour (Ben-Eliyahu, 2003). These findings reflect observations from a centre that provides support and complementary therapies to cancer patients. The centre was established in response to a lack of psychological support for cancer patients within the NHS. The manager of this centre took part in this research, and she explained that the complementary therapies they offered helped people to feel in control of their illness. There have been some remarkable stories of recovery and remission against the

expectations of NHS clinical staff. The manager suggests that

the therapies themselves are a means to an end ... reducing anxiety... it's the common denominator which runs through all the therapies ... it gives the person permission to talk. The minute another human being is there, willing to give something to them, that person will open up and talk. The complementary therapies are a facilitating machine – the main thrust is psychological support. (Intervention, Health, 11/2002).

There have been a number of MHAZ funded interventions designed to provide support on an individual basis. Some of these are call lines, such as the Campaign Against Living Miserably (CALM), a helpline aimed at young men, and the Fag Ends helpline to provide smoking cessation advice. Other interventions include: the provision of Citizen's Advice in GP surgeries, recognising that often people seeing their GP are really suffering from stress related to difficult living conditions; a support group for women with a mental illness recently discharged from hospital; a support group for the parents of children addicted to drugs.

The negative health impacts of stress and loneliness, and the positive health impacts of social support and feelings of control, relate directly to the links between socio-economic circumstances and individual health experiences. However,

[t]his is not to argue for stress counselling rather than poverty alleviation and social reform ... ill health is associated with prolonged exposure to psychological demands when possibilities to control the situation are perceived to be limited and chances of reward are small. (Brunner and Marmot, 1999; p.26).

The behavioural, material and psychosocial influences on health are not mutually exclusive and cluster together to create compounding effects (Graham, 2000a; Kawachi *et al*, 2002; Wilkinson and Marmot, 2003). There is a growing literature

which suggests that these effects can also interrelate to generate cumulative effects over time (Graham, 2000a). This is known as the lifecourse effect.

Key stages in the lifecourse are: infancy (reflected in inequalities in infant mortality rates); childhood (geographical concentrations of children living in poverty); education and qualifications (educational achievement has a social gradient); employment (types of employment vary by geographical areas); later life (more people with limiting long term illness in poorer areas); retirement (premature death rates mean that there are fewer pensioners in poorer areas) (Shaw *et al*, 2000). So, for example, normative values established in childhood can determine adherence to health promoting or damaging behaviours in adulthood (Lynch *et al*, 1997; Wilkinson and Marmot, 2003). Lynch *et al* (1997) found that

adult behaviours and psychosocial orientations are patterned by childhood [socio-economic status], and so [the findings] do not provide support for the “free choice” conception of adult behaviour, because in this view adult behaviour would be unrelated to childhood conditions. (Op. cit., p.817).

Similarly, in an analysis of changes in life expectancy in the 19th century by birth cohort, Davey Smith and Lynch (2004) suggest that it is early childhood conditions that have the greatest effect on later life health status. However, Blane (1999) argues that there does not seem to be any one stage of life that is most important for later health. Rather each stage would appear to be able to have both positive and negative influences on health (Blane, 1999). The different life stages have differing degrees of influence for different later health outcomes (Blane, 1999; Graham, 2000a). Each stage is also interrelated, for example educational attainment is linked to childhood circumstances, but this also determines future occupational status (Lynch *et al*, 1997;

Blane, 1999; Wilkinson and Marmot, 2003). Social class makes a large long term contribution to health outcomes (Blane, 1999). However, current financial circumstances are also important in determining adult health status (Graham, 2000a), and Graham (2000a) concludes that

socio-economic inequality is made up of an intricate web of hierarchies which individuals negotiate as they journey from childhood through adolescence and into adult life. (Op. cit., p.4).

To summarise, there are three pathways through which lifecourse circumstances may impact on individual health through behavioural, material and psychosocial influences: *latent effects* (early life environment manifesting in adult situations and behaviours); *pathway effects* (the early life environment sets individuals on certain trajectories); *cumulative effects* (where circumstances at each life stage have different levels of influence on current health, based on the intensity and duration of the experience) (Kawachi *et al*, 2002). In these ways lifecourse effects on health are fundamental to an understanding of the origins of health inequalities (Kawachi *et al*, 2002), as the relationships between adult socio-economic conditions and health may reflect prior environments (Marmot *et al*, 1999).

It was on the basis of these understandings that the HAZs set out to forge links with other government initiatives which were implemented by the New Labour government to address different aspects of social exclusion. By connecting, for example, with Sure Start programmes, the Children's Fund, Education Action Zones, Employment Zones, and so forth, the MHAZ hoped that they would be addressing some of the broader determinants of health over the lifecourse.

3.6.2 Area level influences on health

Health outcomes are the product of factors working at both the individual and area levels (Graham, 2000a; Joshi *et al*, 2000; Marmot, 2005). Area characteristics describe the nature of the area itself, and not just the people in it. Again, these influences have both material and psychosocial components.

Areas have material characteristics that are intrinsic to that place, such things as quality of housing, environmental pollution, traffic volumes, rates of road traffic accidents, and how well resourced the area is in terms of shops and services, recreational facilities, public transport and primary health care (Graham, 2000a). One of the consequences of widening inequalities can be that less is invested nationally in social welfare or public services in poorer areas (Kawachi *et al*, 2002), exacerbating existing conditions of poverty. Shaw *et al* (2000) demonstrate that poor areas tend to stay poor, and since the 1980s spatial poverty has been increasing. Using London as an example, they show that the distribution of poverty in the city has remained relatively unchanged since the 19th century. Some of this is due to the patterns of migration discussed earlier, where poor people who move or die are replaced by more poor people (and similarly in rich areas), and that poor housing is replaced by more poor housing (Shaw *et al*, 2000).

Again incorporation of these ideas was evident in the MHAZ strategy and informed one of its high profile interventions (part funded by the Merseyside HAZ) namely 'Alleygating'. This put gates on the entrances to the alleys running between the backs of terraced housing. These have been highly successful in reducing crime rates in these areas, and they have been very popular with the residents, enhancing their sense of security.

Areas can also have marked cultural differences due to different mixes of ethnic populations. Figure 3.6 demonstrates how the populations of Merseyside PCTs have differing degrees of ethnic diversity. High concentrations of one particular cultural group can generate different social norms in that area, which may in turn affect attitudes to and experiences of education and employment (for example), and the pathways between the two and their impact on wealth (Davey Smith *et al*, 2000). This in turn will be reflected in the health experiences of the people living in those areas.

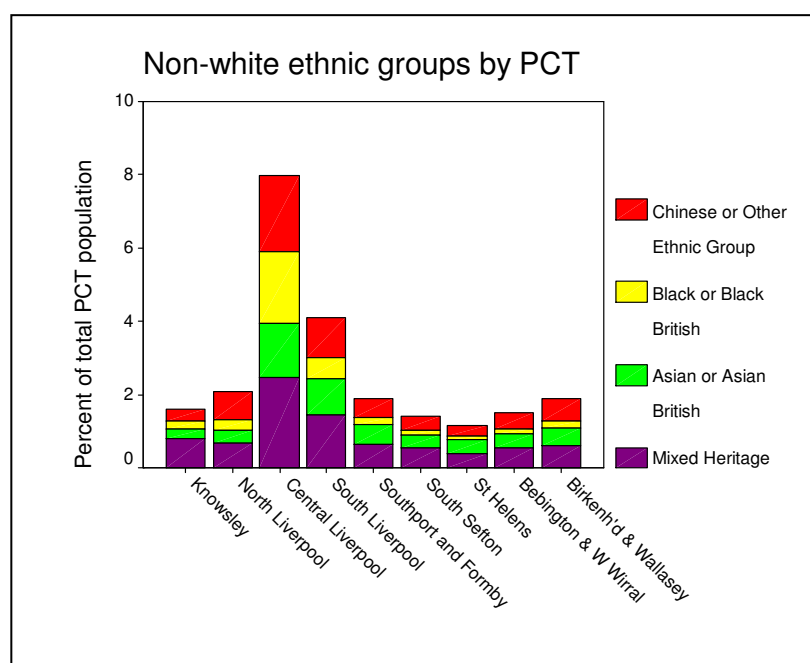


Figure 3.6 Percentage of population identified as non-white ethnic groups, by Merseyside PCT (Source: NWPFO, 2004)

The psychosocial characteristics of areas are determined by the way in which the material and social characteristics of an area interact to either promote or diminish wellbeing amongst those that live there (Graham, 2000a; Kawachi *et al*, 2002), and how these effects may be different for different groups (Kawachi *et al*, 2002). For

instance, access to local facilities and participation in local networks have been shown to have beneficial health effects (Graham, 2000a). Local networks may be affected by social group properties such as ethnicity, age, income, cultural norms, and the general health of the people who live there (Kawachi *et al*, 2002). Just as social support can have positive health effects for individuals, at the group level social cohesion can have a powerful health effect (Stansfeld, 1999).

An innovative project in one MHAZ district connects school children with older residents in a Dawn Patrol. The older residents put a card in their window at night if they are well, and the children look for these cards on their way to school. If the card is missing, the children report this when they get to school, and arrangements are made for the older person to be visited. In another MHAZ funded initiative, work was underway to establish a Time Bank – a reciprocal form of volunteering where people within the community exchange ‘good deeds’ in an attempt to develop some social cohesion. So that one person might mow the lawn of another, and in return that person might do the ironing for someone else.

One consequence of a lack of social cohesion can be increased crime rates and higher levels of violence, which are often associated with more deprived areas, as well as feelings of isolation and loneliness (Wilkinson, 1996). This in turn can reduce a sense of safety and security and increase stress levels within the community. Wilkinson (1999) suggests the increases in crime and violence are the result of people trying to generate a sense of control and feel more powerful in relation to others, and that the underlying emotion is a sense of shame associated with being lower down the social hierarchy (Wilkinson, 1999).

This section has considered both the individual and area level influences on health

outcomes. All of these influences combine to affect health and wellbeing (Joshi *et al*, 2000; Kawachi *et al*, 2002; NWPHT, 2003). Although the socio-economic influences on individuals are important, area characteristics also matter, but most poor people live outside poor areas (Shaw *et al*, 1999; Joshi *et al*, 2000; Shaw *et al*, 2000). Therefore, area-based initiatives alone are insufficient and need to be supported by programmes which address individual inequality (Joshi *et al*, 2000).

The biological routes from socio-economic status to ill health suggest that the higher incidence of morbidity and mortality in poorer areas is due to the stress of living in conditions of deprivation, with fewer opportunities to build self-esteem and exert control over one's own material and social circumstances. Social support and positive relationships seem vital to individual health, but difficult socio-economic conditions can undermine such positive influences.

3.6.3 The link between income and health inequality

The above discussions highlight the debates about the relative importance of material and psychosocial factors in determining health outcomes. These debates are particularly fierce when it comes to understanding why health inequality is so strongly correlated with income inequality, that is understanding the pathways between income levels and health outcomes. Part of the problem is that there is little evidence to suggest how best to reduce health inequalities (Macintyre *et al*, 2001; Oliver and Nutbeam, 2003; Petticrew *et al*, 2004); most of the evidence in the 'policy primeval soup' for health inequalities has been explanatory in nature (Petticrew *et al*, 2004).

The widest income inequalities occur in neo-liberal market economies (Navarro and Shi, 2001; Wilkinson, 1996). Neo-liberal market economies are characterised by an

emphasis on market forces, or competition, as a means for generating economic growth. Individuals and groups can become excluded when they are unable to compete effectively within this arena. For example, the loss of manufacturing jobs has contributed to the decline of areas like Merseyside. So, it is argued that the causes of ill health will be both determined and affected by the political context (Starfield, 2001). A study in Canada has concluded that “[l]ow income is a major cause of cardiovascular disease” and that social-exclusion is the “process that explains how low income causes cardiovascular disease” (Raphael, 2001a, p.xii). Increases in the levels of low income and social exclusion have resulted from a move to neo-liberal economic policies in Canada (Raphael, 2001b).

The corresponding argument that more equitable societies have better health is reflected in Sen’s and Wilkinson’s assessments of the large increases in life expectancy during the decades of the two world wars (see Figure 3.7) (Wilkinson, 1996; Sen, 2001). Sen (2001) suggests that this is the result of a greater commitment

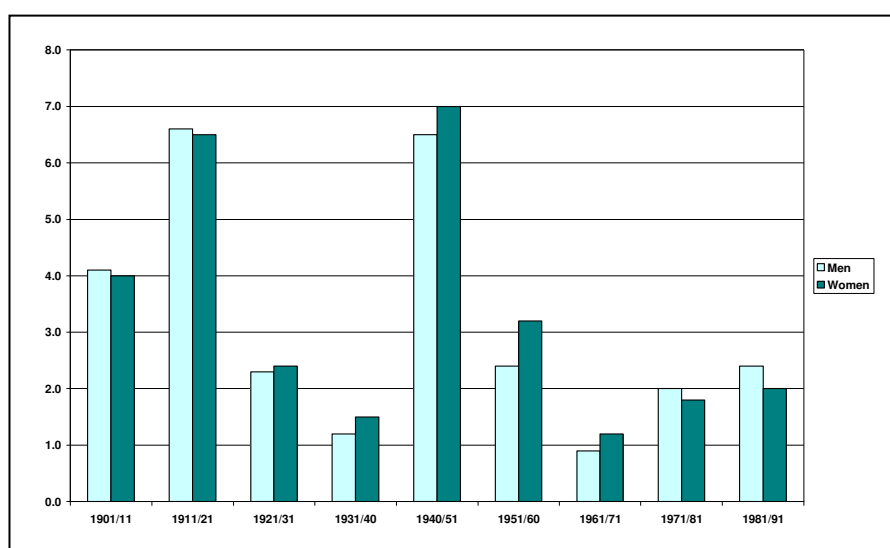


Figure 3.7 Increases in life expectancy in England and Wales each decade 1901-91 (Source: Wilkinson, 1996, p114).

to collective welfare during the war years. Although it is often argued that health improved due to a better diet during this time (Wilkinson, 1996), Wilkinson (1996) believes that the improved national health resulted from the interplay of three factors: a sense of camaraderie as people faced common enemy; deliberate attempts to reduce the unequal distribution of resources and to encourage full employment; policies to promote a sense of unity and co-operation.

These three factors fed off each other and resulted in a more cohesive society (Wilkinson, 1996). The link between social wellbeing and physical health outcomes is indicated in the comments of one member of the MHAZ Steering Group during our interview for this research:

This summer the hospitals were very quiet ... could well be just the state the Nation's in – the general feel good factor – we'd had the Commonwealth Games, we'd had the Jubilee, people were feeling happy, were feeling good. When people feel happy and feel good the health service is not under so much pressure. (Strategic, Health, 12/2002).

This analysis forms part of the basis for Wilkinson's argument that greater levels of social cohesion exist in more egalitarian societies, and that greater socio-economic inequalities lead to greater health inequalities through the breakdown of social relationships that result from harsher living conditions (Wilkinson, 1996). Furthermore, such analyses suggest that although there has been an overall improvement of material circumstances associated with economic growth, the increasingly inequitable distribution of the spoils of those improvements challenge the *de facto* argument that economic development is therefore good in and of itself (Baum, 2000; Sen, 2001). What is more important for social wellbeing are the

choices made about how the benefits of economic growth are distributed throughout society (Baum, 2000; Sen, 2001).

The social gradient in inequality suggests that poorer health is not simply a problem of material poverty amongst the poorest groups, but that the influences on health outcomes are graded across the social hierarchy. Amongst others, cross country comparisons with Sweden, which has a more collective approach to supporting its population, have demonstrated that many of the factors contributing to health outcomes are amenable to change through policy choices (Whitehead, Burström and Diderichsen, 2000; Whitehead, Diderichsen and Burström, 2000).

Both material and psychosocial factors at the individual and area levels can influence a person's sense of self-esteem, perceptions of control, levels of stress, feelings of exclusion, and uptake of health-related behaviours. Muntaner, Lynch, Davey Smith and colleagues argue for the primacy of material conditions for individual health (Lynch *et al*, 2001; Szreter and Woolcock; 2004). Wilkinson and colleagues do not dispute the importance of material circumstances to individual health, but argue that in developed countries the level of social cohesion – or what is increasingly being referred to as social capital – is a better predictor of health outcomes (Wilkinson, 1996; Wilkinson, 2000; Szreter and Woolcock, 2004). These two are interrelated, but the importance of the debates is the policy outcomes that each might suggest.

There is a real fear amongst the proponents of the primacy of material conditions that promoting social capital could be seen as a cheap fix to the problems of neo-liberal capitalism (Gamarnikow and Green, 1999; Lynch *et al*, 2001; Kawachi *et al*, 2004; Szreter and Woolcock, 2004), suggesting that “*poor communities can pull themselves up by the boot-straps without extra money*” (Wilkinson, 2000, p.411); just as the

harsh conditions of the Poor Law of 1834 were designed to reduce the cost of poor relief by correcting the moral fibre of the poor in a time of market driven economic development (Evans, 1983; Jones K., 1994). For these authors, the only way to address inequality in health is through policies designed to redistribute financial and other resources more equitably.

Often attempts to improve social cohesion or social capital focus on horizontal relationships within specific communities. However, a number of authors have argued that it is the vertical relationships (Lynch *et al*, 2001; Whitehead and Diderichsen, 2001; Szreter and Woolcock, 2004), or social solidarity (Whitehead and Diderichsen, 2001), which get stretched in less equal societies and that this is the cause of the worsening social conditions that lead to disparities in health status. Either way, the correlation between larger inequalities in health status, larger inequalities in socio-economic conditions, and neo-liberal economic policies has led to the conclusion by some that it is the socio-economic values and systems of a country that need to be challenged to reduce inequalities (Birch, 1999; Coburn, 2000; Leon *et al*, 2001; Lynch *et al*, 2001; Scambler and Higgs, 2001). In fact, Lynch *et al* (1997) conclude:

Understanding that adult health behaviour and psychosocial orientations are associated with socioeconomic conditions throughout the lifecourse implies that efforts to reduce socioeconomic inequalities in health must recognize that economic policy is public health policy. (Op. cit., p.818).

The extent of health inequalities results from the socio-political context prevalent within a country. This determines the extent of socio-economic inequalities, the root causes of ill-health. Several possible mechanisms for how socio-economic conditions lead to better or worse health have been discussed above. Ultimately, any

changes to the level of inequalities in health will come from a mixture of policies and programmes to address these different factors. New Labour have introduced many programmes and policies to promote a joined-up approach to reducing poverty and social exclusion, and improving outcomes in areas such as health, education and employment. Many of these programmes also emphasise the need to involve communities. HAZs are one of these programmes, and one strand of the government's approach to reducing health inequalities. None of these policies are designed to promote vertical cohesion, and New Labour does not promote the investments they have made in poorer communities (Toynbee and Walker, 2005). As a result of this, the 'ideas in exile' have done much to promote a more collective approach to health improvement in localities, but they still have to compete with the popular view of health as the result of health care intervention:

Health For All, health promotion, and population health have all contributed to a reorientation in thinking and strategy, yet the focus of health policy remains medical care expenditures rather than investment in health determinants. (Kickbush, 2003, p.387).

3.7 Chapter summary

Health Action Zones were areas of 'special need'. Merseyside is consistently ranked amongst the areas of greatest deprivation in England, and as such certainly qualifies as an area of special need. However, the region includes areas of affluence as well as deprivation, so it is not simply a case of targeting funding at particular areas of deprivation. The Merseyside HAZ had the opportunity to work strategically across the region, forging links between districts and district authorities, as well as within a broad-based partnership.

There are several explanations for how the socio-economic conditions of deprivation lead to greater levels of ill-health. These, to some extent, reflect different understandings about how health is generated, maintained and improved. The medical model conflates health and ill-health and focuses on improvements in the delivery of health care and encouraging people to adopt healthier lifestyles to reduce inequalities. Both of these are important, but proponents of the social model of health argue that these do not explain all the differences in health outcomes observed across various social groups. From this perspective, the socio-economic conditions of people's lives are the most important influences on health.

Lifestyles are not a simple matter of personal choice, but are a response to social conditions and social norms. Health-related behaviours and illness result from a combination of material and psychosocial conditions at both the individual and area levels. The degree of physical deprivation and the psychological responses to it are the result of national and international policy choices. Cross-country studies have shown that both income and health inequalities are worst in neo-liberal market economies, which further suggest that wide inequalities are not inevitable, but can be altered through policy decisions.

Policy options to reduce health inequalities, therefore, need to work at different levels: at the national and regional government levels to alter the wider socio-political influences on poverty and inequality; programmes to address material and psychosocial influences at the area level; programmes to address behavioural, material and psychosocial influences at the individual level. The mediators between socio-economic conditions and health outcomes would seem to be stress induced by material and social conditions, and the social conditions seem to be influenced by

people's self-esteem and sense of control, and perhaps levels of shame, experienced at various positions on the social hierarchy.

The Merseyside HAZ sought to address aspects of all the levels of influence on health in the area of Merseyside. Fundamentally they wanted to raise awareness of the issues within the statutory sector organisations, and to promote systemic change in the way health and health inequalities were perceived and addressed in the region. Health Action Zones were active at the area level, and so were operating within the larger macro level policy development, some of which generates inequalities in wealth and health. Any achievements, or otherwise, the HAZs might have had in reducing health inequalities would have to be understood in this context.

Health Action Zones are one strand of the government's approach to tackling health inequalities. The next chapter will look more closely at how New Labour have approached the reduction of health inequalities, and how the debates presented above have been incorporated into their policy choices.

Chapter 4

'Health inequalities' come in from the cold

Health inequalities were not discovered in 1997 with the change of government and the Acheson Report. What was different in 1997 was that the issue of health inequalities resonated with the political vision of the incoming Labour Government. (Oliver and Nutbeam, 2003, p.283)

There were two clear strands to New Labour ideas, promoting equity and social justice, and building on the Conservative party economic legacy by persisting with neo-liberal economic policies. The first strand clearly resonates with the ideas presented in Chapter 3. It was this desire for justice and equity that plainly underpinned the HAZ policy development. The second strand came with a burdensome micro-management style and a preoccupation with reforming the public sector. It is the conditions associated with this latter thread of New Labour government that caused so much stress within the HAZs. Both of these aspects of New Labour are discussed in this chapter.

The preceding chapter presented some of the arguments and discussion about the underlying causes of health inequalities and the best policy approaches to address them. When New Labour came to power in 1997, they brought with them a focus on social justice and reducing inequalities. The ideas presented in Chapter 3 fit with this vision and value set. Their influence is evident in the policy choices to reduce inequalities, and is clear in the development of HAZs. This chapter will discuss how New Labour values have informed their approach to reducing inequality and health inequality, and how the evolving policy context shaped the implementation of HAZs.

4.1 Putting health inequalities on the political agenda

Evidence of health inequalities had largely been gathered in the cold climate of the Tory years, but the arrival of New Labour into office brought the desire to tackle health inequalities a little closer to the hearth. Kingdon (1995) argues that particular events open windows of opportunity for policy implementation, events such as election victories. These windows are not open for long (Kingdon, 1995; Petticrew *et al*, 2004), however, and action only occurs when there are policy alternatives available that fit the vision and values of the political climate (Kingdon, 1995; Powell and Exworthy, 2001; Exworthy *et al*, 2002; Oliver and Nutbeam, 2003; Exworthy and Powell, 2004). The New Labour election victory brought together their desire to promote equity and justice with the research base on health inequalities to create an opportunity for policy action.

It is argued that for evidence to influence policy decisions it has to be '*scientifically plausible*' (Oliver and Nutbeam, 2003, p.138), which is usually interpreted as meaning quantitative in nature and/or originating from the research community (Armitage and Povall, 2003). However, recent research suggests that policy makers are open to many different sorts of evidence: good stories, qualitative case studies, historical data, and such (Petticrew *et al*, 2004). It seems that what is most important is having that evidence available when it is needed (Kingdon, 1995; Petticrew *et al*, 2004), and that the evidence is appropriate (Whitehead *et al*, 2004). Rather than evidence necessarily informing policy, there are times when evidence is used to support policy decisions that have already been made (Petticrew *et al*, 2004). In this way, policy development is much more iterative and evolutionary than it is a linear process (Kingdon, 1995; Nutbeam, 2004, Petticrew *et al*, 2004).

The following section examines the New Labour project: the values that underpin it and how these inform the New Labour approach to equity and public sector reform. Most of the discussion centres on the alleviation of poverty, and there are stark similarities between these debates and those about the best ways of addressing health inequalities presented in Chapter 3. Just as there are those that argue that the only way to address health inequalities is to challenge neo-liberal economic policies, there are others that argue that poverty can only be reduced by addressing the ‘structural’ causes of poverty.

These structural causes are the same as the wider determinants of health discussed in the previous chapter. Debate, then, centres on whether priority should be given to these macro factors or the micro factors affecting individuals and communities.

4.2 New Labour

When in opposition, the Labour Party reinvented itself in order to become an effective alternative to the Conservative Party (Gray, 2004). They recognised that society had changed from when they were last in power in the 1970s and sought to find a new vehicle for the Labour values of social justice and equity. A number of things were influential in this transformation, including: The Commission on Social Justice, chaired by the then Labour Party leader John Smith, with papers from the Institute for Public Policy Research (Lavalette and Mooney, 1999); the concept of a ‘Stakeholder Society’ (Marquand, 1996); and the Third Way, a centre-left politics which seeks to set itself apart from the old left and new right, whilst taking elements from each (Bevir and O’Brien, 2001; Deacon, 2003; Snape and Taylor, 2003). After their election victory in 1997, New Labour settled on defining themselves as a Third Way party, influenced by Bill Clinton’s administration in the United States

(Lavalette and Mooney, 1999; Giddens, 2003; Snape and Taylor, 2003; Gray, 2004) and a number of countries across Europe (Giddens, 2003). However, the 'stakeholder' influence is still evident in their policies.

The concept of stakeholding was developed in the US in the 1960's and 1970's as a reaction to the excesses of free-market capitalism (Bevir and O'Brien, 2001). In this context stakeholder companies are social organisations based on trust that are not simply focussed on maximising profits for shareholders, but enable all stakeholders (shareholders, customers, suppliers and employees) to participate in the making of decisions (Gamble and Kelly, 1995, Marquand, 1996; Bevir and O'Brien, 2001). Extended to society as a whole, it would need to ensure that "*every individual citizen and important interest has a stake in society and a voice in the way it is run*" (Gamble and Kelly, 1995, p.1). This is not simply strengthening of citizenship and encouraging people to vote. For David Marquand,

Stakeholder economics demand stakeholder politics. And stakeholder politics must be a politics of power-sharing, negotiation and mutual education – a politics that requires transformation of the British constitution and the reconstruction of the British state. (Marquand, 1996, p.3).

For Marquand, at least, a stakeholder approach represents a radical attempt to restructure society to be more egalitarian and inclusive. Holtham (1996) suggests this was why the idea lost prominence, because in this radical form it would alienate the business community and "*in more mainstream form it did not lead to any catchy or marketable policies*" (Holtham, 1996, p.3). The Third Way, however, is "*driven by policy innovation and the need to react to social change*" (Giddens, 2003). This

is less radical, perhaps, but the centre-left is also referred to as progressive politics, and

[t]he aim of progressive politics is to bring about a different kind of society from the one we currently inhabit. (Chen, 2003, p.1)

New Labour values are underpinned by a desire to change society, not the social democratic aim of solidarity, but a society based on a “fraternal” community where people are interconnected and have common values (Blair, 2002). This was expressed in the 1997 Labour Party Manifesto as:

New Labour believes in a society where we do not simply pursue our own individual aims but where we hold many aims in common and work together to achieve them. How we build the industry and employment opportunities of the future; how we tackle the division and inequality in our society; how we care for and enhance our environment and quality of life; how we develop modern education and health services; how we create communities that are safe, where mutual respect and tolerance are the order of the day. These are things we must achieve together as a country. (Labour Party, 1997)

Chen (2003) argues that to achieve this, society would have to be built around the principles of active citizenship, where all individuals are empowered to be active in the public realm. And where people, when presented with a choice between acting for individual gain or public good, would choose to act for the public good first. This, she argues, requires a public who are employed and well educated, in order to give them all an equal voice. Good quality public services freely available to all are an essential part of the public sphere, and of promoting this kind of active citizenship (Chen, 2003).

My vision is of a nation where no-one is seriously disadvantaged by where they live, where power, wealth and opportunity are in the hands of the many not the few. (Blair: Forward in Social Exclusion Unit, 2001, p.5)

When one understands the New Labour project as a desire to transform society so that it is more equal and just, and not merely a softening of the effects of neo-liberal capitalism, then the values that they espouse – opportunity, responsibility, accountability, equity and community (Powell and Moon, 2001; Brown, 2004) – can be understood as elements of the attempt at that transformation. These values, and the policies that promote them, can then be critiqued not just on their own terms, but also in the light of their efficacy in promoting the social transformation that New Labour is hoping for. Tony Blair has acknowledged that passing legislation will not effect this (Blair, 2002), rather “*this is a task of renewal by a thousand small steps, by ministers and civil servants, councillors and public service workers, and most of all by citizens and communities*” (Blair, 2002, p.3, emphasis added).

The New Right believed that high levels of public spending were bad for the economy, created dependency and reduced self reliance (Bevir and O’Brien, 2001). They were disparaging of the old left approach to universal welfare provision which led to bureaucratic inefficiency (Bevir and O’Brien, 2001; Snape and Taylor, 2003). They believed that better management would lead to better services (Snape and Taylor, 2003; Clarke, 2004), but their approach led to a fragmented public sector (Snape and Taylor, 2003). The New Right were not interested in poverty (Deacon, 2003) and their approach to development ultimately led to an increasingly divided society, with the emphasis on competition and individualism not taking into account the essentially social nature of human beings (Bevir and O’Brien, 2001).

The Third Way attempts to distinguish itself from both the old left and the new right, whilst at the same time combining elements from both. New Labour have clung to a belief in the market and have capitulated to the notion that there is no alternative to neo-liberal economic policy, both nationally and internationally (Lavalette and Mooney, 1999; Levitas, 2000; Oatley, 2000; Clarke, 2004; Gray, 2004). At the same time they wish to promote social justice and to reduce inequality. The approach, therefore, has been to lock in economic stability and security and to continue to promote an enterprise culture (Brown, 2004), but to extend the benefits of economic growth throughout society (Blair, 2004a) through redistribution to the poorest people and by increasing provision to the public sector (Deacon, 2003; Brown, 2004; Clarke, 2004; Gray, 2004).

There are those that contend that in practice New Labour has been a continuation of the New Right (Lavalette and Mooney, 1999; C. Jones, 2001; Gray, 2004), continuing to advance the private sector and to introduce new forms of competition and privatisation (Clarke, 2004). But Deacon (2003) argues that in fact New Labour have been more radical than these critics allow, and they have been successful in redistributing some resources to the poor (Exworthy, Stuart *et al*, 2003; Hirsch and Millar, 2004). For example, although at 15.4% Britain still has one of the highest rates of child poverty in the developed world (Womak, 2005), child poverty has “*fallen further and faster than in any other wealthy nation*” (op. cit., p.11) over the last 10 years (Moore, 2005).

4.2.1 New Labour values

Although New Labour claim to have moved beyond ideology to ideas, arguing they have taken a pragmatic approach (Lavalette and Mooney, 1999; Oatley, 2000; Shaw

and Martin, 2000; Clarke, 2004; Gray, 2004) and that '*what counts is what works*' (Labour Party, 1997, p.1), their approach is very much based on a clearly defined set of values.

New Labour values revolve around the interplay of opportunity, responsibility and community (Bevir and O'Brien, 2001; Brown, 2004). The state is seen as an enabler of opportunities (Shaw and Martin, 2000; Bevir and O'Brien, 2001; Snape and Taylor, 2003). Individuals then have the responsibility to make the most of the opportunities provided to them (Bevir and O'Brien, 2001; Deacon, 2003; Clarke, 2004). This amounts to a new moral agenda (Lavalette and Mooney, 1999; Bevir and O'Brien, 2001; C. Jones, 2001; Deacon, 2003). A key facet of this moral agenda is to move people off benefits through supporting them into employment.

Those people who have benefited from the 'welfare-to-work' policies have seen their incomes increase (C. Jones, 2001; Hirsch and Millar, 2004). However, Hirsch and Millar (2004) conclude that "*working-age households without earnings have generally seen their benefits fall behind average incomes, unless they have children*" (op. cit., p.2) and that those people hardest to help into employment will need "*many types of support and opportunity other than going straight into a job*" (Hirsch and Millar, 2004, p.2). New Labour are criticised for not paying more attention to the structural causes of poverty (Oatley, 2000; Bevir and O'Brien, 2001; C. Jones, 2001; Deacon, 2003; Clarke, 2004), and for not recognising that there are many for whom employment is not an option (C.Jones, 2001) and that there is a mismatch in supply and demand for employment that contributes to many areas remaining poor (Oatley, 2000).

Although New Labour have acknowledged the underlying determinants of poverty (and, therefore, health), and have programmes to address both lifecourse issues and structural issues in localities, their approach to poverty alleviation is mainly behavioural (Deacon, 2003), which is consistent with their values of opportunity and responsibility. They have adopted both coercive and punitive approaches to persuading people to shoulder their responsibilities, with people being threatened with losing benefits if they are not seen to be actively seeking employment (Bevir and O'Brien, 2001).

That said, New Labour recognise that many people and communities have been excluded from the advantages of economic development in Britain, and so many of their policies for social justice involve increasing the income of the poorest households, and tackling social exclusion and promoting social cohesion within the poorest communities. Thus the two values of opportunity and responsibility come together in the community (Levitas, 2000; Shaw and Martin, 2000; Powell and Moon, 2001; Snape and Taylor, 2003), but not society. Levitas (2000) argues that “‘community’ is used as a deliberate alternative to ‘society’, in order to signal difference both from the neo-liberal New Right and from forms of socialism dependent on intervention by the state” (op. cit., p.191). In reality, the Thatcher and Blair views of society are very similar:

I think we've been through a period where too many people have been given to understand that if they have a problem, it's the government's job to cope with it ... They're casting their problems on society. And you know, there is no such thing as society. There are individual men and women, there are families. And no government can do anything except through people, and people must look after themselves first. It's our duty to look after ourselves and then, also, to look after our neighbours.

People have got their entitlements too much in mind, without the obligations. There is no such thing as an entitlement, unless someone has first met an obligation. (Thatcher, 1987, p.10)

It is time that we abandoned the notion of leaving everything to some nebulous concept of society or focusing entirely on individual responsibility. We should replace these ideas instead with a concept of shared responsibility in which we act as a country to create communities in which individuals are given opportunities but accept their obligations, where they are given rights but have responsibilities, and where we understand that ... the well developed individual, capable of playing a strong and vibrant part in society, is likely to arise best from a strong and vibrant community. (Blair, cited Levitas, 2000, p.191)

The onus is still on the individual to fulfil their obligations, but Blair recognises that individual capacity is related to the socio-economic circumstances of the community (Levitas, 2000), and many of the New Labour policies are designed to address the complex and interconnecting facets of deprivation in communities and areas (Deacon, 2003).

New Labour wants to make public service provision to communities the gel that rebinds society following the divisions generated through the neo-liberal policies of the Conservative governments. The problem with this is that the problems underlying this separation extend throughout society, and by focusing attention on the poorest communities they once again become the ‘problem’ and the scapegoats for much wider structural and ideological issues (Lavalette and Mooney, 1999; Shaw and Martin, 2000; C. Jones, 2001).

What Blair and New Labour do not appear to want to challenge is that the socio-economic circumstances of communities are shaped by national macro-economic

policies, or what are often referred to as ‘the structural causes’ of poverty (Oatley, 2000; C. Jones, 2001; Deacon, 2003). These are the same as the wider determinants of health discussed in Chapter 3, and it has been seen in Chapter 3 that neo-liberal capitalism results in the widest inequalities.

The government seems keen to learn the lessons of the past, but in the face of rising poverty and persistent unemployment, inequality, violent crime, failing families, and environmental deterioration, debate seems unable to move beyond blaming past political opponents and promoting the same old ineffective solutions. Until and unless we develop policy approaches that engage with the root causes of poverty, unemployment, and disabled and alienated communities, we will be destined to relive the policy failures of the past. (Oatley, 2000, p.96)

The New Labour focus on developing individual capacity and social cohesion, or social capital, within the most deprived communities, mirrors those concerns expressed in Chapter 3 that the focus on area-based social capital would deflect attention away from the macro-economic influences on inequalities. In the past poverty has been explained by the moral deficiency of the poor as individuals (K. Jones, 1994; Jones and Novak, 1999), but now there appears to be an added dimension of explaining poverty as a moral deficiency of poor communities (Levitas, 2000; Bevir and O’Brien, 2001; Deacon, 2003). The New Labour project, therefore, places a strong emphasis on social justice and equity in order to integrate the poor into the rest of society (Levitas, 2000; Deacon, 2003), without extending the obligation of responsibility evenly throughout society.

Even though New Labour have been successful in raising the incomes of the poorest members of society (Exworthy, Stuart *et al*, 2003; Toynbee, 2004b), inequalities continue to widen under New Labour (C. Jones, 2001; Toynbee, 2004b), with the

wealth of the richest 1000 people in Britain increasing by nearly 30% in one year alone (Chittenden, 2004; Toynbee, 2004b). Blair has no intention of taxing the rich (G. Jones, 2005) dismissing the idea as gesture politics (Toynbee, 2004b), rather the goal of New Labour is to ensure that everybody can enjoy a decent minimum standard of quality of life (Bevir and O'Brien, 2001). Toynbee (2004b) argues that “a tax on the lucky that is earmarked for the unlucky would be social justice for all to see” (op. cit, paragraph 14). The moral gaze exerted ever downwards also ignores the activities of the rich working at the pinnacle of the UK’s biggest companies, and that is fundamentally unjust:

It hardly matters how well or badly you do; win an executive position in the board of a major company, and you’ve won the national lottery. Do well, and you can “retire” on a fabulous pension while still young enough to do another job. Do badly, and you’ll win a year’s pay, compensation for loss of bonus, holiday pay, lapsed share options ... Either way, it’s not an example to encourage diligent behaviour from the workforce. (Collins, 2004, paragraphs 6 and 7).

There are many calls for addressing the structural causes of poverty and for reducing socio-economic inequality to reduce health inequalities, but this would require substantial income redistribution. This is ruled out by New Labour because it is too close to the Old Labour ‘tax and spend’ approach that they are trying to distance themselves from (Powell and Exworthy, 2001). Instead New Labour claims to be redistributing assets to create better opportunities for all (Powell and Exworthy, 2001).

4.2.2 *New Labour and the public sector*

Universal public services are one of the main values espoused by New Labour (Blair, 2004a), although they do not see the State as the sole provider of those services (Blair, 2004b). Health and Education have consistently been at the centre of the New Labour General Election campaigns (Labour Party, 1997; Labour Party, 2001). One of the corner stones of the New Labour approach to the public sector has been the ‘modernisation’ of services, an extension of the New Right managerialism (Clarke, 2004; Gray, 2004). This has resulted in a rapidly changing policy agenda (Gray, 2004), with a constant emphasis on more radical reforms to the public services (Blair, 2004b).

There are two strands to this modernisation agenda. On the one hand, New Labour introduced the audit state (Gray, 2004) and aims to raise standards through central control and targets (Bevir and O’Brien, 2001; Gray, 2004). On the other hand they wish to promote ‘joined-up’ solutions to entrenched problems with complex causes (Bevir and O’Brien, 2001). These two facets of their policy are often in conflict with one another, and together with the New Labour emphasis on social justice contrasting with their belief in the market as the site of innovation, they represent an essential paradox at the core of the New Labour project (Chatterton and Bradley, 2000; Deacon, 2003; Snape and Taylor, 2003; Clarke, 2004). New Labour are trying to marry vertical processes which create division, inequality and mistrust with horizontal processes that require trust-based collaboration and networks to address problems in the round.

Chris Jones (2001) revealed a depressing picture amongst state social workers where top-down bureaucracy effectively controlled the day to day lives of the frontline

workers, removing flexibility and creating stress. These people were spending 90% of their time on paperwork, and the regulation of their work had turned it into a factory process with greatly reduced contact with, and therefore opportunity to help, the people they aimed to assist (C. Jones, 2001). This approach neglects the fact that the clients of the service are human beings who need time and support. It also fails to recognise that people drawn to work in the public sector do so because they wish to help people, and that such a paring down of their roles leads to reduced job satisfaction and stress (C. Jones, 2001). Similar findings have come from research across two different local authority social services departments (Coffey, 2004). The following comment was posted on the internet in response to a 2005 BBC1 Panorama programme on the state of the NHS under New Labour:

I agree patient through put [sic] has increased but patient care has been all but destroyed in the process. The current way of working is to get patients in and out as quickly as possible. A production line. A couple of years ago I loved radiography, and would have recommended it as a career. My advice now would be under no circumstance consider a career in the NHS, unless your [sic] want to spend 3 years obtaining a degree, then work very long hour [sic] with high stress levels and low pay. Sorry this sounds so negative but this government is very close to destroying the NHS by not looking after the workers. (Panorama, 2005, paragraph 20)

This heavy top-down control also gives the impression that the government does not trust the frontline workers to do their jobs well (C. Jones, 2001; Marquand, 2001; Coffey, 2004).

These audit processes can be seen as reflecting the New Labour values of opportunity and responsibility at the institutional level. In each case responsibility is promoted through monitoring processes and punitive measures designed to enforce

compliance (Bevir and O'Brien, 2001; Deacon, 2003; Snape and Taylor, 2003). Opportunities arise when institutions earn their 'green lights' or 'three stars' in the league tables, when they may earn more freedom.

In contrast to this emphasis on top-down regulation, partnership and community participation are central to the New Labour vision for modernising public services (Bevir and O'Brien, 2001; Hoggett, 2003; Snape and Taylor, 2003) as both an antidote to the competition introduced by the Conservatives, and because New Labour believes that the best way of tackling entrenched deprivation is through 'joined-up' working (Snape and Taylor, 2003).

No one needs reminding how much talk there is these days about the need to 'think outside your boxes', engage in 'joined up' thinking and action, get beyond a 'silo mentality' and so on. Of course there is nothing new about this; policy-makers complained about the scourge of departmentalism back in the 1970s when Corporate Management was seen as the answer to the problem of co-ordination and integration in government... What is striking, then, is just how obdurate this problem has been, how remarkably resilient to transformation the systems of governance appear to be. (Hoggett, 2003, p.118).

