

**BRITISH LABOUR GOVERNMENT POLICY TO  
REDUCE INEQUALITIES IN HEALTH: RESPONSES IN  
AN INNER-LONDON BOROUGH 1997-2003**

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# **BRITISH LABOUR GOVERNMENT POLICY TO REDUCE INEQUALITIES IN HEALTH: RESPONSES IN AN INNER-LONDON BOROUGH 1997-2003**

## **ABSTRACT**

The stimulus for this research was the publication of the Green and White papers: *Our Healthier Nation (OHN) – Saving Lives* (DoH, 1998/9).

The aim was to ascertain factors affecting the pattern and speed of local reactions to the new policy. These factors were predicted to be similar to those found in analysis of pre-1997, Conservative government, public health policy. However, the particular hypothesis of the thesis was that tensions in the Labour Party and government concerning aspects of the wider determinants of health would also play a role in affecting local implementation. Of specific importance was the equivocal determinant of 'income inequalities'.

A case study of one inner-London borough was undertaken. Data collection was by way of in-depth interviews, participant observation and a review of local and national policy documents.

Findings based on fieldwork are:

1. The implementation process was protracted. Delays need to be distinguished from policy failure.
2. Staff views did influence the pattern of implementation. However, some widely-held beliefs did not affect local work developed in response to the policy. This was primarily because no permission had been granted by central government for local staff to act on these opinions.
3. Local NHS staff needed clear guidance on how to prioritise work, this was not provided until 2003.
4. Unresolved anomalies exist in NHS and local authority public involvement work relating to health inequalities reduction. This is because the policy highlights the wider determinants of health, including income distribution. The latter is a politically partisan subject. The 'neutral' state bureaucracy is less adept at facilitating 'citizen' influence over the issue than political parties have been. However, sections of the Labour Party itself appear to have some interest in directing involvement away from party organisation.

**Keywords:** health inequalities; public health; Labour Party; trade unions.



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IN HEALTH: RESPONSES IN AN INNER-LONDON BOROUGH 1997-2003**

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### **For**

Sean, Ruth Thomas, Daniel, Erin, Liz and Lucretia.

# INTRODUCTION

## Foreword

On the morning of the 2<sup>nd</sup> of May 1997, the dawn of Britain's first Labour government in eighteen years, Mustapha Bello introduced to the speakers' platform "Mr Blair, Mr T. Blair".

The dingy, low-ceilinged room in a South London NHS health promotion unit was packed with representatives of the capital's African voluntary organisations, as well as managers and staff from the health promotion unit. A universal cheer went up. Claps and laughter followed. Terry Blair, the sexual health team leader of the unit, then proceeded to get back to the topic of HIV prevention work within South London's African communities. The audience, many of whom were suffering from lack of sleep and sore heads, tried to concentrate on the immediate tasks of the day.

These NHS and voluntary sector staff were all openly satisfied with the change of government. As 'street-level bureaucrats' (Lipsky, 1980) working in and around the NHS, one of the largest state bureaucracies on the globe, they had been, on this occasion, prepared to let slip political neutrality and revealed themselves as 'street-level politicians'.

The new government was considered by local NHS staff to herald the possibility of important policy changes. Indeed, a swathe of new health-related Green and White Papers quickly emerged. The complex relationships between the Labour government, the Labour Party, local people whom policy was intended to affect, and the local NHS and voluntary sector staff charged with implementing new policy, provides the backdrop to this thesis. In particular, the author focuses on the local implementation of policy to reduce health inequalities, outlined in the Public Health Green and White Papers of 1998 and 1999, *Our Healthier Nation*, (DoH, 1998); *Saving Lives*, (DoH, 1999).

Just as NHS staff have their own divided political affiliations, opinions and history, so too do members of the Labour Party (Rose, 1984: 147; Seyd et al, 1996:7). The two

groups may of course overlap, as they did in this study's geographical research area. The hypothesis presented is that broad political considerations, issues and tensions in the party and government, evident in the first term, played a part in affecting the pattern and speed of local public health policy implementation. The aim is to address the consequent research question: did broad political considerations, issues and tensions in the Labour Party and government, evident in the first term of office, play a part in affecting local policy implementation? The thesis analyses local responses to the national policy to reduce health inequalities, taking into account national and local political dimensions.<sup>1</sup> The tensions particularly discussed are those concerning income distribution.<sup>2</sup> 'Centralisation' versus 'decentralisation' of power and responsibility is also considered.

In order to contextualise the role of the tensions referred to in the hypothesis, the thesis also aims to describe the main and most immediate influences on local reactions to the policy. These are predicted to be among those identified in *The Health of the Nation (HOTN): a policy assessed* (Universities of Leeds and Glamorgan and the London School of Hygiene and Tropical Medicine, hereafter LSHTM, 1998: 13-15,83,147). In general, the HOTN assessment highlights the impact of both institutional arrangements and local staff views. The extent to which the assessment's recommendations were adopted may also be expected to affect local implementation.

## Setting the scene

The remainder of this introduction takes the form of a short précis outlining the study's interest in *Saving Lives* (DoH, 1999) and the subsequent chapters' contents.

<sup>1</sup> 'Health inequalities' may be defined as the gap in health status between different social groups. *Saving Lives* shows, in graphic form, mortality trends by social class, in men of working age, between 1930-32 and 1991-93. "During the 1980s and 1990s the gap between rich and poor widened and the health gap grew wider." (DoH, 1999: 44, Figure 4.2).

<sup>2</sup> 'Tension' is taken here to be demonstrated by inconsistencies, disputes or sidelining. It may operate at a number of different government levels and there are various ways in which it is thought that wider government tensions concerning income inequalities may affect local health inequalities policy implementation. Some of these effects are clearer and more significant than others. They include the following – 1. directly influences income distribution policy (which in turn may affect health inequalities). 2. affects organisations wanting to, or able to influence income distribution. And may affect relations between central government and localities. 3. affects policy processes or administration of policies, relating to income inequalities (e.g. health inequalities policy) because these policies are expected to be consistent and 'joined-up' with wider government policy (Powell, 2002: 245). 4. affects staff perceptions and incentives, which may in turn impact on local implementation.

### **Research issues arising from the public health White Paper of 1999**

*Saving Lives* links the population's health status to the 'broader determinants of health'<sup>3</sup> (DoH, 1999: 3) and to involving local people in plans affecting health (DoH, 1999: 126). The document is clear that there is a connection between income and health. It sees poverty as a breeding ground for poor health and says that health inequality is widespread: the most disadvantaged having suffered most from poor health (executive summary: 10). Its aim is to "...improve the health of everyone and the health of the worst off in particular." (executive summary: 8). The opinions of those involved in local implementation of the public health policy, regarding these issues, are described in the thesis.

In *Saving Lives* 'people, communities and government' were given clearly defined and different roles, listed in tables in the report's appendix 1 (DoH, 1999: 145-152). National government was to address national issues and local people, local issues. The links between local people and national issues were not mentioned, as indeed they are not in the much-reproduced 'social model of health' diagram (Dahlgren and Whitehead, 1991).<sup>4</sup> This again is precisely the approach adopted by Acheson in the *Independent Inquiry into Inequalities in Health* (1998).<sup>5</sup> This thesis sees as an important area for research, issues concerning the influence communities have over the broader determinants of health.

The relationship between political organisation and income inequalities reduction is highlighted in the thesis. This is because, not only does a wide body of opinion consider, as *Saving Lives* (DoH, 1999) does, that income inequalities affect health inequalities,<sup>6</sup> but also, government policy may affect the character of political

<sup>3</sup> Defined as 'general socioeconomic, cultural and environmental conditions' (for example, see: Acheson, 1998: 6).

<sup>4</sup> Popay et al (1998) and Wainwright (1996) provide critiques of this model.

<sup>5</sup> The inquiry was commissioned by the new government to provide public health policy recommendations. Acheson (1998: 7-8) recommends 'upstream' and 'downstream' policies to reduce health inequalities. Upstream policies are those that deal with the wider influences on health inequalities, such as income distribution. An example of a downstream policy is - improved local provision of facilities for taking physical exercise. Acheson (1998: 30) stresses the need for policy development that favours the less well off (those on below average income).

<sup>6</sup> Opinions along these lines were expressed in submissions to the DoH following the publication of the Green Paper, *Our Healthier Nation* (1998). For example, the submission of The Public Health Alliance, among other suggestions: "...recommended developing a wealth ratio index and setting 5-

organisation, including trade union organisation (Katz and Mair, 1995; Mair, 1994; Heffernan, 2001: 34-35). Evidence from political science indicates the importance of political parties and trade unions in influencing levels of income inequality (Mulé, 2001; Castles, 1982; Rose, 1984; Atkinson, 1983: 131-137). The Labour Party and other European social democratic parties have been traditionally associated with policy to reduce income inequalities (for instance: Tawney, 1964: 202-210).<sup>7</sup> So it was felt to be important to make contact with local leaders in these two labour movement fields. Their perspectives were compared with views from staff working in the voluntary sector, some of whom were found to be influenced by a 'social capital for health' approach to health inequalities reduction (Swann and Morgan, 2002).<sup>8</sup> Therefore, in looking at wider political considerations pertaining to health inequalities, it is important to take into account how post-1997 government policy may have influenced involvement in local political organisations. As Parry et al suggest:

“The extent and direction of citizen activity is not simply the product of individual and group initiative. It is affected by structural opportunities and by the extent of the encouragement offered by elites.” (Parry et al, 1992: 416).

### **The research process and chapter contents**

The study has observed the actions and opinions of staff in response to the new policies in one borough, within one health authority area. The health authority chosen was Lambeth, Southwark and Lewisham, which was given overall responsibility for

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year targets to reduce the gap between the wealth of the richest and poorest in society.” (The Public Health Alliance, 1998: 11). In 1999 a goal was set by the Labour government of halving child poverty by 2010 and a relative definition of poverty was adopted. However, on the basis of analysis up to 2002, it is not certain that the target will be achieved (Piachaud and Sutherland, 2002: 28).

<sup>7</sup> “Despite a veritable explosion of charitable activity in Victorian England, the heyday of ‘good works’ evangelism passed without making a noticeable difference to the scale of the problem [that of mass working class poverty].... The appearance in virtually every European country of a social democratic party in the period 1870-1914, many of them Marxist, and of increasingly powerful trade unions with close connections to such parties, must be considered as of cardinal importance in [initiating action through the state to address this ‘social question’]. Here was an important lobby for ‘the right to work’, free education, old-age pensions, restricted hours of labour, national insurance, workingmen’s compensation, the minimum wage, a national health service, family allowances....” (Callaghan, 2000: 3-4).

<sup>8</sup> “Social capital can be broadly described as the resources within a community that create family and social organisation....Key constructs within the concept...include social relationships, group membership, shared norms, trust, formal and informal social networks, reciprocity and civic engagement.” (Swann and Morgan, 2002: 4).

local health inequalities policy implementation and development in 1997. Over a five year period from this time, accountability for public health was gradually moved to NHS primary care trusts at borough level and the investigation centres on Lewisham. The borough, being one of the most deprived in the country, is an area where policy to reduce health inequalities is highly relevant.

Through a process of participant observation, semi-structured in-depth interviews, informal questioning and documentary analysis the author has observed, or received accounts of, all the key stages in work to address health inequalities in Lewisham over the course of six years. Interviewing and observations covered a wider range of staff and related personnel than might ordinarily be expected in an NHS-centred policy implementation study. This is because of the broad layer of issues considered to influence levels of health inequalities, - income inequalities being the main cause considered in this thesis.

In the first chapter a brief review of literature on ‘the policy process’ situates the work in this theoretical context. Then concepts from political science that are relevant to the research question are looked at. Chapter 2 gives a historical background to public health initiatives and looks in more depth at the policy issues under investigation. Chapter 3, ‘The research plan and process’, provides a description of the methods used in the work.

It is found that progress in implementing health inequalities policy was distracted by national policy primarily intended for more acute services. The way in which current and new NHS institutions responded to *Saving Lives* (DoH, 1999) is discussed in detail in chapter 4, ‘Institutional change’. The key institutions being: the new Primary Care Groups and Trusts (PCGs/PCTs);<sup>9</sup> the Healthier Lewisham partnership; the Health Action Zone (HAZ); *The NHS Plan* (DoH, 2000); the Health Improvement and Modernisation Programme (HimP); and the target setting apparatus.

<sup>9</sup> North and South Lewisham PCGs were formed on April 1<sup>st</sup> 2000. They were merged to create Lewisham PCT on April 1<sup>st</sup> 2002. Most of the interviews took place before this date, but data continued to be collected for another 15 months. Therefore the titles PCG and PCT are both found in the thesis text.

Central government was clear in *Saving Lives* (DoH, 1999) that it had its own particular role to play, including work on income redistribution, and that local workers had other roles. But if central government was not seen to be doing its bit, and local workers felt that income redistribution was a key element of the policy, then for them, the importance of local work might be called into question. Again this was a factor highlighted in the HOTN assessment (LSHTM, 1998). Chapters 5 and 6, on 'values', investigate the extent to which local work was in fact distracted by these issues. Having reviewed the effect, on new public health policy implementation, of both local institutional changes and staff views, this is contrasted with the role of broader tensions. Unresolved problems in the development of political participation at the local level are considered in chapter 6, 'The participatory framework'.

## **Conclusion**

Placement of some powers and responsibilities into local hands by central government may be a process calculated to retain other important powers at the central level. In particular, the author seeks to show that research in political science on power relations should be brought to bear on developments in 'local democracy' associated with new policy to reduce health inequalities. Drawing on Lukes's (1974) view of power, it is posited that the public involvement aspects of policy to reduce health inequalities may be disguised to look as if they are meeting an agenda demanded by others and not those 'in power'. However, as the subsequent discussion and conclusions unfold, it will be clear that specified nuances and caveats to these propositions are required.

The influence and powers of implementers in the local arena can be usefully compared with the findings of Lipsky (1980). He does not find them able to convert policy to make it chime with their own ideals. Instead, through individual compromises they find themselves creating a social programme that is counter to their strategic wishes.

Research in this field is part of, what has been coined, "the health inequalities industry" (Klein, Health Equity Network conference, 2002 ([www.ukhen.org](http://www.ukhen.org)) and correspondence). However, this investigation takes a broad perspective that integrates



developments in government policy towards democratic participation with developments at the local level to address health inequalities. Thus, the author hopes to shed light on the long-term prospects for health inequalities reduction. These will, however, be closely tied to the character and fortunes of the Labour Party. The party's direction, in turn, is in part connected to its relationship with its local members and their relations with the community.

# **Chapter 1**

## **A POLITICAL SCIENCE FRAMEWORK**

### **Introduction**

Be they civil servants, NHS staff or local government managers, 'state officials', as well as elected politicians, have a pivotal role in the processes investigated here. In order to analyse the part played by each, and the outcome of their activities, there is a need to locate the research in a theoretical context that highlights the character of the state in which they operate and of which they are a part. Theories of the policy process and, in particular, 'implementation', also need to be analysed in order to further situate local 'policy responses'. The purpose of this chapter is to locate local activity in all these complexities. This is achieved through undertaking a review of the theoretical approaches to policy-related actions and political power, and by looking at the implications of these for local work aimed at reducing inequalities in health.

First, a summary definition is required. Like 'the market', the modern British state, with which this research is concerned, is not one entity, but is composed of numerous institutions and undertakes many different functions. The executive, the legislature and the administrative arms are key components of the state. The branches are said in constitutional legal theory to embody the separation of powers, thus guaranteeing the neutrality of the decision making process. Welfare services controlled by state departments are significant within the contemporary British context. As Hill distils it: "The basic definition of the state is as a set of institutions with superordinate power over a specific territory." (Hill, 1997a: 10). See also Dunleavy and O'Leary (1987) and Self (1977).

Firstly, the chapter looks at theories of the policy process. A description is provided of the concept of 'stages' and, in particular, the implementation phase. Also outlined are the perspectives of 'top-down' and 'bottom-up' theorists. Secondly, features of the state and its internal and external relations are crucial to understanding this policy implementation process. The concepts of democracy, class and power are defined, as they help in analysing the interests of the state and its officers. Then the state -

portrayed as both a neutral body and as a biased driver of local activity – is analysed. The final section of the chapter focuses on political parties, and Labour in particular, as parties can affect policy on income differentials.

## **1. The policy process in the modern state <sup>10</sup>**

### **Policy stages**

Hill (1997a: 6-10) discusses the meaning of the concept of ‘policy’ and looks at various definitions. For instance, he quotes Friend, Power and Yewlett’s (1974: 40) definition that – ‘policy is essentially a *stance* which, once articulated, contributes to the context within which a succession of future decisions will be made’. This definition alerts us to the idea that policy is an active process taking place through time and is not the consequence of value free debate. In this thesis the author accepts a schema recommended by Hogwood and Gunn (1984: 10), deLeon (1999: 25), Hill and Hupe (2002: 6) and Parsons (1995: 80-81). This means, firstly, that for practical purposes the policy process may be regarded as divisible into a number of stages which are passed through in order. Hogwood and Gun (1984: 4) provide a list of nine stages.<sup>11</sup> But, secondly, some cautions must be sounded. Hill (1997a: 24) cites various issues to take into account and Sabatier (1999: 7) is even more sceptical. A brief amalgam of their warnings may be set out as follows: (1) policy is part of a continuous process and initiation can start anywhere in the system, (2) stages in this process may be of differing length and import and various feedback loops, along with the interjection of other influences, may operate to blur the sequence of stages. Thus, the process is more complex than the framework indicates, (3) to identify a progression of stages does not provide information on causal processes.

Wolman (1981) also divides public policy programmes into stages. These are, broadly, ‘formulating’ and ‘carrying out’. Within these two parts there are ten sub-groups and various categories below these. The purpose of breaking the process down is to identify, at each stage, issues that may determine programme success and failure.

<sup>10</sup> The heading is taken from Hill’s title (1997a).

<sup>11</sup> These are: “(1) Deciding to decide (issue search or agenda-setting) (2) Deciding how to decide (or issue filtration) (3) Issue definition (4) Forecasting (5) Setting objectives and priorities (6) Options analysis (7) Policy implementation, monitoring, and control (8) Evaluation and review (9) Policy maintenance, succession, or termination” (Hogwood and Gunn, 1984:4).

Going through Wolman's stages in order, a critique is provided in appendix 1.1 of issues relevant to this study.

By breaking down the policy process into stages, but at the same time recognising a blurring of the 'stages' formula, particular features in the process that are of relevance to the thesis can be discerned. This thesis has not attempted to offer a final assessment of programme success or failure in relation to outcomes, i.e. it has not measured the extent to which work led to health inequalities falling. Therefore, Wolman's hypotheses on determinants of policy success and failure have not been fully tested. However, at the same time perspectives on his observations have been provided.

Adopting a 'qualified stages approach' means that the unique elements of the research can be more clearly highlighted. The policy under investigation lends itself to an approach that focuses on particular feedback and links between stages in the policy process. It is posited that the policy is itself impacting on the terms of the policy process, because it concerns factors that can affect the political involvement of social groups in influencing policy. "[The] state can effectively dictate and shape the policy agenda by its own decisions on who shall and shall not be incorporated into the policy process, a good example being the [1980s] attack on trade union and local authority representation on health authorities in Britain." (Mohan, 1990: 80).

And as Hill notes:

"There is an interesting tendency for journalists to exaggerate the political aspects of the policy process and for political scientists to play them down. The latter is partly a recognition of the complexity of the policy-making process – the long transforming process from initial goals to final outcome, a process in which the party political input inevitably becomes watered down. The model used here acknowledges the importance of this, but it is suggested that the party political or ideological element in the policy process should not be given too little attention." (Hill, 1997a: 112)

Other work suggests that government may produce policy in order to be 'seen to be doing something' (Edelman, 1977). A version of this might be the deliberate setting

of targets for health improvement that are very easy to achieve. This was widely considered by NHS staff to have been a 'trick' in implementation of *The Health of the Nation* (1992). At least one senior figure working in public health in Lewisham believed the tactic had continued into the 21<sup>st</sup> century.

### **Implementation**

Although the fieldwork addresses the implementation stage, that is, Hogwood and Gunn's stage 7 (1984: 24), the thesis's proposition is that the pattern of local implementation activity is affected by government concerns that relate to wider issues than those immediately associated with the public health policy. Thus, the present author has agreed with Sabatier's later work (1999: 7) and others who critique the 'stages' model.

Furthermore, as the extent of the links between health inequality, income inequality and poverty are not precisely spelt out in *Saving Lives* (DoH, 1999) there is scope for diverse interpretation both within government departments and at the local level (Hogwood and Gunn, 1984: 204).

Many of the best and most thorough implementation studies make good use of comprehensive criteria checks to assess how far policy is likely to move from opinion as to what legislation would be desirable, to enactment. For instance, Exworthy and Powell (2000) and Exworthy, Berney, Powell (2002) use Kingdon's (1995) three 'streams' - problems, politics and policies. These streams may, or may not, converge to provide, or block out, 'windows' for successful policy development and implementation (Exworthy, Berney, Powell, 2002: 83). Exworthy et al (2002) show that some convergence in policy streams has increased the extent to which health inequalities work is 'on the agenda' nationally and locally. But blocks caused by deficiencies in performance management, insufficient integration between policy sectors, and contradictions between health inequalities policy and other policy initiatives have hampered implementation. Hall et al (1975) analyse a number of case studies to build up a set of criteria for policy introduction and modification. Sabatier (1986: 276) cites at least 21 studies that have used six conditions for effective implementation, as developed by Sabatier and Mazmanian (1986: 273-4).

This research has simply used the HOTN assessment (LSHTM, 1998, referred to in the introduction) as a benchmark against which to judge OHN implementation, but there has been no systematic adoption of theoretical criteria checks to assess the success or failure of implementation. Therefore, the work should be regarded as a study of *aspects* of implementation at the local level, rather than as a standard implementation study.

A strong justification for interest in the research topic under investigation is provided by the evaluation of Conservative government public health policy (LSHTM, 1998). In it one of the key factors said to influence implementation was government 'acknowledgement of the socio-economic determinants of health'. This was needed in order to gain credibility with local staff. The assumption was that local implementers' views on the credibility of policy affects their work. Specifically, views on socio-economic policy issues and government action in this field will affect implementation in this way (LSHTM, 1998: 147). Thus, the author of this thesis wished to assess and track the way in which staff views on an aspect of the socio-economic determinants of health - income inequalities - might affect implementation.

Furthermore, the HOTN assessment was chosen as a benchmark for the research for the following reasons. Firstly, it was produced by respected academic sources, employs an acceptable methodology, and its research is well resourced, with, for example, data collected from 256 face-to-face interviews in total, covering 8 health regions. Secondly, this thesis starts at one point in a policy process; the HOTN assessment and its object of study can be seen as part of a developing picture of policy to improve health and reduce health inequalities, and thus it gives some historical perspective to the particular point of departure made here. Given that it assesses Conservative government policy, it also helps in considering those elements of contemporary British public health policy that remain unchanged under differing complexions of governing party and those that may shift (Parsons, 1995: 603-13).

As mentioned, the thesis concentrates on analysing processes unfolding at the local level rather than the larger issue of assessing the likely outcome or success of the

policy.<sup>12</sup> However, cross-referencing is made to the factors found to have influenced the implementation of the Health of the Nation policy (LSHTM, 1998: 147). Among these are: resources, support from central government, organisational structures, partnerships, commitment of organisations and individuals, acknowledgement of the socio-economic determinants of health, along with local demographic features, and finally, local authority cultural and political features. It was predicted here that the uptake or discarding of the assessment's recommendations for public health policy would affect *Saving Lives*'s implementation.

Moreover, given some of the responsive alterations made to the policy within the last five years, and improvements in local implementation, the present author concurs with analysts of policy development and implementation who take the view that a long-term perspective on policy success is needed. Examples of academics providing this view are Parker (1975: 371-407), who describes the long struggle for clean air policy change, Hill (1981: 271) and Sabatier (1986).

#### **'Top-down' and 'bottom-up' perspectives on implementation**

Of relevance to this work is the 'top down – bottom up' debate and links, or feedback loops, between state and party activity within pre-implementation stages and 'bottom up' responses (Parsons, 1995: 463-470; Hill and Hupe, 2002: 41-56; Hill and Hupe, 2003: 473-474).

Put simply, the top-down approach can be characterised as stressing the perspective of legislators and the distant government authors of policy decrees. The observations of Pressman and Wildavsky (1973) are pertinent here, since their study showed that local actions might translate policy aims into unsought outcomes.

Hjern (1982) and Hjern and Porter (1981) draw attention to the complexity of organisations' involvement in policy implementation and to the normative democratic issues involved. Hjern (1982) takes a 'bottom-up perspective'. He suggests that

<sup>12</sup> Don Nutbeam has highlighted "the difficult decisions facing the DoH in identifying specific public health programmes that will have an impact on health inequalities because of the paucity of evidence concerning effective interventions. This has made decisions on priorities very difficult." (HEN conference, 2002 and correspondence). Again, due to the focus of this thesis, this very real and important area has not been addressed in a systematic way.

negotiations between local implementers and local people affected by policy should influence its development. However, Sabatier (1986) seeks to shore up the democratic legitimacy of government policy making. He suggests that local staff should implement the policies of elected government and not have undue autonomy and freedom to influence policy (Hill, 1997b: 214). The present research is concerned to identify where policymaking is taking place and to show any changes in the site of policymaking and attendant powers. This challenge relates to the main aim, since policy may be shaped and reformed by local staff or it may be more influenced by wider political tensions.

Lipsky (1980) is also associated with the 'bottom up' perspective. He argues that the aggregate of individual behaviour among front-line public service staff can effectively become policy. Here, as referred to in the introduction, the author investigates how the opinions of local staff might affect delivery of a policy that is tied to one of the most fraught of political questions, that of income distribution.

To summarise, it has been shown that an analysis of 'stages' in the policy process is useful in unpicking and referencing local responses to policy to reduce health inequalities. At the same time, one should not expect to see policy-related actions neatly mapping this schema. The political process of policy development and implementation is more complex, and as is shown in the next section, is related to the context of the modern state.

## **2. Theories of the modern state**

The various branches of the state, referred to in this chapter's introduction, control or co-ordinate, to a greater or lesser degree, the policy process. The state is seen as a neutral arbiter of competing interests or demands in some models and as a biased player in others: putting its own policy interests, or the interests of particular classes and groups, above those of others. Certain key concepts immediately arise in analysis of British state activities, namely, democracy, class, power and pluralism, and these are therefore discussed. Using these concepts the role of the state is looked at, firstly, as a neutral body, and secondly, as an interested party acting as a partisan player and directing policy on behalf of certain classes or groups. A description of these



theoretical concepts is required in order to attempt to apply them to, and thus increase understanding of, activity and causal processes in the local area under investigation.

### **Democracy**

The concept of democracy is intertwined with that of the state. Let us take a simple definition of the democratic principle, offered by Arblaster: “..that people should, as far as possible, make or participate in making the decisions that affect them most closely”. It is Arblaster’s opinion that “this principle could beneficially be applied far more widely in modern societies than it presently is.” (Arblaster, 1994: 102). As he points out, for many centuries democracy had a pejorative and negative meaning and it is only in the twentieth century that it became more widely accepted. The reason for reticence was, in part, fear of redistribution. The attitudes of higher and lower income groups towards rules governing democracy have a divergent history. If the poor could choose, then, as they out-numbered the rich, surely they would vote for movement of funds from the latter to the former group?

Nine different ‘models of democracy’ are provided by Held (1987). These are outlined in appendix 1.2. It is possible to select from Held’s models those that are most relevant to this study’s findings. Of particular importance (see chapter 6) are four forms of democracy: (i) representative (Held’s type 3b); (ii) direct (Held’s type 4); (iii) legal (Held’s type 7); and (iv) participatory (Held’s type 8). Elements of Held’s models were encountered in the aspirational values of different local staff, in the rationales cited by both the Department of Health and local staff as underpinning current institutional change, and in institutional arrangements that were present in the borough at the time of the research.

The study found that a number of staff tended to blend elements of Held’s models and switched between models when discussing different issues. Motivations for supporting different features within the models ranged from the view that population health would be improved by the development of the particular democratic principles, through to the view that the current system was corrupt and did not enable decisions to be taken that the majority of residents supported. What was aspired to (the ‘ought’) and what was in reality being developed (the ‘is’) at times became merged in interviewees’ responses and clarification was then sought. While staff thought some

features of Held's typology ought to be strengthened, suggested below are the models whose elements actually existed in Lewisham at the time of this research.

It is suggested that Lewisham residents mainly experienced a combination of Held's 'developmental democracy' (representative, type 3b) and 'legal democracy', although other features of different models may apply. Both models incorporate representative mechanisms. Representative democracy has many different overall forms, depending on a blend of elements. Elections indicate one aspect of its operation. The main elections, forming one part of the system of representative democracy in Lewisham, consist of:

- election by all the borough's electorate of MPs, MEPs, councillors and more recently the London and borough mayors
- selection and election of these candidates to stand for the Labour Party by Lewisham Labour Party members
- election of representatives of the voluntary sector to sit on the new Local Strategic Partnership
- election of tenants representatives within tenants associations
- election of professional representatives to sit on PCTs
- election of representatives to sit on the community council (N. Lewisham area)
- internal election of voluntary sector officers who do not necessarily then act as organisational reps
- internal election of union representatives
- non-elected representation also forms part of the representational structure of organisations in Lewisham. For instance, chairs and non-executive members of the new PCTs are appointed by the Secretary of State for Health.

However, the system is changing because of a number of new developments, which in turn have various causes. Recent changes in Lewisham's system of representation and democracy include: the formation of a community council; a decrease in participation by Labour Party members and a decrease in their powers; a rearrangement of the responsibilities of councillors and a planned decrease in their numbers; the formation

of 'Hubs';<sup>13</sup> the formation of a 'citizens' panel'; and, increased investment by statutory services in public involvement workers,<sup>14</sup> who are either based in the statutory or voluntary sector. Previous changes, such as the demise of local representation on national wages councils, are also pertinent.

Staff showed preferences for particular models and indicated a variety of assessments of current democratic practices. There was found to be little consensus on the overall real, and ideal, direction of change. Given, as is argued here, that the application of different democratic rules will affect income inequalities, this lack of consensus is of significance to the present research. The effects on the worse off, arising from changes to democratic structures, need to be considered.<sup>15</sup>

### **Class**

Before theories of the state are examined it is necessary to give a very brief definition of 'class' since 'population groups' have already been referred to. For the purposes of this research two definitions of class are taken, suited to different analyses. The first is the sociological definition, used in many studies of health inequalities. Here class relates to type of employment, as assessed by the National Statistics Socio-Economic Classification (NS SEC),<sup>16</sup> or may be analysed on the basis of title of newspaper read and other sociological characteristics (socio-economic status groups). Thus, the author would concur with Baldwin: "Classes may be defined by more than their relations to

<sup>13</sup> 'Hubs' were renamed 'Area Forums' in May 2002. There are 6 in Lewisham covering 3 wards each. They are regular meetings open to all residents in the area to meet with councillors and council officials. "They are not decision-making bodies but can serve as consultative mechanisms and make a vital contribution to the work of the council." (Lewisham council website, September, 2003: [www.lewisham.gov.uk/PerformancePlans/BVPP2003/governance.htm](http://www.lewisham.gov.uk/PerformancePlans/BVPP2003/governance.htm) )

<sup>14</sup> The term 'public involvement work', in the context of this thesis, covers state funded initiatives to support public influence over a range of issues. While some NHS staff may associate public involvement only with patient involvement, the thesis takes the latter term to be one aspect of the former, generic, term. The thesis is concerned with public involvement that may affect the broader determinants of health, rather than with feedback mechanisms that aim to improve the patient experience. It is argued, later in this chapter, that non-state funded public involvement, in the form of participation in the labour movement, should also be taken into account when considering the public's influence on upstream health determinants.

<sup>15</sup> It is the author's view that national and local democratic structures are still assessed for their impact on longer-term power relations and the ability of certain groups to accrue resources. A recent example has been debate on the pros and cons of elected mayors. Here, negative campaign literature highlighted the business interest in acquiring a single person with whom to liaise, while the pro-mayor lobby emphasised more power for residents and less for local elites (for example, Baker, 2001; Freeman, Trimmingham, Baker, 2001; Bassam, 2001; Burch and Holliday, 2000: 75).

<sup>16</sup> A new system of classification was introduced in 2001. "NS SEC has forty categories that can be aggregated...into fourteen operational categories, which in turn can be aggregated into eight, five or three analytical classes." It is based on occupation, employment status and size of organisation (Rowan, 2003: 34, 33).

the means of production; their political behaviour may therefore not be immediately determined by economic evolution.” (Baldwin, 1990: 48).

However, a second way of looking at class, associated with a Marxist position, also has explanatory value in relation to analysing health inequalities policy. This is the relationship of different groups in global society to the means of production. Owners and controllers of capital used to secure the means of production may have different interests in relation to income inequalities from those employed and paid by wages. It is also the case that owners of the ‘means of production, distribution and exchange’ are, as well, controllers of employment. Because of this they are able to influence governments in a way that employees cannot. This is a reason for challenging assumptions of the benefits of interest group politics over party politics for people on lower incomes. Business will normally have more resources and leverage to lobby government than interest groups composed of lower income populations. Lower income groups may instead achieve more through forms of democracy that rely less on financial resources and more on the legal authority of votes. Within the binary formula of the Marxist position further distinctions can be made. For instance, Poulantzas (1973) outlines a class schema that differentiates the interests of state employees and their families from private sector employees and their families.<sup>17</sup> Some local interviewees employed the second definition. One respondent for example, saw the owners of media outlets wielding significant power to control politics. Others felt that the control of owners of capital over employment implied that income differentials would never change.

Social stratification beyond class is also important in understanding the context of policies to address health inequalities and access to influencing policy. The mass entry of women into the labour market, which accelerated from the 1960s, has had huge social ramifications that are still developing. Similarly, over the last 40 years, the migration of populations, particularly from the Caribbean and Africa, to South London, increases the need for health inequalities to be analysed in relation to race as well as class.

<sup>17</sup> Debates between Wilkinson (1999) and Muntaner, Lynch and Oates (1999) highlight the importance of the second general formulation of class.

As Verba et al (1978) seek to show: “In general, political and socio-economic stratification hierarchies are likely to be closely aligned.....The economically and socially better-off dominate politics. Government policy, in turn, maintains and reinforces the position of those who are better off.” However, their findings indicate that through political organisations and institutions the ‘have nots’ can gain more involvement. “In the absence of *explicit* contestation on the basis of social class the haves in [US] society, came to play an inordinate role in political life.” (p.307). But, strong institutional constraints can result in a more representative activist population with, in turn, more egalitarian socio-economic ramifications (p.295). It is for this reason that the institutional arrangements for political participation are considered to be of relevance to the topic of this thesis.<sup>18</sup>

### **Power**

A typical starting point for a discussion on power in contemporary society is with the pluralist tradition, discussed further under its own heading below. In the work of Dahl (1957), for instance, the use of power is visible - winners and losers can be identified, because the latter act as the former decides. At the same time, access to decision-making arenas is open. Active and legitimate groups in society can all participate in the formation of policy. Schumpeter (1943: 269-273) sees widespread public participation in democracy as tied to competition between party leaders for votes. Here the principal function of the public is to ‘produce’ a government. However, Benn and Peters (1959: 289) see a wider variety of different relations between the state and associations in society, with the state sometimes controlling or competing against social groups or service providers.

Developments in the theory of power consider the possibility of suppression of observable conflict (Bachrach and Baratz, 1970; Lukes, 1974). In the ‘three dimensional’ view of power, not only may agendas be ‘rigged’ to prevent particular groups raising their interests (the two dimensional view), but also interests themselves may be shaped by the context. Lukes gives an example where, if workers are dependent for employment on a factory that is polluting their town, then they may

<sup>18</sup> A comparison can be drawn with Tudor Hart’s ‘inverse care law’ referred to in the next chapter. Here the worse off, most ‘in need’ of political representation, are least likely to acquire it, without explicit assistance from political organisations.

then not feel interested in reducing pollution levels, because they know this may affect employment (presentation by Stephen Lukes at LSE, 7.3.02). For Lukes, open conflict is not necessary for power. The most effective use of power is hidden and prevents conflicts from starting.

Lukes's detractors, for example, Polsby (1980), Hindess (1976) and Benton (1981), argue that, among other problems with this analysis, Lukes finds himself in the tricky position of needing to ascribe interests to actors who are unaware of such interests. Benton, for example, suggests the emphasis on hidden interests, or 'false consciousness', is a means of explaining away the failure of the working class to live up to intellectuals' expectations.

In Lukes's model, power may be hidden; therefore, in order to study situations where it may operate, a comparative approach, such as that used by Crenson (1971) is helpful. This research is, in part, concerned to identify possible factors affecting the ability, or inability, of different local interests to influence the distribution of income, since this is considered to affect health. As part of this assessment the thesis looks at what factors might inhibit income and health inequality from becoming issues of local importance. It considers whether 'democratic goal posts' might be moved in order to keep the issue of income inequalities off the agenda. The research seeks to find out if NHS work is, through unintended consequences or chance, influencing the ability of some groups to raise issues of income inequality. Different forms of involvement might favour different interests. Public health and NHS practice clearly supports some forms of public involvement and is not involved with others. This issue is returned to in chapter 6.

Crenson, in his famous study of air pollution legislation, believes that: "Air pollution ...is not the only urban problem that has been a victim of political neglect. Poverty and racial discrimination ...have been present in American cities for some time but provoked little in the way of political action...The decisions that we fail to make often seem to be more critical for the life of the nation than the ones that we do make."

(Crenson, 1971: preface vii).<sup>19</sup> Certain people and institutions, and certain combinations of people, policy and institutions, his study held, had the power to enforce inaction (p.33). Some towns, it was found, acted more decisively to address air pollution than others. Both Crenson's and Lukes's view of power provides an important theoretical framework for the present research and analysis. Tawney (1964), Anderson (1974), Gramsci (1957, 1971), Le Grand, 1982: 142-51 and others also describe the ways in which demands for increased equality may be damped down. This thesis generally considers - particularly in chapter 6 - the local factors that lead to inaction and act as barriers to political and social organisation that might be associated with upstream income redistribution.

### **The neutral state**

The main theories associated with a conception of the state as predominately 'neutral' are those of rational-legal authority, stemming from the work of Max Weber (1864-1920), and pluralism, as exemplified by Robert Dahl (1915-). Both do, however, incorporate an acknowledgement of openings for potential state biases. The importance of these perspectives for the current research will be explained.

### **Rational-legal authority**

Weber describes one method of legitimating authority as being on 'rational', non-arbitrary grounds:

“...resting on a belief in the ‘legality’ of patterns of normative rules and the right of those elevated to authority under such rules to issue commands.... In the case of legal authority, obedience is owed to the legally established impersonal order. It extends to the persons exercising the authority of office only by virtue of the formal legality of their commands and only within the scope of authority of the office.” (Weber, 1947: 323).

Weber distinguishes rational-legal authority from charismatic and traditional authority.<sup>20</sup>

<sup>19</sup> Lukes considers Crenson's study to contain certain “elements of the three-dimensional view of power” (Lukes, 1974: 60).

<sup>20</sup> “The march of bureaucracy has destroyed structures of domination which had no rational character....” (Weber, in Gerth and Wright Mills, 1991: 244).

While some of the details of Weber's bureaucratic system may appear arcane,<sup>21</sup> a respect for the ideals of this system of authority can still be found to permeate through NHS staff thinking and practice.<sup>22</sup> Four points are listed to show the relevance of Weber's theory of rational-legal authority to the thesis. Firstly, it may affect the extent to which staff situated in a bureaucratic system feel able or confident to pursue their own notions of the most effective route to achieving the policy goals as set by higher authority. The particular health policy of concern here can be associated with politically highly charged redistributive elements. The economic policy of the government has been less clear in relation to income inequality than to health inequality, leading to perceived inconsistencies in policy and uncertain implementation. The extent to which 'street-level bureaucrats' may be willing and able, to follow their own agendas is particularly interesting in these circumstances (Lipsky, 1980). It is assumed that staff espousing values that respect rational-legal authority will perceive boundaries in their ability to take an independent approach to implementing policy.<sup>23</sup> These values and norms are reported in chapter 5.

The hierarchical nature of NHS structures is also of relevance to the implementation process. To the extent that a hierarchy exists, it is not a single entity but is fractured by loyalty to professional groups and 'competing baronies'. Nevertheless, some deference to the norms of the bureaucracy is assumed to exist and to be of relevance to this research. Political leaders appear to regard the National Health Service as too hierarchical and it has been posited that local staff should be given more flexibility in order to carry out effective work. Commands from the higher centralised levels of the NHS are now seen as too broad-brush to apply to variations in local needs: "...a one-size-fits-all nationalised industry monopoly approach – must change", said Alan Milburn, Secretary of State for Health (Milburn, 5.2.03).<sup>24</sup> However, as will be seen,

<sup>21</sup> See for example Weber on Bureaucracy in Gerth and Wright Mills, 1991: 196.

<sup>22</sup> A most obvious example being local staff handbooks, which in the case of new Primary Care Trusts formed in Lambeth, Southwark and Lewisham entail at least 50 different staff policies.

<sup>23</sup> "The individual bureaucrat cannot squirm out of the apparatus in which he is harnessed...the professional bureaucrat is chained to his activity by his entire material ...existence." (Weber, in Gerth and Wright Mills, 1991: 228). Bureaucracy, in Weber's words, is an 'iron cage'.

<sup>24</sup> The reasons Milburn gave for the new drive for 'localism' were fourfold. The first reason, which ignores issues of economic migration, was that: "...the uncertainty engendered by globalisation is driving people to take refuge in what they know – in their families, their communities, their regions. People find shelter in the very local because the local can be influenced even if the global cannot.". The national has of course been ignored here. The next three reasons are more orthodox: different communities have different needs; health services are delivered locally and local staff should be trusted



in this case study attempts to allocate various responsibilities to local public health departments proved unsuccessful in the early years of Labour's return to office.<sup>25</sup>

Secondly, it could be said that, as the policy under investigation itself takes a non-neutral position towards the status quo of health and income distribution, an ethic of bureaucratic neutrality might mean that local institutional responses stagnate. As Weber says, "Discipline in general, like its most rational offspring, bureaucracy, is impersonal. Unfailingly neutral, it places itself at the disposal of every power that claims its service..." (Gerth and Wright Mills, 1991: 254). While Weber's formula appears clear, it needs to be seen in the context of somewhat confused directions, mixed views on which power does legitimately claim authority and the desire of the post-1997 British Labour government to represent the whole nation. Given this environment, the bureaucrat's aspiration to follow orders neutrally might gravitate to the most conservative position, that is, one that does not encourage partisan pressures for income redistribution.

Aside from direct work to reduce health and income inequalities, it will be argued in chapter 2 that political self-organisation of affected groups has, in the past, assisted reduction in health inequalities. It is the local state's attitude towards encouraging citizens' political self-organisation that, it is argued here, provides particular problems for bureaucrats working within a 'neutral' framework. This is because state officials would be using the cover of the neutral state to pursue policies that may affect the future fortunes of partisan interests. However, as will be discussed in chapter 6, the activities of state officers can be interpreted as undermining the work of minority political parties and Labour Party organisation in Lewisham. The Labour leadership can be seen to 'subcontract' the building of formerly party-based democratic structures to council and voluntary sector officials, who construct non-party

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to innovate locally; and finally, "In a consumer society more people are demanding public services that are responsive to their own needs and offer greater personal choice." Stringent national rules on the use of the NHS logo are one example of contradictions in this drive for 'localism' (DoH, 2000: 15).

<sup>25</sup> The rational bureaucratic account of authority is not simply concerned with the state, it may be applied to political parties as in the work of Michels (1915).

substitutes.<sup>26</sup> To summarise, officials' uncertainty might be predicted regarding - what it means to be neutral in the context of a policy that in some respects requires biased work, that is, work aimed at supporting particular sections of the population. Any contradictions in policy will add to this insecurity.

Thirdly, Weber allows that bureaucrats might develop self-serving tendencies and this is also relevant to a study focused on NHS orientated systems. An NHS executive and budget-holder earning £60,000 might, for instance, be unenthusiastic in advocating that NHS pay structures be flattened, even if evidence suggested that this would help health inequalities reduction.<sup>27</sup> It is also the case that state employees may work in ways that promote bias because of unconscious prejudices. This applies in respect to definitions of 'local' and 'national' within health inequalities policy and practice. A local state employee may tend to consider local issues to be those that they have control over, and national issues to be ones that national government has control over. However, pensions policy, highlighted in the Acheson report as being of significance to health inequalities, is an example of the somewhat random categorisation of issues. For many local residents, pensions are an important issue, possibly more important than increasing provision of fruit in schools. But for local NHS staff the issue is one they cannot do much about, and therefore it is not a 'local' issue.

Finally, another dimension of the relationship between state bureaucratic interests and health and income inequalities policy is the role of the state as employer of lower income workers. Different levels of state enterprise are considered in some of the literature to benefit different sections of society. State sector employment was used as a bulwark in certain countries against increasing income inequalities caused by unemployment from the mid-1970s and income inequalities were found to be higher in states with lower state employment (Duncan, 1989). Thus further scope for conflicts of interest arise since state managers may be required both to promote efficiency and to provide employment opportunities.

<sup>26</sup> Boundary confusion between the role of the state and the role of the party is considered by, for example, Mair (1997).

<sup>27</sup> Within an 'evidence' culture, referred to in chapter 2, the availability of research to support a variety of different responses to health inequalities (Carlyle, 2001), increases the bureaucrat's 'room for manoeuvre'.

At this point we should note that fierce debate has raged as to the proper functions of the state. Hayek (1944)<sup>28</sup> is associated with a view advocating a minimal state. His position is that it is impossible for one set of bureaucrats to hold the knowledge required for planning industrial production and for complex services such as the NHS. The market is better placed to respond efficiently to needs through a huge number of adjustments made by managers at local sites. The NHS internal market - whose development in the early 1990s was in part influenced by this thinking - remains largely in operation and, as will be seen in chapter 4, affects the context of the policy implementation under investigation.<sup>29 30</sup>

*The Managerial State* (Clarke and Newman, 1997) emphasises the 'New Right's' drive, in the Britain of the 1980s and 90s, to depoliticise decision making through the dispersal of power to managerially controlled organisations in both the private and public spheres. The weakening of trade unions and the decline of collective bargaining, the impact of which was unevenly distributed, mainly affecting working class occupations, is coupled with an at times paradoxical attempt to 'capture' the customer and use them to legitimate managerial control. At the same time 'public choice theory'<sup>31</sup> is used to raise suspicions about self-interested vested interests and the inefficiency of distribution systems not based on price mechanisms (Clarke and Newman, 1997: 144, 70, 107, 84, 52). However, some realignments have taken place

<sup>28</sup> Following J.S. Mill in *On Liberty* (1859).

<sup>29</sup> The effects of the 'internal market' context on the subject of this investigation relate to, firstly, implications for the siting of public health departments in relation to other NHS services; secondly, the status and powers of the medical profession to influence local spending decisions which may or may not favour public health objectives; thirdly, its effect on NHS wages and income inequalities; and finally, the institutional changes made post-1997 were, in part, to address problems with the operation of the internal market, and as will be seen, affected implementation of policy to reduce health inequalities.

<sup>30</sup> The relationship between public health concerns and wider market provision is most apparent in areas where production and distribution is considered damaging to health, an obvious example being tobacco sales. However, a deeper critique of market relations is implicit in three areas of work relating to health inequalities research: firstly, in work that suggests the market will not allow income differentials to fall far below their current levels (Muntaner and Lynch, 1999); secondly, 'health impact assessment' work (Taylor and Blair-Stevens, 2002) is implicitly critical of the ability of market relations, on their own, to produce good decisions; thirdly, the increase in communicable diseases such as diphtheria and conditions such as 'stress' in states of the former communist bloc has been documented by Wilkinson (1996). The states of Cuba and of Kerala in India are lauded in the health inequalities literature, and at the same time their political cultures are among the most unsupportive of decision making via capitalist market relations in the world.

<sup>31</sup> Public choice or rational choice derives from economic theory. The premise is that rational agents, be they public bodies or individuals, will choose to maximize or optimise benefits to them, given constraints. Decision-making behaviours such as voting are analysed from this perspective. The perspective has also influenced social capital theory (Coleman, 1994).

since 1997 and it can be said, using evidence from health inequalities policy for example, that it is now easier to articulate concerns over inequalities and egalitarianism. Although, Heffernan (2001) and others alert us to continuities between Conservative and, post-1997, Labour programmes.

### **Pluralism**

As has been referred to in the discussion on power, for Dahl, government agencies may pursue their own preferences, but external interest groups have freedom to successfully influence policy and control the excesses of political leaders.<sup>32</sup> Support for these arrangements and encouragement of a proliferation of diverse pressure groups is associated with the pluralist position.

For Latham, the state, as portrayed by the 'official groups' of the US Congress and White House, replicates in legislation the majority opinions of a plurality of different organised and incipient groups in society, be they trade unions, churches or business associations. The system described is also praised by Latham and other pluralists for acting as a bulwark against totalitarianism (Latham, 1952: 223-5, 47).

An example of local work informed by pluralist values is the commitment by the 'local state' to support community development work aimed at promoting health. This state-funded work in urban Britain supports voluntary agencies and community groups. In Lambeth, Southwark and Lewisham community groups are funded by the health promotion department, via small grants schemes, in order to provide health promotion activities and to develop organisational infrastructure. The prime motivation for this relationship is that the groups are seen as being closely engaged with local and diverse sections of the population, such as relatively small populations of various African communities, which statutory sector workers may find 'hard to reach'. A vibrant community group culture tends to be generally supported among public health and health promotion staff. For some staff, as will be seen, public involvement in groups is thought to bring health benefits simply through the process of participation. However, for others, echoing pluralist sentiments, involvement will

<sup>32</sup> "Citizens are very far indeed from exerting equal influence over the content, application, and development of the political consensus. Yet widely held beliefs by Americans in a creed of democracy and political equality serve as a critical limit on the ways in which leaders can shape the consensus." (Dahl, 1961: 325).

also help to influence policy and to develop 'social capital'. Chapters 4 and 6 will look in more detail at the range of staff opinion on the role of voluntary and community groups.

It is an assumption of this thesis that the local 'democratic system' is geared towards control via political parties and is biased against effective policy control via pressure group participation.<sup>33</sup> In the words of one Lewisham MP, 'Politics in this country is arranged along party lines' (Joan Ruddock, July 2000). To this one might add: "...the centrality of political parties in structuring political campaigns, controlling legislative debates, and directing the actions of politicians gives parties many venues in which to represent the interests of their supporters." (Dalton and Wattenberg, 2000: 8).

Thus, if democratic control within parties changes and party political participation is not encouraged, routes to influence will be curtailed. Political parties control access to legislative arenas. Yet it is suggested that a significant change is taking place in public-party relations: "...we are witnessing a broad and ongoing decline in the role of political parties for contemporary publics..." (Dalton and Wattenberg, 2000: 23). This thesis finds an urgent need for clarity on how local people are expected to influence upstream issues, such as pensions. Conflicting messages, supported by differing interests, are currently likely to mean that lower income people have diminishing access to influencing government policy.<sup>34</sup> This is discussed further in the section on the Labour Party below.

### **The partisan state**

The idea that the state may act to support the interests of particular classes, social groups, and particular types of business, has been developed in a number of alternative ways within different theories of the state. The possibility that the state might act in a biased manner is of great importance in the analysis of health and income inequalities policy. Examples as to why this is so, based on three different

<sup>33</sup> Dahl notes the differences in analysis between English, American and European writers (Dahl, 1961: 5-6).

<sup>34</sup> At the same time local populations may be gaining more influence over downstream issues such as traffic calming schemes. The current local model of democracy and the new structures being introduced should not, in the author's opinion, be regarded as the only formulas capable of increasing the influence local residents have over these downstream issues. Different models of democracy can produce similar types of changes to the local environment. For example, public sector trade unions have, in the past, influenced issues such as the timing of bus services.

theoretical approaches, are therefore set out below; i. a rational-choice variant, ii. the Marxist perspective and, iii. an 'elite theory' viewpoint (one elite theory type, can also be connected with a Marxist perspective). Under this last category is included a brief discussion on the power of the medical profession.

#### *Rational choice variant*

Firstly, if, the state is self-serving and state employees may arrange their functions in such a way as to enhance their own interests, as is suggested by Weber (Gerth and Wright Mills, 1991: 226; Dunleavy, 1991) then we might suspect that work conducted at the local level to address health inequalities could be arranged more efficiently. Indeed, we might question whether any of the work is worth doing at all since much of the lobby for policy creation prior to 1997 came from local staff, who, it might be argued, now benefit from being employed to carry out the work. From a 'rational choice' perspective, the possibility that local state workers might organise their work so as to suit their own purposes, for example, to demonstrate the need for their employment, should be taken into account. An assessment of the efficiency and cost-effectiveness of delivery structures is made in chapter 4.

