Giving urban policy its 'medical': Assessing the place of health in area-based regeneration

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Abstract

How does regeneration affect health and how have successive urban policy evaluations sought to measure such impacts? This paper draws on a systematic review of national-level evaluation documentation relating to government funded area-based regeneration initiatives in the UK since 1980. The review examined whether health impacts had been intended and, if so, how they had been measured. The process and difficulties of conducting the review raise significant questions about policy formulation and evaluation. Is evidence-based policy possible where evaluations are not stored centrally? In short, models policy development as 'enlightened' or incremental is hard to sustain where a lack of systematic storage of data means that researchers, policy-makers and practitioners may struggle to produce clear answers to important policy questions.

Keywords: Area-based initiatives, regeneration, health, systematic review

Introduction

The role of evidence is considered by the current Government to be a key feature of effective policy development (Davies et al, 2000). In urban policy, no less than other sectors, evidence has been seen as an essential ingredient of responsive modes of local area governance and attempts to gather information relevant to effective policy design and implementation. Social scientists and their research now appear to have a greater role in policy development even if some have been critical of the inflexibility and confidence suggested by the 'evidence-based' terminology, and there have been deeper debates about how such data can be 'translated' into policy (Pawson, 2001). In urban policy initiatives like the Neighbourhood Renewal Unit, the web-based information management system Regen.net and commitments to review past policies (Dabinett et al, 2001) there is the suggestion at least of a greater receptiveness to information that will help deliver better and more fine-tuned policies. However, this climate of optimism belies a potential difficulty in our ability to extract evidence, and of sufficient quality, to allow firm insights into the mechanisms of local change to arise.

The general profile of evidence in policy has been raised in recent years within Government (Strategic Policy Making Team, 1999) but there have also been increasing concerns that the collation of such evidence has not been systematic in the social sciences. This has led to a belief in a greater role to be played by extensive and

systematic reviews of research literature that may at least generate reasonably accurate insights into the extent of current knowledge bases. The danger here has been particularly located in the idea that 'what works' can be identified without being mired in many of the contextual and micro-social processes that serve to highlight the contingent nature of much evidence in social research. Nevertheless we argue that attempts to distil, summarise and collate past research efforts are likely to pay dividends when considered with sensitivity and restraint in their application.

Since the arrival of New Labour in 1997 poor material circumstances, low quality environments, high crime, low educational attainment, high levels of worklessness and poor health have been treated with around fifty area-based policy initiatives (hereafter ABIs). Recent criticism has focused on this proliferation as well as the overlapping of roles, while practitioners and residents stumble through a maze of various units, programmes, partnerships and pathfinders (Audit Commission, 2002, DETR, 2002). The urban policy agenda has developed in a way that recognises that many social problems are inter-linked and that addressing one 'problem' may therefore impacts on others. This stems from a much longer history to urban policy that had its roots in urban sanitation and health where these were seen to link directly to material housing and city environmental conditions.

The links between health and disadvantage have been recorded in Britain for more than a century. The Black report of 1980 reviewed the evidence and demonstrated that social disadvantage was related to lower life expectancy and higher rates of disease, worry and stress as well as fewer health services with greater demands on them (DHSS, 1980). Increasingly such linkages have been seen in geographical, as well as social, contexts so that the health agenda has become incorporated into regeneration action as with the current New Deal for Communities programme in England. The overlapping geographies of deprivation and health inequalities has been identified and addressed through a series of government department 'floor targets'. For example, in February 2001 the Secretary of State for Health announced the first national health inequalities targets for England (DH, 2001), to reduce by 2010 by at least 10% the gap in mortality between manual groups and the population as a whole and to reduce by at least 10% the gap between the quintile of areas with the lowest life expectancy at birth and the population as a whole.

In the light of the above, this paper details work that set out to identify the role of health in evaluations of ABIs from 1980 to date. The review had a number of key questions.

- Have these major urban policy interventions of the last twenty years had health impacts?
- Would we know if urban regeneration had had such impacts given centrally available evidence from evaluations?
- If we were policy-makers concerned to look at such available evidence what might we learn?

This paper looks at the extent to which impacts on health have been a) an intended and b) a measured element of the regeneration agenda of this period. Through an analysis of the national-level evaluation documentation relating to area-based regeneration initiatives in the UK we were able to look at the relative prevalence of health as a programme objective and its measurement.

It is important to highlight that the review work provides a review only of centrally commissioned and held government evaluation documents. We did not use local evaluation documentation given the complexity and inconsistent availability of such records. While this is a partial view of the full evidence-base in some sense 'out there', the feasibility of locating such documentation as well as any 'grey' literature was seen as too challenging to fall within the scope of this particular review. Our guiding rationale was that if, as researchers, we could not access this documentation centrally it would be unlikely that policy-makers could identify such documentation either.