This utopian vision (Levitas, 2000) of how the country can work better together fails to take account of differing inclinations, capacities, opportunities, priorities, funding streams and associated forms of accountability of individuals and organisations working in very different ways (Hoggett, 2003).

This is the essential paradox at the centre of New Labour: on the one hand they have extended competition, the market and privatisation into the public sector much further than even Margaret Thatcher would have dared (Lavalette and Mooney, 1999), but on the other they require different organisations to 'join up' and work in

partnership. It will be seen later in this thesis how the tension between these two facets of New Labour put such a strain on the structure of the HAZ in Merseyside that it became unsustainable.

4.2.3 *Area-based initiatives*

The New Labour approach to social justice through empowering individuals within communities and emphasis on joined-up working have come together in a (large) number of area-based initiatives (Smith, 1999; Chatterton and Bradley, 2000; Oatley, 2000; Powell and Moon, 2001; Tunstall and Lupton, 2003). There has been a long history of area based poverty (Smith, 1999; Powell and Moon, 2001; Tunstall and Lupton, 2003), and interventions to address this are not new to New Labour. Whilst the Conservative governments targeted their programmes at those areas with the most potential, New Labour has targeted the areas of greatest need (Tunstall and Lupton, 2003). There are arguments for and against area-based approaches to tackling poverty. These pivot around the same discussions presented earlier in this chapter, and in Chapter 3: is poverty manifested in people or in places, and where is the most appropriate level of intervention – society, community or individuals?

Area-based approaches to poverty alleviation recognise that there are ‘area effects’ where a number of problems overlap (Smith, 1999; Tunstall and Lupton, 2003), and where this combination of conditions puts extra strain on the public sector serving those populations (Smith, 1999; Oatley, 2000). Chapter 3 demonstrated how several factors combine to deepen divides between affluent and poor areas and so area-based programmes recognise that some areas need extra help (Smith, 1999). In addition, it is believed that area-based programmes have the potential to capture a greater number of poor people (Smith, 1999; Tunstall and Lupton, 2003), and that they may

empower the people living there and help to generate social cohesion (Smith, 1999; Oatley, 2000; Tunstall and Lupton, 2003).

As we have seen, area-based approaches are criticised because most poor people do not live in the most deprived areas (Shaw *et al*, 1999; Smith, 1999; Joshi *et al*, 2000; Oatley, 2000; Shaw *et al*, 2000; Tunstall and Lupton, 2003), and so would be excluded from the benefits of the programme. Also, by targeting assistance at the areas most in need, it means that the same areas receive most of the help which creates an imbalance with other areas with similar needs (Smith, 1999). This can also create competition between the different areas, both in terms of competing for resources (Tunstall and Lupton, 2003), and in competing to identify themselves as the most deprived (MHAZ, 2000), which is in itself psychologically damaging (Jones and Novak, 1999; MHAZ, 2000). Reflecting earlier discussions, the main argument against area-based approaches is that they distract from addressing the structural causes of poverty, which require action at the national level (Smith, 1999; Chatterton and Bradley, 2000; Oatley, 2000; Tunstall and Lupton, 2003).

Smith (1999) and Tunstall and Lupton (2003) conclude that there are some benefits to area-based approaches. They may be useful for helping the urban poor, the unemployed poor and poor children (Tunstall and Lupton, 2003), but they cannot solve poverty on their own (Smith, 1999; Chatterton and Bradley, 2000; Oatley, 2000; Tunstall and Lupton, 2003). Another rationale for area-based approaches is as test beds for new policy directions (Smith, 1999; Oatley, 2000; Tunstall and Lupton, 2003). A number of the New Labour area-based initiatives have been established as bottom-up initiatives based on partnerships with the space and funding to be creative and test out new policy approaches (Smith, 1999; Oatley, 2000; Tunstall and Lupton,

2003). HAZs were the first New Labour area-based initiative to be introduced. Powell and Moon (2001) concluded that the primary aim of HAZs were to act as test-beds for policy development that could be fed back into the mainstream.

4.3 New Labour and health inequalities

Kingdon (1995) quotes one of his research participants as saying: “A *new administration comes to town, and they ask, ‘What should we do first?’ Something right away*” (op. cit., p.168). HAZs were something done right away, they were the first New Labour statement of intent to address health inequalities. For New Labour, health inequalities are unfair and unjust and so tackling them is part of their agenda on social justice (Powell, 2003; Graham, 2004). For example:

The reason why tackling inequalities in health is at the heart of what we are doing is that inequalities in health are the most profound and far reaching inequalities of all. Poor people are ill more often and die sooner, and you cannot get more unequal than that. Frank Dobson (Hansard, 1997, Column 641)

[F]or over fifty years the health gap between the better off and the worst off has widened, not narrowed. For me, that offends against all this government stands for: a society based on fairness and justice, in which each citizen gets the opportunity to fulfil the potential of all their talents. Alan Milburn (DoH, 2002b, p.2)

Graham (2004) identifies three approaches to addressing health inequalities. The first explains the poorer health of poor people as a condition of poverty, and hence as health disadvantage. From this perspective good health is seen as a need, and policies to address health inequality focus exclusively on the poor. There are links with the social exclusion agenda discussed above, and similarly this approach is criticised for ignoring the structural determinants of health. The second approach is

concerned with the gap in health status between the richest and poorest in society, referred to as the health gap. Here health is understood as a human right, and emphasises the need to improve the health of the poorest people at a faster rate than that of the richest people. Again, the focus is on the poor. Finally, health inequalities can be understood in terms of the health gradient discussed in Chapter 3. This perspective asserts the moral equality of all people, and improving health becomes a population wide goal, which is complex and challenging to address. There is evidence of all three perspectives in the policies introduced by New Labour (discussed more below) (Graham, 2004), but the health gap approach is dominant (Powell and Exworthy, 2001; Exworthy *et al*, 2002; Graham, 2004).

The New Labour approach to equity, based on 'joined-up' working (Powell and Exworthy, 2001; Exworthy *et al*, 2002; Hunter, 2003a; Oliver and Nutbeam, 2003; Graham, 2004), is evident in New Labour health policy (Powell and Exworthy, 2001). This stems from the recognition of the complexity of the context within which health is generated, and that to improve health and reduce the health gap requires action across many different departments (Exworthy *et al*, 2002; Exworthy, Blane and Marmot, 2003; Hunter, 2003a).

In reality, there is very little evidence of what works in addressing health inequalities (Macintyre *et al*, 2001; Powell and Exworthy, 2001; Exworthy, Blane and Marmot, 2003), and especially so for addressing the wider determinants of health (Exworthy *et al*, 2002; Nutbeam, 2004). This means that most of the available evidence is concerned with individual level interventions (Davey Smith *et al*, 2001), and as government policy is evidence-based (Nutbeam, 2004), most of the interventions focus on individual behaviour change (Davey Smith *et al*, 2001; Deacon, 2003).

In Chapter 3 we saw how developments of WHO policies and the Black Report had influenced the way people addressed health inequalities locally. It is probably not surprising then that Exworthy *et al* (2002) found that the new government agenda reflected long standing local strategies:

The actual policies [related to health inequalities] that have come down from government have been ... have reflected really what people on the ground have been trying to do for the last 10 years but haven't been able to. They haven't had the opportunity or the initiative or the money. (LA manager, quoted in Exworthy et al, 2002, p.86).

This time the government provided the opportunity and the money.

4.3.1 New Labour's health inequalities policy

When New Labour came into power in 1997, they brought with them a fresh approach to health (Exworthy, Blane and Marmot, 2003; Hunter, 2003a; Graham, 2004). This is reflected by the government appointing the first Minister for Public Health, establishing the Social Exclusion Unit, commissioning an update to the Black Report on health inequalities (Acheson Inquiry), and updating the Conservative public health policy *The Health of the Nation (Saving Lives: Our Healthier Nation)* (Bull and Hamer, 2001; Hunter, 2003a).

The Independent Inquiry into Inequalities in Health became known as the Acheson Inquiry, after its Chair Sir Donald Acheson. It was convened at about the same time as the HAZs were announced in 1997 (Acheson, 1998). There were three conditions imposed upon this enquiry: the proposals needed to be based on evidence; no increase in public spending; recommendations needed to be made within a year (Macintyre *et al*, 2001). The report, known as the Acheson Report (Acheson, 1998),

made 39 recommendations covering areas as diverse as poverty, education, employment, housing, transport, nutrition, the lifecourse, ethnicity, gender and health care. Only three of these recommendations related to the NHS (Exworthy, Blane and Marmot, 2003; Hunter, 2003a).

There were three main recommendations: that all policy should be subjected to a health inequalities impact assessment; that priority should be given to families with children; reduce income inequalities and improve the living standards of the poor (Exworthy, Blane and Marmot, 2003; Oliver and Nutbeam, 2003). The report used the Dahlgren and Whitehead model of health (Figure 3.1), and emphasised the socio-economic explanations of health inequalities (Exworthy, Blane and Marmot, 2003). It was generally well received, but it was criticised for lack of prioritisation amongst the policy proposals; for the weak evidence base for some of the recommendations; and for the lack of cost benefit data (Exworthy *et al*, 2002; Exworthy, Blane and Marmot, 2003).

The Acheson Report has become the bench-mark against which new policy is assessed for its impact on health inequalities (Exworthy, Blane and Marmot, 2003; Oliver and Nutbeam, 2003). One of its early impacts was to inform the development of the update to the Conservative public health policy *The Health of the Nation* (HOTN) (DoH, 1992). The then minister for public health, Tessa Jowell, commissioned a review of the HOTN strategy, and many of the findings of the review were taken on board in the development of the New Labour policy, *Saving Lives: Our Healthier Nation* (Hunter, 2003a).

This new policy emphasised the socio-economic determinants of health and the need to reduce inequalities (Exworthy *et al*, 2002). It proposed a national contract for

health where the government, organisations, communities and individuals all worked together to improve health (DoH, 1999c). Although warmly welcomed, it has been criticised for being too medical – focused on reducing cancer, coronary heart disease, accidents and mental illness (Hunter, 2003a). Nevertheless it demonstrated the government's commitment to public health.

In the Green Paper (DoH, 1998) for this policy, HAZs were linked to the broader public health agenda and once again introduced as important in the government's action to reduce health inequalities:

They will provide a framework for the NHS, Local Authorities and other partners to work together to achieve progress in addressing the causes of ill health and reducing health inequalities. (Op. cit., paragraph 3.51).

By the time the White Paper (DoH, 1999c) was published, there are far fewer references to the role of HAZs, and these references say nothing about health inequalities or their root causes, suggesting that HAZs were already losing ground within the developing health policy agenda:

[HAZs will] provide a local focus for the delivery of information and programmes at local level aimed at helping individuals improve their health and the health of their families. (Op. cit., paragraph 1.36)

Health action zones are leading the way in breaking down organisational barriers. They are using imaginative new ways of providing services which cross boundaries between organisations. (Ibid, paragraph 10.23).

Alan Milburn replaced Frank Dobson as Secretary of State for Health in October 1999. From the first it was clear that Alan Milburn's priority was to reform the NHS (Hunter, 2003a), an important election issue (Exworthy *et al*, 2002; Hunter 2003a). With the NHS Plan (DoH, 2000) the emphasis in health policy was brought back to

the NHS and the delivery of health care (Hunter, 2003a). Many in the public health community became anxious that public health was losing visibility as an agenda item (Hunter, 2003a). This seemed to be reinforced when the role of Minister for Public Health was reduced from that of undersecretary to junior minister when Tessa Jowell was replaced by Yvette Cooper in October 1999.

There was a similar concern within the HAZ community about the reduced visibility of the HAZ initiative. This concern grew when the NHS Plan (DoH, 2000) proposed that HAZs could be absorbed into the emerging LSP structures (Bauld *et al*, 2001), with the suggestion that only ‘successful’ HAZs would continue:

The NHS will help develop Local Strategic Partnerships, into which, in the medium term, health action zones and other local action zones could be integrated to strengthen the links between health, education, employment and other causes of social exclusion. In the meantime effective health action zones will continue. (Op. cit., paragraph 13.24)

In the mean time, the reform of the NHS went on a pace. The *Shifting the Balance of Power* (StBoP) (DoH, 2001) strategy proposed to abolish Health Authorities and Primary Care Groups replacing them with Strategic Health Authorities (StHAs) and Primary Care Trusts. PCTs would assume many of the responsibilities of the Health Authorities, but would be smaller, and so could be more responsive to the needs of the communities they served. In addition they would put a greater “*focus on team working and on enabling and supporting people and less on hierarchy and control*” (DoH, 2002c, paragraph 1.1.3).

The neighbourhood renewal strategy was also introduced at this time (SEU, 2001). This strategy formalised the Local Strategic Partnerships, which were introduced in belief that a

lack of joining up at local level has been one of the key reasons for lack of progress in tackling neighbourhood deprivation ... it has been no-one's job at local level to pull together all the different agencies with an impact on deprived neighbourhoods. (SEU, 2001, paragraph 5.4)

The LSPs were to build on existing partnership structures, such as HAZs, and the Local Authorities were to take the lead in bringing the partners together (SEU, 2001). They were in part a response to the criticism that the government had introduced so many area-based initiatives that people on the ground were finding it difficult to manage their duties to collaborate (Bauld *et al*, 2001; DETR, 2001).

In the follow-up document to StBoP, "*The Next Steps*" (DoH, 2002c), the HAZs are praised for their achievements across the HAZ Principles, reflecting a renaissance in interest in these programmes. However, they were no longer 'blazing trails' or in the 'vanguard of the war against health inequalities'. Following the disbandment of Health Authorities, HAZs had the options of aligning themselves with PCTs, Local Authorities or LSPs, to take effect from April 2002. However, HAZs only had guaranteed funding until the end of March 2002. This was extended by one year in December 2001, but the funding insecurity added to the concern of those who were uncertain if the HAZs would be allowed to run their course.

As the government became more focused on sorting out the NHS through StBoP, there was a growing sense of despondency within the public health community that the government had reverted to a focus on downstream issues (Hunter, 2003a). The government eventually became aware of these concerns (Hunter, 2003a), and restated their commitment to public health and reducing health inequalities through: the introduction of two Health Inequalities targets in 2001; the Cross Cutting Spending Review of 2002, focusing on the reduction of health inequalities; and a

consultation on *Tackling Health Inequalities*, resulting in an ‘action report’ that was published in 2003 (Hunter, 2003a; Nutbeam, 2004).

In all, there have been many policies and initiatives aimed at improving the circumstances or health of the worst off in society (Kendall, 1998; Exworthy, Blane

Stage	Selected examples of policies
Nature and extent of the problem	Independent Inquiry into Inequalities in Health, 1998
Broad policy developments required	Government interventions in deprived areas, <i>2000 Spending Review</i> (HM Treasury: 2000) <i>A new commitment to neighbourhood renewal</i> (SEU: 2001) DoH <i>Consultation on a plan for delivery</i> (DoH: 2001) <i>2002 Spending Review</i> (HM Treasury: 2002)
Public services response required to both improve health and reduce health inequalities	<i>Saving Lives: Our healthier nation</i> (DoH: 1999) Government interventions in deprived areas, <i>2000 Spending Review</i> (HM Treasury: 2000) <i>A new commitment to neighbourhood renewal</i> (SEU: 2001) DoH <i>Consultation on a plan for delivery</i> (DoH: 2001)
Implementation in the NHS	<i>The NHS Plan</i> (DoH: 2000) National Service Frameworks, 2000 onwards <i>NHS Cancer Plan</i> (DoH: 2000) Local modernisation review (DoH: 2000)
Action and targets across government departments	Public Service Agreements - PSAs (1998 and 2002) <i>Opportunity for all</i> (DSS: 1997) Government interventions in deprived areas, <i>2000 Spending Review</i> (HM Treasury: 2000) <i>A new commitment to neighbourhood renewal</i> (SEU: 2001) DoH <i>Consultation on a plan for delivery</i> (DoH: 2001) <i>2002 Spending Review</i> (HM Treasury: 2002)
Trailblazer initiatives which contribute to reducing health inequalities	Health Action Zones and other action zones Sure Start programme New Deal for Communities PSA pilots Neighbourhood management pathfinders Healthy Living Centres
Mainstream planning processes and plans for local delivery of targets across the NHS and local government	LSPs HIMPs Ministerial committee (overseeing Delivery Plan)
Mechanisms for monitoring targets	Neighbourhood Renewal Unit Basket of cross-government indicators NHS performance assessment framework PSS performance assessment framework Best value performance indicators

Table 4.1 Stages in health inequalities policy development (Source: Exworthy, Stuart *et al*, 2003, p.51)

and Marmot, 2003). These have included Modernising Local Government, Health Improvement Programmes, National Service Frameworks, Public Service Agreements, Welfare-to-work programmes, a continuation of Single Regeneration Budgets, Sure Start, Child Poverty strategy, New Deal for Communities, other area-based initiatives, and many more (Bauld *et al*, 2001; Bull and Hamer, 2001; Exworthy, Blane and Marmot, 2003; Oliver and Nutbeam, 2003; Graham, 2004). It is clear that HAZs became just one thread in the weave of these policies and initiatives.

All together these policies reflect the New Labour commitment to joined-up working, improving circumstances for the worst off in society, and targeting the most deprived areas. These policies also demonstrate the New Labour fixation on targets as the means for driving change. Table 4.1 summarises the stages in New Labour health inequalities policy development.

4.3.2 *Critique of the New Labour approach to reducing health inequalities*

The NHS remains central to New Labour health policy (Exworthy, Blane and Marmot, 2003; Hunter, 2003a), and this has led some to believe that the New Labour emphasis on health inequalities and the wider determinants is simply rhetorical (Exworthy, Blane and Marmot, 2003; Hunter, 2003a). In addition, the pace, quantity and direction of New Labour policy caused problems locally (Exworthy *et al*, 2002; Exworthy, Blane and Marmot, 2003; Hunter, 2003a), especially with collaborative working (Hunter, 2003a). The health sector has been subjected to the same heavy top-down, command-and-control approach to service improvement that has been discussed above in relation to social services departments (Exworthy, Blane and Marmot, 2003).

The accompanying preoccupation with endless targets, performance management systems and all the other paraphernalia of modern managerialism has prevented the very 'joined upness' that the government says it seeks. (Hunter, 2003a, p.25)

Exworthy *et al* (2002) found that local stakeholders felt the government emphasis on 'joined-up' government did not extend far beyond a few signatures on joint reports, and that there was little evidence that government departments were genuinely collaborating with each other. There was a great deal of frustration that department directives and performance monitoring came down in 'silos' (Powell and Exworthy, 2001; Exworthy *et al*, 2002), and this could impact on people's ability to work together due to differing accountabilities (Exworthy *et al*, 2002; Exworthy, Blane and Marmot, 2003).

Large numbers of targets can be overwhelming (Powell and Exworthy, 2001), and can therefore stifle the innovation and creativity New Labour claimed to want to support because local leaders needed to focus on meeting centrally-set targets (Hunter, 2003a). The Cabinet Office Performance and Innovation Unit has been critical of the linear model of policy delivery which dominated thinking in central government (Hunter, 2003a). The vertical route to policy implementation is not linear, encompassing many different nodes and networks (Exworthy *et al*, 2002), and is more complex than government directives suggest (Hunter, 2003a). Hunter and Killoran (2004) conclude that the government needs to move towards flatter, network based models of implementation that are more appropriate for complex organisations.

The relative emphasis given to different facets of policy in performance management frameworks indicates the government priorities. Health inequalities were not seen to

be a high priority, rather the emphasis has been on national health service priorities (Exworthy *et al*, 2002):

*When you get down to the hard nuts and bolts, all that is really being monitored is waiting lists, waiting times and financial balance and for as long as we focus in those four [sic] things, then tackling health inequalities will depend on the personal determination of individuals. (HA director, quoted in Exworthy *et al*, 2002, p.88).*

The retreat back to a national concern with reforming the NHS created a conflict in local priorities, and led to public health and health inequalities work being given less attention locally (Powell and Exworthy, 2001; Exworthy *et al*, 2002; Hunter, 2003a; Hunter and Killoran, 2004). These changes put the early focus on public health at risk (Exworthy *et al*, 2002; Hunter, 2003a).

*Then if you go back to the sort of schizophrenia about how serious is the NHS, is the government about tackling health inequalities because, you know, at the same time as we are doing this long-term [health inequalities] programme, ten years to 'save lives', three years to develop the HImP, the thing you get all the missives about is 'Why are you overspending?', 'Why were there 25 people in the corridor at [the local hospital] last night..?' And you can't do both within available resources consistently and robustly. (HA Director, quoted in Exworthy *et al*, 2002, p.90).*

This analysis indicates that far from being simply 'pragmatic' policy implementation is an essentially political process (Hunter, 2003a; Hunter and Killoran, 2004), reflecting the observations of Kingdon (1995) that policy action occurs when political will and evidence come together at an opportune time. One of the influences on the political priorities is the high profile of the NHS with the public (Powell and Exworthy, 2001; Exworthy, Blane and Marmot, 2003). This has kept

the NHS at the centre of New Labour health policy, creating a conflict with those who were initially enthusiastic about the government's emphasis on public health and reducing health inequalities.

Finally, Exworthy *et al* (2002) concluded that the “*outcomes of the policy process were contingent upon the character of local policy networks and especially the influence of [champions]*” (op. cit., p.92). These two aspects also proved to be important to the success of the HAZ in Merseyside.

4.4 Health Action Zones as New Labour public policy

Up to now this chapter has considered what the New Labour values are, how they have influenced the development of public policy, and specifically health inequalities policy. A number of common themes have emerged, and these revolve around New Labour values, their approach to poverty and ill health, and the conflict between a heavy top-down agenda and flatter organisational structures fostered through the New Labour obligation to ‘join up’:

- * New Labour is committed to equity and social justice, and there is some evidence that their policies are having some success.
- * Communities and individuals are the focus of New Labour action to tackle deprivation and narrow the health gap.
- * To achieve this, the government has placed a great deal of emphasis on collaboration and ‘joined-up’ solutions to complex problems.
- * One facet of the social justice agenda is to make public services more responsive to the public needs through modernisation.
- * Heavy top-down, command-and-control, policy implementation is part of the modernisation agenda, which is not compatible with the flat, networked structures that result from collaboration.

- * Opportunity and responsibility are important New Labour values, and the interplay between these is used to coerce organisational change, and to raise the moral stakes within poor communities.
- * There is a dispute about the extent to which this approach can reduce poverty and health inequalities when New Labour also adheres to economic policies which exacerbate poverty and widen inequalities generally.

Many of these points are evident within the HAZ policy initiative. They are area-based programmes, based around a central partnership between the NHS and Local Authorities, to address the underlying determinants of health and to assist in the modernisation of services. The tension between these last two facets of New Labour policy has been particularly evident within the HAZ initiative since Alan Milburn became Secretary of State for Health.

The vision and values of key individuals are important for raising and maintaining certain issues on the priority list for government action. Policy entrepreneurs are influential in raising issues and ministers are both influential in raising issues and acting on them (Kingdon, 1995). Consequently a change in minister can change what stays on the agenda, or how items on the agenda are dealt with (Kingdon, 1995; Chabal, 2003).

Chabal (2003) argues that the management style of ministers is indicative of the types of policy they make. This is evident in the influence of the first two Secretaries of State for Health on the implementation of the HAZ policy. Frank Dobson, an old-school Labour politician (Ashley, 2003) with a 'trusting-experimenter' management style (Lannin, 2003), introduced HAZs as an opportunity to foster collaboration, engage frontline staff and improve the conditions for the poorest areas based on local

needs (Dobson, personal communication, March 2003; Lannin, 2003). Alan Milburn, a New Labour ‘moderniser’ with a ‘hitter-driver’ management style (Lannin, 2003), introduced stringent performance monitoring and shifted the focus of HAZs to support the health and social services modernising agenda (Bauld *et al*, 2001; Lannin, 2003).

Lannin (2003) found that the two main aims of HAZs are a compromise between Tessa Jowell’s preference for the HAZs to address health inequalities through the wider determinants of health, and Alan Milburn’s preferred focus on modernisation. It is perhaps no surprise, then, that once Alan Milburn became Secretary of State for Health he changed the focus of HAZs from local needs to supporting the national priorities of modernising services and reducing the incidence of cancer, circulatory diseases (stroke and coronary heart disease), mental ill-health and accidents.

This was a central feature to the concerns evident within the Merseyside HAZ at the beginning of this research. The next section identifies some of the other concerns. The HAZs were constantly evolving, as was the context within which they operated. The difficulties and opportunities that emerged as the research progressed are discussed in later chapters. The following section will focus on the situation for HAZs in 2000 and 2001.

4.4.1 *The evolution of the HAZ policy*

The National Evaluation of Health Action Zones, led by Professor Ken Judge of Glasgow University, produced two main reports in 2001: “*Health Action Zones in Transition: Progress in 2000*” (Bauld *et al*, 2001) and “*Building Capacity for Collaboration: The national evaluation of Health Action Zones. Context, Strategy*

May 1997	Labour government elected Frank Dobson appointed as Secretary of State for Health Tessa Jowell appointed as Minister of State for Public Health Alan Milburn appointed as Minister of State for Health
June 1997	Health Action Zones announced
July 1997	Independent Inquiry into Inequalities in Health commissioned
October 1997	Alan Milburn announces HAZ funding and invitation to bid for HAZ status
December 1997	<i>The new NHS: Modern, dependable</i> published
February 1998	<i>Our healthier nation: A contract for health</i> Green Paper published
November 1998	<i>Independent Inquiry into Inequalities in Health: Report</i> (Acheson Report) published
April 1998	<i>New NHS</i> arrangements come into force, Primary Care Groups established 1 st wave of HAZs
1998	<i>Modernising Local Government</i>
April 1999	2 nd wave of HAZs – including Merseyside HAZ
June 1999	Health Act passed
July 1999	<i>Saving Lives: Our Healthier Nation</i> White Paper published Local targets for reducing health inequalities <i>Reducing health inequalities: An action report</i> published
September 1999	First National Service Framework (mental health) published <i>Opportunity for all – Tackling poverty and social exclusion</i> published with the aim to eradicate child poverty in 20 years
October 1999	Alan Milburn appointed as Secretary of State for Health Yvette Cooper appointed as Parliamentary Under Secretary for Public Health; Ministerial responsibilities include health inequalities
November 1999	Sure Start programme begins
January 2000	<i>Wiring it up</i> report published (Cabinet Office)
July 2000	<i>The NHS Plan</i> published National health inequalities targets to be introduced Public service agreements (<i>2000 Spending Review</i>) published (HM Treasury)
Autumn 2000	Inequalities and public health task force established
January 2001	<i>A new commitment to neighbourhood renewal: National strategy action plan</i> published (SEU)
February 2001	National health inequalities targets announced
March 2001	Health Select Committee inquiry into public health published
June 2001	General election; Labour returned for second term A cross-cutting review on health inequalities announced as part of the <i>2002 Spending Review</i>
July 2001	<i>Shifting the balance of power: Securing delivery</i> published – giving PCTs new powers; creating Strategic Health Authorities; and reducing the DoH's direct management role Government's response to the Health Select Committee report on public health published
August 2001	DoH <i>From Vision to Reality</i> document published DoH <i>Tackling health inequalities: Consultation on a plan for delivery</i> starts
November 2001	DoH <i>Tackling health inequalities: Consultation on a plan for delivery</i> ends Wanless (interim) Report (<i>Securing our future health</i>) published
December 2001	Additional year of HAZ funding announced
March 2002	<i>Tackling health inequalities: Update</i> published Initial HAZ funding ends, have one more year
April 2002	Wanless (final) Report (<i>Securing our future health</i>) published Health Authorities disbanded – replaced by PCTs and Strategic Health Authorities
June 2002	Hazel Blears appointed as Parliamentary Under Secretary for Public Health DoH <i>Consultation on a plan for delivery</i> published
July 2002	<i>2002 Spending Review: New public spending plans 2003-2006</i> published (HM Treasury)
October 2002	<i>Health and Neighbourhood Renewal: Guidance from the Department of Health and the Neighbourhood Renewal Unit</i> published
November 2002	<i>Tackling health inequalities: A summary of the 2002 Cross-cutting Review</i> published (HM Treasury/DoH)
December 2002	Final 3 years HAZ funding announced, to be paid directly to PCTs
March 2003	MHAZ Co-ordination team and Merseyside wide programme disbands

Table 4.2 Selected policy 'events' applicable to tackling health inequalities in the UK, with reference to HAZ milestones (Adapted from Exworthy, Stuart *et al*, 2003, p.5)

and Capacity: Initial findings from the strategic level analysis.” (Barnes *et al*, 2001).

Whilst acknowledging the successes of HAZs in creating partnerships, generating change and involving communities, these two reports highlighted some of the concerns that resulted from the change in Minister and the rapidly evolving policy arena (Table 4.2 provides a summary of the policy changes as they relate to key milestones in the development of the HAZ initiative). In summary these concerns were:

- ◆ The HAZs were set up to generate local solutions to local priorities. When Alan Milburn became Secretary of State for Health, they were forced to adopt the national priorities for health improvement, challenging the intended “bottom-up” nature of the programme.
- ◆ HAZs were expected to be involved in finding solutions to winter pressures within the NHS, leading to a move away from the broad determinants of health to a more medical model of health improvement (Bauld *et al*, 2001).
- ◆ Rather than recognising the long term nature of the HAZ programmes, there was a pressure for quick wins (Barnes *et al*, 2001):

The pressure to have early wins by Government is in contrast to the long term development of innovation and sustainability which is supposed to be at the heart of the HAZ. (Health Select Committee, 2001, paragraph 39)

- ◆ Budgets were cut by 26% across all HAZs due to a first year under spend equivalent to this amount. HAZs had varying degrees of under spend on their initial budgets, but each had their budget cut by this amount. For MHAZ this meant a net drop of 10% in their budget allocation, and subsequent budget allocations have been at this reduced amount. According to Bauld *et al* (2001)

the repercussions of the budget cuts were more than financial. To many HAZ partners this suggested that the HAZ programme was no longer a priority to the national government, which resulted in a loss of commitment to the process.

- ◆ Similarly, although HAZs were set up as seven year programmes, the funding was only guaranteed until March 2002. This was extended for one year in December 2001. The funding insecurity also resulted in uncertainty about long term ministerial support, a break down of trust amongst some HAZ partners and a loss of commitment to the programme (Bauld *et al*, 2001). Some HAZs started winding down their programmes, and the MHAZ decided to focus on short term projects and sharing the learning gained for the 2002/2003 financial year.
- ◆ Along with the budget cuts, there was a change in the way the money was delivered to HAZ partners, resulting in a loss of flexibility in how it could be spent.
- ◆ The new minister also introduced a stringent performance management framework, requiring the production of high level statements every six months.

... Ministers have made constant demands on HAZs and they have had to justify every decision made. Paradoxically, for bodies intended to be flexible and innovative they have been subjected to bureaucratic scrutiny of an intensity which goes beyond that accorded to already existing bodies. (Hunter et al, 2000, p.15)

- ◆ Time pressures experienced by the HAZ teams also affected their ability to involve communities effectively (Bauld *et al*, 2001).
- ◆ A further concern came with the announcement that HAZs would feed into the development of Local Strategic Partnerships (LSPs) (Bauld *et al*, 2001). It was

unclear how HAZs would relate to LSPs and what the implications of this were for the long term sustainability of HAZs and their programmes.

In addition to these issues, there were also changes in the structural context of the HAZs which had an effect on their work. Shortly after the introduction of HAZs, local governments underwent a modernisation process precipitated by the policy “*Modern Local Government: In Touch with the People*” DETR (1998). As has been discussed above, the NHS underwent its own modernisation process outlined in the policy documents for “*Shifting the Balance of Power*” (DoH, 2001; DoH, 2002c). At the very least, these processes have affected the amount of time the partner representatives have been able to give to partnership meetings. In Merseyside there was a drop in attendance at partnership meetings concurrent with these organisational changes.

The NHS organisational changes had repercussions for the make up of district partnership boards, the MHAZ Steering Group and the MHAZ Policy Group. There was a need to ‘debrief’ outgoing partnership representatives, and familiarise incoming partnership representatives with the partnership processes (Freeman, 2002). All of this takes time. The changes occurred at the same time as HAZ funding was uncertain, and therefore at a time when MHAZ would have wanted to maximise their impact. One member of the core MHAZ co-ordination team expressed some frustration at the additional work this created.

4.4.2 *The changing agenda and the Merseyside HAZ*

At the beginning of this research there was a palpable frustration with the changing circumstances. As a second wave HAZ, the people of the Merseyside HAZ had

heard that there could be a shift in emphasis for the HAZs towards the national priorities of cancer, CHD and mental illness. They took the pragmatic approach of making these central to the MHAZ goals, although in reality these were local priorities too. Therefore the change to addressing national priorities was not quite as damaging as it was for other HAZs that had chosen to focus on other local needs, such as children's health.

In Chapter 1 it was explained how aspects of the programme were devolved down to the five partner districts of MHAZ. The districts had some leeway in implementing the programme according to their local needs and there were notable differences in the approach taken in each of the districts. One of the districts had chosen to focus on a service centred programme based (coincidentally) on the national priorities above. As the original MHAZ Co-ordinator in that district explained:

The basic tenet that we used here for the local money was to advance the plans that we wanted to see put in place. So we didn't necessarily take the innovative route. ... We absolutely wanted it to be next to our local priorities, not an innovative/come up with all kinds of schemes that will be unsustainable in the longer term. ... [Priorities were] mental health, older people, CHD, cancer. The big hits really. The things that came round that HAZ had to then reprioritise itself around anyway. (MHAZ co-ordination, 03/2002).

Other MHAZ districts had chosen to be innovative, and one had designed their programme around community based interventions. The changes in priorities, therefore, initially caused a great deal of frustration. Two years later, most of this frustration had dissipated. People had realised that the HAZ programmes were contributing to the national priorities, although there were times when some creative

reporting had been needed to demonstrate that. This is reflected in comments from two of the MHAZ District Co-ordinators during this research:

When we look at our health needs assessment for the Borough, the national targets that hit HAZ – they're the same here. So, whilst that ruffled a few feathers at the time, it's not deflected us from using HAZ funding and HAZ approach to try and meet real needs, the genuine needs that exist on the ground. (MHAZ co-ordination, 04/2002).

It was pretty bad when central government came in and changed the emphasis from HAZ being innovative and trying new things out – and really determining at a local level what the priorities were within the broader context – to concentrating on coronary heart disease, cancer and mental health. It just changed the whole focus. Now we responded to that by making sure that we allocated a heading against all our projects. But I've got to say that, if you look at it in great detail, you might be hard pressed to find some of the connections between cancer and some of the projects that we've claimed are fitting the cancer [category]. We have played the game. And if central government want us to do that, then we will do that. (MHAZ co-ordination, 03/2002).

Civil servants in the central HAZ team recognised the pain that the change in priorities had caused to the various HAZs. However, one of the civil servants felt that most of the HAZs were already contributing to the national priorities, even through innovative interventions like Farmers Markets and healthy walking schemes, and that more had been made of this shift in priorities than was necessary.

My personal view is that some of this has been exaggerated ... when we were discussing this [change in priorities] with the HAZs and Regional Office colleagues, we were at pains to point out that actually quite a lot of the work that HAZs were doing was already focusing on those priorities ... It felt to me that some HAZs had actually re-interpreted what

they were doing quite successfully to demonstrate, in all honesty, that they were contributing to these priorities. (Strategic, Health, 06/2002).

Similarly, although the short start up time had caused many bureaucratic headaches and had limited the ability of the various parts of the MHAZ to consult with communities, these had largely been overcome a few years into the programme. The pressure for quick wins had also been turned to an advantage, as it was felt that these quick returns had generated trust in the ability of the Merseyside HAZ to deliver and had enabled a dialog about long term goals.

However, this is not to underestimate the impact of these changes. Financially they meant that less money was available for innovation and prevention. In the end, though, the biggest impact on the MHAZ programmes was the NHS reorganisation that came with the *Shifting the Balance of Power* policy, and the associated funding insecurities. As HAZs were directed more and more towards the mainstream their funding became less certain. The central DoH HAZ team acknowledged the difficulties and understandable frustrations that these two areas created, and suggested that the HAZs which would survive these changes would be those with the strongest partnerships.

4.5 Chapter summary

The environment produced by New Labour has created both opportunities for collaborative action and difficulties in working in that way. There is an essential paradox at the heart of New Labour's agenda. In adopting the 'Third Way' they have sought to marry a social justice agenda with neo-liberal practices in terms of managing the economy and reforming the public sector. The public sector is key to the New Labour social justice and equity agenda and as such has been subjected to

constant modernisation and reform, entailing a heavy centrally driven bureaucracy and frequent change. In this chapter it has been seen how the New Labour top-down and rapid changes in policy and policy emphasis have caused problems for the HAZs, especially in their early days. This is one of the many paradoxes within the New Labour approach to modernisation: the introduction of new, more flexible, ways of working and a burdensome top-down agenda.

The HAZs encapsulated both of these aspects of New Labour: an area-based, collaborative approach to reducing health inequalities and modernising services. They were test beds for new policy directions, but they were also on the receiving end of the rapid policy change agenda. As such they were ideal sites for exploring the tensions between the New Labour social justice and modernisation aims.

Chapters 3 and 4 have presented many theories relating to health, health inequalities, poverty and social exclusion. These have been offered as a background discussion of those factors that have influenced the New Labour policies towards public health and inequality. There are similarities in the critique of area-based approaches to improve health and address social exclusion, and in the belief that inequality generally results from national macro policies that limit opportunities. However, it is conceded that area-based approaches can have value as test-beds for policy development and for addressing the problems of specific groups. HAZs were the former. The various theories also have relevance in understanding the motivations of New Labour, and the specific methods of addressing health inequalities and social exclusion are reflected in the diverse, and often innovative, interventions that the MHAZ supported.

The HAZs were essentially agents for change. There are many theories about how change occurs. Individual behaviour change has been linked to attitudes and theories such as the Health Belief Model, Stages of Change, Role Models, and Diffusion Theory all relate to processes linking attitudes and behaviour. At the group level, theories such as Interest Group, Conflict, and Social Movement theories are based on ideas about group dynamics and collective action. These and other theories will have relevance here, particularly at the intervention level, but also in describing the diffusion of ideas throughout the MHAZ networks. However, the primary concern in this thesis is the conflict between the different ways of working utilised by New Labour in its vertical, macro processes and promoted in its horizontal, micro processes.

New Labour seek to force change in the public sector through organisational change and monitoring. HAZs sought change through networks and partnerships, echoing the approach to health promotion advocated within WHO Healthy Settings (Kickbush, 2003). These are two overarching theories of change, which use within them many other change theories. It is these two theories of change, therefore, that are being tested in this research for their efficacy in supporting the action of those implementing policy in localities. The rest of this thesis will explore how these tensions unfolded with reference to one HAZ, that in Merseyside. This will help to throw some of the issues presented in Chapters 3 and 4 into greater relief.

Chapter 5

Implementing policy in a context of change: the strategic view

You can't run something like HAZ without support.

(MHAZ co-ordination, 03/2002)⁶

Chapters 3 and 4 have discussed the Health For All approach to health improvement and how these principles are mirrored in New Labour values and the New Labour agenda for tackling health inequalities, and the way these come together in the HAZ initiative. Frank Dobson wanted HAZs to release local energy and enthusiasm, to empower frontline staff and foster links between agencies. Primarily HAZs were intended as a quick fix to health service funding and a test bed for new ideas around modernising services and reducing inequalities. Chapter 4 set out the changing policy agenda within which HAZs had to operate. As with other HAZs the pressures for a quick start, quick wins, changes in programme priorities and heavy bureaucracy caused a great deal of frustration within the Merseyside HAZ. On the whole, however, they adapted to these well. The serious challenges to the programme came from the NHS reorganisation resulting from the *Shifting the Balance of Power* policy (DoH, 2001) and the related late decisions about funding the remainder of the initiative.

⁶ The interview data is referenced according to the roles those people had in relation to the MHAZ, occasionally their positions had changed at the time of interview and in these instances it is their earlier relationship that is referred to. "Strategic" are those people involved with developing the policy and programme nationally and locally, "Intervention" are those people who managed MHAZ funded interventions; these quotes are referenced to indicate the sector the interviewee worked within. Quotes labelled "MHAZ co-ordination" are from those people at the regional and district levels who co-ordinated the delivery of the Merseyside programme. All references include the month and year of interview.

The Merseyside HAZ was recognised nationally as one of the strongest HAZs in terms of partnership working. The Steering Group prided itself on the cohesive nature of the group and their willingness to work for the greater good. It had helped the HAZ to negotiate the changes highlighted above and to keep the HAZ programme strong in Merseyside. The introduction of new members to the Steering Group as a result of the change from Health Authorities to PCTs disrupted this consensus. Insecurity about the HAZ funding, financial difficulties within the PCTs and a remit similar to that of the HAZ enabled some of the PCT representatives to argue successfully for the disbandment of the regional focus of the programme.

This chapter will look at the rise and fall of the strategic implementation of the HAZ in Merseyside in the context described above. It is an example of how different aspects of government policy can work against each other. It might be that the assimilation of the HAZ work into the individual PCT remits satisfies the government's requirement that HAZ learning be mainstreamed. However, for the people working within the MHAZ structures this process has been quite distressing and there is a feeling that something important may be lost without a regional co-ordination of the work. This in part explains why local authority representatives on the MHAZ Steering Group fought for representation on the Cheshire and Merseyside Public Health Network, the successor organisation for MHAZ regionally. Fundamentally, these people enjoyed their involvement with the HAZ and relished their opportunity to be visibly contributing to the health improvement agenda. The HAZ experience has generally been a positive one for those working at the strategic level, and this chapter will consider why that was.

5.1 MHAZ organisational structures

5.1.1 Forming the Steering Group

Merseyside applied for HAZ status in the first wave of the initiative, but the culture of competition for scarce resources on Merseyside was evident in the way this bid was sent to the Department of Health.

The problem with the first bid was that there was political reticence in terms of joining with other districts in Merseyside. And we didn't get the first bid, first round, and it was said that it looked like four districts' separate policies cobbled together as Merseyside, and there was a very strong line from region that it should be a Merseyside bid. (MHAZ co-ordination, 03/2002).