There is potential for increasing or decreasing the functions of the state and reorganising relations between state workers and service users, as suggested in the previous discussion on democracy. It is reasonable to speculate that some sectors of society would benefit from a decreased role of the state in the provision of health care, for instance, and that other groups would lose out. Indeed, the relationship between the growth of state spending up to the early 1980s, followed by a subsequent 'reining in', and, the increase in income inequalities from that point in time, is of significance to health inequalities policy.<sup>35 36</sup>

#### *A Marxist interpretation*

Secondly, if the structure of the capitalist system of production requires that the state ensure that certain inequalities, including those of income, are maintained, then perhaps addressing the effect (health inequalities) rather than the cause (the needs of

<sup>35</sup> Data provided by Dr James Banks, Institute of Fiscal Studies, University College London (UCL), in a health inequalities seminar organised by the public health department, UCL, 13.3.02.

<sup>36</sup> "By the 1980s public sector spending in OECD countries accounted for 45 per cent of all economic activity.." (OECD, 1986, Table R8: 163, in, Duncan, 1989).

the capitalist system) is bound to lead to failure. The Marxist case might take issue with Wilkinson (1996) for only attending to the fact that income inequalities exist, rather than looking at their cause – the mode of production (Muntaner et al, 1999; Fine, 2001: 106-8).<sup>37</sup> The fact that the International Monetary Fund recently recommended that Sweden increase its income inequalities in order to assist its economy could be used as an example to lend weight to this suspicion (Artus, IMF press briefing, 3.4.2000).

A concern that has absorbed governments since the National Health Service's creation in 1948, has been how to obtain 'value for money' (Abel-Smith, 1978). A political benchmark for efficiency is required. The state, it might be argued from a Marxist perspective, is only interested in ensuring that working class populations remain healthy in order that they join the workforce and act efficiently as employees. Thus, the state functions in order to promote the long-term sustainability of the capitalist system.

One strand of thinking within the current health inequalities debate does seem to be in the tradition of direct economic determinism (see chapter 2, conclusion). Shaw et al (1999) exemplify this in mapping every increase in income inequality directly to an increase in health inequality. This perspective, as the findings here show, is prevalent at the local level. The author's view is that while the pattern may, or may not, be so clear cut, political organisation influencing a demand for redistributive policy needs to be taken into account.<sup>38</sup>

<sup>37</sup> Wilkinson's theory (1996) is referred to in the next chapter.

<sup>38</sup> It has also been argued by Katz and Mair (1995) that political parties might exploit the state as an alternative source of funding. Here an argument is made, on the basis of evidence from the case study, that exploitation of the local state by professional parties goes beyond simple financial benefits. The state is being used to substitute for population mobilisation, because of a reticence among the party elite to allow local party control. The dangers of this process are highlighted by Dalton and Wattenberg: "When parties make fewer and fewer efforts to mobilize citizens they worsen inequality of participation. ....the lack of response by parties in government to the changing realities of dealigned politics [may be seen] as further increasing the gap between the governors and the governed." (Dalton and Wattenberg, 2000: 284). If, as was argued above, there remains some loyalty towards rational-legal authority within the NHS staff group, local staff are then not well positioned to challenge these developments. They may also be unwise to, from the perspective of preserving and enhancing their own role in public participation work.

### *Elite theory*

Thirdly, if an elite group of better educated, politically conditioned people who also have business acumen, will always exist, then there is not much point in worrying about whether non-elite people are more likely to die, say, 7 years younger (this view might be associated with Pareto (1966), cited in Hill, 1997: 45). On the other hand if it is this elite group of individuals who are blocking progress because their privileges were acquired by means of luck or force, then we might wish to emphasize the importance of equal opportunities laws, education and inheritance tax. An 'instrumental' Marxist perspective as exemplified by Miliband in *The State in Capitalist Society* (1969), might apply. This could point to the ability of the elite, for reasons of their personal networks and contacts, coupled with finances, to use the state 'instrument' for their own purposes.<sup>39</sup>

Of relevance to the particular policy under investigation is the role of medical doctors in influencing the direction of health policy and acting as a professional network. "*Professional networks* are characterized by the pre-eminence of one class of participant in policy making: the professions. The most frequently cited example of a professionalized policy network is the National Health Service (see Ham, 1981)." (Rhodes and Marsh, 1992: 13). Alford (1975) is associated with a view that places (non-public health) doctors at the forefront of controlling the implementation of new health policies (Hill and Hupe, 2002: 35; Parsons, 1995: 263; Ham, 1999: 206). However, this under represents the complexity of Alford's position. In *Health Care Politics* (1975) he is discussing the power of the medical profession in the US. Within this particular context he believes: "The efforts of ... diverse individuals and groups, whether aimed at specific or general [health] reforms, are likely to fail." (1975: 218). Therefore, the medical profession is able to dominate the health policy process. However, his understanding is that within the European setting the situation is different.

In Alford, the role of political parties, as distinct from a plurality of 'community and user interests', in controlling the provision of health care, is appreciated, for example:

<sup>39</sup> Cohen provides recent illustrations of elite networking, as described by Miliband (Cohen, 1999: 236).



“The stronger and more centralized states in European societies, coupled with *much larger socialist and communist parties and movements*, have [led to] to a deeper critique of the role of the state in society. Issues of ...socialized medicine...have become important in many European countries, whereas they remain peripheral debates in the United States. Such issues spark abstract discussions of vague possibilities in the United States; they have been the immediate focus of mass political demands in Europe.” (Alford and Friedland, 1985: 423, italics added)<sup>40</sup>

Thus, Alford can be interpreted as giving credence to this thesis’s interest in the ‘distribution’ of public involvement, between political parties of the left and disparate community groups, as a factor affecting health policy.

A caution against applying Alford’s work to non-US settings is also provided by Wistow (1992: 52) and Harrison (1988: 74-5). Harrison’s view is that the role of government vis-à-vis the medical profession, in controlling the activity of the NHS, has been strengthened, in a small part, by the cooption of NHS management, but also because of political imperatives to control both costs and organised labour.<sup>41</sup> Doctors can be useful to government in helping to ration spending, but threats to their clinical freedoms have also resulted in increased attempts to practice ‘evidence based medicine’ (Harrison, 1988: 54, 125, 129-30). Salter (1998) also emphasises the political problem of balancing expectations with costs. “The translation of health care rights into demands upon the political system is influenced by the interaction between the ideology of the welfare state and the characteristics of party politics in an electoral democracy.” (Salter, 1998: 210). Even Ham (1999), who can be most associated with a view that emphasises the importance of the medical lobby in directing NHS activity, recognises that in some specialisms this is of less significance: “While it is difficult to overemphasise the strength of medical interests, it should be noted that in some areas of service provision other interests may also be important. For example,.... community health services and prevention..” (Ham, 1999: 174). Public health has

<sup>40</sup> See also, Alford, 1964: 12-13.

<sup>41</sup> Harrison (1988: 52-3) provides a graphic example of the changing concerns of NHS administrators/managers. In 1982, 4 out of 14 ‘typical problems’ for this group were directly union related, and a further 5 out of 14 problems were indirectly union related. By 2003, following the a series of controls and reorganizations, legitimate speculation suggests, that less managerial time was spent on these union related issues, although this has not been a focus of this study.

generally been considered to be the poor relation of acute medicine and even family practice (Lewis, 1986).<sup>42</sup>

The power of the medical profession, acting en bloc, is an element in a hierarchy of influences that can legitimately be taken into account when considering the pattern of responses to policy to reduce health inequalities. This power is considered within this research in relation to, for example, the tendency for general practitioners to emphasise secondary over primary prevention. But, the thesis has not focused on the power of the medical profession for the following reasons: (1) the profession generally had no, or little, relationship with many of the services and planning arrangements associated with the policy under investigation and referred to in chapter 4;<sup>43</sup> (2) there was no evidence of any professional hostility to the principle of attempting to ensure that different population groups were receiving services on the basis of 'equal need', or, equity audit; (3) there was evidence, reported in chapter 5, that some NHS general practitioners, at least, tended to share a view with other staff, that levels of income inequality were too high. Opinion on issues, such as the role of trade unions or income distribution, did not necessarily divide down professional fault lines. Nevertheless, there were important differences in values and viewpoints between NHS staff.

Thus, "...conventional wisdom has emphasized the dominant nature of professional rather than political or managerial influences on both the pattern and the provision of health *care* through the NHS." (Wistow, 1992: 51, italics added). But, this present research is concerned with health promotion and public health work at a time when, due to political change, increased funding had been allocated to some (but not all) services in this area. The success of attempts to control the autonomy of the profession also had a growing impact throughout the late 1990s, for example, via restrictions on prescribing, as cited by Wistow (1992: 65). It can also be argued that

<sup>42</sup> The present author also interprets Alford as warning against a too hasty an adoption of the normative values of Burns et al (1994: 278-9) and Keane (1988: 144-5), quoted approvingly by Parsons (1995: 614). They champion the 'energy and strategic protection' of the non-party realm of civil society. This is acceptable only where the role of party organisation is understood, a subject that is returned to in section 3 of this chapter.

<sup>43</sup> For example, the 'fruit in schools' scheme, the Sure Start initiative, provision of money advice within primary care, the increased role of NHS human resource services in working with local youth training initiatives, the healthy walks scheme, new arrangements for public involvement, the health inequalities conference, etc.

yearly NHS budget cuts (or “efficiency savings” (Clarke and Newman, 1997: 85)), pre-1997, had increased public support for the medical profession. For these reasons attention here is focused more on broader political factors affecting policy.

To summarise this section on the state, - we have looked at theories of the state as a neutral arbiter and as a partisan or biased player, supporting its own policy interests or the interests of particular social groups or classes. The author argues that both general perspectives help to explain the work of local staff in operationalizing national policy to reduce health inequalities. This is firstly, because state employees may apply boundaries to their work, based on certain conceptions of the state’s requirements for neutrality. These boundaries are investigated further in chapters 4-6. Secondly, aspects of the work of the state may be controlled by a variety of self-serving forces. Numerous partisan pressures affecting the operation of the state are no doubt worthy of investigation within the health and health inequalities field. Here the author concentrates on arguing that party-political interpretations of changing economic circumstances,<sup>44</sup> combined with other national political imperatives, have had an impact in structuring local responses to the public involvement element of health inequalities implementation. Given this, it is argued that local public involvement in upstream elements has been adversely affected (Pauly, 1997). The next section looks at these issues from the perspective of the labour movement.

### **3. Political parties and the policy process**

#### **Introduction**

This section considers how the classes that have poorer health and are less well off might exercise power over the policies of the state. It is argued in chapter 2 that in order to best achieve the upstream recommendations of the Acheson report the less well off need to influence policy. Of particular relevance is how lower income groups influence income distribution. This, it is suggested, needs to take into account theories of collective action and the role of political organisation (for instance: Castles, 1982; Parry et al, 1992; Rothstein, 1992; Sharpe and Newton, 1984; Verba, Nie, Kim, 1978; Baldwin, 1990). Opinion is divided on the extent to which ‘labour movement’

<sup>44</sup> Which in turn may have political antecedents.

organisation can influence the reduction of income inequalities. It has been assumed from the available evidence that such a relationship can exist, although it may be stronger or weaker in different locations and at different times. It is also dependent on contingent factors such as the strength of organised opposition, or the parallel interests of middle-income groups (Baldwin, 1990; Esping-Anderson, 1990).

Intra-party power relations may also affect government policy towards income distribution and 'citizen activity'. Party elites controlling aspects of government policy may be mindful of the effect policies will have on their support within the party. Mulé, in *Political Parties, Games and Redistribution*, 2001, describes this process (see also, Panebianco (1988)). So, we should consider the possibility that internal Labour Party issues and culture might influence the character of local democracy, which in turn is relevant to the direction of local implementation in the public health field under investigation. As with 'bureau-shaping' public sector managers, who were found to not necessarily want a large workforce (Dunleavy, 1991), the Labour elite may have 'cut-off', in some ways, the membership (this point is referred to again under the heading 'Reducing public involvement in Labour').

Whilst the state or the party of government might possibly at times control democratic arrangements to secure its interests, research evidence also shows that some state interventions designed to produce social improvement in fact have the opposite effect.<sup>45</sup> Some commentators, such as Klein (HEN conference 2002, and correspondence), believe that many of the social policy initiatives currently being undertaken to address health inequalities are 'good' and therefore, even if their ability to reduce health inequalities is unproven and questionable, they may still be usefully adopted.<sup>46</sup> But this is not the case, at least in respect of one particular policy furrow. Here it is argued that some of the social policies resulting from social exclusion theory (Hills, Le Grand, Piachaud, 2002), adapted for use in tackling health inequalities, have potentially damaging effects. The encouragement of particular

<sup>45</sup> Sally Macintyre (HEN conference, 2002) referred to Petrosino et al (2000) *Well-meaning Programs Can Have Harmful Effects!* This describes the introduction of teenagers to prisoners in order to put the young people off crime. However, the group taking part went on to commit more offences than the control group. Deacon (2000) also provides an example in the work of international NGOs – being, he suggests, too focused on extreme poverty and therefore causing more problems for people in lower income groups.

<sup>46</sup> Klein himself was focusing more on income distribution.

forms of public involvement may be to the detriment of forms that would be more beneficial to lower income groups. Policy may be ‘doing bad by doing something’.<sup>47</sup> This is particularly true of ‘public involvement’ work. It may seem uncontroversial and appropriate to try to boost social capital (Piachaud, 2002: 18), but the state, controlled in part by the party of government, is not necessarily neutral in this process.

Public involvement policies could do the ‘wrong’ thing. For instance they might encourage or increase: anti-party sentiment (Poguntke and Scarrow, 1996), ‘partisan dealignment’ (Dalton, 2000: 23), political cynicism (Parry, Moyser and Day, 1992: 179-189) and “generally inefficacious outlooks” (Parry, Moyser and Day, 1992: 173). Non-party methods of involvement are considered by some analysts to be more costly for lower income groups (for example, Scarrow, 2000: 84; Verba, Nie, Kim, 1978: 307-8; Togeby, 1992, cited in Scarrow, 2000). This highlights the importance of accurately diagnosing the causes of ‘partisan dealignment’ and unpacking the concept of ‘political disengagement’ which is considered to be an indicator of ‘social exclusion’ (Hills, Le Grand, Piachaud, 2002).

Now will be considered, firstly, the particular features of the Labour Party that are relevant to the question of income and health inequalities and, secondly, the party as a form of public involvement.

### **The specific character of Labour**

Of key importance to the research under discussion, it is argued, is the historic function and organisation of the British Labour Party. The two main British political parties are not just bodies that happen to be in favour of different policies. The Conservative and Labour parties traditionally have roots in the communities they represent, and are, in part, formed from these differing populations. In relation to income and health inequality policy, different parties’ supporters have different interests.<sup>48</sup>

As Verba et al (1978) state:

<sup>47</sup> This being an inversion of Kirp, 1979.

<sup>48</sup> A large literature exists on changes in working class identity, or embourgeoisement theory, Goldthorpe and Lockwood (1963) being one famous study.

“There is ...an *asymmetry* between the processes by which upper-status and lower-status citizens become politically involved. It does not require any explicit group-based process of mobilization of upper-status citizens to take a disproportionate role in political life....lower-status groups, in contrast, need a group based process of political mobilization if they are to catch up with the upper-status groups in terms of political activity.” (Verba et al, 1978: 14, italics added).

Lower income groups may also have different interests in relation to public involvement. If the constituency of party membership tends to be less well off, then, in order to acquire comparable funds to those of parties with a wealthier cohort of members, the Labour Party needs to organise larger numbers of members and trade union affiliates, or will need to break in some way from this funding formula. Epstein says:

“Of necessity, a working class party has had to have a collective organization of working-class members to support its leadership, whether that leadership was middle class or working class. The organisational problem is entirely analogous to that of trade unions. Only in large numbers can there be strength. Dues cannot be high and so must come from the many rather than the few.” (Epstein, 1980: 130).

By reporting this the aim is to highlight the particular importance of organisation, democratic rules<sup>49</sup> and collective action for groups that are less well off and have less access to resources and start with less power. Trade union influence on the Labour Party has been, and continues to be, it is suggested, significant in providing this ‘group-based’ organisation.<sup>50</sup>

British Conservative government had presided over significant shifts in income distribution and growing income inequalities (for example, Mulé, 2001:108).<sup>51</sup>

<sup>49</sup> See Minkin (1980, 1991) and Lipsit, (1958) who carefully analyse democratic institutions, or rules, used in labour movement decision-making, producing exemplary historical records of activity.

<sup>50</sup> Although as Hecló notes, the role British trade unions played in forming welfare policy proposals in the 20<sup>th</sup> century was limited, especially in comparison to their role in Sweden (Hecló, 1974: 300-301).

<sup>51</sup> The fact that there were tensions in the Labour Party and government concerning policy on income distribution throughout the time span of the research period, is backed up by much evidence. For

Members of the respective parties generally opposed each other on the income inequalities issue. “There is a clear division of opinion regarding the redistribution of income and wealth towards ordinary people. Labour members support such a commitment while Conservative members oppose it.” (Seyd et al, 1996: 5).

In the Commons Health Committee hearing on public health (House of Commons, November 16<sup>th</sup>, 2000), Labour MPs were delighted to draw the conclusion, from evidence provided by Professor Sir Michael Marmot, that income inequalities had increased during the years of Conservative rule, and that health inequalities were linked with income inequalities. They guffawed theatrically on hearing this (personal observation of committee). Thus, Labour members and MPs can be associated with policy to reduce income and health inequalities.

Voter choice correlates with health inequalities. Standardised mortality ratios show positive correlations with Labour voting:

“For the years surrounding the three elections of 1983, 1987 and 1992 overall standardised mortality ratios showed substantial positive correlations...with Labour voting... Labour and Conservative voting explained more of the variance in mortality than did the Townsend score.”<sup>52</sup> (Davey Smith, Dorling, 1996: 1573).

According to Dorling, Davey Smith and Shaw (2001: 1336): “This reflects the socio-economic characteristics of individuals who vote for these parties, with Labour being identified with the working class and the Conservatives with the middle class.”

Davey Smith and Dorling’s statistics show the very real differences in Labour and Conservative constituencies and highlight the need to pay attention to ‘Labour’ in all its guises, when considering health inequalities policy implementation. Labour voters had reason to expect that, post-1997, ‘things would only get better’ in terms of health

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example, Levitas (1998: 142-5) documents ructions over the December 1997 abolition of lone-parent premiums for child benefit, income support and housing benefit. And in May/June 2003 disputes between senior party figures over “new taxes to squeeze the ‘rich’” hit the headlines again (*Daily Mail*, 24 June, 2003:33).

<sup>52</sup> The Townsend score is a standard measure of social deprivation.

inequalities, while Conservative voters might have been fearful of a damaging policy reversal with regard to income distribution. This mix of raised expectations and wary concern among different sections of the population had the potential to place unwelcome pressure on the new Labour government.

### **Labour and public involvement**

Beer saw the party membership as having had some power to influence party policy, especially in the 1950s (Beer, 1982). Dictation of policy by the leadership was not absolute, as predicted by Michels's 'iron law of oligarchy': 'who says organisation says oligarchy' (Michels, 1959). With some qualifications, Minkin also found various constituencies inside the party able to inform policy development and the trade unions act as an important factor in his analysis (Minkin, 1980: 316, Minkin, 1991: 622).<sup>53</sup>

McKenzie provides an alternative perspective. He considers that the power of the membership should be restricted and that they should be used simply to assist in electioneering (1964: 558).<sup>54</sup> He sees this as beneficial in a parliamentary system, where MPs' prime responsibility is to the electorate not the party membership. As will be seen, confusion and disagreements over which constituencies of the population should be given priority in influencing decisions still abound. As Day and Klein found some, but not all, Labour councillors saw themselves as accountable to the party (1987: 230). If in Lewisham, the citizens' panel, the community council and the Hubs (council-run residents' meetings) propose clear action points, with which the elected councillors and MPs disagree, the question arises: whose decision should or will prevail?

As might be anticipated from the previous discussion on the partisan state, a Marxist analysis suggested by the work of Coates, for example, views policy development in the Labour Party as conditioned by the operation of capitalism. Here the rank-and-file have little or no power in relation to that of the parliamentary party. But even in this analysis the leadership's power over policy creation is not always absolute. The

<sup>53</sup> For example, in pressure for policy on a statutory minimum wage (Minkin, 1991: 429-431, 620). The national minimum wage has had less impact on differentials than other, less publicised policies and it has been offset by continued growing inequality in original incomes in the market place (Piachaud and Sutherland, 2002: 10; Shephard, 2003).

<sup>54</sup> See also his study of working class Tory voters (McKenzie and Silver, 1968).



unions have some, largely dormant, powers. An upsurge in radicalism from 1970-74 led to the election of less compliant union leaders who drove forward more redistributive policy (Coates, 1980: 57-85). This worried establishment opinion and, some have argued, stimulated the rise of Thatcherism (Panitch and Leys, 1997: 87).

While pressure groups may pressurise MPs and councillors, these representatives can – as one Lewisham Labour councillor said - continue to do as they wish in the meetings where they vote. Ordinary party members did have more power to influence councillor actions than non-party members. However, deliberate Labour Party decisions, culminating in *Partnership in Power* (Labour Party, 1997), have been taken to curtail ordinary members' contact with and influence on councillors and MPs. The consequences, for better or worse, are felt locally. On the one hand it can be said that Labour, particularly since the focus groups of the early 1980s and those of the 1990s led by Philip Gould (Gould, 1998: 326-333), has been very keen to measure public opinion. However, it has at the same time been reluctant to encourage policy debate within the party (Smith, 2000: 145-147, 153) and engage with trade unions. As the Mayor of Lewisham said in interview, the deselection of local MPs by Labour Party members over policy disagreements would now be more difficult than it was in 1997.

Within popular 'social capital' reasoning, which links increased community involvement with improved health (Gillies, 1997), there is no reason why Labour Party and trade union membership should be any less important than membership of other groups. Indeed, various discussions on social capital refer to trade unions, for example, Putnam (1993) and Peters (2001: 60).<sup>55</sup> The fortunes of the role of the Labour Party can be compared and contrasted with the development of the role of 'faith groups' in public health and health promotion work (Lewis and Randolph-Horn, 2001). Yet, as Seyd et al (1996: 6) explain, there has been important involvement in the party by lower income groups:

“...working class members play a more active part in local Labour politics than their middle-class counterparts. They are more frequent attendees at party

<sup>55</sup> Putnam finds that trade union membership is twice as high in 'civic' areas of Italy as 'non-civic' areas. Although, his summaries neglect to mention this point, for example, he says: “Good government in Italy is a by-product of singing groups and soccer clubs, not prayer.” (Putnam, 1993: 115, 176).

meetings and they are more active in delivering party leaflets and canvassing voters; they also have a stronger sense of political efficacy, or a belief that individual political involvement results in political influence. Furthermore, they regard party activism as a good way to meet people and to receive a political education. This suggests that grassroots activism is not, and need not become solely a middle class preserve, if the Labour Party provides appropriate incentives for working class recruits. However, working class members also feel more strongly that the party leadership does not listen to ordinary party members.”

A lot has changed regarding the public’s involvement in the Labour Party since 1996. Some of the issues raised by the above statement will be returned to in chapter 6. Here the quote is simply used to draw attention to the fact that analysis of health inequality policy implementation, which incorporates public involvement policy, can usefully include questions about the role of the local Labour Party. The Labour Party itself, as will be described in chapter 6, appears to have been less concerned with ‘providing appropriate incentives for recruits’ and is more interested in asking members how involvement in voluntary organisations might be encouraged (Labour Party, 2002: 8). Interviews with senior Labour Party representatives in Lewisham back up this observation.

Of key importance in explaining these developments is Rose’s suggestion that the first constraint on new governments comes from within the party of government and these internal pressures are traditionally more acute for the Labour Party given its historical formation (Rose, 1984: 147). However, the present author concurs with Rose in stating that: “To recognise the importance of parties is not to argue that parties are all-important in the government of Britain.” (Rose, 1984: 142-143). The thesis highlights other factors governing the success of policy implementation, not least the role of the local implementers. Nevertheless, it does aim to focus attention on an aspect of implementation that has been underreported.

#### *Reducing public involvement in Labour*

An analysis of reasons why the party leadership decided to curtail membership powers from 1995 onwards can usefully incorporate elements of elitist, pluralist,

Marxist and rational choice theory, used in the previous discussion on the state. That these powers have been curbed means that suspicions are legitimately aroused when current government policy also states that local communities should be involved in policy aimed at reducing health inequalities. Listed below are reasons, from the perspective of the party's leadership, as to why the internal regime of the party needed to change.

Firstly, elite theory reasoning may be applied. Having been out of office since the 1970s, the party had to appeal to voters who did not share the views of the membership. Since the membership would object to fiscal policy that diverged little from the previous two Conservative governments', their voice would need to be muffled. The elite echelons of the party structure needed both to control the strings of power and to amend membership powers in order to meet these ends (Gould, 1998). The argument has been made, by implication, that elite power is more beneficial.

The longer-term implications of this approach appear to be, not only less active involvement by the membership in the party, but also a lower turn-out of support at the polls in areas like Lewisham. The conundrum is that whilst Labour's share of the votes went up in 1997, "at the same time [the party] was less able to bring citizens of low socio-economic status to the polls." (Wattenberg, 2000: 76).

Secondly, from the pluralist perspective, it might be argued that members still do have access to powers, but that now a more representative plurality of voices is able to influence the structures of the party. As Scarrow et al suggest, steps have been taken to by-pass 'sub-leadership groups' within the party (Scarrow et al, 2000: 150). But the result, as Dalton and Wattenberg point, out is "...better described as moving towards consultative democracy rather than direct democracy." (Dalton and Wattenberg, 2000: 268). The same consultative methods are being developed within the wider population, with party structures in Lewisham by-passed in favour of structures described in chapter 6, that is: Hubs, citizen panels, the community network and the Local Strategic Partnership.

Thirdly, a Marxist-variant line of reasoning may be taken, holding that the party has no choice and its policies are determined by the economic circumstances flowing

from the end of the post-war consensus and the liberalisation of the global economy. Labour is incapable of controlling the operation and the pressures of international capitalism, as limits to their influence are prescribed by the laws of capitalist accumulation. The fear of upsetting markets has long haunted Labour ministers, and this recent statement from Alan Milburn (former Secretary of State for Health) indicates the type of trade-offs made: “It’s perfectly reasonable that people [cabinet ministers] should be able to express a view, so long as you are responsible about it and you don’t undermine markets and confidence.” (White and Winton, 2002: 2). Labour peer Roy Hattersley and others provide another perspective that also associates organisational change with economic developments. He considers that there is less interest in local government now because, as a result of privatisation, the local state has few powers and responsibilities.<sup>56</sup>

Fourthly, the party restructuring may be seen from the perspective of a rational choice or bureau-shaping approach. This might hold that leaders of an organisation do not necessarily want to extend the size of the domain under their control, as more employees provide more problems (Dunleavy, 1991). This can be seen in the attitude of the leadership to the membership, as witnessed in interviews with one Lewisham councillor and the Labour Mayor who questioned the need to encourage increased party membership. This echoes Epstein’s suggestion that it is more efficient to win an election with a low party membership than with a high one (Epstein, 1980: 117-118).

Our interviews and observed discussions at the local level demonstrate that people draw on elements of these general theories – elite, pluralist, Marxist and also rational choice, to perform their own analysis of the value of different forms of public involvement, and to assess dynamic trends. As the value of the Labour Party diminishes as a vehicle for public influence, more import may accrue to other methods of consultation and involvement. However, it is not clear that the developing institutions are more democratic in relation to upstream policy, if assessed against the definition of democracy provided earlier.

<sup>56</sup> The links between private versus public ownership and public health issues are made in Hattersley’s article on Birmingham City Council. These relate to funding for public health infrastructure, democratic participation, worsening pay and conditions and housing provision (Hattersley, 2001).

Our perception is that the Labour Party has become more elitist than hitherto. No attempts were being made in Lewisham to draw the population into party structures, despite an acknowledgement that activity levels had fallen dramatically since 1997. Scarrow holds that one option for increasing membership participation is to provide 'political rights'. "Parties need to provide reasons for supports to enrol, and political rights may become an increasingly important enticement as ongoing changes force parties to alter their mix of enrolment incentives." (Scarrow et al, 2000:132). However, one councillor said, and other members concurred, that political rights had been withdrawn in the last five years.

Our fieldwork indicated that the view existed among some at the local level, endorsed by party officials, that the worse off were really being disempowered for their own good, as part of the Labour leadership's better judgement concerning electoral calculations. Lower income groups are better off with Labour in power, even if the government won't meet all their demands. These same groups may have less power than they used to, in internal party organisations, but what was the point of that, when the party as a whole had no power?

Mair (1997:11) salutes the effectiveness of modernised parties in adapting to external environments. But, there are a number of potential dangers for parties representing the worse off, in these developments. Firstly, as is reported in chapter 6, no 'young blood' is now coming forward to fill party positions. Secondly, with voter mobility increasing, the party may well lose power again and then ordinary members would be even worse off, in terms of access to influence, than they were before. Thirdly, even if, as Epstein holds, the membership is liable to hold more extreme views than the electorate, this does not mean to say that their opinions will always be wrong, or that they themselves are incapable of receiving and acting on reports from opinion polls and focus groups. Fourthly, Campbell's research on social capital for the Health Development Agency suggests that the location of small numbers of committed local activists within communities, perhaps in the form of party members, can provide benefits for non-party members and non-activists. She writes:

“...we argue that this feature of social capital [local community activist networks] was the most effective in distinguishing between the communities of Farley [low health] and Sundon Park [high health]. However we ...specify that the role played by this form of social capital in people’s lives often took an indirect form. It was not necessarily the case that large numbers of people were personally involved in these networks...the presence of these often very small-scale successful activist networks and groupings in the community generated an amorphous sense of what we shall call ‘perceived citizen-power’...” (Campbell, 1999:134-5).

Thus, with fewer incentives for small numbers of people within the local population to become active Labour Party members, non-activists may also lose out. Finally, a more democratic party might allow wider internal analysis of opinion polls and focus group results, in order to safeguard against biased research questions and interpretations by elite leaders.<sup>57</sup>

‘Supply-side’ reasons for the loss of party members and activists, such as the distractions of TV entertainment, should not be discounted, although those listed by Dalton et al (2000) are not the most convincing. It should be noted that supply-side reasons for low party involvement might be applied equally to participation in community groups and ‘new social movements’ as to party involvement (McLaverty, 2002: 189).

Despite the supply-side pressures and intra-party trends explained by pluralist, Marxist, rational choice and, in particular, elite theory, the importance of party democracy for lower income groups is still considered relevant in this research. We can usefully turn to an analogy to illustrate the reasons why an engaged party membership, with political powers to hold representatives to account, continues to be important, especially for lower-income groups via the Labour Party. We might compare the party membership to trade union negotiators and the party leadership to company employers. In this situation it is sometimes found that spaces do in fact exist for improvement in conditions, which, without a probing negotiation, were denied. On

<sup>57</sup> Examples of the use of ‘leading’ research questions are provided by the 1998 *Annual Survey of Supporters’ Opinions* (Labour Party, 1998).

the other hand, it could be that the company really is about to go bust, and excessive demands will lose the employees their jobs.<sup>58</sup> The role of unions in society is contested, in the same way the national and local Labour Party leadership clearly appeared to have an ambiguous attitude to the membership. The dangers of not using the checks of membership opinion, both for the population base they represent and for the leadership's benefit, are, it is argued, at least a possibility.

### **Trade unions**

Having compared Labour's membership to union negotiators, the role of trade unions is now investigated. As references to the work of Beer, Minkin and Coates pointed out, historically and to some extent currently, the trade unions have had a particular role in influencing Labour Party policy. At times this role has been aligned with the leadership and not with the membership.

Government policy clearly affects the ability of trade unions to organise, although other supply-side factors should, as with party organisation, also be taken into account. This complicates relations between the state and the political organisation of the less well off. The effect of political changes post-1980 on the ability of trade unions to influence earnings distribution is considered by Metcalf et al (2000): "The labour market has been deregulated as a consequence of the legislative onslaught against unions...". Market competition and unemployment should also be taken into account. (Metcalf et al, 2000: 1). However, the authors find that:

"Although the move away from national bargaining to decentralised bargaining has caused pay dispersion to rise, workers in the organised sector have much lower pay dispersion than those in the unorganised sector....Unions narrow the wage differentials between women and men, blacks and whites, those with health problems and those without, and between manual and non-manual workers.... Unions remain a major egalitarian influence on the British labour market." (Metcalf et al, 2000: 16-17).

<sup>58</sup> A further danger in an excessively elitist attitude to the membership might also be that the same approach develops in relation to the opinions of the population as a whole.

Atkinson (1983: 131-137), Gosling and Machin (1995) and Machin (2000) have also found that trade unions influence a reduction in income dispersion. Baldwin suggests that unions have played a historical role in influencing the development of welfare policies liable to affect income distribution. For instance, he cites Labour's plans for superannuation developments in the 1950s as requiring union support: "Crucial for the success of Labour's plans was the union reaction." (Baldwin, 1990: 237). However, his research indicates that class alliances are equally important in supporting egalitarian welfare policy. For this reason we might also be suspicious of the local targeting of welfare policies and regeneration funds to the worst off, since in the longer term this practice may lead to a middle-class withdrawal of support. A similar view is taken by Esping-Anderson (1996) and Timmins (1998).

Given the links between Labour and the unions, reduced trade union membership may also mean a reduction in Labour Party income. So once again the legislative powers of the state can be seen to have affected the future powers of partisan political forces. Trade union powers can be dependent on local government management regimes adopting varying attitudes towards workforce organisation, for example, through acquiescence, patronage, or 'clamping down'. The author would argue that it is still necessary to consider national and local government policy relating to trade union legislation and support for trade union organisation, as being of relevance to the implementation of health inequalities policy. This is because they can link local people with upstream policy formation. According to trade union respondents, local NHS and local government services are not investing resources in supporting union organisation, as they did in previous decades. NHS project work directed at reducing health inequalities in Lewisham and elsewhere has made no connections with trade union groups. 'Building capacity' among community groups takes precedence over 'building capacity' among trade unions, which are known to affect Acheson's upstream recommendations and Whitehead's 'wider determinants of health'. Thus, the state acts in a partisan way towards partisan forces associated with supporting lower income groups. Chapter 6 returns to this topic and describes the views of trade union officials.



## Conclusion

In this chapter some theoretical concepts that are useful in situating and ordering an analysis of complex local activity have been introduced. These local processes can now be analysed in relation to theories of the policy process and state interests. In discussing the concept of democracy particular emphasis has been placed on rules that provide the less well off with non-arbitrary levers on state policy. The way in which democratic rules might work for the less well off in affecting upstream policy has been highlighted as an issue for investigation at the local level.

National policy to reduce health inequalities and local NHS implementation supports a particular form of increased public involvement. This form has a pluralist pedigree: at least rhetorically imbuing community groups and state-managed consultation with significant powers. However, it is suggested that, because of the increasingly elitist trajectory of the Labour Party, the new local systems that are being introduced may be competing with what is now a less supported system, whose ethos is that legitimated power rests with elected councillors and, in-turn, party members. The author concurs with Mair in saying that: "...Western democracies remain essentially party democracies, their governments remaining party governments." (Mair, 1997: 13). However, the picture of democracy is in transition, and competing conceptions are potentially clashing with one another. The task here is to report on this 'shifting of the balance of power', and its theoretical potential to affect a long-term reduction in health inequalities. The democratic changes impact on all levels of analysis, but they particularly affect involvement in influencing the upstream 'wider determinants of health'. The local framework for public involvement is increasingly managed through non-elected bodies. Local Strategic Partnerships (LSPs) continue this trajectory.<sup>59</sup>

The effects of these changes on the political power of lower income groups seem at first sight, negative. Chapter 6 investigates further whether The Labour Party is supporting a de-emphasis on democracy arranged via the party system. This chapter

<sup>59</sup> LSPs are "central to the delivery of" neighbourhood 'regeneration and renewal'. "They are non-statutory bodies, which aim to bring together at a local level a range of stakeholders – from the public, private, voluntary and community sectors. Local partners working through the LSP will be expected to take many of the major decisions about priorities and funding for their local area." Office of the Deputy Prime Minister, Neighbourhood Renewal Unit website: [www.neighbourhood.gov.uk/partnerships.asp](http://www.neighbourhood.gov.uk/partnerships.asp) (2003) (Hamer and Smithies, 2002).

has suggested that the alternative to representation via the party will not improve the voice of the worse off vis-à-vis the upstream recommendations of the Acheson report. Local consultation mechanisms, supported by the state, may not be an effective substitute. Local state workers are not in a good position to point this out, due, firstly, to a residue of support for rational-legal process and a desire, perhaps for laudable reasons, to uphold the principle of the neutral state. Secondly, employment interests inhibit local discretion in this area. Thirdly, there is a lack of understanding of the options, linked to the fact that staff themselves are part of the party dealignment phenomenon. Fourthly, there are important political divisions among NHS staff, including NHS public health staff.

A balance sheet of democratic privileges accruing to the less well off is required in order to assess long-term factors in the causal chain leading to health inequalities reduction. This is because there is a relationship between particular forms of democracy and the powers of the less well off to control income distribution, coupled with the effect of income inequality on democracy. There may or may not have been an increase in access to effective influence over certain downstream issues at the local level, for instance over traffic calming schemes.<sup>60</sup> But at the same time, the technical, cultural and theoretical ability of individuals to influence upstream issues through the democratic rules of the labour movement may also have diminished. The development of NHS and local government institutions since 1997 will, it is argued, influence these processes. These institutional changes are discussed in chapter 4. Staff values and their impact are considered in chapter 5. Chapter 6 concentrates on the particular issues of public involvement in relation to upstream and downstream factors in health inequalities reduction.

<sup>60</sup> Provided by one NHS public involvement manager as an example of the issues that the borough's community council might influence.

## **Chapter 2 PUBLIC HEALTH BACKGROUND: HISTORY AND POLICY**

### **Introduction**

The purpose of this chapter is twofold. Firstly, it shows the link between the study's interests and public health history. In doing this, the impact of 'political-social organisations'<sup>61</sup> on health is considered to a greater extent than in other analyses.<sup>62</sup> Secondly, the chapter introduces recent debates within the health inequalities literature in order to highlight issues for investigation at the local level.

Particularly important is the fact that the health of a population can be improved by measures that are not specifically 'public health' policies. Within this framework, and of significance, is the extent to which health inequalities are viewed as being linked to income inequalities. Given these links, consideration is needed as to how public health practice affects grassroots organisation, which might, in turn, influence income inequalities. In later chapters, it will be seen that there are differences of opinion, among staff on the ground, relating to these issues.

*Saving Lives* (DoH, 1999), the first Labour government White Paper on public health for twenty-two years, is reviewed in the light of a particular reading of public health history. The movement of public health interest into the fields of income inequalities and 'social capital' can be compared and contrasted with the discipline's interest in drains and poverty one hundred and fifty years ago. Policy in these areas is, and was, politically contested. Public health practice is subject to political biases which result not only from the beliefs of different factions within the profession, but also from the desire of civil servants and state funded researchers to appear politically neutral.

The chapter divides into four sections. (1) A brief history of different approaches to public health is provided, falling into two parts (1.1. and 1.2). (2) Some recent debates concerning health inequalities are outlined. (3) *Saving Lives* (DoH, 1999) is then

<sup>61</sup> 'Political-social organisations' means here, not only various loose formations of professional interests, but also political organisations with formalised rules for members, such as, for example, the Chartists.

<sup>62</sup> One exception being Navarro and Shi (2002).

looked at in more detail, historical and political interpretations of *Saving Lives* and the *Independent Inquiry into Inequalities in Health* (1998) led by Sir Donald Acheson (3.1 and 3.2) are considered respectively. (4) On the basis of this discussion, the author highlights developments and responses that are of interest to monitor at the local level, providing a further justification for the choice of research question.

## 1.1 Public health – a historical overview

Past policies are referred to somewhat disparagingly in *Saving Lives* (DoH, 1999: 6). However, some facets of past approaches are still visible within current policy. To start with, the thesis examines the period from around the middle of the 19<sup>th</sup> century to the middle of the 20<sup>th</sup>, concentrating on the earlier years of this period. Later 20<sup>th</sup> century developments are discussed in the next section (1.2). One of the reasons for looking at this history is to highlight different approaches to public health. Therefore, the analysis does not necessarily give equal weight to different periods of time.

The context of public health in the 19<sup>th</sup> century is that of a rapid increase in the population of the urban poor, linked to industrialisation in agriculture and the growth of factory production (Hobsbawm, 1963: 122-124). The evidence shows that at the beginning of this process the general health of the population deteriorated, especially in the countryside, which is not to say that the original base was high. Then followed a remarkable improvement in health. To take just one example: deaths of babies under one year per 1,000 live births in England and Wales stood at 295 in 1841/45, while in 1926/30 the equivalent figure was 136 (Greenwood, 1936).<sup>63</sup>

This history is looked at from a number of different perspectives and causal levels. The advantage of this is to show the complexity of the matrix of reasons for health improvement and the leeway for political ‘games’ or strategies (Gintis, 2000).

Table 2.1, below, indicates various ‘ideal type’ class perspectives and causal levels within: 1. the material reasons why health improved between say, 1841/1845 and 1926/30, 2. the motivations behind a desire for improvements, affecting health

<sup>63</sup> Mackenbach (1994: 330) notes previous improvements in European population health in the late 17<sup>th</sup> and mid-18<sup>th</sup> centuries.

indirectly and directly, 3. aims and objectives for such improvement, which affected health indirectly and directly, 4. approaches to specific health improvement, and 5. organised agents of change. These points are discussed in order in the text below.

Three general points can be made about this approach to public health history. Firstly, it takes into account the fact that health may be improved as a by-product of other primary policy development and motivations. Even within a public health framework, it makes a distinction between immediate, or downstream, causes, and the upstream causes of those causes, these secondary causes often being of more interest to policy analysis. Casting up the causal chain (Graham, 2001b: 298; Hamlin, 1998: 56, 106-9), it recognises that the reasons why a population's health improves may be directly, indirectly, or not at all linked to measures designed to lead specifically to health improvement. In other words, some approaches to health improvement work better than others, whether direct or indirect. Secondly, it considers the various positions of different classes in relation to motivation, targets, approaches and organisation. Thirdly, it recognises that health improvement is achieved through a matrix of factors and that the effects of different causes may be difficult to distinguish. Various academic commentators have stressed different factors within this table, as indicated by the footnotes. This then leaves ample room for political opponents to champion divergent strategies.

**Table 2.1 Different causal levels in public health improvement – showing political and class components in determining change (1840s to early 20<sup>th</sup> century)**

**1. The reasons for achieved health improvement**

1. Increases in economic surplus resulting from industrialisation and imperialism, coupled with - 2. redistribution of services and wealth to the working class.	Increased employment and wealth of the working class (Hobsbawm, 1963).	Improved education and working conditions (Greenwood, 1936; Blane, 1989).	Improved nutrition (McKeown, 1976, and others).	Improved housing, sanitation, water supply (Szreter, 1988) (a).	Working class organisation providing goods and services.	Improvements in scientific knowledge, statistics, medical practice and health care.
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**2. Motivations for developments associated with health improvement**

1. Experiences of hardship – hunger, cold, stench, dirt, illness and death. 2. because the superior conditions of other classes deemed increased prosperity feasible. 3. because political organisation enabled joint working and appeared to result in successful campaigns.	Desire to ensure an adequate supply of industrial labour and military recruits. (Chadwick and Alison disagreed with Malthus on issues relating to the supply of labour (Flinn, introduction to Chadwick, 1965: 65). (b).	1. Concern to forestall greater insurrection 2. to address fears of crime 3. to address middle-class fears of fever and cholera in particular ('plague is the oppressor's reward', see, Hamlin, 1998: 70). 4. concern over infection risks to medical practitioners entering working class areas (Simon, 1897: 183).	Because of professional, religious, political commitments (c). Because suffering had been brought to the attention of a wider audience by, among others, Charles Dickens (Flinn, 1965: 38).	Because improvements would not cause too many difficulties for higher social classes given overall economic performance.  Because of the cost to the middle and upper classes of supporting families made destitute due to the illness and early death of wage earners (Simon, 1897: 184).	Technical advances.	International comparison (Sweden is referred to by Chadwick, 1965: 422-423). Laws passed by German Reichstag, referred to by Simon (1897: 487).
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**3. General aims and objectives, which lead directly or indirectly to health improving actions**

1. Enhanced political powers such as increased suffrage 2. working class organisation and changes in legislation to allow working class organisation 3. improved working and living conditions 4. justice in the context of extremes of wealth and poverty.	A reliable supply of labour and soldiers.	Improved education, health and working conditions.	Legislation to control conditions relating to housing, sanitation, water supply, education and working conditions. Improved housing, sanitation, water supply etc.	Aspects of aiming for a profitable business environment.	To address other motivations (above).	Decentralisation of power to local authorities (Simon, 1897: 379-380).
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**4. Specific approaches to health improvement**

Via legislation and investment to improve sanitation (associated with Chadwick).	Improving working conditions (associated with Engels and others).	Organisation of health services.	Teaching individuals how to take care of their health.	Improving medical interventions.	Improving nutrition (associated with W. P. Alison).	Regulating local authorities and the medical profession (Simon, 1897: 472).
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**5. Organised agents: advocating or blocking change**

The medical profession (eg, Hamlin, 1998: 96).	Political parties and groups, e.g., the Chartists, the Communist League and the International and London Working Men's Associations (d). The Health of Towns Association. (e)	The state bureaucracy (f).	Trade unions.	Business.	Working class friendly societies, mutual aid societies, co-operatives. Lobbying associations providing services. Middle and upper-class philanthropy. (g)	The church And others.
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**Notes:**

- (a) Szreter (2002) does not dispute McKeown's (1976) view that nutrition was important in health improvement, but he adds that public health policies such as clean water played an important role.
- (b) The public health implications of 'too many unskilled workers' in the 21<sup>st</sup> century are considered by Graham (2001: 308).
- (c) In the present time Pereira (1993) and Oliver, Healey, Le Grand, (2002) have stressed the need to specify equity objectives. The latter authors arguing that not all health inequalities are sufficiently inequitable to warrant action and that political lobbying by academics has resulted in biased presentation of statistics.
- (d) Described by Hobsbawm (1975: 134-135).
- (e) The Health of Towns Association is described by Lewis (1952: 110-113, 166). The lobbying group was set up by Chadwick, Lord Ashley (Earl of Shaftesbury) and others to combat class forces hostile to sanitation improvements. Chadwick supplied data, but the association was 'fronted' by his supporters, as the civil servant wished to appear 'neutral'.
- (f) The state is discussed further in chapter 3. The tension between centralisation and decentralisation of public health policy issues is highlighted by Chadwick's proposals. The state's role was challenged by public health demands. "In the late (1850s and 1860s) alone, the heyday of economic and philosophic *laissez faire*, the legislature intervened to regulate, among other *specific* health matters, the organisation and education of the medical and pharmaceutical professions, the sale of poisons, the adulteration of food, burials, vaccination, the health of prostitutes, the diet of merchant seamen, housing, overcrowding and sum clearance, industrial hygiene, bakehouses and alkali works." (Lambert, 1963: 606).
- (g) For example, the Association for Promoting Cleanliness among the Poor; the Metropolitan Association for improving Dwellings of the Industrious Classes; the Society for the Improvement of the condition of the Labouring Classes. These, and more, are listed by Simon (1897: 213).

*Reasons why health improvement was achieved (row 1, table 2.1)*

Firstly, it is important to look at the factors said to be responsible for the improvement in health of the British population in the period in question (1840s-early 20<sup>th</sup> century). The significance of different potential factors has been contested. Of particular interest has been the relative contribution of sanitation measures, championed in the 19<sup>th</sup> century by Chadwick (1965), and of medical science, debated by Illich (1975), McKeown (1976), and Szreter (2002).<sup>64</sup> However, there now seems to be some consensus that increases in working-class living standards were of fundamental importance to health improvements. Blane cites a two-thirds increase in individual living standards between 1870 and 1914.

“The increased real wages were spent in a variety of ways. A large proportion was individually spent on the purchase of commodities, particularly a more varied, less protein-deficient diet.... Some was collectively spent on, for example, the sanitary reforms. Some was spent at work on Friendly Society subscriptions which offered benefit during illness and unemployment, and finally some was ‘spent’ at work in the form of shorter hours and a less punishing work regime.” Blane (1989: 25).

Greenwood may be thought of as a ‘lost prophet’ of public health, writing in the 1930s of causal factors that were to gain recognition in later decades. He considers the various contributions of reduced housing density, improved food supply, medical care, sanitation, water safety and factory legislation. He concludes, “the respective forces of the major mortalities are determined by the stamina vitae woven in childhood”. In other words, the principal factor causing improved mortality is improvement in the environment of children. But he also sees environmental factors coming into play after childhood as important. He does not consider any one environmental factor, from housing to nutrition, to stand out over and above another (Greenwood, 1936: 705-7).

<sup>64</sup> In *Medical Nemesis* (1975), Illich accused medicine of producing iatrogenic illness and thus being a threat to health. McKeown also questions the role of medicine, while Szreter argues that medical science and sanitation advances combined with improved nutrition to drive advances in life expectancy. He reasserts the positive impact of purposive public health interventions (table 2.1, note a.).



*Motivations for improvement (row 2, table 2.1)*

One of the strengths of Greenwood's analysis is his recognition that motivation for improvements in living and working conditions, and in particular, for improvements in the lot of children, played an important role in the introduction of legislation that was beneficial to health. "The factory legislation was inspired by horror of the cruelties endured by children". He notes that trends in public feeling are vital to securing policy change. "To make life more liveable seems to me quite as worthy a motive for hygienic reform as to make it longer." (Greenwood, 1936: 684-5, 703).

However, just because conditions were deplorable does not mean that they would be acted on (Hamlin, 1998:10). It is also important to bear in mind that the urban poor themselves were organising through trade unions, co-operative societies and broader political movements, to achieve improvements in conditions, both at work and more generally. Engels, in *The Condition of the Working Class in England* (1969, first published in English 1887) takes a chapter to discuss labour movements in 1840s England, mainly among cotton factory workers and coal miners. Co-operative societies organised the provision of goods and services to the advantage of the working class. For example, milk was sold at reduced rates due to mass distribution through the co-operative (Gurney, 1996). The Co-operative Women's Guild established in 1883 was "successful in organising for state benefits and better health facilities for working mothers." (Smithies and Webster, 1998: 8). Thus, collective agency provided long-term levers for health improvement.<sup>65</sup>

As Doyal and Pennell (1976: 145) note, Chartism<sup>66</sup> was seen by the state as a threat to social order. According to Simon<sup>67</sup> (1897) parliamentary records of February 1840 show requests for a Select Committee to: "inquire into the causes of discontent among great bodies of the working class...to remove as far as possible any reasonable

<sup>65</sup> Here theoretical underpinning appears to diverge from Blane, et al (1996: 7) who equate the relationship between behavioural and structural factors in health with the agency/structure debate in sociology. However, given that they previously link the behavioural approach with individual action, they do not seem to view 'agency' as collective or class agency, which is the view taken here.

<sup>66</sup> The Chartists were a large and relatively short-lived political organisation lobbying for democratic change. The six points of Chartism were: universal suffrage, abolition of all property qualification, annual parliaments, equal constituencies, salaries for MPs and the secret ballot. Their petition was drawn up by the London Workingmen's Association in 1837 and was to serve as the programme of a new political Labour Party (Rothstein, 1983: 38-39).

<sup>67</sup> Simon was the Medical Officer of the Privy Council, reporting 1859-72, "etc, etc, etc". (Simon, 1897: 280 and title page).

grounds for complaint in order thereby to strengthen the attachment of the people to the institutions of the country.” The debate led eventually to an agreement to proceed to an inquiry into health. According to Simon, in the discussion, “many references were *of course* made to the “Chartism” of the time.” (1897: 188, italics added). The upper and middle classes were, in part, motivated by a desire to control deeper demands for reform. Lewis finds that Lord Ashley, Earl of Shaftesbury and the civil servant Chadwick, author of the influential government report *An Inquiry into the Sanitary Condition of the Labouring Population of Great Britain* (Chadwick 1842), considered that:

“The sullen resentment of the neglected workers might organise itself behind the trade union leaders and the six points men [referring to the six demands of Chartism]...and thence, if a Chartist millennium were to be averted, the governing classes must free the governed from the sharp spur of their misery by improving the physical conditions of their lives.” (Lewis, 1952: 183).

Chadwick’s sanitation schemes and support for urban parks would, it was hoped, neutralise political unrest. He reports approvingly on the free opening of Manchester’s gardens and museum, specifically timed to coincide with, and thus pull support away from, a Chartist demonstration (Chadwick, 1965: 337).