The paper is divided into the following sections. First we describe the methodology used to collect relevant documentation for the review. Second, we look at the extent to which national regeneration evaluations measured health impacts. We then move on to look at the changing profile of health as a part of the urban regeneration agenda over the last two decades before distilling the key message of the work in relation to urban policy and the current climate promoting evidence-based policy.

Aims and methods of the review

The primary aim of the research was to examine the stated and measured health impacts and outcomes identified in project evaluations of all the urban area-based regeneration interventions over the past twenty years. Two key objectives were attached to this programme of work. First, to identify all of the relevant evaluation literature for the full range of programmes over this period utilising access to a wide range of professional research and literature databases (including databases covering unpublished or 'grey' literature). Second, to weigh up the measured outcomes and impacts of these evaluations where these could be identified in the documentation. Distinctive problems were encountered in identifying measures in many of the programmes where health was stated as a funding theme but did not feature in end or mid-term project evaluations (we later reflect on the importance of this for centralised policy development and improvement).

Five relevant electronic databases were searched (IDOX Information Service (previously the Planning Exchange) 1980-2003), HMIC (1988 to date), INSIDE (British Library, 1980-2003), COPAC (1980-2003), and BIDS 1980-2003). Because of the specific nature of the review topic, the databases were searched for any text containing the programme names or their commonly used abbreviations e.g. Single Regeneration Budget or SRB. Bibliographies of located documents and identified relevant web-sites were also searched: http://www.odpm.gov.uk/ and http://www.landecon.cam.ac.uk/urban/urgsrb.html. Experts, one for each programme, were contacted to identify any further documentation available that may not have been identified in the search strategy. Searches for bidding guidance and evaluation frameworks for programmes proved patchy, both the ODPM and Scottish Executive library did not keep copies of such documentation nor did they hold copies of the bidding guidance for programmes making an assessment of the aims of some programmes difficult to unpick.

Inclusion and exclusion criteria - National evaluations which reported on impacts, outcomes or effectiveness of the programme or national evaluation frameworks for a specific programme were identified. These related to the following programmes:

- Urban Programme
- Single Regeneration Budget (SRB)
- Estate Action
- Urban Development Corporations (UDCs)
- New Life for Urban Scotland (New Life)
- Small Urban Renewal Initiatives (SURIs)
- City Challenge
- New Deal for Communities (NDC)
- Social Inclusion Partnerships (SIPs)

Exclusion criteria were set to eliminate evaluations and annual reports stemming from local projects. Where it was clear that documents were only reporting on the use of a strategy for delivering regeneration or its process of implementation, rather than on achievements, effectiveness, impacts or outcomes of ABI investment, they were excluded. For example, the use of inter-agency partnership working in the delivery of ABI programmes.

Screening and selection process - Titles and abstracts of identified documents, where available, were screened independently by two reviewers. In some databases only the title was available (COPAC, HMIC, INSIDE). Where only the title was available one reviewer initially screened the titles to exclude obviously irrelevant and duplicate documents. Following screening of the title and abstracts the reviewers met to compare selected documents. Where there was disagreement or uncertainty the full document was retrieved and documents screened independently by two reviewers according to the inclusion and exclusion criteria. A data extraction form was constructed to ensure that both reviewers extracted the same relevant data. A total of 856 citations were identified through the search strategy. From this 76 documents were obtained for more in-depth screening and a total of just 29 documents were included in the final review list according to the criteria set-out above. Table 1 below sets these out in summary form and includes details of health outputs, activities and impacts.

Table 1 shows the major themes of evaluation for each programme indicating the key areas in which programme impacts and success were assessed. We have supplemented this with more specific information on the areas in which health effects were noted and divided these up into health outputs, activities, and impacts. *Health outputs* refer to the measurement of levels of use or through-flow relating to a variety of health services, here we have included measures such as number of users of a health clinic. By *activities* we mean health-related processes (for example building a new clinic or raising awareness of an issue or promoting multi-agency working). By *impacts* we mean directly measured changes in the quality of resident's health, either self-reported or objectively measured. This also represents an ascending hierarchy of effectiveness with impacts representing the most direct and important changes in individual and local health quality and which, as we will see, were rarely monitored or measured. We now give more detail on the nature of the health effects measured in the evaluations for each programme.

i. The Urban Programme and Urban Programme Scotland (1969-1980s)

The Urban Programme was the first key urban policy to follow the Community Development Projects of the 1960s and 70s. The programme operated as a grant-based initiative that dealt with urban areas of special social need and stress (DoE, 1984; JURUE, 1986; Whitting et al, 1986). Local authorities administered the programme across the UK, including both capital and current expenditure programmes, with the Government later setting up an Urban Renewal Unit to help co-ordinate local authorities' area-based approaches. Funding was made at the ratio of 75 percent central government to 25 percent to be met by the local authority. Within the Urban Programme health featured as a theme under which projects might be funded (Duguid, 1983; DoE, 1986c).