What was first put in were four separate bids pulled together by a covering letter or something. Three were the same colour and St Helens and Knowsley was a different colour, so we couldn't even get that agreed at that point. So that was turned down. (MHAZ co-ordination, 03/2003).

They were invited to apply for the second wave, and this time they set up a development group with representation from across Merseyside. The reticence towards joining up for the first bid was transformed in preparing for the second bid because people wanted to make sure it did not fail for a second time, and “*we took that on willingly*”. The group came together

[r]ecognising that we need to do better, needing more time and effort putting into it, and recognising that we were talking about a Merseyside agenda, and not an individual parochial little bit. (Strategic, Local Authority, 04/2002).

The HAZ in Merseyside was able to build upon the experience of the Healthy Cities programme that had been running in Liverpool for 15 years. The Healthy Cities co-

ordinator was part of the development group and the group in general comprised people committed to improving the health of the people in Merseyside.

I think being able to input the experiences that we'd had in Liverpool around joint working on public health, the development of the City Health Plan, etc, helped to lay some of the foundations for the HAZ. Because it's the same ... Health For All, Healthy Cities principles ... but it had the money attached to it. But it was the same way of working. But I think it went one stage further ... you've really got to try and bend mainstream delivery. (MHAZ co-ordination, 03/2002).

There were some very dynamic people as part of that – they were the real think tank behind HAZ – very much 'these are the things we want to avoid'. Some of the fundamentals of HAZ, the approach and the fact that the programme is so broad, came from that development group. (MHAZ co-ordination, 03/2003).

From this point on there was a strong partnership supporting the HAZ in Merseyside. The development group evolved into the Merseyside HAZ Steering Group, with some of the original members choosing to step out of the Steering Group so that more appropriate people could join.

The Steering Group had the task of managing the programme regionally. Each district sent a representative from the two main partners – the health service and the Local Authorities. The partnership had two chairs: the Chief Executive of one of the partner Local Authorities the Chief Executive of one of the partner Health Authorities, replaced by the Chief Executive of a partner PCT following the NHS reorganisation. They took it in turns to chair the meetings, and this joint commitment from the Health and Local Authorities was seen as a strength of the Steering Group, demonstrating joined-up working and offering good leadership

within the partnership, and championing HAZ within their home organisations and networks.

And so we thought it was important that we had representatives from both the Local Authorities and the Health Authorities on the Steering Group. We thought it would be a nice, almost symbolic gesture, to have joint chairs: one chief executive from the Health Authority, one from the Local Authority. So there's a symbolic element to that, but also it turned out to be a practical element to reinforce the view that we're all taking it sufficiently seriously to be able, from both the health and the local authority community, to invest the most senior officer's time in making the partnership actually work. (Strategic, Local Authority, 04/2002).

The Steering Group remained strong due to a commitment to development. Every alternate meeting was a development meeting, and these meetings helped the partnership to work well together.

Partnership working was extremely effective at that level. We were able to work as a partnership, rather than coming from a very parochial, sort of, back ground. We would make decisions for the greater good rather than for the geographical areas that we were coming from. I don't think there was ever a tension there. I think very early we got to the stage where we could do that very effectively, because a lot of development work had gone into getting us to work as a team. We seemed to gel as team very quickly. (Strategic, Health, 11/2002).

The development of the steering group has meant that people have gelled as a group and been able to get more difficult things on the table. It's built trust, and all the basic things that you get out of good partnerships. (MHAZ co-ordination, 03/2003).

As people left this partnership, they nominated substitutes and the MHAZ Co-ordinator spent time with these new members to help introduce them into the

partnership. This, together with the development meetings, enabled the partnership to stay strong until the NHS reorganisation took effect in April 2002.

The strength of this core partnership has enabled the group to make difficult decisions and to adapt to the changing priorities and funding insecurities emanating from central government. Right from the start the group worked through consensus and the decision to pool funds and redistribute them to the districts, based on local need, demonstrated their willingness to work together across the region.

[W]hat we have done has been underpinned by a principle of equity ... everyone has pockets of deprivation, we are looking for Merseyside initiatives that can spread good practice, but we also recognise that people are going to want to see something happening in their area as well. I think we have managed to achieve all of those outcomes, without once [over the life of the programme] ever having a row about why are you spending a pound here if you're not spending a pound there, and what about my bit – which has never entered the debate. Which I think has been a singular testament to its success. (Strategic, Local Authority, 04/2002).

The biggest tension in the early days ... was the fair allocation of the money. Given that we were guaranteeing that that would happen, because of the catch up ... that didn't have to be a problem. (Strategic, Health, 11/2002).

The commitment has been absolutely immense ...To bring, at the time, four Health Authorities and five Local Authorities together, to get a consensus view – it was consensus, and we've operated on that throughout – I think comes into the major miracle category. We've been able to keep that going, even through the rough times, and I think that's been a critical test of the strength of the HAZ. (Strategic, Local Authority, 11/2002).

That is not to say that there were no disagreements or challenges to the way the programme was implemented in those regions, just that these were apparently managed without acrimony or self interest.

We learned a lot around the table. We've learned a lot as a Steering Group together. And we still have issues. And I think it's good that we still have issues because we still question each other closely, but not argumentatively. (Strategic, Local Authority, 01/2003).

In the early days we were clear that we were not devolving a pot of money to go away and do what you want with it, we were devolving particular aspects of the programme. Some bits of the programme stayed Merseyside wide and other bits went local. Were some tussles with that – we did it to maintain the focus on the principles and the goals. Once the local partnerships and the local co-ordinators were established, we were able to let go of that more. (MHAZ co-ordination, 03/2003).

5.1.2 Facilitating the HAZ network

Goal Leads were appointed within the Steering Group to oversee the programme for each of the four main Goals (see Appendix A). There were two Goal Leads for each Goal, one from a Health Authority and one from a Local Authority. These Goal Leads were to be advocates for that Goal, reporting back to the Steering Group on the achievement of Goal outcomes across Merseyside. The Goal Leads also co-ordinated a number of sub-groups relating to their activity, with membership drawn from across the district partnerships. A report from the National Evaluation of HAZs considered that in “*assigning these Goals to the different leads, the truly cross-boundary way of working was demonstrated in Merseyside from the outset of the HAZ*” (MacKinnon, 2003, p.13).

By the time this research began the number of Goal Leads had dwindled. One former Goal Lead felt that this happened because the programme had become established and there was no longer the need for such a close watch to be kept on the activity.

[The goal leads] were instrumental in getting that programme up and running. But heart disease and cancer were done purely through those convenors. We did something of an evaluation of [the proposals] at the beginning, but once the programme was established we had less involvement, we wanted the maximum delegation as possible ... which is the principle of HAZ. (Strategic, Health, 11/2002).

However, another Steering Group member felt this was a great loss to the programme. The Goal Leads were an integral part of the 'Making It Happen' goal, they not only managed the Merseyside wide part of the programme, but through the sub-groups helped to ensure that the goals were addressed in the districts with a focus on how that contributed to the programme across Merseyside. They had a second role of performance managing the efforts in the districts to ensure that HAZ money was used to meet HAZ aims, to make sure that it was not 'robbed' to balance budgets locally. This person felt that Goal Leads had been lost in the NHS re-organisation and that the role had been lost "*because the champion had been lost*".

The loss of the Goal Leads was not good. We had people who had a view of the goals right across Merseyside. The champions have moved on but they've not been replaced. HAZ suffered because of it. The Goal Leads came from all five districts to decide what to do across Merseyside and to look into local partnerships, to audit / performance manage the programmes. When money goes locally there's a temptation to rob it, so there's value in having someone removed from the frontline who can take a more objective view. (Strategic, Health, 12/2002).

Recognising the complexity of the Merseyside HAZ programme and the degree of investment in certain key areas, the Steering Group also identified a number of HAZ Convenors. These were people or organisations with expertise in a particular area (such as cancer, CHD, food and health, transport, workplace health) and who would be able to advise the Steering Group on the effective investment of HAZ monies. This spread the HAZ network even further as these people were links into the networks of interest that they represented.

Early on in the programme the acute Trusts expressed concern that they were not more involved in the HAZ. Funding shortages in this sector meant that any Department of Health money available was seen as an opportunity to meet their needs. It was not that these Trusts misunderstood the role of the HAZ, but rather that they felt their need to make targets was the most immediate problem. HAZ did fund projects in the acute sector. Some of the medically focussed Convenors were a way to engage more with the acute sector; in addition a chief executive from one of the acute Trusts was invited onto the Steering Group.

The convenors were a response to criticism from the hospital sectors that they were not sufficiently involved in HAZ. ... One of the tensions that might have led to the acute sector not feeling involved was their inability to influence the allocation of the funding. We invited an acute sector Trust Chief Executive onto the Steering Group. (Strategic, Health, 11/2002).

The HAZ chose to support the NHS financially throughout the life of the programme in recognition of the funding problems that this sector experienced. These decisions were mutually beneficial. It helped the health sector continue programmes, but it also raised the profile of the HAZ in those areas, and gave the HAZ some 'quick wins' which helped to secure additional government money.

Initially it was a case of saying “we could give money to this”. In the first year we made some quick hits, but substantial ones, we made some good decisions. We went against the grain in some areas, particularly money to Health Authorities for stuff they were already doing. We made sure we stood out and did things slightly more efficiently and probably at a higher rate. That was the gain; we got more government money on the back of that. (Strategic, Local Authority, 01/2003).

One downside to funding these NHS programmes was that they would have to be picked up later through mainstream funding and “*we’re talking millions*”. The reality was, of course, that HAZ continued to fund the programmes through the uncertainty of the NHS re-organisation, and some of these projects have now been picked up by the Cheshire and Merseyside Public Health Network.

After three years funding, with money for one extra year, we continued to fund schemes that had been tried and tested and that professionals couldn’t afford to lose. (Strategic, Health, 11/2002).

The disadvantage for HAZ of funding NHS programmes was that less money was available for innovative work.

[The shift in emphasis caused] *a big, big administrative burden. It didn’t fit with trying to involve the community, being flexible, innovative, etc. We have to make sure boxes are ticked. (Strategic, Health, 12/2002).*

In the early days HAZ money was used for dubious things like hospital equipment, resourcing health care for asylum seekers. If we hadn’t used HAZ money they would have had to take it out of mainstream budgets. (Intervention, Health, 01/2003).

However, the decision to fund these initiatives in the NHS was seen as a positive reflection of the partnership in the Steering Group, and especially of the commitment to that partnership by the members from Local Authorities.

HAZ continued to support health service programmes after the three year life of the initial funding in recognition of the problems the health service was having, which was a strength of the Steering Group. (Strategic, Health, 11/2002).

5.1.3 The Districts

The bulk of the interventions were delivered in the districts. Each district implemented the HAZ programme differently. The differences ranged from the roles and responsibilities of the district HAZ co-ordinators, the nature of the local health partnerships, the focus of the programmes locally, and the way initiatives were selected and monitored. One Steering Group member commented that they were like “*five different political parties*”. These differences were generally regarded as a positive reflection of the flexible, locally focussed HAZ approach. The arrangement was not without its difficulties and one person working at the regional level expressed frustration at the difficulty it caused in trying to work with the district HAZ co-ordinators as a group. They all had different levels of autonomy and power, and this could affect the way they worked together and their relationship with the MHAZ central co-ordination team.

There were a lot of power issues there, I think, within the different district partnerships. ... They seemed to be very different in how they were arranged, the structure anyway. And certainly the HAZ co-ordinators, their job descriptions seemed very different. They were doing quite different things. ... I noticed that some people felt quite frustrated, the co-ordinators, because they spoke of certain people who had a lot of power and just couldn't get past certain things. ... They were pulled in all sorts of different directions, really. ... It was difficult in terms of the Central MHAZ Team trying to understand some of those issues. (MHAZ co-ordination, 12/2002).

This was a minority view, and the devolution of work down to the districts was often cited as a strength of the HAZ programme in Merseyside, and the district co-ordinators themselves received praise from both the strategic and intervention levels for their enthusiasm, dedication and support.

The devolved programme was an integral strength of MHAZ. (MHAZ co-ordination, 09/2002).

I can't praise the local co-ordinators enough. They've done a brilliant job ... the translation from a strategy, into a policy, into a plan, into action – all five boroughs have been terrific. A lot has been down to the ability of the local co-ordinators to get partnerships going. They've delivered. (Strategic, Local Authority, 11/2002).

In [district] the HAZ concepts will live on because of [the co-ordinator]. It is more difficult to say if they will live on elsewhere. I think both [district co-ordinator] and [MHAZ Co-ordinator] are really dedicated and believe in it. If you live in an area where somebody was thinking 'I've only got six months funding left, I think I'd better go', it might seem as though it's fallen apart without that person. I suppose you do try and think how much is down to the personality and how much is down to the ethos of HAZ, really. ... I guess if [district co-ordinator] wasn't there it would carry on now. I'm sure it would in fact. ... I suspect it's gone right into our mindset now about how to make a difference. (Intervention, Health, 01/2003).

The experiences of these five co-ordinators were as varied as the structures within the districts. Three of them had largely positive and empowering experiences of being district HAZ co-ordinators.

It's been a big achievement. (MHAZ co-ordination, 03/2002).

The general experience has been very positive; I'm looking forward to the next few years. (MHAZ co-ordination, 04/2002).

I found the whole thing very stimulating and challenging. (MHAZ co-ordination, 05/2002).

Of the other two, one remained positive about HAZ and the work in that district despite some difficult personal circumstances, but the other did not enjoy the experience at all asserting that it “*HAZn’t happened for me*” at one HAZ meeting. An exploration of these experiences highlights the degree to which the HAZ ethos was embraced in each district, the difficulties that a quick start up to the programme caused and how different organisations addressed this.

These latter two co-ordinators had come into their posts in the second year of the MHAZ programme. All the funding in those districts had been committed in the first year of the programme, and the administrative systems were unclear. It was hard for these co-ordinators to identify what had been funded and why, and who the contacts were. This seems to have occurred because the task of implementing the programme had been given to people as an additional responsibility to already busy jobs, and there had been pressure for a quick start. When these co-ordinators came into post it took them both a year to work out where the HAZ money had been spent and why, to rationalise monitoring forms and establish effective administration systems.

There were not good systems in place when I came. There was a lack of structure, sketchy project applications, appraisals, etc. (MHAZ co-ordination, 03/2002).

There were a lot of problems in [district]. I don’t know what the allocation process was, how the interventions were approved and leads chosen. From day one, going through the monitoring process was difficult because I didn’t have contact details, etc. It’s now sorted out, I know who’s doing what. It’s now closely monitored. (MHAZ co-ordination, 04/2002).

In the other districts, the co-ordinators took up their posts within the first year of the programme. Even though two of them started quite late in the first year, there was still work to do in developing the programme and setting up the administrative systems. This seems to have enabled them to engage with the HAZ in a much more positive way.

The partnership had actually been set up ... one of the reasons I was appointed was that they realised they couldn't do it by a number of officers sitting around a table. They needed somebody whose job it was to help it to happen. When I came, the early part of that was actually getting the processes in place ... once I was here, I was able to go out a lot more and raise awareness within other agencies. (MHAZ co-ordination, 05/2002).

The partnerships in these three districts were strong and committed to the HAZ programme. Unlike the Steering Group, there had been struggles between members in the early days of these partnerships. Persistence, development meetings and changes in membership had overcome these difficulties and three years into the programme the partnerships had come together well. It was obvious that money and specific people had been key in this transition.

The partnership between the Health and Local Authorities has been working very well, has been building over time. People in the right positions were willing for that to happen. ... The other things [beyond funding that the partnership] had been looking at were not particularly focused. And I think that's been partly around the leadership ... things haven't moved on quite the way they would had there been a different Chair ... I know that things will move on differently now that [person] has taken over as Chair. (MHAZ co-ordination, 05/2002).

We fixed several days during the year to look at development needs ... If [the money] dries up, work will stop ... the whole ethos around HAZ will

just disappear ...Need champions at the local level, at Merseyside level, at regional level and at Central Government. (MHAZ co-ordination, 03/2002).

These three co-ordinators felt supported and valued and able to contribute in a positive way to the HAZ programme locally and regionally. Over time, their roles evolved to include more than HAZ work, but this was a natural progression as the New Labour agenda expanded around them.

Over the last two years it has changed quite a lot from looking after HAZ funding. Now we're taking on board health inequalities for the LSP. (MHAZ co-ordination, 04/2002).

In terms of the structures and how we link things up, there are bodies meeting at the high, top strategic level, but also at the level of the developing of interventions, the approving of interventions, and the monitoring and evaluation of interventions. So that we're now calling the HAZ [partnership] the Health Inequalities Subgroup – it's a subgroup of the strategic planning body that we have in [district]. ... the HI subgroup is looking at the links between separate funding streams that contribute to health inequalities. So that none sit in isolation ... somebody has an overview of how they contribute to the bigger picture. (MHAZ co-ordination, 04/2002).

The Health Partnership is now also the thematic partnership for health within [district] LSP. ... We're trying to promote links with the other themes which are all to do with the underlying determinants of health: community safety, education, housing, and the environment. (MHAZ co-ordination, 05/2002).

In contrast, the other two co-ordinators expressed dissatisfaction with their working arrangements and their inability to implement the HAZ programme in the manner they would have wished.

One co-ordinator had no health partnership to manage the HAZ programme with them and had been seconded to the district LSP, and then again to a community New Deal partnership. This last position enabled them to bring HAZ principles to that partnership and to advocate for a more holistic health perspective. Although clearly enthusiastic about the HAZ approach and the opportunities that HAZ had brought to the district, it was frustrating for the co-ordinator to be managed by so many organisations. This co-ordinator felt they had been “*spread too thinly*” and that the HAZ needed a dedicated co-ordinator. They felt these secondments reflected a lack of commitment to HAZ within their home organisation, and felt the job of co-ordinator was seen as little more than an administrative role. This would seem to be a failure in communication. In reality the co-ordinator’s manager had been acknowledged as a champion of the programme and she felt that the co-ordinator was an asset to the HAZ, and the co-ordinator’s secondment to the LSP an opportunity to broaden the HAZ network.

The other co-ordinator was frustrated and angry at the way the HAZ had been established in their district. The HAZ money had been spent on an existing agenda, committing all the initial three years funding and therefore leaving no room for development.

When I came into post all the HAZ money had been committed prior to me being in post right up to the position now ... we’re now closing off year three of the initial three year programme. So I’ve had little or no scope to develop anything with the HAZ, all the decisions were made before I came into place. ...What I did find is that there were not very good systems in place when I came here. ... Everything seemed to be, from coming in totally cold, standard NHS stuff more than anything that was really innovative. (MHAZ co-ordination, 03/2002).

From the interviews conducted in this district it would seem that some of these interventions were in themselves quite innovative: one involving a partnership between the NHS and Local Authority to deliver sheltered housing services to people in their own homes; another providing nursing care support to people in their own homes. People within these interventions expressed the opinion that the district had a strong history of innovation. Something that was recognised at the Merseyside strategic level of MHAZ, but also with some sadness that the district had not taken advantage of the opportunity to build on that culture of innovation:

There are some areas of work in [district] that are quite innovative. ... I suppose where I think [district] is falling down to some extent is the willingness to really take it to the next step. I feel as if it's missed out on opportunities that could really have pushed everyone further. I feel quite sad, really. (MHAZ co-ordination, 03/2003).

This sadness is reflected in the frustration felt by the co-ordinator there. Because the decision to commit all the money up front and the insecurity about future HAZ funding, meant there were limited opportunities to engage with and develop an innovative programme with the health partnership in that district.

It's caused a lot of frustration. Its like anything else with a group like that, it can start off quite interesting and innovative and dynamic because its got decisions to make, its got appraisals to do, it can argue the pros and cons of a particular project and agree a programme and have ownership on that programme. Once that's done and some of the principle players go by the wayside and its just a case of you're there to be reported to, you're not asked to make anymore decisions because all the decisions have been made a long, long time ago. So really it's been a self fulfilling doom for the group ... it's had a totally negative effect on the role of the group. ... It's quite difficult to engage a group on a regular basis. (MHAZ co-ordination, 03/2002).

There was a strong sense that these two co-ordinators felt isolated within the organisations they worked for and from within. It is perplexing because there were strong champions of the HAZ programme within those organisations. For whatever reason, these people did not feel supported in their work locally.

The differences in the experiences of the district co-ordinators resulted from the extent to which these co-ordinators were able to work in a HAZ way themselves, and the degree of support they received. The co-ordinators from two districts were not on permanent contracts; one of these was the most unhappy of the co-ordinators. The lack of a permanent contract compounded the frustration felt by this co-ordinator. The insecurity about future HAZ funding left them extremely insecure about their future employment. This insecurity was not evident in the other co-ordinator without a permanent contract who said:

I took the chance of leaving a full time post, and it hasn't disappointed at all. (MHAZ co-ordination, 05/2002).

I did not get any sense that the first co-ordinator received much in the way of support or encouragement locally. In contrast the latter was highly regarded throughout the MHAZ structure, and was acknowledged as one of the strongest supporters of the HAZ approach. This in itself reflects the differing commitment to the HAZ values within each district.

There were also differences in the degree of influence each co-ordinator had over the programme locally and regionally: one feeling impotent in the aftermath of decisions made prior to their arrival, another sitting on the main HAZ Steering Group as the local authority representative from that district. Their different experiences demonstrate the importance of working in a supportive environment, of feeling

valued, and of having the funding flexibility to develop a programme with a partnership in accordance with the overall programme values and therefore personal values.

5.1.4 The Merseyside HAZ Co-ordination and Support Team

As elsewhere, the HAZ team attracted people for whom the HAZ principles and ethos were a close fit with their own values and priorities. The team had a flat organisational structure where everybody was encouraged to work autonomously, but to contribute to the team as a whole. This structure took some adjustment for people not used to working in this way, especially those coming from a more traditional hierarchical structure, but on the whole the team enjoyed this approach.

I came from an acute trust – very formal structure, very focused, a hierarchy. [This structure] did take some getting used to. It was very flat even in the Health Authority at that time. I'd always been in a [job] section with other [job] people. That itself was unusual to come into a team where I was in the minority. At that time I was the only [job] person. There was no common language. [The first six months were hard.] But since then I have settled into it now and I like it. (MHAZ co-ordination, 09/2002).

The role is so different, because it isn't a hierarchy in our place, everyone works basically as a team. That is a good thing. I've never worked anywhere like that before – where you're not afraid to ask people anything or to whinge at people. (MHAZ co-ordination, 10/2002).

It was good to go into a different area than I was used to. ...Working with some of the colleagues was really good; working with other people to try and sort things out. ...Having a certain amount of autonomy to do things and suggest things was good, very useful. (MHAZ co-ordination, 12/2002).

The flexible, adaptable way of working enabled the team and the HAZ programme to adjust to the changes earlier on in the programme. It also enabled the individuals to develop professionally and to become more involved with the decision making over time.

I've been able to shape a lot of it, which is satisfying. (MHAZ co-ordination, 09/2002).

It's been great in terms of personal achievement. (MHAZ co-ordination, 10/2002).

It's given you the opportunity of improving yourself. I came in as a [job], I certainly don't think of myself as that now. The role is so different. ... You're given the opportunity to present your own ideas, other places are not like that. (MHAZ co-ordination, 10/2002).

The team considered that they had been successful in supporting the Steering Group and interventions. As the hub of a much larger network, they were able to promote contacts through:

- Simply connecting people:

Someone called about evaluation - have we got a project who has done a good evaluation, to pick their brains? [Team member] put them in contact. ... It's the way we network ... we put people in touch with other people. (MHAZ co-ordination, 10/2002).

- Through organising 'whole systems' events such as the Quality Of Life, Older Persons, and Open Day:

That's what we're about, what the Open Day was about – linking with each other. (MHAZ co-ordination, 10/2002).

- Through the communications policy. This won two awards, one for the HAZ work around older people, and one for strategic communication. These awards recognised the way MHAZ worked:

Trying to be inclusive, getting the right people there, and getting all the information out in an easy friendly manner. Trying to have good communication around all that kind of thing. ... We built up quite an expertise in that. (MHAZ co-ordination, 10/2002).

The overall strategy included developing the MHAZ corporate image, publications, events, press releases, and the production of a newsletter that included not only information about the HAZ but also information about conferences and government policy. A website gave up to date information about the HAZ, including the districts, and online access to HAZ documents, many of which were aimed at the community. The communications strategy was also rolled out through the five districts.

Our ethos was that we would communicate on a Merseyside wide level and then get it out to the HAZ/HIMPs and they would cascade that at a borough wide level. (MHAZ co-ordination, 10/2002).

- Through training for monitoring and evaluation, and the funding of HAZ Fellowships and the MPhil studentships.
- Through participation in the HAZ working groups, actively promoting the work of HAZ in other partnership organisations, such as LSPs and PCTs, and sitting on steering groups of other initiatives.

The team made every effort to support the Merseyside wide interventions, visiting those that were struggling with the monitoring, giving advice on evaluation, and so on. Naturally, as with all groups of people, there were clashes in personality and differing views. Some of these were resolved when individuals left the team. The people left at the end of the programme worked well together and were proud of their achievements. This made it especially hard when the NHS re-organisation brought new members onto the Steering Group who did not appear to recognise or value the work the team had been doing. The manner in which these individuals set about to

dismantle the Merseyside focus of the HAZ caused great distress to the co-ordination team members, and left them feeling very angry.

At our last meeting I could have quite happily thumped people because they were sort of “Well, what’s HAZ done then? Can you write down what we’ve actually done?”. They’ve just got no idea. (MHAZ co-ordination, 10/2002).

This was not about job security, but was about being valued and supported in the work they had invested so much into and had derived so much from personally – through personal development, but mainly through feeling they had made a difference to Merseyside.

I felt like saying “For God’s sake, what do you think we’ve been doing for three years?”. ... As [team member] said earlier, instead of just saying “we haven’t got enough money, and we’ve got all these problems”, they want to do this to justify their position. ... It could ruin things for us, it really could ... If it came to funding and it was knocked back just because of [district] I would be bloody furious. (MHAZ co-ordination, 10/2002).

... there has been a lot of upset over the insensitive way in which [the team’s] success with, knowledge gained and future with HAZ has been discussed. [Team member] said that the whole process had been conducted in a most un-HAZ way ... (Research notes, 01/2003).

The co-ordination team, and the Making It Happen approach that they supported, were clearly valued beyond these few people as an important part of the success of the HAZ in Merseyside:

I think they’ve got a strong team, and I think that’s important. (MHAZ co-ordination, 03/2002).

Things like the community involvement step-by-step guide, the HAZ events, publications. I think all of that has helped. ... That central team has been crucial. (MHAZ co-ordination, 05/2002).

The core team have a range of skills that collectively is not available as a resource elsewhere. I certainly considered that that was valuable in its own right and could be called upon to do a lot wider things - and has been and was doing - than just the HAZ. (Strategic, Health, 11/2002).

There appeared to be a good working relationship between the central MHAZ co-ordination team and the district HAZ co-ordinators.

I've had great support from MHAZ. (MHAZ co-ordination, 04/2002).

I also got very involved with the Central Team, working with them on other things like the Open Days and other events. And doing some of the initial briefings sessions at Pall Mall. I've been involved in helping to promote HAZ locally and further a field. (MHAZ co-ordination, 05/2002).

There were problems, of course. The district co-ordinators expressed frustration that they did not know what Merseyside wide interventions were being funded in their districts, which made it difficult to foster links between local and regional interventions. Communication generally between the district co-ordinators and the central team was not always as effective as it might have been. This lack of communication was accepted as a problem on both sides, and was understood to result from a lack of time.

The co-ordination and communication between MHAZ and the local HAZ could be better, but that is a two way problem. (MHAZ co-ordination, 03/2002).

I think it sometimes seemed as though we weren't sure what was going on [in the districts], and they weren't sure what was going on centrally as well. (MHAZ co-ordination, 12/2002).

5.1.5 Making It Happen

The HAZ in Merseyside was much more than a funding stream. Money was invested in an overarching goal of 'Making It Happen' to facilitate "*strategic change within the core business of partner organisations*" (MHAZ, 2000, p.5). The philosophy behind this approach was to spread tendrils of the HAZ Principles and ethos out into Merseyside organisations to generate a greater understanding of health in all its dimensions. The more this was understood, the more sustainable it was felt the outcomes of MHAZ would be. There are several ways in which this approach has been successful:

- The engagement of local politicians and senior officers from the core partners through the MHAZ Policy Group, Steering Group and local health partnerships. These people have been champions for HAZ and the HAZ approach in their own organisations.
- Funding and supporting interventions – the monitoring processes required intervention leads to assess the progress of their intervention against the HAZ Principles.
- Actively promoting the work of the HAZ through a corporate identity, publications and press releases.
- Engaging people through HAZ Convenors, MHAZ Fellowships, seminars, training, forums and whole systems events.
- Increasing the capacity for partnership working, especially between the Local Authorities and the health sector.

- Working under a Merseyside banner. This was often cited as an enormously positive aspect of the HAZ. It was felt that a regional approach was stronger in dealing with inequalities and health promotion.
- Forging links with other initiatives in the region.
- Engaging with new partnership structures – PCTs and LSPs – to share the learning from the HAZ approach.
- Linking people on an informal ad hoc basis.
- The ‘HAZ way of working’: a flexible, adaptive, collaborative and supportive approach to engaging with others.

Merseyside Health Action Zone works in the spaces between organisations, providing a network, breaking down barriers, overcoming obstacles and creating joined-up solutions ... (MHAZ, 2002, p.12).

Everyone involved with MHAZ at a strategic level contributed to the process of ‘Making it Happen’, but the practical work primarily came from the central HAZ co-ordination team and the district co-ordinators. Their work was collectively considered a real strength of the HAZ, and the strong central team provided a range of skills that was not available as a resource elsewhere. The ‘Making it Happen’ approach was identified as part of the lasting legacy of the HAZ in Merseyside.

5.1.6 Monitoring and the Central NHS team

Collectively, throughout the MHAZ, very few people liked the monitoring or performance management procedures they needed to comply with. They were often felt to be too time consuming and people rarely believed the information they were guided to share reflected the complexities and nuances of the work that they did. These procedures were acknowledged as a “*necessary evil*”, but were undertaken with varying degrees of commitment, especially within the interventions.

For the co-ordinators there were two facets to the monitoring processes of the HAZ. The first was the local monitoring and how useful the data collected was to the co-ordinators themselves. The second was how they felt about the performance monitoring they had to complete for the DoH. On the whole, the monitoring information gathered from the interventions was considered a useful indication of how that intervention was progressing. Some intervention leads were more conscientious about filling the forms in than others, so the quality of the information provided varied. One group consistently identified as being 'difficult' to get monitoring information from were the leads of interventions within the health service. There was a sense that health service staff considered HAZ money to be theirs by right – as it came from the DoH. There was also no culture of external funding within the NHS. Some of these difficulties were overcome at the regional level by developing the capacity of the NHS intervention leads in this respect.

The monitoring forms were intended to facilitate reflection and learning as much as demonstrate progress. Many of the co-ordinators stressed that it was acceptable for interventions to 'fail' because of what could be learned from the process. Some of the co-ordinators supplemented the forms with visits to the interventions, which was part of the supportive approach adopted by the HAZ. These visits encouraged the sense of working with people rather than directing them. The MHAZ co-ordinators used the monitoring forms and visits as an opportunity to foster links between interventions. This helped to relieve the sense of isolation that many of the interventions felt.

When I read the monitoring forms I can see the connections between interventions: I'm the link. I will link them up with each other. (MHAZ co-ordination, 04/2002).

I will be involved in the site visits ... particularly where the [monitoring] returns are poor. ... but I've always been very keen to look on that more as a case of engaging and finding out what the issues are and seeing what we can do together to resolve them. (MHAZ co-ordination, 09/2002).

The frustrations with the burden of monitoring and performance management were just as evident within the strategic sections of MHAZ as they were within the interventions. In addition to the 'traffic light' performance monitoring, MHAZ had to produce High Level Statements summarising the work within the HAZ. In the same way that the local monitoring gave the co-ordinators a general impression of how the interventions were doing, these High Level Statements were valued by the civil servants in the DoH. The forms gave examples of processes and good practice that could be shared with ministers and other civil servants.

The statements are very useful for general information. We're not involved in the monitoring of performance, but I understand that they are invaluable. (Strategic, Health, 06/2002).

These statements were unanimously dismissed as a waste of time by the district co-ordinators. None of them could see how these forms could be useful as they were of too high a level to reflect the actual work on the ground, with no sense of continuity or progression within the interventions.

MHAZ monitoring is a complete waste of time. By the time it gets presented to the DoH it is so overarching it's meaningless. ... there's no audit trail, it gets lost in the vastness of MHAZ. (MHAZ co-ordination, 03/2002).

We produce high level statements and I'm yet to be convinced of their value. (MHAZ co-ordination, 04/2002).

Nobody can see the value of high-level statements. ... I don't think anybody reads them in the Department of Health. If they do, they're meaningless because it doesn't make a lot of sense ... (MHAZ coordination, 04/2002).

However, one of the DoH civil servants explained that for them the detail of the projects was less important, that needed to be captured by local evaluations.

I think there are two levels here, the local and the national. A lot of people from the HAZs have said that you can't transfer projects between areas, so you can only advertise learning locally. It's not the actual project that's important nationally, it's how they are doing it, it's the processes that need to be drawn up to the national level. (Strategic, Health, 06/2002).

The high-level statements were in reality just one means of assessing the progress of the HAZs. "Traffic Light" performance monitoring, site visits, conferences, network meetings, general contact and support, and the National Evaluation reports all gave other opportunities to learn about the work within the HAZs. The DoH civil servants expressed enthusiasm for the visits they made to the various HAZs, which allowed them to see the benefits of HAZ directly.

We're able to go out there and talk to the people working in the projects and some of the people that they're working with. And that's fantastic because you can actually see the policy working. It's brilliant! (Strategic, Health, 06/2002).

One of the best parts is getting out and about seeing things, meeting people. Some of it's completely brilliant. That's helped me, helped each of us who's done it, to be ambassadors on part of HAZs, to sell their achievements or ambitions. (Strategic, Health, 06/2002).

The opportunity to host such visits was an important opportunity for the MHAZ to promote the work it was doing.

Instead of a dry meeting, taking people round in a bus to see what was going on. Getting a feel for the energy, the real energy around a lot of the projects. (Strategic, Health, 11/2002).

This visit to Merseyside as part of their mid year review resulted in the following statement in a letter from the regional NHS Executive office:

It is our view that Merseyside is one of the leading HAZs in the country – both in its action to tackle inequalities and in relation to the modernisation agenda. We have made this judgement on the ability of the HAZ Partnership to deliver real results for the communities it serves. There is a tremendous energy and commitment to the HAZ and its work programme illustrated by the contribution of participants on its last Review Day (October 2000). ... Well worth a visit! (Dolan, 2001, p.1).

These various forms of assessment led the Merseyside HAZ to be identified at this time (ibid) as one of the:

- 8 “most advanced” HAZs;
- 6 HAZs that had made “notable progress” against the Service Modernisation priorities;
- 3 HAZs described as an “exemplar” in its development of programmes to take forward Ministerial Priorities (CHD, Cancer and Mental Health).

In the first years of the Merseyside HAZ, they were bombarded with requests for information, often at short notice. This information was used by the central DoH team to promote HAZs and their successes throughout government.

I think [the central DoH team is] ministerial driven. You know, they're getting asked questions and they've got to produce, and they've got to

produce the figures and Health Action Zones have got to be seen to be working, and that kind of thing. (MHAZ co-ordination, 10/2002).

A lot of it was building up links and letting people know that HAZs were there and had done all this work. (Strategic, Health, 06/2002).

We were a conduit to feedback the activities and ideas of HAZs to the Department, also across Government. (Strategic, Health, 06/2002).

The frustration with the burden of responding to these requests was evident when I first began working with the Merseyside HAZ. The MHAZ Co-ordinator estimated that as much as 50% of the team's time was spent responding to these requests and the stringent performance monitoring. Another central MHAZ team member expressed her concern that some of this information had already been provided in the monitoring.

[Monitoring information] would go to Regional Office and the Central [DoH] Team. Consequently we'd get asked questions where the information was there in the monitoring and high level statements. So there was a feeling that your information would go a little bit into the ether really. (MHAZ co-ordination, 10/2002).

This person acknowledged that they received feedback from the central DoH team about what had been passed on to ministers, and that the information accurately reflected the work of the MHAZ. Yet somehow, she still remained unconvinced that the information they shared was useful. This seems to reflect a more general problem of people feeling disconnected from processes that happen above them, perhaps because they are not directly involved.

In the early days of the initiative, the central DoH team had the job of supporting the work in the HAZs, and bringing the different HAZs together. They set up networks

of interest and hosted meetings for the HAZs as a whole. This was something that the civil servants greatly enjoyed and valued.

The things that I've really enjoyed about the job have been involvement in specific subject areas: working on some of the HAZ networks. The employment network, for example, that I was involved with for a while ... developing an occupational health network. They may not sound very big in themselves, but it's actually been very exciting to do that from the start, to do that with the HAZs who were interested. (Strategic, Health, 06/2002).

Equally their efforts were appreciated on the ground in the MHAZ.

Yes, [felt supported]. There were a lot of networking meetings when we first started. That was a lot of what they were doing at the Central Team. They were organising communications networks, community involvement networks – quite a lot of things going on around the national HAZ agenda. (MHAZ co-ordination, 10/2002).

This was part of that HAZ ethos of support and working in an inclusive way. It was a different way of working for the civil servants, and it created a great deal of enthusiasm for the HAZ initiative.

It's good to be part of things like this because it makes you think about what you are doing, and you realise that actually HAZs are the right thing to do. (Strategic, Health, 06/2002).

In terms of my involvement, and our involvement generally here, it was really quite hands on and I actually found that very exciting because I'm not used to developing policy in that way. And I think it's a good way to do policy, actually. ... I felt we were very much working with the HAZs. We weren't sitting down saying you've got to do it this way. (Strategic, Health, 06/2002).

By the time of my interviews, this team had been quite drastically reduced. The StBoP policy was taking effect and the focus had shifted to helping HAZs share the learning that they had acquired. The central DoH team felt that this was a natural process of change within government. It did not indicate that HAZs were less important, just that the policy agenda had moved on.

HAZs were set up ... just before a number of other initiatives to explore different ways of doing things at that time. Over time things change. Government priorities change and ministers have different ideas about how they want to implement policy. ... it's not that they're out of favour as such, it's that policy has evolved ... (Strategic, Health, 06/2002).

Unfortunately, this was not the way the changes were interpreted locally. They contributed to the sense that HAZs were no longer on the 'frontline of the war against inequality'. Together with the late announcement of extended funding, the changes at the DoH created a great deal of insecurity and consternation within the various HAZs. Some 'haemorrhaged' staff, and the civil servants were on the receiving end of much of their frustration.

It's always difficult to have to be involved in explaining to people that what they had envisaged from the outset is changing. ... it's been a bit uncomfortable at times ... people on the ground having to refocus and feel pretty powerless about that. To a large extent we're really fairly powerless too actually. Those decisions are made at the top and we act as a conduit to translate them. (Strategic, Health, 06/2002).

The Merseyside HAZ managed to maintain its enthusiasm for the approach and the programme during this time. A lot of this was due to the consensus and commitment within the Steering Group who hoped to continue the work, even if core funding was not forthcoming.

5.2 The dissolution of the Merseyside HAZ

The creation of PCTs in April 2002 through the *Shifting the Balance of Power* (DoH, 2001) policy created several problems for the Merseyside HAZ. Firstly the central HAZ co-ordinating team was hosted by the Liverpool Health Authority, and so needed a new base. Secondly, representatives on the Steering Group from the health sector changed and were distracted and less able to give their support to the HAZ. Thirdly, the contacts in the health sector were moving around, which made it difficult to determine who to talk to. Fourthly no money was provided to fund these changes which meant that there was less mainstream money available to fund successful HAZ initiatives.

The consequences of this reorganisation for the regional work of the Merseyside HAZ were dire. In the short term, the central co-ordinating team accepted the offer to be hosted by the Central Liverpool PCT, which meant a change in name only. The staff were all permanent employees of the LHA, and their contracts were transferred to this PCT. They had also been offered a home at the Wirral MBC, but it was felt that as this would require a physical move it would be too disruptive, potentially taking 6 months out of a relatively short term programme. These two offers, however, reflect the commitment of the two chairs of the HAZ Steering Group to the programme. And both men provided valuable support to the co-ordination team in the troubled days ahead.

At the same time as this reorganisation was happening, it became unclear whether the HAZs would receive further funding. They were granted an additional one year of money in December 2001. This extremely late announcement contributed to a feeling that HAZs had somehow fallen from grace and were no longer valued. There

was much dissatisfaction, and many people left HAZs in other locations. In Merseyside there was still a great deal of optimism. The strength of the Steering Group and the co-ordination team paid dividends at this time. Most of the HAZ funds actually came from outside the central HAZ pot, and it was felt that a smaller programme could still be supported if central funding were to end.

These additional funds largely came from the health authorities' Health Inequalities Adjustment monies which were a combination of previous HAZ Deprivation Uplift monies (received in 1999/00 and 2000/01) and New Money. As an example of the value of these: the Merseyside HAZ allocation of the HAZ core funding in 2001/02 was £3.967m. The HAZ Deprivation Uplift equivalent, across all Merseyside HAs was £6.511m, and the additional Health Inequalities Adjustment monies across all Merseyside HAs was £5.615m. The Merseyside Steering Group had agreed to pool and redistribute the HAZ Deprivation Uplift monies along with the core funding⁷. When this became part of the Health Inequalities Adjustment, the agreement continued that the HAZ Deprivation Uplift would continue to be pooled and used with HAZ core funding. However, "*HSC 2000/034 does not explicitly state that HAZs should receive from their host HAs funds that equated to the HAZ deprivation uplift in 2000/01 – this is a matter for local discretion*" (Dolan, 2001, p.2), a position re-iterated with the announcement of funding for 2002/03 (Lucy, 2001).