Health improvement was part and parcel of the general living improvements that were sought by the organised working-class. The relationship between living circumstances conducive to good health and those that are sought their own sake, is discussed by Greenwood:

“It is certainly hygienically right to eat plenty of good food, to work and to play in moderation and to live in a large, well-ventilated and equipped house. It is also pleasant to do so. A great many, perhaps a majority, of hygienic improvements would certainly have been adopted for hedonistic reasons if people had been able to afford them.” (Greenwood, 1936: 680)

In the same way the Chartists and later political parties were not just concerned with health improvement, but with general living and working conditions, as well as political rights. Nevertheless, they did influence the drive for public health reform.

Opposition to the demands of the Chartists came not only from Chadwick, but also from those whom he himself opposed. Among those he criticised were the staunch defenders of *laissez faire* political economy, such as Malthus (Hamlin, 1998: 74).

*Aims and objectives that lead, directly or indirectly, to health improvement (row 3, table 2.1)*

Examples of improvements sought that might affect health are provided in table 2.1. Aims will depend on assessments of feasibility and political and economic desirability.<sup>68</sup> It may be that primary motivations concerning the relief of personal suffering, as opposed to professional desires to see health improvement within a particular population, would lead to different primary objectives for improvement. It is also the case that, although motivated in part by a desire for health improvement, the objective or target for improvement may at times focus on political factors seen as blocking progress, for example, the lack of political representation for the urban poor. The point is that tactics may differ from strategy.

The campaign for improved health by the organised working class was targeted more widely than that of the medical profession. This is not to suggest that members of the two groups were never allies, the latter body having, in some respects, more credibility and therefore more influence. In order to achieve legislative changes of benefit to themselves, lower income groups needed to gain a stake in control over national policy. Thus, the political-democratic rules linking the local population with the national legislature were significant.

Simon saw progress in public health as linked to decentralisation of powers to local government. However, his analysis was extremely circumspect. He refused to be drawn into making generalisations about the benefits of decentralisation, and recognised that central control and recourse to legal authority is necessary in order to

<sup>68</sup> The task of deciding exactly which programme to adopt is, of course, still undertaken today Macintyre et al (2001) describes a selection process.

ensure that local areas operate in the best interests of public health (Simon, 1897: 379-380).

*Approaches to specific health improvement (row 4, table 2.1)*

Even where a more focused aim of direct health improvement is considered, a number of different approaches have been taken since the nineteenth century, when modern histories of public health begin. In England the public health movement of the mid-nineteenth century focused on municipal reform: alleviating overcrowding, improving sanitary conditions, and keeping “filth” out of food and drink.<sup>69</sup> The Public Health Act of 1848 and the Consolidating Act of 1875 made provision, for example, for the control of the water supply, sewage disposal and animal slaughter.

Blane outlines less successful health education tactics that concentrated on providing health advice in the context of poverty:

“While the record of health education during this period [1870-1914] was, with the exception of health visiting, not particularly distinguished, preventive reforms achieved perhaps their greatest successes. These reforms need to be seen in context, however, because they interacted with a rise in real wages..”  
(Blane, 1989: 23)

The focus of the working class was on organising to advance political rights, provision of collective services, campaigns for better working conditions and individual struggles to purchase better food, clothing, housing and nursing/medical care. But improved nutrition and shorter working hours were low priorities for expert preventive medicine, whose aims stayed firmly within the boundaries of the political status quo. ‘Sanitation measures’ were the only reforms specifically aimed at public health improvement to be promulgated. Scientific and medical discoveries backed up the sanitary reforms, for example, the finding that cholera was a waterborne disease (Simon, 1897: 241; Donaldson and Donaldson, 1993: 110-112). In the area of sanitary reform expert opinion and lay interests coincided. However, air-borne infections were reduced more significantly than any other cause of death, and this was because of the

<sup>69</sup> German, French and Scottish public health practice, as represented by Virchow, Villerme and Alison respectively, have a divergent history (Amick et al, 1995: 4, Flinn, 1965: 23; Krieger, 2000: 27).

increased immunity that improvements in diet and working conditions brought (Blane, 1989: 27).

*Organised agents for change (row 5, table 2.1)*

As will be evident from the preceding text, particular social agents or organisations may be regarded as levers for acquiring changes that affect health. The Chartists, sections of the medical profession, parties representing *laissez faire* capitalism, different sections of the Christian church, trade unions, state officials and others, all attempted to influence policy and tried, in different ways, to discredit opponents and also to build alliances.

The public health issues being addressed and the way they were tackled, were intimately bound to political questions. At times the social backdrop was “incipient revolution” and the stakes were high (Hamlin, 1998: 3). Choices were being made as to which groups of people would have access to better health. Under these circumstances “The history of public health ... ceases to be a subdivision of state growth or medical science and becomes part of the history of the acquisition of political rights or ...the history of class struggle.” (Hamlin, 1998: 2). While public health leaders recognised the links between poverty and health improvement, they were, nevertheless, reluctant to recommend actions that impeded commercial conditions, encouraged ‘unthrift’ and laziness, and increased taxes (Simon, 1897: 440, 445, 450, 457). Simon argues that the poor, who do not pay taxes, should not be granted the vote. Whereas for the Chartists and the nascent Labour Party, the conditions of the poor could be improved by their representation in national policy making.

Within this setting, the organisation of different agents lobbying for various policies becomes a factor in the ‘causal chain’ of health improvement. While Graham (2000a, 2000b, 2001), Krieger (2000) and Hamlin (1998) go some way to recognising this, even they, it is suggested, are not really explicit enough in their analysis. Graham (2001: 307; 2000: 4) highlights, as part of the chain, the political choices facing national governments and the impact of free market approaches in the 20<sup>th</sup> century. However, she does not refer to political organisation in this chain.

Krieger says that some 19<sup>th</sup> century figures ‘go one step further’ than Alison (and way beyond Chadwick), in their analysis of the causes of epidemics and early death. Virchow and Engels lay “blame at the feet of governments who collude with industry to keep wages down and working hours long, suppressing labour organising and squelching democracy.” (Krieger, 2000: 27). Krieger’s observation is significant. However, the conclusion Engels drew was that organised labour and Chartist demands for democracy would help the condition, including the health, of the English working class. He regarded these bodies, and not just the policies of the government, as causal agents (Wheen, 1999: 196). Krieger concludes that “The fundamental tension, then and now, is between theories that seek causes of social inequalities in health in innate versus imposed, or individual versus societal, characteristics.” (2000: 27). However, the present author suggests that public health academics’ interpretation of ‘societal characteristics’ or ‘socio-economic determinants’ has not given sufficient attention to the political characteristics of the socio-economic, so that even on the ‘imposed/societal side’, there are fundamental tensions.

Hamlin (1998) does provide a public health history that recognises the political nature of public health questions (Hamlin, 1998: 15, 74). Nevertheless, his book is primarily a historical study of Chadwick, and therefore does not look in detail at the impact of the various social movements and parties active at the time.

The status of public health work in the 19<sup>th</sup> century may also have been assisted by its independence from the health system with its attendant powerful professional groups. It can be suggested that it was less in the shadow of curative medicine than it is now, and therefore had more ‘clout’.

*In summary*, various approaches to health improvement in this period have been set out: health education, medical and scientific intervention, improvements in living and working conditions, and increased wages to support a more balanced diet. The actual effects of these approaches differed, as did the motivations of key players, and their prime aims and objectives for improvement. The 19<sup>th</sup> century provides us with a spectacle of relationships between protagonists supporting divergent ideas. Crucial among these are the English *laissez faire* political economists, the ‘Chadwickian’

drive for bureaucratic centralisation<sup>70</sup> coupled with his desire to ‘scotch’ Chartist working-class organisation (Hamlin, 1998: 104, 74) and the countervailing working class lobby; plus interests concerned with unemployment, welfare dependency and a lack of good quality labour. This thesis considers that different political and social organisations should not be neglected in analysis of current public health developments.

The debate between Chalmers and Alison in 1840, witnessed by Chadwick,<sup>71</sup> itself suggests that, in the 21<sup>st</sup> century, the interconnection of public health practice and political organisation, needs to be carefully assessed by researchers looking at policy implementation. In the 19<sup>th</sup> century, public health and state professionals, such as Chadwick, had a relationship with organised groups of the working-class whose demands were for reforms likely to benefit health. Yet for political, tactical and class reasons, these professionals were not always supportive of working class organisations, despite these organisations being active in the causal chain influencing health improvement. They also had their own arguments with other sections of the establishment as the debate between Chadwick and Malthus testifies. Whilst the late 20<sup>th</sup> and early 21<sup>st</sup> centuries provide a very different political, social, economic and epidemiological environment, the author is still concerned to investigate whether similar processes may be occurring in different guises.

## **1.2 Further twentieth century developments**

Gilbert (1970) demonstrates that the major British policy changes between 1914 and 1939 were especially to do with unemployment, pensions, slum clearance, and the demise of the poor law and subsequent municipalisation of poor law hospitals. Professional groups positioned themselves as attempts were made to create a national health service. Criticism of national health insurance came from “experts in health matters who in other things were politically conservative. Generally [this criticism] centred on the narrowness of coverage and the inadequacy of care offered..” (Gilbert,

<sup>70</sup> This is said to have dimmed in his later years.

<sup>71</sup> “...Chalmers held that demoralization, destitution, and disease could be overcome not by impersonal institutions of state but by a morally united parish community, through a mix of exhortation, market incentives, pervasive moral oversight, and, at last resort, minimal and carefully targeted relief in kind...Chalmers seemed to represent a Christian political economy that merged the call to help the needy with a faith in the market.” (Hamlin, 1998: 75). The links with modern communitarianism and some interpretations of social capital theory are easily made.

1970: 259). The tradition of public health, as understood by 19<sup>th</sup> century reformers, was still in the hands of medical officers of health concerned with sanitation but not the impact of living conditions on health status.

A number of overlapping phases of public health activity have been identified from the 19<sup>th</sup> century onwards (Ashton and Seymore, 1988:15; Naidoo and Wills, 1994: 72). Here is briefly considered some further 20<sup>th</sup> century developments in public health. These are, the role of medical advances, the individual behaviour change model, the 'new public health', community development, and the Conservative government's *Health of the Nation* (DoH, 1992) strategy.

### **Medical advances**

In the 20<sup>th</sup> century unprecedented changes in technology affected all spheres of the economy, as well as medical and surgical developments. These changes were highly visible and touched millions of British lives throughout the period. "It seemed obvious to contemporaries, if not to the public health profession, that the decline in infectious disease mortality owed much to the progress of medical science." (Blane et al, 1996: 1).

However, as has been seen, the relative contribution of health care and medical advances to health improvement has since been challenged. The subject is still controversial and assessments are dependent on baseline definitions and social assumptions. Medical and surgical practice tends to have more 'immediate' and verifiable results than public health measures. This may well impact on local views as to the benefits of preventive measures, while traditional accounting methods also tend to favour 'short term' technologies (Spackman, 2002; Oxera, 2002).

### **Individual behaviour change**

Research moved on to identifying behaviours detrimental to health. For instance, "By 1954 the link between smoking and lung cancer was clear." (Blane et al, 1996: 4). Recession in the 1970s also provided an impetus for questioning spending on medical practice. A watershed document, produced by the 1974 Labour government was entitled *Prevention and health: everybody's business, a reassessment of public and personal health* (DHSS, 1976). This is characterised by Naidoo and Wills (1994: 67)



as coming from the tradition that sees health problems as the result of individual lifestyle choices. However, although this is one of its themes, the document does in fact recognise the role of government in developing: “clean air legislation, steps to reduce road accidents, improvements in housing standards...[and ensuring] that undue commercial pressures are not placed upon the individual and society.” (DHSS, 1976: 17).

The significance of the document is not just that it takes an individual behaviour change approach: “Most of us can improve our own health and that of the community.” (p. 95). It is also sceptical of clinical interventions. Taking whooping cough mortality as an example, it notes that the death rate fell by 80% between 1895 and 1935, and that this was not due to vaccines, which did not appear until the 1930s (p. 91). The document also called for more research into health inequalities, the result of which was the Black report (DHSS, 1980). In a discussion on the causes of health differences between classes, and between countries, the following comments are made:

“Housing, nutrition, life-style, education and income may all play a part. It is said that the organisation of society in such countries as Sweden reduces the social class differences. This may well be so, but it is noteworthy that other nations with widely differing structures of society have caught up and passed us in the past few years.” (DHSS, 1976: 57).

The potential pressure on governments to find evidence that fits wider political objectives is shown in this passage. As will be seen, the individual behaviour change model was suited to Conservative economic philosophy and similarly the post-1997 Labour government has been characterised as constrained by its prevailing orthodoxies (for instance, Moran and Simpkin, 2000).

The success of health information campaigns was thrown into question by the results of the famous ‘Multiple Risk Factor Intervention Trial’ (MRFIT) of the 1970s, conducted in the US. In that trial, behaviour change programmes were shown to have had less success than predicted (Wilkinson, 1996: 20). The individual behaviour change model became associated with ‘blaming the victim’ and this was seen as a

deflection of responsibility away from the upstream causes of ill health (Ryan, 1971: 163).

### **The 'New Public Health'**

By the 1980s a body of health promotion and public health opinion consolidated a move away both from clinical solutions to health improvement and from a 'victim blaming' behaviour change model. The new approach valued public involvement in promoting health and supported 'healthy alliances' between services to address public policy issues. More attention was also focused on the determinants of health inequalities, and on the context in which the prevention of disease takes place. It was argued that preventive work could not rely solely on the provision of information (Gray, 1979: 115, 146).

In 1986 a World Health Organisation conference produced *The Ottawa Charter* which outlines these areas as important for health promotion:

1. Building a healthy public policy
2. Creating supportive environments
3. Developing personal skills
4. Strengthening community action
5. Reorienting health services.

At Alma Ata in 1977 the WHO had also announced five principles of health promotion. The first of these advocates involving "the population as a whole in the context of their everyday life, rather than focusing on people at risk for specific diseases." (Naidoo and Wills, 1994: 75).<sup>72</sup> This principle links with Rose's observation that:

"a preventive policy which focuses on high-risk individuals may offer substantial benefits for those individuals, but its potential impact on the total burden of disease in the population is often disappointing....The visible part of the iceberg (prevalence), is a function of its total mass (the population average)...(Thus) most cases may arise among the many at lower risk rather than among the few who are at high risk.." (Rose, 1992: 73).

<sup>72</sup> Chen and Berlinguer (2001: 41) say "...the model of state responsibility for universal access [Health For All] in primary health care promulgated at Alma Ata in 1978 has been virtually abandoned." However, in relation to the research period and locality described here, interviewees far from abandon the model.

The importance that this observation is awarded at the local level may affect the nature of public health practice. Its message is evident in health inequalities policy updates, such as the *Cross-Cutting Review* (DoH, 2002: 31,43).

### **Community development and the community health movement**

‘Community development’, a term that originates in the 1960s, is an important element of health promotion. Its philosophy is that communities themselves should be supported to define and take action to meet their needs (Community Health Initiatives Resource Unit, 1987). In 1969 the Wilson government announced a programme to develop a series of Community Development Projects (CDPs), to be administered by the Home Office, as part of a wider Urban Programme. A history of their ups and downs is contained in Loney’s *Community Against Government* (1983). The book highlights different perspectives within community development, and notes the tensions that occurred when communities extended their demands beyond what the Home Office viewed as appropriate.

The Health Education Authority<sup>73</sup> set up a community and professional development division in 1988. However, this only lasted a few years before being disbanded. Although many projects did not survive, initiatives such as *Local Voices* (NHSME, 1992), continued to stress the need to involve the public in service planning, and indeed expanded this requirement further into mainstream health services in the 1990s. Post-1997 policy puts even more weight on the use of community development for health improvement within area-based regeneration schemes and supports this approach in helping to build ‘social cohesion’ (DoH, 2002: 53). It is an area of work that, the author suspects, is influenced by the wider political strategy of the post-1997 Labour government, combined with the non-political remit of NHS staff.

<sup>73</sup> The Health Education Authority (HEA) was a special government organisation contracted by the DoH to act as the umbrella body running health education campaigns and to support health professionals and health promotion departments. The organisation was reconfigured in 2000, becoming the Health Development Agency, and its focus shifted towards increased provision of research evidence.

*The NHS Plan* (DoH, 2000) has resulted in a further increase in local NHS investment in patient involvement work.<sup>74</sup> But in addressing health inequalities, local government and NHS departments' work on public involvement comes together. Firstly, within *Saving Lives* there is a belief that local people must be involved in developing the policies that most affect them (DoH, 1999: 126). Secondly, new local government legislation also supports a particular form of citizen involvement (District Audit, 2002: 9-10). Public involvement is particularly emphasised in New Deal for Communities and other post-1997 regeneration schemes, in which the local authority plays a key co-ordinating role (DETRA, 2000). These regeneration programmes require health 'pathways' and health service input and they are seen as important for health inequality reduction. Public health and health promotion staff are heavily involved in supporting this work. Therefore, NHS employees are also working within a local authority framework concerning public involvement.

### **The Health of the Nation**

In 1991 the Conservative government consulted on proposals for a health strategy for England – *The Health of the Nation* (HOTN) (DoH, 1992). Central to the government's programme was to be the setting of specific targets for improvements in health. Joseph Califano, who had been American Secretary of Health, Education and Welfare (HEW) in the late 70s, influenced this approach. In 1979 he issued a set of goals for reducing mortality within different age groups by the year 1990 (Califano, 1986: 223).

Initially, the HOTN strategy did not include any programme for addressing health inequalities. However it did "recognise that as health is determined by a whole range of influences – from genetic inheritance, through personal behaviour, family and social circumstances to the physical and social environment – so opportunities and responsibilities for action to improve health are widely spread from individuals to government as a whole" (p.5). And in 1995 a Health of the Nation supplement called *Variations in Health: what can the department of health and the NHS do?* was produced (DoH, 1995). This documented local interventions, advocated strategic or

<sup>74</sup> In 2002 there were at least 3 whole time equivalent NHS staff employed in patient involvement work in Lewisham and many more staff hours devoted to the work.

'healthy alliances' to address the variations in health, and provided an excellent source of statistical information for local health authorities. Research funding was made available to evaluate projects aimed at achieving the HOTN targets by improving the health of the less well off.

As referred to in chapter 1, an assessment of the strategy was produced (LSHTM, 1998) in order to inform the development of *Saving Lives* (DoH, 1999). Several factors emerged as influencing the implementation of HOTN, which are provided in table form in appendix 7.1 of this thesis. It was concluded that: "A health strategy needs to acknowledge the importance of the socio-economic determinants of the health of the local population if it is to be credible with those responsible for implementation locally." (LSHTM, 1998 b: 147). For this reason, the present research looks at a snapshot of local views to assess if this credibility has been achieved.

The assessment does not, however, specifically investigate whether credibility comes from local players' beliefs about the compatibility of national economic policy with health improvement, and how a loss of credibility might affect the policy's effectiveness. This has provided a strong justification for pursuing the research questions posed here, that is, for considering how local responses are influenced by wider political policy. The 1998 assessment does not appear to have sought the views of respondents on the relationship between national economic policy and local health policy. So it may be that problems were not so much to do with HOTN in itself, but rather with other relevant government policy that demoralised potential local champions of HOTN.

The HOTN strategy does seem to have had more potential for results than actual success, and it is more similar to *Saving Lives* than the latter document acknowledges. The speciality of public health medicine failed to grasp the opportunity presented by the HOTN (LSHTM, 1998: 28). However, it is recognised that a number of flaws in the strategy meant that it lacked weight on the ground (p. 147). Although, perhaps the key flaw was that policy in other areas of government was seen to be in conflict with public health objectives.

## 2. Inequalities in health

Now follows a selective review of the health inequalities literature and an attempt to show how a reading of the key works has influenced the issues that have been investigated at the local level. There is a vast number and ever-expanding supply of research texts in this field (Muntaner and Lynch, 1999: 59). Here, the present author simply provides an outline of what appear to be the most relevant publications and theories. The section starts by looking at the main explanations of inequalities in health. The theory that income inequalities, rather than absolute levels of poverty, lead to health inequalities is then outlined, along with accounts that emphasise the life-course, location, race and social capital.<sup>75</sup> The section then proceeds to a discussion highlighting points of most relevance to this study.

The current extent of health inequalities is set out in *The Widening Gap: health inequalities and policy in Britain* (Shaw et al, 1999), which is referenced in the Chief Medical Officer's annual report (DoH, 2001: 5).<sup>76</sup> Health inequalities were found to be increasing at the time of Labour's return to office (Abbasi, 1997). Since then there has been some indication of a fall in at least one determinant of health inequality, that is, smoking among low-income groups (DoH, 2002: i).

The Black report into inequalities in health described four types of explanation for health inequalities (Townsend et al, 1992). These were: artefact, selection, cultural or behavioural, and materialist. Definitions are provided in appendix 2.1. The first three explanations have been variously dismissed, although they are still thought to account for some observed statistical variations in health status between social groups (Blane, 1985; Macintyre, 1997). The 'materialist' explanation is described as one that emphasises "hazards inherent in society, to which some people have no choice but to be exposed, given the present distribution of income and opportunity." (Davey Smith et al, 1990: 373). The Black report stated a preference for this type of explanation.

<sup>75</sup> The health of women within the inequalities literature is discussed by, among others, Bartley et al (2000) and, within a global context, in Evans (2001).

<sup>76</sup> The government has documented numerous examples of significant inequalities in health. For instance: "In the 45 to 64 age group, 25% of professional women and 17% of professional men report a limiting long-standing illness, compared to 45% of unskilled women and 48% of unskilled men" (DoH, 1999.b: 2).

Le Grand (1986) sets out some problems associated with the Black report under three headings: health indicators, groups (the 'who' issue) and inequality measures. The health indicators used were limited since they concentrated on mortality rates, due to difficulties in collecting morbidity data. On groups, differences between social classes, as defined by occupational group, are emphasised. According to Le Grand this supports a subtle hypothesis that:

“...occupation is the major determinant of ill-health, and that inequalities between other groupings are simply reflections of the more basic occupational inequalities. But [Le Grand says] neither of these propositions are likely to command universal agreement....inequalities between income groups, the sexes, races or regions may be just as important for policy purposes as those between occupational groups.” (Le Grand, 1986: 3)

These other non-occupational groups were dealt with more extensively in the Acheson report (Acheson, 1998). The 'who' topics of race and area are briefly considered under those headings, below. Criticism over inequality measures was made on a number of grounds (Le Grand, 1986: 4), for example, a charge of inadequately accounting for changes in the relative size of population groups over time (see also, Illsley (1980, 1986), Klein (1982), Hart (1986), Oliver et al (2002)). Macintyre (1997) suggests that the Black report's explanations were not “hard” enough to warrant intensely polarised debates.<sup>77</sup> Nevertheless, for the purposes of this thesis, the key point is that hard or soft materialist explanations are widely supported and significant commentators would agree with Le Grand in saying that: “..the best way to reduce inequalities in health significantly is to reduce inequalities in income..” (Le Grand, 1982: 51). Even if this statement is incorrect, the findings reported here suggest that responses at the local level are affected by its credibility, and at the same time, local actions might affect long-term leavers controlling inequalities in income.

Le Grand also considers inequalities in health care as opposed to health outcomes (the 'what' issues, see below) (Le Grand, 1982: 4). Disputes continue on the extent to

<sup>77</sup> The materialist link has been made strongly, and has also been vigorously contested, in the academic literature (For instance: Wolfson et al, 1999; Dorling et al 2001: 1336; Wilkinson and Marmot, 2002: 9; Gravelle, 1998). But for our purposes the important issue is that some link was made in *Saving Lives*.

which different income groups use NHS services more or less, relative to need (Le Grand, 1982: 29-30). Developing the work of Sen (1992), Powell and Exworthy (2003: 54) describe the 'what' question as focusing "on the good to be 'distributed: health care or health itself...". Having presented an account of seven definitions of equity in health care systems, ranging from, 'equal expenditure per capita', to, 'equal health, focusing on health rather than health care' they place equality policies in a matrix of five 'what' dimensions and five 'who' dimensions. The what's are: spending, provision, access, use, outcomes, and the 'who's' are: class, race, gender, client, geography (Powell and Exworthy, 2003: 55). This is important since it alerts us to issues in the subject of health inequalities that are underreported in this thesis due to its particular research focus and space and time constraints; for example, to take the middle of the matrix, issues of access to services by gender.

Wilkinson has developed a thesis, set out in *Unhealthy Societies* (1996), which puts a further twist on the Black report's materialist perspective. He argues that following 'epidemiological transition':<sup>78</sup> "the scale of income differences in a society is one of the most powerful determinants of health standards in different countries." (Wilkinson, 1998: 8). Here it is not just absolute poverty that affects health, but relative poverty. The extent to which this theory has been taken on board by *Saving Lives* is discussed in the next section; however it should be noted that the policy implications of the theory, if it is correct and received in a supportive political climate, are potentially significant.<sup>79</sup>

The proposition is, however, challenged, for instance, by Judge (1995: 1282), who does not dispute the importance of poverty per se, but mainly the impact of income inequalities. He says that data fails to support the hypothesis that an egalitarian distribution of income is related to higher levels of health. He finds that it is "much more likely that they [differences in life expectancy] are the product of many influences, which probably interact over long periods of time." For another critique

<sup>78</sup> The concept of 'epidemiological transition' (Wilkinson, 1996: 43, Illsley and Baker, 1997) states that as countries become more prosperous, further increases in Gross National Product per capita (GNPpc) bring little health improvement. And the main causes of death shift from infectious to degenerative diseases. The concept has been criticised by Mackenbach (1994) for being too vague and ill defined.

<sup>79</sup> The Whitehall studies (Marmot and Shipley, 1996; Marmot et al, 1997), which show graduated poorer health linked to consecutively lower job grades, are used to support his claim.



see West (1997). It might also be argued that whilst infant mortality rates and income differentials are lower in Sweden than Britain, for example, “in terms of both average levels of adult self-reported health and social inequalities in health, the two countries show surprisingly similar patterns.” (Diderichsen et al, 2001: 254). Finally, data can be read as indicating that health inequalities started widening before income inequalities. This is if tables showing health inequalities over time (DoH, 1999: 44; DoH, 2003: 13) are compared with income inequalities over time (Shephard, 2003: 4).

Navarro (2002), Muntaner et al (1999) Moran and Simpkin (2000: 93) and Krieger, (2000: 29-30) critique the psychosocial framework that Wilkinson uses to explain the links between health and income inequalities that he has observed. This:

“directs attention to endogenous biological responses to human interactions. Its focus is on responses to “stress” and on stressed people in need of psychosocial resources. Comparatively less attention, theoretically and empirically, is accorded to who and what generates psychosocial insults and buffers, and also to how their distribution – along with that of ...pathogenic physical, chemical or biological agents – is shaped by social, political, and economic policies.” (Krieger, 2000: 30).

Perhaps more clarification is needed on Wilkinson’s findings before they can be confidently accepted (Plant, 2000). Statistical analysis, beyond the scope of this thesis, would be required to make a firm judgement. The debate is complicated further by the fact that, for some, including practitioners at the local level, increasing the incomes of the less well off is best done through income redistribution, whether or not Wilkinson’s theory is correct. Research demonstrates widening income differentials can have knock-on effects for the less well off, affecting absolute standards of living, for example, via housing availability (Livingstone, 2002). This, it is argued here, provides a justification for focusing on the effect of income inequalities on health using a connection that does not need to rely specifically on Wilkinson’s psychosocial theory. Whilst redistribution via tax to the least well off is possible in a context of widening income inequalities (Brewer et al, 2004), this redistribution could be greater

in the context of diminishing income inequalities.<sup>80</sup> The Acheson report (1998) argues for policies that improve the living standards of the less well off and further reduce income inequalities. Therefore, the connection made between health and income inequality is within the paradigm of the Acheson report and the implications of the link are worthy of the research provided here, even if judgement is withheld on Wilkinson's particular thesis.

### **The life-course approach**

Here, less controversially, the impact of socio-economic position on health is analysed from the perspective of its effect at different stages in the human life cycle (Davey Smith, Gunnell and Ben-Shlomo, 2001; Kuh and Ben-Shlomo, 1997). Different diseases are found to be more or less sensitive to insults at different stages of human development. Of particular importance are exposures in the period of foetal development (Barker, 1991) and these exposures are likely to vary according to wider social patterns of economic distribution (Davey Smith et al, 2001: 92). There are, of course, numerous implications and ways of interpreting this research in relation to policy development. Its impact can be seen in the Acheson report's recommendations, where particular attention is paid to women of childbearing age (1998: 67).

### **Neighbourhood and area effects**

Graham's *Understanding Inequalities in Health* (2000a) collects a number of articles on the theme of the influence of home and place, and suggests that: "Investing in [geographical] areas is a central plank of the UK's new public health policy." (Graham, 2000a: 127). This is partly because different geographical areas have been associated with differential health impacts beyond what might be predicted by the class position of individuals living in a neighbourhood (Macintyre et al, 2000: 130;

<sup>80</sup> Of course, taxing the rich 'until the pips squeak' is politically contested. Economic arguments are used against policies of further redistribution to the less well off. Chancellor Lawson's view, in 1988, was that higher tax rates would produce lower revenues (Johnson, 1994: 173). Indeed, from the mid-1970s "the expectation was that as the economy recovered, 'trickle down' effects would benefit the least well-off." (Mulé, 2001:2). Milton Friedman and the Chicago School influenced these views, he says: "...with respect to changes over time, the economic progress achieved in the capitalist societies has been accompanied by drastic diminution in inequality". Government-led redistribution from the rich to the poor, via taxation, was not advisable (Friedman, 1982:169-70). However, some writers are more circumspect: "The point at which redistributive policies do start eating into the efficiency of the economy or start themselves to cause inequalities is not clear cut." (Johnson, 1994: 180). And others directly oppose the Thatcherite perspective, for example: "The facts do not support those who argue that considerations of efficiency rule out egalitarian policies. In fact macroeconomic evidence tends to point in precisely the opposite direction...". (Corry and Glyn, 1994: 205).

Lupton and Power, 2002: 134).<sup>81</sup> Macintyre recognises that social rented neighbourhoods can also have social characteristics that support health. These features relate to the concepts of social capital or cohesion, referred to below.<sup>82</sup>

### **Ethnicity and race**

Nazroo (1999) says that the effect of race and membership of minority ethnic groups, as opposed to class effects on producing health inequalities, may have been over reported by some previous research. The *Cross-Cutting Review* states: “Many people from Black and minority ethnic communities also experience other social conditions which impact on health status and risk-taking behaviour, including poverty, poor housing and racism.” (DoH, 2003: 38). Key facts from the *Health Survey for England, 1999* (Bajekal and Erens, 2001), the most extensive survey on the health of black and minority ethnic groups ever carried out in England, are included in the *Cross-Cutting Review* (pp.37-38).<sup>83</sup> The extent to which work to address health inequalities should target black and minority ethnic groups in Lewisham, as opposed to all ethnic groups in social classes V to III M, has been an issue in various local discussions over the past five years. The nature of these conversations is reported in chapters 4 and 5.

### **Social capital and social exclusion**

One important perspective on the health inequalities literature concerns debates about the various concepts of social capital<sup>84</sup>/exclusion/isolation/solidarity/cohesion. These ideas are generally associated with Bourdieu (1997), Coleman (1994) and Putman (1993). Piachaud (2002: 6-11) discusses various definitions of social capital and quotes, among others, Putnam’s view: “By ‘social capital’ we mean features of social life – networks, norms, and trust – that enable participants to act together more effectively to pursue shared objectives.” (Putnam, 1996:56). Burchardt et al (2002:1-3) note that the term ‘social exclusion’ is contested. The British ‘Economic and Social Research Council’ who fund research on the subject, say that they want social

<sup>81</sup> As Glennerster et al (1999: 7) say: “The most powerful attack on the whole idea of area-based strategies came from Peter Townsend. It began in his Barnett Shine Memorial Lecture and was developed in Chapter 15 of ..... *Poverty in the United Kingdom...* [Townsend, 1979]”

<sup>82</sup> Home Office advice on how to build and maintain cohesive communities is provided for local authorities and their partners in order to combat civil unrest (Home Office, Guidance on Community Cohesion, 2002).

<sup>83</sup> See also: McKenzie (2003).

<sup>84</sup> Defined in the thesis’s introduction.

exclusion studies to help in “understanding the processes by which individuals and their communities become polarised, socially differentiated and unequal” (ESRC, 1997; Burchardt et al, 2002: 3).

Barry (2002) highlights some of the difficulties with defining exactly when groups are excluded. Addressing this issue, Putnam distinguishes between ‘bonding’ and ‘bridging’ capital. Bonding may increase exclusion by the formation of closed tight-knit groups while bridging may reduce exclusion. Here again, there is ample room for normative interpretation affecting policy recommendations. Self-organisation of population groups may lead to more bonding, whereas state-led policy to address social exclusion may attempt to encourage bridging. The example of the Mafia is often given to illustrate negative social capital (Sen, 1999: 267-8; Fine, 2001: 92), but political organisation on estates with poor health records - and the attitudes of public sector staff towards this - is of more relevance to this study. It may be that some institutional features of statutory bodies are biased against supporting particular forms of political self-organisation. Whether these organisations are classed as providing social capital supportive of health is likely to be a contentious subject on many grounds.

Phillimore notes:

“...levels of health provide a sensitive guide to the conditions in which people’s lives are led.....Not everything that distinguishes one social milieu from another...will show up in the health record....Nevertheless, levels of mortality summarize the cumulative impact of multiple influences upon people’s lives, in a way that has no parallel among routine socio-economic indicators.” (Phillimore, 1993: 175).

Poor health has not only come to be used as a marker for social exclusion (Social Exclusion Unit, 1998, para 1.24), but, it is also through working with regeneration projects at the local level (New Deal for Communities, SRB and the Neighbourhood Renewal fund (DETR, 2000, 1999; SEU, 1998)) that public health practice aims to improve health among the worst off.

The relationship between social capital and health is also reinforced by Wilkinson's thesis, referred to above, on the effects of income inequality. Thus, government might attempt to strengthen social capital to improve health, within a policy framework of higher or lower economic redistribution.<sup>85</sup> Inculcating a 'duty to participate' might either save money or save having to follow the 'higher risk' political strategies of income redistribution (Petersen and Lupton, 1996: 146-173).

### **Strategies and Tactics in Health Inequalities Reduction – Discussion**

The shelving of the Black report following publication again highlights the political nature of work to reduce health inequalities (Black, 2000). As Bechhofer asserts: "social inequality is immensely important in matters of health, .. it would require considerable redistribution to make much impact, and this is a very hot political potato." (Bechofer, 1989:14).

Carr-Hill (1987) and Shaw (et al) (1999) are among many distinguished academics who have been obviously frustrated by lack of government action, given the body of evidence amassed that indicates income transfer is required to resolve the problem. Carr-Hill summarises his survey article with the statement that "the time is long overdue for a redistribution of resources to eradicate poverty." (p. 509). And Shaw says, "It is clear that the most effective way of reducing inequalities in health in Britain is to reduce poverty. The poor have too little money and the solution to ending their poverty is to provide them with more money." (p. 191). As the history of public health showed, collective agency can provide long-term levers for health improvement tied to macro-economic policy. The tactics required to follow this strategy do not appear to have been comprehensively investigated within the 'health inequalities' literature. Social capital is increasingly used as a concept to both explain health inequalities and to offer policy solutions. However, within academic discussions concerning the evolution of social democracy, issues such as the role of trade unions (Korpi, 1983) and the role of the formation of state institutions (Rothstein, 1992) are key to the future egalitarian nature of different societies, a point referred to in chapter 1.

<sup>85</sup> As Moran and Simpkin (2000: 90) point out, governments of the centre right and left have attempted to address social exclusion.

Sweden is often held up as an example of good health (Chadwick, 1842, 1965: 422-423; DoH, 1976; Navarro and Shi, 2002). It is a country whose wealth distribution, Carr-Hill and Shaw presumably feel, should be matched in Britain. However, if such a change is sought, consideration should be given to preparing the ground for such movement. Campaigning for intermediary measures might prove more successful than simple demands for redistribution. In a study on the development of Swedish labour market policy, which examines the way trade union interests were built into the policy process, Rothstein suggests that “In some, albeit probably rare, historical cases, people actually create the very institutional circumstances under which their own as well as others’ future behaviour will take place” (1992: 52). As Rothstein describes so elegantly, redistribution in Sweden did not come out of the blue, it involved a series of tactical political struggles and manoeuvres, based on experience and theory.

Lowi (1972) has put forward a framework for categorising policy which distinguishes between those which redistribute, distribute, regulate, and design/redesign institutions. In the light of this typology *Saving Lives* (DoH, 1999) may perhaps be seen as regulatory, but it is clearly not redistributive in and of itself. In order to achieve its goals however, redistribution is considered necessary (Carr-Hill, 1987). Lowi suggests that redistributive policy may require, and/or result in, more general political mobilisation than other types of policy; it is affected by the pattern of local and national political mobilisation (Lowi, 1972). This thesis upholds the view that, as suggested by public health history, in order to address the question of redistribution for health gain, the political links between the local and the national should be closely examined. The ability of the less well off to access national policy-making processes remains as important an issue now, for all agents, as it was 150 years ago. We should be aware of all the various cultural, political and economic strategies that are, or could be, employed by those supporting or opposing redistribution.

Shaw (1999: 198) makes no distinction between the tactical merits of redistribution via tax, reduced differentials, or NHS services. Middle-class NHS users may or may not be accessing services more than poorer users (Tudor Hart, 1971; O’Donnell and Proper, 1989 (cited in Wilkinson, 1996: 67); Rein, 1969). But there is little evidence to suggest the middle class are ‘over-using’ the NHS. According to Esping-Anderson, withdrawing provision welfare from this section of the community is likely to lead to

alienation, a withdrawal in support for state-funded services, and calls for further tax cuts (1999).

At the local level different opinions on approaches to health inequalities reduction can be detected. Bold calls for wealth redistribution to reduce health inequalities contained in a report by Shaw et al (1999) led to the publication of an interesting short article in the *Health Service Journal* (Miller, 2000: 16). Harry Burns, director of public health at the Greater Glasgow health board, is quoted as saying that the findings of Shaw's report are 'naïve'. He says: "We are focusing on policies that will improve life for children from birth, antenatally and even pre-conception, improving the ability of parents to bring up their kids as citizens with aspirations. Social inclusion policies are the best way to turn the areas like Shettleston around." This might be labelled as a social capital approach, informed by life-course research. Following Levitas's categories, set out in *The Inclusive Society? Social exclusion and New Labour* (1998), this could possibly be named a 'MUD' approach. 'MUD' (Moral Underclass Discourse) emphasises the needs of the 'underclass'. In contrast, the focus of Phil Hanlon, professor of public health at Glasgow University, and Daminan Killeen, director of the Poverty Alliance in Glasgow, is on jobs and economic development. This is an approach that adopts the 'socio-economic model of health' perspective. Turning to Levitas again, this might be called a 'SID' view. In 'SID' (Social Intergrationist Discourse) emphasis is on participation in paid work, but is not focused on unpaid work and poverty among non-workers. The authors' perspective (Shaw et al, 1999) can safely be called 'RED' (Redistributionist Discourse), that is defined as one where poverty is the central issue. The analytical lead for Shaw et al's view was provided by the Black report (1980). However, they do not fully explore, at least in the report under discussion, the processes that produce inequality; a fact that is, in general, one of the main critiques of this thesis. Finally, the chair of Greater Glasgow's health board and of the Healthy Cities Partnership, David Hamblen, is concerned by the negative press coverage Glasgow received on publication of Shaw's report. Perhaps this might be called a 'marketing' perspective.

Although it must be pointed out that the quotes from these Glasgow stakeholders are short and possibly misrepresentative of the individuals' views, the article shows some of the different opinions that might be found at a local level in inner-London. The

local perspectives show different strategic and operational concerns, and may indicate different definitions of policy success and failure. It is unclear whether, beneath this, rests divergent opinion on the point at which health inequality becomes inequitable (Oliver et al, 2002). Normative responses to the level of health inequalities were observed in local fieldwork, as are beliefs about the levers of collective action, such as trade union organisation.

### **3.1 The Public Health White Paper ‘Saving Lives’**

The public health White Paper *Saving Lives* (DoH, 1999) was the stimulus for this research. It is a policy document open to diverse interpretations whose implementation at the local level therefore suggests the need for investigation. The present author expected that the response to the policy would be in the arena of both beliefs and of action, and would depend on various factors, such as concurrent work pressures. A brief summary of the public health rationale upheld in the document follows. After which the document is analysed from historical and political perspectives.

Firstly, ‘health’ in *Saving Lives* is seen as being determined by more than just health care. Issues such as housing, access to healthy food, and income all affect the prevalence of illnesses such as cardiovascular disease and stroke. Using this multi-factorial determinants argument, a health improvement strategy means engaging all government departments responsible for issues ranging from transport to agriculture. Within this perspective, central government is viewed as responsible for those social and economic policies relating to the broad determinants of health. In particular, government policy on unemployment and low wages is seen as a crucial determinant of health status. But individuals are also regarded as having a responsibility to look after their health by, for example, taking regular exercise and not smoking.

Secondly, *Saving Lives* holds that there are currently significant inequalities in health status, with those on low wages or unemployed experiencing higher death rates at younger ages and longer periods of sickness. Differentials in health status are again found by ethnic group and by gender. Populations located in different geographical regions of the country also experience varying rates of diseases. Government would



like to see greater improvement in health among those with the highest levels of morbidity and mortality; in other words, a reduction in health inequalities is sought.<sup>86</sup>

Thirdly, trends in British health over the last 150 years indicate a gradual improvement in life expectancy. This pattern, as described in *Saving Lives*, has been generally shared by all sectors of society, although the gap between the health of social class I and V remains, and in some populations, in relation to some causes of death, the situation has declined.

Fourthly, the government aims to see specific improvements in the numbers of people dying from the following causes: cancer, coronary heart disease and stroke, accidents and suicide/undetermined injury. Targets are set in *Saving Lives* for these reductions to be met by 2010.

Finally, reference is made to a need to involve the public in the planning of interventions to improve health. Local communities and partnerships between different local agencies and sectors all have a role to play, for instance see (DoH, 1999:147).

Thus, in summary, for *Saving Lives*, social, environmental and economic factors are important determinants of health. It is this broader agenda that is the focus of the research, and partnership working between agencies, such as health service and local authority bodies, constitutes the fieldwork environment. The thesis is concerned with three inter-linking issues found in *Saving Lives* (DoH, 1999). These are: (i.) the link between poverty and health and its implications; (ii.) decisions about centralisation-decentralisation, and in particular the role of individuals and communities vis-à-vis the role of government; and, (iii.) state-led public involvement and its ramifications. Referring back to previous points made in this chapter, it can be said that local staff opinion concerning government economic policy on income distribution may affect

<sup>86</sup> It should be noted that health inequalities may be defined in relation to medical care provided through health services. Access to health services, their utilisation and resulting health outcomes are all measures used to assess inequalities (Rein, 1969). Examples of inequalities in service access and use are described by Acheson (1998: 111-119). Outcome may also be measured by mortality or morbidity. But, as Carr-Hill (1984) explains, although morbidity data is extremely important in devising effective policy, the quality of morbidity data is less reliable than mortality data.

policy implementation. Local political organisation, in turn potentially influenced by local state employees, can also affect the determinants of health, as set out in *Saving Lives*.

Early speculation in this thesis suggests that with detailed fieldwork, the above simple summary will be shown to hide more complexity and implementation difficulties than is at first apparent. This is because a White Paper or policy document is a generalised view of the entire policy field. Only detailed, local research can test the assumptions and the fit between government objectives and the local conditions. The outcomes will depend heavily on the feasibility of implementing generalised policy.

### ***Saving Lives*: historical and political interpretations**

*Saving Lives* (DoH, 1999) came out in two parts, the main body of the text and a supplement, which was a reply to the Acheson report (1998). Firstly, the main document is discussed. The features considered are: the extent to which public health theory associated with previous governments' policy has been retained or amended to suit the new government's ideology. This discussion looks at the question of a balance between secondary and primary prevention, as well as particular issues in the 'health inequalities' literature and the role of local targets and associated 'centralisation versus decentralisation' implications. Finally, the links made between downstream public involvement and upstream policies are reviewed. As Edelman (1977) notes, in a discussion on American 'acceptance of inequality', government policy should be considered both from the perspective of its rhetoric and the extent to which words will translate into actions. The present author attempts to use this perspective in interpretation of the document.

The approach to public health in *Saving Lives* reflects many of the themes of 'New Labour'. Six are listed here. These are, firstly, a "third way" that rejects both the "old nanny-state approach" and the view that government has no responsibilities beyond those that can be controlled by individuals (DoH, 1999: 6-7; see also, Paton, 1999: 74; Giddens, 1998; Klein and Rafferty, 1999). Secondly, 'rights and responsibilities' (DoH, 1999: 9), is a relationship associated with 'conditional citizenship' and 'communitarianism' (for example, see Dwyer, 1998; Moran and Simpkin, 2000). Thirdly, 'partnerships' (DoH, 1999: 8, 123), implying an emphasis on joint working

across agency boundaries (see Rouse and Smith, 2002: 47-48). Fourthly, criticism of the so-called 'nanny state' (DoH, 1999, foreword: v, 7). This is a phrase popularised by the Conservative press to mock government social intervention and now adopted by Labour. However, it is used in *Saving Lives* to distance the document from the 'victim blaming' model, discussed previously.<sup>87</sup> Fifthly, the series title *Our Healthier Nation* echoes the 'one nation' thesis (Gould, 1998: 250-253) and might be seen to advocate a bridging of the gap between rich and poor. Alternatively, 'one nation' language fits well with a view that class divides are a thing of the past and could consequently downplay options for social democratic style redistribution.<sup>88</sup> The rhetoric of 'our one healthier nation' is unlikely to become a reality without a truer meeting of the two nations of rich and poor (Gould, 1998: 252). Finally, 'social exclusion' (DoH, 1999: 3) is also referred to, a topic mentioned previously and to which will be returned to in subsequent chapters.

*Saving Lives* does not fully abandon the individual behaviour change model seen in the earlier Labour government's *Prevention and Health: everybody's business* (DHSS, 1976). However, unlike the Conservative's *Health of the Nation* programme, it does make use of subsequent research that has shown a clearer causal link between ill health and poverty. Thus, government action to increase the minimum wage is explicitly seen in *Saving Lives* as contributing to public health goals. But it might be argued that, in practice, the politics of the Labour government that launched *Prevention and Health* was far more supportive of economic equality. Evidence for this can be found in speeches by Gordon Brown compared with Labour economic policy speeches of the 1970s. The actual manifestos of the two governments are even further apart. The rhetoric of *Saving Lives* may be clearer than the 1976 policy as to the economic determinants of health inequality, and the Treasury, for instance, is now recognised as a key partner in health policy. However, the practice of government across all departments could be less supportive of health inequality reduction because of maintenance of income inequality levels above those of 25 years ago (Townsend, 2000: 66).

<sup>87</sup> Labour's policy is not as extreme as the analysis provided by *The Daily Telegraph* might lead one to believe: 'Health advice 'nannies' killed off by ministers' (12.1.00:1).

<sup>88</sup> National governments may have the capacity to pursue different redistribution policies, as Graham (2001) suggests in her comparison of Finland and Britain.

The health improvement targets provided in *Saving Lives* may be predicted to skew local work towards secondary prevention, since they relate to mortality. As we have seen in a discussion on Rose's work (1992), people presenting with clinical symptoms will only be a proportion of the people with sub-clinical problems present within the population. In order to reduce the number of deaths, it would be possible to concentrate initiatives only on those presenting with clinical problems. That is, to concentrate on secondary prevention work, and not to focus so much attention on work to reduce the causes of disease, i.e. primary prevention work. Secondary prevention initiatives gained considerable weight in the document's translation from a Green to White Paper. For example, the Healthy Citizens' programme is comprised of three initiatives: a 24 hour health advice-line called 'NHS Direct'; expansion of 'first aid' training, including increased sites for defibrillators; and an Expert Patients' programme, designed to enable those with chronic illness to increase their own role in managing conditions.

It is unclear why *Saving Lives* uses the language of 'responsibilities' in relation to individuals taking action to look after their health, except in order to sound consistent with 'New Labour' language. The vast bulk of literature on the subject would show this to be inappropriate (see for example, Benzeval, et al., 1995), and even the document itself recognises that healthy lifestyles are influenced by social situation.

Discussed in the thesis's introduction was one of the subtlest features of the document - that is, the lack of a link between upstream policy and local people. In respect of trade unions, all references in *Our Healthier Nation* (DoH, 1998) were deliberately deleted on transition from Green to White paper. Employees' sense of control within the workplace, is referred to, but only outside the context of control via trade unions. Therefore, the thesis reviews local views on the links between public health policy and trade union membership.<sup>89 90</sup>

<sup>89</sup> Business, as represented by the Confederation of British Industry (CBI), has been largely unresponsive to wealth redistribution. The Institute of Directors has produced documents arguing for tax reduction and more specifically, the abolition of inheritance tax (IOD 1997a, 1997b).

<sup>90</sup> By deciding to maintain most Conservative trade union laws, New Labour may have given more power, than any previous Labour administration, to a business class which has proactively argued against a reduction in inequalities (Panitch and Leys, 1997: 254). The redress, via the 'Fairness at Work' policy (Department of Trade and Industry, 1998), has been comparatively minimal (Diderichsen, 2001: 245).

As Klein has noted, there are a number of tensions in the organisation of the NHS (Klein, 1982). However, the specific tension for NHS management between a requirement to reduce health inequalities and the responsibility of dealing with union claims for improved terms and conditions in a cost-efficient manner is not specifically referred to in his article. This tension also exists in state-led health partnerships with private businesses, where the same companies may also be involved in lobbying central and local government on, for example, a lower minimum wage, fewer restrictions on working hours, fewer tax increases relating to road-use and land-use for building and parking.

Research has indicated health benefits from participation in decision-making (Rutten, et al 2000). However, the operation of Labour as a mass democratic party, traditionally representing and providing some limited access to involvement of the less well off, has not been raised, to the author's knowledge, within any academic discussions on health inequality. The author therefore seeks to investigate this issue further when looking at the implementation of public health policy in the 21<sup>st</sup> century, in the case study area.

The aim to reduce health inequalities is central to *Saving Lives*. The action plan to tackle poor health, as the first lines of the executive summary state, is to: "Improve the health of everyone. And improve the health of the worst off in particular." However, Wilkinson's thesis, referred to earlier, is that it is not just absolute levels of poverty that affect health, but it is also the psychosocial consequences of income inequalities. To what extent is this accepted by *Saving Lives*? This is not clear, although section 6.11 would appear to concur with Wilkinson's view. This reads as follows:

"In countries with greater income inequality, health inequality is greater too. And there is evidence that social stress, reflected in the extent to which an individual has low control over his or her job, increases the risk of coronary heart disease and of premature death. Similarly the degree of social cohesion, the strength of social networks in a community and the nature of people's

work may all affect their risk of dying from coronary heart disease.” (DoH, 1999: 77)

The White Paper also instructs that: “Campaigns to improve health must concentrate on the least healthy.” (preface). However, Acheson recommends concentrating action on the less well off, as opposed to the least well off. Thus, in general, while a firm government commitment to aim to reduce inequalities in health can be seen, this is coupled with ambiguity. There is ample room for diverse interpretation on the details of how to achieve the policy aim at the local level. There is also room for post-policy reinterpretation by government.

### **3.2 The Acheson Report (1998) and *Reducing Health Inequalities: an action report* (DoH, 1999b)**

As referred to earlier, a response to the Acheson report (1998) was produced alongside *Saving Lives* (DoH, 1999). This was called *Reducing Health Inequalities: an action report* (DoH, 1999b). The Acheson report itself had been commissioned by the new Labour government just two months after the 1997 election (Exworthy et al, 2002: 82). It gives a series of recommendations, over 40 in total, as to how health inequalities should be tackled. The report was welcomed in public health departments at the local level and also by the government in its initial response (DoH, 1999b). The recommendations can be divided into those requiring national responses and those that can be acted on locally. While the report was not organised in this way, Acheson came to mark his copy of the report with ‘L’ for local and ‘N’ for national, so that he could emphasise to local players what they should focus on. Examples of local issues were - the further development of the role and capacity of health visitors (recommendation 23.1) and nicotine replacement therapy on prescription (recommendation 26.4). Examples of national issues were - the uprating of benefits and pensions (recommendation 3.2) and more generally: “policies which will further reduce income inequalities..” (recommendation 3).

Exworthy observes that while the Acheson report was “generally well received”, some pointed to “the lack of prioritisation, the weak evidence base for some recommendations and the lack of cost-benefit data supporting their analysis [e.g.

Illsley, 1999; Williams, 1999; Klein, 2000; Davey Smith, 2001; Macintyre et al, 2001; Oliver et al, 2001].” (Exworthy et al, 2002: 82). *The Cross-Cutting Review* also refers to these critiques of the Acheson report. Marmot and Law were commissioned to review evidence that had been published since the original inquiry (DoH, 2002: 25). The evidence base was not systematically weaker or stronger according to whether the recommendations were directed at local or national work, although the political risks were perhaps unevenly spread, e.g., the addition of one drug to the prescribing list holds less potential for long term political ramifications than a significant uprating of benefits and pensions. Later chapters in this thesis report on how ‘Acheson’ was used locally. It was found that there were no disputes over the evidence provided to justify the report’s recommendations. The recommendations were unquestioningly accepted. The problems encountered were around prioritisation and the lack of clarity over what was ‘the local role’. (See the reference to Day and Klein (1987) below.)