Around 80 percent of Urban Programme funding came from the Department of the Environment with the rest made up by the Department of Health and Social Services and the Directorate of Education and Department of Transport. Overall 2.6 percent of UP funds were spent on health projects during the 1985/86 period, for example. However, this rose to 27% of UP projects for ethnic minorities (of £38.8 m, 12% of the full value of the UP between 1985/86) (DoE, 1985).

Across the Urban Programme evaluation documentation we found few measurements of health or wider impacts in terms of quantifiable measures of input or outputs. Health Boards also contributed about 5% of the total funds involved in the UP. In searching through all the available national level documentation it was not possible to discover to what extent the programme had been a success, either in terms of its own goals or in relation to more specific questions about health. A far greater concern for evaluators appeared to be the processes of putting the programme in place.

In fact the only measures of health we found related to the number of health projects, an activity rather than an outcome. In the 1985/86 annual report this was given as 357 projects with the number of clients (i.e. an output measure) given as 22,561 per week. There was no sense of whether this was an improvement or worsening of any baseline position. For 'advice' projects the same details were given and the comment included that 'health and education projects are well represented' in the UP (DoE, 1987:15). For Scotland alone we also found four projects that could be considered to have clear health impacts. These included projects on advice or counselling on alcoholism. However, for these no impacts or outputs were detailed. Health appeared as a small programme output and, where this could be identified, the measures used were generally insufficient to get an impression of any deeper impacts other than simple flows of clients.

Table 1: Major evaluation domains and health effects (Health outputs, activities and impacts)

Programme	Major Impact Domains	Health Outputs	Health-related Activities	Impacts
Urban Programme	Economic Environmental Social (included health)	Daycare facilities Number of health projects 357 Number of clients per week 22,561	Advice/counselling on alcoholism Improving primary and community care and services for priority groups Health and ethnic minorities	
Urban Development Corporations	Property Economic Employment		None reported	
City Challenge	Dwelling improvements Job creation Business	SMRs and Limiting long term illness in certain case studies Health centres	Integrated health and voluntary social services	Health of CC residents was on average poorer than elsewhere
Estate Action	Property rehabilitation and investment Crime and incivilities Estate-based management Health Environment	Reduction of social stress (homelessness and crime) linked to health Family health/fear and worry about crime i.e. stress		
Single Regeneration Budget (SRB)	Economic, Housing, Social, Environmental, Community, Education, Enterprise, Health (local HA priority care groups, Healthy Living Centres and HAZs)	Access to a doctor and services No. of new health facilities No. of new sports facilities		Changes to residents self-reported health (worsened) Mortality (% per 1000) only Hull and Nottingham case studies had health components. Satisfaction with health centre – quality and accessibility. Drug prevention
SURIs	Employment and population Housing (tenure, prices, vacancies)	Neighbourhood satisfaction		
New Life for Urban Scotland	Employment Demolished/new/improved dwellings Residential satisfaction/population movement Quality of life for residents	Quality of life for residents		
Social Inclusion Partnerships (SIPs)	Population & households, employment & training, educational attainment, housing, crime, community involvement & development, poverty, internet access, physical transformation, health	Access to health services		Limiting long term illness, low birth weight babies. coronary heart disease, cancer, stroke, smokers*

* *Major problems reporting these and unable to assess trends over time*

ii. New Life for Urban Scotland (1988-1998)

The New Life for Urban Scotland was designed to bring significant reinvestment to some of the poorest large-scale public rented housing areas. Introduced in 1988 it had the aim of comprehensive regeneration, economic improvement, the involvement of local people and an improved role for the private sector. Implementation took place through four peripheral housing estates in central Scotland, designated as multi-agency partnerships. No details of specific health impacts were given in the evaluation framework but the social objectives of the programme include a reference to: 'improving health services and support for families in deprived areas' and work towards the better co-ordination of local health services[15].

The only direct indicator of health impacts was found in the use of Standard Mortality Ratios (SMRs, i.e. deaths per 1,000 population), found to range between 92 and 145 across the four designated areas. Poor diet, stress and drug abuse were also focused on but were not measured in the evaluation directly. High levels of health problems were found and were also attributed to an influx of more people with greater problems during the partnership period. A further impact identified in the evaluation documentation (Cambridge Policy Consultants, 1999b) suggested that the partnerships had had the effect of raising deprived neighbourhoods higher up the health agenda.