It was this continued pooling of the HAZ Deprivation Uplift monies that had been the basis for believing that the HAZ could continue without core funding from

⁷ The value of these funds was unchanged from 2000/01. This was essentially a funding reduction, as there had been no cost of living increase. The funding in 2000/01 was reduced by 26% from 1999/00 because of an across the board under spend by HAZs. The Merseyside HAZ had been under spent by 15%, representing a cut of 11% from money committed to the programme. Some of this money was allowed to be carried over to 2000/01, but as a one-off concession. Financial agreements made between the HAs and the HAZ off-set some of the overspend resulting from the reduction in funds.

central government. However, the PCTs inherited huge debts from the HAs, and, as has already been said, there had been no money provided to fund the change from Health Authorities to Primary Care Trusts. This had two ramifications for the HAZ. There was no money to fund NHS interventions funded by the HAZ (let alone voluntary/charitable sector interventions), and the PCTs needed all their funds to make their accounts balance. Not only was there a reluctance on the part of some PCTs to pool the HAZ Deprivation Uplift equivalent of the HI Adjustment, but

what we had was one of the chief execs from [district] saying something that was completely unsayable ... which was 'lets raid the HAZ money for our deficit'. (MHAZ co-ordination, 03/2003).

This began a process of debate and negotiation which led to the PCT Chief Executives agreeing that they would prefer to keep HAZ funds with the PCTs to be used locally. The process was exacerbated by the fact that the bulk of the discussion on whether to disband the regional approach occurred when it was not known if HAZs would receive core funding for the final three years of the initiative. The decision to provide this funding came in December 2002, this time HAZ funding was to be incorporated into the baseline allocation for PCTs. This on the basis that StBoP had indicated that HAZ programmes should be mainstreamed within PCT activity. Merseyside, though, was one of a few multi-HAZs that worked across multiple PCT and LAs, and the regional work had been highly valued. The PCT Chief Executives felt that the health agenda had moved on, and that a Merseyside focus for the programme was now superfluous and in danger of duplicating efforts elsewhere.

[District PCT CE] produced a paper ... suggesting that the developments of LSPs, PCTs and the Cheshire and Merseyside Public Health Network had overtaken the need for a discreet MHAZ programme. The learning from MHAZ should be taken forward into these organisations. (Research

notes, 01/2003).

The proposal was to move the central co-ordination role to the emerging Cheshire and Merseyside Public Health Network, although this came with no funding. In the end it was agreed that the PCTs would contribute some money to fund a small co-ordination team for the Network, and that the HAZ databases would be rolled over into this structure. It was presumed that some of the HAZ co-ordination team would fill the posts in this Network co-ordination team, but that was unattractive:

The PCTs are assuming that they will do the job descriptions of the three posts in [the Public Health Network], and [we] will be able to say that the jobs are substantially what we're doing now and have the right to transfer into them. I'm not convinced that they are the same weight and the same responsibility as the jobs we are doing now. (MHAZ co-ordination, 03/2003).

Observing the process, the hurt and anger expressed by the central co-ordinating team resulted less from the suggestion that HAZ was no longer required at a regional level. Privately key people in the organisation acknowledged that they had believed the need for a separate initiative had passed. The New Labour public health agenda had moved on considerably since HAZs were introduced and much of what they had been set up to do was now incorporated into the remits of the PCTs and LSPs. What hurt so much was the approach taken by new Steering Group members, questioning the value of the work of HAZ and with one person referring to the co-ordination team as 'human resources'. It took two of these 'human resources' to be visibly upset in a Steering Group meeting for the new members to recognise that they were dealing with human beings.

[Two MHAZ team members] went to the meeting, even though they knew it would be difficult to listen to the group discussing their futures. [One

of them] *had to leave, and [the other] welled up. This seemed to bring it home to [PCT Chief Executives] that they were dealing with real people and their livelihoods.* (Research notes, 01/2003).

The remarkable aspect to all of this was the reaction from the LA members on the Steering Group. They were outraged at the attitude adopted by the instigating PCT members. They had been champions of the HAZ all along, and greatly valued being part of the Merseyside health improvement agenda through the HAZs. They were committed to the Merseyside focus of the programme and felt very poorly treated, and through this fought very hard for LA representation on the Steering Group of the Cheshire and Merseyside Public Health Network. This they achieved, and it seems that it is the only Public Health Network in the country to have LA representation on the Steering Group, and one of the few to have a co-ordination team.

It was evident that the PCTs were saying this is our money and ... People from the Local Authorities were saying, but it isn't your money, it's to be used across the board for making a difference in relation to health. (Strategic, Local Authority, 01/2003).

The impetus for disbanding the regional focus of MHAZ originated amongst the new Steering Group members from the same district that the unhappy co-ordinator worked in. Perhaps the decision to 'not go the innovative route' and to spend all the HAZ funds upfront on an existing agenda left this district with nothing particularly different to show for the HAZ programme there. There had been no money available for the co-ordinator to do development work with the health partnership around the HAZ principles and ethos. It has also been suggested that one of the Chief Executives from these PCTs believed that the changes in primary care were of greater value in tackling health inequalities than programmes such as the HAZs. The combination of this person's reticence about the HAZ initiative generally and a local

programme that had not been particularly strong on HAZ ethos, might explain the lack of value placed on a regional focus to the MHAZ. It is, however, an example of how a strong partnership can be disrupted at a time of financial insecurity, and when the overall context has changed.

5.2.1 Merseyside wide approach

By the time the MHAZ was disbanded a lot of the approach they had taken had been mainstreamed through the PCTs and LSPs. Other government initiatives had a community focus and the Neighbourhood Renewal programme had made explicit links with health improvement (DoH, 2002d). But one of the acknowledged strengths of the Merseyside HAZ had been its regional focus.

It was part of why we were able to do a district wide thing as well – over the whole of Merseyside – otherwise that would have been difficult to find the mechanism for. ... Everybody knew that the whole of Merseyside was part of the HAZ. I think it overcame some of the sensibilities about who gets what ... the competitive process. (Intervention, Health, 11/2002).

With the emergence of the Cheshire and Merseyside Public Health Network you can see how much more readily networking happens at a Merseyside level than it does in Cheshire. And I don't know to what extent that's just because they're different areas, and I suppose there's more common issues for Merseyside. But it's something that wasn't happening before, but it is happening now. ... Is it because there's a HAZ that's provided that focus? I don't know, possibly. (Strategic, Health, 12/2002).

There seemed to be no other organisation that could keep health and health inequalities on the agenda at a higher level, and link all these different organisations to keep things moving towards addressing inequalities. There was a fear that the

more innovative work that HAZ had championed would not continue and that the steps they had taken to foster a regional approach would be lost.

The danger would be the loss of the wider connectiveness [if HAZ goes]. We've got a lot of value in being connected, not just at the Health Authority level, but across Merseyside, and the PCTs are smaller than Health Authorities. It is becoming much more localised without necessarily understanding what the advantages are of being connected in the broader community at the Merseyside level. People don't live just in their local communities, when it comes to health, education and work, they move around. And that has to be understood. (Strategic, Health, 11/2002).

We are in danger of losing the resources to fund key workers, for example the food worker, one person who can develop an expertise across Merseyside. ... Some things need to be done across Merseyside, for example, smoking cessation. (Strategic, Health, 12/2002).

I think there's certain things we've learned. Like how we can work together across Merseyside on the strategic/direct community based project is important and that has to be brought into the mainstream for everybody, PCTs or Local Authorities, to deliver it as we see fit. But it's still got to be joined-up and still got to work as a strategic overview of where we are going. It'd be wrong to lose that in my view. (Strategic, Local Authority, 01/2003).

What concerns me is some of the really innovative stuff that HAZ has done may not be picked up or developed. Some of the really off the wall stuff that we have taken a risk with – I'm not sure that would get resourced at a local level because people have to justify it locally. If it's contributing to something across Merseyside, it carries more clout. I think all the benefits of work across Merseyside could be lost. (MHAZ co-ordination, 03/2003).

5.3 A sense of achievement

5.3.1 *HAZ successes*

The HAZ was a beginning, the achievements of this organisation were a start to the process of change needed to reorient health debates to include a fuller appreciation of the social model of health and the role of agencies beyond the health services in health improvement and reducing inequalities. There was evidence that the HAZ principles had changed the way that some people worked within the statutory sector.

I'm very positive about the whole HAZ experience, both in terms of the innovations it's allowed, and also the concepts and the principles and how that has filtered into mainstream thinking and mainstream partnership working. (Intervention, Health, 01/2003).

To some extent it has shown the way. It has influenced us because it has given us the opportunity to do something different to the run-of-the-mill kind of thing. And it has also challenged us into doing something different together, which is important, as a partnership. (Strategic, Local Authority, 01/2003).

Although some people noted that it was hard to isolate the influence of HAZ from other similar changes resulting from the New Labour agenda.

I think there's a general shift in ways of working, so things like community involvement are taken far more seriously than they ever were. Whether that's as a result of HAZ, or whether it's all around the general policy push that's been in that direction ... (Strategic, Health, 12/2002).

Where HAZ champions had moved to new organisations within the health economy, they had taken that approach with them. And so there was evidence that HAZ had influenced the way some new partnerships, such as the PCTs and LSPs, chose to work.

We want champions/advocates in the communities to make networks real, and engaging with communities to help their own health. Non-executives on the PCT Board are drawn from the community, its community driven. The stuff that HAZ was doing. We will keep it going with HAZ money. (Strategic, Health, 12/2002).

There's definitely been a change in people's understanding of what health is, what we're talking about when we talk about health. The ownership of it – Local Strategic Partnerships, the connection with wellbeing – that's certainly shifted. There's more recognition of the Local Authorities' role. Health inequalities are being talked about a lot more. (MHAZ co-ordination, 03/2003).

Successes identified ranged from the provision of small grants to communities (£1000) to the Making It Happen workstream:

I think for me the thing that then began to make it feel real was the small grants. (MHAZ co-ordination, 03/2002).

The nicest thing about HAZ in [district] is the small grants ... £1000 can change people's lives. (MHAZ co-ordination, 04/2002).

Having grants up to £1000 gives people the opportunity to come together for the first time. (MHAZ co-ordination, 04/2002).

[MHAZ] enabled a style of doing things which we are not always particularly well resourced to do. Particularly with communications; it enabled us to be more professional about communications and about the involvement of stakeholders in the community – people – in things. Whole systems events – didn't have the skills, time or resource to do that except in that core team. That professionalism was invaluable for getting an effective result. ... Making It Happen should be the lasting legacy of MHAZ. (Strategic, Health, 11/2002).

Making It Happen was a strength of HAZ. (Strategic, Health, 12/2002).

The money and the way in which it was managed internally and used to match funds also strengthened the approach. It represented the strength of the Steering Group, and an opportunity to engage more partners. More than anything, it brought extra money into Merseyside: over the first four years of the programme, £16m core HAZ funding was enhanced by £26m from the HAs and PCTs which drew down £21m of matched funding, giving a total of £63m available for use in the health improvement agenda in Merseyside. This demonstrates that it can only take a small amount of money to generate change, especially when the knowledge is there to match the funds elsewhere.

The focus on the social model of health helped to engage a broad range of partners. People from the LAs especially were excited about being able to contribute directly to the health improvement agenda. It was readily accepted that the LAs had an important role to play in improving the wellbeing of the people of Merseyside through the services it could offer. Although the Steering Group worked well together and were proud of their willingness to make decisions for the greater good, the money was almost exclusively health service money. The HAZ core funding came from the Department of Health, and the additional health deprivation monies from the HAs and PCTs directly. Each partner organisation contributed to the management costs of running the Merseyside wide programme, but there was still a tendency for the money to be identified as health service money. It would have been more equitable for the funding of HAZs to come jointly through the health service and local government. It would have marked the programme clearly as a joint venture between these two sectors. That said, it was a brave move for a Health Secretary to set up an organisation that required local authority participation.

There were certain strengths of the MHAZ organisational structure that enabled and supported these outcomes. The leadership of the Steering Group chairs, the MHAZ Co-ordinator, and the work of the regional and district co-ordinators all promoted the HAZ programme. The structure and programme was adaptable, accommodating the twists and turns of the central government changes. There was an enormous amount of commitment to the HAZ initiative. The social model of health facilitated a wider engagement. The organisation was based on clearly defined principles and values which created a framework around which people could work. At the centre of all of this were the people who took part as members of the Steering Group, as co-ordinators of the programme, in the district health partnerships. All played a part in promoting the HAZ approach.

5.3.2 *Cycles of initiatives*

In many ways HAZ is just the latest manifestation of a number of initiatives based on grass roots development. The Principles are similar to the values that have underpinned a number of interventions like community development, Healthy Cities, and so on.

A few years ago I looked at community development and health and what some of the influences had been on that. Some of it came from feminism, the civil rights movement, from liberation theology. You get these sort of values that converge and come together with things like Health For All, and then HAZ following from that. I think that's why there's a good fit with other people's ways of working and principles. The principles behind counselling – respect, empathy and genuineness - if you've got those in your dealings with individuals, then a lot of the other stuff about equality and involvement and all of that, flows from that. ... it's very much a social justice agenda that's behind it and people can identify with that. (MHAZ co-ordination, 03/2003).

HAZ is another example of how that alternative set of principles will not go away, will not ever go away. Sometimes it gets a big burst of strength and acceptance, but it's very, very rarely strong enough to impact on what is the established way of working. (Intervention, Health, 11/2002).

These earlier initiatives have come and gone without seeming to make any lasting change, and “each new initiative is trumpeted as if it's new”. HAZ was seen as part of this cycle of change, and was criticised for not making more explicit links with its origins in Healthy Cities.

There could have been ... a better connection up to Healthy Cities. With all short term projects, including HAZ and Healthy Cities, they're always reinventing the wheel, instead of acknowledging that things are growing out of a certain political climate. (Intervention, Health, 11/2002).

In fact, things do move forward with each cycle. People take what they have learned with them. The difficulty is in retaining corporate knowledge, which might leave with the people when they move on. The political and economic climates are important factors in the longevity of these approaches. A grass roots movement which seeks to empower people in communities might in the end become threatening to governments. Often this sort of work existed in pockets or was structured in such a way as to restrict their greater impact.

Go back to the Thatcher era when there was very little funding, development projects did survive and were very innovative, but there was no legitimacy, no co-ordination, so they weren't in a sense a threat. (Intervention, Health, 11/2002).

I think we move forward. The issue might be do we move forward at the right level? Should it be at a higher level? But we always move forward, because I think we do learn. (Strategic, Local Authority, 11/2002).

New Labour has introduced a number of initiatives based on these models of inclusion. Sure Start and the New Deal for Communities, in particular, have had the same bottom-up approach to partnership working as Health Action Zones, with similar successes (Myers *et al*, 2004). There has been a recent outcry at the government's decision to expand and mainstream the Sure Start approach (BBC, 2005; Glass, 2005). It is feared that parents will lose their control over the development of these projects and that the projects will suffer from not having ring fenced funding. Similar arguments were made about the mainstreaming of HAZs in Chapter 2. There is a danger that the mainstreaming of such innovative approaches reduces their potency, as the overwhelming pressures of funding and media attention might serve to promote the status quo. New Labour, however, have given a legitimacy to these values, at least in part. It is to be hoped that sufficient numbers of people have experienced the value of working in this way for there to have been sustainable change.

There was a phase when people were into development workers and saw their uses and potential. Then they became mainstream so nobody thought of them as particular anymore, so it didn't matter if they disappeared. (Intervention, Health, 11/2002).

[HAZ] made that approach stronger and more recognised ... it legitimated it ... it was part of a large programme. It was possible to point to that all the time. ... It wasn't quite big enough to be a proper revolution. ... It's sown the seeds. It's left the seeds behind. (Intervention, Health, 11/2002).

It is a cycle, about a ten year cycle: different governments, different flavours of agenda. Some things I'm doing now I was doing ten years ago ... if not longer. But it's more on the agenda at the moment, politically, than it was then. (Intervention, Charity/Voluntary, 11/2002).

There will be stronger partnerships where HAZ will continue; stronger services, possibly already a strong sense of community, although HAZ would have strengthened that. In areas where it fizzles out, it's difficult to tell. Communities go through cycles. As people change and come in and out of jobs, things change. HAZ may fizzle out there, but someone may join the council in five years that will get the whole thing going again. (Strategic, Health, 06/2002).

5.3.3 Community and involvement

HAZs were charged with involving communities in their development, and this is something that statutory sector participants in the MHAZ felt had not been achieved in the early days (consistent with national evaluation findings). The pressure for a quick start up precluded any serious community consultation on the nature of the programme. One district felt that there had been enough consultation in that area to know what the community priorities were:

[W]hat we've done ... is go to consultation overload. Communities were consistently telling you, in every policy you looked at, what is was ... what their specific needs were, and so I think it was felt that we had sufficient evidence in terms of the sorts of programmes and initiatives. And also we built in this 'send us your good idea', and as soon as communities knew there was money there was no stopping them. There was no need to worry that they hadn't been involved because I think being able to fund some of their good ideas – particularly the small community grants fund – that made Health Action Zones real to them. I think initially they probably did feel that it was something happening at quite a distance from them. (MHAZ co-ordination, 03/2002).

It was also felt that the reduction in funds and the change in emphasis limited effective community engagement because of the loss of flexibility that these entailed.

However, there are two ways in which HAZ could engage with the communities:

facilitating change within the statutory sector so that they are better able to engage with communities themselves, and by funding initiatives working directly with community groups.

Initially, the MHAZ addressed community involvement by focusing on raising awareness of the HAZ within Merseyside, especially within the areas of highest deprivation. The approach taken was to build on existing community development activity and consultation/participation to identify the gaps and opportunities for improvement through MHAZ. For some projects funded by SRB and EU Pathways monies, this led to the addition of a health dimension in their programmes. In addition, each district ring fenced funding for small scale schemes to involve community groups. The MHAZ created a Community Involvement Think Tank (CITT) at the suggestion of local community organisations. This suggested the development of a community involvement guide for organisations, which has now been published (MHAZ, 2001). This pack has 10 worksheets to assist organisations assess and improve their capacity for community involvement (MHAZ, 2001). This involvement guide has also been supplemented by a *Sharing the Learning* seminar on how to work with communities.

One of the most successful ways in which HAZ has facilitated community involvement is through the funding of the position of a co-ordinator for a Healthy Living Centre Network across Merseyside. This network made connections between and supported community groups applying for HLC status across Merseyside. There have been 43 applications for HLC status in Merseyside. Twelve of these have been successful in gaining New Opportunities Fund money. Another seven have obtained funding from other organisations. There is no other HLC Network in the country,

and the HAZ investment in this has paid dividends. Merseyside received nearly one third of the North West funding on HLCs. And the co-ordinator felt that these projects would be stronger and more sustainable because of their connection through the network.

[T]hat kind of leap of faith has had a really positive benefit to the community groups that I'm working with. (Intervention, Partnership, 10/2002).

When I go out and talk to local communities and talk to people who are doing something on the ground, and I think 'God ... WOW ... we did that'. It makes it worthwhile ... it's been worth it because it's made that huge difference to the lives of individuals, which is what it's been all about. (MHAZ co-ordination, 03/2003).

Some of the districts have more direct community involvement on their partnerships, or through NRF links.

5.4 Conclusion

All HAZs have been subjected to heavy pressures and constant changes from central government. After three years, the expectations of how HAZs would contribute to the changing New Labour agenda had altered significantly from their original aims. However, most of the HAZs managed to maintain their original focus by some creative reporting. The frustrations that these changes caused initially were enormous, however, and the accommodations that the Merseyside HAZ made, whilst politically astute, did affect the flexibility of the programme they were hoping to deliver.

The MHAZ took the decision to try to meet these changing requirements within the regional programme of the HAZ, leaving the districts to maintain their local

priorities. All areas of the programme were affected by the funding insecurities, and these caused a great deal of concern. These insecurities reflected a government trying to manage an evolving agenda and to maximise the learning from HAZ. The DoH civil servants were clear that the HAZs had had support amongst the ministers and that they had influenced the wider policy development. However, within the HAZs the late decisions about funding contributed to a growing belief that HAZs had fallen out of favour.

These funding insecurities were related to the NHS reorganisation resulting from the StBoP policy. PCTs were created with many of the same priorities that the HAZs had had. HAZs were expected to align themselves with PCTs, but for a multi-HAZ like the one in Merseyside this created difficulties. The Merseyside focus of the programme had been a major strength of the programme and there was a fear that this focus would be lost.

After the initial failure to obtain HAZ status, senior officials in the statutory sector came together in a most remarkable way behind the HAZ programme in Merseyside. Working together for health improvement has been empowering, and especially so amongst those working in the Local Authorities. There was probably always a sense that HAZs were a different facet of the work of the NHS within that sector, albeit a new and exciting one for many. This seems to have contributed to the collapse of the regional programme; the Steering Group members from the PCTs felt that their agenda had shifted to include HAZ style ways of working, and that HAZ was in danger of duplicating mainstream work if it continued.

Funding garners attention and generates an incentive for disparate organisations to work together. The Merseyside HAZ money, whilst not substantial in itself, has

been used to draw down additional funding, broadening the HAZ network. The opportunity to fund interventions with visible outcomes has also maintained interest and enthusiasm for the programme. Decisions taken around funding NHS interventions have helped to engage the health sector with the philosophy. But money without a programme is just money on the bottom line. It is easily 'robbed' for other things. The combination of a programme based on specific principles and money to fund interventions which fit those principles, coupled with a flexible and supportive delivery structure, has the power to transform the way people prefer to work and the satisfaction they get from those jobs.

There were aspects of the experience of working within the Merseyside HAZ that people found difficult. This dissatisfaction can be distilled down to personality clashes, a lack of time and resources to do the work in the way they wished, and a clash in values between some aspect of the organisation and their own priorities. It has to be said that such complaints represented a small portion of the feedback on the inner workings of the Merseyside HAZ. Similarly, the positive feedback suggested the value of good connections and relationships with other people, the opportunity to work flexibly and innovatively, and having the resources and support to work in a way that fit personal priorities.

Chapter 6

Change on the ground: the intervention view

One of the other things about the Health Action Zone is that they are quite flexible. ... They are there to support you, but I don't feel that they constrain you. ... I feel that you've got a lot more flexibility to be innovative, and to do things than you do have with other funders. (Intervention, Partnership, 10/2002).

The previous chapter presented findings on the HAZ programme at a strategic level. This chapter is based on data collected about the experience of being involved with a HAZ funded intervention (see Appendix F for a brief description of the interventions included in the data collection). Throughout this chapter I refer to the main contact in an intervention (an individual, group or organisation in receipt of HAZ funding) as the 'intervention lead'.

6.1 The Interventions

The HAZ focus on health improvement through addressing the underlying determinants of health is apparent through the interventions that the programme helped to fund. These individual interventions very much reflect the different debates on how best to improve health and reduce health inequalities. Some are focussed on making statutory services more responsive to their clients' needs; others address lifestyle issues such as smoking, diet, exercise, etc.; others aim to address the underlying determinants of health, supporting individuals and communities to improve wellbeing by, for example, addressing issues around employment, housing and the sharing of resources.

There are some headline interventions, such as: the Campaign Against Living Miserably (CALM), a helpline aimed at young men; the Merseyside Racial Harassment Prevention Unit which works in partnership to facilitate the reporting of racial abuse; Alleygating to put gates on the back alleys of terraced houses; LINX to assist sex workers to take up education, training and alternative employment; Crystal Clear, a campaign against glass injuries outside pubs, bars and clubs; the HLC Network.

The interventions represented in this research are equally broad and cover both the aims of modernising service delivery and addressing the wider determinants of health. Some of the statutory sector services included are: programmes to take smoking prevention and cessation advice into schools; the provision of sheltered housing and nursing home care in the clients' own homes; employee health screening in a Local Authority. Box 6.1 describes two projects in a Hospital Trust which improved the delivery of care to patients.

This intervention lead was successful in obtaining HAZ funding for two projects:

1. The Occupational Therapy department had a tiny monthly budget to share between 10 members of staff. The equipment needed to facilitate patient discharge from hospital, like grab rails, were provided by the social services departments from the districts that the department served. This could take anywhere from a week to six months. A small allocation of £5,000 transformed the way this department was able to work. They were able to purchase basic equipment, such as grab rails, to give to patients "*as a gift from HAZ*". Having this store of equipment not only facilitated patient discharge and therefore their quality of life, but also improved staff morale. An evaluation of this intervention led to the successful application for funds from that Hospital Trust to purchase wheelchairs and other larger equipment that could be lent to patients.
2. There was similar success with an intervention to provide hearing disability equipment on the wards. This not only benefited patients, but members of staff with hearing difficulties. Again this resulted in an improvement in staff morale.

Box 6.1 HAZ funded additional equipment within a Hospital Trust

Although the projects described in Box 6.1 are things that one might think should have been provided through mainstream funding, clearly the funds were not being made available through that Hospital Trust. The opportunity to provide these services was transformational for the person involved. In an organisation where people are trained to expect 'no' as an answer, it taught her not to give up and to keep pushing. HAZ provided her with the means to provide evidence of the benefits of having this equipment. Something that as an outsider might seem fairly self evident, but within an organisation that has been expected to be cost effective, at least in part, through cutting costs at the frontline, these projects have been truly innovative and empowering.

Within the NHS you're brow beaten to expect 'no', and to expect that there isn't any funding and so you go without. But the message I got from HAZ, and also from other things that HAZ gave me the confidence to do, is if there's a problem don't give up on it, tackle it. And if people say 'no' keep going and find another way round it. (Intervention, Health, 01/2003).

The Health Action Zones employed the social model of health described in Chapter 3, and so the interventions to address the underlying causes of ill health have covered a broad base. Included here are: a project to support social enterprise; advocacy to promote social inclusion for children with disabilities; a project providing grants to innovative community initiatives; an educational initiative to encourage people to take control of their lives. Box 6.2 gives more detail about a project developed within a Local Authority to address fuel poverty amongst the elderly. Most of these projects are aimed at people on low incomes or those living in areas of deprivation, and in that way contribute to the HAZ Principle of promoting equity. Many are also delivered in partnership with other agencies or groups, following a whole systems

approach to improving health and wellbeing. For example, Box 6.3 describes a project to provide multidisciplinary services to older people in the community.

Two districts working in partnership obtained funding to put central heating into the homes of people over 60 years of age who currently had solid fuel heating. The money was matched to government grants for central heating and the districts were able to install central heating in 40 homes. When the money ran out for central heating, the project obtained money for solar powered security lights. In both cases the intervention lead acknowledged the links between these services and reducing the likelihood of the older person falling – either over the coal or in the dark! They commented that it is cheaper to install central heating than it is to provide a hip replacement.

This programme also offered a range of services to the residents that were optional: visits by the Fire Service, Age Concern, the Police, an occupational therapist; access to a 'handy man'; a benefits health check. All of these enhance wellbeing, and so contribute to health improvement.

Box 6.2 An intervention to address fuel poverty and wellbeing.

This intervention provides an integrated service for older people. Members on the team come from the Social Services (social workers and administrative staff), the PCT (accident prevention, pharmacist, health visitor, district nurse) and the local hospital Trust (therapists and therapy assistants). It was a project conceived before HAZ, but MHAZ money helped it get off the ground.

Box 6.3 Multidisciplinary support for older people in the community

Taken as a whole, the MHAZ funded interventions reflect the inner arches of the rainbow model of the determinants of health suggested by Dahlgren and Whitehead (Figure 3.1). Many of these interventions seek to promote social inclusion and work directly with people in the communities of Merseyside. The problems of these communities are so longstanding that they are unlikely to be addressed quickly, however.

There's probably been more money poured into this area than anywhere else in the country and it's still a mess ... it isn't a community at all ... this is a collection of very diverse communities living in the same area. There's a lot of suspicion, a lot of jealousy, a lot of people speaking to

their own interest groups. It's going to take time. (Intervention, Charity/Voluntary, 03/2002).

I don't think people realise how vast the problems are. ... They say 'all the money you've had, where's the results?' ... But, for example, [community] ... was in decline for 30 years, and you can't put right with 5 years SRB what took 30 years to decline. Decline happens a lot faster than improvements. But what you can do is slow down the decline, and that's all really the funding can do. (MHAZ co-ordination, 04/2002).

There was some frustration expressed at the nature of funding for community based projects. If it is possible to fund health care research over 20 years, why is it that community projects are limited to short term funding? Short term funding adds pressure to (often small) community based organisations. It does not recognise how long it can take a community development worker to establish trust within a community and to develop a base from which to implement the project. If further funding is not forthcoming then that trust can be lost.

[SP1]: *When you hear people saying that they've done health research ... followed a group of people for 20 years ... Have they had to sit down to get funding every three years? I doubt it. ... If that's the way forward with that kind of research, surely when you're doing something in the community – when it's so hard to get people motivated in the first place ... you can't do it in 18 months, you can't do it in three years. [SP2]: You've got to go at the pace of the people that you're actually dealing with. [SP1]: I don't think that even in 18 months that's given me enough time to get round and cover every avenue ... that networking, that being accepted, takes up a lot of time. ... If I go ... some of the things that I would want to continue would get lost at that point. [SP2]: If we brought*

in another person they'd be spending six months to get themselves accepted. (Intervention, Charity/Voluntary, 10/2002).⁸

One intervention lead felt that HAZ could play a role in promoting a more joined-up approach to funding allocation within a district.

If HAZ does become something, it would be good as a place to ... go to approve any monies being spent in the borough. Where it's run through a series of tests, health being one of them. (Intervention, Local Authority, 11/2002).

People working closely with these disadvantaged communities felt that true change was only likely to happen when the community groups themselves were joined together in networks, rather than competing with each other.

It's going to reach a pitch where it's going to be counterproductive to keep funding little bits of things. Things like HAZ are great and have done very well, but a future development with long term funding would be far more beneficial to get people to work together. ... It's all to do with trust really, and people having confidence in each other. (Intervention, Charity/Voluntary, 03/2002).

Need to find some way to get [the projects] networking. ... One group's gain is another group's loss because we live in a market economy. ... Groups competing together for funds creates antagonism. Yet loads of people do say we should get resource networks together, we should be sharing good ideas. (Intervention, Charity/Voluntary, 01/2003).

The benefit of creating community networks is evident from the results of the work of the HLC Network funded by HAZ, discussed in the previous chapter. This intervention is a key facet of the approach to engaging communities taken by the

⁸ This interview was with two people, identified as SP1 and SP2 in this extract.

HAZ in Merseyside. The network is run using principles that complement those of the HAZ well.

6.2 HAZ values

6.2.1 HAZ Principles

The HAZ programme is built around the HAZ Principles and the general ethos is to raise awareness of health inequalities and the social model of health, and to support people to make changes in the way services are delivered. At the intervention level the Principles were promoted primarily through the monitoring process. Intervention leads would have to demonstrate how their work fit with the HAZ Principles as part of completing the monitoring forms. For the interventions within the voluntary/charitable sectors and more innovative partnerships, these Principles were a natural fit with the way they already worked. This meant that for a lot of them working with HAZ was more comfortable than working with other funders because they did not have to adapt their explanations of what they were doing to fit someone else's values or priorities.

The things HAZ wanted are the same things that we wanted ... there are times when we had to think carefully about how we fitted in ... maybe we didn't have to stretch it as far with HAZ. (Intervention, Charity/Voluntary, 11/2002).

[HAZ principles] closely fit the way we work. [Organisation] has its own values. The HAZ one about enhancing quality of life ... is a big one for us. It helps us think about outcomes for people. (Intervention, Charity/Voluntary, 11/2002).

It's not an idea HAZ have given us. It's a lovely coincidence. (Intervention, Charity/Voluntary, 01/2003).

Within the statutory sector, the HAZ approach was a new way of working. Used to working within hierarchical, money and time poor institutions, the opportunity to take risks and work closely with patients and communities was energising. This contrasts well with the discussions in Chapter 3 about the health damaging effects of working, and living, lower down in hierarchical structures. The intervention leads from the statutory sector were visibly buoyant and enthusiastic about working in the way that HAZ supported.

The monitoring is hard work, but it's OK. It prompts you to think in a certain way, it gives you chance to reflect. (Intervention, Local Authority, 10/2002).

I suppose the long term thing is not to get caught up in the funding and to look at the ethos. (Intervention, Health, 01/2003).

Possibly a bit more freedom and certainly a willingness to try it and test it [in HAZ], even things considered a bit off the wall. I don't see how the NHS is going to change because resources and money is so limited. They won't have money for something a bit whacky; they've got to be driven by Trust outcomes. (Intervention, Health, 01/2003).

For one Merseyside wide intervention engaging people from different sectors, HAZ provided a framework for understanding the ethos of the programme.

[HAZ] gave them a framework ... to understand [the project]. I suppose Healthy Cities could have been an umbrella, but that tends to be identified very closely with Liverpool ... it gave people an opportunity to see that there were things going on outside of Liverpool and that there was some extremely good practice ... Rather than Liverpool being seen as the hub of innovation. (Intervention, Health, 11/2002).

6.2.2 *Providing support*

Support is an important part of health and wellbeing, whether this is as an individual trying to make a change in lifestyle, a group trying to start something new, or within the work environment. MHAZ chose not to manage projects themselves but to facilitate and support others to do this. It is more sustainable and creates a greater base for change, both professionally and in terms of the project outcomes. It also places a great deal of trust in those delivering the programme locally and in the interventions. It is part of the inclusive approach promoted through Health For All and HAZ Principles.

The interventions themselves provided support to people through groups or through the nature of the programmes. This was either through the provision of inclusive services, such as those described in Boxes 6.2 and 6.3, or through programmes giving more direct psychological support.

Constructive counselling and support from the family support group, sharing their feelings – it takes away the isolation and helps to bring quality back into their life. They become more knowledgeable, [gives them the] ability to cope better. (Intervention, Charity/Voluntary, 11/2002).

It's a group mentoring scheme ... They've just relaxed with it, gained confidence, grown. They really have supported each other. (Intervention, Charity/Voluntary, 11/2002).

Similarly support is extremely beneficial for organisations and groups, especially in the community sector, reflecting the arguments for community networks above.

Community development is not just about boxes and ticks and bums on seats, it's about individuals who are striving and pushing and struggling all the time. You could do a lot worse than just have someone that they

can phone up to ask if it's OK if they did something, is it right to do this?
(Intervention, Partnership, 10/2002).

It's been important in acknowledging that there is that support framework that all projects depend on, and if they don't have it then they won't do as well. So it deserves time, money and attention of its own.
(Intervention, Health, 11/2002).

HAZ co-ordinators at both the regional and district levels offered support to the interventions in many different ways. One of the things that people in the interventions enjoyed about HAZ was how flexible the co-ordinators were prepared to be. They were supportive in allowing the interventions to be flexible with the money, with outcomes and with deadlines. This flexibility reduced the pressure on interventions and allowed them to be adaptable to their own circumstances.

HAZ has enabled us to play around and find the right way. (Intervention, Local Authority, 10/2002).

They are quite flexible [with the money]. If anything changes you can go back to them. (Intervention, Charity/Voluntary, 11/2002).

This perception was born out in some of the interventions who felt that there was less 'red tape' involved with the programme.

There is less red tape with HAZ. They are more open to trying to look at more qualitative outputs, as well as the actual numbers. (Intervention, Charity/Voluntary, 01/2003).

One of the things is the autonomy that came with it as well. It meant that we could provide something without going through red tape and without having to make a bid [for Trust funds]. (Intervention, Health, 01/2003).

In a similar way, MHAZ largely left the projects alone to get on with the work. In the same way that the regional MHAZ co-ordinators were grateful when the constant requests for information from the Central DoH team lessened, so the people in the interventions appreciated the freedom that MHAZ gave them.

Their policy of not interfering, or not appearing to interfere, is quite good. (Intervention, Charity/Voluntary, 10/2002).

We have been allowed to get on with it. We haven't felt pressured by HAZ. (Intervention, Health, 11/2002).

In a way you feel that HAZ at least trusts you to get on with the job. (Intervention, Charity/Voluntary, 01/2003).

The district co-ordinators were at the heart of this support mechanism, and they received a lot of praise for the way they worked with the interventions. They were often mentioned by name as being supportive, approachable and helpful. Particularly so in terms of help with the monitoring forms, but also more generally too.

We've had good contact with [district co-ordinator] as well. The support we've had off her has been fantastic. The passion she has for some of our projects is absolutely brilliant. (Intervention, Charity/Voluntary, 01/2003).

It was [district co-ordinator] who met up with me and guided me through the process, and has stayed in touch supportively since. (Intervention, Health, 01/2003).

I'd have to say that [district co-ordinator] been extremely supportive. She's been very supportive ... whenever I've needed help she's been at the end of a telephone. That's been really important. (Intervention, Partnership, 02/2003).

In one instance the district co-ordinator was invited onto the Steering Group of a project where the programme manager felt her Steering Group was creating barriers for her.

[District co-ordinator] has joined the Steering Group and has been very much involved in the project. She's been very active and supportive in the project. (Intervention, Charity/Voluntary, 10/2002).

In the last chapter it was explained how one of the district co-ordinators had a very unhappy time working with MHAZ. This stemmed largely from his working conditions. Similarly, I encountered one person who was hugely distressed at the lack of support she was receiving from an externally appointed management body. HAZ itself had been very helpful to her, but she needed the management team to help her with administration and the procurement of HAZ funding, which they were not doing. She commented that as an individual providing a service on her own time (and often with her own money), she needed good management support to help with funding, and so on. Without this she did not feel safe, and was rapidly succumbing to high levels of stress.

The New Labour target and change agenda create stress in the working lives of those on the receiving end of them. The lesson from the HAZ in Merseyside is that it is much more productive to work with people to deliver change by giving them some freedom and flexibility, and support when they need it. This approach helped the intervention leads build relationships with the co-ordinators, and their positive experiences of the programme meant that the intervention leads felt able to approach the co-ordinators for advice and further funding.

Can go back and ask for money for different pieces of work; can go back for developmental stuff. ... They are also willing to back you and take on

the case for you and with you as well. (Intervention, Charity/Voluntary, 11/2002).

There's lots of links there as well, there's lots of people ... It's like a network because there's always someone you can pull on for advice. That's made a difference. (Intervention, Health, 01/2003).

I think I might in future be tempted to get in touch with somebody like [district co-ordinator] and say 'can you point me in the right direction; can you give me any advice?'. So, it's relationships as well as money and equipment. (Intervention, Health, 01/2003).

What has been inspiring in my work with the HAZ is to have encountered so many people who were empowered and enthusiastic about their connections with MHAZ. Some of this is the result of congruence between personal and organisational values, but a lot of it was due to the support they received from MHAZ co-ordinators, and the added value of being connected with the HAZ.

6.2.3 Added value

The Merseyside HAZ offered a number of other services that also provided support to the interventions and helped to imbed the HAZ Principles. They provided training on how to fill out the monitoring forms, on how to conduct an internal evaluation of an intervention, they provided free access to publicity, and held whole systems events. All of these facets to the HAZ programme helped to make and reinforce relationships.

An often cited advantage of the HAZ has been the opportunities for learning new skills through the training MHAZ provided. By far the most appreciated form of training was the evaluation workshops. The sessions promoted a 'theories of change' approach to evaluation which emphasises evaluation as an opportunity to learn from

the processes of implementation, rather than just marking success against pre-established outputs. It also encourages a more flexible approach to data collection and presentation than numbers based evaluations. Recognising that human stories are hard to capture in numbers, people are encouraged to supplement numbers with photographs, video clips, drawings, poetry, and so forth. Through these workshops, MHAZ promoted the view that there were opportunities to learn from the doing of interventions, as well as from what they were able to achieve.

What was really valuable was the evaluation day we had. That was really good. ... [gave some ideas on] how to look at it in a different way. (Intervention, Local Authority, 10/2002).

I did the evaluation two days That was good because I thought it had to be written, but it doesn't – you can put your photographs in – which is good, especially for community groups. ... I've changed the way I send our evaluation forms in. I look at different things now ... (Intervention, Health, 01/2003).

One of the HAZ principles was to promote a Whole Systems approach to health improvement. Some of the most popular applications of this tactic were the whole systems events that HAZ staged, especially the Open Day at Aintree Racecourse in October 2001.

The Open Day brought people from over 200 interventions together. The morning session was reserved for networking between these organisations, and the afternoon was open to the public. A colleague and I, as MHAZ funded postgraduate students, had a stall at this event. The diversity of interventions was quite remarkable. Near us an intervention encouraged young men to listen to each other ... and experience being heard ... through group drumming sessions; this next to an intervention supporting people with mental illnesses back into employment. Also nearby were

PCTs with interventions ranging from supporting older people to encouraging healthy eating. The MHAZ encouraged the interventions to make connections with each other and to find the links between the work they were doing. This day helped me to get a feel for the depth and breadth of the interventions the MHAZ funded. It was a good opportunity to hear many different stories, and many of the issues discussed in this thesis were reinforced by those conversations.

There were other such events focussed on specific issues, for example: quality of life, older people, community involvement, health impact assessment, planning the Public Health Network. The training and these events were a useful opportunity for networking, and they also helped to raise awareness of the broad base for health improvement that the HAZ was supporting.

I thought that day was excellent, to go around and see all those things going on. And the breadth of stuff was fascinating. ... The opportunity to network with other people was a really good idea. Because you do pick up things for your own projects, and for your own clients. (Intervention, Local Authority, 10/2002).

Well, the Aintree day ... everybody was buzzing. There was so much to learn from each other; contacts that we made; things that we never knew were going on. (Intervention, Local Authority, 10/2002).

They've had quite of lot of workshops and events which enable us ... to get out and meet other people from other parts of Merseyside that are doing different things. It's always good really, it refreshes you and gives you new ideas. (Intervention, Charity/Voluntary, 01/2003).

The MHAZ also provided the interventions with free access to publicity. This was undoubtedly of mutual benefit as projects were obliged to acknowledge their relationships with HAZ. But the benefits were primarily in raising awareness of the

intervention. It also helped to promote connections with other organisations and opportunities for mutual support through the sharing of literature.

[Make connections with other organisations] through publicity ... and we swap information. ... I think [publicising successes] came through from HAZ. Because they talk about publicising what you do, what's good about what you do ... publicity was really important ... you're actually publicising good practice. (Intervention, Charity/Voluntary, 11/2002).

The HAZ in Merseyside was able to provide these additional opportunities to interventions because they were local to those interventions. For most of the projects their funders are at a distance and so are not aware of local circumstances and are not involved in local networks. Some of the people commented on the value of HAZ being local and part of the local networks. This was especially important in terms of the support that the HAZ co-ordinators were able to give to the projects, which was an often cited strength of the programme.