This thesis takes the view that, while Acheson (1998) says what needs to be done at the national level, the factors affecting the likelihood that these recommendations are acted on and influenced, should be theorised and considered as part of a comprehensive policy analysis. For instance, while Acheson may recommend a redistributive increase in pensions, numerous academics in political theory and social policy have demonstrated how different factors affect the likelihood of this outcome. For example, redistribution may be affected by constellations of power relations, such as the extent of middle-class risk taking (Baldwin, 1990) or the organisation of political parties (Castles, 1982) and trade unions (Rothstein, 1992; Unison Focus, 1997). It is an assumption of this thesis that some of the activities of the local and national state can affect political and social forces that, in turn, influence the likelihood of Acheson’s national recommendations being extensively implemented.

The terms of reference of the Acheson report are set out in the DoH’s response (DoH, 1999b: 3) and each recommendation of the report is dealt with. For instance: “We recommend policies which will further reduce income inequalities, and improve the living standards of households in receipt of social security benefits. (*Independent Inquiry into Inequalities in Health* (1998), recommendation 3). The government’s response to this recommendation includes a somewhat vague commitment to increase the opportunities for all members of society to participate fully in the economic and

social life of the community in which they live. If the objective had been to return inequalities in health back to their 1970-72 level (which it was not) then it might have been reasonable to compare pay differentials, tax and benefit policies, and unemployment levels with that period in order to assess the chances of achieving the aim. However, no such intention was made clear, at least at the time of the document's publication. A stated intention to redistribute income became slightly clearer towards the start of the second Labour term (Blair, Hackney school speech 18.9.02; Jones, 2002). Sir Donald Acheson was disappointed with the government's action report (DoH, 1999b). However, he was more satisfied with subsequent redistributive budgetary measures, and took these as a possible indication that the recommendations of his inquiry had been noted (Acheson interview, 30.3.00).

This thesis reports in its findings that the DoH's failure to respond adequately to the Acheson report had an important local impact. The lack of any translation of the report into a template for local action resulted in severe delays and increased difficulties in the effective co-ordination of local work. It was not until half way through 2003 that this omission in support from 'the centre' was rectified, with the publication of *Tackling Health Inequalities: a programme for action* (DoH, 2003). This failure may have been guided by general beliefs about the benefits of decentralisation. It may also be the case that senior DoH staff were unsure what they should recommend as the most important things the NHS should do locally. In the words of one senior official who observed early construction of the policy: "their hearts were in it, but their minds were uncertain." (civil servant, informal interview, 2003).

In 2003 it was found that the Acheson report was still in use locally and relevant to local public health planning. *Saving Lives* was not by this date such a read document. It had been superseded as a practical guide because of its failure to provide national targets, which meant that its details quickly became outdated. Having said that, the principles and tensions that characterise it are still as relevant in 2003 as when it was published.



#### **4. *Saving Lives* within the local setting**

Here, looked at briefly, are developments that might be expected at the local level, and questions to be asked, following analysis of *Saving Lives* and associated literature. This takes into account the thesis's aim of looking at local implementation with a particular lens, sensitive to national and local political dimensions and within this, the political tensions of income inequalities and central versus local control.

1. Firstly, one might expect more of a stress on health improvement within the local NHS and in partnerships between the NHS and local government. For instance: "The roles of the NHS and of local authorities are crucial. They must become organisations for health improvement, as well as for health care and service provision." (DoH, 1999: 8).
2. Increased funds should be available to develop the public health function (DoH, 1999: 140).
3. Local targets for improving health and reducing health inequalities should have been set out in the local Health Improvement Programme from 1999. Although health inequalities targets had to be developed at a local level, by contrast, national targets were set for health improvement, but not for health inequalities. This was despite a strong lobby for national health inequalities targets in response to the Green Paper (DoH, 1998). In the White Paper's preface it was stated: "We reject the previous Governments' scatter gun targets. Instead we are setting tougher but attainable targets in priority areas." (DoH, 1999: preface). So, it will be interesting to see how these local targets were established. In particular, we will look at how inequalities targets developed locally.<sup>91</sup>
4. The balance between secondary and primary prevention initiatives may be contentious since the national targets for health improvements may favour secondary prevention practice.

<sup>91</sup> In *The NHS Plan* the government reversed its decision not to provide national health inequalities targets (DoH, 2000).

5. Given the initial belief held by some policy makers, that decentralisation in public health would aid implementation,<sup>92</sup> benefits from this approach should be seen in local strategy development and implementation.
6. Given the central aims of *Saving Lives*, one would also expect to see campaigns to improve health concentrating on the least healthy (preface). However, as was noted in the discussion on health inequalities, and as clarified in the Acheson report (1998) and the *Cross-Cutting Review* (2002) the less well off, not just the least well off, should be targeted. Therefore, local debate and confusion might be expected; this will be about the extent to which health improvement work should be targeted.
7. Research should be alert to the possibility that local players may have mixed views on their role in influencing income inequalities and other upstream determinants of health. Day and Klein show the difficulty of assigning responsibility for outputs or outcomes to any single service. Where a 'holistic' view of accountability is adopted and responsibility for factors over which local agencies have little control – such as the social and economic environment – “...all-embracing accountability might all too easily become meaningless..” (Day and Klein, 1987: 246).
8. Given *Saving Lives's* imperative to involve local people in policies that affect their health, a number of questions need to be asked about local democratic structures. For instance: does political practice, such as the use of citizens' panels and attitudes to trade union representation, conflict with a desire to reduce inequalities in health and therefore wealth?

The above points, raised as issues in the author's reading of *Saving Lives*, have been used to structure the research. The first findings chapter, chapter 4, concentrates on the institutional changes delineated in points 1-6 above, as well as developments heralded by parallel Department of Health initiatives, particularly the creation of primary care trusts. The second findings chapter, chapter 5, assesses staff opinion

<sup>92</sup> As demonstrated by the requirement to provide local targets and by the lack of guidance on the local implementation of Acheson (1998).

regarding these institutional changes and staff views on the question of income inequality referred to in point 7, above. The final findings chapter - 6, deals with point 8 and focuses on public involvement in issues affecting income inequalities. This is because *Saving Lives* makes a link between health and income inequalities.

## Conclusion

It is apparent from reading *Saving Lives* (DoH, 1999) and the Acheson report (1998) that both consider a separation in responsibilities between 'the local' and 'the national' appropriate. This is legitimate, in that local staff have a particular role to play, as do national agencies. But little consideration is given to how grassroots forces might influence national policy or might combine to create national political movements. This is a state of affairs, which is, albeit unintentionally, portrayed in Dahlgren and Whitehead's famous diagram of 'the main determinants of health', reproduced in the Acheson report (p.6). In this diagram, individuals form the centre core with rings expanding outwards towards determining socio-economic factors. Thus, the people appear more as subjects determined 'economistically' by wider forces, rather than as agents capable of impacting on socio-economic factors.<sup>93</sup> Yet as the reading of public health history showed, political movements, based on grassroots involvement, but linked to a national political voice, can affect these determinants of health. While Chadwick is associated with leading public health improvement in the 19<sup>th</sup> century, he himself, according to various accounts, was influenced by the Chartist 'threat'. The thesis is concerned, in part, with the character of political movements that might influence the wider determinants of health. More specifically, the research looks at the way in which staff views and unfolding institutional arrangements at the local level might affect the power of these movements. Thus, it is an intention of the thesis to seek to redress the fact that little consideration has hitherto been given, in the public health literature, as to how grassroots forces might influence national policy.

<sup>93</sup> "Economism [was] a concept developed by Lenin in several articles of 1899...which criticized some groups in the Russian social democratic movement for separating political from economic struggles and concentrating their efforts on the latter..." (Bottomore, 1985: 143). Of course 'socio-economic determinants' are not the same as 'economic determinants' and it is, therefore, unfair to overly criticise the diagram. But interpretations of the model have often not given due emphasis to political aspects of the social element (for instance, Benzeval, Judge and Whitehead, 1995: 23). The thesis is interested to see if this academic tendency is repeated locally.

Public involvement is a key feature of post-1997 public health policy, but it is confined to a role in local developments. The danger of local consumer-orientated methods of public involvement undermining party politics is a subject that is growing rapidly in the academic literature. For instance, as Wilson, Leach and Wingfield say, it is possible to argue that these methods “distract from political participation because they enable individuals to interact with public bodies as customers rather than citizens, thus avoiding the messy complexities of politics” (Leach and Wingfield, 1999; Wilson, 2001). Various divergent opinions are developing as to why local involvement is to be supported, for example, Rowe and Shepherd (2002) categorise conceptualisations based on consumerism, citizenship and new public management. There is also an increasing tendency to regard local participation as primarily useful as a cost-effective investment in regeneration projects and other local government services. Some commentators value the health enhancing features of increased social capital, which are to be encouraged through community participation (Gillies, 1997). Others see local participation as a necessary step in enhancing democracy, defined as increasing self-government and the power and authority of the people (Arblaster, 1994: 9).

The development of the ‘new public health’ was described in this chapter as, in part, a reaction to earlier models such as the ‘medical model’, the ‘individual behaviour change’ model, the so called ‘nanny state’ model and ‘victim blaming’. *Saving Lives* has clearly attempted to learn from these developments, but determining a programme of effective local work to reduce health inequalities has, as we will see, not been an easy process. Exactly what should be done locally that does not encroach onto the terrain of ‘individual behaviour change’ has been hard for agencies to determine, even when they do not, in principal, support the model. Recurring tensions over centralised control of the National Health Service, coupled with moves towards local autonomy,<sup>94</sup> has not helped to resolve these difficulties. Public health policy has been caught up in these polarised battles between the centre and the localities, whereas a model of mutual support would have, it is argued, been more productive. The problems of delegation from the centre are exemplified in the failed attempt to get local health authorities to set their own targets to reduce health inequalities, at least

<sup>94</sup> As addressed by, among other policy documents, *Shifting the Balance of Power* (DoH, 2001).

before national targets had been set. Here the mantra of ‘local autonomy is good’ clearly did not live up to expectations. Sir John Simon’s caveats as to the advantages of decentralisation appear no less valid after a century of public health practice.

That policy towards health inequalities changed with the election of a Labour government in 1997 highlights the political nature of the subject. The shift is underlined by the Chief Medical Officer: “The government-commissioned Acheson Report, showed the importance of social, economic and environmental determinants of health and served as the basis of the White Paper *Saving Lives: Our Healthier Nation*. The document commits the government to addressing the fundamental determinants of poor health.” (DoH, 2001: 5).

The extent to which the state ‘problematise’ the fact that some groups within the population live, on average, a number of years longer than others, is based on values and beliefs held within a political context. The assertion that those tending to be worse off, also tend to have worse health and also tend to be Labour voters, means that these three inter-linking factors create a tension when the agency tasked with policy implementation is the ‘political neutral’ NHS. Yet links between health and income inequalities mean that the NHS is forced to enter, in some way, into the political fray. As we will see it does this in a particular manner that highlights the difficult position that it has been led into. The review of the literature indicates that local initiatives to reduce health inequalities may encounter pressures to expand horizons of activity, in order to take into account the links between health and wealth. Counter pressures, for instance to keep NHS activity politically neutral, are also likely to operate. This might lead to either frustration or to less ambitious work at the local level.

The imperative to ‘involve people in the policies that affect them’ is associated with the ‘new public health’, the Ottawa Charter<sup>95</sup> and now *Saving Lives*. The difficulty in helping people to be involved in policy development, whilst at the same time not referring to political organisation for fear of being politically partisan, is a problem that the local NHS grapples with and which the thesis seeks to investigate further.

<sup>95</sup> The Ottawa Charter is referred to in section 1.2 of this chapter, under the heading ‘The ‘new’ public health’.

## **Chapter 3 The Research Plan and Process**

### **Introduction**

This chapter outlines the research design used to investigate the inquiry's hypothesis. The hypothesis, described in the introduction, is that broad political considerations, issues and tensions in the Labour Party and government, concerning aspects of the 'wider determinants of health', played a role in affecting the pattern and speed of local implementation of the policy to reduce health inequalities. The hypothesis was set in context by making comparisons with the factors that were found to affect the implementation of previous public health policy (LSHTM, 1997).

The chapter, firstly, looks briefly at the relationship between the methods chosen and the epistemological and theoretical background to the study. Then discussed are the pros and cons of a case study approach within the field of policy implementation studies. The particular case study area is described along with research access issues. Following this, the research design and methods are outlined. The methods discussed are: in-depth interviews, participant observation and documentary and data analysis.

Whilst the approach adopted relies primarily on qualitative data collection, the author would concur with the social science literature that questions both a neat fit between quantitative methods and empiricism, and that which rules out an empiricist use of qualitative data (Bryman, 1984; King, Keohane, Verba, 1994). Data, be they qualitative or quantitative, may be used in different ways. They may be allowed to speak for themselves and tell us 'facts', an approach associated with a positivist or empiricist orientation. Or they may be placed within a theoretical framework and interpreted by means of some rules of logic, in order to provide varying degrees of foreknowledge (Eckstein, 1975). Alternatively, there is a relativist or post-modern approach that claims, to a greater or lesser extent, that all 'facts' and descriptions are open to interpretation and there is no one correct view of what has happened, is happening, and will happen. Here the author treads a path, as May (1997: 15, 136) and others advise, bridging the extremes of positivism and post-modernism. One advantage of looking at research from divergent epistemological perspectives is that it may sensitise us to questions surrounding the validity of the research methods

selected. A positivist perspective would be concerned to question thus: ‘Can we trust a single case study? Can we trust these open-ended interviews?’ And a more post-modern perspective might ask: ‘Can we trust these policy recommendations, based as they are, on ‘ruleful’ assumptions?’.

As advised by, among others, Clyde Mitchell (1983), Eckstein (1975), Hall, Land, Parker and Webb (1975) and Pollitt et al (1990), the case study approach needs to start with a preliminary theoretical framework. This has been developed in the preceding chapters. Pollitt et al (1990: 179) suggest that initially, and in practice, this process can mean a rather general movement towards establishing relevant concepts. A somewhat similar and iterative process occurred in developing and undertaking this research. Acheson’s (1998) terms - ‘upstream’ and ‘downstream’ - and *Saving Lives*’s split in responsibilities between local people and national government, coupled with missives to involve local people in factors affecting their health, suggested a paradox that theories of democracy and power might help to unpack. At the same time these and related theories suggested the need to investigate local institutions, values and democratic models that might have been sidelined without the theoretical signposting.

## **A Case Study Approach**

Whilst a single case study, focusing in depth on opinions and events in one geographical area over a five-year period, is a legitimate and appropriate method for considering the thesis’s research question, it is not the only approach that might have been adopted. It was taken with the knowledge that it might complement other research. It was not designed to be the only contribution to the field, as others have, for instance, done surveys (Benzeval, forthcoming). One of the interviewees in this case study, by coincidence, had replied to her questionnaire of 2000, administered by Queen Mary’s College, University of London. Multiple case studies have also been conducted over shorter time-spans (Exworthy and Powell, 2000). The pulling together of a series of complementary and comparable case studies into a meta-analysis can successfully move us towards the Popperian criteria of results being replicable and generalisable (Popper, 2002).

Attention to contextual material is recommended, this enhances comparability, and legitimate claims can be made of being able to move beyond 'situational relativism' (Pawson and Tilley, 1997: 22). The features of the case study area are described in a separate section below. A number of features in the study area are taken into account, for example, that it is an inner-city area that attracted HAZ funding. It may be suggested that, for various reasons, NHS professionals working in Labour voting areas are more likely to espouse egalitarian values than their equivalents in Conservative voting areas. Further research would be needed to test this view; and it does not mean that the results are not generalisable to geographical areas more relevant to the policy under investigation.

'Realism' in social science (see for example, Keat and Urry (1975) and Sayer (1984)) attempts to overcome the problems of both positivism and relativism. In lay terms, it does not accept that immediate observable empirical data is the only reliable source of evidence and the only way to reveal causal processes, but at the same time it wants to be able to produce a hierarchy of truth which is grounded in reality. To do this it emphasises 'theory' and 'context'. The author endorses the view that a rigorous account of theory and context can help in elucidating realities that are less than immediately observable but which, nevertheless, make sense as fact. The methodological problems posed by positivism and relativism may not entirely disappear as they might also be applied to the contextual and 'beneath the surface' factors themselves. But the increased role of context and theory in research methodology, as exemplified by Pawson and Tilley (1997) and Chen and Rossi (1989) (see also, Magee, 1985: 22), is applicable to case studies and helpful in enhancing their value.

"The realistic explanation of programs involves an understanding of their mechanisms, contexts and outcomes, and so requires asking questions about the reasoning and resources of those involved in the initiative, the social and cultural conditions necessary to sustain change, and the extent to which one behavioural regularity is exchanged for another." (Pawson and Tilley, 1997: 154)



An attempt has been made to follow the research values inherent in this statement, in particular by asking questions about reasoning, and, social and cultural conditions. The theoretical base has not simply been applied to assessing the inputs and outputs of a programme but has attempted to set up and test an explanation of processes and in doing so the study's design was altered, for instance by the inclusion of local councillors among the interviewees (Chen and Rossi, 1989).

Case study methodology developed from ethnography and social anthropology, used to analyse human behaviour in context. According to Yin "...you would use the case study method because you deliberately wanted to cover contextual conditions – believing that they might be highly pertinent to your phenomenon of study." (Yin, 1989: 13). And it would be used when "the boundaries between phenomenon and context are not clearly evident." The way in which the research question has been posed makes good use of this facet of the case study method.

The questions asked need not dictate the method adopted (Bryman, 1994). Having said this, decisions to concentrate on particular aspects of the data available were taken with the knowledge that these were areas that surveys, for instance, might find more difficult to determine accurately. Whichever method is chosen must be explicit, as it can affect the data. Here an unusual opportunity was presented to work in this way (Yin, 1989: 40) and this also contributed to reasoning that the method was appropriate.

The case study approach should, according to Yin, employ a variety of different methods for empirical data collection (Yin, 1989: 8, 92). "Any finding or conclusion in a case study is likely to be much more convincing and accurate if it is based on several different sources of information..." (Yin, 1989: 92). The present researcher used participant-observation, in-depth interviews, documentary analysis, and participant-testing or action research (described below). This represents a form of triangulation. Triangulation of analytical models is exemplified by Allison's 1971 study of the Cuban missile crisis, in which he uses three different models drawn from political science in order to interpret the same events. This is also an approach that the author has attempted to draw on in theoretical discussions in chapters 1 and 2, although the data are not systematically analysed from three perspectives.

Decisions on which case study area to pick need not focus on what is likely to be the most representative of cases. Hakim (1987: 63) describes ways in which typical, deviant or critical cases may be of use. Here, the particular case may be regarded as typical of areas significant to the policy implementation under investigation.

The case study may also vary according to whether it is exploratory, descriptive or explanatory (Yin, 1989: 4). According to Hakim: “ ..special effort is required to achieve the intellectual rigour of an explanatory study, and case studies can all too easily slip back into being descriptive and exploratory in the main.” (1987: 72). In this study the author has provided an exploratory account of developments and attempted to explain particular aspects of the implementation process. If recommendations for future actions, based on assumed values, are to be made, then some forecasting based on predictions of regularity is required (Eckstein, 1975: 88). A purely exploratory or descriptive account on its own is less helpful in this task, while provision of some rationale for the observed phenomena will mean that prediction becomes more feasible.

In *Change, Choice and Conflict in Social Policy* a series of case studies showing policy innovation, development and reform are described. The conclusions drawn from these studies include “certain propositions about what determines the priority that an issue attains.” (Hall, Land, Parker and Webb, 1975: 476). The propositions include: legitimacy, feasibility, support, association, trend expectation, origin, information, and ideology. These provide a wide framework within which to consider the determinants of health inequalities policy in inner-London.<sup>96</sup> An assessment of factors at play while the policy was being developed may point to drivers and blocks likely to continue into implementation. This is particularly so as policy often develops further once implementation starts, as was very much the case with the policy investigated.

<sup>96</sup> In one of the case studies the events and circumstances preceding the Clean Air Act, passed by the British parliament in 1956, are outlined. The conclusions of the case study investigation are related to Hall et al’s overall framework. For example, the issue of clean air was in an ‘acutely competitive position’ (p. 381), not least because available technical solutions and information pointed to the need for reformed housing design, but post-war housing demands were for simple and rapid expansion. An ideological brake on further legislative controls was also being promoted by the then Conservative government. The act eventually got through because it was legitimate, feasible and had strong support.

The policy considered here appears to have been founded on the strengths of legitimacy, key support, trend expectation, origin and ideology. This is because it was associated with a twenty-year build-up of academic interest, research practice, central and local political ideology and administrative experience. However, problems still remained which primarily related to information and feasibility, but also drew out specific issues within the category of 'support'. The questions and observations regarding local implementation developments sought to assess support and, related to this, opinions and ideologies regarding feasibility.

An important research study in the USA (1971) builds on the above criteria. Crenson's analysis involves two detailed case studies and investigates opinions related to the "issue-ness" of air pollution. The subjects were 'leaders' – from mayors to local labor council presidents - in 51 American cities (Crenson, 1971: 32). Crenson discusses the extent to which data from these interviews can be taken as evidence. But for our purposes, the interest is that he was assessing not only what their opinions and influence helped to make happen, but also what this cocktail prevented from taking place. Certain people and institutions, and certain combinations of people, policy and institutions, it was held, had the power to enforce inaction (p. 33). Similarly, Bachrach and Baratz (1962) strongly suggest that the 'issues' kept off a public agenda are as important as those placed on the agenda for discussion.

Stephen Lukes, in *Power: A Radical View* (1974), refers to Crenson's study as containing "certain elements of the three-dimensional view of power" (p. 60), which Lukes's book describes. Lukes is concerned with possible bias in the way political agendas are controlled, and with methods deployed to suppress latent conflict. This is a potentially treacherous line of enquiry, criticised by Polsby (1963), since it involves assessment of things that did not happen. However, Crenson's study uses a comparative approach, which has been widely accepted as useful (Hill, 1997a: 40). This is because it allows factors present in some geographical areas, where policy implementation moved faster than expected, to be noted against those processes and institutions that were different in the sluggish implementation areas. Crenson's research thus empirically supports Lukes's theory. The research design does not explicitly seek to further validate Lukes's theory. As outlined in chapter 1, the author

used Lukes's theory for planning the research, in that it provided for the possibility that certain 'activity' and processes may be unfolding, which can easily be overlooked.<sup>97</sup>

### **Case study area and key service components**

The case study concentrated on aspects of policy implementation in the London Borough of Lewisham. This was part of Lambeth, Southwark and Lewisham Health Authority (LSLHA) until 1st April 2002. On this date the health authority was officially disbanded and the six primary care groups of Lambeth, Southwark and Lewisham (LSL) became three primary care trusts whose boundaries were coterminous with those of the local authorities. The health promotion department continued to work across the three boroughs of LSL after April 1st 2002, a situation that, as will be seen in chapter 4, caused some local friction.

In 2001 the second 'Lewisham health profile' was produced by a partnership of council and NHS public health and health promotion staff. This was an update of a 1996 document containing population and health statistics. It also provided more information relating to the 'wider determinants of health' than its predecessor and gave some information on 'partnerships for health improvement and regeneration'. The initial meetings to plan the 2001 document were more ambitious in their aims to link health with its wider determinants. Nevertheless, there is a perceptible change in character between the two reports. Given the previous discussion on Labour's public health policy in the 1970s its full title is of interest: *The Health of Lewisham – everybody's business* (THL).

Lewisham's population in 2001 was approximately 242,000 (THL, 2001: 6). The index of multiple deprivation score (IMD)<sup>98</sup> shows that sixteen, out of twenty-six wards in the borough lie in the most deprived 20 per cent of wards in England. Lewisham is the eleventh most deprived borough in the country (THL, 2001:9). The age profile is comparatively young (THL, 2001:6). "It is estimated that 69,500 of

<sup>97</sup> One example, picked up in the interviews, being, 'non-activity' in recruiting Labour Party members.

<sup>98</sup> "The Index of Multiple Deprivation [IMD] score, developed by the Department of Environment and Transport [DETR], is a composite of seven components called domains [child poverty, access, education, employment, income, housing and health]. The higher the domain score the more deprived the area." (THL, 2001:6).

Lewisham's total population (28.7%) are of black and other minority ethnic origin, for England and Wales the figure is around six per cent." (THL, 2001:6). New census data were released in 2003, which showed a similar picture (Wallace, 2003).

Those services and partnerships associated most closely with work to reduce health inequalities were: the Healthier Lewisham Partnership, the LSLHA, the health promotion department, the local authority, the NHS community health trust and the other NHS trusts, the voluntary sector and, from 2002, the primary care trust. As will be seen below, all these parties in the 'governance network' (Rhodes, 1988) have been included in the data collection processes.

## **Research Access**

Having commenced employment within the LSL health promotion department in March 1997 the present author was well placed to conduct the study from the perspectives of participant observation, local documentary analysis, in-depth interviews, informal questioning and follow-up questioning.

Permission was not explicitly sought to conduct participant observation for a number of reasons. Firstly, the research strategy did not require any information of an individual or professionally sensitive nature that would reveal the identities of associated actors to be included in the writing up of the report. Secondly, given the partnership nature and changing membership of many of the meetings that were the subject of participant observation, a genuine attempt to gain agreement of all those involved would have been too disruptive to the business in hand.

These guidelines would clearly not apply in other participant observation scenarios. It was believed that the research findings could easily be reported so as not to cause any personal damage or offence. Moreover, this would not require self-censorship that would interfere with the accurate presentation of findings. In other research situations the best method of obtaining data may also be classed as unethical and therefore ruled out. However, in this case no real problems of this nature were envisaged. In 1999 the author enquired as to whether NHS ethics committee approval for the research was

required, she was informed by the local NHS research manager that it was not (see appendix 3.1).

Furthermore, whilst not a justification for more covert participant observation, the intention was only to report on those processes that would legitimately be considered to be within the public domain. It was fairly open and common knowledge that the research was being conducted and it was not a secretive operation. It is also the case that to break from ethical considerations would be damaging to future employment opportunities within the local NHS. This is not to say that the substantive content of the thesis is altered by considerations of future employment, but simply that presentation of the main findings is not restricted by the need for confidentiality. The possibility of conscious or unconscious researcher bias must be considered and may have inadvertently operated in some form within the thesis production. Again, the formal processes of methodological openness are one attempt to mitigate against the pressures of unconscious bias. An awareness of and deliberate attempt to overcome potential factors, such as professional association, has been a focus of attention. But it is also the case that some pressures that might result in bias were not present. For instance, state or business commissioned studies may be pressurised to play down policy recommendations known to be at odds with government or company thinking (an example is given by Crenson, 1971).

## **The research design**

The research questions specific to this implementation study were, in part, influenced by the research opportunity offered. This is a situation that might be regarded as luxurious by research workers contracted to provide reports for institutions such as the health service, charitable bodies and trade unions.

The plan was to trace the progress of government strategy when it arrived 'on local desks' and was placed in staff briefs and on the agendas of local organisations. This would provide a unique perspective on the factors influencing progress at the local level. Participant observation would provide a crosscheck on interview reports. Government policy to reduce health inequalities reached the case study area in different forms, but broadly speaking it was as White Papers, NHS directives and

local government directives. 'The implementers and their work' was a complex and constantly changing target for research. To detail all the aspects of work on the subject and its evaluation was beyond the scope of the study. The decision was made therefore, to concentrate on specific aspects of implementation, including the development of local targets and strategy, actors' beliefs, and relations with non-NHS forces shaping public participation.

The time period 'in the field' was extensive (March 1997 to July 2003) and therefore a number of phases of implementation could be discerned. The research design was able to respond to these new groups and structures. As will become evident in later chapters, the plans for target setting and strategy development constantly evolved and observation moved with this situation.

## **The research methods**

Further details on the key methods employed will now be provided.

### **In-depth interviews**

Thirty-seven, in-depth semi-structured interviews (May, 1997: 111-113) were conducted with a range of key staff responsible, in various ways, for the process of policy implementation. Interviewees were chosen in order to gain as wide a perspective and range of opinions on the process as possible. Interviewing continued until the researcher was satisfied that no more broad perspectives, representative of local work cultures, would be acquired. Those interviewed included: public health department staff, local authority staff, voluntary sector staff, local councillors, trade union officials, and non-public health NHS staff. In each department more than one interview was conducted in order to widen the range of opinions identified.

The interviewer shared a general remit for work on the topics discussed at the interviews with many of the key interviewees. This poses potential hazards since it may be suspected that under such circumstances interviewees could tailor their answers to fit what they felt were the views of the interviewer. Care was taken to try to avoid this problem. Firstly, the work site was separate from the locality of the research subjects. The health promotion unit where the researcher was based was in

Southwark and the field study area was Lewisham. Therefore, the author's connections with the staff interviewed in Lewisham were mainly limited to formal meetings and the majority of interviewees were people who the author had not met previously, at least outside of formal settings. Secondly, the interviews were conducted relatively early on in the researcher's attachment to Lewisham. Thirdly, the staff member that the author worked with most closely was not interviewed. The impression was gained that interviewees did not know what the researcher thought about the topics in question, as many of them asked at the end of the process what the author's views were.

All those interviewed were informed by letter about the nature of the research. It was decided that assurances of confidentiality would generally assist the confidence of interviewees in providing more 'honest' responses.<sup>99</sup> Therefore, this was put in writing to all interviewees, aside from the 2 mentioned. Some then volunteered, without this being requested, that the interview need not be treated as confidential (see appendix 3.1).

Details of the interviewees are listed in figure 3.1. In order to maintain anonymity, job titles have been merged in the reporting of the data in chapters 4-6. Thus, while 3 chief executives (2 NHS and 1 CHC) and 2 chairs (1 PCG and 1 health authority) were interviewed, all of these have been reported as 'chief executive (NHS)'.

In line with elite interview techniques, the interviews progressed flexibly (Dexter, 1970). A series of topics comprising of five broad issues guided the interview process. These were: 1. introductory issues: personal context, changes in importance of the issue, success or otherwise so far. 2. target setting locally. 3. national and local balance of responsibilities and effects of actions. 4. public involvement. 5. redistribution. Twelve questions were developed in order to prompt discussion on the topics (Appendix 3.2). Discussion was allowed to digress and to focus on areas of importance to the interviewee. Given the specialist roles of interviewees the same questions were not posed in the same order in all interviews and some questions were dropped. For instance, some questions on NHS target setting would have been

<sup>99</sup> The mayor of Lewisham's letter stated that he would be identified in the thesis. The letter sent to Sir Donald Acheson prior to the interview did not say that the interview would be confidential.



inappropriate for use with local authority and voluntary sector staff. And some specific questions were asked of councillors.

The topic areas might have been raised in a more unstructured manner with no recourse to specific predetermined questions. However, in this instance it was considered that a semi-structured process, containing elements of both open interview techniques and more formal procedures, was appropriate. The reasons for this approach were, firstly, opportunities to assess interviewees' general concerns were more available in a less formal arena. Secondly, the research question pointed to a need to raise issues that were not necessarily part of the normal content of local discussions on the subject. Therefore, it was considered that specific interrogation to obtain views would be needed. Unless particular questions had been asked about the Labour Party and the trade unions, for instance, it was anticipated that these areas would not have been raised. The impression was that interviewees did welcome the 'permission' granted, by the asking of specific questions, to talk on subjects related to the area they were working in, but outside the normal content of professional dialogue.

Interviews lasted on average 60 minutes, with some lasting 90 minutes. All interviews were transcribed within three weeks of the interview date. Transcripts were sent to some interviewees for clarification, to check errors, and for elaboration. Informal follow-up of points raised was possible with other respondents. One interviewee was used as a key informant and was interviewed last. The informant's views on others' general anonymised responses were discussed for cross-checking and validation.

Opportunities were taken in conferences, seminars and meetings to ask questions of the Minister for Public Health, local members of parliament, councillors, senior NHS and Department of Health staff, trade union officers and general practitioners not formally interviewed.

Observation and questioning of staff from groups not specifically represented within the interviewing programme was also undertaken. In particular health visitors, district nurses, school nurses, an environmental health officer and a trading standards officer were questioned.

**Table 3.1 Categories of Interviewee**

<b>Title provided in thesis text against quotes</b>	<b>General titles included in this category<sup>100</sup></b>	<b>Sector</b>	<b>Number of interviewees</b>
Health promotion worker	Health promotion manager Health promotion specialist	NHS health promotion	2
Senior manager (NHS)/ Senior practitioner	Public health specialists HAZ senior workers Staff employed in public participation roles Members of the Healthier Lewisham Partnership Board	NHS health authority	7
Director of public health/consultant in public health	Consultant in public health Director of public health	NHS	2
General practitioner	General practitioner	Primary care	1
Chief executive	Chief executive Chair	NHS/CHC	5
Community development worker/voluntary sector worker	Community development worker	Voluntary sector, joint local authority/NHS post	7
Local authority officer	Middle management/senior management – partnerships	Local authority (London borough of Lewisham)	3
Councillor: ‘New’ Labour, ‘Old’ Labour, <sup>101</sup> Socialist Party	Councillors	Local authority	4
Steve Bullock	Lewisham Mayor	Local authority	1
Trade union official	Trade union official	Trade union	2
Civil servant/senior manager (NHS)	London Region (NHS) and DoH officials	Civil service	2
Sir Donald Acheson	Former chief medical officer. Chair – Independent Inquiry into inequalities in Health	Academic. Former civil servant.	1
Tessa Jowell (telephone interview agreed but not arranged)	Former Minister for Public Health	Government Minister	(1)
<b>Total</b>			<b>37</b>

In order to look at the local implementation process there is a need to uncover: “Who the *dramatis personae* were, [their social relationships,] what they did and how they reacted to the events in which they were involved.” (Clyde Mitchell, 1983: 204). Some contacts for in-depth interview emerged in the course of participant observation.

<sup>100</sup> Where unique titles exist, broader descriptions are provided.

<sup>101</sup> The aim was to interview councillors from the right and left of the party. A contact with knowledge of the local party identified the interviewees.

Twenty of the 37 interviewees were women. This reflects the position of women in NHS public health and community health management positions in the borough. Five interviewees were of African or African-Caribbean origin and three were from other minority ethnic groups. As with the gender balance, no specific attempts were made to interview staff from minority ethnic groups. Work roles, followed by availability, were the deciding factors.

The social class background of the interviewees is assessed here only on the basis of unsolicited comments made at interview or in post-interview chatting while sharing car or train journeys. On this basis, eleven interviewees came from backgrounds where one or more of the following factors existed: father in manual occupation, lived in council house, brought up on low income. A further eleven came from backgrounds where father was teacher or businessman, went to private school or was “middle-class”. The class background of the remaining interviewees was not ascertained. Whilst the choice of interviewees was not organised to acquire an average profile of workers from the employment sectors concerned on the basis of gender, race and class, in the event the distribution was fairly representative of the local staff profile.

Some questions asked at interview depended on the special experiences of the interviewee. Thus, there was little to be gained in focusing on the topic guide section referring to the details of target setting in discussions with community development workers or local councillors. Other areas concerning income inequalities and trade union involvement were asked of all respondents. In the course of discussion the particular concerns of interviewees were allowed to develop. Prompting also took place where it was felt that less than full answers had been given.

### **Participant observation**

The researcher was employed as Business Manager at the health promotion department for the case study area in March 1997. The role initially involved working as part of the department’s senior management team on areas such as budget management, marketing, building refurbishment. However, given the post holder’s previous experience and reorganisation within the department, the role developed to take on a broader health promotion management remit. Part of the new role of the post was to be a ‘borough link’. This was an innovation for the department, made in

response to the gradual move towards trust status of the six primary care groups within the three boroughs: thus in 1999 three of the five senior managers became 'borough links'. The post of Senior Manager, health policy and business, which the Business Manager's role had developed into, became the Lewisham link. This meant the post would be responsible for working with the Healthier Lewisham partnership, of which the health promotion department was a part, and acting as a conduit for information flowing between the department and the borough. Since the Healthier Lewisham partnership was widely recognised as the most likely body to take the lead responsibility for raising the profile of health inequalities work in Lewisham, this presented an ideal opportunity to follow through new national policy implementation in a local setting.

Participant observation took a number of forms. Firstly, some observation was 'simple', that is "passive unobtrusive observation"; for instance, in the recording of early Primary Care Group board meeting discussions (Robson, 1993: 159). Secondly, some observation was of a more participatory nature. The 'Lewisham link' work involved sitting on a planning group for the organisation of a health inequalities conference and on a post-conference sub-board. Here the researcher was able both to observe and interact with colleagues and to experience first-hand the issues facing local staff when they come to attempt to follow through government policy. Thirdly, the researcher was able, in the course of work, to ask a range of staff informally for their opinions and to discuss aspects of health inequalities work.<sup>102</sup> Fourthly, opinions expressed in informal settings, in corridors, making tea and coffee, travelling to meetings and in social settings provided occasional confirmation of previous observation and a context to the work. Finally, opportunities to attend academic seminars and London public health network conferences on the topic of health inequalities were occasionally provided to the staff of the health promotion unit. The researcher attended some of these in a work capacity and at others colleagues took notes or made tapes. Invitations to attend various other 'one-off' events were also sent to the health promotion department and taken up by the researcher. For example, she attended a session of the House of Commons health committee enquiry into public health, a briefing on the health remit of the new GLA and a Public Health Association

<sup>102</sup> For instance, staff came to the health promotion department for courses and one-day training events.

meeting with the Minister for Public Health, Yvette Cooper. This activity gave the researcher an invaluable 'feel' for the context, culture and salience of the issues being researched.

Striving towards objectivity in order to provide an accurate account of what took place may pose problems for the participant observer. Getting to like or dislike colleagues, having worries about employment opportunities, not wanting to let people down, and generally being 'too deep into the trees to see the wood', could all be problems within this research method. However, there are a number of advantages, the following two being key. Firstly, it makes the balance of concerns and issues for local staff easier to assess, even when compared with the picture gained from in-depth interviews. Aspects of local implementation that may simply not appear on interview topic guides or in questionnaires may also present themselves. Secondly, researchers not using participatory methods are still at risk of being influenced by prevailing opinion within work settings in a way that detracts from being open to understanding the nuances of the local setting.

The local forums within which decisions on health inequality reduction and strategies to achieve these target reductions were made, were as follows:

- North Lewisham PCG board meetings

- South Lewisham PCG board meetings

- Lewisham PCT board meetings

- The Healthier Lewisham partnership board steering group

- The Healthier Lewisham partnership board health inequalities sub-group

- The health authority's HimP sub-group on health inequalities (covers Lambeth, Southwark and Lewisham)

- The Lewisham HimP group

- Health authority board meetings

- The Lewisham PCGs public health workstream

- One-off, ad hoc meetings.

Although observation was semi-structured, the intention was to pay particular attention to the areas listed as follows. In practice, this list can be organised under the topics of the interview guide.

*a. Targets.*

Every discussion referring to health inequalities targets was of particular interest as the requirement for local areas to set their own targets immediately posed difficulties for local implementers.

*b. Evidence of beliefs on the links between income and health inequalities, and of the relative importance of national work compared to local work.*

This was a key theme of the interviews, and observations provided a cross-reference, validating and enriching the interview data.

*c. Links with local elected politicians and taking issues to elected politicians (MPs and councillors).*

Any mention of local politicians was noted. References normally related to getting politicians to conferences and having photographs taken with them. In the course of 6 years the number of unprompted individual references to local politicians observed in public health, health promotion, primary care and interagency settings was less than 10.

*d. Strengthening participation in the political process.*

The reason for observation of points *c* and *d* is because of concern to note support for public involvement in influencing the upstream and downstream causes of health inequalities.

*e. Linking with national public health organisations.*

This point is derived from the previous analysis of public health history, where professional lobbies were correlated with changes in public health practice. The reasoning associated with points *c* and *d* is also pertinent.

*f. Training for staff on health inequalities issues.*

This was taken as a general measure of commitment to, and understanding of, the need for changes in practice in order to address the policy issues. Given the aim of improving public health capacity, outlined in *Saving Lives*, developments in public health training were anticipated. These were not evident until 2003; when funding

was made available for health impact assessment, project management and change management training.

*g. Similar issues to those described by Loney in relation to the CDPs (Loney, 1983).*

That is, statutory concerns over the 'politicisation' of community development work, as well as frustrations among community development workers about their remit.

*h. Inter-borough disputes on funding distribution and concerns and pressures resulting from funding issues.*

Given institutional changes and a new work remit, it was considered likely that issues regarding finance would arise. The extent to which financial concerns blocked progress was monitored.

*i. Staff workload pressures.*

Again as in point *h*, this issue would be likely to mean delayed or distorted implementation.

*j. Reduction of action on inequalities to 'allocation of care' issues. For example, GP protocols on treatment of chest pain.*

Given the change in emphasis noted in chapter 2, in the move from Green to White public health paper, that is, an increased focus on secondary prevention, this item was considered worthy of observation. Hall et al (1975) refer to the importance of competition between different policy priorities. The competition between primary prevention and secondary prevention, bordering onto acute care, is a central conundrum of modern public health practice.

*k. NHS staff involvement in issues affecting the wider determinants of health.*

Work involvement was noted, and this was most informative in providing information on what projects were being invested in, from a time and financial perspective. For example, knowledge of funding for work on warm homes and energy efficiency, and staffing allocated to this area, was ascertained from agency work plans and events, rather than from observation at the level of individual conversations.

*l. Evidence of staff views on the relationship between wealth inequalities and trade union organisation.*

See point *m* below.

*m. Evidence of staff views on the role of local and national Labour policy affecting inequalities.*

Points *l* and *m* were issues that were part of the interview topic guide. Any 'natural' occurrence during the participant observation was to be noted. With regard to *l* none occurred within the 6 year period. As far as *m* goes few comments specifically on Labour policy affecting inequalities or redistribution were observed. In some meetings discussions on poverty took place and these have been reported in the text. But these issues were not discussed much when staff across the organisation were socialising. As the interviews indicate, this does not mean that the same people did not have opinions on the subject.

*n. Evidence of participants and forums being controlled in order to minimise dissent.*

This concern arose from a reading of Crenson (1971) and Lukes (1974). Some examples of this activity is provided in chapters 4-6.

*o. Evidence of grappling with the difficulties of the subject.*

As has been noted in discussion on Hall et al (1975) 'feasibility' was seen as a potential block at the local level; thus the concern to monitor this point.

*p. Conflict in prioritising between inequalities in health caused by either inequalities in income or disadvantages associated with minority ethnic group membership.*

A recommendation to address health inequalities associated with minority ethnic status was included in the Acheson report (1998). This area did not necessarily generate conflict. However, given the general confusion as to where to begin work to reduce health inequalities, this added dimension was likely to create more questions as to the correct priorities. The extent to which income inequalities are the cause of inequalities in ethnic minority health status is analysed by Nazroo (1999). The researcher was interested to observe whether debate within the academic field was mirrored at the local level.



*q. Other issues arising, which were not anticipated but were considered to be relevant to the research topic, were noted and included in the analysis.*

This was a particularly important point. Subjects of relevance that had not been preconceived in planning the topics of interest to observe were noted when they arose.

Pre-interviews and post-interviews observation concentrated on firstly, building-up corroborative evidence to show that the interview topics were credible and of sufficient research interest. Secondly, it added additional sources and reconfirmed opinions expressed in interview. No new discrete staff opinions were encountered post-interviews, but the weight and richness of the data was enhanced. The implementation environment and reaction to new policy elements continued to unfold, intensifying certain findings and causing others to become less significant from a staff, if not a research, perspective.

### **Documentary evidence**

All the relevant local documents were easily accessible to the researcher. Minutes of certain meetings such as the health authority board were circulated to the health promotion managers as a matter of course and national policy was also made available to staff.

Local policy documents, minutes, monitoring submissions, the local health improvement programme and the Lewisham community plan are among the documents studied. This documentation was a source of factual information and gave a perspective on priorities within the borough. Policy documents in general had a tendency to show a side to the work that was 'confident', 'professional' and 'in control'. The researcher also witnessed some of the debates, disputes, uncertainties, confusions and frustrations that lay behind many of these local public documents.

Minutes of meetings were used as factual records and reminders of attendance. Although, participant observation of meetings often revealed more of a picture of the feelings of the agents involved and their doubts about how to proceed, that went beyond the formal minutes. Local documentary evidence was reviewed for its key features and linkages with other sources of data. However, no formal content analysis was conducted at this stage.

Some comparison has been made throughout the research with developments in the London boroughs of Lambeth and Southwark. This has been achieved by a review of key documents, for instance HimP development. However, informal inquiries and updates from within local public health and health promotion sector, where many colleagues worked in the two boroughs was the main source of information. Whilst the characters involved were different in each area, a broadly similar pace of progress was noted; although it might be argued that in 1997 Lewisham started with and maintained a lead, in relation to the sophistication and effective functioning of its health partnership structures.

A close review of the national documentation such as the Green and White public health papers (1998, 1999 respectively) was undertaken using an informal content analysis approach (Berelson, 1952). Firstly, the documents were read to gain an overview and a perspective on how they related to the research question. With this general knowledge of the documents' contents, a broad list of headings was drawn up, including such features as conceptions of health promotion, that is the 'medical model' and the 'new public health model'; fit with New Labour strategy; local role - national role; and, role of income inequalities. These headings related to themes noted in the general reading, and issues known to be of relevance following a reading of public health history outlined in chapter 2. The headings assisted in the identification of examples of text that matched the categories' subjects. Picking out quotes from the text which related to the subjects chosen helped in developing a thorough knowledge of the policy and in formulating the interview questions and observation points.

## **Analysis of the data**

The interview data was analysed at a number of levels. Firstly, as referred to above, within the interviews themselves, additional probing on points considered to be of particular interest meant that data were being actively sifted, prioritised and in some senses informally analysed even at that stage. Secondly, the themes and headings through which the data were coded were, in part, generated both by a later reading of the transcripts, and by the researcher's mental sifting of what respondents had said, which, throughout the process of interviewing, transcribing and initial analysis

remained in active memory. The fact that the environment within which many of the interviewees operated was known of, in a professional sense, to the researcher prior to interview possibly meant that what they said was more vivid and easier to remember than where interviewing takes place on the basis of, for example, a random sample of survey respondents.

A gradual process of theme development, coding and theme refinement took place in reading the transcripts. The themes to emerge as practical headings were broad and seemed to divide most easily into three: 1. Administrative issues, practical barriers, 'rowing' tensions.<sup>103</sup> 2. Values, philosophy, principles, ideas, 'steering' tensions. 3. Speed of change, assessing change, achievements, impacts, implementation and evaluation tensions. This is probably because the interviewees tended to divide responses into what affected their individual jobs, what their own beliefs were about the issues raised, and how they saw general developments in the work at the local level. To some extent this tripartite division has been mirrored in the writing-up of the findings. However, the headings picked out in *Saving Lives*, those chosen for observation and the interview topics, also shape the themes picked out from within the three-way division of the interview data.

The number of sub-headings under these themes became very long, at thirty, twenty-two and fourteen respectively. After coding five transcripts using all the sub-headings it was considered that the process was becoming unnecessarily complex. The remaining transcripts were coded only according to the main themes and exemplary sub-code issues were highlighted.

In writing about the interview data, in chapters 4 to 6, some reference has been made to quantitative values. Information on the relative numbers of staff in different sectors describing particular views is given. Whilst the interview sample is not statistically significant, the respondents were considered to represent the range of local staff influencing the implementation process. Therefore, the balance of views within the interview group is of interest in the analysis. However, at the same time, even if one

<sup>103</sup> The distinction between 'rowing' and 'steering' is made by Osborne and Gaebler (1992). Rowing being generally associated with the work of local agencies performing duties that they are instructed to undertake by government departments with strategic objectives who steer the work. Here, their metaphor has been adapted to use solely at the local level and 'speed of change' has been added.

interviewee held a view that no other respondent shared, this view might hold sway and be of more influence because of the power and alliances of the respondent. This is why the context to the interview data is important in deriving implications.

Grounded theory (Strauss and Corbin, 1990; Glaser and Strauss, 1968) was not employed in a comprehensive manner for the start of the study. The data gained was analysed using previously considered theoretical guides and concerns. However, the recommendations of grounded theory were taken into account in that, theoretical interests were “open to modification and challenge by the interview data analysed.” (May, 1997: 125). In analysing the data, techniques recommended to enhance rigour were adopted, for example, looking for opposites or extremes and making comparisons. The objective was to become sensitive to properties that would otherwise be overlooked (Strauss and Corbin, 1990).

Methodological debates have questioned the extent to which interview texts can be trusted to provide a ‘true’ representation of actions, events and beliefs (May, 1997: 128). Here the position is taken that some scepticism is required and that factors supporting bias need to be considered in order to assess the level of mis-reporting. However, the author can also envisage situations where statements of beliefs and understanding of events will, firstly, be a truthful reflection of the respondents’ current views and secondly, lead to future action based on these responses and beliefs. Therefore, the process, while open to question, is worthwhile. The factors potentially biasing responses in the interviews were considered to be: 1. The pressure to appear to understand and conform to professional policy, evidence, culture and rhetoric, based on both employment concerns and social concerns. 2. The need to have an opinion and therefore to respond with a varying of a depth of belief. 3. NHS acute sector concerns influencing thinking within discussion on public health. 4. The topical news of the day. 5. Linking to point 1, the need to justify work conducted post hoc, and the need to justify employment at the local level. 6. Other unknowns.

An explicit attempt was made to set interviewees at ease and to create a neutral atmosphere. The impression gained was that respondents said what they believed to be true and were not intimidated by any consideration of the interviewer’s views. However, this does not overcome the power of cultural pressure to conform to wider

professional and social norms. The interview data gives a view of directions of thought and a range of possibilities for action and change. They also provide a benchmark by which to assess other findings. They are not a 'signed and sworn statement' that cannot be changed by environmental developments.

## **Conclusion**

An ideal opportunity to observe the implementation of policy from aspiration to implementation was provided to the researcher by way of firstly, a new work role allowing participant observation in one London borough, and secondly, a change of government and consequent public health policy changes.

A theoretical framework was sketched out in order to direct the data collection towards an explanation of specific issues. A case study approach was adopted, firstly, in order to take opportunistic advantage of the opening provided by the researcher's position. Secondly, the case study method was thought to allow the broad context of implementation to be considered. The ultimate aim was to ascertain factors influencing the direction of implementation that might be missed by 'less contextualised' research.

In order to attempt to increase the reliability of the data and rigour, a process of methodological triangulation was adopted. Data from semi-structured interviews was considered against data obtained from participant observation on the same issues (Yin, 1994: 93). Within the interview and participant observation setting a conscious attempt was made to search for alternative perspectives, accounts and views that differed between each other. At every stage in the data collection and analysis process the researcher consciously attempted to look objectively at the information presented. Deliberately valuing a desire to find different views and values in the local setting helped this, along with analysis techniques referred to in this chapter (Strauss and Corbin, 1990).

Analysis of national documents both informed the development of the research focus and, as subsequent national policy was released, it was considered from the perspective of the key emerging research issues. The opportunity to remain for a

period of over five years in the same work environment provided temporal context to what, in particular periods, appeared to be factors of greater or lesser significance. For example, the Health Action Zone initiative seemed to be of greater significance in 1998 than in 2002. In contrast, the 'issue-ness' of health inequalities was sustained throughout the period, although it fluctuated at particular points.

Whilst all these factors helped to increase the rigour of the research, the account should still be seen as 'striving towards' reliability. An attempt has been made, in chapters 1 to 3, both to provide clear theory, emphasising the case study's context, and a full account of the research methods. The net has been tightened but holes remain, as they do in all research (Popper, 2002: 38).

With hindsight, aspects of the research process may have been altered and improved. Firstly, an even narrower set of research issues would have resulted in a more focused thesis. The author could for instance have structured the research more around the findings of *The Health of the Nation: a policy assessed* (LSHTM, 1997). Secondly, if the author had had prior experience of using NVivo or a similar software package for examining qualitative data, analysis of the interview data would possibly have used this tool. NVivo's use may ease and speed-up future qualitative analysis, but it is not thought that its use here would have increased the rigour of the process. Generally, the focus of the research was in part driven by the good opportunities available for data collection. Freedom from both the restrictions of collaborative programmes and the need to meet funders' requirements allowed for a particular type of creative autonomy in respect of the research subject.

The purpose of this qualitative research has been to produce an account that is reliable enough to build explanations and provide an exploratory and descriptive account. However, the possibilities of researcher bias, local interviewee distortions and the potential salience of deprioritised theory and observation means that these are explanations that should be seen as part of a broader academic programme and used as 'checks and balances' against other research generated by a variety of methods.