Self-reported problems and satisfaction were noted in each area and at different points across time during the partnership period. Table 2 gives the percentage of those of working-age who said they were permanently sick and those who said they were satisfied with the local provision of health services. This appeared to show a general decline followed by improvement in relation to permanent sickness and consistent improvement with regard to health services respectively. Overall the evaluation appears to show a concern for health impacts and outcomes, but with some variability in the direction of change during the intervention period. This raises a perennial problem with project evaluation, that of causation. Even if the changes could be directly linked to the programme, the variability of change over time makes theorisation of causation distinctly difficult.

Table 2: New Life for Urban Scotland: Health Evaluation Measures

% of working age who said that they were permanently sick	1988	1994	1998
Castlemilk	16	23	13
Ferguslie Park	15	17	10
Wester Hailes	5	9	6
Whitfield	6	11	6
% satisfied with the provision of health services			
Castlemilk	64	77	93
Ferguslie Park	64	60	90
Wester Hailes	71	75	94
Whitfield	37	55	65

Source: Cambridge Policy Consultants (1999b)

The New Life for Urban Scotland documentation suggests that some of the evaluation measures may not have been appropriate. For example, the use of SMRs as a measure does not sit easily with the focus on diet, stress and drugs. In addition the co-ordination of health services did not appear to have been examined.

iii. Estate action (1985-1995)

Estate Action aimed to help local authorities in England improve quality of life on run-down housing estates. The programme operated across 36 Metropolitan Districts as well as all of the London Boroughs but was extended to all local authorities in 1987 (Pinto, 1993; DoE, 1997). While health did not appear as a measurable aspect of the programme the available documentation emphasised a connection between social stress and crime and wider health risks (DoE, 1996). The programme ran from 1985 to 1994 when it was incorporated into the Single Regeneration Budget by which time nearly £2bn was spent.

Although health was connected in the theory of the evaluation process no data were available on any of the impacts measured other than the broad direction of the changes noted. In one of the major evaluations it was noted that (DoE, 1996) social stress, conceptualised as levels of crime in the areas, had been reduced on four estates while social stress, measured as homelessness, had been reduced on three. In the 'DICE' (Design Improvement Controlled Experiment)study the health of residents improved in an examination of four case study areas, however, no figures were given nor any information on how health measures had been constructed (DoE, 1997).

iv. City Challenge (1992-1997)

City Challenge was designed to introduce competition for urban funding. The Challenge Fund could be applied to by partnerships drawn from the public and private sectors in order to stress the need to attract outside investment. Within the funding guidance, health featured as a possible project category. The aim of this process was to stimulate wealth creation, widen social provision, improve environmental quality and promote enterprise culture in disadvantaged areas within cities (Johnston et al, 1998). Health agencies were a partner in every City Challenge partnership. In all there were 31 partnerships, each attracting funding of £37.5 million each.

Poor health was viewed implicitly as part of the problem of wider social deprivation and a documented characteristic in all partnerships. However, the evaluation of City Challenge provides little in the way of information about health impacts (DETR, 2000a). In a report on one local initiative reported in the national evaluation we found records for SMRs and limiting long-term illness, for the Bolton City Challenge health awareness project (European Institute for Urban Affairs, 1996). Here a one-stop health provision centre had been provided for an area whose residents were seen to have poorer health than elsewhere. No other detail is given and it is not clear whether any impacts were recorded, even for this local example of a health project. It appears significant in terms of evaluation design that while health agencies were partners in City Challenge health was neither an explicit objective nor an area for evaluation.

v. Urban Development Corporations (1981-1998)

The UDCs provided significant funding for projects linked to infrastructure, the environment and job creation through the creation of non-statutory bodies which had significant powers relating to land purchase and planning. The programme was largely designed to bring land and buildings into effective use; encourage the development of existing and new industry and commerce; provide attractive environments; and improve housing and social facilities (CLES, 1989; Bourn, 1993; DETR, 1998). The programme was implemented through the Corporations themselves that often straddled local authority boundaries and had a variety of powerful capabilities, for example, in relation to land purchase and sale. Nowhere in the

evaluation documentation was there any evidence of intended or measured health impacts and it is not clear whether any of the social projects funded by UDCs might have had any unintended consequences. Public expenditure on the UDCs was significant and amounted to £2.1bn between 1991 and 1998. In the overall sequence of ABIs the UDCs appear as singularly focused with a retreat from wider programme aims outside that of property and commercial activity.