You've got [phone access] if you need it, and that comes down to it being ... funded at a local level by local people. They're actually, I feel, interested in the success of the project a little bit more than how much money you're spending. (Intervention, Charity/Voluntary, 10/2002).

Because we do work with social services and health, there's other people in the field that know about us. Health Action Zones are a part of all that as well. ... They're not asking for explanations all the time, which can be frustrating with other funders. (Intervention, Charity/Voluntary, 11/2002).

At least having somebody locally, and in [district co-ordinator] having somebody very locally who knows the borough, knows the local situation, she knew what she was talking about. ... talking about somebody who knew the area and had a good grasp of what we were trying to achieve.

... She was very, very supportive and positive in her help and that.
(Intervention, Partnership, 02/2003).

6.3 HAZ enabled

The money, support and added extras all combined to create an environment in which innovation, a focus on equity and addressing the wider determinants of health could be promoted through work on the ground. We have seen in Chapter 5 how one of the MHAZ districts chose to use HAZ money to fund an existing programme of work. There were two interventions from this district included in the semi-structured interviews. One of them derived a great deal of value from being part of the HAZ. This project was a partnership between health and social services and so was already looking to make wider links. The other intervention from this district was based in the health sector and HAZ money was used to expand an existing service. The women interviewed were passionate about their work in this last intervention, but they had very little involvement with the HAZ, and so it brought no added value.

It expanded a scheme that was actually there before. So, although we didn't create anything new with the HAZ money, it enabled more people to benefit from the scheme. (Intervention, Health, 10/2002).

In another interview, the intervention lead began by saying that HAZ was simply a funding stream, but after reflecting throughout the conversation ended by saying that HAZ had been 'great'. He had had HAZ money for a number of projects in his district, some in partnership with another district. It was obvious that the passion and vision for these innovative interventions came from this man himself. He clearly understood the health value of the work he was doing to improve the wellbeing of people in that district. He was also particularly adept at forming partnerships and

working collaboratively. The flexibility and support that came with the HAZ approach gave him more freedom to make these connections.

Because of the effectiveness of his work, he was invited onto the HAZ partnership in that district. This seemed to bemuse him in some ways, but was a further invaluable opportunity for him to make links with other agencies, and to promote his work in other areas of the council. For me this was a most remarkable interview. It was inspiring to see how passionate someone outside the health arena could be for improving the health of the people he worked with. I suspect his story reflects those of the bulk of the other people interviewed. I would think that for most of them HAZ was initially just a source of funding. Over time the HAZ approach seems to have left most of the people interviewed enthusiastic for HAZ programme.

Originally it was just a funding stream. What I have tried to do is to forge stronger links with HAZ. ... I've got a lot of support from them, and that has helped me to do my job better. (Intervention, Partnership, 10/2002).

The starting point for all these interventions was the money they received from HAZ. The manner of this funding was a great success. The fact that HAZ paid up front was a huge benefit to some of the smaller projects. It was amazing to me that different funding bodies would expect small organisations to cope with receiving funding in arrears. The argument being that the interventions had to prove that they needed the money before it was provided. Projects with the backing of large charitable organisations were able to manage this gap in resources, but it was an added stress to smaller organisations.

HAZ were also flexible with funding if an intervention had been unable to spend their money in the expected time frame. Other funding streams, like NRF, placed

limits on where and on whom the money could be spent. Again, HAZ had no such restrictions, and this was more conducive to delivering equitable services.

They fund up front, rather than in arrears, which is always a benefit for groups in delivering projects. (Intervention, Charity/Voluntary, 10/2002).

It's put in money and resources, I think, where it's needed and it's given people control. (Intervention, Local Authority, 10/2002).

It is [my vision] but it's allowed me to go to a pot of money that's not restrictive. If I'd gone to NRF with similar projects I would have been restricted to three wards, which wouldn't have worked for me. ... Every council talks about social inclusion and then they put these ward barriers everywhere. (Intervention, Local Authority, 11/2002).

HAZ funding brought multiple and different benefits to the projects in receipt of it. Reflecting the MHAZ aim of using HAZ funding as an opportunity to bring down additional money, there were several mechanisms through which the interventions were able to achieve this.

6.3.1 More money

Many interventions in the voluntary and charitable sectors are dependent upon multiple funding streams. Some of these require that matched funds be procured before they release their own money. MHAZ deliberately set out to match funds with the European URBAN programme at the Merseyside level, and the Pathways programmes at the district level. Other interventions have been able to match HAZ funds with other funding bodies.

The Lottery indicated that we would be eligible for Lottery funding provided that we had matched funding, and they suggested that it was HAZ. (Intervention, Charity/Voluntary, 03/2002).

We're really grateful to the HAZ because without HAZ we wouldn't have had enough matched funding to bring in the European money. We wouldn't be here, definitely not. (Intervention, Charity/Voluntary, 01/2003).

In one case, HAZ provided the money for the salary of a case worker which kept a programme alive in that district, and so enabled additional money for community based projects:

If it wasn't for HAZ we wouldn't be here in Liverpool now. ... As you know, in order to keep your project running, or in order to keep an idea going – something like this, you have to scratch and scrape wherever you can. Without that £20,000 from HAZ, which kept [person] job here, with that comes 120 grants. The HAZ money has actually brought in 120 x £1500 [grants into Liverpool]. (Intervention, Charity/Voluntary, 01/2003).

HAZ enabled statutory sector interventions to get further funding through generating evidence of success in their HAZ interventions, and through building relationships.

The utilities have a statutory obligation to spend a certain percentage of their money on energy efficiency measures, and now got the commitment that they will do it in deprived areas. ... If I've got a project put it to them to see if they will fund it. (Intervention, Local Authority, 11/2002).

The money I got initially through HAZ, £5000 and £8000, because that was successful put in bids to the Trusts, so now got other things –£33,000 for wheelchairs; £20,000 worth of chairs; £20,000 worth of toilet rails. Things that weren't there on a plate, but because I kept chasing around after them, I got them in the end. (Intervention, Health, 01/2003).

Two such interventions are described in Box 6.1 above. Another intervention also used HAZ money to purchase equipment that could be fitted immediately in a client's home. These were simple things like large button telephones, jar turners, and

tap turners. This improved the service the intervention was able to provide. Obviously the provision of this sort of equipment is of benefit to the clients and patients that the interventions worked with. But there was also an added value in the improvement in staff morale resulting from being able to do a job in the way that they wished to, and also in the attention they received.

The staff have enjoyed it as well. (Intervention, Local Authority, 10/2002).

When I got the money, I was able to go back to those wards and say 'when I did the checklist it showed that you haven't got this equipment'. Now I was able to say, 'here you are, you can have it'. Again we're talking about maybe £100 to £200 per pack, but just to be given something and for them to see this really is not saying something for the sake of it, but is actually following up with positive action. That was the start. (Intervention, Health, 01/2003).

6.3.2 Innovation

The HAZs were set up to be trailblazers and to take risks. The Merseyside HAZ funded many innovative projects, and created opportunities for others to be innovative. For example MHAZ added money for innovation to the government smoking cessation funding (Support), which was quite prescriptive in how the main funding could be spent. This enabled this service to be more creative in how it engaged people with smoking cessation: it funded the Fag Ends smoking cessation helpline; engaged pharmacists in providing smoking cessation advice in communities; formed an alliance with the Fire Service – they advertised the smoking cessation service on their fire engines, and the smoking cessation service put people in touch with the fire prevention service.

Another thing we did – we've worked with the Merseyside Fire Service. That's another link, that if I hadn't have done that HAZ day in Aintree, that I wouldn't have made. (Intervention, Health, 01/2003).

The Merseyside HAZ promoted the development of new ideas and created the space to test these out. A number of the interventions commented that they would not have been able to start without HAZ funding.

The work that I'm doing is unique ... I'm the only person in my post in the country. ... that investment, that trust, that faith that HAZ has given to that project has been well rewarded. (Intervention, Partnership, 10/2002).

Where HAZ money came in was in providing the money to establish the team. ... It wouldn't have happened without HAZ monies. I don't think 3 years ago - the commitment was there - but I don't think the funding was available at the time. HAZ monies have been very important in providing the means to make it happen. (Intervention, Partnership, 02/2005).

There were also cases of HAZ enabling existing interventions to continue. These were projects in the voluntary/charitable sector that were dependent on external sources of funding. The projects were making a big contribution to the wellbeing of the people they worked with, and in the end were saving the statutory sector money. New Labour want this sector to help in the delivery of services, but to do that they would have to be operating from a more secure funding base. One of these highly regarded interventions has now closed due to their inability to find continuation funding.

We wouldn't have got the [second lot of] Lottery funding otherwise. (Intervention, Charity/Voluntary, 03/2002).

The project wouldn't have carried on without HAZ money. (Intervention, Charity/Voluntary, 11/2002).

In some districts HAZ money was deliberately used to pump prime new initiatives. This was a valuable asset for the programme. It enabled people to try out new ideas, test out theories, or to just get things going.

Trying those theories out, seeing what worked, what didn't. Seeing how staff coped with working in a different way. ... It's sometimes difficult to implement change, people can be suspicious. Where it's a pilot scheme and people are seconded or volunteer, then there's a bit more commitment and they will try a different way of working. (Intervention, Local Authority, 10/2002).

What HAZ funding did, it enabled us to test out the theories. We have learned things along the way and have changed. We've refined the service. But the HAZ money was vital in establishing the project. (Intervention, Partnership, 02/2003).

This meant that it was acceptable for interventions to fail. From a HAZ perspective something could always be learned from the processes that an intervention went through, so there was no real failure. This freedom to take risks generated enthusiasm for HAZ amongst the people working this way. This contrasts sharply with the environment within the mainstream statutory sector, and the pressures put on the HAZ programmes nationally to demonstrate success.

And being able to say – well, it didn't work on this front, but it worked here, and that's the bit we'll go with – and it's being bold enough to say that. (Intervention, Local Authority, 10/2002).

The thing I like about it is that you don't need to say it's a wonderful project, because you don't know how it's going to turn out. (Intervention, Local Authority, 11/2002).

One thing with HAZ ... it's a big way into trying new ideas ... I think that has made a big difference. Because you can try things and say 'no this

didn't work, we'll try it a different way', or go back to the old way, or whatever. ... I think that makes a big difference, especially to the community groups. (Intervention, Health, 01/2003).

This support of pump priming and risk taking meant that HAZ funded schemes that the people working in them felt would not have been funded elsewhere. As a result of this, some of these schemes were able to demonstrate their value and have since influenced similar projects funded by other government initiatives.

I don't know where else I would have gone to get funding for a project like this ... I do feel that I am now in a stronger position to look for funding elsewhere to continue, because of the commitment that HAZ made. (Intervention, Charity/Voluntary, 10/2002).

[The Eco House] is the best project we've been involved with and you couldn't have got funding for it anywhere but HAZ. ... Because of that Eco House we've done down there, Sure Start are going to create the next Eco House, they've asked us to get involved in it. (Intervention, Local Authority, 11/2002).

It was about HAZ saying to each PCG here's £70,000, and we came up with little projects ... which was a good forerunner to neighbourhood renewal funds ... because we'd done some of that thinking about it differently, and looking at what would help develop the community rather than imposing services on them. (Intervention, Health, 01/2003).

MHAZ had created these opportunities for innovation, and it was felt that those opportunities might disappear without HAZ funding. People felt that the mainstream needed to have ring fenced monies to provide a forum for testing new ideas and for health improvement more generally.

To provide [cutting edge] services for those sorts of [clients], funding needs to come from some sort of government or statutory funding. I don't

think it should be left to Trusts. (Intervention, Charity/Voluntary, 11/2002).

6.4 Complaints

These glowing accounts of working with HAZ were not universal. They were the majority view, but there were one or two people who felt HAZ had either added nothing new, or who felt that the co-ordinators could have been more supportive. There were only a few people who had no complaints at all. Most of the grumbling was about the monitoring, the opportunities for mainstreaming successful interventions, and some felt MHAZ could have been more helpful in putting interventions together with the NHS.

6.4.1 Monitoring

The preceding chapter presented the frustrations of the MHAZ co-ordinators about the monitoring systems they were subjected too. The experiences of those working at the strategic level are reflected in the experiences of those working in the interventions. Similar concerns were raised: the information provided is not representative; it takes too much time; it is not clear what happens to the information. Just as the information the strategic workers provided was useful to those in the civil service, so the information provided by the interventions was useful to the co-ordinators. In both cases the forms were supplemented by site visits, events and close contact with the interventions. The frustration is understandable, however, if a person feels that their future funding is dependent upon how well their work is represented through the official documentation.

Monitoring is usually perceived as a burden, and this is especially true for small organisations with multiple funders. Some of the monitoring procedures are complicated and time consuming, and time is a precious commodity for most of these people. Just as the monitoring processes at the regional level took time away from working directly on developing the programme, so the monitoring and other bureaucracy imposed on interventions takes time away from delivering the service. Interventions might be delivered by a small group of people – perhaps only one person – and they may have multiple funders. All of these funders have monitoring requirements, and some of them are very time consuming.

[Funding from different streams] *is a big burden. It's not a good use of my time to be chasing funding.* (Intervention, Charity/Voluntary, 11/2002).

[Other funders are] *very much number driven, and they're very untrusting. For example, [for other funder] ... every quarter we have to produce payslips to prove still working on project. ... But we're European funded and subject to very strict audit.* (Intervention, Charity/Voluntary, 01/2003).

NRF was very difficult. It's a long process and you have to claim it back in arrears. So you've spent it, and then you have to send them stuff, and then they give it to you ... for community groups working on the very borderline; that could be very difficult. ... A lot of people don't have that spare capacity. (Intervention, Health, 01/2003).

Some people had little time to invest in filling out reports, and others wanted to be able to tell the story of their achievements and learning. The response to the HAZ monitoring is therefore diverse. The monitoring processes were also diverse. Each intervention had to fill out a form once every six months for the MHAZ Central Team. Three of the districts used these same forms, but the other two added their

own monitoring processes on top. The most negative response to the monitoring procedures came from one of these districts.

It is the most horrendous monitoring and evaluation I have ever been through. ... It's all higgledy-piggledy, and that's the only way to describe it. There's monthly forms, quarterly forms and then six-monthly forms. So, twice a year you are filling in a quarterly evaluation and a six-monthly evaluation at the same time. ... It's the time taken out to complete those that takes time out from actually delivering the project. (Intervention, Charity/Voluntary, 10/2002).

This is not to suggest that the projects felt they should not be monitored. Most people were pragmatic about the need to complete the forms, and some found the HAZ forms friendlier than those of other funders.

Monitoring is a pain sometimes. But then it's necessary. HAZ has been one of the more flexible about it. (Intervention, Charity/Voluntary, 11/2002).

I feel [monitoring forms] are a necessary evil. They're alright when you've done the first one, because you can cut and paste after that. ... Whether you could make them any simpler, I don't know. ... There must be things that come out of the fact that HAZ makes you focus on what you can learn from it and how you can share it. (Intervention, Health, 01/2003).

Despite the general concern about monitoring, there was praise for the HAZ system in that it allowed for reflection on the processes as well as assessing the outcomes. This fits with the HAZ ethos of learning: that projects can fail because there is always something valuable to be learned from the processes that they went through. People working in the interventions appreciated the opportunity to discuss these processes.

That's the thing I like about HAZ, they do have the tendency to think more long term. They do take on board the process and not just the outcomes. (Intervention, Partnership, 10/2002).

They are very supportive of the fact that it's hard to get people involved on a community level and that people will hang back. But on the other side, I think they do need the figures. (Intervention, Charity/Voluntary, 10/2002).

Often monitoring systems are very quantitative, and so do not provide space for the unquantifiable outcomes and nuances of an intervention. The HAZ monitoring endeavoured to provide this flexibility. For some it achieved this aim, and for others it did not.

What we're asked to report on are what are the outcomes more generally ... it makes you look at what comes out of it slightly differently, I think. (Intervention, Local Authority, 10/2002).

They don't look for any numbers, they're not number focused. (Intervention, Charity/Voluntary, 11/2002).

The monitoring forms are basically the boxes. ... The work I do doesn't usually [fit into boxes] ... because its not health orientated. ... That's why comments would have been better than a monitoring form. (Intervention, Local Authority, 11/2002).

Because HAZ approached health improvement using a social model of health, there was a broad range of projects that received HAZ funding. Some of the people in these projects had not been exposed to 'health' terminology before, and this was quite daunting. There was a crib sheet, and the co-ordinators provided training and support in filling the forms out, but this was still not enough.

They are very jargonistic as well ... they send guidance notes out to explain what the words are on the form ...went out to see [district co-

ordinator] *to go through the form ... when I came to look at it the next day I thought 'what did she say that meant'?* (Intervention, Charity/Voluntary, 10/2002).

I think the HAZ ones are fine once you get used to their different way of wording things. They all look a bit scary at first, they are always worded a bit differently. ... They sent a helpful form with it. (Intervention, Charity/Voluntary, 01/2003).

The discussions around mainstreaming brought out the debate of what constitutes evidence of success. These debates were reflected in the perceived value of the HAZ monitoring. Some people, mainly within the statutory sector, felt that there was insufficient 'hard evidence' on the forms to convince potential funders within the statutory sector of the intervention's worth. Others felt that there was insufficient room on the forms to be creative in representing the richness of the processes and outcomes of the interventions. Interestingly, both camps suggested that the interventions needed external evaluations to produce credible assessments of their value.

Without that hard evidence, it's really hard to convince the statutory agencies to pick up HAZ funding. (Intervention, Health, 01/2003).

I would prefer an A4 piece of paper where I can write outcomes/observations ... it doesn't need to fit in a box. ... We've got JMU doing an external evaluation. (Intervention, Local Authority, 11/2002).

There is a separation of requirements needed here. Just as one of the DoH civil servants argued that their requirements for HAZ High Level Statements were to obtain a feel for the success and processes involved. MHAZ used the monitoring forms to get a feel for what the interventions were doing. In both cases there were

other options for exploring the detail and managing the learning from what had been undertaken. This is why MHAZ promoted evaluation with the interventions. Bauld *et al* (2005) also found that the purpose and uses of monitoring needed to be clarified. There is still the problem of what constitutes credible evidence to support applications for mainstream funding. Traditionally it has been accepted that statistics are the only acceptable measure of success. However, politicians and the statutory sector are beginning to recognise the value of ‘a good story’ (Petticrew *et al*, 2004) and other qualitative measures.

We’ve been sending briefing up all the time about how important HAZs are and how much they contribute to the public health and inequalities agenda ... it’s been a learning process for [the ministers] as well, because we’ve had to say we can’t actually say how many lives have been saved but we can tell you about the variety of work and give examples. It’s taught them to look at things in a slightly different way. (Strategic, Health, 06/2002).

We’ve shared [qualitative evidence] with ministers. ... I don’t recall that they came back and said ‘what does this mean? How many lives have been saved?’, I think they have been realistic enough to have understood that these kind of public health programmes can take a long time to deliver results. And sometimes it’s a bit speculative, and that sometimes you can only estimate the contribution which a particular piece of work can make to improving someone’s health, and you can’t necessarily prove it. (Strategic, Health, 06/2002).

6.4.2 Mainstreaming

Although one of the advantages of HAZ has been its willingness to fund the unusual, and to pump prime interventions, this has raised issues in terms of mainstreaming those interventions that are successful. The presumption has been that the

mainstream statutory sector would continue supporting these projects, but the reality is that funding is tight in these organisations, especially following the NHS reorganisation.

I find it absolutely baffling that you seem to be able to get money to pilot a project and start something off, but once you've proved it's successful it's much harder. ... Why is there nothing in place to give that security to something that is so obviously in need, used and giving benefit? ... It isn't reinventing the wheel; it's just trying to keep the wheel going every 18 months to two years. (Intervention, Charity/Voluntary, 10/2002).

It's almost like temporary money to pump prime new ideas. Somebody's got to pick that up at the end of the day. That has to be statutory agencies, got to because it wouldn't be right to continue to fund it out of small pots or magic money. ... That's public health's role and community development's role to make sure that all the money doesn't go on tangible things. (Intervention, Health, 01/2003).

Some of the interventions in the charitable and voluntary sectors felt that HAZ could have done more to assist with mainstreaming by bringing the interventions together with potential funders, especially the health sector.

One of the things I think may have been good to focus on, I think could have been stronger, is for projects that have been set up by HAZ, to provide more ... links with health. (Intervention, Partnership, 10/2002).

That's what HAZ should be doing now, kite marking examples of good practice and marketing them to funders. ... They've got the political clout [to put projects and funders together]. (Intervention, Health, 11/2002).

6.4.3 HAZ could have promoted themselves more

There were two opposing views about whether or not HAZ promoted themselves enough. At the strategic level it was felt that it was not important whether people

had heard of HAZ itself, it was more important that they knew about the interventions and services funded through HAZ. It was more important that HAZ had touched people's lives. However, within the interventions it was felt that HAZ could have promoted themselves more for two reasons: to advertise that the funding was available:

I think sometimes they could promote themselves a bit more, because they don't push 'this is what we've done'. If you look in the Echo, every week there's something about the Liverpool Women's Hospital, but then you don't see what HAZ has achieved. ... Then people would know they're there, because some community groups don't know that they're there, what they're for and how to access them. (Intervention, Health, 01/2003).

Secondly to champion their own successes:

I've spoken to people about HAZ and they've said that if it wasn't for the work that the [intervention does] they wouldn't really respect anything the HAZ are doing. It's not that HAZ aren't supporting anything good, it's just that people don't know what it is that they're supporting. (Intervention, Partnership, 10/2002).

HAZ had originally aimed to be a commissioning service rather than a bidding service. This was never really clear, but certainly they did not want to encourage a free-for-all in terms of requests for funding. This is why, with the exception of the small grants schemes, the programme was not widely advertised. One person felt they spent too much time and money promoting themselves through events, sponsoring awards and glossy brochures. He felt their time would have been better spent in supporting projects to find mainstream funding.

Money's spent on promoting HAZ. Does HAZ need promotion?... Instead of organising all the promotions, and that, their time would be

better spent interviewing people and getting those projects mainstreamed.
(Intervention, Local Authority, 11/2002).

Taken in the broader view, the events and awards were part of the Making It Happen approach of spreading a philosophy, rather than promoting an organisation.

It's quite likely that if you stop somebody on the street in some of the more deprived communities in Merseyside that you will find somebody in their life has been touched by the Health Action Zone, even though they don't necessarily know that. (MHAZ co-ordination, 03/2003).

6.5 The Social Model of Health

The Health Action Zones aimed to improve health by, in part, addressing the underlying determinants of ill health. At the beginning of this chapter I gave an indication of the breadth of the interventions MHAZ funded. It was clear from my meetings with people working outside the health sector that they understood the links between the work they were doing and health improvement. The links they identified covered a broad range: recognising that people supported in their own homes live longer; links between employment and health; the way that social conditions limit lifestyle choices; the links between living conditions and health; the need to tackle problems in the round.

I've always felt that work is a key thing for people's health or ill health.
(Intervention, Local Authority, 10/2002).

One of our projects was a training programme for health workers showing how putting insulation in homes improves health. (Intervention, Local Authority, 11/2002).

We don't feel you can target any one issue on its own anymore.
(Intervention, Charity/Voluntary, 01/2003).

Just as the senior officers of the Health Authorities were enthusiastic about the role of their organisations in promoting health and wellbeing, the people from these interventions enjoyed being part of a wider model of health improvement.

I suppose it seems to me that HAZ has had a much wider breadth of funding. ... It's not so specific, which is good. ... We can't provide everything, nobody can. It's good to be able to refer people on to some where else, because it means they're getting out and meeting other people. ... I think that's what HAZ has been able to do – looking at the big picture – because things do dovetail in. (Intervention, Charity/Voluntary, 11/2002).

HAZ are basically – I hope and I feel and I dream – are co-ordinating an approach to overcoming [the underlying causes of ill health]. ... Don't want to lose free health for all. I certainly want to see HAZs and Health Authorities fighting for principles like that, because health is politics. It's as simple as that. (Intervention, Charity/Voluntary, 01/2003).

This broad approach to health improvement helped to forge links between different agencies.

We've trained district nurses, doctors, a whole range of people ... so that when they go and visit somebody they can refer back to me to go and do something about [insulation]. (Intervention, Local Authority, 11/2002).

Although this focus on the social model of health was appreciated there was some concern that it would not be maintained in the face of the medical model. For example the New Opportunities Fund (NOF), which funds Healthy Living Centres, introduced these initiatives very much from a social model perspective. As time has gone by, however, the NOF has retreated to the medical model. There was a sense that the same would happen when HAZ moved to the PCTs.

I think HAZ sees health in its widest form, that's why it will fund something as obscure as the things that I'm doing. ... Sometimes you even forget that HAZ is to do with health ... I think they've got their definition right. Holding onto it might be difficult – that's the sort of feeling I get. (Intervention, Charity/Voluntary, 10/2002).

PCTs are getting all the power and they'll deal with a medicine basis ... but that's not what HAZs are about to me. (Intervention, Local Authority, 11/2002).

However there remains a tension between the conflation of health with health services within the media and the wider public arena, and the goals of initiatives like HAZ. In a recent report on the BBC programme North West Tonight (25 January 2005), the Secretary of State for Health, John Reid, was being questioned by the programme anchor, Gordon Burns, about the inequalities in cancer survival rates between the North and South of England. Gordon Burns focussed on the 'post code lottery' of cancer treatments, and looked completely nonplussed when John Reid repeatedly explained that the major causes of the differences in cancer survival rates were the less affluent social conditions that people lived under in the North. Firstly, it is heartening to see the Secretary of State for Health make such a strong case for the social model of health. Secondly, it is disappointing that this is still not widely understood within the general media. This focus on health care means that the first priority of the NHS remains the provision of health services, which is frustrating for those working in the broader field of health improvement.

People have expectations of what the health service delivers and that's health care. Health improvement is not what Joe Public sees as the role of the health service. While we keep chipping away that that's what it's about, can't really take risks with that. I can see why the first line of call goes to things that are health services. (Intervention, Health, 01/2003).

There were both positive and negative unexpected consequences both of the interventions and of the changing political agenda. Some of the interventions recognised that their work would prevent ill health and reduce dependence on medicines, therefore saving the health services money. In some cases the clients of the interventions were so empowered by their experiences that they went on to develop self help groups.

In Sefton and St Helens there are people who attended the [intervention] courses who've set up self help groups for people with their conditions, and those self help groups are flourishing. (Intervention, Health, 11/2002).

Lots more young people got involved in school clubs because we know them and because of the trust in the relationship. (Intervention, Charity/Voluntary, 11/2002).

Two of the statutory sector interventions also reported benefits to the staff.

The reputation of [department] was that it was somewhere you went and were never seen again. ... But this has allowed us to promote this softer side. (Intervention, Local Authority, 10/2002).

That possibly was one of the unexpected benefits ... it raised awareness and made it possible for employees to admit to similar problems [difficulty hearing] without the fear of discrimination and repercussion on the job. (Intervention, Health, 01/2003).

However there was also a fear that government initiatives work in competition with the voluntary/charitable sector and so undermine their work. Even if the services provided were not in competition with each other, these government initiatives can pay higher salaries and that would make it difficult to retain staff. There is also a danger that if a project loses funding that the client group perceive this as a service

that has been withdrawn. This could create bad feeling towards the organisation that had been providing the service, and could be detrimental to the trust that might have been accrued through providing the service in the first place.

There's lots of initiatives coming out. There's lots of money in Sure Start, there's lots of money in government initiatives. If they were to duplicate services, it would have a big impact on us. ... They've got regular funding ... salaries are very, very good ... we couldn't compete in the voluntary sector. (Intervention, Charity/Voluntary, 11/2002).

It looks like something's been taken away from them; something they had. (Intervention, Local Authority, 10/2002).

For the ones that were planning over the seven years [of HAZ, the funding withdrawal] is a disaster. And the bad feeling that can result from that - nobody costs it or thinks about it. (Intervention, Health, 11/2002).

6.6 Conclusion

Flexibility with money and reporting, support from co-ordinators and the wider HAZ programme, and the trust that the HAZ approach engendered, all contributed to a groundswell of enthusiasm for MHAZ. There were, naturally, things that the people working in the interventions felt HAZ could have done better. But really they were asking for more of the same: more connections; more support; more flexibility. Clearly these are important opportunities for enhancing the work experience of people on the frontline.

The real benefits to people on the ground – that is the people of Merseyside – have been delivered by the people working in these interventions, often working extremely hard with few material and temporal resources. The experience of feeling

part of a greater whole as been extraordinarily empowering for some of them, especially when their work is seen to be a success.

It's nice to see the benefits [of funding community projects]. That's why it's hard when it goes into prescribing budgets and hospital overspend, because you just don't see anything for it. (Intervention, Health, 01/2003).

That was a huge achievement for me personally. And also the fact that the outcome was so positive and very, very visible as well. (Intervention, Health, 01/2003).

It is a very rewarding job. It attracts a lot of positive publicity; it brings its own paybacks. (Intervention, Partnership, 02/2003).

The MHAZ has provided a framework for these interventions to get together. It has provided added value through the training it provided and the events it hosted. This seems to have fostered a sense of being part of a larger approach to health improvement. It remains to be seen whether such a co-ordinated approach will be fostered by any other regional organisation, such as the Public Health Network. It would seem to be an asset for these interventions. One of the DoH civil servants commented that

I don't think HAZs are there to advertise themselves to the public in general. They're there to make sure that the bureaucracies that are serving those people are working properly. (Strategic, Health, 06/2002).

In Merseyside there appears to be a layer between the general public and the bureaucracies, and that is the intervention layer. It has been enormously successful to engage these interventions from both the statutory and charitable/voluntary sectors. People have enjoyed that sense of joined-up working, and that is a key component of the New Labour agenda for tackling inequalities and promoting social

justice. People in the statutory sector have become more adept at obtaining external funding for services they wish to provide. New Labour want the charitable/voluntary sector to become more involved in the delivery of services. As one person working in this sector observed, they can be seen as the cheaper option. However, their efficiency is marked by constant funding insecurities and the heavy bureaucracy needed to seek funding and satisfy the requirements of their multiple funders.

This layer would benefit from more stability and security. The fast pace of change within the health sector takes time and money away from being innovative. The charitable/voluntary sectors need a better system of funding to feel safe.

Chapter 7

Delivering change: the people factor

The important thing is people. Any process that you set up is giving people opportunities to take risks, to have new ideas, find new solutions and put things into practice. What we've really done is invested in individuals, and encouraged them to work together in groups and in partnerships in order to do that. And you can't wipe that out. Once it's there, it's there. So that, hopefully, people who have been exposed to that ... it'll be of some benefit. (MHAZ co-ordination, 03/2003).

Health Action Zones were expected to be innovative. Powell and Moon (2001) have argued that they were intended to be test beds to inform future policy decisions. It has already been shown how the learning from HAZ has been fed into the policy decision making processes; not necessarily to the benefit of those working in the HAZs. Although decisions to support the NHS through various funding crises, the HAZ funding cuts and changes and the pressure for a quick start up all restricted the MHAZ opportunity for innovation, there were examples of creativity and innovation in both the projects funded at a regional level and in the 'Making It Happen' approach. The districts chose to innovate to different degrees and in different ways. The findings presented in Chapter 6 demonstrated how valuable it has been to people working in interventions to have that freedom to take chances. MHAZ has funded the 'whacky', the different and given opportunities to clinical staff that they would not otherwise have had. MHAZ co-ordinators have supported people throughout these opportunities, and this has generated a great deal of enthusiasm for the HAZ and for the approach it has taken.

Often change is talked about in the abstract: we create change, we implement change, and so on. What is very apparent from these findings is the importance of people in those processes. People are not simply neutral cogs in the wheel of change; they are the mechanism through which change occurs. People have different capacities for change, and different approaches to change management work with those capacities in different ways.

The story of the Merseyside HAZ demonstrates how people can come together under circumstances conducive to collaboration, but that those associations can be broken when circumstances change. The HAZ started at the beginning of the New Labour government, when much needed to be done to raise awareness about health inequalities and there was a need to be seen to be doing something quickly. HAZs contributed to the growing recognition of the need to tackle health inequalities and the value of cross sector working in doing that. The HAZ in Merseyside has been particularly successful in facilitating the engagement of a broad base of organisations in the task of improving the health of the people of Merseyside. There is now a network of people who have been exposed to the HAZ approach and who now choose to work in a similar way.

This chapter will explore some of the lessons that have been learned across all parts of the MHAZ: from the policy makers in the DoH, through the strategic managers and co-ordinators, and out to the interventions. These lessons centre on innovation, collaboration, change processes, ways of working and the people themselves.

7.1 HAZ Way of Working

The previous chapters have described the approach that Merseyside HAZ has adopted. This has the HAZ Principles at its core and so much of it is common to all

HAZs and the DoH HAZ team. It is commonly referred to as the ‘HAZ way of working’. In a stakeholder meeting for the local evaluation of MHAZ, participants were asked to picture this approach, and many drew the analogy of a spider’s web. In the feedback, the following elements to this way of working were identified (Springett *et al*, unpublished, p.38):

- ✓ Flexibility
- ✓ Non-hierarchical
- ✓ Breaking down barriers
- ✓ Non-judgemental
- ✓ Cross boundary working
- ✓ Communication, networking, linking together. Connecting on different levels – individual, organisations, geographically.
- ✓ Partnership – bringing together people who would not normally talk to each other
- ✓ Nurturing
- ✓ Growing and evolving
- ✓ Emphasis on the individual rather than on job roles they perform
- ✓ Community ownership of own health care.

In a follow up questionnaire, “Making connections e.g. networking”, “Partnership working”, “Widening the view of health”, “Cross boundary working”, and “Breaking down barriers” were identified as the characteristics which most clearly defined the ‘HAZ Way of Working’ (op. cit.). Many of these elements have also been identified through this research. Overall, these findings would characterise the MHAZ style as supportive, flexible, adaptable, flat, trusting and with a focus on learning. This ‘HAZ way of working’ has often been referred to as a positive thing. Working in this way, building networks of trust, has been hugely energising and empowering.

It has demonstrated that there is a way of working; that you have to get people who are committed and signed up to it. And if you get that, you

get the energy; you can release a tremendous amount of energy. I think you can demonstrate that throughout the five partnerships. (Strategic, Local Authority, 11/2002).

It's getting [people] to think 'I'll talk to them over there'. It's getting people to think outside the box. (MHAZ co-ordination, 10/2002).

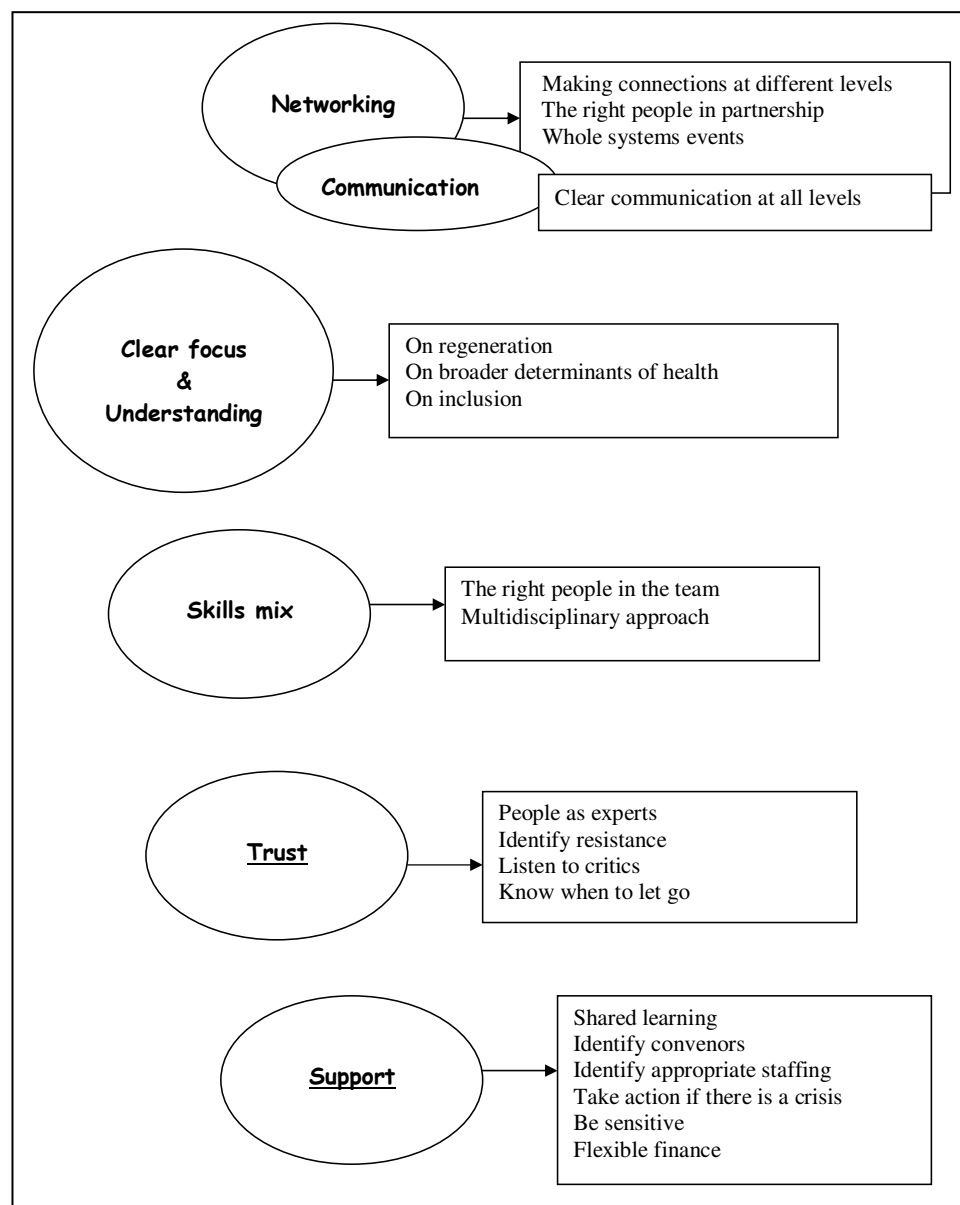
Working with a whole different range of people and overcoming the barriers, because, whilst you might have been working across those sort of barriers before and you would overcome them on a personal level ... on such a scale, we had not overcome those sort of barriers before. That was extremely positive. And very much putting more resource behind doing things properly. (Strategic, Health, 11/2002).

HAZ comes up with new ways of working that will improve the health of the people that is not the standard - normal - way. (Intervention, Local Authority, 11/2002).

Springett and colleagues have developed a model for this approach in conjunction with the core MHAZ team (see Box 7.1). Some of these elements have been discussed in the earlier chapters, especially the value of support and the trust that it engenders at all levels of the organisation. One of the people I interviewed commented that resentment towards policies and initiatives arises when the people delivering them fail to recognise the emotional impact that they have on the people at the receiving end.

The disaffection was to do with the lack of engagement with the emotional impact of what we do. (Intervention, Health, 11/2002).

There has been evidence of this from the way the central government changes affected the HAZ delivery teams, and the disaffection of the two district co-ordinators working in environments where they felt unsupported.



Box 7.1 'HAZ Way of Working' defined by the core MHAZ team (Source: Springett *et al*, unpublished, p.39)

This chapter will look more closely at the human side of the Merseyside HAZ: the energy released through giving people the chance to try something new; the things people gain from being connected; the enthusiasm for being able to work differently; the opportunities this has afforded; and lastly the importance of having the right people involved.

7.2 Innovation and risk

PCTs were created in order to bring the decision making about primary care services closer to the communities they serve. The reorganisation created an immense amount of change in the system, and a great movement of people within and between districts. The requirement to collaborate through Health Improvement and Modernisation Plans, Community Plans and LSPs ostensibly mirrored the HAZ work across agencies. Even though the introduction of PCTs led to the collapse of the regional focus for the MHAZ, one member of the Steering Group felt that it had enhanced local partnerships:

In some ways its kind of the creation of PCTs and this sort of organisational change has been a step back, I think, for the Merseyside wide partnership working. But it's also strengthened local partnerships.
(Strategic, Health, 12/2002).

The sort of transformational change intended through the *StBoP* policy takes careful management if it is to be effective (Handy, 1993; Upton and Brooks, 1995). Macintosh and MacLean (1999) recommend three stages: visioning the new structure using the principles of learning organisations; introduction of chaos to break down existing systems; feedback to ensure that the new structures are maintained.

There are elements of this approach within the interplay of the Merseyside HAZ and the setting up of PCTs. The HAZ was firmly founded on the principles of a learning organisation. Learning organisations recognise the value in individuals as well as systems, and try to create organisations that are flexible, innovative, and tolerant of mistakes and generate openness and trust (Lines and Ricketts, 1994). This meant that some of the people working within the new PCTs had been exposed to this way of working. The reorganisation introduced chaos,

[StBoP] has introduced a bit of instability into the system, which means you can get change in there as well, doesn't it? People are more open to new ideas, thinking things through, rather than 'we did that x years ago: it didn't work then, it won't work now'. You get far less of that kind of suspicion. (Strategic, Health, 12/2002).

Where the new structures included people who had had exposure to the HAZ, this could generate and reinforce a more innovative approach.

Speaking of my own PCT, the energy, drive and commitment to doing things differently is immense. That's not necessarily the same for every PCT. ... If funds are devolved locally, this PCT will be doing its damnest to use that money to change how things are done. But then maybe I've got the HAZ background and maybe that helps. (Strategic, Health, 12/2002).

However, there are a limited number of people with HAZ experience, and the concern is that the pressures being exerted on the PCTs centrally will force them back to focussing on clinical outcomes.

There's tremendous financial pressure in the health system at the moment. ... So there will be a temptation to make the books balance and meet the targets. (Strategic, Health, 12/2002).

If your director of finance says you're not having any new projects, pick up HAZ projects already started with the new HAZ money, then that's not allowing you to take any risks, is it? (Intervention, Health, 01/2003).

If Health Authorities had still been there, we would have been able to push this a lot faster, but because we've had this reorganisation in the middle of it there's a danger that we slip backwards. (MHAZ co-ordination, 03/2003).

The key factor in the success of the PCTs to move towards a more innovative approach is the people that are involved. Innovation is dependent upon the willingness of key individuals to take risks.

It's not a sectoral difference, but individual differences in the comfort of delivery [of the training]. It depends on the willingness of individuals to take risks. (Intervention, Health, 11/2002).