## **Chapter 4**

### **FINDINGS – INSTITUTIONAL CHANGE**

#### **Introduction**

The incoming government of 1997 initiated reorganisation of local NHS services. In so doing it demonstrated an apparent belief that particular structures and institutions exacerbated NHS difficulties, and that restructuring would relieve those difficulties. Government policy recognised in institutional arrangements the ability to shape and control staff action, which, in turn, affects service delivery. The then health minister, Alan Milburn, is quoted as saying in July 2001: “Unless you get the structures right, you won’t get delivery” (Eaton, 2001: 10).

The new institutions and structures dominating NHS public health work environments in Lewisham from 1997 were: two primary care groups (North and South Lewisham PCGs officially operated between April 1999-April 2002), one primary care trust (formed in April 2002), the health action zone, reforms in local government and health partnerships, and requirements to set and meet targets. Observations showed that these structural changes influenced the implementation of policy to reduce health inequalities. Over the five-year period, from 1997, work was slowed down by constant reorganisation. But by the sixth year the reshaping of institutions linked to public health departments resulted in, on balance, a position of increased strength for the discipline of public health within the local NHS. This chapter describes these developments.

Academics, politicians, journalists and members of the public from across the political spectrum are keen to understand the relationship between increased NHS funding and increased delivery. For many, money appears, in colloquial terms, to have been thrown at the service and to have disappeared into a ‘black hole’. When funding has been increased, an inability to demonstrate improvements within a relatively short time frame (for example, two years) is met with the speculation that money is being wasted on increased management. Some argue that the NHS is

unreformable and should be privatised. Explaining time lags in delivering change is thus crucial to the future organisation of the service and indeed, to the future of the welfare state in Britain. The chapter gives an insight into how policy implementation became delayed in the NHS, and provides a warning to those who make too speedy, and often negative, assessments of longer-term progress in meeting objectives.

New organisational structures might legitimately be seen as a key to understanding the implementation of the policy under investigation. However, notwithstanding their importance, the hypothesis is that the new NHS institutional environment should be seen within a broader political and values-based context that has also affected policy implementation. In order to decipher the boundaries between, and the comparative influence of, these different levers of change, it is necessary to firstly plot what is possibly the most straightforward component – the new institutional setting. To aid analysis of the implementation of government policy, itself apparently influenced by a structural and institutional perspective, this chapter describes the particularities of the new local ‘institutional arrangements for the provision of public services’ (Hood, 1987: 504; Rhodes, 1995: 52). However, the limitations of remaining within a descriptive institutional paradigm that underplays subjects’ behaviour and values should be highlighted (Dunleavy, 1982; Le Grand, 1997). The belief that particular reforms and the ‘modernisation’ of structures will improve delivery is based on assumptions and analysis of agents’ opinions and reactions (Hay, 1995). Government reform of NHS institutions also takes into account wider political imperatives and opportunity costs.

The chapter concentrates on observed institutional changes post-1997. In doing so it also juxtaposes these developments with the tensions of centralisation versus decentralisation and, to a lesser extent, with the ‘problem’ of income distribution. New Labour’s NHS restructuring was not primarily brought in to meet any pledges on public health improvement. As will be described, upheavals in the name of improved patient care were not always helpful to public health policy implementation. Before ‘values’ are placed centre-stage in the next chapter, consideration should be given to the extent to which institutional and administrative factors helped or hampered the progress of local work to reduce health inequalities. While supporting an approach that interrelates policy and implementation (Barrett and Fudge, 1981), itself



developed in response to a greater appreciation of the significance of agents' values, it is still necessary to assess the pressure of institutional structures on agents. Accepting that values will have influenced the historical formation of structures need not, of course, lessen the immediate power of institutions to impinge on and distort negotiation, planning and action.

The definition of institution used here starts with the "...general agreement that, at their core, [political] institutions are "the rules of the game" (Rothstein, 1996:145, brackets added). Thus, institutions will include, for example, the requirement to set and work to public health targets, the organisation of partnership bodies, the development of primary care trusts, new duties placed on local government, the requirement to publish health improvement and modernisation programmes and the reorganisation of NHS pay scales.

The chapter will consider how recent institutional changes have affected the extent to which local agents with a specific interest in public health can control the health improvement work-plan and raise the profile of action to improve health. It will look at the extent to which public health agenda setting is free from a medical dominance that drives health improvement measures towards secondary and tertiary prevention work. Also considered is whether the temporary nature and instability of prevention programme budgets has been addressed by post-1997 changes. All these features - control over agenda setting, freedom from medical dominance and budgetary stability - are elements to be considered in an assessment of the power of the public health interest in the new NHS. Have recent institutional changes strengthened or weakened this interest? What are the longer-term effects of recent institutional changes likely to be? These questions will be addressed in the course of this chapter.

The chapter takes the following form. Firstly, it describes recent change and stasis in the structures of NHS and other agencies with a role in public health policy implementation in Lambeth, Southwark and Lewisham (LSL). In doing this, the key institutions that impact on public health will be taken in turn. These are: the primary care groups (1999-2002) and trust (April 2002 onwards), the Healthier Lewisham partnership, the Health Action Zone and other initiatives, and the local authority. Specific work to address health inequalities within these institutions is discussed.

The work then reports on plans and targets, covering, *The NHS Plan* (DoH, 2000), the development of LSL's Health Improvement Programme (HimP) (LSLHA, 2001), the Lewisham Health Improvement and Modernisation Programme (2002) and the related target setting process. According to *Saving Lives* (DoH, 1999) the HimP was to be central to achieving the key aims of that White Paper (DoH, 1999: 125), that is, improving the health of everybody, and the worst off in particular (DoH, 1999: viii). The HimP was required to set out "locally-determined priorities and targets with particular emphasis on addressing areas of major health inequality". It was also to be a "vehicle for setting strategies for the shaping of local health services." (DoH, 1999:125). Local staff perspectives concerning HimP development will be considered.

Generally, the chapter will be looking at the extent and nature of local change resulting from the health inequalities policy first outlined in *Saving Lives*, and the impact of parallel organisational changes on capacity to address health inequalities. The likely sustainability of developments, their trajectory and main dependencies will also be considered.

## **Institutional Change**

### **The Development of Primary Care Trusts**

Whilst the House of Commons Select Committee hearing on public health (2001) concentrated on the problems and challenges within the discipline of public health, the extent to which work within the field has been distracted by reorganisation aimed at improved patient care should not be overlooked.

Prior to 1998, the establishment of NHS Trusts, via the National Health Service and Community Care Act of 1990,<sup>104</sup> had been the last major reconfiguration of NHS services. Ripples from this old policy were still influencing local service reconfiguration as PCGs (Primary Care Groups) were being introduced from 1998. For example, in that year two NHS trusts providing community services merged to

<sup>104</sup> The Act gave effect to the Conservative Government's White Paper *Working for Patients* (1989). See Klein (1995: 198).

create the Community Health South London NHS Trust covering Lambeth, Southwark and Lewisham. This was because the optimum size for a community trust had not been agreed in the initial stages of trust creation, in the early 1990s.

The formation of NHS trusts broke up district health authorities, with direct patient services and related administration being provided by acute, community and specialist trusts, and the remaining health authority staff purchasing or 'commissioning' services from the trusts and undertaking certain public health functions. Health promotion departments were sometimes retained by health authorities and sometimes moved into community trusts. In the case of Lambeth, Southwark and Lewisham the health promotion departments attached to the three respective health authorities were merged and retained by the merged health authority. At a later date this merged department was moved into one of the community trusts and renamed 'Health First'; the two community trusts then merged. Thus, between 1986 and 2002 a member of staff continuously employed within the local health promotion department, would have been paid consecutively by five different employers. This situation has been typical for tens of thousands of NHS staff. However, the impact of reorganisation on service delivery has varied. The 1998 transfer of 'Health First' staff from one community trust to a larger merged trust, for instance, had virtually no effect on health promotion service delivery. Previous mergers had disrupted LSL health promotion staff, led to job losses and a refocusing of services. Consequently, as consensus among these staff indicates, there was a short-term loss of service but longer-term service improvement.

Two reasons, different sides of the same coin, were given by the Conservative government for the creation of NHS trusts in the early 1990s. Firstly, a separation of the 'purchaser' from the 'provider' role would 'free providers to concentrate on delivery' (Bartlett and Harrison, 1993: 90). Secondly, planners would be distanced from providers who might influence decisions on service investment to their own advantage (Dixon, 1998: 5-7). A third, and related justification, was linked to an understanding of the properties of markets in economic theory. Providers would need to compete for contracts and survival, using price and quality as levers (Enthoven, 1985: 38-42).

However, alternative explanations as to why government had created trusts were on offer. The view that the 'floating-off' of NHS trusts was a precursor to their privatisation was widespread (Unison, 1994). A belief that the division of the service into smaller local employer organisations was designed to weaken trade union power, by splitting union branches, appears not to have been widely held, outside select union circles (trade union official in interview). Labour, the main opposition party up to 1997, made a number of pre-election commitments: to scrap the internal market, to retain the purchaser-provider split and, in response to those urging a re-integration of trusts with health authorities, an end to constant service reconfiguration and upheaval (The Labour Party, 1996: 1,3).

Once in power the Labour government proceeded however, to institute a further series of profound changes in NHS service configuration. The lynchpin of this reshuffle was the creation of primary care trusts (PCTs). At first sight it might have looked as if PCT development would have little impact on public health strategy implementation. After all, public health departments were safely established in health authorities and, it was suggested, PCTs were only designed to mitigate the two-tier service created by GP fund-holding (Mulligan, 1998:75). However, the public health role of PCTs was wider than that previously logged in primary care. They were to be responsible for the health of the whole population in their geographical patch, not just for patients attending local surgeries and health centres (*The New NHS, modern - dependable*, DoH, 1997).<sup>105</sup>

The reasons for PCT development were again seen by non-government sources in a way at odds with official explanations. Some local non-medical NHS staff saw movements that would eventually undermine the autonomy of the family doctor, as they would be required to join primary care trusts (Le Grand, Mays, Dixon, 1998: 138). They regarded the changes as being generally positive. One primary care manager said that: "The GPs do what they want. It takes so long to do anything about bad practice. You've got to be really tough with them." She praised the work of one

<sup>105</sup> PCT development reintroduces a situation where purchasers and providers of community and health promotion services are employed by the same organisation, thus breaking one of a number of pre-1997 Labour policy commitments. This allows for future budgetary choices of a more immediate 'zero-sum' nature within the new PCT environment.

manager in rigorously pursuing complaints against doctors. There was also a view among some that family practitioners would not do anything, particularly relating to health promotion or training, without arguing for extra cash. She joked: “They expect to be paid bonuses to come to their own disciplinary hearings.” (non-interview discussion). However, the work of some local GPs was highly regarded.<sup>106 107</sup>

Interviews with non-medical staff involved in PCG development indicate satisfaction with the role PCGs were seen to have played in facilitating increased communications between GP practices. “[In Lewisham] we’ve not had the fighting that’s gone on in other areas I think. There were GPs that didn’t talk to each other from one year to the next, but they’ve seen us building bridges for them, making links so they can work together now.” (chief executive). Within Lewisham a number of prominent GPs were members of PCG boards and in interview professional loyalty did not appear as intense as may have been predicted from the literature.

The dropping of pre-1997 policy commitments by Labour is an indication of the rapidly changing policy environment.<sup>108</sup> Staff were sometimes uncertain of the status of old policy. By 2003 some public health staff were surprised to learn that *Saving Lives* was still public health policy. As a civil servant in interview said: “Old policies are not officially dumped. They are simply replaced by new policies, so that it is difficult to tell if policy still stands or not.”. As has been noted by Barrett and Fudge (1981), one change in policy often leads to unforeseen consequences and the need for further policy shifts. Therefore, the power to improve services through institutional change may be diminished.

Seven examples of the impact of local PCT development on the strength of the public health interest in the NHS will now be described. 1. Firstly, the development of PCTs from PCGs, over the same time period as work to address health inequalities was

<sup>106</sup> Non-medical staff on a number of occasions indicated that they felt GPs who were prepared to work in the inner-city were sometimes among the most dedicated.

<sup>107</sup> These doctors, from the inception of the NHS, were said to be able to hold the government to ransom and GPs negotiated terms in 1948 which gave them ‘self employed independent contractor’ status (Klein, 1995: 12; Carrier and Kendall, 1998: 74). With the move to PCTs non-medical managerial authority was extended within the primary care setting via the control exercised by PCT boards.

<sup>108</sup> For example, the loss of a clear purchaser-provider split between public health and health improvement services.

expected to commence, had a disruptive effect on the later work in LSL. There was general agreement among senior NHS staff in Lewisham that PCG and PCT formation distracted attention from planning work to reduce health inequalities. One senior practitioner commented: “I don’t think we will do anything useful until the PCT stuff is sorted out, because we are completely, almost completely, diverted by the PCT process..”.

Public health staff time was taken up with PCT development in a variety of ways.

1. A number of secondment arrangements were put in place to initiate PCT organisational development and these had disruptive knock-on effects on staffing, recruitment and retention, further down the organisational line.

Public health staff time was also required in a more ad hoc manner. For instance, staff attended PCG board meetings in order to familiarise themselves with the new developments; they worked on PCG strategies and plans; they assisted in the training of new PCG staff and they were involved in their own internal department meetings to consider repositioning in order to adapt to the changed environment.

2. The second impact of PCT development on public health is that responsibility for the health of the population of Lewisham was split between the health authority and the emerging PCTs over the period 1997-2001. The eventual home of accountability for public health was not clear at the outset, and was only slowly clarified via local disputes, formal circular (clarifications of: *Shifting the Balance of Power*, DoH, 2001) and government statements. As late as July 2001, the public health responsibilities of PCTs were still developing. Yvette Cooper, minister for public health, addressing a King’s Fund conference attended by LSLHA staff at this time, signalled that PCT boards would incorporate a director of public health. This was how public health staff in Lewisham first heard the news.

An uneasy division in responsibilities emerged between the director of public health at the health authority and the two PCGs led by their chief executives, the most open dispute being over the creation of an LSL-wide ‘health improvement board’. This was seen as a useful development by leading figures within the health authority, but was bitterly opposed by chief executives and others within the PCGs from across LSL.

The details of public health responsibility had not been worked out in the original policy that introduced PCGs/PCTs (*The New NHS – modern, dependable*, 1997; *Shifting the Balance of Power*, 2001), leading to unnecessary uncertainty and, over a five-year period, the lack of a robust structure for public health planning. Eventually the home of the public health directorate was firmly established in the primary care trust. However, the relationship between the health promotion and public health departments was still uncertain at mid-2003.

3. The above two points account for a temporary slowdown of strategic planning to reduce health inequalities. The third impact of PCTs on this work is generally more positive and relates to the increased role in public health work of non-medical and non-specialist practitioners and staff. The institutional developments associated with PCGs and PCTs brought together, in new ways, groups of staff who share a public health role. In June 2001, late in the process of PCT development, a ‘Public Health Away-day’ was organised by the ‘partnerships manager’ of South Lewisham PCG. This event brought together approximately 25 staff members from a range of organisations. The voluntary sector was represented, alongside staff working in community health services, health promotion, primary care management and the health authority’s public health department. The morning started with a discussion on the meaning of public health for the different organisations represented. The feedback from participants indicated that progress had been made, firstly, in articulating and staking-out a broad coalition of staff in support of a number of core public health principles. And secondly, in recognition among those present that public health is not just the domain of the public health department. A ‘public health workstream’ for the PCT was launched, which subsequently met five times and drew up draft ‘principles for public health in Lewisham’. Again, input came from a range of organisations. However, medical public health consultants did not contribute significantly to this public health development work of the Lewisham PCGs, the reason being that consultant numbers at this time were spread thinly across the three boroughs of Lambeth, Southwark and Lewisham and some informal assessment indicated that Lambeth, at least, required more support.

Moves to increase the status of non-medical public health staff had been in train since 1993. However, this trajectory was been sped up by the formation of PCTs. With

three times more PCTs in 2002 than there were health authorities in 1997, it was likely that public health at PCT level might not be led by a medical consultant in public health. This is a policy that was signalled in *Saving Lives* (1999: 136). The long-term implications for the power of public health within the NHS and the local authority area will be, in part, dependent on the ability of this non-medical and medical public health coalition to find senior support within the new PCT.

4. The increased public health role of primary care staff also creates a challenge to primary preventive work. GPs will acquire more influence over public health, a move that predisposes an emphasis on secondary prevention via prescribing.

5. The PCGs started to provide new opportunities for discussion concerning public health within a local geographical area, with regular items pertinent to public health on the board agendas of both North and South Lewisham PCGs and the new whole-borough PCT. These discussions, one for instance concerning poverty and its effect on health and possible local action, have, in effect, brought discussion on public health issues to a wider number of local staff from primary care, the local authority and the voluntary sector. A public involvement group, led by the PCG, was also initiated. It ran for two years and then its work was transferred to PCT control. Attendance was high, at around 20, with staff and some service users coming from a wide range of organisations. Closer working relationships between GPs and other practice staff within the new management framework have also been referred to in interviews with local staff.

6. Co-terminous boundaries between the new PCT and the local authority in Lewisham began to act as a lever to assist public health work, the reasons being, for example, that NHS staff with a public health brief were no longer required to acquaint themselves with all the relevant departments of three London boroughs. Public health staff specialising in particular topics may however, not be in sufficient demand in so small a geographical area; requiring collaborative funding arrangements and networks that are administratively time-consuming.<sup>109</sup>

<sup>109</sup> It should be noted that “the local health economy” for public health is not the same as it is for acute health and statutory social care services.



7. Finally, a deciding factor will be the continued availability of resources for primary and secondary care and the extent to which public health finances are 'ring-fenced'. One senior practitioner in the PCG suggested that money should be switched from the acute sector into prevention. However, as the director of public health pointed out, acute services within LSL were unable to meet NHS executive targets for 2002/3. The movement of resources away from the acute sector is therefore unlikely to be acceptable to any major stakeholders. The focus on reducing waiting times was considered, in some staff discussions outside of the interviews, to be driven by 'the media'. The profile of problems in the acute sector being exaggerated at the expense of longer-term health improvement strategies. To a lesser extent, acute sector consultants and the medical profession lobby were also seen to highlight secondary care issues to the detriment of primary prevention. However, cynicism with regard to the medical profession was generally focused on what was regarded as an over obsession with pay and conditions.

Overall, the power of a PCT to act as an institutional lever in facilitating the improved status of public health work, and thus its ability to champion measures to reduce health inequalities, is not clear-cut. On balance in 2003, the trajectory looked positive. However, from the local perspective, the outlook for public health swung so rapidly between 2001 and 2003, that caution in predictions is advisable.

Before the organisation of the HimP is discussed in more detail, the author outlines developments within three other major potential contributors to health improvement and health inequalities reduction: the Healthier Lewisham Partnership, the Health Action Zone and changes associated with the London Borough of Lewisham.

### **The Healthier Lewisham Partnership (HLP)**

The HLP was a significant local force in planning and delivering health improvement work throughout the research period. Its basic structure saw little substantive change

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Other more minor impacts of PCT development were also evident, and again demonstrate the unintended effects of policy change (Pressman and Wildavasky, 1973; Barrett and Fudge, 1981). For example, protracted uncertainty over former 'joint finance' monies for health improvement, being resolved only by March 2003.

over eight years.<sup>110</sup> The partnership was made up of representatives from key local agencies seen as having a role to play in joint working for health improvement. The services and directorates involved from Lewisham council have been: adult education, social care and health, housing, equalities, environmental services. The voluntary sector was represented by Voluntary Action Lewisham, Lewisham Community Partnership and two other small voluntary groups. Other agencies represented include: the police, the NHS mental health trust, the primary care trust (formerly the primary care groups and before that the community health trust), the public health department, the health promotion department and others. The partnership has had a number of sub-groups including, for example, a coronary heart disease sub-group, and a sub-group charged with delivering an updated Lewisham health profile (The Health of Lewisham, 2001), and most importantly for this study, a health inequalities sub-group which met in three distinct phases, set out below.

In 1999 it was agreed that the then chair of Healthier Lewisham would suggest to the Joint Executive Team of the council that Healthier Lewisham be requested to hold a conference on health inequalities. This was in order to respond to the Acheson report and look at how Lewisham should address health inequalities: “The chairs at the time suggested that perhaps we hold a conference to open the debate out ....and – what felt like wading through treacle - to get some sort of clarity for Lewisham.” (senior manager, NHS).

In order to plan for this conference a small ‘inequalities sub-group’ was set up. This consisted of: an equalities officer from the council, who was later made redundant due to council reorganisation; a worker from Lewisham Council for Race Equality who was also made redundant after three meetings due to grant reductions to her organisation; the co-ordinator of Healthier Lewisham who was funded jointly by the council and the health authority; and the present author, from the health promotion department, who joined the group after the first two meetings. A health inequalities lead from the health authority’s public health department came to one pre-conference

<sup>110</sup> The fact that the HLP was set up before 1997 supports those interviewees who did not believe that the policy objective to reduce health inequalities, described in *Our Healthier Nation*, had significantly changed local practice.

meeting. Prior to the conference three other council officers from different departments also attended.

The discussions of the group revolved around deciding the aims and objectives of the conference, who should be invited to speak, who should be invited to attend, what the conference should be called, what workshops should take place and what outcomes were sought. As such, it provided a useful insight into the difficulties faced by local staff planning work to address health inequalities. The main problems encountered were, firstly, the high turnover of staff at the level involved in the conference planning, as indicated above. Secondly, there was uncertainty as to the extent to which the conference should focus on poverty or on race. One group member in particular, felt that race was the key issue to be addressed. Thus, in addition to distractions caused by the organisational upheavals of PCT formation and health authority disbanding, there also existed profound uncertainties as to how to work most effectively to reduce health inequalities. Aside from the Acheson report, which was interpreted as prioritising income redistribution, no national guidance on local effective strategies had been produced. Therefore, the focus of the conference became vaguer and expanded into the area of income inequality, which local agencies were not well equipped to tackle. Disputes over the remit of the conference were resolved by group members leaving (for unconnected reasons) and by the fact that the conference was organised to incorporate workshops on a range of subjects including race and poverty.

However, despite uncertainty as to how to prioritise work to address health inequalities, personal tensions in the group were minimal as all the participants appeared interested in the subject and happy to work together. The impression was that work to address health inequalities was more rewarding than other aspects of all the group participants' workloads.<sup>111</sup>

<sup>111</sup> This factor in health inequalities work has been noted in other settings and is referred to later in this chapter.

The conference took place in November 2000,<sup>112</sup> and as a direct consequence a renewed 'health inequalities sub-group' of Healthier Lewisham was established with a membership from a wider number of organisations. This group met nine times after the conference before being disbanded for reasons outlined below. The membership of the group was not static, and some members had a higher regular attendance level than others. The following were members: a researcher from the community trust, a worker from a drugs project, two members of the local pensioners forum (the only group members not attending in a work capacity), a PCG manager, the co-ordinator of Healthier Lewisham, the project officer from Healthier Lewisham, a manager from the community trust, a HAZ funded community development officer, a council information officer, a council equalities officer, a health visitor (one attendance only), and the present author. Thus, the membership was not from director level, but was composed more of 'middle managers' and policy officers. It was drawn from interested conference attendees who had filled in a form in the conference pack. Attempts to involve other staff were largely unsuccessful.

No one staff member attended all the meetings, some giving apologies on the grounds of other work commitments, indicating that the group was seen to be of less immediate value than other forums. It was nevertheless the only group in Lewisham that was specifically looking at health inequalities. It was suggested at the first meeting that the chairing and note taking would rotate, thus sharing 'ownership' and the workload. This decision increased the lack of continuity and meant that no one person took responsibility for leading the work. The group disbanded in the run up to the formation of PCTs. The main reason for the break up was that a high proportion of staff either changed jobs or faced an uncertain future and attendance fell to two in the last two meetings of the group.<sup>113</sup>

<sup>112</sup> Observations from the event are used intermittently throughout the thesis.

<sup>113</sup> Another feature of the group was the continued attendance of two African-Caribbean older pensioners. They had been the only voluntary agency representatives to indicate an interest in the group following an invitation that was circulated at the health inequalities conference. Within the group they were relatively quiet. A concern was expressed that if members of voluntary groups were to attend, then these two older women were not representative of the wide range of local bodies. Some group members commented on the issue outside of the meeting, but this did not lead to any action.

As a direct result of the women's attendance the pensioners' forum was allocated a small financial contribution towards an event that contained a health promotion-related element. Of importance to the thesis is the fact that the women operated politically in a way that attempted to address both upstream and downstream factors affecting pensioners' incomes. Within the research period, not only did they

The main work of the group was to decide which of the conference recommendations to focus on and what work to commission from a relatively small budget (£13,000) to cover these decisions. As with the pre-conference inequalities sub-group, the discussions are an excellent source of data in understanding the tensions attendant in local work to address health inequalities. The conference had produced lists of recommendations from five workshops, many of which were very general and required large investments, for example, one suggestion was to increase nursery places and another to improve housing, both being financially and administratively outside the power of the group to influence.

The group started by looking at the conference's workshop reports and recommendations. One group member had an interest in the issue of monitoring of service use by minority ethnic groups so it was decided that work in the borough on the subject should be researched and, if necessary, support provided by the group to assist any work already underway. The second area considered was the funding of a 'fruit in schools' scheme. This was agreed because it was known that work was already underway to provide fruit to children in certain schools and it was thought that money to extend the scheme would be well spent. Finally, a small allocation of funds was granted to the pensioners' forum to support a one-off health event. The impression was of opportunistic work based on some background knowledge of effectiveness but dictated more by the fact that initiatives were already taking place that could be 'piggy-backed' to create additional benefits. One or two group members had other ideas that they raised but which were not pursued. For example, one felt that after a gap of one year, another conference on health inequalities should be organised. Another suggested increased investment in benefits advice in primary care practices, and a third argued for more investment to support community development workers.

There was a general sense of not knowing what was best to do. As one public health consultant later said: "...there is a very very wide range of what is acceptable to do, there is a very big agenda. I suppose decisions have to be made on pragmatic grounds

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attended the pensioners' lobby of the annual Labour Party conference - the demonstration called on government to increase in the state pension - but they also suggested more support for local trading standards inspectors to crack down on traders who 'ripped off' older people.

about something that is important enough, and that will help you progress things a bit..”. This wide range of possibilities combined with three significant factors that hindered progress. Firstly, a belief among almost all the group members that income inequalities were the real issue and that what they were involved in was “small fry”. Different group members put this view forward on a number of occasions, but it was impossible to address, and therefore appeared to cause some disillusionment and demotivation. Secondly, no steer was provided by any national guidance, despite the increasingly prevalent idea in other sections of the NHS that ‘the centre’ was too domineering. Thirdly, given that a number of things were acceptable to do, lack of leadership in the group meant that staff with particular projects in mind were not provided with good reasons as to why their ideas should not be carried out.

The disruptive influence of PCT development and constantly changing initiatives is exemplified by the July 2001 meeting of the group. The initial two thirds of the meeting was taken up with updates concerning relevant institutional developments. For example, a large allocation of ‘National Strategy for Neighbourhood Renewal’ money needed to be spent before April 2002.<sup>114</sup> This money was to be administered in future by the, as yet unformed, Local Strategic Partnership (described previously). Bids for 2001/2002 were therefore being handled through established joint finance channels. A report on progress was made to the inequalities group.

Following this agenda item it was agreed that a proposal to bid for HAZ monies to be used to employ a lead senior officer for the group, which had been suggested at the previous meeting, was to be dropped. This was due to the ‘current climate in which too much is going on’. The HAZ priorities for 2002 were not known and it was assumed that a bid for the post would have to be made against these priorities. The priorities were not known because PCT development meant that the LSL HAZ was ‘refocusing’ towards the borough level. On top of this, the public health department had just been informed that they would, after all, be moved into PCTs by April 2002 and that the health authority would merge to form a new strategic health authority. It was for these reasons that it was put to the group that there were too many changes underway, making recruitment unmanageable.

<sup>114</sup> £700,000 was initially allocated to be spent in 18 months.

It was held by members of the group, and by Healthier Lewisham members more widely, that departments and agencies such as housing, health and the voluntary sector should co-operate in order to deliver effective work to reduce health inequalities. We will now go on to look briefly at one initiative that was designed to support this co-operation - the Health Action Zone.

### **The Health Action Zone (HAZ) and “initiative-itis”<sup>115</sup>**

The LSL HAZ was given the go-ahead by the DoH in 1999. Over £3,000,000 per year was allocated over a seven-year period, with the aim of improving health through joint agency working, assisted by a relaxation of rules governing inter-agency partnerships. The main LSL HAZ theme was children, and its work programme was aimed at the least advantaged in order to reduce health inequalities. Special administrative structures were set up for running the HAZ. It had its own director and six other central support staff, some of whom were, as with PCT development, seconded from other NHS departments.

One interviewee suggested that HAZ funding arrived before adequate plans to receive the money had been put in place. HAZ used its funds to support a large number of small projects aimed at prevention of ill-health and health improvement. HAZ-commissioned research has criticised arrangements for bidding for these funds, suggesting that they failed to adequately involve smaller voluntary agencies providing services to black and minority ethnic groups (Bitel and Hill, 2001).<sup>116 117</sup> Under-

<sup>115</sup> Lord Hunt coined the term ‘target-itis’. (Hunt, 2003: 18)

<sup>116</sup> The report concluded that the LSL HAZ commissioning process was institutionally racist (defined below). This was “based on the fact that there is little evidence to show that *specific* consideration was given to minority ethnic issues, even though a significant minority of the population in LSL is from these communities.” (Bitel and Hill, 2001: ix). Three of the main failings were as follows: 1. The commissioning process was found to favour larger established voluntary and community groups and, as Black and minority community based organisations tended to be small, there was an in-built bias against them being allocated funds (p.24, 34). 2. “... ethnic monitoring was not a specific requirement of the HAZ.” (p.ix). 3. There was no explicit community involvement strategy, and “community consultation failed to materialise into community involvement”. (p. 21). Generally: “The desire to be seen to be equitable and fair was thought to run contrary to deliberate action to target excluded communities and organisations that could reach them.”. (p.23). The report also suggests that another key problem with HAZ commissioning was the conflict between a ‘top-down’ approach whereby the HAZ responded to the health improvement priorities of central government and a ‘bottom-up’ approach to addressing local needs as identified by the local communities (pp: 21-22). However, no examples of this clash are provided. The HAZ responded with a new ‘developmental commissioning’ structure to address these criticisms.

spending and late spending became a major problem as staff struggled to cope with additional workloads. Perhaps more fundamentally, the fact that baseline public health and health promotion budgets were decreasing, at a time when new money was being allocated to temporary HAZ projects able to ‘demonstrate innovation’, perpetuated the transient nature of many public health work programmes.<sup>118</sup>

Evaluation of the HAZ as a whole is fraught with difficulty, for example, because some individual HAZ-funded projects were felt by local staff to have been highly successful and others less so. However, whether these projects would not have taken place without the HAZ structures, as opposed to the HAZ finance, is open to dispute. From the second year of the HAZ, criticism from local staff regarding the initiative began to increase. One public health interviewee asked (in relation to the HAZ) “do I sound cynical?” However, a number of local NHS staff believed that LSL’s HAZ was considered to have achieved more in comparison with Health Action Zones in other parts of the country. This was repeated to the researcher on one occasion with some amusement.

The HAZ suffered, on a larger scale, from a similar problem to that faced by the inequalities sub-group: namely, it did not know what the *most* effective programme of action was. HAZ staff also believed that reducing income inequalities was of paramount importance and this gave some of them a sense that they were “just using sticking plasters.” It was acknowledged by senior staff that the HAZ spread itself too widely, encompassing too broad a set of targets (HAZ, 2001). However, as with the inequalities sub-group, much of the investment made by the HAZ was, nevertheless, justified on the pragmatic grounds advocated by the consultant in public health quoted previously. That is, that the problems of the boroughs were so great that initiatives

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<sup>117</sup> The Macpherson inquiry (1999) collates a number of definitions of institutional racism. For instance institutional racism can influence [police] service delivery “not solely through the deliberate actions of a small number of bigoted individuals, but through a more systematic tendency that could unconsciously influence [policy] performance generally” (brackets added) (6.5, Dr Robin Oakley). The inquiry found “Racism, institutional or otherwise, is not the prerogative of the Police Service. It is clear that other [statutory] agencies ... also suffer from the disease.” (6.54).

<sup>118</sup> The health promotion department lost two WTE posts between 1997 and 1999, due to reductions in the baseline allocation.



addressing any number of themes from accidents to fear of crime are likely to be of some benefit.<sup>119</sup>

Other initiatives were funded in a similar way to the HAZ. Regeneration funds were received for particular geographical areas on a three to five year basis. Healthy Living Centre funds are allocated on a five-year basis. Sure Start funds were based on a seven year timescale, with a taper in funds from year three.<sup>120</sup>

In respect of housing regeneration initiatives, the Socialist Party councillor and the chair of the chamber of commerce both commented that the need for huge initiatives to develop housing and estate facilities was the result of previous under-investment. The Socialist Party councillor expressed a view that, in the event of recession, these initiatives would be easier to dismantle than changes to the council's core budgets, which had not increased.

In numerous meetings, jokes were made about the number of new initiatives and the accompanying terminology, reporting mechanisms and planning groups. This humour was particularly evident in joint meetings between local authority and NHS staff when the new initiatives from each organisation had to be quickly summarised. The realisation that both sets of statutory services were working to strategies that firstly, spawned acronyms and that secondly, seemed to frequently change their names, emboldened staff to mock what was going on. For example, the community plan became the community strategy, and the health improvement programme became the health improvement and modernisation programme, while at the same time as the modernisation audit was required, the borough plan, as well as the community plan, was on the agenda. Which strategy documents were to be overarching was sometimes never agreed before the revised strategy template came out. The spirit of staff humour

<sup>119</sup> Examples of HAZ investments included: breakfast clubs scheme, primary care based money advice, a warm homes project, borough-based community development co-ordinators, early intervention schemes for children with language/literacy delay, emergency contraception projects funded with pharmacists' training, youth employment solutions project, supported employment projects, and many more (HAZ, 2001).

<sup>120</sup> Staff shortages and recruitment difficulties were noted in respect of some public health project work. This was assumed to have resulted from the increased number of public health initiatives, particularly those linked to regeneration and Sure Start. For instance, it was reported in interview that one community development post could not be filled until the fourth interview round, adding to delivery and under-spend difficulties.

provided mutual support in keeping up with the pace of change and allowed employees not to feel belittled if they did not know about the latest policy. For example, one email sent by a senior manager of the PCT ran: “For those of you who are remotely interested the new jargon term for the combined PCIP and SAFF is the Franchise Plan. We had the ADP for a short while but that seems to have gone by the board. Hey ho!.....Hmm....”<sup>121</sup>

The HAZ was set up with the intention of forming new links between staff in order to plan multi-agency initiatives. However, for Lewisham the multi-agency planning structure for public health work, namely Healthier Lewisham, was already well established. The HAZ benefited Lewisham by supplying funding for a number of posts and projects. While the funding was welcomed, there was no benefit in it arriving as special HAZ money from a special HAZ team at the health authority. At the beginning of the HAZ initiative the slogan – ‘aiming to do things differently’ had a certain inspirational effect, and it encouraged suggestions for new work that might otherwise have gone unsaid. However, the HAZ meetings that staff attended were over and above their regular workloads, and those who were not involved in the process from the outset became excluded. Two local staff argued that the development of PCTs gave an opportunity to move public health back into the local authorities, and that responsibility for leading the HAZ would have been a good place to start. However, as will be seen in the next section, a number of changes were also taking place in the local authority at the time.

### **Local Authority Changes**

Lewisham council had a reputation among some interviewees for being a flagship for New Labour ‘modernisation’. It was among the first councils in the country to move to a cabinet system (DETR, 1998). Labour councillors not given a cabinet role were allocated ‘back-bench scrutiny’ duties. They were also, according to one ‘New Labour’ councillor, able to spend more time engaging with their local communities and seeking their views.

<sup>121</sup> PCIP = Primary care investment plan. ADP = Area development plan. SAFF= Service and financial framework.

Changes from the committee to cabinet system were also accompanied by changes in the internal structures of the local Labour Party. 'Old' Labour councillors noted the passing of a system where party members could effectively influence party and therefore council policy via a process of voting on resolutions passed from the wards to the general committee of the party. A new 'Hub system' was set up in 1999, whereby local residents are invited to non-party political meetings attended by council officers and 'back-bench' councillors. This system was designed to encourage residents to voice their opinions on local services. Interviews with both 'old and new' Labour councillors indicate that the 'Hub' system seems to be, in effect, a replacement for policy formation through channels controlled by the Labour Party membership. The democratic implications of this transformation and its consequences for the representation of those likely to experience poorer health will be discussed in chapter 6.<sup>122</sup>

In the course of this research the author heard no positive or negative comments, or analysis of any kind, from NHS staff, with regard to the new cabinet structure. This demonstrates the detachment of NHS community development workers from formal local democratic structures and a culture that does not regard partisan democratic structures as relevant to health improvement.<sup>123</sup>

The involvement of council directorates in public health issues, for instance via Healthier Lewisham, was mixed. The Directorate of Social Care and Health had perhaps the most involvement in Healthier Lewisham. Regeneration initiatives such as the New Cross - New Deal for Communities and various single regeneration budget allocations were led over five years by a combination of Lewisham Challenge Partnership (LCP) and the council's regeneration department. LCP was a 'quango' made up of representatives from local business, NHS trusts, the voluntary sector and the council. It received and managed the allocation of regeneration resources; the Local Strategic Partnership replaced it in 2002. More attention came to be paid to the

<sup>122</sup> Low turnout in council elections is also an issue, which will be touched on later.

<sup>123</sup> Pejorative asides, with no confirmed factual backing, were made in meetings of local NHS staff, they referred to general 'corruption' in the council relating to the business transactions of former councillors.

impact of schemes on the health of residents.<sup>124</sup> A number of local community development workers also believed that more effective account is now taken of the views and desires of residents affected by the schemes. However, one manager did comment that he felt “regeneration workers are always critical of previous regeneration work”. The general consensus was that it had become more widely recognised that a lot of time needed to be devoted to resident involvement in schemes.

Thus, the local authority’s role in influencing change in the status and practice of public health has been both direct and indirect. Firstly, closer links have been developed between NHS public health and health promotion staff and council regeneration officers within particular SRB and New Deal schemes. This strengthened the broader view of public health, that is, one that takes into account ‘the wider determinants of health’. Secondly, changing democratic institutions within the council may potentially have a significant impact on the representation of sections of the population likely to experience poorer health. This issue is discussed in more depth in chapter 6. Now the chapter looks briefly at the impact of three NHS initiatives on local health inequalities work: *The NHS Plan* (2000), the HimPs and the requirement to set local health inequalities and public health targets.

## **Plans and targets**

### **The National Plan**

In 2000, before the full implementation of most of the post-1997 health policies, a new plan for the NHS was brought out by the Department of Health, *The NHS Plan*. PCTs had not yet been introduced, evaluation of the HAZ had not been completed, implementation of local authority changes had not ended - the mayoral election in Lewisham for instance, not having taken place - and the Local Strategic Partnership had not come on-stream. The movement of responsibility for the HimPs to the borough PCTs was not established; and little implementation or evaluation of any work resulting from the health inequalities section of the LSL HimP, had taken place.

<sup>124</sup> Department of Health funds to conduct a major health impact assessment (HIA) in one scheme was backed up by staff HIA training initiatives and the employment by the health authority of a HIA officer to assist with regeneration work.

*The NHS Plan* was precipitated by a ‘beds crisis’ in the winter of 1998, which in turn was exacerbated by a flu epidemic. This resulted in the Prime Minister’s increased concern and interest in NHS delivery. The plan is set out in sixteen chapters, many of which relate to clinical aspects of the service. At the time of its release in Lewisham, the plan was seen by some as a threat to the increasing importance of health improvement work, and was cast as a return to the predominance of the medical model. As one chief executive commented in 2000:

“...*The NHS Plan* has taken over...the HimPs seem to have gone out the window...if we’re not careful all they [the government] will be doing is to focus on *The NHS Plan* and it will ..take away power [to do] anything else really. So I think it is about how we keep putting inequalities on the top of the agenda really.”

Following publication of the plan there was considerable confusion concerning the position of 1997-2000 public health policy. Although it was not explicitly dropped, it was anticipated or guessed by staff at the local level, that the ‘older’ post-1997 public health policy was not now of such priority. In retrospect this guess proved to be unfounded.

The plan contained updated policy relating to health inequalities. It announced the imminent arrival of national health inequalities targets and it focused attention onto inequalities in child health. The national targets were later announced in a ministerial speech, but by mid-2002 they had still not been discussed widely within the local NHS. This was perhaps because of the way they were disseminated, or because of other more pressing demands, such as the allocation of National Strategy for Neighbourhood Renewal funds. It was only towards the end of 2002 that attention refocused onto health inequalities. Thus, it can be said that at least two years were ‘lost’ between the Lewisham health inequalities conference of 2000 and the reestablishment of work to reduce health inequalities in Lewisham.

The health inequalities chapter of *The NHS Plan* was never discussed as such in the Healthier Lewisham partnership board, or in the second phase of the inequalities sub-group. Although it was mentioned in the local health promotion department in one

discussion on *The NHS Plan*, it was not referred to in any public health forums in the same way that the Acheson report was, for instance. There was not a high level of local conversance with the contents of the chapter. The South East London Strategic Health Authority (SELSHA) issued health inequalities monitoring requirements in late 2002, for inclusion in the Local Delivery Plan (LDP).<sup>125</sup> These targets, in part, responded to *The NHS Plan* and it was in this synthesised form that local staff dealt with the plan.

### **The Health Improvement and Modernisation Programme (HimP)**

Here this work discusses the development of two HimPs: the LSL HimP and the first Lewisham borough HimP.<sup>126</sup> The original development of the LSL HimP, published in 2000, illustrates the tendency for public health work to be subsumed into the demands of patient care, be it in the acute or community sector. In 1997 lead consultants in the public health department, the health authority board and significant players in organisations external to the health authority, understood that the HimP would in future be an important new tool for detailing plans to improve health across LSL. It was anticipated that it would strengthen the status of public health within the local NHS. It was also assumed by senior health authority figures that the HimP would be the key to co-ordinating and planning work to reduce health inequalities. Four years later, in 2001, these hopes remained unfulfilled. In that time the LSL HimP had been transformed as a concept, the key players involved in its development had changed dramatically, and there was confusion over its future significance and fate. As one public health consultant commented:

“...the SAFF [service and financial framework] bit stays firmly rooted in the stuff which is about money and numbers and activity...So you have got two documents, one [the HimP] with the kind of ‘good intentions’ bit, and the other is the bit about the money. So it is not surprising that the HimP bit is in trouble..”

<sup>125</sup> ‘Local Delivery Plans (LDPs) set out how the Priorities and Planning Framework 2003-2006 translates into targets for the NHS (and social services). This builds on the changes introduced in *Shifting the Balance of Power* (2001), setting out a new system for planning and performance management.’ ([www.doh.gov.uk/ldp2003-2006/](http://www.doh.gov.uk/ldp2003-2006/) June 10, 2003).

<sup>126</sup> The borough HimP was initiated when there were 2 borough PCGs covering the North and the South of Lewisham. It was completed after the PCT formation.

As another public health consultant said:

“...there is still uncertainty about what the HimP is for, does it really matter....particularly now that there are going to be community plans and regeneration strategies...There is a question mark about what the HimP is for, other than a sort of formal...writing down of things a documentation process ..one that is geared to particular regional requirements...what the HimP is supposed to be has changed.”

An example of this change is that less work on CHD prevention would revolve around the HimP planning process once the CHD National Service Framework (CHD NSF) had been produced.

The HimP's name did not give a clear indication of the balance between the 'health care improvement' and the 'health improvement' elements of the plan. Descriptions of what the HimPs would cover suggested substantial 'health improvement' sections (National Priorities Guidance 1998/ NHS HimP Guidance). However, as time passed 'health care' issues came to the fore. The number of staff with a primary interest in 'health care' development on the LSL HimP groups outweighed staff whose primary concern was health improvement.<sup>127</sup> In addition, due to health authority reorganisation, responsibility for the HimP and health inequalities planning passed from the Director of Public Health to the Director of Corporate Affairs. The health authority's senior, 'non-public health' staff came to describe the HimP in a way that encompassed 'health care' issues to greater extent.

The relationship between the HimP and the local authority's community plan had already caused confusion. Discussion in the Healthier Lewisham group demonstrated that staff were unsure of the relationship between the two documents. And as has been seen, the arrival of *The NHS Plan* in 2000 led senior NHS staff to believe that the HimP was no longer going to be of any interest to the DoH and the NHS Executive. In late 2000, messages from the London NHS Executive to London directors of public health were understood by these staff to indicate the scrapping of the HimP. These

<sup>127</sup> For example, on the CHD group health promotion staff often numbered one, compared to five acute clinical.

local developments were accompanied by NHS guidance on the priority to be accorded to health inequalities work that, two senior health authority employees felt, changed on an annual basis. One of them commented that: “the ‘national planning and priorities guidance’ has been putting health inequalities in a different order of priority over the last three years, so it is not clear how important the issue should be seen as by the health authority. And sometimes it’s put as a general theme and other times as specific issues, e.g. teenage pregnancy, so we need more clarity.”

As has already been set out, the establishment of the PCGs also caused uncertainty and delay in HimP development. In late 1999 PCG, health authority and other senior staff from local agencies (e.g. social services and the voluntary sector), met at Millwall football stadium to discuss the health improvement planning mechanisms. Disagreement was evident, as some PCG chief executives said they wanted the HimP devolved to the boroughs and some health authority staff argued the need for an LSL-wide health improvement board. In the end such a board was never set up. In the same vein, the health authority’s (HA) public health department initiated an internal planning group to organise a conference on health inequalities in 2001. However, this conference never took place as by the end of the year the disestablishment of the HAs had been announced.

In 1998 it had appeared ‘on paper’ that the development of HimPs would increase the importance of public health agenda setting within NHS planning structures. This was the expectation of public health staff on publication of the proposals. Did the rhetoric of a ‘health improvement plan’ help to increase the importance of plans to improve public health and reduce health inequalities within the health authority area up to 2001? The health authority’s annual investment plan had always contained a health improvement element and rationale. The new health authority HimP was arranged around this theme to a greater extent. But, aside from Health Action Zone money, no additional financial resources were available for health improvement initiatives. The restructuring of the health authority, taking the HimP lead away from the Director of Public Health, along with the gradually increasing role of the PCGs in relation to health improvement planning, meant that the HimP at the health authority level in LSL never really ‘lived’ as a document. On the basis of interviews it can be said that



the LSL HimP was not even known about in wider public health-related settings in the boroughs, let alone 'owned'.

Specifically in relation to the health inequalities section of the HimP, a number of developments took place. Firstly, an attempt was made in 1999 to form an LSL wide group, administered by the health authority, and made up of external stakeholders, to write the inequalities section of the HimP. This group only met twice and was then dissolved, for a combination of reasons. The group argued about the priorities for health inequalities work. One attendee described the first meeting as "a bear garden". Some of the attendees wanted the work to focus solely on inequalities between ethnic groups, whereas others prioritised access to services and yet others thought the focus should be on inequalities between those on lower incomes and the rest of the population. The discussion was a more complex and less amicable version of similar discussions that took place in the planning meetings for the Lewisham health inequalities conference, referred to in the Healthier Lewisham section above.<sup>128</sup> This reinforces the finding that local workers had great difficulty in making sense of how to take forward the policy in the most effective way. The options for adopting different priorities and work plans were huge and it was difficult for local staff to know at what point to begin. As one consultant in public health said: "...people always worry that they will pick the wrong health inequality, or they will have done something that is actually trivial when there are big issues like poverty, and race and whatever....."

However, HimP development at borough level then commenced.<sup>129</sup> In this borough setting the HimP was almost exclusively public health and 'health and social care' (local authority) related. It was not expected to contain details of acute clinical service

<sup>128</sup> The problems of the aborted health inequalities group for the LSL HimP also highlight the difficulties in choosing HimP group and health inequality planning group members. As has been noted previously, work on health inequalities was 'popular' among public health-related staff. Senior staff control of the group's membership and the fact that the group was closed down after two meetings demonstrates the way in which staff values may affect institutional formation at a local level where discretion exists.

<sup>129</sup> The importance of borough HimPs was uncertain at first, as it was not known what other local strategic plans would cover and which plans would be more, or less, encompassing or strategic. Originally it was thought that the PCGs were expected to write their own HimPs. However, they were also expected to write annual plans. In the event the public health element of the annual plans became the HimP, and was well submerged in clinical service development issues; where prevention was mentioned, it was of a secondary preventive nature.

developments and focused more on public health development. The extent to which PCTs would want to use the HimP as the main vehicle for all their plans was unclear in 2001. Senior staff thought that if the HimP was separate from the PCT annual plan then it would be easier for it to be jointly 'owned' by the local authority, voluntary agencies, and other relevant parties. On the other hand, the danger of producing separate public health and patient care plans was thought to be that the former might get sidelined. Yet the danger of merging the two documents was that the public health element could be subsumed into clinical affairs.<sup>130</sup> On balance, it appeared that public health would accrue more leverage if the HimP remained independent of the PCT's annual plans and was simply referred to in them. In this way public health would not become too subsumed by acute concerns and would be better placed to work with non-NHS organisations that are as significant to health improvement as the NHS itself.

Following the announcement of the disbanding of health authorities and the march towards PCT formation on April 1<sup>st</sup> 2002, the local Lewisham borough HimP began to take shape. Indeed it can be said that the HimP enjoyed a renaissance, a remarkable rebirth. Staff at the borough level within the PCG were enthusiastic to get on with the job of writing the HimP and good relations were enjoyed with employees in the borough's health and social care department. One local authority officer was given the task of co-ordinating the HimP, and the borough also provided administrative support. An experienced PCG manager chaired the group and a public health consultant provided statistical information. On publication of the Lewisham HimP in 2002 a conference was organised to disseminate its messages and to involve local partnership groups<sup>131</sup> in planning work to address the HimP priorities. The conference format included one session of workshops, requiring Health Partnership sub-boards to list their priorities for addressing inequalities in health. The general tone of the responses

<sup>130</sup> It is also possible to define public health in such broad terms that most clinical and patient care issues can be placed into a public health improvement plan. As almost any aspect of NHS work can be said to be public health, if the discipline moves to a higher status then clinicians can redefine what they are doing to call it 'health improvement'. The issue for public health is - where can measures make most impact on the ground? This problem needs to be analysed across service spending areas. But public health capacity and expertise at the borough level was too weak to perform this role without additional central support.

<sup>131</sup> There were seven partnership groups in Lewisham at the time, all feeding into the 'health partnership board'. The groups were, for example, the older people's group, the children's group and the Healthier Lewisham group (as previously discussed). They were staffed by NHS, other statutory and voluntary sector personnel.

was more concerned with issues relating to fair access to NHS and social care services than the comments from participants at the Lewisham health inequalities conference of 2000. This probably simply reflected the type of participants present at each event. The HimP conference, in contrast to the health inequalities conference, drew in a slightly more senior group of public and voluntary sector staff who had more experience of various local authority and NHS planning structures. Thus, it can be said that the borough HimP placed health inequalities higher up the statutory sector's agenda, at least with regard to the seniority of staff engaged in considering how to address the subject. However, by 2003 minor frustrations began to emerge on the part of some involved in the Lewisham HimP development. Certain local authority staff had come to see the HimP as 'out-of-date', even though it had not been published more than six months previously.

A new health inequalities sub-group of Healthier Lewisham was formed in 2003. This began the third phase of health inequalities work conducted via a sub-group of Healthier Lewisham. The newly appointed Director of Public Health chaired it. Thus, again it can be said that the status of work to reduce health inequalities rose at the end of 2002, following the firm establishment of PCTs and the consequent ability of staff to concentrate on their core objectives.

### **Target and priority setting for health inequalities reduction**

We have looked at the overall framework of the health improvement programme, and prior to that, at its local institutional setting. The chapter now considers how local targets were set. For instance, how was a priority to reduce the incidence of low birth weight babies picked for North Lewisham PCG? In response to critiques of the 1992 *Health of the Nation* public health strategy (LSHTM, 1998), in which targets for health improvement were seen to have been 'set from on high', local target setting was favoured in *Saving Lives - Our Healthier Nation*.<sup>132</sup> This suggested that certain health improvement priorities had been set by national government and others should be picked locally. However, no national targets were set for reducing health inequalities, and local health authorities were expected to set their own local targets

<sup>132</sup> A comparison can be drawn between the problems of NHS target delivery, following *The NHS Plan* (DoH, 2000) and those difficulties experienced in the Soviet Union (Dobb, 1970). Devine (1988) and Nove (1983), among others, seek to address these issues by emphasizing increased local feedback mechanisms.

(*Saving Lives*, DoH, 1999: 125). This is an interesting illustration of centralisation versus decentralisation issues in the NHS.<sup>133</sup> Local target setting came across a number of barriers that will be described.