vi. Small Urban Renewal Initiatives (SURIs) (1990-2003)

Small Urban Renewal Initiatives, or SURIs, were a Scottish programme of housing led regeneration in 15 run-down small town areas initiated between 1990-1995. It was hoped that investment in housing might act as a catalyst for wider regeneration. The key goals of the programme were to widen housing choice, improve housing quality, lever in additional investment, improve economic prospects and develop multi-agency approaches to regeneration (Pawson et al, 1998). The programme was implemented through partnerships involving the central government housing agency (Scottish Homes), local authorities, and local enterprise companies. Between 1990-1998 more than £160m was spent on the programme. Here we found no links or reference to health made in the evaluation documents identified, either implicitly or explicitly. Rather, the evaluation focussed on the direct impacts of housing investment e.g. housing tenure, prices, popularity of local social housing as well as reporting changes in population mix and displacement of local residents. The initial focus on housing quality, which might have had health consequences, was lost in the evaluation.

vii. The Single Regeneration Budget (SRB) (1995-2001)

The SRB replaced many of the smaller funding arrangements for area-based interventions across the UK in 1995 (until 2001). The key emphasis was on a continuing partnership-led approach to regeneration with the possibility of thematic or more widely ranging issues being addressed (Crook, 1995; Brennan et al, 1999; Cambridge Policy Consultants, 1999a; Brennan et al, 2000; ODPM, 2002). Funding could be competitively applied for in yearly rounds with money available for between one and seven years. No formal geographic boundaries were imposed and partnerships were usually between local authorities, the private sector and a wide

range of agencies and community organisations and individuals that sometimes included health authorities. A total of 1,028 schemes have been funded under the SRB with health a theme of some of the projects. In all £5.7bn was spent by the government and with a further £9bn from the private sector. Over the course of the SRB only 6 local projects had health as a key theme, accounting for only 0.25 percent of expenditure overall.

Taken as a whole the diverse projects funded under the SRB have been examined in relation to health in a number of ways. Two specific case study evaluations looked at health issues. In one of these, using three case study areas as a snapshot, health care facilities were covered in a local questionnaire that looked at perceived quality and accessibility (Table 3 below).

Table 3: Single Regeneration Budget:
Satisfaction with health care facilities (Brennan et al 1999)

% (base 186)	Quality	Accessibility
Very satisfied	12	17
Satisfied	28	23
A bit dissatisfied	8	4
Very dissatisfied	2	3
Neutral	20	17
No response	30	36

In another case study mortality rates in three Cornish SRB areas were collected between 1994 and 1998 before and after the programme (Table 4 below). These showed small decreases over the ABI period but there is little sense of whether this was due to the ABI intervention itself. The only external comparison made was with wider English basic mortality rates, 10.7 and 10.6 per thousand for the respective years. Reporting of health impacts also appeared somewhat variable. For example we found references to local health projects in Hull and Nottingham but no more detail or reporting could be found on their impacts.

Table 4: Single Regeneration Budget:
Crude mortality rates 94-98 (Brennan et al 2000)

	Carrick		**Kerrier**		**Penwith**	
	1994	**1998**	**1994**	**1998**	**1994**	**1998**
Mortality rates (% per 1000)	13.4	12.4	11.7	11.1	14.3	14.1

In the three case studies looked at which stood effectively for an assessment of the programme it was found that:

> "Improved health in deprived communities is a key objective of Government, but none of the three SRB schemes focused directly on health improvement or access to health facilities. Any improvement would have had to be secured indirectly through, for example improved housing, better employment prospects or reduced fear of crime" (Rhodes et al, 2002: 180)

In the same report respondents were asked, both in 1996 and 1999, if their health had improved in the previous three years. Based on this cross-sectional data it was found that in SRB areas 27 percent said their health had recently got worse (in 1996) and this increased to 29 percent in 1999. Overall health appears as a more significant element of the evaluation in the SRB programme. However, the measures used and methods applied, in the form of case studies, make the evidence rather limited in terms of any possible wider application to the programme as a whole. Nevertheless, for a programme to which so little was spent on health SRB stands out in its attempt to grasp local changes in some basic health impact and output measures.

The New Deal for Communities (NDCs) and Social Inclusion Partnerships (SIPs) (Scotland)

In both the SIPs and New Deal for Communities health has enjoyed fuller coverage as a key programme domain. The Scottish SIPs were introduced in 1997 and involved local partnerships with local authority leaders in attempting to regenerate deprived and excluded areas of urban Scotland. Forty-nine SIPs were declared, though 14 of these were thematic rather than area-based (for example, ethnicity in Glasgow). The SIPs were given ten-year funding and had monitoring frameworks that required the annual collection of a range of data. The health component of the SIPs focused on limiting long-term illness (documented by every SIP as an aspect of social deprivation) (Scottish Executive, 1999). However, health, community safety and crime were also combined as a single funding theme. These initiatives account for 26% of expenditure e.g. family support and parenting initiatives, health promotion, access to health services, anti-smoking initiatives, counselling as well as home security and crime reduction projects. All except one SIP had health objectives and all SIPs have a Health Board as a partner.