I think PCTs are generally more innovative organisations [than HAs], because they're new and they've got lots of excitable people in them. ... Because you've got new relationships forming ... Because you're part of the same organisation, which weren't previously ... That makes life an awful lot easier. (Strategic, Health, 12/2002).

But again, some of that comes down to people, and there are those people who will stick their neck out and take risks, and enjoy doing that. And other people who will sit back and wait for other people to do it, or will feel threatened by that and will want to go into a huddle and go back to what they feel comfortable with. (MHAZ co-ordination, 03/2003).

These risk takers need to be supported. Catford (1998) has made similar arguments in relation to the work of social entrepreneurs. For these people to effect lasting change in their communities, they need to work in supportive environments. Support has been an important part of the HAZ approach, and it has been well received. It enables people to release their latent talent and desire to work differently.

I've found at ground level there's an awful lot of staff who are passionate about providing a better service for their patients. And they are very keen if they find somebody ... who can assist them in doing that. Definitely the driving force is from the bottom up. The culture needs to encourage people like that. (Intervention, Health, 01/2003).

The Merseyside HAZ has been good at supporting innovation.

What the HAZ has been good at is engaging a far wider range of partners and supporting innovation. (Strategic, Health, 12/2002).

[HAZ has] definitely made a difference to how people work and it's allowed you to be innovative. (Intervention, Health, 01/2003).

The lesson from HAZ to statutory agencies is to take a chance:

I think it's quite interesting to see how when you take some risks that actually, even in a risk taking situation, they come up more times than they fail. I think statutory agencies can learn from that. If you take a risk, it doesn't usually go wrong really, and perhaps stop them from being quite so cautious. (Intervention, Partnership, 10/2002).

Not doing something is more likely to fail, than doing something ... You're not going to make changes and move on unless you have a substantial number of risk takers. (MHAZ co-ordination, 03/2003).

For central government the message is that to generate radical systemic change takes careful planning, supportive environments and time. The constant pressures from central government, in terms of rapid changes and lack of funds, have the potential to undermine the innovative structures they have been courageous enough to introduce.

7.3 Collaboration

One of the cornerstones of the HAZ initiative was to facilitate a whole systems approach to service improvement and tackling health inequalities, focussed on a partnership between Health and Local Authorities. As we have seen these are also key components of the Health For All approach and the principles of global health promotion as set out in the Ottawa Charter. The Merseyside HAZ invested money in Making It Happen, to help build networks of interest around the HAZ principles. There were five partnerships managing the HAZ programme in six districts of action. Beyond this, many links and relationships were developed through formal and

informal opportunities to get people together. Although some of the interventions felt that HAZ could have done more to join projects with each other and with potential funders, mainly people appreciated the connections they were able to make through working with the HAZ.

The rest of this section looks at the many different ways HAZ facilitated people coming together. These connections should prove a lasting legacy of the HAZ. I certainly observed a great deal of enthusiasm for working in this way.

People have made relationships and enjoy working with other people. That's one of the things that people say about HAZ is that they actually enjoy their involvement, and they're not going to let that bit go. (MHAZ co-ordination, 03/2003).

7.3.1 Multi Agency Working

HAZ facilitated a broad range of partners, which is conducive with whole systems working and improving health through addressing the wider determinants.

Developing links that I might not have had, had it not been for the fact that it was HAZ funded. That's thrown open a few more doors. (Intervention, Local Authority, 10/2002).

I think HAZ is great. It has allowed me to do a lot of work that I couldn't have and it's opened my eyes to a lot of areas that I wouldn't have otherwise gone down. (Intervention, Local Authority, 11/2002).

Communities are partners too.

In essence, what it's about is the ethos of engaging communities; engaging ourselves as part of that community and working together in a partnership. That's the important thing that's come out of here. No matter what is said, that's come out and it's really good. (Strategic, Local Authority, 01/2003).

HAZ helped to bring different agencies together. It is not solely responsible for changing the way organisations work together, but it had an influence and helped to get health on the broader agenda.

[HAZ] has got people together in public disciplines – particularly the police and the fire service. Whenever they're doing an area they phone me up and say 'are you doing anything over there because we've got a pot of money to spend?' ... People are working together now. (Intervention, Local Authority, 11/2002).

If I think back to before HAZ ... I [in health sector] wouldn't have known anybody in the Local Authority in [another district] – now I do. (Strategic, Health, 12/2002).

[HAZ] has been different, it been able to join it up in a different way. ... This has made a difference to people's health,; people actually talk about this. (Strategic, Local Authority, 01/2003).

MHAZ has proven that “*multi-agency partners can work together on health*”. There was commitment from both the health sector and the Local Authorities to make this happen. Some expressed a fear that this commitment might be lost without the Merseyside focus of the HAZ. However, one member of the Steering Group has observed a real commitment for the two sectors to continue to work together through the local LSP. There is evidence to suggest that this focus on health improvement should also persist in most of the other MHAZ districts.

The last six to eight months has seen a tremendous improvement in the health agenda being on the agenda of the other partners [in the LSP]. ... The Chief Executive of the City Council has put health right up the agenda. (Strategic, Health, 12/2002).

The interventions provided an opportunity to bring people together from many different agencies, some in quite innovative ways. For instance, one intervention to address fuel poverty amongst the elderly raised awareness through hairdressers.

The hairdressers have been the best. They get their pack and they go away – we give them a load of leaflets – and they put them in the hairdressers. And then while they're talking to somebody, get them to refer them ... so they've been the most productive sector. (Intervention, Local Authority, 11/2002).

7.3.2 Working collectively

People have enjoyed working collectively. MHAZ provided opportunities for people to get together and share tasks. This not only helps to reduce costs, but in one instance enabled a consistent message to be promoted across Merseyside.

Because there are four [intervention] co-ordinators on Merseyside, we have Merseyside meetings. ... Because we're all HAZ funded, instead of just one of us doing a campaign, we will do it between the four of us. To keep the costs down, but you're reaching that broad audience. ... We all have the same book, same basic leaflets, because we've designed them between us. It's just worked better that way, because it just brings it all together, and everyone has been trained exactly the same, which makes a difference. (Intervention, Health, 01/2003).

Working collectively also enables the sharing of learning and experience:

Being involved with people who were actually developing a service, and finding that through collaborating with each other they were learning a lot from each other. And they also could see the benefits of pooling things. ... That has made a big difference, I think. (Strategic, Health, 12/2002).

Partnership working not only facilitates a joined-up approach to solving problems, but can also provide the means for raising awareness of certain issues. One of the interventions found that working in partnership promoted their approach to service delivery within the statutory sector:

Everything we do is in partnership with somebody. We don't do stuff on our own because that means we become a service provider. We are providing a service ... but if we'd done it on our own ... we wouldn't see us having any effect on the local systems ... we promote a strategic approach to it as well. (Intervention, Charity/Voluntary, 11/2002).

Another intervention contact had been invited on to the local health partnership. This allowed him to raise issues within other areas of the council, and resulted in a more joined-up approach to fuel poverty.

It has introduced me to people who have assisted me. ... Fuel poverty has got into a lot more places than it wouldn't have done, because it was just seen as part of poverty, but it's totally different. ... [Being on the health partnership] has got me to know a lot more people in influential places. ... It works for everyone really. Because everybody's talking now, [fuel poverty is] getting involved in all the strategies. (Intervention, Local Authority, 11/2002).

Collaboration can be very difficult when there is a mismatch of values and/or people are constrained by circumstances in their own organisations. The emphasis on targets and different financial systems can create barriers to co-operation. This was recognised, but it was felt these could be overcome by allowing different organisations to implement agreements in the way that is most appropriate to those organisations.

There's still a separation of goals. You've got to be able to demonstrate how the goals come together, and that's got to be done from the top. I

was impressed by ... the Chief Executive of Liverpool City Council, started to do that work by ... getting [the various agencies] to come together, and look at in an informal setting – which is what HAZ had done – ... what their various problems were, and to recognise just how similar their problems were, and how by working together they could actually overcome the problems more effectively. (Strategic, Health, 11/2002).

Everybody understands that the two main bodies [Local Authorities and the NHS] do work in different ways, but people agree on a way forward and then sort it out in their own organisations. (Strategic, Health, 12/2002).

7.3.3 Making links

MHAZ helped to bring people together through formal and informal opportunities. The co-ordinators at both the regional and district levels would connect people they thought could learn from each other. This created self sustaining networks of people. These relationships were sometimes made, and renewed through the events that people were able to attend through the HAZ: training, network meetings, whole systems events. Often the most productive connections were made in informal settings; over coffee or at lunch. One of the intervention leads managing a network said she scheduled long coffee and lunch breaks to facilitate this. People can feel very isolated working in their own projects; having someone to call for advice helped people to feel connected to something larger.

I think that's probably the most important thing ... that we all work in isolation, don't we? We're all doing our own little bits of things, and somehow nobody pulls all of that together. But [the Open Day] has done this, and given you that sort of link. (Intervention, Local Authority, 10/2002).

The event that they ran at Aintree Racecourse promoting older people's welfare in general, I found that very interesting, very worthwhile. I made some good contacts there. ... The fact that they do organise these events ... it is good to be able to make those contacts ... I value that when somebody co-ordinates those events. ... Meet people at other settings as well, so it's been the beginning of relationships. (Intervention, Partnership, 02/2003).

However, some of the interventions felt that HAZ could have done more to bring projects with similar aims together. One such project supported older people in their own homes, and was based in the district that had chosen not to take on HAZ values explicitly. MHAZ had been recognised externally (through an award) for the work they did around older people, including two whole systems events. The last quote above shows how valuable another project supporting older people had found this work. It is surprising that the people from this intervention were not included in that, because they would have valued being able to make such connections across Merseyside.

My only criticism is that I would have liked to have seen a bit more ... feedback on who else is out there, and what they're doing. (Intervention, Local Authority, 10/2002).

One person who was particularly effective at networking, felt that the events MHAZ hosted had diminishing returns in terms of networking. She felt that same people went to these events and it would have been beneficial if new people had been included.

At the beginning the networking potential was really useful ... it has a kind of diminishing returns, because I'm seeing the same people all the time when I'm going to different HAZ events. ... Not opportunities to make new links, great opportunities to catch up ... I don't really know that many more HAZ projects. I think that's a shame, I think that's

what's been missed. A lot of the people who go to the HAZ events are the strategic people ... and I don't get to meet people who are doing HAZ projects, which I'd like to do. ... The stuff done at Aintree was good, but I am one person, I can't man the stall and go and network with people. (Intervention, Partnership, 10/2002).

7.4 Doing differently

The 'HAZ Way of Working' created a structure on which to build networks and programmes of work. It is facilitated by having a strong focus on values – as defined by the HAZ principles – at the core of all the HAZ work. There was evidence that this values based approach is starting to influence work in the mainstream organisations. Individuals commented that it had changed the way they thought, and that they would work differently from now on.

7.4.1 Working differently

HAZ has enabled many people to work differently. The DoH civil servants have been given the opportunity to work in a new way:

There's nothing worse than just sitting there sort of working at some dull policy and working on statistics. Dealing with real lives is much more satisfying. (Strategic, Health, 06/2002).

Although I'm used to developing policy with people who are working in the NHS, this I suppose has felt much more dynamic and exciting than other areas sometimes feel. (Strategic, Health, 06/2002).

Even though the HAZ Principles may be similar to the values and ways of working within the voluntary and charitable sectors, the way in which the co-ordinators worked has been enabling. Within the statutory sector, HAZ has provided opportunities to work differently.

I do think people feel quite inspired ... I think people feel quite inspired by some of our events – put on a bit of theatre or something. I think doing things differently; getting people thinking about issues. (MHAZ co-ordination, 10/2002).

That would be something that is a legacy of HAZ: the projects that HAZ funded have done it. People have had real experience of doing it this way, of using this approach, these ways of working, applying these principles ... and its been running long enough – just – that they've seen what can happen as a result. And that is a really powerful thing. (Intervention, Health, 11/2002).

I suppose the other thing is ... the permission to do things a bit differently ... If you can't create the sort of environment where its exciting, people are learning, and all the rest of it, then you've got set ways of dealing with things ... this gets you out of that a bit. (Strategic, Health, 12/2002).

The flexibility that HAZ brought enabled people to address problems differently. For example, the relationships that one intervention contact developed through working with the HAZ gave him access to statistics he would not otherwise have had available to him. These statistics enabled him to target the most deprived homes, which were not necessarily in the most deprived wards. Some of the other government initiatives target particular wards, and these are the same wards that receive projects and programmes all the time. Poverty, though, is more widespread than this, and this approach enabled this person to target those who would benefit most from the services this intervention provided.

HAZ for me is different from most, not all, other funding streams insofar as its borough wide, and I can concentrate on a particular area if necessary. ... [Other funding streams] are in the most deprived wards. There are other pockets of deprivation in more affluent wards that don't see anything. There's wards in between the two who will never get

anything from anywhere. ... HAZ allowed me to access statistics that I couldn't previously access. So, I will use house conditions and respiratory problems in children, and match the two together [for example]. ... It's allowed me to develop schemes on the back of that. (Intervention, Local Authority, 11/2002).

7.4.2 *It's changed the way I think*

This exposure to a different approach has altered the way that people think and choose to work. Although people might not always have the opportunity to work like this, it is something that they will always carry with them. One intervention contact commented:

For some of those [people running the intervention courses], gaining the skills to work in a very different way is something they'll carry with them. They might not always have the opportunity to work in that way, but they have the ability now, and they have the understanding of what you get out of it. (Intervention, Health, 11/2002).

This opportunity to work differently within HAZ has equally affected people in all parts of the organisational web. Both DoH civil servants talked about how good it has been to be able to work in an inclusive way, and one said it has had a lasting impact on the way she will think in the future.

It's been a really interesting area to work in. ... I've been incredibly impressed by a lot of things that I've seen, but I think it's also helped me to think of different ways of working as well. Probably better now at engaging a wider number of people in my thinking than I was in the past. So I think that's been good. (Strategic, Health, 06/2002).

This was reflected in the experiences of those working in the strategic development of MHAZ.

I've certainly shifted the way that I do things over that time ... (Strategic, Health, 12/2002).

HAZ is different – I've used my regeneration money to do it in a HAZ way, even though I didn't have HAZ money to do it. (Strategic, Local Authority, 01/2003).

And people working in the interventions:

I think the lessons that people have learned [from HAZ] have stood them in good stead for Local Strategic Partnerships, etc., because it got you thinking differently. (Intervention, Health, 01/2003).

So many people I speak to say 'we've tried that and nothing happens', I say be inventive, be pro-active and look for resources. ... Two to three years ago I wouldn't have dreamt of doing that. Now I think if they're telling us to do that, they should provide the resources. And there's no harm [in asking], we've got nothing to lose. The worse thing they can do is say no. (Intervention, Health, 01/2003).

7.4.3 Making a difference

Appleby and Jobanputra (2004) suggest that little is known about what motivates health care providers. The findings from this research suggest that they are motivated by the same thing that motivated the other public sector and voluntary/charitable sector workers included here. The chance to make a difference to the lives of the people they serve. As I recorded in my notes:

It doesn't matter what you do, it's what you're able to contribute and get from it that can really lift you. And that's really a lot of what I've seen with the people I've spoken to from HAZ. (Research notes, 09/2003).

The opportunity to see real results on the ground generated a great deal of enthusiasm.

I think people have got quite a lot of enthusiasm for the projects that they fund, and they can see it making a difference on that level, and that's where it does need to make a difference, on the level of people's lives. (MHAZ co-ordination, 10/2002).

For me it was just wonderful ... there we were offering something that was real. (Intervention, Local Authority, 10/2002).

That's the level [seeing the difference it has made to people] at which you learn to gain your satisfaction ... [It enables] you to go on dealing with the bureaucracy and rug pulling, and all of that. (Intervention, Health, 11/2002).

7.5 Change

7.5.1 Change Context

HAZs existed in a context of enormous change. It has already been shown how that affected the delivery of the programme. The achievements of MHAZ are all the more remarkable for having happened in spite of the changing circumstances within which they were operating. The HAZ at the regional level used itself as a buffer in order to allow the district programmes to continue as near to expectations as possible. These external changes, though, were also complementary to the goals of HAZ. Community involvement has been stressed for the partner agencies.

I think we've achieved [the mainstreaming of HAZ Principles] to a greater extent than a lesser extent. ... and at a time of tremendous change. (Strategic, Local Authority, 11/2002).

At least now there's a thread of change and innovation running through the health service. For 18 years of Tory rule there wasn't ... it was just do less of the same. ... If anything it's just too fast. There's a heavy layer of targets. ... Yes, it's a huge fast paced change agenda. (Intervention, Health, 01/2003).

That's a government thing. Every four years they say 'what can we do to re-organise and show value for money'. If they let things work, it would make a difference. (Intervention, Health, 01/2003).

For me it was like a godsend, really. ... a lot of other [government policy] had happened at the same time ... so it all just came at once ... and this just underpinned everything as well. It all of a sudden seemed to be working. (Intervention, Local Authority, 10/2002).

The New Labour push for rapid change within the public sector and the health sector particularly, does not take into consideration that change needs time to bed in; that people need time to adapt to new systems. Often it was said that change takes between one and two years to be fully effective. The rapid pace of change costs money, disrupts networks and risks undermining the drive for innovation at the core of these new organisations. In learning systems people need time for reflection so that they may learn from their efforts to date. The rapid pace of change and bureaucratic demands makes this much more difficult.

It took me a good couple of years to feel comfortable with those things. (MHAZ co-ordination, 10/2002).

It takes a while for it to sink in, to build up contacts. (Intervention, Local Authority, 10/2002).

Work around supporting or changing attitudes is a long term process. (Intervention, Partnership, 10/2002).

It takes six months to a year [to settle down after a change]. You become very cynical because every time there's a change, there are tremendous costs: new notice boards, new paperwork ... nothing actually changes where we are and what we do ... Please, please stop changing. (Intervention, Health, 10/2002).

It can take three years to get a point where you can start to [influence and change things]. (Intervention, Charity/Voluntary, 10/2002).

It takes so long to set things up that you've lost two years before you've more or less got going. (Intervention, Charity/Voluntary, 11/2002).

7.5.2 Change in the system

The Merseyside HAZ set out to change the way the statutory sector organisations thought about health and to encourage them to work for health improvement. This whole system change is very complex. There are many different factors that need to be taken into consideration: the different cultures of the organisations; their responsibilities; their accountabilities; where the power lies.

One of the things we've had to do with HAZ is to do things that meet the needs of very different individuals, very different sectors, and different organisations. So that we have got tangible products – things that people can take hold of and say, “yes, this has happened in my community” or “this has happened in my organisation” – as well as being able to satisfy people who want to see the whole system change, and the strategic overview of what direction we are going in. (MHAZ co-ordination, 03/2003).

Because it was an outside organisation it answered a lot of problems and gave this organisation a kick start. That's why I view it so positively. Because if HAZ hadn't have been there, I would have been hitting my head against the same brick wall. (Intervention, Health, 01/2003).

We are noticing differences ... different attitudes ... This isn't just about rationing services – making the most use of our services – it's about plugging people into those services as quickly as possible. (Intervention, Partnership, 02/2003).

Money was the catalyst that started the process of change. It brought people together and facilitated change in the statutory sector.

Money has brought people to the table; has got commitment from people. They've seen what it can achieve and they want to stick with it. (Strategic, Health, 12/2002).

But the lesson here is that it does not take a lot of money to generate change. The funding that some of the interventions received was substantial by their own standards, but compared to NHS budgets, HAZ funding was small – only 1% of NHS allocations. Sometimes the HAZ money acted as seed money, but sometimes it was enough to add value on its own.

It doesn't have to involve a lot of money to do things differently. (Strategic, Health, 11/2002).

Quite a small amount of money, really. It added to helping us to get other money. (Intervention, Charity/Voluntary, 11/2002).

Matched funding snowballs ... it's getting that initial money. (Intervention, Local Authority, 11/2002).

I often think that it's the small amounts of money that have made the biggest difference, really. (Strategic, Health, 12/2002).

What was also clear was that innovation at the bottom of organisations needed to be supported by change at the top. We have already had an example of leaders in one district promoting change in that LSP. HAZ did this itself through the Policy and Steering Groups. Other interventions have highlighted the benefits of working to engage at this level of an organisation.

The ones that have come along [to the training] have all enjoyed it. They have all instantly seen the link. A few have gone away and said 'I need to send some of my staff on this'. (Intervention, Local Authority, 11/2002).

You can have a change in policy, but if people on the ground haven't got that awareness and that understanding, then the delivery is not going to change that much. (MHAZ co-ordination, 03/2003).

In general, though, people felt that change happened at the frontline of the statutory sector, but that this was not always supported higher up the hierarchy.

What you have to have in place is the other side. Individuals have to have [HAZ thinking], but to make sure it still happens, the leaders of the various organisations have to have that thinking as well. (Strategic, Health, 11/2002).

I felt I was very passionate and determined and I was pushing things up from the bottom, but it was like fighting a losing battle because it hadn't been adopted at the top. You probably find that in many big organisations. And that's the challenge now, is how to address that and take it forward through leadership. ... Ultimately it should be a top-down and a bottom-up approach, and the two need to work together. (Intervention, Health, 01/2003).

So, what I'm saying is, yes it does sort of come from the ground upwards ... but it has to be with the commitment of senior managers as well. (Intervention, Partnership, 02/2003).

7.5.3 Personal change

The support, flexibility and opportunities that MHAZ provided facilitated personal and professional development amongst the people involved with the programme.

[SP1]: [The project] gave me the opportunity to try different things and to remove some of the [professional] constraints I perhaps had. ... [SP2]: To be given the responsibility to investigate different ways of working ...

in the end we can be quite proud. (Intervention, Local Authority, 10/2002).

All my different backgrounds come together in HAZ, which has just been amazing. It's an amazing opportunity to be able to do that, and to be able to be stretched in so many different directions. To be able to use all of your skills. I must say that HAZ has really stretched me in every skill that I've ever had at different times. (MHAZ co-ordination, 03/2003).

Not only did it change the way that some people preferred to work, but occasionally it enabled profound and lasting change in individuals.

It was one of the things I've gained from a personal point of view. It was like a kick start to other professional issues and personal development for me. ... The links that I've developed with HAZ have now fed back. I'm now sharing some of my expertise with some groups I sit on in [district] and other areas. (Intervention, Health, 01/2003).

7.6 People

Throughout this research it was clear that people as individuals and collectively were important to the success of the programme. The initiative needed champions at all levels, especially in the face of the pressures and changing agenda from the centre. HAZs needed champions amongst ministers, civil servants, senior officers within the health service and local government organisations in Merseyside, within district partnerships and amongst those co-ordinating the delivery of the programme. The Merseyside HAZ had all of those.

Frank Dobson and Tessa Jowell were champions of the holistic approach to health improvement they promoted through the HAZ initiative. Lannin (2003) has suggested that Alan Milburn always wanted HAZs to primarily contribute towards the modernisation agenda. When he became Secretary of State for Health, these

were the changes that he introduced: altering the focus of HAZs away from local priorities to supporting the NHS priorities. That some of the HAZs, including the Merseyside HAZ, were able to accommodate this and still focus on local needs is a credit to the people working within them.

Having that attitude of taking risks and innovating and involving people, doing off the wall things, which we had permission to do. That made a big difference, having that permission, because people then felt protected. They are not exposed as individuals. We're doing it as HAZ, we can do it differently and we can justify why we're being radical about it. If people don't have that cover, then they are going to be very reluctant if they think it could come down to them. We've got Frank [Dobson] to thank for that. (MHAZ co-ordination, 03/2003).

Locally, the Merseyside HAZ would not have been as successful without the vision and commitment of the MHAZ Co-ordinator, and the three chairs of the Steering Group. All of these people have been named as important factors in the success of the programme. The MHAZ Co-ordinator was clearly a driving force behind the delivery and influence of the HAZ in Merseyside. Her Health For All background was a clean fit with the HAZ ethos, and was felt to be positive for the programme as a whole.

I think the other strength is having someone like [the MHAZ Co-ordinator] with a Health For All background. (MHAZ co-ordination, 03/2002).

Take [the MHAZ Co-ordinator]. HAZ wouldn't have got off the ground without her there. It would have done, probably, but she's made so much difference to it, she's just kept the whole thing going, because she's a fantastic leader. (Strategic, Health, 06/2002).

On the whole HAZ has always found ways to make things work. ... and that's because we've got good leadership. I think leadership of the HAZ in Merseyside is very, very positive. [The MHAZ Co-ordinator], who I think, has been absolutely outstanding. She's been a driving force and kept us errant members in check. But we've also had good leadership from the two Chairs, and that is an important message as well. (Strategic, Local Authority, 11/2002).

We had a dual role in relation to the chairmanship [of the Steering Group], which was good. ... They played hop-scotch in relation to the meetings ... that I feel was a good ploy in relation to showing the joined-up working. (Strategic, Local Authority, 01/2003).

They in turn would not have been able to work so successfully without the support and commitment of the Policy Group, and particularly the Steering Group, regional and district co-ordinators. These last three groups especially worked hard to achieve the HAZ aims.

There were the absolute pillars of strength within the steering group and then there were others who were more peripheral. (MHAZ co-ordination, 03/2003).

I can't praise the local co-ordinators enough. They've done a brilliant job. (Strategic, Local Authority, 11/2002).

People in the interventions and at the other levels of the HAZ implementation talked about the importance of having the right people in place to make things work. These people need supporting in their work, and this has been discussed in the earlier chapters: those two factors of having the right people and a supportive environment have been essential to the success of the HAZ in Merseyside. The 'HAZ Way of Working' essentially describes the supportive environment created in Merseyside,

although this was part of the whole initiative, and certainly extended up to the work of the DoH civil servants.

It was [nurse]. Because they went back and said 'she's great'. The word of mouth actually sold it ... after they'd gone back to the office there'd be a glut then of people ringing up, all from the same office. (Intervention, Local Authority, 10/2002).

PCT is being very innovative and very focussed. [Is that because it's a smaller unit?] No, it's the people you have involved. (Strategic, Health, 12/2002).

Part of that supportive environment also needed to be the context that HAZs worked within, and this was the result of the direction taken by the ministers in central government. On the whole the HAZs adapted to the changes in priorities – although this was not particularly easy. The funding insecurities made it difficult to plan, and to keep people engaged. With the change to PCTs new people came onto the HAZ Steering Group, and some of these people did not value the work that HAZ had done, or the added benefits that working across Merseyside could bring. In the context of the changing political agenda, these people were able to introduce doubt into the previously strong partnership of the Steering Group. Here again is an example of how key individuals in particular circumstances can be influential. In terms of the continuation of the HAZ, this was not a positive influence.

Because she's a powerful chief exec, others followed, and at that time it looked as if HAZ was coming to an end anyway. ... Other chief execs joined the band wagon, then the other chief execs found it difficult to stand alone because there are lots of decisions that [they have to make where] they need the good will of their colleagues. So that's the way it went. (MHAZ co-ordination, 03/2003).

The difference in what we might term ‘makers and breakers’ is personal vision and values. Where a person’s vision and value set is congruent with those of the organisation or programme they are working within they can be powerful advocates of the work. Where this is not true, they may undermine it. Sometimes these differences can be lessened through exposure to the programme, and effort particularly designed to bring people in to the team. In the MHAZ case, the insecurity about the funding meant that it was difficult to make this work. Also the ‘breaker’ in this case did not support the HAZ work, and so it was unlikely that her position would have changed. These ‘breakers’ exist in all places at all levels. Sometimes they create immovable barriers to change, and in these circumstances people move on.

There were key powerful individuals that would just not address this, even things that are legislation. Because everything I do is evidence based. ...When that’s given to people in authority and they choose not to act on it, I couldn’t get any further than that. (Intervention, Health, 01/2003).

Equally, there are people within these networks and systems who are visionaries and who create opportunities when the circumstances are favourable to what they want to achieve. They may well make progress when circumstances are not so favourable, but they can be inspirational when working within an environment that gives them the freedom to be creative.

He is a self starter, an innovator, a natural networker. HAZ enabled him to do things the way he wanted to, he probably saw HAZ as an add-on to his own efforts. (Interview notes, 11/2002).

The way I work so closely with my other colleagues, the ethos has rubbed off on them. And the benefits just surround us all the time. That’s

probably the most significant thing. It's changed our working practice on a day to day basis. (Intervention, Health, 01/2003).

Most people fit between these two extremes. For a change in vision and work practices to become widespread there needs to be a critical mass of people able to work in that way, and the conditions to encourage it. This might not need money, just a different approach and the commitment to make it succeed.

You can have a change in policy, but if people on the ground haven't got that awareness and that understanding, then the delivery is not going to change that much. (MHAZ co-ordination, 03/2003).

Pawson (2002) said that it is not interventions that create change, but the resources and incentives that intervention provides for people. It is the people who change. Pawson is referring to the end-users or clients of an intervention. I would argue that all change is facilitated, delivered, or achieved through people. Those people might be politicians, policy makers or key workers. Naturally, change will only be manifested through changes in the lives, work practices and wellbeing of individuals and groups. Chapter 3 highlighted that there are many different factors that might impact on whether an individual or group would change some aspect of their lives as a result of an intervention. What I am suggesting here is that, just as those individuals and groups need support and resources through the projects, so the people developing and implementing the projects need resources and support to do that.

Initiatives like the HAZs, which hope to change the way people think and work, need champions in all parts of the process. These champions for HAZ have been widespread. However, people can also undermine the success of initiatives and interventions. The wrong people in the right place can cause things to unravel, as was demonstrated in Chapter 5. The point being that key individuals have to share

the values of that organisation. Development work may help to draw people in to an existing structure, but that structure needs to be operating in a stable and secure context. The Merseyside HAZ partnership came unstuck because of the uncertainty that was introduced through changes in the Steering Group, but also because there was no secure HAZ funding to underpin the partnership. The way forward at that point was dependent upon the consensus within the partnership continuing, and that was broken.

7.7 The Merseyside HAZ Legacy

From my experience, the majority of people involved with the HAZs have been extremely enthusiastic about their experiences. Frank Dobson said that he wanted to release local energy, and this seems to have occurred. People have enjoyed working in the way HAZ promoted; they have been able to achieve things they might not otherwise have done; this has had a positive effect on the services they have been able to provide, and on their own personal development.

I am privileged to have been part of the development. (MHAZ co-ordination, 03/2002).

I found the whole thing very stimulating and challenging. (MHAZ co-ordination, 05/2002).

It's been a good experience. (Strategic, Health, 06/2002).

It's definitely been a good experience for me. (MHAZ co-ordination, 10/2002).

It's just been really good. (Intervention, Local Authority, 10/2002).

I have been delighted to represent the Local Authority on the HAZ Steering Group. (Strategic, Local Authority, 11/2002).

It's been good and positive for us. (Intervention, Charity/Voluntary, 11/2002).

I'm very positive about the whole HAZ experience. (Intervention, Health, 01/2003).

It's been such a privilege to be in a position to be able to do that. To have the power to do that has been fantastic. And I feel so satisfied by it. And if I never do anything again in my life that makes such a big splash, it doesn't matter. All the things that I used to think could be possible, have been proved to be possible. It has really confirmed a lot of my beliefs. (MHAZ co-ordination, 03/2003).

Equally so, there have been examples within the MHAZ where working in the face of adversity can create enormous amounts of stress and distress. One member of the central co-ordination team told me that they needed to call on all their sources of support to enable them to get through the last few months of the HAZ in Merseyside.

It was excruciating, absolutely excruciating. It would have been easier in some ways to have left sooner, but I couldn't do that, I had to see it through. (MHAZ co-ordination, 03/2003).

People have commented on the loss of trust that results from the withdrawal of funding. It would also seem that nobody thinks about the human costs of expecting people to work in very stressful circumstances.

The 'HAZ Way of Working' will be a lasting legacy of the Merseyside HAZ. This way of working, and the HAZ principles, have changed the way that some people choose to work. The ideas have been dispersed as people with HAZ experience have moved around the system.

They were either HAZ people or people who had become involved in HAZ work – seeded all over the place. That's one of the things about people

moving around the system, they take these ways of working with them. (Strategic, Health, 11/2002).

We'll still be getting benefit out of the HAZ principles well, well down the line from where we are now. I think that's the strength of it. People just do it. They don't even think about it. (Strategic, Local Authority, 11/2002).

Often now you hear people say 'well, we could use the HAZ principles'. (Intervention, Health, 01/2003).

People have enjoyed this way of working “*because they get much more out of it. It's structured and takes account of people as well*”. It has fostered innovation and funded projects that might not otherwise have had funding. The interventions that HAZ enabled will also be its legacy.

Some of the examples of the interventions or projects that we had running that wouldn't have happened otherwise were excellent. Some of the smaller ones were as often as not the best ones. (Strategic, Health, 11/2002).

I think the legacy will come out in a number of ways ... it'll come out in the projects that will continue. ... The Heart of Mersey ... HAZ gave that legs ... (Strategic, Local Authority, 11/2002).

The things which really stand out for me: the Healthy Living Centre Network, which is an absolutely marvellous thing; the smoking cessation services, a biggy for me as well; and some of the things that have been really effective, like the Crystal Clear work. (Strategic, Health, 12/2002).

Ultimately the HAZ programme is about changing people's lives, either indirectly through helping to improve the provision of services, or directly through the interventions.

I guess it made quite an inroad into some of the goals that it set itself really. I think it is really hard because there are so many projects impacting on different things ... it's so hard to measure that. ... But it must have had some impact on particular people's lives on Merseyside. (MHAZ co-ordination, 12/2002).

That makes a difference that it has touched individuals, and for some communities a whole range of things has come together. (MHAZ co-ordination, 03/2003).

For one of the senior members of the HAZ co-ordinating team, this has been a wonderful opportunity to trial the Health For All principles on a large scale.

It's principles again. Health For All principles are about having inequality at the heart of what you're doing, and having a real understanding of that. Working together in partnership, and involving people – involving communities, involving everybody – if you put those factors together, it will work. It has worked – in a big way with HAZ, but in lots of small ways within HAZ as well. (MHAZ co-ordination, 03/2003).

What HAZ has done is proved that by taking that approach (Health For All) and by having the resources, and having the political support to do that, then you can actually make big changes. (MHAZ co-ordination, 03/2003).

The Open Day really brought it home to me. That buzz and excitement ... once people have been exposed to HAZ then they start to look for it again, and start to create it for themselves. The legacy for me is that it has been a life changing experience for some people, and that they will do things differently. (MHAZ co-ordination, 03/2003).

7.8 Conclusion

The HAZs were initiatives based on a set of clearly defined principles. These reflected the principles of the Health For All movement: equity, participation, community involvement and sustainability. In Chapter 4 we saw how these principles were also important in the New Labour rhetoric about social inclusion and health improvement. HAZs seemingly embodied these New Labour values, and had the additional attraction of providing funds for innovation, to allow frontline workers to take risks, in generating evidence of 'what works' in modernising services and tackling health improvement. These opportunities generated a great deal of enthusiasm for the initiative. It has been seen that this enthusiasm was not universal, but it was evident throughout my time with the HAZ. It was remarkable and engaging.

There are several factors that have contributed to this positive response. Firstly, people enjoyed being let off the reins to take chances and to learn. Within the statutory sector, the money provided an opportunity to work in the way people wanted to work ... to feel like they were directly making a difference to the lives of the people of Merseyside. Within the charitable and voluntary sectors, the money helped to support projects that would not have received funding elsewhere. Secondly, people enjoyed working in partnership and being connected to other projects working in the same field. The Open Day opened eyes to the broad approach HAZ was taking to health improvement, and it was exciting to see how one project was fitting into this bigger whole. Thirdly, the supportive, flexible, learning approach that HAZ took – the 'HAZ way of working' - enabled personal development and changes in the way people worked. This was most noticeable in the statutory sector, but was a comfortable fit for the people working in the voluntary

and charitable sectors. Fourthly, and lastly, the enthusiasm and commitment of key people made it work. Where there was dissatisfaction, this can be linked to environments where there was no commitment to the HAZ approach.

Chapter 8

Linking the macro and micro arenas of policy implementation

Ministers want to innovate but they will fail to cultivate innovation unless they adopt a more participatory process to change and become less controlling. Government itself needs to work harder at relationships with their own stakeholders, in particular with staff groups. Political statements about valuing staff may be highly encouraging; but they will be ineffective if the very conditions that would support staff continue to be ignored. (Maddock, 2002, p.15)

This research set out to explore the experience of implementing the Merseyside HAZ from the perspective of those people involved with the development and delivery of the policy in Merseyside. In particular to explore how central government interacted with the local implementation of MHAZ. Emerging from the research are clear findings relating to aspects of central government policy that have hindered local implementation and created frustration, and those factors that have helped to make the horizontal relationships within the MHAZ operation work and generated enthusiasm.

This chapter discusses the findings in relation to literature presented. Firstly the New Labour context will be examined. There are already many critiques of the New Labour top-down managerialism and how this is counter productive to public service improvement. Here the particular ways in which broader government policy and bureaucracy have impacted on the MHAZ will be examined.

Secondly, the way the MHAZ operated was to promote whole system change. The ‘Making It Happen’ goal of MHAZ was the whole systems approach in action. It has been identified as part of the lasting legacy of MHAZ. There were specific features of this work that have been identified as contributing to the enthusiasm people felt for working with the MHAZ. These features are explored in Section 8.2, and compared with the WHO Healthy Setting approach to health improvement.

Emerging from the findings, their analysis and this discussion it is clear that “*policy does not implement itself*” (Barrett and Fudge, cited Schofield, 2004, p.284). People implement policy. The sections of this chapter outlined above demonstrate what has been painful about the New Labour context, and what has been pleasurable about the MHAZ approach. These emotions reflect the fact that policy is interpreted and delivered by people. Schofield (2004) notes that little thought is given to the needs of people implementing policy – those she refers to as the ‘*action agents*’ (ibid, p.286). Section 8.3 provides a final synthesis of the findings to make three observations: people operate according to a set of values, and policy works best when it is line with these values; MHAZ provides evidence that it is possible to ‘join-up’ work horizontally in a locality, but that this ‘joined-up’ approach does not extend vertically to central government; to effect the lasting changes that New Labour desire requires bringing these two things together to create a supportive environment for change.

Finally, the findings from this research also provide an opportunity to reflect on some of the theories about health generation and the reduction of health inequalities at a personal level, discussed in Chapter 3. Work is one of the layers of influence on health and the good and bad experiences of the action agents of MHAZ reflect these

debates. Section 8.4 presents these reflections on health inequalities, and the final two sections of this chapter offer a personal reflection of the research process and a summary of the findings synthesis.

8.1 The New Labour context

Modernisation is central to the New Labour approach to social justice and equity. This is characterised by a rapidly changing policy agenda (NRU, 2002; Gray, 2004), with constant emphasis on radical changes to the public sector (Blair, 2004b; Gray, 2004). Authors have reported that the manner of these changes caused problems for the public sector locally (Exworthy et al, 2002; Exworthy, Blane and Marmot, 2003; Hunter, 2003a). The HAZs have also experienced problems in the face of the pressure from the constantly changing policy context, and the associated loss of visibility in the face of other priorities such as the NHS (Bauld *et al*, 2005). There are two main ways in which this rapidly changing context affected the HAZ in Merseyside: short term stability and long term security.

8.1.1 Stability

The stability of the programme was undermined in a number of ways. The strident central control and rapidly changing policy context reduced the flexibility of the programme and limited the opportunities for innovation. This is consistent with the findings of others (Maddock, 2002; NRU, 2002; Barnes *et al*, 2003; Hunter 2003a; Glass, 2005). In particular changes to the focus and funding of the programme meant that more money had to be spent in support of government priorities, winter pressures and National Service Frameworks. In the early days of my connection with the MHAZ there was a noticeable concern about the implications for the local programmes of these changes in focus. Co-ordinators expressed frustration and

anger that the programme was being drawn away from addressing local needs, and refocused to work towards national priorities in health outcomes. This was particularly so in those districts with a particular emphasis on working with communities. However, a couple of years later these co-ordinators were more pragmatic and reasoned that their local programmes were addressing the national priorities, although the links between the interventions they funded and cancer and coronary heart disease may have seemed somewhat tenuous at times.

The reduction in opportunities for innovation was also keenly felt, especially within the regional work of the MHAZ. In order to innovate, people need to be able to exercise discretion (Maddock, 2002; Rhodes *et al*, 2003; Schofield, 2004) and have the flexibility to respond according to local needs and changing circumstances (Gillies, 1998; Rhodes *et al*, 2003), and, as has already been said, these were restricted in MHAZ by the changes in focus and context. Having flexibility and autonomy improves job satisfaction within the public sector (Schofield, 2004), similarly the loss of flexibility and autonomy can create stress at work (C. Jones, 2001; Coffey, 2004).

The MHAZ chose to use the regional programme as a buffer for the districts, putting greater emphasis on the national priorities through the interventions they funded at the regional level. It was also here that they went for the 'quick wins' that the government demanded. The MHAZ Steering Group also chose to support NHS projects through the NHS modernisation process. Although this was seen as evidence of the strength and level of cohesion of this partnership, people expressed concern that this had also reduced the flexibility of the programme, and opportunities for innovation, in Merseyside.

Other aspects of the policy context affected the efficacy of the operation of the MHAZ. The reorganisations that occurred in both the core partners meant that a number of key personnel changed jobs during the life of the programme. During the reorganisation processes, these people were naturally primarily concerned with their future employment and this was reflected in attendance at partnership meetings. Also, it made it more difficult for people working in the interventions to know who to contact within the statutory sector. Some of these people felt the MHAZ could have done more to facilitate contacts with the NHS particularly in this changing climate.

Another area that interviewees from interventions felt that MHAZ could have been more helpful was in mainstreaming successful projects. One of the impacts of the modernisation agenda, especially in the health sector, was a lack of mainstream funds to take up successful work from interventions. It has already been said the MHAZ continued to fund NHS interventions during this time. This, again, was due to the lack of mainstream funds available to draw the projects back into the public sector proper. In reviewing a number of area-based initiatives, the NRU (2002) found that there were generally inadequate measures available to continue successful initiatives. In the face of other concerns, health inequalities were at this time low on the priority list within the NHS (Exworthy *et al*, 2002; Bauld *et al*, 2005).