In the course of this local NHS work the words ‘target’ and ‘priority’ came to be used interchangeably. The ideal was that precise targets with specific measures to show improvement would be picked. The reality was that no such targets were chosen and instead general priorities were selected, for example, ‘CHD is a priority area’. As one senior health authority manager said of the requirement to produce local targets:

“Priorities were set by the PCGs within the framework of national targets. At the time the PCGs were starting up and we had to give them control of some things and not other things. They picked their own targets and we did not intervene. We would have done if they had picked something silly, but within LSL, because there is so much need, there are so many things that could be done that would be useful, it is unlikely that they would pick something totally useless...though it is difficult to assess what effect particular work on particular issues will have. They really picked priorities not targets, that is, they were not the product of specific systematic analysis, but broad knowledge of local and national needs/priorities.”

The requirement to set local health improvement and health inequalities targets could have been a strong lever with which to raise the importance of public health and to free it from the dominance of clinical medicine. It might have encouraged a more solid and permanent basis for public health work because of the need for sustained

<sup>133</sup> The extent to which NHS staff want local autonomy and freedom to implement their own policies is itself a subject of political concern to governments. Ministers may not be responding to widespread calls for greater local freedoms, but instead may want to provide those freedoms and therefore only hear and repeat those local voices that say the right thing (Carlyle, 2001; Thomas, 1983; Self, 1977: 44, 51). Academics and commentators may also be influenced by the ‘spin’ of governments on the question of the drive for ‘local freedoms’, the benefits of which have been highlighted by successive administrations in the run up to service reorganization (Jones, 1999; Mayo and Lea, 2002). NHS respondents to interviews for the thesis may themselves be influenced by the ‘prevailing wisdom’ that greater local policy control is good. Managers might feel they show themselves to be less competent, intelligent and creative if they support local delivery conducted within the framework of clear national guidelines that have been provided for them. They may want, as it were, to have to add eggs to the instant cake mix. The reverse side of this research dilemma is that it cannot be assumed that if staff don’t ask for and recommend policy, it therefore means that they don’t want it, or would not be happy to implement it.

long-term programmes to deliver change. However, in part because of the institutional factors cited in the previous two sections of this chapter, and for a variety of other reasons which will be discussed, target setting was not as effective as it might have been. Nevertheless, although the requirement to set local targets may not have been justified on the basis of the reasons given in *Saving Lives* - that is, that local circumstances are variable - it did ensure that the profile of public health was raised slightly within the PCG setting. While the particular choice of local targets set was, according to the respondent reported above, of marginal significance, the process of setting priorities was supportive of the public health 'cause', since it forced a certain amount of time in PCG meetings to be diverted to public health planning.

Between 1999 and 2002 the distinction between general health improvement target setting and target setting to reduce health inequalities was often lacking. This mirrored confusion at ministerial level. Government justification for originally not setting a national health inequalities target was two-fold. Firstly, it was stated that if the *Saving Lives* targets were met, for instance around CHD, then because CHD had such a unequal incidence, reducing CHD rates by large amounts would reduce health inequality. Therefore, a national health inequalities target was not required. The problem with this argument, apart from the fact that those groups first benefiting from reduced CHD rates might be those generally least likely to acquire the disease,<sup>134</sup> is that it can be equally applied locally. Yet local inequalities targets were required. The second reason given by the DoH for not setting a national health inequalities target was that it was better for the targets to be set locally because local epidemiology differed between areas. For instance, former mining communities might have high levels of lung disease not experienced in London. In reality, setting local targets proved to be so unsuccessful that this reason was not sufficient justification for not having a national target. Not providing a national target was unpopular with local staff, as reflected in 1997 local returns to the Green Paper.

A public health consultant felt that: "...there is more performance management than I have ever experienced in the health services in terms of the number of things we are supposed to be measuring or progressing.. .I suppose I think I am getting quite cynical

<sup>134</sup> The 'inverse care law' was discussed in chapter 2.

about that kind of target setting really..” (2001). On local targets she said: “..you don’t have much capacity or enthusiasm for making up other ones because you have all got plenty already.”

In the first Lewisham PCG annual plan of 2000, the following priority areas were set. North Lewisham PCG picked - CHD, sexual health and health inequalities. Within the health inequalities section, low birth weight babies were picked. South Lewisham PCG picked diabetes, sexual health and stroke. The LSL-wide priorities for all the PCGs to cover, alongside their individual priorities, were: children, cancers and health inequalities. The national priorities within *Saving Lives* were also to be LSL-wide and PCG priorities. These were: CHD, cancers, accidents and mental health.

A number of points emerge from interviewee responses on the target or priority setting process. Only a small number of ‘inner circle’ staff knew how the targets/priorities were set. Many ‘peripheral’ staff did not even know what the local priorities were, although interestingly, they were all far more aware of the national targets. Those who had been involved in some capacity with the process emphasised its speedy nature and pragmatic approach. Descriptions of the process ranged from: “It was really holding a finger to the wind.”, to, “We did a brief scoping exercise to look at our main local problems and picked them on that basis, with the knowledge in the heads of the people who were present at the time.”

The health authority’s public health department had a role in supporting the PCGs to find targets. One staff member viewed the first year of target setting as “encouraging the PCGs to get used to the process”. Unless the PCGs picked targets that were “daft” the health authority would not interfere. The PCGs themselves had mixed views on the effectiveness of support in target setting provided by the health authority. Some PCG staff regarded it as sufficient, whereas others felt that the public health department was too small to offer effective support. A number of respondents felt they did not have sufficient epidemiological data to make decisions. While no interviewees criticised the targets set or suggested others, in other non-interview settings such criticisms were encountered. Some public health department staff were critical of the ‘low birth weight baby’ target, saying that it was too specific. They expressed annoyance that they had not been consulted on the target chosen. This

dissatisfaction demonstrates a further institutional failing, in that staff working across NHS agencies at a borough level did not meet to discuss setting the targets.

Health impact assessment (HIA) methodology<sup>135</sup> was pared down into a 'rapid health impact assessment' (RHIA) option to assist with priority setting, and this was used in LSLHA to arrive at priorities for investment in health. In the spring of 2001 an internal health authority event was organised at which public health staff ranked a number of potential developments from one to three according to their likely beneficial health impact. This method of arriving at priorities may perhaps have been slightly less arbitrary than the method used to pick PCG priorities. The latter were set by a similar number of staff from the Lewisham area. They chose local needs they considered to be of priority, and combined this information with areas of work that they felt could be most effectively addressed. However, an attempt was made to circulate, check and discuss the draft PCG priorities with a wider audience. Both processes were rapid and did not appear to employ high proportions of time in specifically tailored pre-analysis and data collection.<sup>136</sup>

Considerable resources have been devoted, since the early to mid-1990s, to research and dissemination of evidence on the effectiveness of public health initiatives. This investment did not appear to increase between 1997 and 2001, at least at the local level, where 'evidence facilitator' and 'needs assessment' posts had existed pre-1997. However, the establishment of regional health observatories, the HDA (Health Development Agency) and NICE (National Centre for Clinical Excellence) demonstrates a strengthening of the infrastructure from 2002 and an extension of a

<sup>135</sup> This methodological development in public health planning and priority setting was given added impetus by the Acheson report (1998) which encouraged the practice of 'health (inequalities) impact assessment' (HIA).

<sup>136</sup> Priority setting via a process which starts from a 'zero state' and then attempts to devise strategy based on knowledge and evidence has been researched since before the 1960s (John, 1998). This 'rational' or 'idealist' method was famously criticised by, among others, Lindblom (1959). The process required too much knowledge, which was unattainable and impractical. Instead an 'incremental' approach was suggested whereby certain elements of a policy were taken as given and not up for consideration. A 'middle way' was put forward as an alternative (Etzioni, 1967; Walker, 1984). There is no clear-cut boundary between the 'zero state' and the 'incremental' method. An approach may take more or fewer, external or contingent, factors into consideration. This leaves decisions as to what balance to employ open to normative pressures. The flip-side of critiques of the rational approach is that the incremental approach is 'undemocratic'. It takes areas of potential change, such as the distribution of income and wealth as given, and tends to exclude these issues from the agenda (Hill, 1997a: 99-109, 104).

form of 'rational' practice.<sup>137</sup> No clear links between these public health 'evidence services' and specific instances of PCG priority setting were witnessed in the course of the research. This does not mean to say that those setting priorities were uninfluenced by previous dissemination of information. As one account of the PCG priority-setting process indicated, participants "used the knowledge in their heads". Development of the PCT HimP made more effective use of standard data sources and the public health evidence base. However, even here the timescales of the process dictated a limited use of high quality data, and a number of staff complained that the relevant datasets were either not available or were inaccurate.<sup>138</sup>

### **Further problems in developing work programmes**

A number of other public health service problems were encountered in setting health inequality work priorities. These problems concern the distribution of resources, accountability and central-local relations. They encroach into the terrain of the next chapter, but five inter-linking issues will be discussed initially here.

Firstly, the issue of whether the borough of Lewisham is working towards reducing health inequalities within its patch or between the borough and the rest of the country has caused some local controversy. (See, Bull and Hamer, 2002: 26, who discuss 'national versus local targets'). In 1999 members of one LSL community health council interpreted the requirement to reduce health inequalities as operating strictly within the local base. They therefore concluded that significant resources should be moved from some wards in LSL to other more deprived wards. Barry Quirk, the Chief Executive of Lewisham Council, also gave some support to this intra-borough redistribution argument at the Lewisham health inequalities conference in 2000. He drew different conclusions though, suggesting that, as Lewisham had one of the lowest levels of 'internal' income inequality for any London borough, health inequalities were unlikely to be a major problem for the area. Boroughs such as Greenwich had far more of a problem. The issue arose again in a post HimP-conference Lewisham health inequalities group discussion in 2003. Some group members did not want the aims of the work programme to include: 'to contribute to a

<sup>137</sup> Macintyre et al provide a useful discussion on evidence-based practice (Macintyre, 2001).

<sup>138</sup> For this reason, a mistake was made in according low priority to accident prevention in the 2002/5 Lewisham HimP.



reduction in national inequalities in health'. They felt that the work should be seen to only focus on Lewisham issues.

Secondly, the targeting of new resources to the most deprived wards of the borough is a less sensitive version of the ward redistribution argument. Here, for instance in the 2001 distribution of 'National Strategy for Neighbourhood Renewal' monies, allocation of resources was understood by some senior council officials as needing to be limited to only those wards with the worst indices of deprivation. In a Healthier Lewisham meeting, one local consultant in public health made a case for not allocating the funds simply on this basis, because other wards have high levels of particular elements of the index but a lower overall score. For example, a ward might have a high level of lone parent households, but due to the presence of one wealthy neighbourhood, a higher overall level of deprivation.

Further debates around the current targeting of regeneration funds to very small estate areas also occurred within the local policy community, although no change in procedure resulted. It was recognised that the targeting approach may cause tensions in communities as people from just outside a target area can resent what is seen to be an unfair distribution of resources. In the early years of work to reduce health inequalities, the opinions of Sir Donald Acheson who recommended targeting the less well off, rather than the least well-off, were better known among senior public health staff than officers of the local authority. In the council, officers were more concerned that ward-based targeting was too broad, and they were investing resources in developing more refined sub-ward data and in services and support at a sub-ward level.

Thirdly, the setting of local targets in the context of PCT development may have encouraged the 'bonding' of a more identifiable public health voice for Lewisham. However, national bodies' support for local health inequalities target setting seems to have been pitched at the wrong level. Senior staff in both the PCG and the health authority complained of spending large amounts of time in compiling an increasing number of written returns and reports. The use of targets and reporting processes generally became the *bete noire* of many managers and senior practitioners

throughout the statutory services, particularly before increases in funding allocations were felt at the primary care level in 2002/3 and 2003/4.

One chief executive said: “We keep getting asked to do all this paper stuff. I think I could spend my whole day and my team could, so could [all the other local NHS trusts], filling in forms saying how they are doing, you know some of this stuff is daily, and that means that people’s attention gets diverted.”

On the Modernisation Audit and borough plan of 2001, they said:

“...if we are not careful we might have another year ahead of us of just doing these paper exercises of audits and reams and reams of paper, with no one having the chance to say: we talked two years ago about low birth weight babies, about poverty and the links with ill health, diabetes and CHD – what are we actually doing?”

The frustration was compounded by a lack of new resources and the need to invest over eight million pounds into the care of mentally disordered offenders and other deficits within mental health services.

However, at the same time, there was a lack of clear and well-disseminated direction documents on how to set local health inequality targets coming from the Department of Health, the Health Development Agency or the London regional NHS office. The Acheson report was the most definitive assistance available and it is, as has been seen in chapter 2, problematic as a clear guide to local action. An attempt to address the problem has been provided by the London Health Observatory in its *Health Equity Audit Made Simple* (2003). However, this document only addresses one aspect of a strategy to reduce health inequalities in local boroughs.<sup>139</sup> Thus, the fashionable view in 2003, that ‘the centre’ in the NHS is too dominating and local areas need more

<sup>139</sup> The debates reported by Bobbie Jacobson in 2003, concerning the use of the word ‘equity’ in the report, as opposed to ‘health inequalities’, indicate, in the author’s opinion, a certain lack of empathy with the problems of local implementers. Whilst in academic circles an argument can be made for using the former term, ‘on the ground’ the shift in terminology caused confusion. Staff with a peripheral role to play in public health work were still getting to know the Acheson report, and even some public health and health promotion staff became worried that there had been another shift in policy, as health inequalities appeared to be out, and equity in.

freedom, is confounded by an example, provided here, from work to reduce inequalities in health.

Fourthly, difficulty in monitoring improvements in targets relating to very small incidence was noted in a broad discussion on the HimP in a 1999 meeting of Healthier Lewisham. If the incidence of suicide in Lewisham is below 1 every 2 years then, it was suggested, it is difficult to show the effect of work to reduce suicide in the borough.

Fifthly, HAZ and health authority staff considered that performance management by the London regional office of the NHS Executive up to the end of 2002, indicated the low status that was really afforded to the issue of health inequalities. The subject was never raised in meetings between the chief executive of the health authority and the regional director. On the other hand the subject of waiting lists was raised frequently and, to a more limited extent, that of joint working between social services and the NHS. These discussions were felt by senior health authority officials to be extremely important in setting the direction of health authority work. Lack of data to help with health inequality target setting was thought to be of secondary importance, since if the discussions were to prioritise health inequalities, then “we would make sure the data was there to help the work”.

2000/1 was a low point for staff in the importance accorded to health inequalities work. One consultant said:

“I think that there has not been a strong message centrally that inequalities matter, so compared to all the messages you know – modernisation, waiting lists, national service frameworks... It is clear that there are very strong messages given around other things, so that at a local level... despite Acheson and various other reports, there is a message that says ‘these don’t matter very much’ .. you won’t get ticked-off for not doing very much on this. ... There is not much, if any, management mechanism about making sure that [we’re] doing something different [about health inequalities] from what [we’re] doing already, so quite a lot of it is about re-badging things, and not really about change.”

However, by late 2002 the lack of performance management for health inequalities work was being redressed by requirements to monitor and report on work to the Strategic Health Authority. According to interviews conducted in 2001, this development bodes well for the status and success of local work to reduce health inequalities.

Finally, the CHD National Service Framework (2000) indicates the potential for increased policy implementation success, given a changed relationship between the central NHS and the local level. Here, far more detailed instructions were given to local areas as to what they were expected to have achieved. A public health consultant said: “There is the perception that the CHD one is the best from the services point of view, because it is so precise.” Funding was attached to the document’s implementation. Although this was considered to be insufficient: “We don’t have the money to even get half way to delivering on the cardiac NSF, particularly on statins” (chief executive, 2001). Joint work between agencies to achieve the document’s targets led to an increased sense of shared responsibility for the issue. This is not to say that a rolling-out of such a method would have identical success in every policy area, or indeed that it would in the area of health inequalities reduction. However, the approach does appear to have suited local structures while a lack of such appropriate support from the national level has hindered effective local work to reduce health inequalities.

## **Conclusion**

Labour’s concern to promote public health and to see “good health [as about] more than the NHS”, is clear from its pre-election commitments of 1996. In the executive summary of *Renewing the NHS – Labour’s agenda for a healthier Britain*, public health is discussed a page before GP services. Of the five priorities listed, the first is to: “attack health inequalities” (Labour, 1996: 3). As explained in this chapter, a number of structural and incentive barriers made achieving this political commitment a sluggish project, these are listed below.

Firstly, although Labour had no great appetite for NHS reorganisation, all levels of the party appeared to agree that the Tories had taken clinical service arrangements in “entirely the wrong direction.” (Labour, 1996: 3). Therefore, reform was required and the main area for proposed change was to be primary care. The thesis has explained how the establishment of PCGs and PCTs delayed work to implement policy to reduce health inequalities. Coupled with these hold-ups, the unforeseen consequence of PCT formation was that the health authority, which was to have been responsible for the health improvement programme, was disbanded. The health authority did write a HimP, but by the time it was published staff in Lewisham were not interested in what it had to say, and many did not even see it. The development of Lewisham PCT resulted in five years of protracted uncertainty. This particularly affected public health leadership, as responsibilities moved slowly and at times painfully, from the health authority to the PCT, via the PCGs.

Secondly, the central departments of the NHS provided almost no useful technical support for local staff in planning work to reduce inequalities in health up to 2003. The Acheson report was all there was to go on, and that had been written with the DoH in mind.<sup>140</sup> Staff saw income inequalities as key to improving health inequalities and they were uncertain as to the most effective work that they could do at the local level. This led to some arguments, disillusionment and delays in the work of the local planning groups which had been set up to prioritise work to reduce health inequalities. Academic theory was warning the new government about the dangers of centralist control in the NHS (Le Grand et al, 1998: 141, 143). But health authorities and PCGs were not equipped to set their own targets for health inequality reduction and consequently this requirement was ignored. In any case, the most senior health authority staff interviewed felt that no sanctions would be taken by those responsible for performance monitoring against poor results in health inequalities work. While many local staff were at times bitter, cynical and bemused by numerous new strategies, audits, plans and requirements, it is important to sort the wheat from the chaff of these complaints and to try to understand exactly what their difficulties were.

<sup>140</sup> In August 2001 the Department of Health produced: *Tackling Health Inequalities: consultation on a plan for delivery*. This document provided a list of questions for local players and a year later, in June 2002, fed the results back. However, since it would appear that local players wanted more support in strategic planning to tackle health inequalities, to rely on their own recommendations was not the most appropriate action for the years 2001 and 2002.

Also, it should be noted that different groups of staff might experience different sets of problems and incentives. While some felt overburdened with paper work, none, at any level, seriously criticised certain national initiatives, policies and targets. For example, the national fruit in schools scheme, the Sure Start initiative, the National Service Framework for coronary heart disease, the policy to reduce inequalities in health and the national targets that were provided in *Saving Lives* (DoH, 1999) were all generally supported. Staff were therefore not always critical of central control, in fact, they under performed when such support was not provided. However, they were hostile towards a confusing array of changing requirements. They did not want to be put into situations where their work would be wasted and they would not get credit, because it was out-of-date by the time it was finished.

One conclusion of this investigation may at first sight appear to be unfashionable. That is, that more direction and support from 'the centre' would have helped. However, a more sophisticated recommendation is intended. The local area appears to need *both* more support and less 'interference'. More help is required in providing recommendations on strategic planning and priority setting to reduce health inequalities and less time, according to senior interviewees, should be spent on reporting what has been done.

Thirdly, clinical services were seen to be capable of blocking progress within public health. This was primarily because of acute sector demands on resources. The care of mentally disordered offenders and the prescription of statins were two examples of expensive services. It was generally accepted that treatments had to be provided, but there was also a view that advocates of health improvement strategies needed to make an effort to be heard, otherwise their work would be marginalised further. Initially *The NHS Plan* was widely interpreted as signalling a stronger emphasis on patient care, to the detriment of work to reduce health inequalities. The drive to reduce waiting times was seen as something the government needed to do in order to win elections, whereas there was a concern that health improvement work was not seen as a vote winner.

The investment of additional resources, albeit in short-term projects, such as the HAZ, brought quantitative increases in funds aimed at reducing health inequalities. The

money provided by the HAZ was welcomed by public health staff and was seen as a signal that preventive work was, post-1997, more highly valued. However, the future of this funding was often uncertain from one year to the next, which meant that HAZ staff were employed on temporary contracts and the whole programme appeared unsustainable. The fact that a new management structure was created for the allocation of HAZ funds led to the compartmentalisation of this programme of health improvement work and a duplication of planning arrangements.

While all these barriers led to significant delays in policy implementation, by 2002 and 2003 most public health staff were beginning to recognise progress in the consolidation of NHS and local authority institutions that would support work to reduce health inequalities. This took various forms. Firstly, the PCT's public health department gradually filled its vacancies throughout the period. Secondly, the new Director of Public Health agreed to chair the reformed health inequalities strategy group, which met again in the spring of 2003. Thirdly, national technical support was more forthcoming, for instance, in the form of the work of the London Health Observatory. Fourthly, the new 'co-terminosity' between PCT and local authority was taken by public health staff as an impetus to work more closely with non-social services council departments.<sup>141</sup> Fifthly, funds for health improvement, in the form of, for example, national neighbourhood renewal monies, continued to enter the borough and also HAZ funds were devolved to PCT control. Finally and importantly, the details of national targets to reduce health inequalities outlined in *The NHS Plan* were released and the new strategic health authority began to performance manage targets to reduce health inequalities.

On balance, statutory public health and associated health improvement work at the local level appears to have been institutionally strengthened by the move to primary care trusts. The increase in support from 'the centre', available firstly in the form of policy such as the CHD National Service Framework and latterly, in more specific briefings and targets relating to health inequalities is also considered to be a positive development. This finding contradicts much current thinking. A mutually agreed and understood balance between local and higher NHS roles and responsibilities is needed

<sup>141</sup> This was evident in a programme of local public health networking events where it was agreed that one session should focus on environmental health.

in order to further increase the value of the local target setting and monitoring process.

The character and success of policy implementation is not only dependent on institutional levers. In his critique of *The NHS Plan* Enthoven notes that he cannot entirely predict the outcome of the policy because the people staffing the NHS are an important factor making for success (Enthoven, 2000:8). The Conservative government's *Health of the Nation* policy was unpopular with local staff, not only for a number of technical and managerial reasons, but also because it was seen as ineffective in the context of wider Conservative government social and economic policy. Thus the thesis blends reports of institutional factors, agents' opinions and wider government motivations to create an analysis of health inequalities policy implementation. The next chapter concentrates on the values, beliefs and opinions of local actors.



## **Chapter 5 FINDINGS - VALUES**

### **Introduction**

Much of the literature on policy implementation considers the effect of local opinion on the fate of national directives (Lipsky, 1980; Hall et al, 1975; Kingdon, 1984). The beliefs and values of local staff have the potential to champion or frustrate implementation. Scope often exists for local players to decide on the details of what work takes place, to prioritise or de-prioritise work in such a way as to encourage or stall progress in particular areas and to influence the structure of local institutions. Local staff may feel that national government policy conflicts with their views, or does not go far enough in supporting them. Scope for local interpretation of policy means that implementation is influenced by staff perceptions. Disputes between staff may also arise within the local area, potentially distorting interpretation further.

Government recognises the power of collective staff views to affect policy implementation, as is shown, for example by the following passage:

“At the heart of modernised public services there needs to be a common sense of purpose. Within public health there is a clear consensus about the focus on:

- the protection of the public’s health
- health promotion and disease prevention programmes, and
- reductions in health inequalities.” (Secretary of State for Health, 2001)

Academic criticism of Conservative public health policy in the 1980s and early 1990s informed the incoming Labour government of 1997 (Moore, 1988; Benzeval and Judge, 1990; RSHG, 1991). The TUC and individual unions also attempted to influence policy in this area (TUC, 1982; NUPE, n.d.). In looking at local values it should be noted that, when forming policy in opposition, the Labour Party was said to have listened to the views of NHS representatives and was keen to be seen as the party to be trusted with the NHS and the public’s health (Labour, 1996). However, the thesis is not dealing with this stage in the life of the policy.

This chapter looks at the views of staff working in key areas for implementation of policy to reduce health inequalities. Staff from the public health department of the health authority, the Health Action Zone, the local authority, regeneration services and community workers were interviewed, as were local councillors and trade union officials.

The rationale for the choice of interviewee was described in the methods chapter. They can be grouped in a number of ways, and table 3.1 in chapter 3 should be referred to for this purpose.

The views and beliefs considered here refer to:

1. health inequalities
2. income inequalities
3. NHS neutrality
4. trade unions.

An assessment will be made of three factors relating to the above headings. Firstly, the general characteristics of local views and discrepancies in thinking between different local staff groups. Secondly, the extent to which local staff are 'in tune' with central government, the Acheson report (1998) and academic thinking. Thirdly, the extent to which policy implementation has been supported or hindered by staff beliefs on the issues raised. Reporting on these points is interwoven in the text under the four subject headings listed.

Sabatier (1986: 290) describes three levels of belief among coalitions of actors: deep core, near core and secondary aspects.<sup>142</sup> Sabatier's assumption is that near-core and secondary beliefs will not contradict deep core beliefs but may be more amenable to change. This is not at first sight convincing, since it might be imagined that secondary aspects could influence core beliefs, especially in cultures that allow for open discussion of core beliefs. Whilst the beliefs considered here may not fit with Sabatier's definition of 'deep core' they still relate to issues that, as at least one of the

<sup>142</sup> The defining characteristics of these are: deep (normative) core – fundamental normative and ontological axioms; near (policy) core – fundamental policy positions concerning the basic strategies for achieving normative axioms of deep core; secondary aspects – instrumental decisions and information searches necessary to implement core policy positions. (Sabatier, 1986: 290).

subjects pointed out, will affect career progression within the institutions involved and will also influence the success of policy to reduce health inequalities. They may be of deep significance to those involved. Thus, it might be said that Sabatier's categories are helpful in highlighting layers of belief. But they should not be interpreted rigidly, especially as players may hold contradictory beliefs, not having had opportunity to or 'space' to reflect thoroughly on them.

The thesis is also mindful of the possibility that interested parties may wish to control staff beliefs and/or the publication of their opinions. Government, opposition, private health care industries and trade unions may all accrue benefits from the broadcasting or suppression of dominant and minority NHS staff opinion. As the quote from government on the first page of this chapter indicates, for example, credibility may be enhanced in some scenarios where staff are seen to be 'in tune' with government policy.

## **Views on health inequalities – solutions, blocks and causes**

This section of the chapter looks at local beliefs about the mechanisms by which health inequalities can be reduced. Different approaches to reducing health inequalities were noted by a senior manager who covered health promotion work in the early days of the new policy's implementation in 1997-8:

"The first major problem was in people interpreting what was meant by 'health inequality' in completely different ways. Particularly at the health authority, who at the time when I was there, were still thinking of health inequalities in terms of whether black and minority ethnic populations accessed<sup>143</sup> particular services. And so actually getting them using a broader social model of health and looking at impacting on determinants of health was not ..currency really. So it felt that the difficulties were about a lack of common understanding about what that area of work meant and inexperience in all of us in terms of what that actually meant you did. And I think...things have moved on ...people have started to develop in the last two years..."

<sup>143</sup> Here 'access' to services is taken to mean a combination of Donabedian's 'structure and process', and it results in differences in outcome (Donabedian, 1966).

Differential access to services by black and minority ethnic groups is one element in Acheson's analysis of health inequality causation within a model that emphasises the social determinants of health. So this respondent could be interpreted as noting a difference in the weight accorded to different aspects of the Acheson report. Disputes between staff, for example, on the importance of focusing on access to services, meant that multi-agency planning was frustrated and lines of accountability were challenged in the early days of policy implementation.<sup>144</sup>

Such clear-cut fault-lines in thinking between whole agencies were however, not widely reported, or apparent from observation. But, it did emerge that different respondents gave differing weightings to particular aspects of work to reduce health inequalities. Six areas of contention concerning the impact of different factors can be listed, and the relative importance accorded to these issues in contributing to a reduction in health inequalities will be considered. The areas are: 1. Local post-1997 initiatives specifically designed to reduce health inequalities. 2. The role of NHS services. 3. The role of 'social capital'. 4. The effect of resource restrictions. 5. The extent to which health inequalities were linked to income inequalities. 6. Links between race and health inequalities. These are looked at in turn.

### **1. Local post-1997 health inequalities initiatives**

Staff cited a range of local work areas, initiated or expanded since 1997, that they considered were good examples of effective work to reduce health inequalities. Free fruit in schools and breakfast clubs were the most frequent examples given. It is significant that free fruit in schools is the clearest recommendation for local action in the Acheson (1998) report, thus underlining the influence of the report.

Generally, the expansion of regeneration work in geographical areas such as New Cross was seen as important among staff from all sectors. Effective lobbying to increase social security benefit flexibilities was cited by some staff who knew that this

<sup>144</sup> As reported in the previous chapter, a difference of opinion on the importance of access issues was noted between staff discussion at the Lewisham health inequalities conference (2000) and the Lewisham HimP conference (2002). In the latter conference access was of more concern. This could be attributable to the different mix of staff groups and grades present, generally there were more senior staff from professions such as nursing at the second event.

had been undertaken by the employment group of the HAZ. Staff working closely on programmes to reduce teenage pregnancy and support parenting also saw these as offering improvements. The Sure Start programmes in Lewisham were gearing up during the interview period and these were also regarded as good models for progress.

Interviewees made some recommendations for expansion of this work:

- Accidents and safety work
- Benefits advice
- Increases in numbers of community development workers
- Credit unions and LETs schemes.

The need to increase work to address sexually transmitted infections and mental health promotion was also raised in a number of forums (for instance in the Lewisham public health workstream).

A number of staff, particularly from public health, were satisfied that the general work area of the HAZ picked by LSL in 1997 had been 'children and young people'. The Acheson report clearly supports this choice. There was also some disquiet as to the fact that the DoH had subsequently attempted to expand the remit to include adults and all NSF areas.

Staff were generally supportive of the aim of reducing health inequalities via local initiatives. In this respect they appeared to differ from strong academic advocates of upstream<sup>145</sup> change to reduce health inequalities who seem to be sceptical about the merits of much downstream work (for instance, Shaw et al, 1999). However, staff were unsure of their role in upstream work. If (as most did) they supported the theory of the wider determinants of health and the need for upstream work to address health inequalities, they had difficulty in working out the correct role for downstream workers within this context. Staff wanted to know if support for the need for upstream work meant that downstream workers like themselves, should be involved in upstream type issues, or in influencing upstream work. As will be apparent from the discussion

<sup>145</sup> The terms 'upstream' and 'downstream' used in the Acheson report (1998) were common currency among public health and health promotion staff. But staff with a public health remit, working outside these departments, were not so conversant with the terms.

below, they arrived at different answers. For example, some emphasised a need to educate local people in using their money well and others stressed that nationally, state pensions should be increased.

Recommendations to increase work on benefits advice and community development indicated a model of change which is not within the 'victim blaming' mould, but again is congruent with the 'wider determinants of health' model, as described by Acheson. The area of benefits advice demonstrated the most clear-cut gulf between NHS and local authority thinking. Benefits advice within primary care settings in Lewisham was being reorganised and expanded with the aim of increasing up take. "Putting money in people's pockets" was seen as key among senior primary care staff. However, this was not the council's position, where benefits advice services had been closed down in the early 1990s. One councillor said:

"We have moved away a long time now from the old fashioned anti-poverty strategies that most councils used to have, what did the anti-poverty strategies of councils use to consist of? It was really about benefit take-up campaigns. Whereas now national government is moving from the dependent welfare state to getting people into the labour market. So we have a different range of policies and initiatives to move away from the welfare dependency concept, it is not about take-up campaigns and maximising benefits, even though people should know their rights and entitlements."

NHS staff did also recognise a need for work to improve local employment prospects, education and aspirations, and to reduce school refusal and exclusion. Senior staff in public health and primary care were concerned that the NHS should "facilitate the employment of local people." This concept had been addressed in a HAZ employment workstream project. However, one PCT staff member reported that in a planning forum involving GPs and other practice staff: "they looked at me like I was mad when I suggested that we should encourage local employment." This was because the proposal was considered to be beyond the remit of NHS staff. The high priority accorded to un/employment issues by senior NHS staff was not translated into highly visible initiatives or even known about 'on the ground'; although this situation was changing towards the end of the research period. For example, a 'Recruitment and

Retention Officer' was appointed in the local community health trust at the end of 2001.

Generally, effective work to reduce health inequalities was regarded as “extremely complicated and multi-factorial”, “like wading through treacle” and “something we are struggling with”. Hence the annoyance in some quarters when the HAZ remit was expanded (as referred to above). The need to focus on a smaller number of areas, and ‘not spread ourselves too thinly’ was expressed by three senior members of the health authority/HAZ team. As one said: “I think that there is just so many different things that we could do and the motivation of people is to try and do it all and it is actually quite hard to say, we are not going to do it all”. Some things would need to be left out “which have just as much of an impact on health inequalities.” Reducing health inequalities and improving health was also regarded as a slow process. There was concern that government would want ‘quick wins’ and therefore not prioritise the area of work.

## **2. The role of NHS patient services in reducing health inequalities**

A wide range of non-medical staff connected with public health and health promotion were critical of what they called ‘the medical model’. This was understood to be a view that gave priority to the role of medical services in health improvement and underplayed the importance of the ‘wider determinants’ of health, as referred to in the previous quote. As one senior HAZ worker suggested:

“...[Addressing] health inequalities is just so large because it is about housing, and it is about diet and it is about schools and educational attainment, and it is about parenting skills and life chances and expectations ..Although I think health [that is the NHS], or a large chunk of health, has come a long way about understanding that health is not just about health services...I think translating that theory into practice and joining all those different services – we have still got an awful long way to go..”

Locating ‘medical model’ thinking in the responses of interviewees was not fruitful. Those connected with GPs informed the researcher that GPs now had a clear, or clearer, ‘understanding of the links between health and poverty’. For instance: “If you

talk to GPs about how inequalities affect their patients they are completely *au fait* with it and are very clear about it...so I think that has changed...whether there is any more real change I'm not sure.." (senior practitioner). Another respondent said: "I think amongst a number of GPs there is certainly a stronger recognition of the links between poverty and health.." (senior manager).

Most of the respondents regarded the NHS as playing a role in reducing health inequalities only in conjunction with other agencies. Public health staff, in particular, saw the NHS as having slightly less of a role in this, compared to other agencies. They tended to think that regeneration work was of particular significance. Some staff questioned the extent to which the NHS could really do any effective work to reduce health inequalities and suggested that wider economic reorganisation was required if more was to be done than simply "manage poverty".

One area where the NHS was seen as playing a role was in ensuring equal access to services for asylum seekers. Access to interpreting services was cited as an important component of this. Respondents further from the public health 'core', that is community development workers and councillors, were more likely to regard NHS services as being of particular importance to health inequalities work. Poor patient accommodation, services and care within the local the NHS were cited by a number of respondents as detrimental to the aim of reducing health inequalities.

" We are trying to develop better conditions for [mental health] service users ...the conditions in hospital are not conducive to people getting better...there's a big stench ..when you go into the mental health unit, staffing levels are quite low...the hospital has not even got any facilities for people suffering from mental illness apart from beds, and a few little lounge areas ..." (community worker).

One regeneration officer thought that GPs in some local areas, where people tended to be on lower incomes, were "hopeless".



### **3. Social Capital**

Various staff working in health promotion and community development looked on any research which showed that ‘involvement’ of local people in community activities helped people’s health as a good thing and as providing justification for their work. However, staff were not very familiar with detailed evidence to support their case.

“...just participating in arts, life-long learning, there are all sorts of things going on in this area that people [do] .. and I think those sorts of things.... really can go quite a long way to improving health in the long term..” (community worker). This subject is returned to in chapter 6.

### **4. The effect of resource restriction**

Those who believed that restriction in resources was a very significant element in determining the extent to which effective work could take place tended to be senior NHS staff from both the PCGs and public health. As one said:

“...we need to look at the prevalence of CHD, stroke, renal disease, and diabetes for our ethnic minority population, and we have, but we really need to rejig services.. and ..we have not had the growth money to do that....We don’t have the money to get half way...to delivering on the cardiac NSF, particularly on statins...” (chief executive).

Debt on managing mentally disordered offenders (MDO) of around £5.6 million was cited by these staff as a key problem for local NHS services, as was investment in primary care. The debts of the acute trusts were also referred to. Finance, for these staff, was a lever. “...history tells us that we don’t change the way we do things unless someone has beaten us over the head with money...” (chief executive).

One community development worker felt that investment in preventive measures and a reduction in health inequalities would save money in the longer term. This view was shared by two senior NHS managers. However, they felt that getting sufficient investment ‘up-front’ in order to save money in the long run had been and continued to be extremely difficult, especially given the MDO spend referred to above.

## **5. Links between health and income inequalities**

All the respondents regarded local work to reduce health inequalities as important and, as mentioned previously, did not believe that the only really effective work that could be done was at the national economic level, via for example tax and benefit changes. However, all but three respondents (one from the voluntary sector and two from the health authority) saw a close link between income inequalities and health inequalities. Generally staff working closely with public health, both in the statutory and voluntary sector, tended to see national economic policy as being of relatively more importance than their colleagues.

One public health consultant summed up the relationship between local and national work as follows: “It is a bit like saying the best thing you can do to reduce road accidents is to stop drink-driving or stop speeding, that is true, but it still doesn’t mean that you should not pull a child out of the road ..there is still local action that will need to happen ..” A typical view of the link between income and health inequalities is given by one director of public health: “I am quite sure that the gradient in incomes is matched by the gradient in health...I think the policies of the Treasury have more impact on health than the policies of the Department of Health.”<sup>146</sup>

There was a view in some quarters that aiming to reduce health inequalities was less politically sensitive, and therefore easier, than talk of reducing income inequalities. The chief executive of Lewisham Council in his address to the borough’s inequalities conference of 2000 quoted a King’s Fund fellow, Anna Coote, as having expressed this view to him. There was also a belief held by some staff that they and their colleagues should work with the opportunities available and that central government was not supportive enough to be trusted to deal with the issue:

“ .. It is not enough to say ‘oh it is a big national issue we shouldn’t touch it’, because if we say that in the inner-city then everybody will say it and nothing will happen. ... it may be if you go for one single thing then the best thing should be national and should be around income, but it is better to do something than nothing.....there is no decent primary care service in this

<sup>146</sup> Debates on the subject were presented in chapter 2.

area...it is hard to see how you will get there just from economic policy....so I think that it is quite a disabling message, to actually sit back and wait for somebody else to sort it out..." (chief executive).

Two respondents who had weaker connections with public health, and in one case had not heard of the Acheson report (1998), did not see a connection between health and income inequalities. One health authority employee said:

"I think that there is probably a lot that can be done locally around educating people in how they use their income...I don't think that increasing income is going to be the answer in addressing inequalities in health because people will spend more money on mobile phones, ..computers...dozens of things, rather than actually knowing how to prepare quality food or bothering to travel to buy good quality food because it is a low priority for them, and unless you can change that ..no amount of income will actually improve health. ....I think it [income inequality] is a contributing factor or one of many contributing factors and it is no good tackling that alone."

One community development worker held a similar view:

"unemployed blokes between [the ages of] 30 and 50 spend three times as long in front of a television...the issue is not that they have a low income, but that they take insufficient exercise and the reason why they take insufficient exercise is because they are not motivated to ..I am always fascinated by the fact that if you walk around council estates you will see loads more satellite dishes on council flats than you do walking down residential areas, better class areas ...I don't think there is a straight line relationship between income and health."

Views such as these were almost never heard in public health and health promotion staff circles, but away from this group they were a distinct, if minority, opinion. While these minority opinions may seem to be at odds with those of the director of public health quoted above, the two are connected by a belief in the importance of education, coupled with employment and motivation. Staff who linked health and income

inequalities more closely tended to be those who also thought the NHS had a more secondary role to play in addressing health inequalities, and also tended to be those who wanted to see a reduction in income inequalities. But these correlations in beliefs were not absolute and a range of depth of expression was observed.

Drug and alcohol problems were cited as an area of public health concern by some interviewees, but perhaps less so than might have been anticipated. Due to the local arrangement of services, whereby drug and alcohol prevention work was the responsibility of specific council-led services and not of the NHS health promotion unit, the topic was perhaps lower down on the local NHS' agenda. The view that hopelessness and boredom led to substance misuse, which in turn fuelled crime, was put forward by one staff member outside of the interview setting. This could be interpreted as supporting a perspective that does not see income inequalities as the main cause of local problems.

## **6. Links between race and health inequalities**

A correlation between certain ethnic groups and ill health was widely acknowledged within the local policy implementation community. From before 1997, Healthier Lewisham had one board member who represented a voluntary organisation particularly addressing high blood pressure among African-Caribbeans. The inequalities sub-group, after their conference, started to work to the recommendations of the conference workshop that had looked at issues of health inequalities and race (plus recommendations from one other of the eight workshops). However, the extent to which inequalities in health between different ethnic groups should be the focus of work to reduce health inequalities attracted a range of opinion. As chapter 4 described, the LSL health inequalities group set up to look at the issue for the HimP had two members who believed that race was the only issue to be addressed when looking at health inequalities. Other members of the group felt they were seen as racist for challenging this view. Similarly, within Lewisham one member of the health inequalities conference planning group had the view that race was a more significant determinant of health inequalities than income. Within the latter group, debates and confusion did not cause acrimony, but did, as has been described in the previous chapter, cause delays.

Those black staff interviewed (5) tended to draw attention to general inequalities between different groups particularly those between men and women and those with disabilities, as well as health inequalities between ethnic groups. None of them considered that health inequalities work should exclusively address the gap in health between ethnic groups, although all but one felt it was a significant issue.

The lack of clarity at the local level on the extent to which health inequalities work should address health issues among African-Caribbean and Asian populations perhaps highlights a difficulty that local staff have in easily interpreting the Acheson report (1998) on this. Although the report details gaps in health between different economic groups and between different ethnic groups, it does not compare the influence of both factors. Local staff were not clear as to whether the mortality of, for example, low income white males is likely to be higher or lower than, for example, high income males of Asian origin.<sup>147</sup>

The interplay between ethnicity and social cohesion also appeared to be a source of confusion for interviewees. One community development worker saying: “you can’t link people up in one group because people have all sorts of different value bases now and belief systems.” Another council officer felt that it would be more difficult for Britain to move towards lower income inequalities than for example Sweden, because of the greater diversity of the British population. “We’ve got to juggle to take into account a lot of ‘difference’, that means considering a lot of different agendas and looking in much more detail at smaller communities because we have got an awful lot of diverse communities...”<sup>148</sup>

One regeneration officer also believed that refugees and asylum seekers from Africa and Eastern Europe would not relate to a “socialist philosophy, a Labour sort of view of the world,..OK they have got nobody else to vote for, so they will probably vote Labour, they can’t possibly vote Tory,..so they are inevitably going to, if they vote at all, vote Labour.” He did not elaborate on why non-Western Europeans should be less likely to relate to left-of-centre ideology.

<sup>147</sup> The evidence was briefly discussed in chapter 2.

<sup>148</sup> This, debatable, view is reflected in academic literature. For instance: March and Olsen, 1996, in Hill, 1997b: 146.

In summarising this section on beliefs concerning the effectiveness of different strategies to reduce health inequalities it can be said that there was a high degree of compatibility between the views of local staff and the analysis provided by the Acheson report (1998). That is, staff generally accepted a model of the determinants of health that was socio-economic. However, there was no consensus on the balance between different factors in this model.

## **Income Inequalities**

Given the almost uniform belief among the policy community charged with reducing health inequalities that there is a close link between health and income inequalities, it is pertinent to look at their beliefs concerning income inequalities. Participants were asked to try to stand aside from their work role and say what they really thought about income inequalities in Britain today and whether they thought they could or should be reduced.

The overwhelming majority of those interviewed apparently held a strong belief that income inequalities were too great. One community development worker expressed the following opinion, similar to a number of others: “They can be reduced more than they are, not to the level I would like them reduced to, I don’t think...I think the income inequalities in this country are obscene, ... I do think you could make a major difference to people’s health by reducing them.”

A small number of participants hesitated to say that inequalities should be reduced. They were reluctant to distinguish *reduction* from *elimination*. One community development worker said the following:

“ I think it is a misnomer to talk about income inequality in the first place, ... I think the real issue is about a minimum standard of living that you would reasonably expect people to have access to...otherwise you are getting onto really dodgy ground, you are moving into the realms of the Israeli kibbutz or a commune approach where the skills you have bear no relationship with what your income is ...”

Other participants wanted moves towards reduced income inequalities to be coupled with additional support through services, increased work to reduce racial discrimination and help in encouraging participation. Thus one community development worker said: “...it is preferable to move towards less difference, definitely. Income is just one part of it, initiatives that would support single parents’ groups ...would greatly aid some of the inequality ..and a lot of working class communities and minority ethnic communities work shift patterns, unsocial hours, that is all part of health inequalities, and then links with transport...” . Another senior health promotion officer said: “increased benefits through higher taxation would be something I would go for and community development projects to support people in making the most of what they have and in taking part..” Another interviewee, a council official, felt that people on a low income were more likely to have a fear of authority and not to like to ‘bother the doctor’ for instance and that this should be addressed.

For staff involved in employment training schemes, while there was a view that “basically poor people are less healthy”, there was a marginally stronger sense of employment being the best link to improved income: “getting people into work, having work gives the income, and therefore work and health become closely related.” There was also a view that qualifications were only part of the route to work: “particularly with young black men ..it is not necessarily the qualifications it is ‘job ready’. ....Getting people into the world of work, checking out their own attitudes to work, getting them out of bed, being a team player, being well presented..” A number of senior health service figures also emphasised the close links between income, employment, education and motivation.

Two trade union officials were interviewed for the research. One, an adviser to the Mayor of London and a Unison officer, was asked if it would be possible for the TUC to have a policy on income inequalities. He said that to some degree the TUC does have a policy, and that Unison does so to a greater degree:

“...the Tory budgets, which massively reduced the higher rates of tax, and Lawson’s budget in particular, saw huge give-aways to people who were already rich, and allowed people to literally get an extra ..gardener...I think

you will find that in the TUC budget submissions that it makes every year to the Chancellor and in its general economic policy, certainly in ours [Unison's], we have produced lots of documents on this, we would argue for much heavier rates of tax on the higher paid, certainly a higher rate of tax for those earning over £100,000 if not below, and also a wealth tax, and generally speaking far greater redistribution..."

'Pay differentials' was an area where one 'New' Labour councillor felt the government should improve:

"... something has to be done, it is one thing that the Labour government has failed to do in the last three years is to narrow pay differentials, in fact what it has done, it has seen a bigger difference...and it continues to increase... I think that people should be paid no more or less than their real value, that is easy to say!.. [laughter]. So a senior director of a company who gets an increase which puts their salary up to 4 million pounds a year.... I still have great difficulty in accepting that that person really needs all that money..."

But the same councillor went on to say that:

"What people get paid is important to them, but it may not actually be the most important thing, because if you have got a good home and you have got a good family, and good health, you can do what you like.....there is only so much that other people can do for an individual, it does not matter what the trade union does, the government does, friends do, it doesn't matter where you live, it does not matter what the family does for you, it matters what you think inside, if you have a positive expectation of achieving anything at all then the chances are that you will do it....and the reason that there are these inequalities in geographical areas is that if somebody is told time and time again that you live in an area with massive deprivation and your expectation is really low of ever getting out of that, you never will."

A member of the HAZ team was also concerned about the effect on people from poor areas of being constantly told they are from bad, deprived, sink estates.



Some others echoed the councillor's sentiments that people on high incomes don't 'need' what they have. One chief executive said: "I would be prepared to pay more tax if it would mean there were a level of redistribution, because half the time we don't need stuff that we have, I don't think it is necessary to drive around in £49,000 cars." Whereas one or two others, while clear in stating that they wanted income inequalities to be reduced, stressed that they felt that the rich would not disappear. They made comments such as: "there is always going to be the very rich, but that is OK I don't think we are ever going to get rid of that." (senior NHS manager). Thus debates on income inequalities associated with Tawney (1964) and others, discussed in chapter 1 were very much alive on the ground in local staff opinions stimulated by the interview discussions.

Moving from the desirable to the possible, there were mixed views on whether income inequalities could be reduced. Generally those in more senior positions both within the council and the NHS tended to be more optimistic about the possibilities for change. 'Locus of control' theory would seek to explain such a dichotomy in terms of more senior staff being likely to have a stronger internal locus of control or sense of power (Strickland, 1978; Lefcourt, 1982).

Four NHS employees with close links to public health argued that it was important, based on the evidence of the Acheson report (1998), not to focus redistribution on the worst off but to redistribute to the less well off as well. Notwithstanding a range of caveats the views from this constituency are summed up by a senior practitioner: "I think they should be reduced further, definitely, I think there is still far too big a gap between the haves and the have nots."

There was a body of opinion, particularly within the voluntary sector, that argued that unless the 'economic system', or 'capitalism' was changed, nothing would really improve. This polarisation of solutions has also been witnessed in academic public health-related conferences. It can be related to a context in which New Labour has moved away from social democratic thinking towards a more market-orientated approach. This perhaps leaves some sections of opposition to this trajectory more

willing to consider that nothing can change without fundamental changes to ‘the market system’.

Various reasons for pessimism in the ability of British society to move towards greater income equality were given. Firstly, as referred to in the previous paragraph, a number of staff (5) thought that the market economy restricted the extent to which inequalities could be significantly reduced; that is, reduced enough to affect health inequalities. For instance one community development worker said:

“I was wildly interested in Cuba, short of installing a communist system with similar wages for everyone and a job for everyone, I am not sure how you would achieve that. But the health equality thing (in Cuba) is quite incredible because in a country that is falling apart there is lots of extremely well educated, very healthy people running around, it is an interesting model. The US is a dreadful place to look at, the differences there are even worse than they are here..”.

This interviewee was unaware of the HoC Select Committee’s interest in Cuba.<sup>149</sup>

Another community development worker felt that:

“I would like more equality across the board, but with our market economy that is not going to be possible...the Thatcher years brought us to where we are now ...and Reaganomic theory...their ‘trickle-down’ theories. America is capitalism gone mad, I lived there so I know, our capitalism is a lot more moderate but we are getting there, our model will always be America unless we change our mind-set. When our politicians want to learn something about working with young people or criminal justice or what ever, we go to America, new innovations they come from Harvard, Yale, Princeton whatever...”

<sup>149</sup> They chose to visit the island “since it achieves excellent health outcomes despite the fact that its resources are very limited.” (House of Commons Select Committee on Health, report on public health, 2001, introduction: 12).

One HAZ worker, whilst thinking that reducing income inequalities was “desirable”, considered that there was not sufficient “political will”; and that “there are quite strong political drivers for maintaining or actually increasing inequalities,....in terms of numbers they [the very rich] are an insignificant group although they have a disproportionately high profile and probably disproportionate access to the media that gives them that profile and enables them to voice their opinions loudly.” The HAZ officer considered that the first-past-the-post electoral system meant the ‘middle block’ in electoral terms became the most important, so that even when there was work going on to reduce inequalities it was not worth it for the government to sing about them.<sup>150</sup> An ‘Old’ Labour councillor also thought that the Labour Party was now more concerned with ‘women of Worcester’ than with lower income groups.

A small number of interviewees referred to the effect of new and expensive medical technology on health inequalities. One NHS employee in particular considered that very advanced genetic techniques and replacement body parts would only be available to the very rich and that, as a result, the gap in health inequalities would increase. Pressure from the very rich not to reduce income inequalities would also be sustained because of the medical benefits accruing to them. This interviewee also felt that although reducing income inequalities was desirable, it might lead to an increase in ill health among the better off.

A final note of pessimism regarding the chances of reducing income inequalities resulted from a trend observed over the years by one chief executive who had experience of working with local councillors. “You don’t get them [councillors] thumping the table and saying this is around the re-distribution of wealth issue, that debate does not take place any more and I am sure it did ten or fifteen years ago.” This interviewee’s view was that staff in prominent positions won’t “step out of line....you won’t get an NHS chief executive rolling up his shirt sleeves and saying ...we need to look at the issue of income ...not unless there was a framework within which it was politically safe to do so.. We don’t seem to talk any more about the inequality issues because it sort of plays into that whole issue ..about redistribution of

<sup>150</sup> The journalist Polly Toynbee (2002) shared this view.

wealth.” As a result, she felt the issue was not within popular consciousness, and was less likely to be addressed.

However, there was another body of opinion that was more optimistic about the ability to, and chances of, progress to reduced income inequalities. One ‘Old’ Labour councillor considered that the government’s pledge to reduce child poverty would be effective in reducing income inequalities. And a ‘New’ Labour councillor also gave a range of policy tools that could be adopted in order to reduce income inequalities: “we need a whole raft of national policies to address income inequalities ...through taxation or whatever...” A chief executive cited increased child benefit, tax reform and support with access to mortgages as three initiatives that could be introduced.

One senior NHS manager listed the government’s policies of support for education and employment initiatives and the national minimum wage as positive progress towards reduced income inequalities. She said that she had recently heard a presentation from a member of the Child Poverty Action Group who was optimistic about the effects of the government’s policy to reduce and eradicate child poverty.