The results of the SIPs in relation to health have shown a high degree of variability, predominantly in their ability to effectively collect the monitoring data required of them by the Executive. Long term limiting illness was addressed through household surveys as was access to health services and the percentage of the local population registered with a GP. Attendance at SIP funded facilities/extra projects was also collected. A national evaluation of former programmes across 9 areas (Scottish Executive, 2001) found that health outcomes could not be measured in five of these areas. Ironically, in four of these areas the partnership had accorded a high priority to this theme.

New Deal for Communities was not included in the systematic review presented here largely because it is still a live programme with no completed evaluation. However, it is worth noting that NDC operates with an ambitious health domain with floor targets that are being evaluated using baseline and monitoring data collection frameworks suggesting an approach that has not been matched to date in previous programmes. The health domain features the following indicators: long term sick/disabled, SMR's, SMR's by major disease category, teen pregnancy, percentage of adults who smoke, drug misuse notifications, stress/mental health and the percentage of residents stating their health is not good. Data is collected from a variety of sources including resident surveys of all NDC areas and a range of routinely available local statistics (such as ratio of GPs to population, rates of cancer registration and others).

Theories of health change and the evaluation of area-based initiatives

Our review of available evaluation reports, bidding guidance and evaluation frameworks enabled us to chart the conceptualisation of the connections that might be made between the implementation of area-based policies and health impacts. Such 'theories of change' have become more prominent in recent regeneration efforts where deeper thinking has been undertaken relating to how interventions and contexts on the ground might interact. These connections also enabled some insight into the perceived connections made between investment and the programmes' potential health impacts.

While health might be characterised as one of the more ephemeral concerns of urban policy it is now evident that it has moved up the agenda as links to other social inequalities have been made (See Table 5 below). Since 1980 the regeneration agenda, such as it related to health, has moved through distinct phases with health impacts moving from project-based outputs to a separable domain of evaluation and implementation, as with the current New Deal for Communities programme. It is also evident that various area-based initiatives have provided funding for a wide range of projects that may also have had indirect health implications. For example, the provision of a new play area or health centre. In other words, health may still have been influenced even where such effects were neither intended nor measured. Health impacts have generally been considered as automatic outcomes (such as reducing stress by lowering crime rates) or have been described as simple throughput measures, such as the number of people accessing a health centre. This may partly be explained by the difficulty of connecting the long-run effects of health interventions to the short-term timeframes of policy actions.

Four main linkages between area-based interventions and wealth were found, all asserting relatively mechanistic associations between key independent variables and health outcomes:

- In the Urban Programme the links were between unemployment and the psychological impacts that this could have, particularly for ethnic minorities and their life-chances.
- A strengthening of the role of investment in the environment (such as the UDCs) was matched by a greater stress on quality of life for children in terms of their exercise but also in terms of the danger to health posed by derelict and dangerous land.
- In some of the documentation we also found a link made between poverty and poor health as a self-evident link.
- For the most part what we find are not elaborated accounts of causal pathways to which interventions are addressed but implicit and taken for granted assumptions around such links.