8.1.2 Security

Changing ministerial priorities and the evolving public policy agenda led many to believe that HAZs had lost visibility with ministers and that there was no longer a clearly defined purpose for the programmes as a separate initiative (Bauld *et al*, 2005). HAZs had been established as trail blazers of new policy, and much of the

learning from HAZs had influenced the development of PCTs and LSPs. Money was also at the centre of the feeling of insecurity experienced by all the HAZs (Bauld *et al*, 2005). The HAZs were only guaranteed funding until the end of March 2002, just four (wave 1) and three (wave 2) years into the seven years announced for the programmes.

The main casualty of the changing context was the regional aspect of the work of MHAZ. Locally, the HAZ money continued and those partnerships that existed in the districts became part of the new structures. The literature suggests that heavy external pressures limit the efficacy of partnership and collaboration (Bevir and O'Brien, 2001; Painter and Clarence, 2001; Crawshaw and Simpson, 2002; Barnes *et al*, 2003; Hunter 2003a; Gray, 2004; Newman *et al*, 2004). Partnerships can be put under pressure when there are competing priorities between the partner organisations, such as: different accountabilities (Exworthy *et al*, 2002; Exworthy, Blane and Marmot, 2003); funding and budget concerns (LGA, 2000; van Eyk and Baum, 2002); a lack of understanding of each other's roles – for example the health service adhering to a medical model of health that excludes the Local Authorities (LGA, 2000); and where there is a difference between national and local priorities (LGA, 2000).

The MHAZ Steering Group managed to overcome many of these challenges through their commitment to the values and aims of the HAZ, reinforced through development meetings and support given to new members. This supports the experience of others that the degree to which partnership members worked together towards the partnership goals reflected the quality of the relationships within the partnership (LGA, 2000; van Eyk and Baum, 2002; Evans and Killoran, 2004).

Partnerships have been undermined by the rapid turnover of members and organisational changes within the partner agencies (LGA, 2000; van Eyk and Baum, 2002). This was certainly the case with the MHAZ Steering Group. Without the security of knowing that there would be continued HAZ funding, the group was unable to bring the new members into the consensus. The changing policy context meant that these members had different goals to the existing members, and were not willing to compromise them in order for the regional focus to continue, a conflict that is known to damage partnership structures (Pratt *et al*, 1998; LGA, 2000; van Eyk and Baum, 2002)

8.1.3 *Time issues*

From the outset of this research it was clear that time is an important factor in implementing public policy, but time gets little attention in the literature (Schofield, 2004). There are several ways in which time was an issue. The HAZs were given little start-up time before they were expected to be effective, in common with other New Labour area-based initiatives (Pratt *et al*, 1998; Maddock, 2002; Matka *et al*, 2002; NRU, 2002; Bauld *et al*, 2005). This had ramifications for the way funding was allocated at first and led to long term difficulties in one of the districts where no scope had been left to develop the partnership and programme over subsequent years.

It also takes time for programmes to become established and generate learning. Schofield (2004) found that it takes 18 months for learning locally to be disseminated nationally. Similarly a number of the participants in this research suggested it takes two years for changes to become established. When trying to engage with the community it can take 18 months just to build the relationships needed to begin the work, findings supported by Glass (2005). When it was believed that HAZs would

not get an extension in their funding, people expressed frustration that the Merseyside HAZ was being dissolved before it had had sufficient time to embed the changes that had begun, and to demonstrate change in the health of the local population. It is widely believed that it can take 10 to 15 years for such community development approaches to demonstrate an effect on health outcomes.

Van Eyk and Baum (2002) have argued that time pressures can discourage flexibility and reflection. Some of the participants in this research felt they would have liked more time to reflect on the progress of the programme or intervention. However, these opportunities were scarce. For instance, one of the regional co-ordinators commented that our interview was valuable precisely because it gave them the chance to reflect on the successes of the MHAZ. The constant changes and heavy bureaucracy took up to 50% of the co-ordinators time, and took time away from delivering the programme, a finding true across all the HAZs (Barnes *et al*, 2003).

People working in interventions with many funders expressed frustration that the performance monitoring they had to complete for each funder was time consuming and repetitive. A number commented that it was a poor use of their time. This is not to say that they would prefer no performance monitoring, just that it could be better developed and streamlined. The MHAZ monitoring was generally considered less onerous than others, and was favourably received by some because there was the space for both quantitative and qualitative data. And also because it could provide a useful opportunity to reflect on the progress and processes within the intervention.

8.1.4 *Performance management*

On the whole performance monitoring was considered overly burdensome. This was true of the MHAZ co-ordinators and of people working in the interventions. Both groups felt the performance monitoring they were asked to complete was not representative of the work that they did. The co-ordinators could not see how projects could be tracked from one report to the next, and therefore felt that the forms were a waste of time. In the interventions people both felt that the data asked for was flexible and inflexible. There was some comment that the jargon was confusing, that there needed to be more 'hard' evidence, and that the forms were too restrictive for innovative projects. On the other hand, the people requesting the information found it useful as an indication of progress being made. Both the DoH civil servants and the MHAZ co-ordinators made the distinction between monitoring and evaluation. Arguing that as learning is contextual, local evaluation was more suitable for demonstrating the value of particular interventions. The civil servants particularly valued the monitoring information as it helped them to feed learning about processes upwards and to support the continuation of the HAZs when the future of the programmes was in doubt.

Bauld *et al* (2005) found that some HAZs found the performance monitoring useful locally, and the MHAZ was one of those, whilst others found it clashed with local structures. They also argued that to avoid these clashes in expectations there needs to be more clarity about the purpose of monitoring data, and how that data will be used (Bauld *et al*, 2005). They propose that thought needs to be given on how routine monitoring can contribute to project development (Bauld *et al*, 2005). The data here reveals that different people approach monitoring in very different ways. For some it is a task that has to be done with the least amount of effort possible. For

others it was an opportunity to reflect on the intervention and generate learning. Two factors contribute to these differences: how much time someone has to fill out forms; how much value they place on the monitoring process.

8.1.5 *An unsupportive context*

Schofield (2004) has argued that policy makers are so far removed from the site of policy implementation that they are unaware of the implications of their decisions for those action agents of implementation. This is suggested in the comments of one research participant who felt that the government give scant regard to the emotional impact of their decisions. The constant change directed at the public sector is counter productive and it suggests a lack of commitment by New Labour to the policies that they have introduced. The changes and central management were time consuming and destabilising (Barnes *et al*, 2003; Bauld *et al*, 2005). They also reduced flexibility and limited innovation. Together they created an unsupportive environment for policy implementation and societal change. Bauld *et al* (2005) note that

the issue of whether central government was conveying clear and consistent messages to HAZs, and adequately supporting local efforts, was raised time and time again by project managers (ibid, p.433).

8.2 **The Merseyside HAZ: “Making It Happen”**

The previous section paints a gloomy picture of the impact of the top-down processes on the Merseyside HAZ. These problems caused a great deal of heartache and frustration, but until the final dissolution of the regional programme there were also many positive experiences within the operation of the MHAZ. Until these last stressors, the Steering Group had managed to retain its focus on the MHAZ aims and

goals, sometimes with creative solutions to the changing circumstances. Despite the challenges to these processes, the MHAZ was consistently cited as working flexibly and promoting innovation. These factors, together with the network based approach of the work, generated significant enthusiasm for the values and programme of the MHAZ.

8.2.1 *MHAZ structure*

Bauld *et al* (2005) have described HAZs as networks rather than organisations in their own right. Springett *et al* (unpublished) show how the Merseyside HAZ was consistently understood as a web connecting individuals, groups and organisations across Merseyside. Nevertheless, at the heart of the MHAZ was an organisational structure designed to engage local decision makers, provide partnership governance and manage the programme. This structure (see Chapter 2) was hierarchical in nature, reflecting the different levels at which the programme operated (regionally and in the five districts), and the different operational levels of those the MHAZ wished to engage in the decision making processes (local politicians, senior staff in the health and LA sectors, broader partners and communities). The bulk of the decision making was done in the core Steering Group, which included members from all five districts. The central co-ordination team also attended these meetings as observers. The district partnerships, where they existed, included members from other public services and community groups, and these decided how HAZ money would be spent locally.

The districts all worked differently, but three of the district co-ordinators felt that the partnerships had come together well after initial problems. They felt there was value in having a dedicated co-ordinator to manage the work of the partnership and offer

support to the interventions. This was also true of the regional co-ordination team and the MHAZ as a whole. All those interviewed who worked at this strategic level of MHAZ felt that the investment in managing the MHAZ programme and process had been one of the successes of the HAZ. Within this hierarchical structure, people commented that operationally the organisation was flat and flexible. This was especially true within the Steering Group where development meetings meant that the partnership gelled together regardless of the relative positions of members within their own organisational structures. It was also true of the core co-ordination team where all the people interviewed commented that they had been encouraged to work outside their job specifications and to contribute to the team in whatever way they could.

The local partnerships eventually became part of the emerging LSPs in those districts. Bauld *et al* (2005) found that HAZs generally made little contribution to the development of knowledge about partnership governance. But the Merseyside HAZ was lauded as one of the top HAZs for partnership arrangements, and the success of the structures they introduced is demonstrated by the way these have been mirrored in the governance arrangements for the Cheshire and Merseyside Public Health Network. Coyne (2005) reports similar structures in the Healthy Croydon Partnership, and contends that a dedicated team to support, monitor and develop the partnerships is important to the success of the schemes.

The MHAZ Steering Group remained a strong partnership until the NHS re-organisation that created PCTs. The members of this partnership included in the research felt that this had been achieved through a commitment to the HAZ process and implementing the HAZ programme across the region. Development meetings

helped the group to gel and to form a consensus. Openness and respect between the members meant that they were able to hold each other to account without creating divisions between one another. Some specific decisions to include wider representation from the NHS and to fund NHS interventions during difficult financial circumstances in that organisation ensured continued support for the programme. Although not all agreed with changes that occurred as time went by (such as the loss of Goal Leads), the commitment and consensus remained strong. Much of this echoes the literature on partnership working.

The literature observes that partnerships are enhanced through: a strong commitment to the partnership (LGA, 2000; Matka *et al*, 2002; van Eyk and Baum, 2002; Myers *et al*, 2004; Baker, 2005; Coyne, 2005); shared aims and objectives (LGA, 2000; van Eyk and Baum, 2002; Gillies *et al*, 2003; Myers *et al*, 2004; Baker, 2005; Coyne, 2005); good communications (van Eyk and Baum, 2002; Myers *et al*, 2004); a history of joint working (LGA, 2000; van Eyk and Baum, 2002); openness and transparency (Myers *et al*, 2004); regular meetings (Myers *et al*, 2004); joint training and development sessions (Monks and Ong, 2002; Gillies *et al*, 2003; Myers *et al*, 2004); acknowledging differences (van Eyk and Baum, 2002; Myers *et al*, 2004) and the ways in which different sectors could contribute to the partnership goals (LGA, 2000; Monks and Ong, 2002; van Eyk and Baum, 2002);

All the Steering Group members, regardless of the sector they were from, were advocates of the MHAZ and the way that it worked. Those from the LAs were especially enthusiastic, and gave the impression that being part of the MHAZ had been empowering. This stemmed from the explicit contribution they felt they were making to the improvement of health on Merseyside. So much so, that when

discussions began to discontinue the regional MHAZ programme they were angry and became determined to ensure LA representation on the Cheshire and Merseyside Public Health Network, the successor organisation to the regional MHAZ programme. This, however, does not have the same remit as the HAZ. What has been lost is a central group dedicated to connecting and supporting people working to improve health and reduce inequalities. One of the LA Steering Group members has recently told me that they still feel the loss of the MHAZ co-ordination team, and this person is trying to recreate that role within the Cheshire and Merseyside Public Health Network.

Monks and Ong (2002) report the usefulness of a similar partnership approach with the values of social capital at its heart. They found that one of the advantages of the partnership was its embeddedness within the public sector. From this point the values they espoused were disseminated out into the public sector organisations and influenced ways of working there. This was also true of the MHAZ. The Steering Group members chose to work in an inclusive and innovative way within their own organisations. They were not able to say that was exclusively because of their association with MHAZ, but the HAZ way of working had certainly been one of the influences on their choices.

8.2.2 *Champions*

It was clear that certain people had been essential to the development of the MHAZ as a programme and as a network. These champions of the programme included the regional and district co-ordinators, Steering Group and partnership members, and other people with positions of influence within the broader network. The MHAZ benefited from strong leadership within the Steering Group and the regional co-

ordination team. These people were often cited as the driving force behind the MHAZ programme. These findings are supported in the literature where champions have been identified to be necessary as leaders for both partnership working (van Eyk and Baum, 2002; Barnes *et al*, 2003; Cole, 2003; Evans and Killoran, 2004; Hunter and Killoran, 2004; Myers *et al*, 2004; NESS, 2005), and for spreading ideas and creating change through local networks (Evans and Killoran, 2004; Newman *et al*, 2004; NESS, 2005).

Champions are also important for the successful implementation of policy locally (Johnson and Baum, 2001; Exworthy *et al*, 2002; Gillies *et al*, 2003; Evans and Killoran, 2004). They act as stronger nodes on the implementation network, boosting the messages further afield. In contrast, 'breakers' put themselves first (Pratt *et al*, 1998; Barnes *et al*, 2003), and this was evidenced by the demise of the Steering Group following the introduction of new members. Following the broader public sector changes that created new partnership structures in the LSPs and gave PCTs the duty to address health inequalities there was a sense that HAZs were no longer needed as a separate entity. And yet the main reason for the withdrawal of support for the regional MHAZ programme was the desire to keep HAZ and health inequalities monies locally where they could be used at the discretion of the PCTs.

8.2.3 *Money*

It is ironic that money should be the catalyst for the demise of the MHAZ. Throughout my connection with the MHAZ money has been a significant issue. It has already been seen how funding difficulties created problems within the operation of the MHAZ. At the same time, money has been an important catalyst for change by garnering attention and creating an incentive for co-operation. The MHAZ

followed on from the work of Healthy Cities in Liverpool. To a large extent Liverpool Healthy Cities laid the foundation for the MHAZ work. The fact that there was money attached to the HAZ work was an added advantage. Having money to spend helped to generate interest and ultimately release enthusiasm for the MHAZ approach.

Little is said in the literature of the positive effects of funding. There are some fairly fundamental ways in which money helped in the MHAZ. Some of the interventions required matched funds to other government or European monies, and in this way HAZ money enabled projects to start or to continue. HAZ funded interventions that were able to generate evidence to support additional requests for funding elsewhere. In one instance it kept an organisation in the region that was able to draw down other grants from another funding stream. Coyne (2005) has also found that funding can be stretched in this way.

The MHAZ also took a chance on things that other funders would not have done, and was flexible with how the money was spent, allowing people to be innovative. Money engaged the NHS with the HAZ philosophy, and communities through small grants schemes. In these ways HAZ funding also helped to expand the MHAZ network. The MHAZ also paid at the beginning of an intervention, which was extremely valuable to small interventions dependent upon external funding to survive. All of these point to the value of adequate resources to fund change (van Eyk and Baum, 2002). Often funding is not adequate and is short term. Short term funding is useful for pilot projects, but those interventions that need to build relationships with communities or that are already established need longer term funding to ensure that they are able to continue.

8.2.4 Support and supportive environments

People working within the MHAZ funded interventions placed great importance on the level of support they received from the MHAZ co-ordinators. In particular they appreciated having someone local that they could turn to for guidance and assistance; the flexibility demonstrated in terms of money and reporting; the added value of whole systems events, help with publicity, evaluation training, and the connections they made through the MHAZ. The relative lack of red tape and the flexibility with which they were treated left them feeling trusted, and this added to their enthusiasm for the HAZ.

Gilson (2003) has argued that supportive environments build trust and Monks and Ong (2002) assert that it is the duty of senior people within organisations to create supportive environments that empower frontline workers and generate the space for innovation. Innovation is dependent upon the right people, and the opportunity for them to take chances. These innovators need support to be able to work effectively (Catford, 1998; Maddock, 2002; NRU, 2002; Barnes *et al*, 2003; Schofield, 2004; NESS, 2005).

8.2.5 Enthusiasm

There are hints in the literature of the enthusiasm generated by successful collaboration and partnership working (van Eyk and Baum, 2002; Newman *et al*, 2004; Bauld *et al*, 2005; NESS, 2005). Myers *et al* (2004) found that people enjoyed working in multidisciplinary teams because such work facilitated learning and improved the work they were doing. This is reflected in the findings of Wills and Woodhead (2004) who found that

concerns [about multidisciplinary working] were strongly balanced by the enthusiastic response to the coming together of different professional backgrounds and skills, which was seen as overwhelmingly positive and exciting (ibid, p.11).

Similar enthusiasm and excitement for the MHAZ approach was also very evident in this research.

This enthusiasm stemmed from the opportunities that the MHAZ provided in terms of funding, working innovatively, demonstrating value, and personal development. People enjoyed the autonomy and sense of trust engendered when MHAZ 'left you alone' to get on with the work. This enthusiasm was further enhanced by the support and flexibility provided by the co-ordinators when needed. In particular the HAZ values and funding enabled people to work in the way they preferred to. In the voluntary and charitable sectors the HAZ principles were a good fit with the values underpinning their own organisations and interventions. In the public sector the MHAZ gave people the freedom to do their jobs in the way they desired to, but were often prevented from doing so because of lack of funds and bureaucracy.

A final advantage of working with the MHAZ was the connections that people made. Some of these were facilitated through the whole systems events and the training that MHAZ provided. It was apparent that those connected with the MHAZ enjoyed the relationships that they made, working collaboratively with similar interventions, working collectively in multi-disciplinary teams and partnerships. Through these connections people derived pleasure from knowing they were making a contribution to something bigger, and helping to make a difference to the health of the populations of Merseyside. It is, of course, these connections and relationships between people and groups that compose the network generated by MHAZ.

8.2.6 HAZ Way Of Working

All of the above describe aspects of the HAZ Way Of Working. In Merseyside this has been experienced as supportive, flexible, flat, adaptive, trusting, learning, connecting, a broad view of health, breaking barriers. This inclusive way of working has been appreciated across all HAZs (Bauld *et al*, 2005), and within this context has inspired and excited DoH civil servants, strategic decision makers and programme co-ordinators and those working in the interventions. The civil servants enjoyed making policy with people and being able to see the work of HAZs first hand. They described this as 'exciting' and offered that working with HAZs had changed the way they thought and would choose to work in the future.

It has already been discussed how positive those at the strategic level were about their work with the HAZ. Mention is needed, however, of those that did not have a good experience of working with this organisation. One person in particular was very upset with their experience of working with the MHAZ. This dissatisfaction resulted from a lack of security in terms of their work contract, and a lack of opportunity to work in the way they wished. In this instance the HAZ had been implemented in such a way as to leave no room for flexibility and development. The experience here, and in other pockets of frustration within the HAZ, point once again to the need for time to develop adequate systems, the problems of an over burdensome monitoring regime, the need for funding to support development and innovation, the importance of feeling supported, and the need for local determination and flexibility.

Monks and Ong (2002) have evaluated a programme similar to MHAZ in its structure and aims, but underpinned by the values of social capital. They too have

found that working with a clear set of inclusive values at the core of the work has had benefits in building and supporting networks, facilitating collaboration, encouraging trust based engagement, (community) participation, and empowerment. In terms of participation, this work helped to build networks, to reduce feelings of isolation, to make people feel part of something, people realise they can make a difference. Respondents were asked to identify how they used social capital ideas in practice. The main areas that were identified were (Monks and Ong, 2002, p.9):

- ♦ Using social capital thinking as a theoretical framework to guide work and development of projects;
- ♦ Use social capital as an explanatory framework, for example, understanding the development and improvement of networks;
- ♦ To monitor and evaluate outcomes, in particular using social capital indicators;
- ♦ Use ideas in induction and training of new staff;
- ♦ To develop new local initiatives and to get funding;
- ♦ To change ways of working and organisational cultures;
- ♦ To explore relationships with the statutory sector (from a voluntary sector perspective).

The similarity between these findings, those from MHAZ and the Healthy Croydon Partnership (Coyne, 2005) point strongly to the importance of partnership based approaches founded on values that promote inclusion and collaboration in building networks of trust and energising and empowering local workforces and communities.

8.2.7 *An example of a Healthy Setting*

The similarity between the HAZ principles and the Health For All values attracted many people used to working in this way. They brought with them an enthusiasm for HAZs that reflected the opportunity for them to work in this manner with

government backing. It also meant that there were a number of people working within the HAZs with a particular set of values. This was certainly true in Merseyside, and as has already been discussed the coming together of this value set and opportunity to work according to those values was extremely empowering and energising. The MHAZ, therefore, also provided the opportunity to implement Health For All principles to health improvement and reducing health inequalities through a Healthy Settings approach on a regional scale.

Healthy Settings recognises the complex interaction of factors that impact on health outcomes. From this perspective health is a human right, and health generation is an essentially political activity with equity, participation, partnership and sustainability the values that underpin it. Health for all requires collaborative action to empower and support people to take more control over their own health. This suggests action on three fronts: politically so that public policy becomes 'healthy public policy'; organisationally so that health improvement is an aim generally and so that the health sector works towards preventing as well as treating ill health; and at a personal level so that individuals and groups have the resources to work towards improving their own social circumstances. Central to this approach is the development of relationships through partnerships, networks and innovative projects. All of this requires a supportive environment for change to occur and be sustainable.

From Figure 8.1 it can be seen that many of the facets of a Healthy Settings approach were present in the MHAZ. Firstly, the work was underpinned by a clear set of values and implemented in a whole systems way based on the social model of health. The MHAZ sought to be a catalyst for organisational development and change, and managed this process through the Policy and Steering Groups and local partnerships.

The interventions MHAZ funded were often innovative, but even where more conservative work was funded this was done to generate support within the statutory sector agencies.

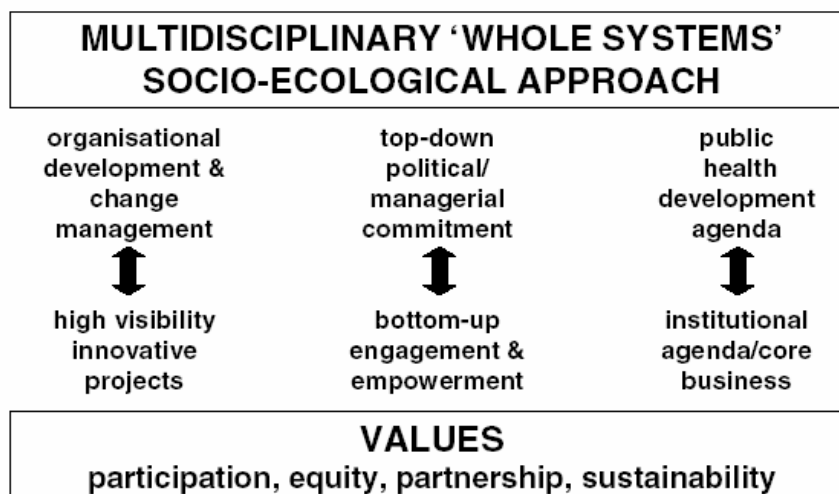


Figure 8.1 A model for understanding the healthy settings approach. (Source: Dooris, 2004, p.55)

The MHAZ developed political and managerial support locally through the partnership governance structures, ensuring that both core agencies and all the districts derived benefit from being part of the HAZ, and through seminars and events designed to disseminate learning. The MHAZ was less successful at engaging and empowering communities at the regional level, with the exception of the toolkit for community involvement and the HLC Network. Bauld *et al* (2005) generally found that HAZs were less successful at engaging communities at a strategic level, and that this aspect of the programme was better achieved locally. This was also true of the MHAZ, where some of the district partnerships included representation from some community groups. However, the MHAZ had been successful in generating enthusiasm and empowering those frontline workers who received HAZ monies.

There was evidence also that HAZs had influenced the core business of the partner agencies and had been successful in pushing health inequalities and the social model of health up local agendas (Bauld *et al*, 2005). Here too MHAZ had been successful in some areas. Key people within the core partners were choosing to work differently, influenced in part by their connection with the HAZ. The developing public health agenda also demanded that they work differently. Those districts with a history of innovation and partnership working rose to these challenges most effectively. What was difficult for the MHAZ was the lack of political support in central government, and the way the developing public sector policy agenda worked against the HAZ organisation and network in Merseyside.

Nevertheless the MHAZ was successful in creating a supportive environment for change, promoting the HAZ principles and changing the way that some people chose to work and think, and developing links with other initiatives. As a number of people commented, MHAZ was able to demonstrate that the Healthy Settings approach can work at a regional level.

8.3 “Policy does not implement itself”⁹

Schofield (2004) has argued that learning generated from the implementation of policy helps to add detail to the policy as it was originally conceived. As test-beds for policy change, HAZs were an opportunity to generate learning about ‘what works’ in addressing health inequalities and modernising services using a whole systems approach. Working within one organisation (the NHS), Schofield (2004) found that the implementation of policy was dependent upon the capacity of the public sector managers to learn how to deliver this policy locally. Similar to the

⁹ Barrett and Fudge (1981) cited Schofield (2004, p.284)

findings from the MHAZ, she found that this learning is facilitated by a flexible and co-operative organisational structure, spare resources, and the availability and quality of experts able to assist with the process (Schofield, 2004). In contrast, learning was constrained by problem complexity, lack of resources, and a lack of information and data. Schofield (2004) proposes an extension of her research into an intersectoral implementation. HAZs are such a policy implementation.

The New Labour policy context has not only created stress and limited local action, but also created opportunities for new ways of working, especially the development of collaboration and partnership (LGA, 2000; Bevir and O'Brien, 2001; Newman *et al*, 2004), facilitating change within the partner organisations (Newman *et al*, 2004). The findings from this and other research have demonstrated that the opportunities that New Labour have created for more innovative and inclusive ways of addressing entrenched problems have suffered from the excessive top-down managerialism and rapid pace of policy change New Labour have engaged as a way of forcing through change. This conflict reflects the paradox at the heart of New Labour project discussed in Chapter 4, where the aims of equity and social justice strain against the choice to use neo-liberal means to reform the public sector and society (Chatterton and Bradley, 2000; Deacon, 2003; Snape and Taylor, 2003; Clarke, 2004).

Taken overall, the findings from this research lead to the conclusions that policy implementation is dependent upon people, and that people work best when they are supported and trusted and, most importantly, asked to act in accordance with their personal values. New Labour have promoted a 'joined-up' approach to tackling entrenched social problems. However, this 'joined-up' work does not extend to the

way they choose to operate with regard to the local programmes they have introduced.

8.3.1 *The people factor*

It has been argued here that public sector workers are motivated by making a difference. Chris Jones (2001) also finds that people are drawn to working in the public sector because they want to help other people. However, the work environment is stressful. Maddock (2002) reveals that nurses leave their jobs because of poor management, bullying, poor communication and uncaring cultures. There has been evidence of this here from people working within other parts of the NHS. Both Jones and Maddock conclude that already stressful work environments are made worse by the increased central control initiated by New Labour as it reduces flexibility, autonomy and displays a lack of trust in the frontline public sector workforce (C. Jones, 2001; Maddock, 2002)

Despite the popular view of public sector workers, everyone I encountered in the public and voluntary/charitable sectors through this research, in all parts of the HAZ policy implementation, were committed to their jobs, hardworking and motivated by improving the lives of the people in England. People are the means through which change occurs, and, as has been argued in the introduction to this thesis, we need to pay more attention to what they tell us they need to work effectively. It is clear from these findings that people need security, stability, support and time to work well. Naturally, there are people achieving without such luxuries, but they quickly become stressed and exhausted in the process. MHAZ was a network more than an organisation in its own right. Such networks are the relationships and connections between people with similar interests and values. This network developed and

succeeded through the efforts of people as champions pushing the messages along, in partnerships developing the programmes, and connecting the frontline in the interventions delivering change on the ground.

8.3.2 *Values congruence*

Action occurs when there are policy options available that fit the vision and values of the political climate (Kingdon, 1995; Powell and Exworthy, 2001; Exworthy *et al*, 2002; Oliver and Nutbeam, 2003; Exworthy and Powell, 2004; Wills and Woodhead, 2004). Wills and Woodhead (2004) contend that values “*are the conceptual, emotional and intellectual foreground to individual and collective practice*” (ibid, p.10), but that values have received little attention for their role in generating a cohesive workforce.

All HAZ work was underpinned by a set of Principles, these principles resonated with the values promoted through the WHO Health For All programmes, but also reflected those of community development. These principles were promoted through the work of the MHAZ and the monitoring processes. It has already been said that this approach ‘legitimated’ a set of values and ways of working that had been in place outside the mainstream for a long time. Having a set of values at its core strengthened the work and achievements of the MHAZ. Similarly, Monks and Ong (2002) have found that learning in organisations has been facilitated by keeping the values of social capital central to their work. Like the MHAZ they found that such a values based approach can enable the transfer of ideas, innovation and new practice, can facilitate ‘mainstreaming’ of services and the building trust between organisations and between communities and organisations, and ultimately can deliver accountability of local government and health.

Just as at the macro policy level, policy works at the micro level when the values it represents resonate with those charged with its implementation. The HAZ values attracted a number of people to the HAZs that had previously worked in health promotion or Health For All. The programme was well received in the voluntary and charitable sectors because the HAZ values fit with the way they already worked. In the statutory sector, these values both introduced new ways of working and enabled people to work in the way that they preferred to do. Schofield (2004) found that values, socialised into a caring environment, are important public service motivators, although she suggested that this needed more research. The findings here support her conclusions, and expand them to note that working in consort with ones personal values not only precipitates action but generates enthusiasm.

The Merseyside HAZ above all wanted to be “*a catalyst for long term strategic change*” (MHAZ, 2000, p.4). Along with other HAZs (Benzeval, 2003; Sullivan *et al*, 2004) it has been successful in facilitating organisational and personal change. The HAZ principles and HAZ way of working have been fundamental to this success. This values and network based approach to whole systems change has generated enthusiasm and altered the way people think about health and health inequalities. The Local Government Association (LGA, 2000) found that partnerships between the Health and Local Authority sectors were put under strain when there was a difference between national and local priorities. This work with the MHAZ demonstrates that it is more than a difference in priorities that creates strain, it is also a difference in values and ways of working.

8.3.3 Lack of vertical congruence

Although Newman *et al* (2004) argue that the role of the state is shifting from governing to governance based on networks, other literature and the findings here demonstrate that there is still a strong element of governing in the New Labour approach to reforming the public sector and society more widely. Commenting on the Sure Start programmes, Glass (2005) found that joined-up working was often successful locally, but like other authors he found that it was more problematic at the national level (Exworthy *et al*, 2002; Coyne, 2005). The civil servants who took part in this research felt that there was an improvement in the way that central government was working together, but that the culture was changing slowly.

There seemed to be little evidence that those in central government were aware of the local impact of their policy changes and centralist tendencies. The linear approach to policy making in central government has been criticised (Hunter, 2003a), and several authors have stressed the need for government to recognise that policy development is iterative, complex and contingent, not linear and predictable (Kingdon, 1995; Exworthy *et al*, 2002; Hunter, 2003a; Nutbeam, 2004, Petticrew *et al*, 2004; Bauld *et al*, 2005). The determination of the government to persist with their ever more radical reforms of the public sector would suggest that there is little understanding of the cycle of change at this level (Mackenzie *et al*, 2003), and almost no emphasis placed on learning from the experiences of those working on the frontline (Coote *et al*, 2004).

This lack of realism about the process of policy implementation means that the consequences of policy initiatives are frequently not given sufficient consideration at the time that policy is developed (Bauld *et al*, 2005). Central government needs to

pay more attention to creating supportive structures for strategic change. It is not sufficient to demand change of others, the government also needs to create an environment within which that change can flourish. The findings here reveal that rapid policy changes and inflexible central control are counter productive to the generation of networks and collaborative working in localities. There needs to be time for people to engage with the new processes and form partnerships, and to plan programmes of work. People need to know that their work is making a valued contribution to the change process. They need to be able to exercise their own skills and knowledge in addressing local issues and to know that *“they would not be expected to overthrow these plans whenever a new national policy was launched”* (Bauld *et al*, 2005, p.437).

Maddock (2002) argues that a more radical way of organising the public sector is needed, one based on whole systems working, a view supported by Hunter and Killoran (2004). This research has demonstrated that it is possible to engage people locally in this way, and that working within a whole systems structure can be both engaging and enjoyable. The problem is that this joined-up approach does not extend vertically to the way central government chooses to work with local public and charitable/voluntary sector organisations. It has already been argued that there is a clear need to synchronise policy processes at the top and the bottom of policy implementation (Exworthy *et al*, 2002; Hunter and Killoran, 2004). Gillies (1998) has argued that *“reciprocity must work and be seen to work across levels in society and across informal and formal networks”* (ibid, p.102), and this is true of policy development and implementation.

The government needs to work in the way that it espouses for those implementing policy locally. They need to build relationships with the frontline agencies, trust that these agencies will implement policy appropriately to local circumstances, ensure that the operating environment is conducive to bedding in and developing these changes, trusting that their own policy initiatives will generate significant change in the operation of the public sector. This latter requires the government to work from the same underlying values that they promote in local partnerships, and time, local determination and a stable environment free from persistent change. The pleasure and excitement the DoH civil servants expressed at working in an inclusive way shows that this is not only possible, but that it is also rewarding.

The government has employed two distinct sets of values in its approach to tackling deprivation and public service improvement. These values come into conflict where they meet in area-based initiatives such as Health Action Zones. Collaboration and partnership are promoted locally to address the entrenched problems of specific areas. These policies though are managed in a way that is counter productive to the flexibility and innovation that the initiatives have been encouraged to seek. Furthermore the radical reform agenda directed at the public sector increasingly retreats to neo-liberal values such as competition to drive up standards. Competition is a process counter to collaboration and so the macro processes of government are working against the micro processes of policy implementation at the local level.

The quote from Maddock (2002) at the top of this chapter also stresses this point. She argues, and the MHAZ has shown, that if insufficient attention is paid to vertical networks and relationships then the government aims of stimulating innovation to address equity and social justice issues will not succeed. Gilson (2003) observes that

such relationships have traditionally been seen as utilitarian, but now the influence of values and factors such as trust are being recognised as being more important than simple behaviour in forming and maintaining relationships. Again this suggests that there needs to be a congruence between the values underpinning the work of central government and those working locally, and *‘where consensus is lacking, activities in one sector may undermine those in another, especially if those activities are informed by contradictory values’* (Tilford *et al*, 2003, cited Wills and Woodhead, 2004, p.10).

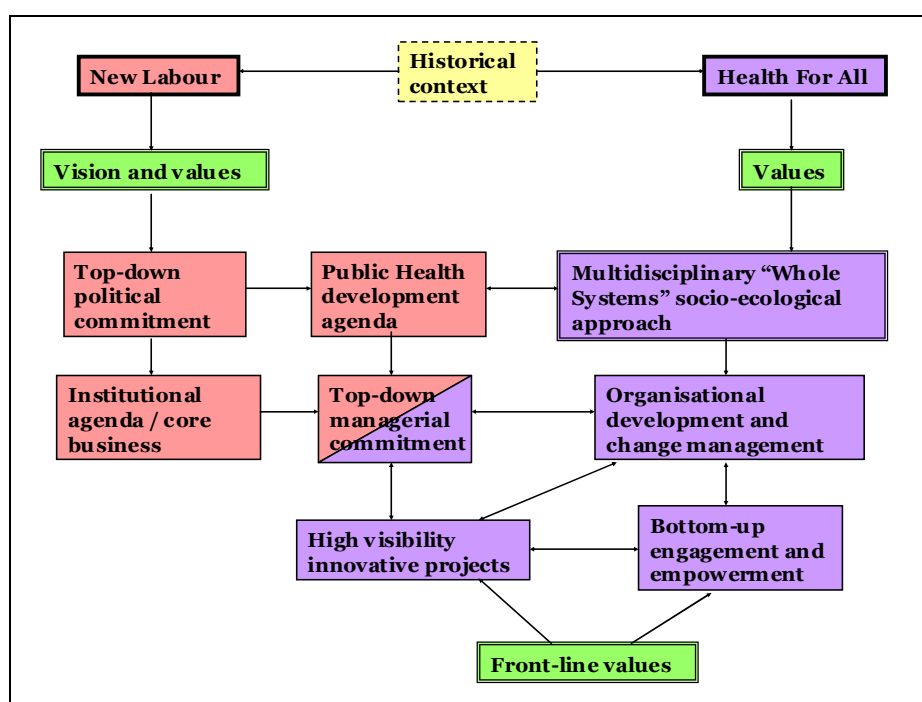


Figure 8.2 Healthy Settings model amended for MHAZ implementation
(based on Dooris (2004, p.55))

Using the labels from Figure 8.1, Figure 8.2 demonstrates the two contrary processes at work within the implementation of the Merseyside HAZ. In contrast to the stress resulting from the efforts that New Labour have employed to generate social and

organisational change, these findings reveal that whole systems working has the capacity to transform the way people think and work. But at the centre of this way of working is the explicit underpinning of the policy process with a common set of values. In short,

Values + flexible support (including money) + people = enthusiasm + change.

8.4 Reflections on addressing health inequalities

The National Evaluation of HAZs had a subgroup looking at the different strategies the HAZs had adopted to reduce health inequalities in their localities. This group concluded that HAZs had had a minimal impact on reducing health inequalities within the populations they were working with (Bauld *et al*, 2005), although there was evidence that small changes had been achieved through specific interventions they had funded (Benzeval, 2003). This impact had been limited in part through the short timeframes and limited resources that HAZs had had (Benzeval, 2003). However, as Benzeval (2003) makes clear, it was never the intention that HAZs address health inequalities on their own, and they were only one part of the New Labour approach to improving health for the worst off in society.

In common with the findings presented from Merseyside, the National Evaluation of HAZs concluded that HAZs had had some success in changing the infrastructure for health improvement by raising awareness of the issues, through partnerships, and promoting the HAZ way of working (Benzeval, 2003; Bauld *et al*, 2005). Many of the different theories of how best to reduce health inequalities were implemented through the broad base of interventions that the HAZs funded, and these improved understanding of what works (Benzeval, 2003).

When health is understood as reflecting a sense of harmony and wellbeing (Townsend and Davidson, 1992; Hunter, 2003b), then emotions become central to whether or not we are healthy. This is an understanding of health prevalent within traditional cultures and supported by the biomedical field of psychoneuroimmunology. Health, though, is generated in many different contexts. The rainbow model of health presented in Figure 3.1 identifies living and working conditions as one of the layers of influence on health. These findings have identified working conditions that have both a positive and negative effect on the emotions of people working within them. It has been argued in Chapter 3 that stress is health damaging and social support is health enhancing. Both stress and support systems have been evident in the implementation of the HAZ on Merseyside. As such these findings provide an opportunity to reflect on some of the theories relating to the production and reduction of health inequalities presented in Chapter 3.

Stress within the MHAZ implementation has been experienced in all parts of the implementation network. Most of this has resulted from the government's changing agenda and heavy bureaucracy. The civil servants charged with delivering these changes found it difficult to be on the receiving end of the frustration and unhappiness of those working in the HAZs. The greatest amount of stress, however, was experienced by those who needed to respond to these pressures. It has been proposed that the stress experienced in being lower down a hierarchy is related to a lack of control over one's environment (Marmot *et al*, 1997; Brunner and Marmot, 1999; Wilkinson, 1999; Graham, 2000b; Wilkinson and Marmot, 2003).

The instability and insecurity experienced by those working on the frontline of the statutory sector or within the charitable/voluntary sectors caused a great deal of

upset. The particular causes of this dissatisfaction have been discussed in detail above, but in brief relate to pressures of time and money, perceived loss of flexibility, inability to work in a preferred way, feeling undervalued, and the need to adapt to constantly changing circumstances. The greatest frustration was expressed by those who felt they had the least control over their circumstances.

By contrast, being connected through networks and working collaboratively generated a great deal of enthusiasm. Glaser (2005) has suggested that feelings of loneliness and a lack of social interaction can create stress. Here, one of the benefits of feeling connected has been the sense of contributing to a larger process of change, in essence a reduction in a feeling of isolation. This supports the arguments for the positive influences on health of having access to local networks (Townsend and Davidson, 1992; Graham, 2000b; Hunter, 2003b). Feeling supported and having access to help has also ameliorated feelings of isolation and a lack of control, confirming the view that social support is important for positive health (Whitehead, 1995; Szreter and Woolcock, 2004). Similarly, a number of the interventions included in this research have demonstrated that working collaboratively and in multi-disciplinary teams can be effective in improving material conditions for people living in Merseyside. Other interventions have demonstrated the transformative power of bringing people together to address a specific issue.

To some extent these two aspects of health resonate with one of the key areas of conflict within the health and health inequalities debates, that is the relative importance of material circumstances and psychosocial determinants of health (Szreter and Woolcock, 2004). Those conditions that create stress echo the argument for material circumstances being the primary cause of different health outcomes.

However, there is still an emotional impact of the physical difficulties these people experienced at work, such as funding issues, time pressures and job insecurity. Support and connections may mollify the effects of material change, but they cannot remove or prevent those conditions. These findings show that the material and psychosocial determinants of health are intertwined. Therefore efforts to improve health need to include strategies for both aspects, further supporting a whole systems approach to health promotion. This whole system, though, needs to work vertically and not just be implemented in the local plane.

Local processes are influenced by the wider context. Horizontal social cohesion may be amenable to area-based action, but it will not solve the problems of inequalities on its own (Rhodes *et al*, 2003). Those who fear that a focus on area-based social capital is seen as a cheap fix to the problems of neo-liberal capitalism (Gamarnikow and Green, 1999; Lynch *et al*, 2001; Kawachi *et al*, 2004; Szreter and Woolcock, 2004) are right to be concerned. To effectively address the underlying determinants of health there needs to be more vertical social solidarity (Whitehead and Diderichsen, 2001) where processes are put in place to generate cohesion throughout the social strata, and specifically in this case, between the national government and its local programmes.

8.5 Personal reflection of the research process

The time and therefore the story, belongs to them. Yet the meaning of the story, what makes it worthy of being told, is what we can see and what inspires us because we are beyond its time. Those who read or listen to our stories see everything as through a lens ... we are the grinders of these lenses. (Berger, cited Back, 2002, paragraph 2.1)

Back (2002) quite rightly says that writing a PhD has the same relationship to time as described in the quote above. The ‘them’ in this case are the people who have taken part in our interviews and whom we have observed. In essence we have dipped a toe in the waters of the lives of these individuals and looked for patterns and differences in the way that water has seemed to us. In my case, the people I have met have been associated with the Health Action Zones in some capacity. Without exception they have been generous in their willingness to talk about their experiences of working with this programme. It has been a privilege to work with them.