The policy most often quoted among interviewees as having a direct effect on income inequalities was the introduction of the national minimum wage. Council officers and members, along with NHS staff, cited its importance and a number of interviewees wanted to see it increase further. A number saw the unions as having been responsible for its introduction. The Unison official interviewed said: “One of our priorities has been increasing the national minimum wage, we have commissioned an awful lot of research over the years and part of our argument has been to do with issues like ill health.” One interviewee with considerable knowledge of local small businesses thought that even they would not be too concerned with an increase in the national minimum wage. What SMEs did not want was a large number of small hikes. For administrative and planning purposes they would much prefer to have larger increases less often; the bureaucracy of managing the increase was their major concern.

There was also uncertainty among all groups of staff as to what could be achieved and why income inequalities in this country were generally higher than Sweden and lower than the US. Many interviewees said that although they wanted to see a reduction in

income inequalities they ‘didn’t know enough about it’. In relation to Sweden’s lower levels of income inequality one public health consultant said:

“I don’t know how it [Sweden] does it. I mean on the one hand, yes I absolutely do think that we ought to reduce income disparity; I do think that it is ridiculous that some people can earn absolutely vast quantities. On the other hand in order to keep our economy functioning I keep hearing the argument about how we are not paying our fat cats as much as everywhere else and they will drain away, so I honestly don’t know.”

### **NHS pay differentials**

Interviewees were also asked what they thought of pay differentials in the NHS. The reason for asking this question was that, in an article in the *Health Service Journal*, a Kings Fund director had said that, before starting work to address health inequalities, NHS managers should firstly address the issue of NHS pay differentials (Appleby, 2000). Generally staff, however, were not very clear in expressing an opinion that indicated they thought that the salaries of the lowest paid staff (e.g., cleaners or porters) should go up in relation to those of the highest paid (e.g., directors, chief executives and doctors).

Senior NHS managers saw strong connections between employment issues and health inequalities. Although, at the time the interviews were being conducted there seemed to be little awareness between senior managers that others in their position shared similar views. Subsequent to the interviews the chief executive of the community health trust left to join the new ‘NHS workforce confederation’ and a number of other, unconnected, recruitment initiatives gained more exposure.<sup>151</sup>

Different concerns within the discussion attracted different interviewees’ attention. One community development worker felt that NHS managers were paid too much, especially in relation to the voluntary sector: “I think that there are an awful lot of people in health who don’t need to be paid what they are paid, I think the money could be better spent.” Another interviewee said that, in the course of consultation on

<sup>151</sup> These were led by the community health trust’s human resources department and the HAZ.

the formation of PCTs, comments had also been made on disparity in pay between the voluntary sector and the NHS, which was said not to support 'partnership working'. The same interviewee also said that pay should not be so low as to need supplementing through benefits as happens in the NHS. They found this situation "staggering.... lunacy...you've got an organisation [the NHS] that in its broadest sense ought to be increasing people's life changes.... and they [its employees] are actually on benefits."

Other voluntary sector interviewees simply felt that nurses were 'drastically underpaid' but did not have any other particular views on NHS pay differentials. One, in particular, felt that all staff providing direct patient care should be paid more than support staff. This person also thought that nurses were poorly paid because the tradition of charitable health provision that had existed prior to the formation of the NHS still pervaded employment rationales (the same view related to the education sector). This ethos meant that wages of, for example, head teachers would only increase on the basis of a 'desperate' need to recruit staff and not because there was a real value placed on public sector work. Another voluntary sector employee thought that pay differentials in the NHS should be looked at because those jobs that were occupied predominately by women saw worse pay. "...it almost feels like there is in-built discrimination that is just there historically."

A number of staff were influenced in their views by a consideration of the London housing market. They considered that almost all but the highest earning staff could not afford to buy housing and were therefore not sufficiently well paid. One interviewee who clearly expressed a belief that NHS ancillary workers, nurses and ambulance staff, should be paid more, thus closing the pay differential with doctors, was the Socialist Party councillor. While one 'New' Labour councillor also thought that pay differentials across all sectors and not just in the NHS were too high, another thought that for NHS services that had been out-sourced, such as cleaning, catering and car-parking, "the market should set the rate". Contractors should be asked in the tendering process if they pay the national minimum wage.

One senior NHS manager thought that it was crucial to consider the issue of pay in order to recruit and retain staff. Since the local NHS was the largest employer in

Lambeth, Southwark and Lewisham, NHS employment terms and conditions had a “huge role” to play in local people’s lives. But the interviewee was unclear what pay scales were being used across the different local NHS employers. Therefore, they felt that an audit of local NHS pay was needed: “I don’t really quite know the truth of what has gone on”. This manager also thought that there was an urgent need to recruit young black men into mental health nursing services. This was because: “87% of the mental health patients on the key mental health wards are black men between [the ages of] 18 and 24, why are we not recruiting young black men to come and do this job? Why are we not having recruitment campaigns that say to those people who may never considered a career in the NHS (not just in nursing)– ‘this is for you’?”

One senior NHS manager did not know that NHS related pay differentials had grown and felt that chief executives needed to be paid the wages they received because their jobs were at least as complex as private sector executive roles where salaries were much higher. However, this manager also considered that NHS pay differentials should not increase and that we should “certainly, if anything, be trying to reduce them.” Another senior NHS manager agreed with the ‘New’ Labour councillor quoted previously. They felt that “the market rules” and that higher salaries had to be paid to get people into the jobs that needed to be done. Whereas one senior NHS manager from within the health promotion/public health service thought that the NHS:

“really needs to consider some of its employment practices. I think cleaning and portering staff being contracted out, that is not congruent with the aim of promoting health, if you are paying people on a subsistence salary....[It is] not just pay differentials, the NHS has to look at issues such as racism, homophobia, sexism and treat them seriously because at the moment the NHS is largely managed by a ...tire of white middle-class managers....the NHS has also got a recruitment problems in nursing, therapy and medical staff in central London where people cannot afford to live anymore.”

One doctor thought that not only should administrative and clerical staff be paid more within the NHS but that services would improve as a result. “I think it is probably true if you are really going to get things to happen....why have you got a 50% chance of going to the diabetic clinic and not getting your records back? Well, people don’t

actually pay records staff much, they don't put much premium on them, so they get the service that they pay for." Though they went on to say that the situation was difficult since in theory to increase nursing and occupational therapy staff salaries you could be "lopping money off doctors", yet the government was, at the moment, putting additional demands on doctors and expecting their good will. The assumption was that the total wage bill for the NHS should be taken into account in NHS pay discussions. This style of thinking was evident in discussions on the relations between the acute sector and public health, where some staff suggested that the only way for public health to gain more funding was for acute services to be cut. The interviewee thought that pay differentials between doctors and nurses were being reduced slightly but "not by very much". However, she posed the question as to "work in a multi-disciplinary team where one person is paid a huge amount more than the others and a couple of people are paid a huge amount less it is not exactly on, is it?"

Another senior manager in the health authority felt that it was very important to address the issues:

"How can we be part of addressing health inequalities which we know has a basis in income inequalities and at the same time be an employer that does not deal with those amongst a whole tranche of the population locally that is employed by the NHS?.... Is enough being done by the NHS? No....I think that people are not clearly focused on the connection [between pay differentials and health inequalities] and are not focused on doing something about it. It is in two different boxes, here is employment policies in the NHS and pay and issues of recruitment and retention and here are health inequalities and I think the two are interlinked."

In conclusion to this section, it can be said that individuals within the local policy community held an almost uniform belief that income inequalities should be reduced. In the course of participant observation these views were never referred to outside of specific meetings about health inequalities, although, neither was there open contradiction of them. Generally staff in interviews swiftly linked health and income inequality, but they were uncertain of the chances of income inequality being reduced. This combination of beliefs fed a sense of personal ineffectiveness in some staff,



while one or two of the more senior staff explicitly challenged, as ‘disabling’, the view that nothing could be changed. A wide range of views was held on the need to reduce pay differentials within the NHS. Generally, senior NHS staff were supportive. However, there was a small but significant body of opinion that felt the market should determine the wages of the lowest paid. This was within the framework of a national minimum wage, but meant that the current pay differentials were considered to be correct.

As mentioned in the previous chapter, health inequalities work was ‘popular’ and one of the reasons for this was that it was congruent with political beliefs about the desirability of reducing income inequalities. One public health staff member even explicitly suggested stressing the links between income and health inequalities in order to encourage more voluntary sector staff to come to meetings planning work in this area.

## **NHS Neutrality**

The thesis has already established the importance for local staff of income inequalities in determining health inequalities. Some staff also saw the question of income inequalities as an area of political sensitivity. Therefore, what NHS staff can and cannot say on the political issue of income inequalities becomes relevant. Staff were asked to consider if they felt that the NHS was supposed to be politically neutral. The findings suggest that there was no very consistent view on the extent to which, in practice, it was, or was not, politically neutral and whether neutrality was desirable, or not.

Some staff regarded the NHS as too politically driven and therefore not geared to addressing real needs. An example given to back this up was the introduction of walk-in clinics in major railway stations. It was argued that this development had been engineered to earn support from a particular constituency of voters; while appealing to commuters, it was not catering to those most in need.

A number of staff, however, thought the NHS should speak out on politically sensitive issues, such as the links between income inequality and health inequality.

One NHS employee said: “I think it is unfortunate that the NHS is so politically neutral. My background prior to this job was in a very campaigning organisation, when I came in to start here I thought ‘this is peculiar the things that people accept as given’.” And a local authority employee thought that “given there is evidence of the impact of income distribution on health then there is actually some imperative for public health advocates, most of whom reside in the NHS...to be leading on some of those issues, so I don’t think that it is a no-go area. Public health departments are best placed to have that kind of role because they are there to advocate on behalf of the public. They don’t all see themselves in that role.” Another respondent, close to the NHS, saw this role for public health - to speak out and to say the ‘unpalatable home truths’ about the NHS - as the job of the director of public health, who she felt had, at times in the past, fulfilled it.

A substantial number of NHS staff did not see their role in health inequalities work as held back by any requirement for the NHS to be politically neutral. This appeared to be mainly because they did not seem to feel any restrictions on what they said or did. However, in at least one case it was because the respondent agreed with government policy. “It does not seem to arise as an issue ...it did arise I suppose with a previous government over issues, locally people were not particularly, at first, very keen on – GP fund holding.”

Only one interviewee saw any serious problems in the NHS becoming embroiled in political issues:

“Voluntary sector agencies have a role as lobbying groups on particular topics... I would be a bit wary of the state mediating local people’s views...acting as the voice of local people on what might be political decisions that go against the local health authority’s interests...I am dead iffy about local statutory agencies becoming lobbying bodies really...I see it as important for the NHS not to be seen as leading a particular lobby group, because I see the NHS’s role as consulting on issues of service delivery ..to try and address local peoples’ needs in the way services are developed. The role of public health is to highlight the impact of policies on health and to ..draw government attention to particular policy areas and to kind of speculate on what kind of

impact it would have. But I think there's a step beyond that which is leading lobby groups to campaign for particular changes which is questionable in terms of the NHS's role and I think damaging to local democratic processes if the state steps in and starts doing that kind of stuff." (NHS senior manager).

In a Healthier Lewisham discussion on priorities for the coming year, an amicable disagreement was witnessed between two senior officers about the extent to which the group should be 'strident' in its stance towards addressing inequalities. Although the resolution of the particular disagreement was weighted in favour of a more vociferous approach, no post-argument change in approach was detected. Another senior NHS manager however thought, that "you won't get anyone in a sufficiently prominent place stepping out of line, in terms of what the central message is...yes it is politically neutral and I think ...if you step outside that political neutrality you probably won't be stepping back." Thus, NHS staff were unlikely to take a lead in calling for a reduction in income inequalities. Lewisham councillors were also felt by this manager to be unlikely to "step out of line" being of a particular "political ilk ....and closely following the centralist line, [that] guided them at elections not to use terms like wealth redistribution...something that you're only supposed to discuss behind closed doors." Therefore, the manager felt that "you need the academics championing...the sort of Peter Townsends, social commentators, to actually set the tone."

The next section looks in more detail at attitudes towards the NHS working with the GLA or the TUC to promote trade union membership. But here it can just be said that the majority of staff interviewed saw no problems in such action with regard to the political neutrality of the NHS.

Summarising this section, it was found that staff were not generally aware of a block on their work in the form of any requirement to steer clear of political issues. They tended to think that they had sufficient freedom to operate as effectively as they could. A few staff did, however, feel restricted and others considered that more senior staff policed themselves, in order to assist their careers.

## **Trade Unions**

Another politically sensitive area, which impinges on health and income inequalities issues, is that of support for trade unions. As referred to in chapter 2, research suggests that a trade union presence in the workplace reduces accidents rates. In the context of a demand for evidence-based practice within public health and health promotion – especially given a lack of research supporting other areas of NHS work - this evidence is significant. Whilst more contested, there is also evidence to suggest that wage differentials will be smaller in unionised workplaces and that, in general, an increased union presence in the workforce brings down pay differentials. Therefore, given the fact that most staff thought that significant links exist between health and income inequalities, it was considered appropriate to question local policy implementers on aspects of their beliefs in relation to trade unions.

Aside from reducing income differentials, trade union and labour movement involvement may increase social solidarity among lower income groups. This provision of a route to a collective voice could increase self-respect and diminish powerlessness. Increased respect within society for people in social classes IIV-V might accrue from reduced income differentials, but representation and a stronger collective power should also be taken into account in an analysis drawing on social capital theory (as defined in the thesis's introduction).

Interviewees were asked in particular what they would think of a TUC or GLA campaign to increase trade union membership being sponsored by the NHS. All but one interviewee was generally supportive, and the responses demonstrate an extraordinary picture of support for the promotion of trade unions. The majority said that they would support such a campaign. However, a number felt that it couldn't happen. These responses are now looked at in more detail along with some of the accompanying comments.

The standard response is illustrated by this quote from a senior NHS manager: "I think that would be a good thing." When prompted to consider the implications from the point of view of the NHS being involved in a political organisation, this particular respondent said that he thought the TUC was politically neutral. When reminded of

the links between the TUC and the Labour Party he went on to say that he still did not think it would be a problem - “particularly if it was looked at locally...I also think that we should be working with the local trades councils and local employers...at a national level there may be problems.”

Others were even more cavalier about the possibilities. One chief executive said:

“I think that there is absolutely no danger at all and the NHS and the local authority and whoever should be open enough to say ‘yes we would want to support that’. But the NHS [and] local council need to get their house in order [over] flexible working hours, pay differentials and look after staff in the workplace, especially their health and safety and particularly their stress management..”

Another senior officer said: “Working with the GLA on it I think would be a useful way forward in terms of taking a broader view because what goes on in Lewisham I can’t think is that infinitely different from what goes on in other boroughs around health inequalities and income.”

Juxtaposing the Chief Medical Officer’s message, at the start of *Saving Lives*, with the benefits of trade union membership, one senior NHS manager said: “I mean they have top 10 handy hints about how to eat vegetables, I don’t see why they can’t have similar hints about “join a union”, or “join a child care co-op” or what ever.”

However, a more cautionary note was sounded by another senior NHS manager: “the NHS is working with a tight budget and it is not always working with a benevolent attitude towards its workforce, the NHS closes down some services and undertakes forms of reorganisation putting things out to private contract ...[where] people [are] paid ..very basic salaries, so trade unions may want to keep a clear space between themselves and the employer.” This respondent felt concerned that the arrangement would be encouraging people to give money (in the form of union dues) to organisations that give money to the current government. So care should be taken in this politicisation of the NHS.

A HAZ worker thought that as long as partnership agreements between the organisations made it clear that they were not completely aligned, then there was “absolutely no reason why it should threaten the neutrality of the NHS. However, as unions don’t reach all communities: “they can never be the single route, but that doesn’t mean that they should be excluded.”

A senior member of the health authority thought that there were mixed advantages in increased trade union power. In order to restrict strike action and yet gain the advantages of reduced pay differentials and improved working conditions, a ‘concordat’ should be negotiated between government and the unions. Another NHS officer thought that although NHS managers might agree to the idea in theory, in practice “it is having the courage and the bravery to actually say ‘this is what we are doing’...” One senior NHS manager was somewhat hesitant: “I can’t imagine it and yet if you think about it, if you are talking about involvement in health inequalities it is through trade unions that we might encourage people to have more of a voice, not only on their own conditions but in terms of health policy. That could be quite a good thing, but I can’t imagine it.” When prompted as to why this was unimaginable, the respondent thought that it was because trade unions were not good at seeing the wider role they could play and that it would involve breaking role boundaries, but “I guess it could happen.”

A community development worker felt that it was potentially problematic:

“I would like to see them do it, but whether they could do it and get away with it without a lot of media and right-wing flack, I really don’t know...I suppose if they highlighted health and safety they could get it past the media...if Labour got in for a second term they could do it...whether they would do that or not obviously that is a different issue, but I think it would be a good idea...”

Another community development worker was more positive and saw no problems, saying that: “I think it would be quite nice actually if your doctor handed you a leaflet about joining a trade union – yes, great I like that idea...I think it could contribute to giving them a friendly face, I think doctors should encourage people to do lots of different things..”

Interestingly, after the bulk of these interviews had taken place, the GLA, did produce a leaflet, in conjunction with the TUC, aimed at encouraging London workers to join trade unions. In September 2002 Ken Livingstone and John Monks, then leaders of the GLA and TUC respectively, handed out the leaflets at Blackfriars station in order to target city workers and gain publicity (SERTUC, 2002).<sup>152</sup> It would appear that staff in LSL responsible for working to reduce health inequalities would have supported this move. One interviewee thought:

“Trade unions have got a bad ‘wap’ obviously over the last twenty years or so, but I still think they are valuable...I think people need some sort of security in terms of their jobs and sometimes the union is the only place they can turn to, but they are not always helpful, sometimes they go with the party line rather than working with the actual client...the union can stab you in the back...but I am for it.”

Another said: “That’s fine...I don’t have a problem with that....there is a mythology that trade unions equals trouble...trade unions have a body of experience and of knowledge and personally I have no issue about people sharing their knowledge and experience to do something together..” (community workers). This second interviewee went on to say: “...it may appear to (conflict with the NHS being neutral) but if you took that point of view then you would not have the NHS talking to any organised group...you can’t live in a world of total suspicion.”

One voluntary sector worker was concerned with working conditions in her sector, and said: “I think trade union membership and common political consciousness not just pay, but pay *and* conditions...because there is so little unionisation in the voluntary sector people do put up with poor conditions.” The Socialist Party councillor interviewed supported the move and said: “.. in all industries and organisations I think it is vital that workers play a role...To increase trade union membership and awareness is a positive thing.” An ‘Old’ Labour councillor said: “I think it’s a good thing and I hope it happens.” A ‘New’ Labour councillor was also

<sup>152</sup> Among other points the leaflet makes is that: “Black workers who are in unions on average earn 32 percent more than black workers who are not members of a union.” (SERTUC, 2002).

supportive saying “In my life I’ve battered my career prospects because of my trade union activities...I don’t think, with the best will in the world, employers are the best people to lead on health and safety it has to be done in partnership.” This councillor also supported trade unions working ‘in partnership’ to play a part in reducing pay differentials. However, having just experienced criticism from Unison for service restructuring, the councillor felt blamed and ‘an anathema’ to some union members.

Another ‘New’ Labour councillor was also supportive:

“Yes, I don’t see why not, it is about recognising that unions are partners, moving away from the ‘them and us’ adversarial scenario.....some people will argue that the NHS should not, that as an employer it is nothing to do with them, it is up to the TUC if they want to increase their membership, that the NHS should not be involved....I think that the trade union movement has been historically at the forefront of reducing income inequalities. It is not the employers that have been in the forefront, it is not in the employers interests to reduce income inequalities, ...I think they (unions) still have a role, not just about income inequalities but in terms and conditions, the whole issues about equal pay for women.”

But the councillor went on to say:

“I think we need to make a business case, I think employer organisations like the CBI should. I am sure that there is a business case to be made about addressing income inequalities...if employers can make a business case for employing disabled people....multi-nationals have always argued that there is a business case for employing people with disabilities, more women and black people...there is a business case for addressing income inequalities ...it is about skilling people, paying people the right money for doing the right jobs, about staff retention..”

A local authority officer, who had previously been a private sector manager, felt that larger businesses would not object and that small businesses would not be affected, as they were often family-run.



“I found [in the private sector, owners] seemed to like the fact that there was a trade union that they could work along side. ...I really feel ... that the trade unions must have reduced accidents at work because in every small [workplace] ..there would always be someone around who had been on a trade union health and safety course [to say this can cause injury].”

The interviewee also thought that some of the main high street retailers had better relations with their trade unions than others. Another manager working in regeneration said: “I would go along with that. There might be criticism, yes, but there will always be criticism.”

One senior trade union officer interviewed said that he would think the union would support the move. However, he referred to three constraints. Firstly, the unions had had a lot of battles with NHS management and while they (NHS management) were not anti-union, because of compulsory competitive tendering and now the private finance initiative (PFI), relations were difficult. Secondly, union members had limited time since “facility time has often been cut and often only allows for purely internal industrial relations issues. I think it is a good idea but there are those constraints, but I think in theory we would all be in favour of that...” The official felt that the unions, and Unison particularly, had been at the forefront of establishing a statutory national minimum wage:

“It is inadequate and increasing it is a central target of our union ...Unison has done research pointing out the connections between poverty and ill health. Fuel poverty is another issue that we have been pursuing, the whole issue of a living wage, the minimum wage, prevailing rates of pay, ...so on the general issue of low wages and poverty we are doing an awful lot...”

Finally, he considered that there was a problem in that local trades councils and trade union resource centres now received less statutory support:

“The trades councils are not particularly encouraged, they are often made up of retired activists, so I think you lack the kind of basis on which to run

campaigns ..[and] organisations to which you can give money for these sorts of campaigns..... Trade union resource centres or support units were funded by local authorities in the past [in South London] and others were funded by the GLC [Greater London Council, disbanded 1985]....But through the 80's and 90's ...these local units or centres tended to have their money withdrawn, overall union membership has declined, trades councils have declined. So,..we are less equipped now than they were in the early 80's or late 70's to take advantage of money that might be available to run local recruitment campaigns. But that does not mean to say that things won't change ...I think the climate is shifting back again to a certain degree. Trade unions are certainly popular according to the opinion polls, in fact they have always been. But there is a prevailing culture, part of New Labour's anti-collectivism anti-labour market regulation which probably means that NHS officials and others would think it would be the last place to put money, not the first. But if we think we can make that argument I think it would be good, perhaps we don't do it sufficiently as a union movement, but it is, as I say, hard. The mechanics of it are difficult, because it is hard to see where that core of organisation exists on the ground...you have not got the resource centres that did exist and were publicly funded..."

The low profile of the trades councils was confirmed by one regeneration officer who had never heard of a Lewisham Trades Council. The union official also referred to government legislation that, "with all its flaws, nonetheless provides a statutory basis for recognition". This had increased membership and collective bargaining. If income inequalities are seen to be closely linked with health inequalities and trade unions are seen as effective in supporting a reduction in income inequalities, then it can be argued that the extent to which government legislation hinders or allows trade union involvement is an upstream public health issue.

Despite the strong support for trade unions among all the groups of staff interviewed, including all the staff with greater responsibilities for regeneration work, no action to support these views was observed locally. An example of this is the development of the Lewisham Local Strategic Partnership (LSP) from 2001. To the researcher's knowledge no local staff member anywhere in any forum suggested that trade unions

be invited to be represented on the LSP. The Unison official interviewed said that he was hoping that unions would be involved in LSPs, since local businesses were to be represented. Perhaps the view of one interviewee outlined above - that staff will not step out of line, without jeopardising their jobs - is relevant to this observation. But this is not an entirely satisfactory explanation. That these views appear to be held, but their expression was not observed in the course of participant observation, means that the culture of the employment environment is not supportive to their being raised. 'Bureau-shaping' and rational choice theory have been used to elucidate what motivates staff at the local level.<sup>153</sup> Neither of these theories explain sufficiently the observed phenomenon. In the author's opinion, if central government were more openly supportive of these proposals then they would find fertile ground in Lewisham and LSL in general. However, without this lead, local staff have few arenas in which to jointly develop ideas and strategies. They use 'off-the-shelf' patterns and instructions to guide their work and do not have the time or capacity to co-ordinate inter-staff debate that would allow for the construction of local consensus on policy that deviated from national policy.

## **Conclusion**

All the key workers in Lewisham involved in leading work to reduce health inequalities had a view of public health and the causes of health inequality that can be said to fall broadly within the model used in the Acheson (1998) and Black (1980) reports into inequalities in health. That is, they regarded work at both a national and local level as valid, and they took a view of the causes and solutions to health inequalities that gives priority to socio-economic determinants. They tended to share a common view about the extent to which health was the individual's responsibility, in contrast to that of society more generally. This balance came down on the 'collectivist' rather than the 'individualist' side, with some exceptions.

'Health inequalities' was regarded as an important issue, one that it was valid to spend time addressing. In this respect their views are commensurate both with government thinking and with Acheson's. This shared vision has helped to sustain local support for the work even in times of great institutional change. If, as has been argued, central

<sup>153</sup> As discussed in chapter 1.

governments will sometimes make adjustments over time-spans in the order of ten years in order to improve policy, then this shared vision at a local level will be helpful in sustaining commitment.

However, *within* what can broadly be described as the ‘socio-economic determinants of health’ framework there was a diversity of opinion. There was support for actions going beyond those recommended by the Acheson report and contained in government policy. The divergence away from government thinking was both in relation to ends and means. The split from Acheson was solely related to means. Local policy implementers connected health inequality with income inequality and supported further moves, beyond those espoused by central government at the time, to decrease income inequality. They also supported the strengthening of structures and institutions that were seen to affect income inequality. This is where they diverge from Acheson, in that his report does not refer to these political institutions, such as trade unions, political parties, and the European Union, but only to the policy that they produce.

Whilst the local policy community held beliefs that contradicted government policy and went beyond the scope of the Acheson report, they tended not to articulate these beliefs in public. There was no discrepancy between opinions voiced by individuals in interview and opinion shared in the normal course of work; it was simply that these opinions were not normally discussed or acted on within the work arena. Here support may be found for Laumann and Knoke’s view that in ‘policy communities’ there will be consensus, which limits the range of arguments that are permissible, legitimate and likely to be accepted as valid forms of controversy.

“Major structural changes in both substantive and procedural matters [rules of the game] are generally off the agenda. The dominant belief systems in capitalist democracies tend to deflect challenges to a set of core values, including private ownership of capital, privatisation of the surplus, and managerial prerogatives in the workplace.” (Laumann and Knoke, 1987: 384-5).

The thesis challenges the extent to which ‘street level bureaucrats’ are understood to be free to influence and develop policy outside of a framework set by central government. Staff had views which did not ‘have anywhere to go’ or, little to co-ordinate them. This did not lead to a strong sense of frustration, as policy was generally progressing in the direction of their beliefs; however, it is relevant to the discussion in chapter 1, on agenda setting and dimensions of power (Lukes, 1974). Items such as the links between trade union organisation and health inequality, or the widening gap in inequality of earnings, were not brought onto the agenda because of co-ordination of the policy agenda by central government. This happened in a way that was quiet and non-confrontational.

In this case study local players seem to have been highly influenced in their practice and their confidence to articulate beliefs, by a shared knowledge of the Acheson report (1998): a prestigious and ‘independent’ inquiry into inequalities in health, which also gained official government acceptance. The further away from knowledge of the report one travelled within the local policy community, the more opinions diverged. Knowledge of the Acheson report appears to have affected the articulation of beliefs. Similarly, the evidence suggests that staff were effectively controlled by government policy, in that, if policy had resonated even more with their beliefs it is likely that they would have implemented it. However, their disagreements with government policy were not normally visible outside of the interview setting.

Staff employed by the NHS did not have a shared vision of rules governing the political role of the institutions they worked for. Where effective practice to reduce health inequalities would take the NHS into politically sensitive areas, there was uncertainty as to whose interests to follow. Where no national or other respected leadership existed, to say what was right or wrong for local staff to do, they appeared to ignore evidence that suggested they should argue for particular kinds of work. This was demonstrated in submissions to the consultation document on reducing health inequalities released by the DoH in the autumn of 2001. Although the document explicitly asked for local views on national policy, submissions from the LSL area contained no mention of support for further reductions in income inequality. This was despite the overwhelming support for such moves across the policy community revealed in this research.

The values of staff at the local level, at the time this research was conducted, cannot be said to have blocked government policy to reduce health inequalities. Generally, the view among staff was that government policy was blocking progress and not extending far enough to meet the needs of local populations.

In analysing policy implementation, Barrett and Fudge suggest that assessing the degree to which policy has changed practice should be considered:

“The degree to which policy represents change can be seen both as a *function* of the polarisation of ideologies, attitudes and value systems participating within the existing social order [if policy doesn’t amount to much then it won’t challenge values] and as a *determinant* of the degree and type of negotiation likely to be necessary if it is to be implemented [if much negotiation is needed then the policy change is significant].” (Barrett and Fudge, 1981: 273, comments in brackets added).

This research found that in the local implementation of policy to reduce health inequalities, the beliefs and values of local players have not been a determining factor in driving changes in practice over the period in question. At the same time staff opinion has worked with the grain of government policy. The change in beliefs has taken place at central government level. The resulting financing of local work has, within the local area, had the most significant impact on the degree to which policy has changed practice. Government policy moved further into line with local values. However, locally held beliefs would not have blocked more radical policy changes. There was more room and appetite for change in policy aimed at reducing health inequalities at the local level than central government permitted or believed possible. The next chapter moves on to look at the local institutions through which interviewees thought income inequalities were influenced.

## Chapter 6

# FINDINGS – PARTICIPATORY FRAMEWORK

### Introduction

The thesis has moved from looking at how the evolving institutions of statutory agencies affected health inequalities work (chapter 4), to the individual views of the agents inhabiting those structures (chapter 5). This chapter now turns to look at the institutions through which those working in local agencies consider public involvement should and does take place.<sup>154</sup> It considers developments in ‘public involvement’ institutions, particularly from the perspective of agents’ access to influencing income inequalities.

Statutory agencies have increasingly stressed the importance of ‘user and public involvement’.<sup>155</sup> In the case of Lewisham Council, this has resulted in the creation of new institutions for receiving the views of Lewisham residents, namely the ‘Hubs’ and the citizens’ panel. The local NHS is also spending increased resources on public and user involvement (PUI).

The thesis considers how residents might influence income inequalities for the following reasons: (1) As described in the previous chapter, staff working in local services believe that there is an intimate connection between health inequalities and income inequalities and generally they would like to see both reduced. (2) Over the last ten years, since the publication of *Local Voices* (NHSME, 1992) and again with the publication of *The NHS Plan* (DoH, 2000) there has been increased investment in local statutory patient and public involvement work which, among other things, aims to involve residents in issues affecting their health. (3) Increased support, from both national government and local players, for a recognition of all the ‘wider determinants

<sup>154</sup> A chronology of institutional changes and related policy documents is produced in Appendix 4.1.

<sup>155</sup> A definition of ‘involvement’ in this context is provided by Lee and Mills (1982: 129). They divide the term into four sub-terms: (1) collaboration, (2) participation, (3) consultation and (4) negotiation. The first implies equal involvement rights, the second, that representatives of interest groups actively take part in the decision-making process. Thirdly, consultation is the seeking of advice, etc, but with no duty to take it. Finally, negotiation takes place where one body cannot get what it wants without seeking an accommodation with another party.

of health', means that a greater understanding of the relationships between the different elements of public participation is required. Increasingly, NHS employees are getting involved in projects that include public involvement, such as regeneration work, yet there is a lack of clarity and consensus as to what forms of participation are to be upheld as best practice. (4) Public health strategists such as Whitehead have also recommended public involvement as a necessary prerequisite for reducing health inequalities (Whitehead, 1992a). There is also a body of academic literature, and a belief among some public health practitioners, that increasing 'social capital' has a positive effect on health. This supposition ties in to views and practice concerning public involvement for health improvement. (5) Some academic and political opinion that holds that, in campaigning via their own organisations - be these political parties or trade unions - the worse off can affect income inequalities to their advantage. These views were reported on in chapter 1.

It is this work's contention that statutory services have difficulty in forming and delivering consistent and rational policy in the area of income inequality because of problems in delineating between party political concerns and areas of importance to public health. The strong correlation between poorer health and Labour voting, reported by Davey Smith and Dorling (1996), highlights the possibility of connections between party political programmes and benefits accruing to groups whose health is better or worse than average. At the same time, the Labour Party itself has been experiencing radical changes in its methods of involvement and in the extent to which local party members are involved and have power. The internal democracy and membership involvement practices of the Labour Party is certainly not an area that NHS public health staff are expected to be informed of, or make comment on. For instance, there has, unsurprisingly never been, to the author's knowledge, any reference to the organisation of the Labour Party in responses to DoH consultation papers on policy to reduce health inequalities. Yet, as the chapter demonstrates, the two areas are linked.

This chapter will look, from a public health perspective, at the institutions that local people might use to influence policy. This is done by looking topics under six points: (1) looks at general conceptions as to how local people influence national policy; (2) reports views on what was happening locally in relation to public involvement; (3)



takes a look at issues regarding a 'traditional' representative form, namely, use of MPs and councillors; (4) considers a new vehicle for public participation in Lewisham: the citizens' panel. And investigates whether there is a consensus among local staff on whether the citizens' panel could be used to consider issues of income inequality; (5) then asks respondents to consider the way in which an 'ideal type' resident might influence income inequalities. And it assesses the extent to which PUI institutions are arranged to exclude access to influence over income inequalities. Using the concept of three-dimensional power, it considers whether agendas within these institutions have been set *a priori*. Following this, participation in more autonomous forms of association is considered, and questions are posed as to whether this participation can be seen as a route to influencing income inequalities. Also considered from this perspective are developments in local involvement in the Labour Party; (6) finally, councillors' views on involvement are investigated further.

Throughout the chapter, differences of opinion between local actors are demonstrated. By, for instance, comparing 'Hubs' with Labour Party branch meetings, the objective is to show that, while there is no clear local consensus on the best way for local people to influence the wider determinants of health, there is also increasing statutory, including NHS, involvement in this contested arena.

It should be noted that some of the 'wider determinants of health', for example housing, can be controlled to some extent locally, while others may fall under more national control, for example, income inequality. The boundaries between local and national issues are not clear-cut.

## **1. Methods by which local people influence policy**

Chapter 1 looked at definitions of democracy and the means by which people are seen to influence policy. A summary of findings on the differing views of local players about this issue is set out here.

### **Democratic models**

Representative, participative and direct democracy were concepts referred to by local players with a role in reducing health inequalities. The current model of democracy in

Lewisham appears to be both in transition and contested. The system is changing because of a number of immediate developments that, in turn, have various causes. Immediate changes in Lewisham's system of representation and democracy include: the formation of a community council (described below); the formation of 'Hubs'; the formation of a 'citizens' panel'; the formation of a community network (also described below); a decrease in participation by Labour Party members and a decrease in their powers; a rearrangement of the responsibilities of councillors and a planned decrease in their numbers; the increased investment by statutory services in public and patient involvement workers, either based in the statutory or voluntary sector.

The community council is funded through the SRB (single regeneration budget). It aims to set up an elected council of residents who can represent the community, but who are not party-based. It covers an area that includes some parts of five wards in North Lewisham. NHS employees have roles in the project, advising on health issues. Those, state-funded, voluntary sector workers involved in setting up the 'community council' were especially driven by particular views on the merits of different democratic systems. They supported participative democratic models, encouraging the direct involvement of all residents.

The community *network* was set up in 2002 as a coalition of community and voluntary groups. Throughout 2002/3 it held comparatively large bimonthly evening meetings (attendance circa 200) to which various speakers, including the council's chief executive, the mayor and Lewisham hospital's chief executive were invited. The meetings also elected representatives to sit on the Local Strategic Partnership.

Held (1987: 262) describes proponents of participative democracy as recognising the need for "direct participation and control over immediate locales" to be "complemented by party and interest-group competition in governmental affairs.." This is in order to input into national politics. However, as will be seen, there was mixed local support for any party political involvement, coupled with a low general level of knowledge and understanding of the party structures.

For a number of interviewees, representative democracy was not functioning adequately. This was either because it needed improving and strengthening, or

because the concept itself was suspect, a more direct, participative democracy being required. A number of specific criticisms came from community development workers who had connections to the formation of the 'community council'. In particular, it was considered that the ability of local councillors to take up issues on behalf of local residents was very limited. At least two reasons were given for this. Firstly, council ward boundaries and the borough as a whole were considered to be the wrong units for discussion of local needs. The latter being too big, and the former not reflecting 'real' community boundaries. Thus 'communities of interest', such as the Somali community, were seen to cover areas spanning parts of three or four wards. However, there was no individual neighbourhood where lots of Somali people lived. Boundary-based political structures were therefore seen to be unable to represent such 'communities of interest'.

Secondly, it was perceived that the councillors themselves were not selected from a wide enough base of people and were also in post for too long. The reason for their narrow base was that they were being selected from within Labour Party branch meetings that had few attendees and yet once selected as the local Labour candidate they were very likely to be elected.

### **Local involvement-national involvement**

Statutory encouragement of local involvement in local issues, but neglect of local involvement in national issues, or issues relating to nationally determined 'wider determinants of health', was seen by one public health director to demonstrate inconsistency in policy. A number of public health staff appeared to have considered the issue prior to interview and drew similar conclusions. One senior HAZ worker said:

“.....there is a difficulty, in that yes OK the local authorities have that form of public involvement ['Hubs' or Area Forums], but there is no direct link at the moment taking that up...everybody in Lewisham, for example, is saying that this estate is really desperate, ... and got to have new windows for example....now that is something that sits at borough level....so in theory, depending on finances obviously, that is something the borough could actually tackle. But, for example, if it was around the level of housing benefit, that is

not something that is decided at borough level, that would actually need to go straight on. There is not, in my reading of the guidance [*Modernising Local Government*, DETR, 2000], there is not that relationship between ...the ground-swell of opinion ...on the ground, which relates to national policy, and the government having any accountability to change national policy in line with what is coming through there.”

Others considered that local councillors and MPs could influence national policy on behalf of local people. One local councillor considered that: “I am in a position where I have more chance of influencing national policy than many people...”. Another councillor said - “I do think that local people do look to their elected representatives to do that [influencing policy]...they do look at an elected representative, councillors or MPs, to influence national policy. You know I don’t think there are other structures, unless it is like consumer pressure or as specific issues, or you know a protest.”

At a local health-related conference, one MP for Lewisham, Joan Ruddock, advised that those wishing to influence national policy should take specific steps, including making contact with her, or other appropriate MPs. She said that: “politics in this country is organised on a party basis, therefore you need to go through the party process.” However, as will be described, this is not the message that comes from other quarters, it is also an issue that is in a state of rapid change.

A small number of interviewees thought that local people were not interested in being involved in any issues that were wider than immediate local concerns, such as street lighting, fear of crime, or finding employment. Those who thought this tended to be people working in areas related to employment initiatives within regeneration strategies. Linked with this idea, that local people were only interested in their own immediate circumstances and immediate local issues, was a view that a lot more work needed to be done to involve local people in influencing local decisions, therefore, to move on to national issues would be premature. Definitions of the terms ‘local issues’ and ‘wider national issues’ were, however, to a certain extent set by local administrators. Benefit levels for instance are a local issue, in the sense that they affect local people, but not in the sense that local authorities control them.

### **Stages of participation**

A 'stages of participation' perspective, as exemplified by the 'ladder of participation' (Arnstein, 1971), meant that involvement was seen as something that had to develop gradually, with residents needing to be involved in local issues, before reaching the point of being interested in such 'wider' concerns.

So for example, one community development worker, involved in employment issues, said, in a discussion concerning the extent to which residents on the estate where he worked would be able to raise wider issues relating to the determinants of health:

“Gosh, I’m not sure that they are at that stage,...that people are ready to engage in that kind of dialogue, and it may take time for them to get to that point. I mean they worry about things like – why hasn’t the lift been repaired for fourteen months... about the fact that in some blocks they are potentially going to be moved out of their homes, where some of them have lived for years....to get them on to thinking about how they might influence those sorts of policies, I think that is a bit early.”

However, one community development worker was critical of 'the ladder of participation', saying that:

“I don’t like it personally...I am always trying to get away from the idea of levels, because I don’t think it works like that, because otherwise you encourage everybody to see themselves on a particular rung of the ladder, and that it is very evolutionary, they have to ‘become’, ..they have to get to some point at the end. Whereas actually, the whole point of our kind of approach ..is that we are so ambitious we believe that we can reach everyone over time and eventually. We will try every different thing that we can think of to try and appeal to different people. But people are very different and they don’t all want the same approach. We talk about ‘multiple ways in’ – you can turn up at an event, you can write a letter, you can phone up, you can have different types of involvement. ..[It] may end up being your life’s work, but I would not

say that the 'life's work' people, like myself, are at the top of that ladder, you know we are all involved in different ways."

Nevertheless, in other areas of the local 'public health community' the 'ladder' was widely supported and used as a descriptive and educational tool, for example, in training run by the health promotion department.

### **Rational Choice**

One respondent took a particularly 'rational choice' perspective on the motivation of estate residents and his views can also be related to a specific reading of the 'ladder of participation' theory.

A classical 'rational choice theory' (RCT) perspective might consider the individual motivations of residents (Ward, 1995), for instance, their motivation to - participate in campaigns to increase the level of pensions, or the national minimum wage, or child benefit, or to change the formula for parks' funding. Crudely, for example, RCT would not see the motivation of a pensioner to be involved in a minimum wage campaign as being so strong as the same pensioner's interest in a campaign to increase pensions. Motivations are seen to relate strongly to immediate individual interests and the perspective does not tend to credit individuals with a wider strategic approach.<sup>156</sup> Thus, for example, one community development worker said:

"I think you will not be talking to a poor person for very long before they want to earn some money...if you are going to encouraged people to participate in the affairs of things, they will be doing it for a rational reason, that that is, they want a job. In other words a lot of people want a job administrating the [SRB] programme, if not, they want to get on a training programme and you can't really, I don't think, expect people to just participate philosophically. They have to be there for a reason, for themselves." (community development worker).

<sup>156</sup> Fine (2001) traces the links between methodological individualism, rational choice and social capital.

## **Social Capital**<sup>157</sup>

A number of staff from all sectors linked the public involvement agenda with the aim of 'building social capital'. The HAZ for instance was seen, in part, by one interviewee as trying to "help people influence decision making and support them so that they feel that they can (and) have a right to, have some influence.."

### **Differences of opinion between local players**

There were some clear divisions of opinion between local employees charged with implementing policy to reduce health inequalities. Divisions existed between, for example, councillors elected from certain estates and community development workers based on the estates. These concern the way in which local residents should be and are, involved in influencing issues relating to the wider determinants of health and, in particular, income inequalities. They concern the value of participative and representative democracy.

## **2. Public involvement - views on what was happening**

Held points out that discussions on democracy often contain both descriptive and normative elements (Held, 1987: 7). This section looks at some local opinions on the current state of public involvement. Later on some local prescriptions for its development are reported.

### **Changes in the nature and level of involvement**

Despite moves by statutory agencies to invest more in public participation, there was a sense from one or two interviewees, from each of the represented sectors, that public involvement had actually decreased over the previous ten years. The Socialist Party councillor, for instance, said that tenants used to have more effective control of policy:

"In the housing committee, there used to be reps from the tenants movement across Lewisham, a rep sat on the housing committee and could have an input into that, which could have an input to the council. For instance, tenants could

<sup>157</sup> Social capital is also discussed later in this chapter.

put forward that they felt that one of the issues respecting to them was low incomes and that could feed through ...to council policy ..”

One community development worker felt that ‘the working class’ in particular, had been ‘disenfranchised’ over the last twenty years. “I think that because of the damage that’s been done over the years to working class communities, in terms of people feeding back centrally ...you can’t do it through the political process that exists, because people don’t bother with those any more half the time..”

A regeneration officer considered that –

“Local democracy, in my view, has become much weaker...At the present time there is a strong Labour central government, they don’t see the objective of having a strong local government, they see it as something that is going to answer them back... the weaker it [local government] is I think, that affects the quality of the candidates you have got coming forward. A few years ago, ten or twenty years ago, you probably had much more dynamic material.”

Other interviewees had not considered public involvement in issues affecting the wider determinants of health, be they local or national. Of these, almost all said that the questions relating to this issue were “very interesting” and they welcomed the questioning. One said: “To be honest I have not really thought...my gut feeling would be yes, I am sure there can be some local work that does start to look at the national, I am not quite sure how you would organise it to be honest.” (NHS senior manager)

### **Support for the ‘public involvement agenda’**

Some interviewees said they were cynical about the whole ‘public involvement agenda’. Their concerns were various. Firstly, there was a small body of opinion that considered that at least “if we are giving people control we have to make sure they want it”. This was coupled with a feeling that people often did not want more control. Secondly, there was a concern that people needed the skills or support to get involved, and that this was not generally prioritised (Senior NHS manager). Thirdly, it was felt that real choices had to be on offer:



“There is absolutely no point in asking the community to identify a problem and then (have them) choose decisions that we can’t do anything about.. and sometimes in the NHS we have to work to such timetables that there aren’t many choices.. and so I think the trick is to identify areas where there really are difficulties and allow the community to participate and also areas where there is enough time to actually do it.. A lot of NHS consultation with patients is a bit of a sham and the community is not going to be interested .. the choices are broadly made by someone and then the community is agreeing with it.. So I have quite strong feelings about it – a lot of it is a waste of time.” (public health consultant).

However, chapter 5 showed that interviewees did not agree on the question of whether income inequalities could be reduced, linked to this there were divergent opinions on what local people can ‘do something about’ and what they can’t alter. Not to involve people in decisions about income inequalities, because you don’t think their opinions can possibly have any effect, is to take a political decision. Such decisions, or ‘non-decisions’ (Crenson, 1971), are clearly being taken by NHS staff.

One interviewee said that she felt that public involvement work had only really developed in Lewisham in the past three years. However, she considered that the provisions for development in the field outlined in chapter ten of *The NHS Plan* (DoH, 2000) were poor.

“I actually think that chapter ten will result in a wave of committees and structures that will further distance decision making from the ordinary person on the street. I think that it is a bureaucrat’s heaven. ....I am not sure that the agenda will be anything other than those quite mechanistic things – how long people wait in the A&E department the quality of the food – obviously there are inequalities in that. But if the new agenda should be inequalities, I am not massively optimistic that that is what the new agenda will be.” (senior manager).

Others felt that gaining participation was too difficult, especially if “your standard meeting format” was used. And that “more assertive contact [using] out-reach [with]

door-to-door discussions was needed” (voluntary sector worker). Another perspective was that national policy was driving local work more and more and that therefore there was less scope for local variation in policy implementation - “with a whole range of initiatives ...coming up from the social exclusion unit ..and a whole raft of initiatives..” (councillor).

Finally, one senior manager thought that we already know what people think about many of the things they are asked about. So the process of public involvement causes unnecessary time delays and the resources used should be considered carefully, as they could often be more effectively employed. This manager considered that a lot more understanding was required generally and in relation to inequalities, on the place of public involvement in local policymaking – it depends on the purpose. His sentiments were echoed by a number of councillors in relation to the findings of the ‘Hubs’ (to be discussed below). Although they approved of the Hubs, they still thought Hubs weren’t telling them anything they didn’t already know.

### **3. Old style representation - taking issues to locally elected councillors and MPS**

Generally the most senior staff interviewed liaised with the MPs of the borough and the ‘deputy mayors’ on the health partnership board. Some of the less senior staff had ad hoc contact with various councillors. Some staff, with a remit to work on health inequalities, had contact with MPs. But it was not felt by them to be appropriate to raise issues on the links between health and income inequalities. As one NHS chief executive said: “ ...my feeling with the MPs is they are busy, they only really want to know if you have got sexy stuff to tell them which will help them sound good, or if they want to beat you over the head because you are messing up.”

However, the same interviewee felt that partnership arrangements with the council now meant that better relationships were developing with senior councillors via meetings of the Health Partnership Board. Another chief executive was impressed with the commitment of a local MP in spending time visiting tenants and small community groups. The MP had advised her that: “...if you want to find out what people are saying then that is where you need to go..”

MPs tended to be contacted by the local NHS when there were particular things staff wanted the members to do. For instance, the public health department was deeply concerned in early 2001 when the inequalities adjustment for the allocation of national funds was announced, since it left LSL worse off than had been anticipated, given levels of deprivation in the three boroughs. Therefore, the MPs were contacted by letter and met with face-to-face.

A senior member of the health authority said that they had not ever discussed the links between income inequality and health inequality with MPs since -

“...we would need to be very clear what we were asking for...we tend not to talk to them so much about the income side of it, but we talk to them about *our* income, our resources. And we brief them about our overall working ..with the local authorities. But we have not specifically gone to them around issues about income, regeneration, income inequalities. I can't imagine that we would, because we would want them to focus on the things we need them to do specifically for us.”

Some other senior NHS staff did not have any links with elected councillors and did not know links existed: “...the PCGs, as far as I am aware ..have actually not had links with the councillors, we have links with the local authorities, but in terms of influencing and shaping and having the ear, no we have not actually made a particular effort to link with councillors.”

Others were unsure of the relationship: “I must admit that that has always been something that I have ..wondered about...what contact *should* we have with them (councillors).” But this senior NHS manager went on to say that she also thought councillors were “driven by power, rather than the drive to really do something about their area..”

As mentioned above, some community development workers were hostile to the political process through which councillors acquired their seats. They felt the councillors were not up to the job, not representative of local people and therefore not

worth working with. “They are chosen in the wrong way and therefore they are the wrong people. If we want community leaders, we have to choose community leaders not politicians...So the obvious thing is to cut the party system out of the very local structure....”<sup>158</sup> According to the workers involved, the introduction of the community council meant intensive neighbourhood development. That is, going into twenty-one identified neighbourhoods and having discussions, debates and workshops about the areas themselves, about what is wrong with them, what is good about them and also asking questions such as: who do you trust to champion your neighbourhood? “..What we are doing is saying – you don’t need to worry about politics, what you need to worry about is your neighbourhood. So it is quite iconoclastic, it is really saying people don’t care about politics. OK, but they do care about where they live, they really do..”

Another community development worker said “..I don’t think councillors are people who represent me or my views, so I don’t vote for them and I probably never will..” This worker again espoused the concept of ‘participatory democracy’ over ‘representative democracy’. However, in discussing a particular councillor, the same worker said that they had been very supportive of developments to make health services more accessible in the local area.

However, another community development worker took a different view of the power of voluntary organisation over political involvement:

“...a lot of people go into the voluntary-community sector ...thinking that you can change [things]. By going in and providing services...it might improve practice ...on a micro level, but why they think that is going to make a difference is beyond me, but some people do think like that....I think it is because people don’t feel part of the political process and don’t really grasp what it is all about or how to go about things ...”

Councillors were involved in the management committees and evaluation panels of various voluntary organisations such as Voluntary Action Lewisham and also the

<sup>158</sup> This view is also reflected in published work by community development workers based in other areas of England (for instance: Atkinson, 2000).

Community Health Council (CHC). They were also developing a role on council health scrutiny committees, which would take over some of the remit of the CHC.

If organisations or partnerships, such as the New Deal for Communities area (covering New Cross Gate), were undertaking local public involvement work and wanted to contact the local Labour Party, which was rare, they did this via the councillors. No contact was ever attempted with Labour Party members, and also, to our knowledge, no attempts were made to contact trade union members.

One community development worker discussed the need for 'political will' to drive health and income inequalities work. However, he felt that power had been removed from the local councillors he had links with. "I think that the chief executives at the health authority, the PCGs and community and borough managers have a lot more juice, a lot more power, a lot more influence, than they [elected councillors] do." A vicious circle was thus set up, in that the councillors were thought to have little power, they were therefore not used and supported and in-turn their status diminished.

The councillors themselves had ambivalent attitudes towards influencing income inequalities policy. In relation to increasing the national minimum wage (NMW), for instance, one councillor, who said he was friends with one of the MPs, said that if he lobbied the MP to say that the NMW should increase, the MP would just say: "OK you can think that, but I am not going to do anything about it.." There was really no point in even trying to affect the policy of local MPs towards income inequalities. On the other hand, another 'New' Labour councillor thought:

"It is very important for MPs to go through their case work and the evidence and take up those issues [of income inequality]. They are the ones who can influence policy...Not many people use their MPs and councillors for those purposes, they come when they are in trouble, they see you as a last resort. I still don't think we use local politicians and our MPs in a pro-active way, as we should."

This councillor's position did not square with the views of those involved in setting up the local community council. She felt that:

“For me personally, I like people to join political parties, obviously personally I would like people to join the Labour Party, but you know, I think people don’t recognise the value of being a party member. I think it is very important. But recognising that a lot of people don’t want to become members, I think they should use politicians in a more effective way, not just at crises points..”

The Socialist Party councillor interviewed approved, in principle, of people using their local MPs and council –

“If there were some genuine opportunities for people to feed back to their elected representatives who could then take issues forward. After all, the council represents a whole area and the MPs represent it. But I have to say that the whole current consultation process, and fashioning the direction in which it [involvement in the Labour council] is going, is one that in real terms excludes people from having a real say.”