Table 5: Focus of ABI programmes and the place of health in programme

ABI programme expenditure where available	Main focus of programme	Links made between programme and possible health & social impacts	Activities labelled as health/quality of life impacts
Urban Programme 1969-1980s approx £274m/year	Grant based programme to deal with areas of special social need through supplementation of existing programmes covering economic, environmental, employment and social projects.	Absence of paid employment linked to poor mental health and reduced life chances particularly for minority groups. Quality of life affected by quality of local environment	Health is a funding theme for improving primary health & community care services for priority groups, accounts for approximately 4-5% of total expenditure. Social projects include initiatives around education, crime, social & welfare services, information, and recreation & sport facilities for adults and children.
Urban Development Corporations 1981-1998 £2120m	Property and economic regeneration to attract inward investment	None	N/A
Estate Action 1985-1995 £1975m	Housing led regeneration- addressing both improvements to physical aspects of housing as well as housing management	Links made between health impacts and social sources of stress from social environment such as fear of crime quality of life	Crime reduction initiatives linked to health impacts.
New Life for Urban Scotland 1988-1998 £485m	Comprehensive multi-agency regeneration programme to improve housing, environment, service provision, training and employment for local people in four areas	Health baseline data and levels of health service provision used to justify selection of areas. Social objectives include a health reference 'improving health services and support for families in deprived areas'.	Partnerships with health boards to promote place of health inequalities on health board agenda. Quality of life activities included: initiatives to improve primary, secondary & community education, childcare, youth, crime & safety, physical environment, shopping, leisure and community facilities and poverty.
Small Urban Renewal Initiatives (SURI) 1990-2003	Housing led regeneration to widen housing choice, improve quality of housing quality and the local environment, improve economic prospects and lever public and private funding	None	N/A
City Challenge 1992-1997 £1162.5m	Comprehensive multi-agency regeneration to improve quality of life of residents in run-down areas.	Health baseline data used to justify selection of areas	Health is a funding theme for improved health facilities, health awareness campaigns and specialist support services e.g. drug abuse. Partnerships with health agencies. Quality of life activities included: improved community centres play areas, sport, leisure and cultural facilities.
Single Regeneration Budget 1995-2001 £5703m + £20301m from private sector	Comprehensive multi-agency regeneration through initiatives on employment, training, economic growth, housing, crime, environment, ethnic minorities and quality of life (incl. health, sport and cultural opportunities)	Objectives incorporated health: 'enhance quality of life for local people including health, cultural and sports opportunities'	Health one of 10 funding themes and accounts of 0.26% of total expenditure for improved health services. Quality of life activities included: crime & community safety initiatives, improved community leisure and recreation facilities.
Social Inclusion Partnerships 1996- £52m	Co-ordinated approach to tackle and prevent social exclusion and demonstrate innovative practices. Main activities focus on education & training, and initiatives to reduce poverty, crime, and promote employment, enterprise, empowerment and health	Health baseline data (long term limiting illness) used to justify selection of areas and part of compulsory indicators for evaluation.	Health/community safety/crime is a single funding theme (accounts for 26% of expenditure) Implemented through local projects on family support, parenting initiatives, health promotion, access to health service, counselling, home security and crime reduction. All except 1 SIP has health objectives, all SIPs have Health Board as a partner.

Source: Evaluation documentation relating to programmes

The significance of health in regeneration

The benefit of looking at central government-run evaluations is the scale of the research undertaken thus allowing insight into the intended and measured impacts and outcomes of major programmes. However, as we subsequently found, only a small sub-set of the national evaluations looked at health impacts. Even in programmes where health had been identified as a funding theme (such as the Urban Programme) we often found very little evidence in evaluation documentation of any impacts being identified.

Work by Curtis, Cave and Coutts (2002) in two case study areas in London found both positive and negative health impacts but also suggested that measurement was difficult. In fact many national programme evaluations were based on local case studies; even where a significant number of these were evaluated and health was included as an impact (such as the SRB) health formed only a very small part of both the spending and subsequent reporting. Even as late as the City Challenge programme an average of 1 percent of total funding was spent on health while in the SRB 0.2 percent of the overall budget was allocated to health projects.

Since spending on health functions across all the ABIs was negligible the generally low level of reporting may appear proportionate. However, achieving a more precise measure of spending and understanding of health outputs and impacts was blurred by the involvement of ABIs in wider actions which may have been *indirectly* linked to health and well-being such as increasing employment, improved housing, reduced crime and an improved environment. Of particular note is that although health boards were involved in funding and co-ordinating in partnership arrangements for some ABIs, this was not matched by subsequent involvement in the assessment of health impacts. In this sense joined-up policy should be a two-way street with a full range of partners taking part in the evaluation of interventions in which they are involved.

In fact, apart from the UDCs and Scottish SURIs, all of the programmes have made explicit linkages to health. However, the wider ability of ABIs to produce detectable health impacts was clearly constrained by the timeframe of such projects, often between 2 and 5 years. Even in the case of the UDCs, SIPs and NDC with their ten-year timeframe this is still a significantly short period in which to observe, for

example, smoking cessation and links to heart disease. This observation was supported by the type of health impacts often intended by the programmes. For example, the DETR argued that communities prefer to see short-term actions that improve quality of life and give the example of better access to health services as a suitable measure or target (DETR, 1996). This report linked health to a strategy for regeneration in two ways. First, through direct benefits in improved physical and mental health and well-being and, second, through other routes that included employment, quality of life, levels of stress and the cost of hospital admissions or medicines.

Three things become clear from this exercise. First, that health formed a small part of the overall domain in which each programme was evaluated. Second, the range of effects measured varied widely in the degree to which health could or should be measured. Finally, it was clear that health impacts have rarely been measured and that such benefits to communities have rarely been articulated or measured. Impacts were widely measured in terms of activities like raising health awareness and providing facilities and other 'responsive' outputs which local residents could use. In other words impacts were largely measured through proxies for some kind of health outputs.