It has also been an enormous learning experience. There have been two areas particularly that have been the focus of learning for me. Firstly, and not surprisingly, I have been improving my skills as a researcher. More is said of that later in this section. Secondly, I have learned not to judge too quickly or to presume too much. These are also important lessons for a novice researcher, but here I am talking specifically about the academic discipline of critical appraisal.

I came to this PhD fresh from an undergraduate degree where I had honed my critical appraisal skills assessing literature in various topic areas. I am passionate about justice and fairness, and I believe that neo-liberalism is neither just nor fair. It is a good way of making money if you are on the sky-side of the coin, but that does not make for a strong society in my view, which is supported by the findings here. I came to the MHAZ believing that it had little chance of reducing health inequalities in the context of capitalist processes that exacerbate inequality. I said as much in my first joint supervision session with my HAZ and university supervisors. I quickly realised that I had been too harsh, especially when many people were working extremely hard to try and make the MHAZ work.

The very little literature relating to HAZs at this time was also very negative about their prospects for success. I asked one co-ordinator how this felt and was told that it was upsetting to be working so hard to make a difference and to be faced with such negativity. This was the beginning of my interest in presenting the actual experiences of people endeavouring to deliver policy on the ground. Rarely are such people presented as hard working and committed. To be fair to them I wanted to tell their story, and to elucidate what makes their jobs harder and what makes them rewarding.

8.5.1 *The research process*

The process of writing a PhD is helped by examining “*the relationship between thinking, listening, writing and time*” (Back, 2002, paragraph 2.3). Time, of course, is a constraint – there is a point by which one is supposed to have completed one’s PhD, and for me that came far sooner than I was ready for it. In common with other aspects of my life, a final deadline proved to be the best catalyst for getting past the (writing) blocks that seemed to beset me. Time, though, is also a measure of the whole process, of the journey of learning – about the subject and ourselves, and of the practical procedures we have undertaken to produce the final document. In this section I want to present a reflection on the journey of learning and on the importance of time in the process, and on the particular lens I have ground in order to tell this story.

As I have said, it was clear to me from the very beginning of my relationship with the Merseyside HAZ that there was a conflict between the heavy top-down bureaucracy experienced by those working in the public sector and their requirement and desire to improve the lives of those they served, especially the poorest in society.

Whenever I talked about my interest in researching this tension I was greeted with interest and enthusiasm. Already in 2000 people were feeling overwhelmed by their duty to 'join-up' and the pressure put upon them to meet targets. Often people commented that they spent so much time in meetings and responding to the changing requirements that they had little time to actually do the jobs they were employed to do.

This tension was apparent within the MHAZ itself, although one Central Co-ordination Team member now working in a PCT has since commented that the pressures they felt in MHAZ were far less than this person now has in the health sector proper. I have always felt that this tension has been an important story to tell. But most importantly, I have been enormously impressed by the obvious energy, commitment and enthusiasm of the people connected to the MHAZ. These people were fired with a passion and desire to make a difference to the lives of the people they dealt with. With only a few exceptions, their connection to MHAZ and the HAZ Way of Working had been extremely positive.

For me this was a lesson in how much people gain from being connected and from being able to realise their personal goals. Values are enormously important in this process. They are what lead us to do what we choose to do. Where our ability to work according to those personal values and goals is stifled, we experience stress. And stress leads to poor health. This is clear from the debates about health inequalities and the best way to address them. In these debates it is often argued that social support is important in promoting health. Social support on its own will not mediate against poor material conditions, but in conjunction with opportunities to do

things differently, support is a valuable mechanism for generating change. Creating a supportive environment is something that the MHAZ did well.

Researching this process has been a long and emotional journey for me. In Chapter 2 I gave a model for the 'real research cycle'. In this model there are periods of clarity and activity and periods of confusion and inactivity. For most of my engagement with the MHAZ the research process has been an escape from difficult personal circumstances. It has been intertwined with a powerful, extremely personal, emotional journey. As has been said earlier, this enabled an extended observation of time the MHAZ was in operation. It also meant that the process for me had many breaks, and many of the interviews were conducted at a time when my thought processes were not as clear as they might otherwise have been.

In Chapter 2 I discussed different types of interviews and explained that I chose to use a more conversational style in the interviews for this research. This had two benefits. Firstly it helped to put the other interview participants at ease, and therefore usually elucidated more of their personal experiences than perhaps a more structured approach might have done. The second benefit was that it helped me to get over my nerves, and to put me at ease. I started this process as a novice researcher with many concerns about conducting the interviews 'properly': making sure I covered all that I wanted to; making sure the interviews recorded well; making sure I did not ask leading questions or behave in a manner that would lead the other person's responses. I know I made mistakes in all these areas. It is part of the process of learning. Occasionally my inexperience led to lively debates, or stilted conversations. But all the interviews were the product of two people, and sometimes the energy in the interview had more to do with the other person or people involved

than it had to do with me. By keeping an interview journal I was able to reflect on these things afterwards.

It was clear, though, that there were emerging themes from these interviews. These themes were verified in presentations and conversations with people associated with the MHAZ. They were also verified in conversations with others associated with the HAZs elsewhere. This helped me to build trust in my approach and the style I had adopted; a trust that was further confirmed in conversations with more experienced researchers.

My frequent withdrawal from the research process also meant that there were a number of occasions when I had to re-engage with my research and the data I had gathered. On each occasion I was drawn to similar conclusions, again reaffirming the ongoing analytical process I had undertaken and the findings that were emerging. I had fully expected to find my final research question to be very different from that I had started with. In fact there were many twists and turns in my efforts to understand the implementation experience at MHAZ. In the final analysis, though, the research question and objectives were fundamentally the same. The nuances of these are certainly different, and the findings relating to the importance of people and their values were unexpected.

8.5.2 Impact of researcher on analysis

Like all researchers I have a particular view on the nature of the topic being researched. I have discussed earlier my beliefs on health and the generation of health inequalities. In this respect it is probable that my personal values acted as a filter when deciding which themes and categories were most dominant within the data, as these will be the themes that resonate with my values and interests. It is possible that another researcher would

have found other data more resonant, or put data together in different ways. It is in this way that research is rarely unbiased.

In Chapter 2 I described how my conclusions are similar to those of others researching the MHAZ. This chapter has demonstrated that many of the themes from the analysis have also emerged in research with other HAZs, Sure Start programmes and organisational social capital. It is probable that all of these researchers have a similar value set, and one that is in common with those working in these initiatives, and so would reach similar conclusions from similar data. This is in essence one of the key arguments of this thesis – that values shape how we perceive the world and determine how we wish to act within it. The researcher is no different.

My desire for fairness has caused me to look at how people work together and whether people get what they need to be able to work effectively. Issues around these things are those that have caught my attention in the data. It is why I have focussed on those actions of New Labour that have not helped people deliver on New Labour aims; it is why I have focussed on those things that have helped people work in the manner they wish to; and it is why I argue that this data demonstrates that people work best when they are supported, trusted and have flexibility and resources to work creatively.

8.5.3 Impact of funding and supervision arrangements

I have been jointly funded and supervised by the MHAZ and the University of Liverpool. Both of these organisations could have engaged me in this research with a particular agenda in mind. At no time have I felt pressured to pursue any particular direction in my research, or to favour any conclusions. My supervisors at the MHAZ focussed on familiarising me with the work of the MHAZ and facilitating access to some of the

systems and conferences associated with their work. Our meetings were an opportunity for me to gather and clarify information about the HAZ. My first supervisor at the MHAZ had an academic background and provided additional guidance on keeping a research journal, my interview schedule, and gaining access to people for interviews. She also gave me valuable feedback on my interview technique after I had interviewed her (when she was no longer my supervisor).

I have maintained critical distance in my research through my work with my supervisor at the University who made me question my relationship with the MHAZ and how this could impact on my research, and through peer review and academic reading. I have had to give an annual presentation at the University and this has afforded the opportunity for close questioning by my peers and academic staff within the department. I have also given joint presentations to people connected with the MHAZ, and these have generated critical feedback from the audience. The findings from other research also enabled me to reflect on my own work to ensure that I was not ignoring areas that were potentially difficult for me to address. Finally I chose to work mainly at the University, only engaging with the MHAZ through visits, supervision, meetings, interviews, seminars and conferences. This meant that I was not fully embedded in the field of research, and my primary working influences were academic.

I have written above how my initial scepticism about the potential achievements of the MHAZ has been softened by the realisation that, without exception, the people I have met are all working extremely hard and with a great deal of commitment to the ideals of improving the lives of the people of Merseyside. Although my close relationship with some members of the MHAZ could potentially have made it difficult for me to maintain a critical distance, it has been a key feature of this work that very few people have had

complaints about the internal workings of the MHAZ. However, there have been criticisms of some of the aspects of the MHAZ work, and I have tried to represent these fairly.

8.5.4 Strengths and limitations of the research

Notwithstanding the issues already discussed concerning my privileged access to the MHAZ and people associated with it, this close relationship was undoubtedly a strength of this research. It reflected the inclusive values espoused by those working with the HAZ in Merseyside, and it enabled me to observe and explore the joys and frustrations of implementing this HAZ. As a piece of policy ethnography, this research has enabled a closer look beneath the HAZ policy to examine what helped and what hindered the process of implementation in this context. As such it provides valuable insight into what can be done to facilitate the implementation of such policies, and how this government has been working against its own creative and innovative ideas. It has added to an emerging literature on the importance of values and support in policy implementation.

One weakness of the research is that I could have taken more advantage of my close relationship with those working with MHAZ to strengthen the observation aspect of this research. I did not attend Steering Group meetings, for instance – it was felt to be inappropriate at the time that I asked. I could have spent more time in the office observing the day-to-day operation of the Merseyside arm of the HAZ. I had intended to do so whilst reviewing minutes from Steering Group meetings. This was one of the casualties of the vagaries of my personal life. In this way the internal triangulation of the data was weakened. However, as mentioned earlier, external triangulation verified my findings, so I mainly lacked a richer source of data for

analysis.

I would have preferred to have fully transcribed the interviews. This would have made the analysis more straightforward. Because I took detailed handwritten notes from the interviews, the data could not be analysed using computer software, and the analysis process was very labour intensive. In addition, it would have provided documents that I could have shared with the interview participants for comment. From an inclusive research perspective this is an important step in honouring the role the research participants have played. I had intended to send summaries of my conversations to the interview participants for them to comment on. This fell by the wayside for the same reasons that I did not transcribe the interviews – I did not have the time or energy at that stage of the research process. The fact that this data has not been verified by those who own it is a weakness of this research.

8.5.5 *What have I learned to do differently?*

There are things that I would have liked to do differently, had circumstances been different. I would have preferred to have been more systematic in my approach to the research; to have had fewer periods of inactivity, and to have been working to a clearer framework, because that is more comfortable for me. Although there have been advantages to a lengthened research process (discussed earlier), it has also meant that I have had to re-engage with the process on several occasions and this takes time and energy. I would in the end have liked the whole process to have taken less time, but this belies the real advantages to me as an individual and as a researcher for the flexibility of the process as it did unfold.

In addition, it would have been better on reflection to have been clearer about confidentiality and anonymity with the interview participants, and to have had a

more formal, documented informed consent process. This is good research practice and would have provided the research participants with a clearer understanding of how their conversations with me would contribute to the overall research.

8.5.6 Dissemination of findings to relevant policy and research communities.

I do feel it is important that the participants receive something from the process. A number of them said that they would look forward to reading my 'report'. In this light I intend to produce an executive summary of the main findings from this thesis and to share that with all the participants from the formal interviews. I also hope to present my findings orally to a similar audience, and perhaps one that includes partners in the Cheshire and Merseyside Public Health Network, ChaMPs. I will disseminate the findings to a wider audience through articles in relevant journals and through conference presentations.

8.6 Discussion Summary

There are two common threads to the discussion of the findings and my own reflection on the research process. Firstly, at the beginning of my research I, like many other academics and politicians, lost sight of the fact that the processes I was researching were happening through fellow human beings. People who were largely working very hard and to the best of their abilities to effect change in difficult circumstances. Change only occurs through the efforts of people and this research has provided more evidence of what it is that people on the frontline of delivering New Labour policy need to be able to do that well.

And this is the second common observation. People need supportive environments. I needed and received a great deal of support from many people to remain engaged

with my PhD and to complete my thesis. The enthusiasm people felt for the MHAZ reflected the MHAZ investment in creating a flexible and supportive environment for innovation and change. The unhappiness people felt with the New Labour policy and managerial processes resulted from the time taken away from their core work to respond to these processes, and the instability these processes introduced into the working lives of people.

In essence these two aspects of the HAZ implementation reflect the two sides of the New Labour Third Way aims. The bottom-up HAZ processes reflect their concern for social justice and equity, and especially the 'health gap' approach to reducing health inequalities by targeting resources at the more deprived areas. HAZs were also a quick fix to inequities in NHS funding allocations, and as such were probably always a stop-gap measure. This fits with the assertion by Powell and Moon (2001) that HAZs were mainly test-beds for new policy aimed at reducing health inequalities and modernising services.

The second strand the New Labour Third Way aims is the adoption of the neo-liberal emphasis on reform and competition as the means to service improvement. In this context it is manifested in the constant pre-occupation with 'modernising' the public sector and micro-managing the operation of those services. This is the policy context that created so much frustration amongst those associated with the HAZs, and, as a number of authors have commented, is disempowering. In one real sense, therefore, this research provided an opportunity to explore these two aspects of the New Labour philosophy through the experiences of the people involved with the MHAZ programme. It provides an opportunity to assess what might or might not contribute to the New Labour goal of changing society.

Chapter 9

‘A good start in difficult circumstances’¹⁰

Government attempts to give public health policy a higher priority over health-care policy have failed; have been eclipsed by the NHS reforms started in 1997, but pursued in a frenzy from 2001 following the NHS Plan; or have simply fizzled out having made little impact (possibly because they have not been given a chance). (Hunter, 2003b, p.159/160)

This thesis has at its core the story of the implementation of the Merseyside HAZ, revealed through policy ethnography. It shows how the HAZ came into being through opportunities created by New Labour, and how this opportunity generated excitement at the possibility of putting a particular set of values into practice with government support. Over time this support waned, and New Labour top-down reform and managerialism created insurmountable pressures on the initiative. At the heart of this tension is the conflict in two change management processes: a collaborative, flexible, whole systems approach to local change and a prescriptive, burdensome attempt to force change in public sector organisations. These two ways of working are influenced by different value systems. This reflects the paradox at the heart of New Labour, and as such the experiences of the MHAZ offer insight into the macro level policy processes of New Labour’s Third Way.

New Labour came to power in 1997 claiming a new pragmatism about ideas and not ideology. What counts is what works. They took the ideological position of combining the neo-liberal economic approach introduced by Margaret Thatcher with the social democratic value of supporting a strong welfare state. New Labour

¹⁰ Bauld *et al* (2005, p.427)

maintained the socialist ideals of equity and justice, but rather than basing these on shared ownership of resources, they proposed a fairer access to opportunity. This opportunity was to be coupled with people taking responsibility for themselves. Rejecting the call for substantial income redistribution, they instead focused attention on sharing the benefits of economic growth more equitably through fair access to public services, and through rectifying the effects of social exclusion and deprivation within the poorest communities.

New Labour introduced a plethora of area-based initiatives and policies aimed at addressing various aspects of poverty, inequality and social exclusion. Area-based initiatives have been criticised because they miss most of the poor people. However, they are useful as test-beds for policy change. Health Action Zones fell into this category. Their underpinning values and commitment to whole systems change reflected earlier approaches to health development promoted by the World Health Organization, particularly through its Healthy Settings programmes. The Healthy Settings values are those of the WHO Health For All programme and are closely related to those of the HAZs, represented by the HAZ Principles. In this way, the HAZ programme attracted many people who wanted to work with the Health For All principles on a large scale rather than on the side-lines, or even behind the scenes, of government policy.

Although policy change may be a natural state of affairs within the statutory sector, the speed with which change is now occurring is unhelpful (Hunter and Killoran, 2004). New Labour have instigated a number of policies which are showing to be beneficial, but which need time to bed in and become second nature. There is an essential conflict between the rapidly changing policy arena, and especially the need

to demonstrate quick results in the delivery of public services, and the needs of the people charged with delivering those changes on the ground (Crawshaw and Simpson, 2002; Barnes *et al*, 2003; Crawshaw *et al*, 2003; Hunter and Killoran, 2004; Newman *et al*, 2004). In many ways New Labour is shooting itself in the foot by focusing too much attention on targets and bureaucracy and not enough on the real changes in working it has facilitated through programmes like Health Action Zones. In Liverpool and the Merseyside region this has added relevance in that it has so often been the site, since the early 1960s, of government initiatives and plans to counter the impact of poverty and deprivation in all its dimensions from education to health, employment to crime (Rooney, 2003). As Rooney has so pertinently noted, the various and many interventions have had a variable impact, but that what is telling is that so often little is learnt or remembered from initiatives. It would seem that those working in the field and the various agencies charged with implementing the new initiatives rarely have the chance to absorb lessons of one set of projects before another set come sweeping through. It would be of great concern if the MHAZ was to become yet another example of this process.

Partnerships work when there is a shared set of values, a commitment to the partnership, and a flexible structure that is adaptive to change (Pratt *et al*, 1998). The relationships within such partnerships are based on, and build, mutual trust and support (Gillies, 1998; Exworthy *et al*, 2002; Gilson, 2003). In Merseyside, the core HAZ partnership – the Steering Group – saw many changes over the time of the initiative, but remained strong until the NHS reorganisation and funding insecurities introduced instability into the system. It had been strong because of the common commitment to reducing health inequalities on Merseyside, underpinned by the values represented by the HAZ Principles, and through a commitment to

development that enabled the partnership to adapt to the many changes and restrictions the central government imposed upon it.

Money had been important in bringing this partnership together, and in maintaining interest in the HAZ programme. It provided the opportunity for people to take risks and be innovative. For some frontline staff it had enabled them to work in the way that they wished to, but were normally too constrained by the system to do so. MHAZ funded many projects that should really have been funded out of mainstream budgets but could not be because the money was not there. This combination of funding extra things, and whacky creative things, meant that there was difficulty mainstreaming projects once HAZ money had run out. This was especially true as the NHS reorganisation occurred alongside the HAZ funding difficulties, and the PCTs inherited massive debts from the Health Authorities and so had little money to spare for additional projects.

Three things are clear from the literature and the findings of this research. Firstly, two distinct ways of working collided in the HAZs. The New Labour top-down, command-and-control, approach to generating improvement in the public sector is overwhelming, time consuming, distracting, stressful and gives the impression that the government does not trust public sector personnel (C.Jones, 2001; Maddock, 2002). It also runs contrary to the ethos of the joined-up solutions that New Labour wants to find to the intractable problems of deprivation and inequality (Hunter and Killoran, 2004). Joined-up working requires flatter, more flexible structures (Powell and Exworthy, 2001), with a shared set of values and commitment from the different partners. This is difficult to achieve if the partner organisations are swamped with

directives from their own government departments, and if these directives are not complementary to one another.

It is possible to build these flatter structures, and for them to work. It takes strong and capable leadership (Barnes *et al*, 2003; Cole, 2003; Evans and Killoran, 2004; Hunter and Killoran, 2004; Myers *et al*, 2004), support (Maddock, 2002; Gilson, 2003), and the opportunity to be creative (Maddock, 2002). The resulting organisational structure, in Merseyside, was flat, flexible, adaptive, supportive and helped people and organisations to make connections throughout the region. People enjoyed working in this way. This pleasure at the 'HAZ Way of Working' extended from the central civil servants down to frontline staff in the statutory sector and those working in the voluntary sector, justifying Frank Dobson's belief that HAZs would promote collaboration and release local energy and enthusiasm. This is in stark contrast to the pain people often experience working on the frontline of the statutory sector (C.Jones, 2001; Maddock, 2002; Coffey, 2004).

Secondly, these different ways of working reflect different underpinning values. The HAZ principles were similar to those of people working in the interventions. Combined with the HAZ Way of Working, this was liberating and left people feeling supported and connected. People liked the resources and freedom to be creative. They liked the autonomy that came with this, but knowing that there was someone to call if they needed help. They liked connecting with other people, projects and organisations. They liked feeling they were contributing to a bigger process of change. They liked the flexible, supportive approach that HAZ took, it left them feeling trusted. And they liked feeling like they were making a positive and practical difference to people's lives. The central civil servants enjoyed making policy with

people, and having the opportunity to visit the HAZs to see the effects of the programmes on the ground. One of these civil servants used the word ‘exciting’ several times when describing her work with the HAZs. These findings reflect the arguments that Catford (1998) makes in support of social entrepreneurs working in ‘Peckham-style’ community initiatives:

...the success of these initiatives rests on the engagement of individuals and organisations in shared endeavours. This in turn requires co-operation and communality, the sharing of power, and the commitment and engagement of key actors ... it is the long-term relationships, trust and ethic of co-operation which provide the basis for innovation necessary for social as well as economic development. (Catford, 1998, p.96).

In one crucial aspect, the MHAZ story is revealing in exposing the imagination and energy of health workers when given the opportunity to put into practice their ideals and principles about health equity and social justice. As the thesis has revealed, for many working in the HAZ, the experience was liberating and exciting and in marked contrast to their earlier experiences when they felt constrained and often demoralised. In addition, this research has revealed that within a creative and supportive environment the capacities of health workers can be released and realised with profound benefits for the quality of service provided.

In contrast, the MHAZ staff were subjected to a barrage of changes and heavy monitoring that tested their ability to adapt. These changes resulted from the particular vision of the Secretary of State for Health, Alan Milburn (Bauld *et al*, 2005). Just as the initial design of the HAZs had reflected Frank Dobson’s vision and values (Lannin, 2003; Bauld *et al*, 2005), so the changes in emphasis were a reflection of Alan Milburn’s priorities and values. This demonstrates how important

individual Ministers are to the policy process (Kingdon, 1995; Chabal, 2003). Individuals are important as makers and breakers throughout the policy implementation process, and conflict and consensus are both dependent upon the degree to which individual values are shared. The values behind the top-down reform and management agenda are the opposite of those described as working within the MHAZ. They suggest a lack of confidence in frontline staff and promote competition as the means to raising standards of service.

Thirdly, people are the medium through which change occurs and they need to be supported in their efforts to make that happen. It is the vision, energy and drive of individuals, working alone or collaboratively, that generate change. Catford (1998) has argued that social entrepreneurs need supportive environments, and this is true of all champions. Individual vision and drive can achieve wonders, but it is unsustainable if those individuals are working in an environment that is contrary to what they believe and are trying to achieve. The MHAZ Co-ordinator and the two Chairs of the Merseyside HAZ were named several times as instrumental to the success of the HAZ. They created an environment where others felt supported and were able to work collaboratively for the good of Merseyside as a whole.

Intrinsic motivations are particularly diminished when individuals feel that external interventions undermine their own self-determination or self-esteem. But such interventions can build intrinsic motivations such as trust when they are perceived to be supportive, fostering self-esteem and enlarging self-determination by giving individuals freedom to act. (Gilson, 2003, 1462).

The MHAZ partnership unravelled with the introduction of people to the Steering Group who did not share the values of the existing members (Pratt *et al*, 1998; Barnes *et al*, 2003). With time and funding, it may have been possible to incorporate

those people into the HAZ Way of Working. Unfortunately, the money was not secure, and the changing policy context made it easier for these new individuals to argue that the Merseyside focus was no longer needed. This is an example of how a few individuals can undermine an otherwise strong partnership when the context within which the partnership is operating has become unstable (Barnes *et al*, 2003).

In summary, the conflict in ways of working and values at the macro and micro levels of policy development and implementation caused a great deal of frustration and pain. This left those at the sharp end of policy implementation reeling, feeling undervalued and not trusted. In contrast, the way the MHAZ operated generated enthusiasm and demonstrated the power of working collectively with common aims. Through this approach people felt connected, supported, appreciated and empowered. These findings further support the efficacy of WHO Healthy Settings at a regional level, provided there is a strong core partnership supported by a dedicated support and co-ordination team.

In the introduction it was argued that there is a need for a greater understanding of what needs to be in place locally for national policy to be implemented successfully (Hunter, 2003a). Exworthy *et al* (2002) have argued that there needs to be greater synergy between the central and local processes of implementation. From these findings it is possible to expand on that to suggest the following:

1. New Labour need to ensure that the values and ways of working at the macro and micro levels of policy implementation work in harmony with one another. This requires greater consideration of the impact of policy change at the local level. Persistent and rapid change is overwhelming and can create an enormous burden on statutory agencies. There needs to be fewer changes and, therefore, better long term planning of strategies for the public sector to improve the degree of stability and security experienced by frontline workers. Finally, the government needs the

courage to give innovative initiatives the time and support they need to come to fruition.

2. A heavy monitoring and target agenda is time consuming to execute. This is true of both the statutory sector and charitable/voluntary organisations. Be realistic about targets, performance monitoring, and league tables, and create the space for people to assess their work in a way that is meaningful. Trust these frontline workers, they know their jobs best and most of them want to do them well. They enjoy making a difference to people's lives.
3. Make sure there is money for people to do the tasks asked of them, but also to take some risks and be innovative.
4. Ensure that there are strategies in place for sustaining work that is successful.

Evidence from alliances for health, learning organisations, and community social capital, suggests that relationships based on trust and mutual respect generates innovation, and enhances health. This is in direct conflict with the principles of neo-liberal capitalism which emphasises individualism and competition as means for individual improvement and economic growth. In following the Third Way, the New Labour government is trying to marry both means of transformation. The propensity for a collaborative approach to innovation to take longer to achieve, seems to lead to a rapid retreat to neo-liberal approaches (Hunter, 2003b).

It is perplexing that the government does not seek to capitalise on the benefits that it has created, but rather seeks to control – and therefore reduce the effectiveness of – the processes needed to create change. Flexibility is what is needed, and a small amount of money to fund innovation. Most importantly, this thesis demonstrates that change is best achieved when there is synergy in the values and ways of working at the macro and micro levels of public sector delivery. Much has been said about the paradox at the centre of the New Labour philosophy. Using the Merseyside Health

Action Zone as a case study, this thesis has demonstrated the destructive effects of trying to blend two oppositional value systems, and resulting ways of working, and calls into question the efficacy of the New Labour Third Way approach to promoting social justice and societal change. Persisting with these juxtaposed methods will undermine trust and alienate the public and charitable/voluntary sectors, and limit the probability of sustainable, beneficial change. In revealing the need for greater vertical co-ordination, this thesis indicates that New Labour would have been better adopting the Stakeholder philosophy for public service improvement that they rejected for the Third Way. If New Labour were prepared to work in this way the government might achieve the societal transformation it is aiming for:

At one level, therefore, trust is important to health systems because it underpins the co-operation throughout the system that is required for health production. But trust-based health systems also offer more to society. Rather than simply being shaped by the changing basis of societal values, a trusting and trusted health system can contribute to building wider social value and social order. (Gilson, 2003, p.1461)

Appendix A

Merseyside Health Action Zone Goals

(Source: MHAZ, 2000, pp.4-5)

Together we are determined to turn the tide of deprivation and health through:

- Getting our own house in order
- Creating a testing ground for new solutions through shared learning and experimentation
- Adding a health dimension to related policies and initiatives e.g. New Deal, transport, crime and disorder
- Identifying strategic gaps and opportunities for the investment of HAZ funding to create synergy and produce results
- Using HAZ as an 'umbrella' to create joined up policies, joint work on common objectives and efficient use of resources

Goal 1: We will reduce levels of poor health, preventable death, impairment and disability through modernising and improving health and social care by:

- Reducing inequalities in access to quality services for cardio-respiratory disease, cancer, infectious disease and mental health.
- Empowering people to manage common illnesses better by increasing awareness, providing accurate information, and enhancing the role of pharmacists and other primary care professionals. Together with influenza vaccination for at risk groups, this will help to reduce winter pressures on health services.
- Tackling ill health, accidents and violence due to alcohol through partnership working with the Police, Local Authorities and service providers.
- Changing attitudes about health away from dependency and towards a person centred empowerment approach which involves people in decision making about their health and wellbeing

Goal 2: We will promote healthy employment opportunities by:

- Working with schools and other organisations to increase employability, particularly of young people
- Promoting healthier workplaces through putting our own house in order' as major employers and working with the private sector
- Improving access to employment by overcoming the barriers like poor health, attitudes and practices within organisations, inaccessible buildings and transport
- Supporting marginalised groups of people in training and into employment by working with partner organisations, the voluntary sector, New Deal, Employment Zone and local EU Pathways community partnerships to add a health dimension to local regeneration initiatives

Goal 3 - We will increase the proportion of people who have an active independent life by:

- Providing support for people to remain in their own homes for as long as possible and preventing loss of independence by providing safe, secure and energy efficient housing, and support to people following bereavement.

- Modernising rehabilitation services
- Tackling specialist staff shortages through recruitment and training
- Supporting local community transport initiatives to reduce isolation for marginalised people.

Goal 4: We will enhance quality of life by:

- Using health impact assessment expertise to review policies in order to enhance their potential for health improvement e.g. transport, housing, community safety, New Deal.
- Working with local people to research what affects their wellbeing and quality of life and sharing this information with partner initiatives to ensure policies which make a positive difference.
- Building on the strengths of local communities and marginalised people through community development, befriending schemes, healthy living networks, self help initiatives and opportunities for capacity building.
- Providing access to affordable healthy food by working with food retailers and other private sector partners to tackle food deserts and evaluating other schemes to increase income for marginalised people.

Goal 5: Making it Happen:

- The Merseyside HAZ is about major strategic change within the core business of partner organisations. This will provide a framework for the sustainability of solutions identified through the HAZ. Our Making it Happen workstream will ensure the effectiveness of the HAZ change process.

Appendix B

Merseyside HAZ Partners

(Merseyside HAZ, available at: www.mhaz.org.uk, accessed 18th March 2003)

Partnership working is the cornerstone of MHAZ. In order to tackle the causes of poor health we must work in partnership with many organisations on Merseyside, making the best use of money, staff and time. We will achieve more together with our partners than we would do working separately.

HAZ Core Partners

The combined strength of the nine Primary Care Trusts and related NHS Trusts and the five Local Authorities is a major force for change within Merseyside. Together we are major employers, a major influence on the economy, a major purchaser of goods and services and a major influence on the environment.

Bebington and West Wirral PCT
Birkenhead and Wallasey PCT
Knowsley PCT
Liverpool Central PCT
Liverpool North PCT
Liverpool South PCT
Southport and Formby PCT
South Sefton PCT
St Helens PCT

Liverpool City Council
Metropolitan Borough of Knowsley
Metropolitan Borough of Sefton
Metropolitan Borough of St Helens
Metropolitan Borough of Wirral

HAZ Partners

Merseytravel
Merseyside Fire Service
Merseyside Police Authority
Merseyside Waste Disposal Authority
Safer Merseyside Partnership

Local Members of Parliament

Cheshire and Merseyside Strategic Health Authority

NHS Trusts:

University Hospitals Aintree Cardiothoracic Centre, Liverpool
Clatterbridge Centre for Oncology
Liverpool Women's Hospital
Mersey Regional Ambulance Service

Mersey Care
Royal Liverpool & Broadgreen University Hospital
Royal Liverpool Children's Hospital
Southport & Formby Community Health Service
Southport & Ormskirk Hospital
St Helens & Knowsley Community Health
St Helens & Knowsley Hospital
Walton Centre for Neurology and Neurosurgery
Wirral & West Cheshire Community Health Care
Wirral Hospital

Local Medical, Dental, Optical and Pharmaceutical Committees in Liverpool, Sefton, St Helens & Knowsley and Wirral

Community Health Councils:

Liverpool Eastern, Liverpool Central & Southern, South Sefton, Southport & Formby, St Helens & Knowsley and Wirral

Liverpool John Moores University
University of Liverpool
Liverpool Hope University College

Merseywise - Further Education
Education Action Zones
Training & Enterprise Councils
Careers Services
Employment Service
Liverpool and Sefton Employment Zone
Trade Unions (Merseyside)
Benefits Agency
New Deal Partnerships

4 Drug Action Teams
5 Crime and Disorder Partnerships
Merseyside Probation Service

Government Office North West
North West Regional Assembly
Local Regeneration Partnerships SRB/Pathways

Private Sector - Mersey Partnership, Wirral Investment Network,
Chambers of Commerce
Network on Disability
Employer Coalition - New Deal

Housing Corporation
Housing Action Trust

Community and Voluntary Organisations
6 Councils for Voluntary Service
Merseyside Youth Association
Faith Communities

The People of Merseyside

Appendix C

Sue Povall - PhD Status Report at 10/03/03

General: I need some help prioritising the 'extra' activities I have agreed to. I'm not spending enough time on my PhD (although they all help me towards it), and I don't have enough slack time built in to deal with stuff at home.

Research: I have my last interview, with xxxxxxxxxx, on Tuesday 11th March. I have made arrangements to see Frank Dobson on Monday 24th March in London. I still want to make arrangements to see Stephen Hesford, West Wirral MP, to talk about HAZs. Last week MHAZ organised an event at Aintree Racecourse to discuss the links between the Cheshire and Merseyside Public Health Network and MHAZ. Unfortunately, I only found out about this afterwards, and so was not able to attend.

Writing: More work on my methodology chapter.

LYAC Book Project: We have had two meetings at the University about this. The first on Wednesday 26th February with xxxx, xxxx, xxxx and myself to introduce Diane to the project and to clarify the role of the University. I think, in the end, we were successful in clarifying how the University can assist LYAC in this project, and in providing some guidance to xxxx about some of the issues they need to deal with. The meeting on Monday 3rd March was for all partner organisations. xxxx from BBC Radio Merseyside could not attend. Again, I think we succeeded in clarifying the University's role, that of xxxx as primary writer, and some ideas about what the content of the book might be.

Arab Arts Festival Evaluation: Got some good ideas from Chris as to how we could evaluate the event itself. Some reading about participatory evaluation. Went to the steering group meeting on Friday 7th March. Most of this was taken up with discussing the Museum's part in the festival. At the end we reached agreement that we would have a separate meeting to discuss and plan the evaluation. I would like to do a participatory evaluation, as one of the goals of the evaluation is learning from the process. The other advantage to this is that all the participants can collect information for the evaluation as we go along. This meeting has been arranged for Tuesday 25th March at the Museum (1-3pm).

Globalisation and Social Exclusion Unit seminar: Met with xxxx and xxxx on Wednesday 5th March. We had a good planning session. I will do the introduction. We have agreed to run the session along the lines of a debate. I will present some of the linkages between globalisation and health using a model from the Bulletin of the World Health Organisation, using HIV/AIDS as an example. xxxx will put the positive side of the argument, xxxx the negative. We hope this will spark a useful discussion.

POHG: Read and commented on the POHG position paper prepared by Clare Bambra and Debbie Fox.

Teaching: I did a one hour lecture on Health Inequalities to students on the BA Community Justice course - the same lecture on two occasions, Thursday 6th March. I had some good, positive, feedback about MHAZ in the second session. Extra validation for my research findings.

HAZ Evaluation: None.

Notes:

- I have ongoing SPSS work for xxxx (which is getting more complicated).
- There is a meeting to discuss a North West Health Inequalities Research Group on Friday 14th March.

For next time:

- *Research:* Start analysing interview recordings and other notes. Plan a interview schedule for my meeting with Frank Dobson, and send him a letter outlining the broad themes I wish to discuss.
- *Writing:* Finish my methodology chapter.
- *LYAC Book Project:* Meeting of all participants on Monday 10th March.
- *Arab Arts Festival Evaluation:* Familiarise myself in techniques to use at the evaluation meeting on 25th March.
- *GSEU seminar:* Work on my 10 minute presentation/introduction. The seminar is on Wednesday 26th March.
- *POHG:* Nothing planned. Next meeting on Monday 24th March. xxxx is organising a joint lecture with the Duncan Society.
- *Teaching:* None.
- *MHAZ Evaluation:* None.

Appendix D

Example of letter of introduction, strategic level

Recipient address

Date

Dear xxxx,

I am writing to confirm my appointment with you on xxxx, and to give you some background to the meeting.

As you know, I am doing a PhD jointly funded by the Merseyside Health Action Zone and the University of Liverpool. My research is looking at the Health Action Zone (HAZ) policy process as experienced by people involved with and/or connected with the Merseyside HAZ. I would like to talk with you because of your involvement xxxx. The information shared in this interview will be strictly confidential. However, with your permission, I would like to record our conversation for future reference.

The topics I wish to cover are:

- ♦ Your involvement or connection with HAZ.
- ♦ Your experience or observation of the HAZ process: positive or negative.
- ♦ What is different about HAZ and/or how you feel HAZ has made a difference.
- ♦ What can be learned from the HAZ experience and how that could be continued or brought into the mainstream.

If you have any questions or concerns, please contact me on my mobile phone xxxx, or through email: xxxx.

I am looking forward to talking with you.

Best wishes,

Sue Povall

PhD Student

Appendix E

Interview schedule

1. Your involvement or connection with HAZ.
 - ♦ Job role?
 - ♦ Relationship to HAZ?
 - ♦ How long been connected to HAZ?
 - ♦ What did you know about HAZ before that connection started?
 - ♦ What do you know now?

2. Your experience or observation of the HAZ process.
 - ♦ What has been good - what has been achieved, what has made a difference to you or your job or your project?
 - ♦ What has been bad - what have the constraints been, what has been difficult, what has frustrated you, what has got in the way of your job/project?
 - ♦ Has HAZ been able to meet its initial goals?

3. What is different about HAZ and/or how you feel HAZ has made a difference?
 - ♦ What other ABIs or community development projects have you been involved in?
 - ♦ Merseyside has a long history of regeneration initiatives, has HAZ been any different?
 - ♦ Do you feel that HAZ has been able to make a difference to the people or organisations of Merseyside? If so, in what way. If not, why not?

4. What can be learned from the HAZ experience and how that could be continued or brought into the mainstream?

Appendix F

Interventions included in data collection

- A project to deliver more cost-effective and appropriate services for people with mild to moderate mental health problems. Often people are referred for psychiatric treatment when they do not need it. The project aims to provide more patient centred care and to work more closely with GPs and other services to improve understanding of mental health treatment/service options.
- Community based support groups for parents of children who are addicted to drugs.
- Community enterprise, supporting people from deprived communities who want to set up their own small businesses.
- Community health forum acting as a facilitator and catalyst for local people for any health issue. Services include a shop front information and resource area, a local newspaper, an outreach facility for other initiatives such as the Fag Ends smoking cessation service, conferences about specific issues such as Asperger's Syndrome, facilitating local support groups such as the West African Elders.
- Developing volunteering opportunities within specific schemes, such as older people and young mothers. Providing the opportunity to improve skills within those groups.
- Disability awareness and the purchase of disability aids for hospital wards.
- Employment skills training for young people from disadvantaged backgrounds who probably did not complete their formal education.
- Food and Health Forum, an MHAZ supported initiative to promote healthy eating and other issues around food and health. This particular intervention was to introduce water bubblers in schools. Evidence shows that children do not drink enough water in schools, and drinking more water helps them to concentrate and stay alert.

- Health Improvement Co-ordinator for a Primary Care Group (prior to NHS reorganisation), using HAZ money to funding projects with the community, rather than imposing services on them.
- Healthy Heart Service – developing disease registers in PCTs to help patient quality of care.
- Healthy Living Centre Network Co-ordinator, providing support to community based partnerships applying for HLC status and funding.
- High profile community resource centre.
- Holistic support for people with cancer (not funded through HAZ).
- Inter-sectoral team providing support for older people in the community: accident prevention; pharmacist advice, health visitors, district nurse.
- Organisation providing grants of £1500 to people in disadvantaged areas with ideas that will benefit them and their community. Focus on sport and art to promote community development. Examples of the projects funded are: Baby Barrow where baby products are provided at cost through a credit union; using photography as a way of recording change through regeneration; health and beauty course for people with disabilities.
- Project to include a representative of the Citizens Advice Bureau in GP surgeries. Recognising that the underlying reasons for people visiting the GP might be to do with stressful living conditions, especially in poorer areas.
- Project to install gates across alleys behind terraced houses. This improves security for the residents and reduces crime locally. It also provides employment opportunities for the long term unemployed, rehabilitated drug users, and other excluded groups.
- Project to raise awareness about domestic violence and to provide support for the victims of such violence.
- Project working with sex workers using an holistic approach to improving their health and wellbeing.
- Provision of health screening for local authority employees.
- Provision of nursing home equivalent care in the patient's own home.

- Purchase of equipment for an Occupational Therapy department to facilitate the discharge of patients from hospital.
- Sheltered housing pilot project to provide sheltered housing support to people in their own homes. This is a joint project between council and health services.
- Smoking cessation services, a government initiative funded through HAZ. HAZ provided additional funds to allow for more innovative approaches.
- Social housing department of a Local Authority with several projects, some in conjunction with another district: central heating for people over 60, insulating homes, cold monitors, security lighting ... these projects were used to facilitate inter-sectoral work to bring in security assessments from the Police, fire safety check from the Fire Service, health visitors, and benefits health checks, electrical equipment from utility companies; dawn patrol where children look out for a card in the window of elderly people to indicate that they are all right; eco house in a deprived area which functioned as a community resource centre and was designed and equipped by the community, with assistance.
- Social inclusion for children with disabilities – advocacy for the participation of the children in the things they become involved in.
- Stress reduction courses where the trainers are drawn from across statutory sectors and community organisations. The project trains the trainers, the courses are provided at the partner organisation's expense.
- Support for asylum seekers to fast track qualification conversions so that they can work here – especially doctors, nurses, etc.
- Support for people who have been hospitalised with mental ill-health to help them back to work through: support groups, working with employers to make sure they have positive mental health policies; mentors in work; buddies; case workers.
- Support for the establishment of a 'time bank', reciprocal volunteering within a community. So that one person might mow the lawn for a neighbour, and that neighbour might do someone else's ironing. The underlying goal to help build social capital in poor communities.

- Support group with the aim of keeping women with mental illness out of hospital. The group provides mutual support, training and some funds for the women to pursue their own interests.
- Young person smoking cessation and prevention project, providing information on smoking and smoking cessation in primary and secondary schools.

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