Overall we found it difficult to assess health impacts or outputs at the national level, even where these were sometimes considered to be important aspects of the programme in question. Even where programmes had a health theme it was almost impossible to determine the benefits of this stream of funding either in terms of direct health impacts (such as levels of coronary disease) or in terms of outputs (such as number of people using a health centre). Due to the associated shorter-run timeframe, there was more evidence in respect of outputs but even here it was patchy and rarely centrally reported.

Conclusion: Urban policy amnesia?

The research presented here started from a point at which evidence on regeneration impacts and health impacts were seen as lacking in systematic analysis. However, the wider implications of this, for research and policy, are manifold. In looking at the available evidence at a national level for the health impacts of area-based initiatives

we have found such evidence hard to unearth, even in programmes where health was a key feature of the regeneration initiative. In the context of rising interest in the health impacts of area regeneration programmes in England, Wales and Scotland this has clear implications for institutional 'policy-learning' over time.

We have noted that the slender evidence on health outputs from ABIs may reflect a mismatch between their short life-span and the time needed to detect health impacts which operate over much longer cycles. In many neighbourhoods where ABIs operate populations are highly mobile, making inferences about impacts all the more difficult to discern or to track. In this context it is perhaps understandable that evaluations have often sought to look at basic outputs and project activities rather than more sophisticated measures of health impacts. Indeed, given the problems associated with attribution more widely one might question the appropriateness of pursuing measures seeking such evidence.

As ABIs often continue to be applied to a similar set of urban areas over time it is likely that much cumulative learning could be achieved in relation to embedded processes and programmes in places of central disadvantage. In addition, if health impacts are addressed at the local level through ABIs we would hope and expect to find these impacts relayed through to national-level evaluation documentation. However, this appears not to have been the case for most of the programmes analysed here. For example, while we know that health was one of the domains for funding in the Urban Programme there was almost no evidence of how this money was spent or what impacts or outputs it had. This raises the question of how evidence-based policy and practice may be delivered when policy lessons are neither gathered nor collated so that policy-makers might use such evidence.

The generally difficult process of conducting the review, primarily in terms of obtaining documentation, also raises wider important questions about policy formulation and evaluation. How can government collate programme level outputs to allow effective evaluation? The lack of systematic storage of data and documentation means that researchers, policy-makers and practitioners will continue to struggle (if indeed they try at all) to produce policies assembled on past evidence and experience. It would seem that, perhaps as many suspect, policy is constructed in cyclical rather than incremental ways. Since departments responsible for programmes have not

routinely stored and catalogued programme documentation, retrospective evaluation and cumulative policy learning are made difficult. It seems unfortunate that policy should be developed in such an amnesiac way.

Explanations, theories and measures of health change are present to some degree but appear to change and are dropped or adopted for no clearly stated reasons. Further, there has been no clear articulation of policy theories by which area regeneration is expected to improve health outcomes. It would also appear that there has been no clear assessment of which health effects might reasonably or predictably be expected to come from regeneration whether this be in the form of social or physical environments conducive to healthy living, health behaviours or infrastructure. Although health outcomes were not in the remit of some ABIs many of the programmes may have had important secondary impacts (such as community centres and drug awareness projects or increased labour force participation). The apparent absence of evidence on health impacts cannot however be inferred to be proof of an absence of impacts – it is simply that we do not know about them.

Within an ideology of joined-up thinking the currently widened and emboldened regeneration agenda has included a range of themes that promote a message of greater effectiveness than is perhaps warranted. At the national level and in terms of a cumulative advance in the diagnosis and treatment of urban social problems it would appear that urban policy has not moved as far forward as it might have. Here policy research appears as a legitimating point of closure rather than the keystone to a new or 'enlightened' policy (Weiss, 1986). While some have described programme design as a 'research free zone' (Pawson, 2001) one might still hope and expect policy formulations to be based on evidence from the broad costs and benefits of past successes and failures.

Overall our work here suggests that even were the architects of future ABIs to consider key health aspects of their impacts it would be highly difficult to assemble enough evidence at the national level to determine effective future directions. When these various problems are considered together with the churning of politicians and programme administrators, keen to place their 'new' stamp on policy, it would seem that the wider domain is characterised by restricted envelopes of knowledge which do not merge into or inform subsequent administrations or regeneration regimes. This

knowledge is often restricted to localities and more often shelved than acted on as part of a process of organisational learning. In this context it would appear that we may have the opportunity to learn more from the future administration of urban policy than its myopic past.

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