He felt that MPs in marginal constituencies were more likely to be responsive and that even then it would be down to the amount of influence the particular MP had in their party.

#### **4. New style involvement - the Citizens’ Panel**

The citizens’ panel is a Lewisham borough council scheme that seeks the views of 1,000 Lewisham residents, chosen at random. It is similar to other schemes now used in a large number of councils in the UK. The panel has been used to gain opinions on numerous local issues, from library developments to the services that should be provided by healthy living centres.

Interviewees were asked if they thought that the citizens’ panel could be invited to comment on what they thought of income inequalities. The results are summarised in

**Figure 6.1** This shows the answer to the question: 'Could and should the Lewisham Citizens' panel be asked to comment on income inequalities?'. Each arrow runs from the organisation of the respondent to their answer. There is one arrow per interviewee who responded.

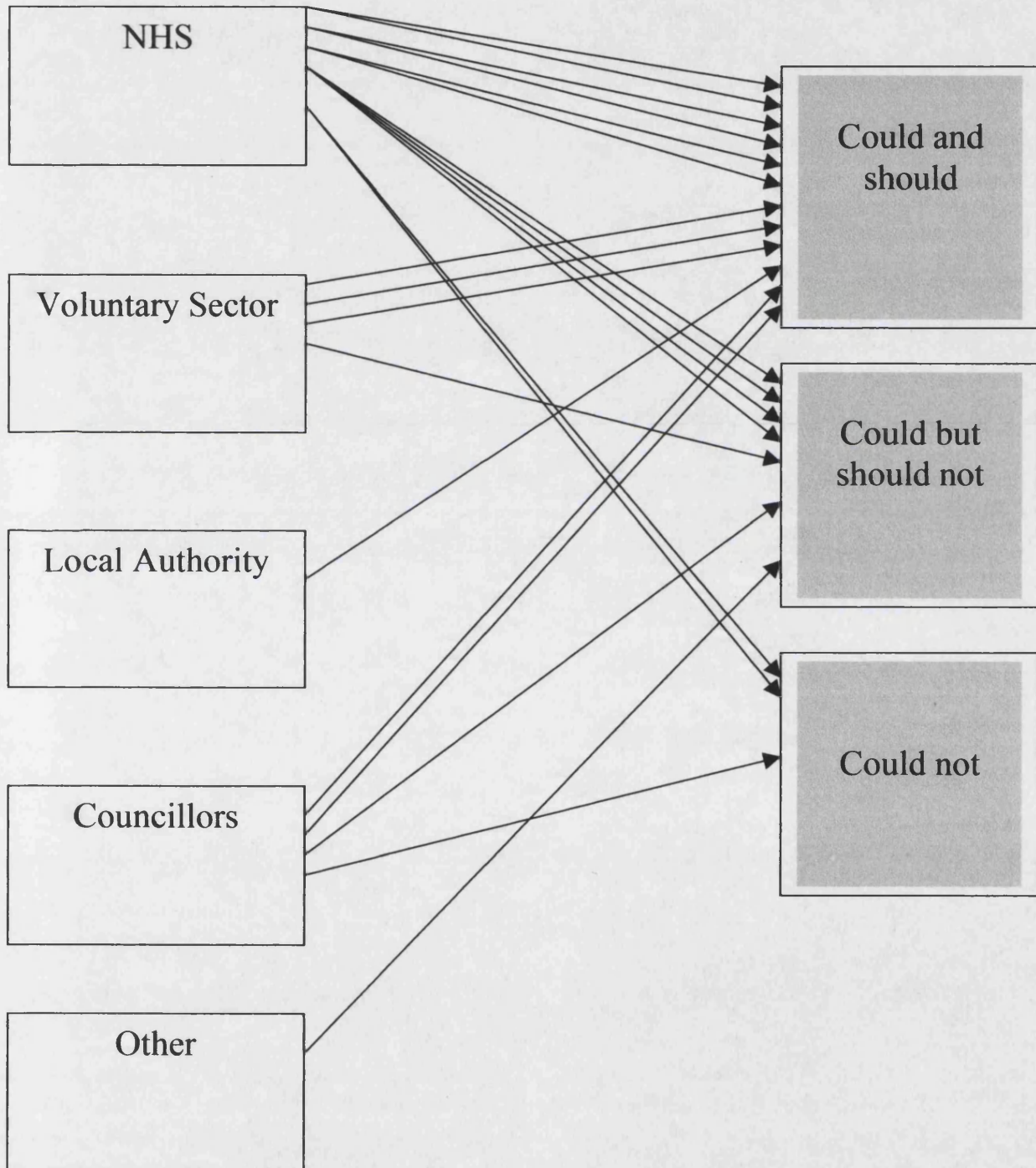


figure 6.1. These findings show a lack of clarity at the local level as to the role of the citizens' panel. They expose the perceived importance of controlling the use of the panel, both in relation to what is put to it and to the way in which findings are then used. It is clear that consultation on an issue like income inequalities, which has a big impact locally but which is also a national political issue, has not been thought through locally.

Of those NHS staff recommending that the citizens' panel should take up this issue, one chief executive suggested that the question be addressed by a new local NHS-led forum set up to co-ordinate public and user participation. But generally she felt that the issue of income inequalities, although being a national issue, also "has a direct impact on our people in Lewisham." And therefore was of relevance to the citizens' panel.

Another senior member of the public health department thought, along with a number of other respondents, that the panel should only be asked to come up with "recommendations that you can do something about", or "what would make a difference to people's economic position locally." So her proviso on using the panel for this issue was that questions should have a local focus and that discussion should be about what Lewisham could do to reduce income inequalities. Another NHS manager thought that the council should consult the panel about income inequalities among its own employees.

Other respondents also felt that the panel should only be used for things that people locally had the power to do something about. But they, therefore, concluded that the panel should not be used to discuss the issue of income inequalities. Of them, one NHS director in particular said: "People can contact their MP and councillors, but fundamentally it takes real national government commitment to say – 'we are going to have a redistributive policy'. I don't want to say to people not to have local mechanisms, but in terms of influencing the national agenda, I am sceptical about what impact it might have." She cited an anti-globalisation demonstration that had taken place the day before as evidence that people do care about wider national issues, but said "what happened to them? – they were penned in." In other words, they had no



impact. So she concluded: “I think the best that local people can do is influence local agendas.”

A public health consultant felt cynical for another reason. Firstly, she thought that panels of this nature tended to be biased against those who are “at the bottom of the heap – the substance misusers, mentally disordered offenders...”. And that anything they were asked would produce a “middle of the road” view. Secondly, she said that –

“In a democracy everyone will say yes to everything, until it affects their pockets. So they say - yes we will do this - and then you say - you will be paying more per pound in tax - and they say ‘no’. So I bet you, everyone would say yes, and if it affected them they would say no.. Is that just too cynical?”.

One senior manager had used a citizens’ panel to acquire recommendations on priorities for healthy living centres. However, she thought that people would “tinker with the research to meet their own needs” and that therefore, the panel could, but should not be used to ask about income inequality. Some senior NHS staff had not heard of the panel and could not comment.

Of the voluntary sector staff interviewed most thought that it should be used for discussing income inequalities. However, there was again some cynicism about the panel, particularly since it had reportedly won an award and its members had all been given free computers. “They should be kept busy and asked all sorts of things, given that they keep winning prizes.” Of those voluntary sector staff who did not think the panel should be asked, the feeling was not strong, but the reason given was simply that it was felt no one would take any notice of what local people thought. This cynicism was also reflected in the view of the Socialist Party councillor, who thought that: “The only consultation in my opinion that takes place in a lot of boroughs and particularly in Lewisham, is to consult, in effect, on decisions that have already been made, to give them some legitimacy.”

Another comment, repeated a number of times, was that the panel members would have to be well supported in order to understand the questions. It was also felt by

some respondents that the presentation of information by council officers was likely to 'push people down the road the council wants'. A councillor however, thought that "if you were looking for a particular answer you would have to be careful how the question was framed and consider how people can look objectively at an issue without seeing it from the perspective of their own personal gain." He cited the case of Bristol Council which had held a poll on cutting council tax or funding schools and had, in his opinion, got into trouble when people had said they wanted the former. And a 'New' Labour councillor said, "what people often say they want is not what is necessarily good for them, in as much as the whole holistic view of the thing is concerned".

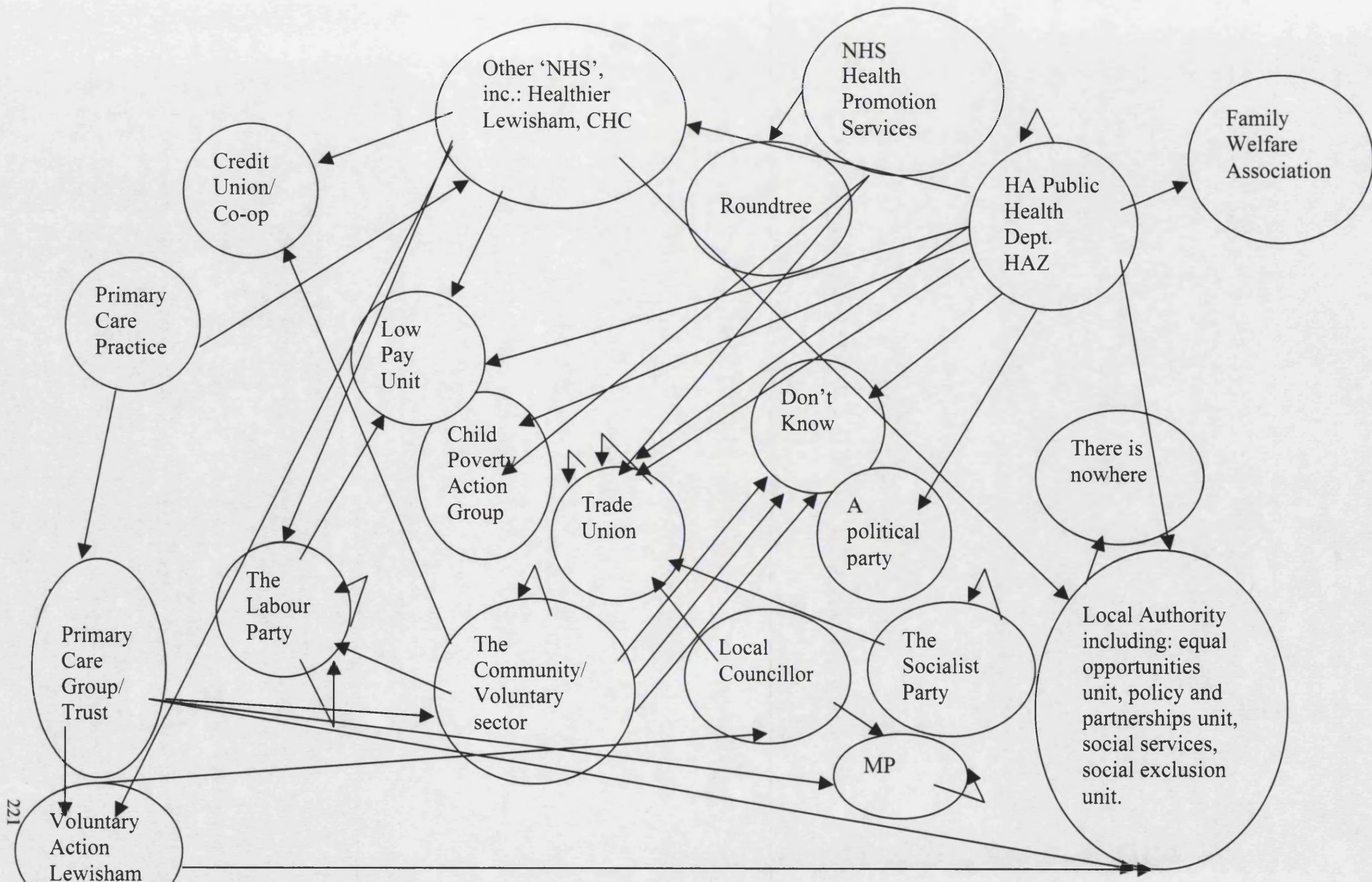
Another 'New' Labour councillor thought that the purpose of the panel was not just to get answers, but also to 'engage citizens'. A health authority employee also cited the role of the panel, in allowing people a 'foot in' to public engagement. She had seen a number of members of the public first becoming involved because of an invitation and then, eventually moving into more substantive public positions, such as non-executive NHS Trust member.

Local authority strategy to involve residents also involves schemes such as the Hubs, which will be discussed below.

## **5. Local organisation to reduce income inequality**

A consultation document on transport prepared by the Social Exclusion Unit in 2001 asked 'Do people in local communities know who to go to if they want to influence transport services?'. In a similar vein, interviewees were asked – 'if a local person said they wanted to see a reduction in income inequalities, what local organisation would you suggest the person contacting?' This question attempts to see control of income inequalities from a local person's perspective, in a similar way to 'patient pathways' work, which tracks services users between departments. We seek to look at options considered to be available locally for input into this policy.

Generally respondents said they found the question 'very interesting'. They either offered suggestions for organisations for people to join, or to go to in order to find out



**Figure 6.2** This shows the answer to the question: 'if a member of the public in Lewisham wanted to see a reduction in income inequalities, which organisation should they join or where should they go?' The arrows represent the answers of those asked. An arrow starts from the respondent's organisation and travels to the organisation(s) they recommended. One respondent may come up with more than one answer. Some, for example, the Socialist Party councillor, recommended their own organisation so the arrow is shown going back into their own circle.

more information. However, the imaginary person was often referred to organisations which themselves had referred elsewhere (see figure 6.2).

### **The Labour Party**

If they did not mention sending people to the local Labour Party, as indeed the majority did not, interviewees were then asked – ‘What about the local Labour Party in Lewisham?’. To which a number gave answers along the lines of this senior public health manager: “No, it is interesting that it did not cross my mind”. Others were not aware at all of the local Labour Party. Some considered that it would not be appropriate. One saying, for instance, that because the party was in government, anyone in the Labour Party wanting to change policy on income distribution “would be frowned on”. And another senior NHS manager saying that - “..I suppose I have a fundamental problem of advising someone to go to the Labour Party at the moment. I don’t see any evidence that it [inequalities reduction] is really at its heart and is what they passionately feel.” Even people who mentioned that they were themselves members of the Labour Party and cited policy that they felt was effective in reducing health and income inequalities, did not recommend others going to the Labour Party as an organisation to be involved with in order to reduce inequalities.

There seemed to be little conception as to where Labour Party policy might come from, although generally it was assumed that it did not come from the membership. Both council and health authority officers with responsibilities for involving the public had never had any contact with the local Labour Party membership and knew nothing about its structure, organisation or membership.

### **Social capital and non-party methods**

There was fairly widespread support for statutory services to ‘engage with building social capital’. One NHS manager characterised the best way to ‘build social capital’ as offering support to the type of “community based organisations, staffed by volunteers, meeting on a Wednesday night..” Another manager explained social capital light-heartedly as “people being nice to each other”. There was a belief among a number of interviewees that people would be enfranchised by being involved in these local voluntary organisations, “in terms of individuals developing a feeling that they are able to participate.” The same respondent said of local political parties: “ I

have no personal contacts with any political parties, I don't know anything about how they work." (NHS manager).

At the same time, a number of community development workers (CDWs) did not know anywhere to suggest that people should go. One, for instance, saying: "I don't know whether such groups exist, and I don't know where local people come together to talk about such things in any shape or form, all I can say is if someone came here and asked such a question I would have to say - 'I don't know I will try and find out for you'."

One CDW specifically said they would recommend - "don't go into politics, go to the community-voluntary sector". However, another CDW did recommend the Labour Party, saying - "I know it sounds ridiculous, but I would say go along to your local Labour Party branch". She said that it was wrong to think the issue could be addressed simply via the community-voluntary sector, adding that cynicism towards politics serves a function "because it is more familiar and comfortable. I am not saying that the political process isn't a nightmare to negotiate and that it is not full of things that the rest of society is full of like sexism, racism you know." However, she also felt that locally, people were going to associate the political process with the council and that "people will be aware of the shady dealings and the shenanigans around the council."

Another senior NHS manager mentioned the reputation Lewisham Council had for being 'corrupt'. She had heard this discussed on a number of occasions in the past two years. The association between Labour Party membership, the council and local politics was echoed by one CDW who said, when asked about the Labour Party as an organisation to go to: "No they wouldn't spring to my mind, and that is probably because of my own prejudice about local government, which is a kind of closed-shop - cliquy little groups of people.." One health authority employee said that the health authority and its partners should "put their own house in order first". In other words inequalities in terms and conditions in the health services should be addressed first.

## **Trade unions**

The largest single number of responses recommended going to 'a trade union'. One senior health authority manager added that, in the past she would have recommended a trades council, but that they no longer operated.

Three out of the five councillors interviewed said that they would recommend joining their own party, thus contradicting those CDWs who recommended not 'going to politics'. The Socialist Party councillor said that his party supported, among other things, a move to increase the national minimum wage and index linking of pensions and thus would be where people should go to effect change. One Labour councillor had an extremely non-proselytising attitude, saying that although they were a member and personally supported joining the Labour Party, "for other people I would recommend the Low Pay Unit." Giving the impression that encouraging people to join the Labour Party was either, not quite an acceptable thing for a councillor to be doing, or, a forlorn hope. One councillor simply recommended joining a trade union.

To summarise to this section it can be said that statutory and voluntary sector workers responsible for reducing health inequalities in Lewisham do not have a clear vision as to how people affected by poor health, possibly due to their economic circumstances, might influence the economic context in which they find themselves. It can be argued that income inequalities are not controlled by statutory and voluntary sector staff, whereas services are, and that therefore this finding should be anticipated. However, in the observations documented in the previous chapter we saw that the same group of staff generally considered income inequalities to be an important factor in determining the level of health inequalities. The context of increased investment by statutory services in various initiatives to involve the public should also be noted. Statutory services are encouraging participation in community groups in order, among other things, to promote social capital. But party political bodies do not enjoy this signposting.

## **6. Councillors' views on involvement**

Considered below, in more detail, are the opinions of local councillors on issues pertinent to the public involvement and health agenda.

### **The importance of councillors in relation to the public health agenda**

Firstly, this section looks at the types of issues councillors have brought to them at their surgeries and raised with them via other 'one-to-one' routes. These issues vary from ward to ward, depending on the population profile. However, they are all subjects that may be classed within 'the wider determinants of health'. For instance, housing was cited by three of the councillors interviewed as the main problem that people came to them with: "The main problems they come to me with is poor housing, over-crowding and issues relating to that." Although for one of the councillors, based in a ward with a higher level of private housing, education was the single largest cause for contact by his constituents. Other issues raised included roads and traffic safety concerns, race and immigration issues,<sup>159</sup> parking, street-cleaning, and planning. Of the more direct health problems one councillor said: "The odd case that I get on the health front is to do with tenants who have got mental health problems. Because they have been re-housed into the community and there has been a lack of interagency working in supporting that tenant with the mental health problem." The councillors believed there were links between housing and health. They had also been encouraged to take this view by NHS staff. For instance, " ...the GPs tell me - if I had prescribed good housing the health of all my patients would improve, or my patient case load would decrease by a quarter, if not a half." The extent to which the points system, which positions applicants on the housing list, is affected by medical concerns was however challenged: "...a GP letter does not really give you more points to be honest."

Aside from being seen by many constituents as having power over issues that cover the wider determinants of health, councillors collectively also have some power to influence income distribution in Lewisham directly. As one said "...we use everybody's council tax to address.. the areas where we have the biggest priorities." This councillor also added, somewhat tongue-in-cheek, that when people paying council tax from higher property bands say, - " 'I pay a lot of money, I want some of that money back [in services]' - you have to remind them that the whole purpose of

<sup>159</sup> One said: "In my case as well, because I am a [ethnic minority] councillor, I get people calling from other wards in Lewisham and also from outside Lewisham."

the system we work in is not ‘to those that have should be given’, but ‘to those that have shall be taken away!’”

Councillors have other powers to influence the health agenda. As has been seen, many sit on the boards of voluntary groups that have a role to play in health issues and some are non-executive members of local NHS trusts. With proposed changes to the role of the community health council, councillors will acquire new powers to initiate enquiries into health services. MPs are seen by both councillors and staff as having more power to affect national health and income inequalities.

Later on in this chapter, overlap between the various systems of representation is discussed. Before that, a digression is required to look at the councillors’ remit and structural position.

### **Modernising local government**

Changes heralded by the White Paper *Modernising Local Government* (DETR, 1998) involved granting increased powers to some councillors and decreasing the power of others. In Lewisham a cabinet, consisting of the mayor and six deputy mayors, was formed in 1999. The borough was one of the first councils to move to this system. In 2001 a local referendum took place, the results of which supported holding elections to agree the mayor. The non-cabinet councillors now have a role in developing closer links with constituents and acting as ‘scrutineers’ of council policy. A number of statutory and non-statutory sector staff mentioned that they thought these non-cabinet councillors now had less power. One regeneration manager said, for instance: - “..if you are a back-bench board member then you probably sometimes wonder what on earth you are doing it for, especially since...very few people came out to vote for you...”

### **Labour Party democracy and the role of the party and its candidates**

In Lewisham the changes in council structure that got underway from 1997 ran in parallel to changes in the internal institutions of the Labour Party. One of the most significant changes in the latter appears to be the ruling out of resolutions from branch (or ward level) meetings, to the party central committee, in order to inform the local policy of the party. “There has been no new party policy since 1997, only that created



by the ruling group. I suppose they use the focus groups more now than anything else.” The reason given for this change by one ‘New’ Labour councillor was that – “I don’t want to go to a meeting where somebody moves a motion, and somebody seconds it, and somebody opposes it, and you know who was there, only six people, and it becomes a party mandate at a local level. That is ridiculous, that is not democratic.” Looking at these arguments a vicious circle can be seen. Members don’t want to attend meetings because they have less power in the form of debating motions and passing resolutions, yet because branch meetings are so small, they are not thought to be suitable places to pass such resolutions.<sup>160</sup>

Generally, it can be said that councillors have found themselves encouraged to be less accountable to Labour Party members and to spend more time listening to the views of the electorate and residents, whatever their political affiliations or lack of them. For the Socialist Party councillor this meant that: “I think [as a Labour Party member in Lewisham] going to the bus stop you’ve got more power than going to a Labour Party meeting!”

The councillors see themselves as being accountable to a number of different groups. – “I am accountable to the ward I represent because I have to give a councillors report. I am accountable to the political party that elected me and therefore I have to go along with the policy of that party....So I am accountable to the ward, the party and I am accountable to the people who elected me.”. But the ‘New’ Labour councillors appeared to have a stronger sense of representing non-Labour members and voters. One said for instance: “...it is not about proceeding to all your long held beliefs about ...socialism, because that has not won for us in nineteen years, it is about finding out what other people want, delivering on that, and then trying to find ways of getting closer than that, back to the roots.” In other words, the art of political compromise was imperative to the holding of office.

The selection of candidates, particularly MPs, within the Labour Party is seen to be of crucial significance to the party’s leading group. This suggests that council members have certain powers to support, or disrupt, national and local policy. The party was

<sup>160</sup> Quorum rules should apply to minimise these difficulties.

seen to manipulate the selection of candidates to produce ones holding the same views as the leadership. The most notable cases being those of Ken Livingstone, Rhodri Morgan and Denis Canavan. While these 'big names' have been prominently reported, they are only a small fraction of those candidates who have undergone 'controlled selection'. That is, selection that does not follow normal party procedures. The Socialist Party councillor, with an obvious hostility to the party in power, referred to a Lewisham example: "I know previously.. local wards were able to play a major role in the selection of their councillors and I know that is becoming less and less the case...When someone stood against me the Labour candidate was imposed on them...he was not selected by the local ward, he was imposed by the local machinery of the party." The 'Old' Labour councillor interviewed said: "Things are far less transparent than they used to be. You used to be able to remove people."

### **Labour Party membership**

Given the increase in statutory attention given to public involvement work, it is important to note that Labour Party membership and attendance at ward meetings fell considerably between 1997 and 2003. This is the case in Lewisham, London-wide and nationally. All of the councillors interviewed agreed that there was far less participation by members in ward meetings in Lewisham and that membership was probably down. The Socialist Party councillor said there were "...less...people prepared to go out to campaign for the [Labour] party." Two Labour councillors corroborated this.

No attempts had been made to increase Labour Party membership, especially among lower income groups. As an 'Old' Labour councillor reported, fund-raising dinners were organised at £60.00 per head. "So people who are on low incomes, even if they are lifelong members, there is no way they are going to spend £60 per head. That happened in West and East Lewisham. In Deptford there was one that was £25 per head." Public meetings organised by the Labour Party to attract new members were considered to be "not something we would do." by one 'New' Labour councillor. The reason given was – "because people read papers and see the television, people think that they know what is going on, so public meetings are no good, unless you have one of half a dozen people (Tony Blair, John Prescott, Paul Boateng, Jack Straw). However, another thought it was important: "I think occasionally we should hold

public meetings on a specific issue, whether it's an area based issue, or a wider issue." No local party leaflets in non-English texts had been distributed. No local membership drives had been initiated, let alone any that targeted lower income groups.

The 'New' Labour councillors were less concerned about decreases in membership levels and attendance at ward meetings. They also gave different reasons for diminishing attendance. One saying:

"I personally don't think that New Labour is a factor in that decrease in activism. I think it is the old unwieldy, boring structures and what goes on in those structures that actually killed hard activism in the party. Who wants to go to a ward meeting now on a wet night and talk about motions and resolutions with three other people? That is why we have got to think of new ways of meeting, that is why we introduced local forums and themed debate and presentations from outside speakers and politicians."

The councillor thought that the character of the membership had not changed, in that it was still a mix of "working class, middle class, white collar workers, that's the membership of Lewisham Labour Party."

However, one 'New' Labour councillor also commented that the age profile of members had gone up by ten years since 1990 and that retired members were not being replaced by young people. The enthusiasm of previous generations of Labour Party members in Lewisham is demonstrated by, for instance: - "When I started, elections for branch officers, even polling district officers, who were responsible for the 'redipacks' and the canvas sheets in an election, were contested. Well now you don't get enough people to do anything at all." Another councillor said that since 1998 no members would canvass in elections, and the only people going out were the candidates themselves. However, this councillor asked the rhetorical question - "Is it important that people attend ward meetings and that the membership is increased?", to which they replied "I'd suggest that both those things are not important any longer....I think in 2001 there are other ways of doing things."

### **Trade unions**

As described in chapter 5, there was widespread support for trade unions among the professional population under investigation. However, as also reported in that chapter, the strength of endorsement for unions indicated in private interviews did not find matching advocacy in public, or result in any practical consequences.

Trade union officials argued that union membership and the activities of trade unions in lobbying the Labour government had led to a reduction in income inequalities. They supported further reductions, for example via an increase in the national minimum wage. However, local statutory support for union activity had been reduced over a period of twenty years.

The Socialist Party councillor considered that the TUC gave contradictory signals in respect of its thinking on income inequalities policy: supporting a national minimum wage and criticising fat cats, yet at the same time not wanting to commit to a target on income inequality reduction. The cause of this anomaly he put down to the influence of New Labour on the TUC. A number of community development workers were both supportive of trade union aims and at the same time critical of their methods and organisation.

The lack of joint working between trade unions and statutory workers assigned to public involvement work possibly suggests political reasons for a lack of integration. Examples of this lack of involvement were: trade unions not having been invited onto LSPs (Local Strategic Partnerships), a lack of consultation with unions in public participation exercises, and no joint working or support on health issues and health and safety issues, outside of the internal structures of statutory agencies. This contrasts with increased statutory support for very modest voluntary agencies. The assistance ranging from funds to run small-scale health promotion events to support with infrastructure costs granted in part because the organisations were seen to promote social capital.

### **Electoral turn-out**

Despite differences of opinion on the importance of a fall-off in Labour Party membership and the consequent drop support at elections, all the councillors were

concerned about low turnout in local elections. In recent by-elections turnout had been “barely above 10%”. A ‘New’ Labour councillor believed that the development of the post of directly elected mayor should help to increase turnout, saying - “If we modernise the way we run the government in Lewisham, if we change the way that people are elected, if we change their responsibilities, if we make them more accountable, if we make them more known, then you might actually start getting to the stage where we get bigger turn-outs.”.

Unsurprisingly, the Socialist Party councillor saw the situation differently. He said that the reason for the low turnout was that:

“There is massive disillusionment in the political parties, people are not rude, but say ‘you’re all the same’. And ...many people would not have heard very much of us, and [it is hard] trying to convince them that we are different....The party that they have known, that they almost automatically went out to vote for, is not there any more.”

Statutory and non-statutory staff also referred to low turnouts. One senior regeneration officer believed that if more money was spent in local areas -

“...politics would start to reinvigorate...If, no matter what they complain about, nothing happens, it is not responsive, so you sort of say, ‘I am not going to play this game, I won’t vote.’ With local management and local money coming in, turn-out is much higher...”

Another council officer, with responsibility for public participation, argued in a meeting of the new public participation forum that the reason for low turnout was because people were generally happy with service provision.

### **Comparison between ‘Hubs’ and ward meetings**

Despite the council policy of encouraging Hubs and the parallel decreased attendance at ward meetings by Labour Party members, many of the issues raised in the two forums overlapped. At least, it was unusual to find a Hub discussing an issue that could not be found to have been discussed in a ward meeting, but a ward meeting

might discuss issues not thought suitable for a Hub. The issues of street cleaning, lighting, violence and racism had all been discussed in ward meetings and in the past, branch resolutions had been passed on these sorts of issues. The Hubs also had discussions on what could be done about violence, or education standards for example.

Councillors did not like specific items of casework being raised in Hub meetings, such as council tenants complaining about specific repairs not having been carried out. They saw the groups as attempting to be more strategic. “There is a danger of the Hub turning into a casework session, we try and stop that. ‘Grandma is having problems with the dustman’, we try to manage the discussion and avoid individual casework issues”. Exactly why these meetings should not be boring, when ward meetings are, was not explained.

Some topics tended to be referred to more than others in the Hubs. Despite the large budget for social services, issues such as support for children with special needs, were almost never raised. These problems were therefore filtered out of discussions among councillors about the Hub reports. All the councillors made asides suggesting that they really knew what issues the Hubs would raise. Some were more cynical about the process than others, but they all portrayed a certain scepticism about the ‘added value’ of the information gained through the process. – “...every Hub comes up with the same issues – perception of crime and the reality of crime, housing, roads, the cleanliness of the parks...”. Another councillor said: “...almost all the issues that come from the Hubs the council already knows about.” (Citing – street cleaning, pavements, lighting, street-drinking).

Neighbourhood housing committees were also considered by one councillor to be frustrating, as they tended to move away from discussing national strategic questions such as: “-‘how we can attract more money into the housing service in Lewisham, and into our particular neighbourhood? How can we address the standards of care-taking, of repair and maintenance on a regular programme basis? How can we address the vacancies, the voids?’”. The housing representatives however, were said to discuss immediate issues about their personal housing experience, such as:

“-‘Why is my light bulb not changed, why is my toilet still not flushing, why have the stairs of my block only been cleaned up to the fourth floor?’ - They are not the strategic issues that they should be talking about. They wait a month or six weeks before raising these issues, whereas the light bulb, toilet, the stairs issues should be addressed to someone on the day that it does not happen, not wait to come to a community forum...I just despair, because you know exactly what is going to be said - ‘My toilet is still blocked.’”

Councillors were asked to consider at which meeting, a Hub or a Labour Party branch meeting, a Labour Party member would have more chance of being listened to. Thus, given competition for time, which meeting would someone be better off attending? A ‘New’ Labour councillor thought that if someone was a member of the Labour Party that would not change the way they raised local issues, i.e., they should go to the Hubs. “But they [also] have an input at a ward meeting, or in the political context, to say ‘how does this square with national policy’.”

An ‘Old’ Labour councillor thought that residents would now have a stronger voice in a Hub. “Nowadays, you know about the closure of a school after it has happened, you’d read about it in the paper. Council officers are not obliged to do anything about what someone says in a Hub. You can’t stop things, the Hub is more of a talking shop.” However, the councillor saw more power as having rested with Labour Party members in the past. – “If I did something [as a councillor] that was bad I could not be re-selected, or the ward could pass a vote of ‘no confidence’ in me.” This was corroborated by another ‘New’ Labour councillor who said: - “I think you would probably get more results if you raised it at a Hub meeting, as a citizen, than if you raised it at a ward meeting, as a party member.”

However, this same councillor later indicated that, for issues of income inequalities policy, the ‘political route’ was more appropriate than the Hub. “...if you are talking about policy influence, that is where you start using the political route and the political system, and get involved in the political system and the political structures, if you are talking about say, addressing income inequalities.”

The Socialist Party councillor supported the principle of trying to extend local democracy and wanted to see proposals “for something far more democratic.” The Hubs, however, were “not going to have any real teeth because it is not going to have any budget towards it.” He saw local decision making as being weighted towards business and councillors: “I can’t really see what influence that Hub or anybody else can have when half the elected councillors are not having any say in what is happening.” The role he thought they had was as follows: “My suspicion is, as much as anything, it is just something to give the back-bench councillors something to do, now that they in effect have not got a role under the new cabinet system.”

Thus, there is considerable overlap between the Hubs and the pre-1997 Labour Party branch meetings.<sup>161</sup> Also discernable is competition for people’s time between the two systems. While it may be that residents now have more ‘voice’ if they attend a Hub, on the basis of the former operation of branch meetings, they would previously have had a more powerful ‘voice’ at the branch.

There was also competition for Labour councillors’ time, between encouraging people to join the party and come to ward meetings and encouraging people to attend the Hubs. ‘Back-benchers’ were investing time in supporting the Hub and, according to one ‘New’ Labour councillor, – “That is partly about rediscovering what is their so called ‘representational role’. Yes, you are elected on the Labour Party manifesto...., but as a councillor, after the election, you represent everyone, not just the ones that voted for you. I represent eight thousand in my ward, not the nine hundred and something that voted for me.” Although council services were not allowed to be ‘party political’ and could obviously only encourage development of the Hubs, Labour councillors could also encourage party membership development. However, their time was diverted into the Hubs. Council officers supported elected members in this process and encouraged them to attend. One ‘New’ Labour member saw the new structures as giving councillors added responsibilities and new ways of being accountable. “In the past most of us [councillors] would have said attending a ward meeting to give your councillors report is more important than attending a Hub meeting, but now it should be given equal importance.”

<sup>161</sup> Personal observation of a Community Network meeting in 2002 suggested that the social profile of meeting participants was very similar to that of the local Labour Party in 1997.



Inside the Hubs there were felt to be opportunities to promote the Labour Party, through being seen to be good councillors:

“...there are great opportunities there ...to promote party politics and policies...your intention is never to go to a Hub meeting ‘because I want to recruit ten new members to the Labour Party’, it is not as obvious as that. It is all indirect, it is like saying look what we are trying to do, we are trying to do ABCD because we are Labour councillors and we are a Labour council or a Labour run or dominated council, and it is about promoting the Labour Party indirectly.”

There was disagreement concerning the best place for residents to spend any time that they might have to devote to ‘being involved’. Competition seemed to exist between the community council, voluntary organisations, the Labour Party and the Socialist Party. Clearly the advice of some NHS staff and workers involved in the community council was to some extent at odds with the advice of elected representatives, both from the Socialist Party and from ‘New’ and ‘Old’ Labour. However, the messages were mixed. On the one hand, a statutory sector (NHS) worker applauded and wanted to encourage (for reasons of increased social capital) one or two people meeting in a voluntary organisation on a Wednesday night. On the other hand, a councillor is dismissive of people meeting in the ‘voluntary organisation’ that is the Labour Party on a wet night and does not think such meetings are worth supporting because they are boring. Another CDW however, thought that there was a tendency for community workers to think that everything could be achieved through voluntary work, but, as has been seen, she considered that involvement in ‘the political process’, meaning party politics, was necessary.

## Conclusion

A number of preceding findings justified the investigation reported in this chapter. Firstly, staff with a public health remit tended to think that a reduction in income inequalities would lead to a reduction in health inequalities.<sup>162</sup> They might therefore

<sup>162</sup> This view was founded on speculative, ideological and evidence-based reasoning.

be interested in how people with poorer health, broadly determined by poorer economic circumstances, can influence those circumstances. Secondly, they showed a fairly widespread belief in the concept of 'social capital' and in benefits to health from participation in civil society. Thirdly, there has been a major increase in NHS resources devoted to public and user participation over the last five years.

The findings show that little attention has in fact been paid by NHS staff to public involvement on issues concerning income inequality and to the relationship between current statutory public involvement activity and forms of involvement that might be suited to influencing this particular 'wider determinant of health'. The reasons for this are multi-faceted and interrelated. NHS staff cannot promote a particular political party, they can only promote involvement in particular voluntary organisations. This is because of their duty to remain politically neutral. They are also part of a culture in which younger staff members are becoming less informed and involved in Labour Party activity. All those interviewed who were, or had been members of the Labour Party, were roughly over the age of forty.<sup>163</sup> They take their cues on relations with local political parties from wider local and national political leadership and not simply from their individual opinions.

Staff tend to think, for the best of motives and quite understandably, that they should only invest time and resources into public involvement work where they have the power to oversee the changes members of the public might then request. However, decisions on income inequality within the country as a whole, and even within single local authorities, are not only controlled by people within discrete authority areas. Representatives of local areas, for example, trade unions, MPs and in the past Labour Party members, must negotiate on behalf of local people with representatives from other areas, in order to influence manifestos and policy. These negotiations may be fruitless. It cannot be guaranteed that if Lewisham residents, via some route or other, persuade their local MPs to support a reduction in income inequalities, that a reduction will take place. However, to support an ethos that recommends to local people, in deeds and words, that they should not participate in politics is, in effect, to make a political statement. So, even if NHS workers bypass political structures

<sup>163</sup> Although one younger local NHS worker stood as a Labour Party councillor in the 2001 local elections.

because they believe they have no right to be involved in them, they are still influencing their development or diminution. The fact that NHS workers, using staff time and budgets to promote involvement in community organisations, remain silent about, or hostile towards, involvement in political organisation, feeds into a state bias against party activism. This is not to say that other state processes might not support other levels of party development.

Referring back to the definition of (public) involvement provided by Lee and Mills (1982) and outlined in the introduction to this chapter, it can be said that many local staff aspired to work in collaboration with the public and that forms of participation, consultation and negotiation were all in evidence locally with regard to particular health improvement-related projects and public involvement forums. However, Lee and Mills's definition tends to assume clear-cut topics and alternatives from which choices can be made. This thesis's perspective has been broader, in that it has attempted to demonstrate that public involvement methods employed by state workers may affect the future availability of public involvement opportunities. Also, it has noted a tendency for some topics to be 'out of bounds', whether discussed in collaboration, participation, consultation or negotiation with state employees. The topic of income distribution was noted in this respect.<sup>164</sup>

Representatives of the Labour Party were divided on the extent to which they wanted to increase membership and to devolve power to the membership, compared to working with their wider electorate in new structures. Generally, though not exclusively, those classified as 'New' Labour (chapter 3) tended to emphasise 'listening to the whole population', over 'being held to account by the membership'. Voluntary sector workers involved in community development and public participation work have no 'route in', within their work roles, to supporting a strengthened Labour Party membership organisation and generally do not pay any attention to this form of public organisation. However, as the author has sought to show, the strengthening of non-party based public involvement is, in some senses, in competition with party based and more autonomous self-organising forms. Councillors devote time to Hub work, which is supported by statutory sector

<sup>164</sup> This observation is similar to problems encountered with Lindblom's theory of 'partisan mutual adjustment' noted in chapter 4 (Hill, 1997a: 104).

employees. But therefore, elected members now have less time, and are less supported, in building party organisation.

The time and attention of residents is also being competed for. On one estate, for example, the state funded and NHS supported, community council is vying for residents' interest, with a small thorn in the local Labour leadership's side, the Socialist Party. Some workers associated with the community council would positively not recommend involvement in party politics, as a method of affecting income inequalities. This directly challenges the work of the Socialist Party and undermines those 'Old' and 'New' Labour councillors who still believe in the merits of Labour Party membership. Another voluntary sector worker, associated with 'New' Labour, was unsupportive of trade union membership of the Local Strategic Partnership, saying that trade unions were 'out for themselves'.

The actions and recommendations of NHS staff are linking with other forces, not least of all the Labour Party itself, in setting up vicious circles that are undermining the collective and representative institutions that may seek to influence income inequalities. The study has found 'New' Labour councillors themselves making no connections between community participation and the Labour Party; they saw little point in building the membership. A commentator known for his links with senior Labour figures, who has been generally sympathetic to the New Labour project – the Director of the Institute of Public Policy Research - corroborates this situation. Matthew Taylor writes that, since 1997:

“Party membership has fallen by (at least) a third... Local Labour parties may not be wracked by political conflict but in many areas this is the silence of the grave....[For the New Labour 'modernisers']... Party members are seen as unrepresentative, poorly informed and only useful as campaign foot soldiers...ultimately they [the modernisers] hold out little hope that the party can be of much value to either the national government or local community. While no Labour politician would publicly subscribe to such views, they represent the implicit consensus in government and the opinion of most journalists...there is no modernisers' blue print for the party...As the party withers it damages the whole project of representative democracy...New

Labour's leaders are aware of this but it is symptomatic of their pessimism about party renewal that their answer was the now largely discredited idea of directly elected Mayors" (Taylor, 2003).

The trend towards a "decline in relevance of parliament and party politics for the formulation and development of public policy" has been well reported (Held, 1987: 217). However, that NHS staff and institutions might also support this process has not been so widely considered, excepting in debates around elected non-executive board members and trade union powers.

In contrast to one conception of the communitarian ideal, the state is now paying more for a service that was previously provided by free association between residents. Staff should be clear as to whether the system being developed is better for lower income groups, or whether more control over a potential party of government, would be to the longer-term advantage of the less well off.

## Chapter 7

## CONCLUSION

### Foreword

The hypothesis put forward in the thesis's introduction was that work to reduce health inequalities at the local level would be affected by key political considerations and tensions within the new Labour government and party. Primarily these were tensions concerning policy on income distribution and linked to this - the balancing of central and local control. It was suggested that these tensions would play a part in affecting local policy implementation. Other factors influencing the pattern and speed of local reactions to the new policy were predicted to be among those listed in *The Health of the Nation – a policy assessed* (LSHTM, 1998). And it was suggested that local work would be influenced by the extent to which that assessment's recommendations were adopted. Cross-referencing is made here with the key findings of the HOTTN assessment. Appendix 7.1 provides a point-by-point comparison.

As this final chapter was being written the government published *Tackling Health Inequalities: a programme for action* (THI) (DoH, 2003). This provided a fitting end-point for the research. The document is a plan for further operationalising existing evidence of how local services can work to reduce health inequalities. It summarises what is known and suggests steps that can be taken locally. Thus, a key observation of this research, that over a six year period little support was provided from the centre as to what actions should be taken locally, had finally been addressed.<sup>165</sup>

However, attention must be drawn to a diagram reproduced on page 12 of the THI report. This shows the impact of direct personal tax, benefit and expenditure tax changes since 1997. The poorest decile has gained by over 15% and the richest has lost by just under 5%. The data source is the Institute for Fiscal Studies (IFS). The data are correct, but at the same time misleading. In a second IFS published diagram,

<sup>165</sup> The need to provide local areas with support in the form of suggested work topics, as listed in THI, was still disputed within the DoH at the time of its drafting, with some, more strongly than others, holding the view that 'local freedom and decentralisation' was the imperative. Evidence of the effectiveness of interventions and practical considerations helped to justify the provision of clearer guidance. (View of two civil servants provided to researcher).

which is not reproduced in THI, income inequalities, as measured by the Gini coefficient,<sup>166</sup> are plotted from 1979 onwards. The diagram shows that:

“Over the 1980s, there was a considerable increase in inequality... It stabilised in the early 1990s, and then fell slightly over the last Conservative government. Since Labour came to power, [it] increased once more. Indeed, despite the slight [statistically insignificant] fall in 2001-2, income inequality over the past two years has been higher than in any other period covered by our data.” (Shephard, 2003: 4).

The fact that the first IFS diagram was chosen for reproduction in *Tackling Health Inequalities* (THI) and the second was not, validates the view that there are government tensions in relation to the issue of income inequalities at the heart of health inequalities policy. The effect this tension has had on local policy implementation has been one of the main subjects of this thesis.

Local understanding, based on reading THI, of the extent to which income inequalities have increased or decreased, might influence local action such as, for example, the redistribution of services or the commissioning of ‘money advice’ in preference to other new provision. But a variety of other mechanisms, whereby Labour government tensions concerning income distribution may have affected local policy implementation, were considered in this thesis, these are discussed further in this chapter.<sup>167</sup>

At this concluding juncture an overview of the thesis is provided by way of a short chapter-by-chapter review. Then the chapter discusses in more detail the findings in relation to theory; in particular, central-local tensions and the question of the partisan state and income inequalities are discussed. Then are listed some further conclusions

<sup>166</sup> “The Gini coefficient is a popular measure of income inequality. It collapses the entire income distribution into a single number between zero and one; the higher the number is, the greater is the degree of income inequality.” (Shephard, 2003: 4)

<sup>167</sup> The ways in which tensions over income inequalities may have influenced local implementation were suggested as follows, by affecting: 1. income inequality levels (which in turn may affect health inequalities). 2. organisations wanting to, or able to influence income distribution. 3. policy processes relating to income inequalities, because these are expected to be ‘joined-up’ and consistent with wider government policy. 4. staff perceptions and incentives, which may in turn impact on local implementation (introduction).

relating to government learning and adaptation, and some policy recommendations based on the findings are provided before a summary to the chapter and the thesis.

## **An overview of the thesis**

The thesis's introduction set out the hypothesis, as reiterated above, and explained the key topics in *Saving Lives* (DoH, 1999) of relevance to the work<sup>168</sup> and the relationship of these topics to issues and tensions in the Labour Party and government. In so doing, the author demonstrated the potential for a causal relationship between tensions in the party and government and the pattern of local implementation of policy to reduce health inequalities. This possibility existed, not only because of issues relating to the Labour Party, such as the fact that it was associated with redistributive policies by its membership, but also because the policy of reducing health inequalities was associated with income redistribution, and the 'neutral' NHS was unaccustomed to dealing with such a highly charged political issue.

The fact that there were disputes over income inequalities within the ranks of the Labour Party and government is clear, and examples of such tensions were provided in chapter 1. It is also the case that the government's aims and record on combating income inequalities and child poverty were unpublicised and mixed (1997-2003). Those who argue that income and health inequalities are linked will consider that the result of this hesitant approach is likely to be less progress to combat the latter form of inequality.

Chapter 1 gave the thesis a theoretical background in political science, introducing the concepts of power, democracy, class, the neutral state and the partisan state. The thesis argued that issues affecting local implementation of policy to reduce health inequalities could be productively analysed using these concepts. The theoretical concepts were applied to organise and analyse the subsequent enquiry and are referred to in the next section, below.

<sup>168</sup> These were: i. the link between poverty and health, and its implications; ii. decisions about centralisation-decentralisation, and in particular the role of individuals and communities vis-à-vis the role of government; iii. and lastly, state-led public involvement and its ramifications.



Chapter 2 investigated public health history and, using secondary sources, reported evidence of an association between collective action, among those with poorer health, and health improvement. Then it discussed in more detail the content of *Saving Lives* (DoH, 1999) and the literature relating to health inequalities. Listed were developments, which, from a reading of *Saving Lives*, one would expect to see if the policy were being implemented according to its letter, given other concurrent recommendations such as those in Acheson (1998). These points can be found just before the summary in chapter 2 and findings relating to them are included in this chapter.

The research methods employed were outlined in chapter 3 along with a justification for the case study approach adopted. Because of the wide range of factors thought to influence health and the argument put forward in the introductory chapters that labour movement organisation can also affect the wider determinants of health, local councillors, trade unionists, council and voluntary sectors workers, as well as NHS and DoH staff, were interviewed.

In chapter 4, the first of three findings chapters, institutional changes in local statutory services were investigated for their impact on implementation of policy to reduce health inequalities. This was in order to provide a realistic context to the thesis's specific research topic. The institutional context was key to understanding the experiences of staff working to address the policy. The main conclusion was that formation of Primary Care Trusts diverted attention away from work to reduce health inequalities. Referring to the points made in chapter 2 on 'local responses anticipated from a reading of *Saving Lives*', the study found that partnership work to support health improvement was already well established in Lewisham and that the extent to which health improvement work was supported varied according to the year in question. There was a low point at around the time *The NHS Plan* (DoH, 2000) was announced. Having said this, funds for the Health Action Zone, Sure Start schemes, New Deal for Communities and other regeneration work did increase money for work relating to health improvement. But mainstream budgets for related services such as environmental health, the youth service and the health promotion service were not increased and in some years even declined. However, lack of financial resources was generally a greater problem in HOTN implementation (LSHTM, 1997). Because,

post-1997, most health improvement money was effectively ‘ring fenced’, the power of general practitioners within primary care groups and trusts to argue for secondary prevention work over and above primary prevention was not as evident in the case study area as might have been expected.

*Saving Lives*'s requirement for local health authorities and trusts to set local targets for health inequality reduction was ignored and instead general priorities were agreed. The thesis also found that there was local confusion as to the most effective activities to support in order to reduce health inequalities and that, to a lesser extent, government hesitancy with regard to economic redistribution fuelled staff uncertainties. By July 2003 a strategy for local action to address health inequalities had not yet been agreed.<sup>169</sup>

The thesis can really only speculate that tight public expenditure constraints in Labour's first term and Number 10's reluctance to even talk the rhetoric of redistribution at this time had an impact on health inequalities policy. To be pinned down to a national target of reducing health inequalities, when many felt health and income inequalities were linked, was perhaps too much for a government that was keen to see that all its policies were consistent with each other and ‘joined-up’.

Respondents' values in relation to health and income inequalities, NHS neutrality and trade unions were discussed in chapter 5. It was reported that staff strongly believed in an association between health and income inequalities and wanted both reduced. There were mixed views on the need for, and extent of, NHS neutrality. Also, generally, there was wide support for recognising the potential role of trade unions in public health practice.

Chapter 6 described developments in the institutions through which local people might influence upstream factors affecting the wider determinants of health, such as income inequalities, and it reported on views and values in relation to this issue. The roles and functions of those institutions were found to be unclear and in dispute. For example, there was a lack of consensus over the correct function of the citizens' panel

<sup>169</sup> This is not to say that successful work started post-1997 had not already been completed.

in relation to influencing income inequality. There was no clear view from across the range of interviewees as to how local people might control the wider determinants of health. In particular, some councillors were found to have contradictory views on the role of the Labour Party in public involvement, a subject returned to later.

Having provided an overview of the findings we will now look at them in more detail in relation to the theoretical approaches provided in chapters 1 and 2.

## **Findings and their relation to theory**

### **Introduction**

The findings indicate that the impact of local staff views has been constrained by the national political framework outlined, in part, within the public health White Paper, *Saving Lives* (DoH, 1999). That is to say, local staff actions have not strayed much beyond the boundaries of the policy outline therein. Despite staff holding views advocating an increased emphasis on income redistribution and more support for trade union organisation, these opinions did not have an appreciable impact on the implementation process. No local work to involve trade unions in supporting health inequality reduction was carried out in the six-year period of the research, despite government requirements to target manual workers in order to improve their health fastest (DoH, 1999c). Little steer from central government was coupled with the fact that most key staff believed that health and income inequalities were linked and lacked trust or understanding of the government's position on the latter. This produced uncertainty about exactly how local services could influence income distribution, and, ultimately, wasted time. This is demonstrated by the local Health Action Zone's targets on reducing income inequality, for instance, - to instigate a "5% reduction of households with below half average income by 2005" (LSL, HAZ, 2001:1). While this target was discussed and agreed, it was then ignored, due to its being outside of the control of the HAZ. The uncertainty generated delayed work. Local staff regarded national policy relating to the wider determinants of health as being of particular importance and were influenced in their enthusiasm for local work by what they considered to be supportive or unsupportive government action.<sup>170</sup>

<sup>170</sup> A finding of this nature was also identified in *The Health of the Nation – a policy assessed* (LSHTM, 1998).

The reporting of these findings is not intended to suggest that local NHS staff views would never divert the intentions of national policy makers in the way suggested by Pressman and Widavsky (1973). However, three factors in the research subject are considered to have led to staff compliance. Firstly, staff charged with implementing the policy were broadly supportive of it and pleased to see the change of government that had led to the change of policy. Secondly, there was no real staff organisation that was capable of planning an alternative professional strategy towards work aimed at reducing health inequalities. Whilst individual staff might hold views about the need to support organisations that assist lower income groups in influencing national policy, they had no effective forum in which to share these views. A review of the pervasive organisations and intense professional and non-professional public health lobby of the nineteenth century as outlined in chapter 2, shows current public health staff association to be comparatively feeble. Thirdly, whilst staff did not appear to generally believe that the way they worked was constrained by their employment as ‘politically neutral civil servants’, some were, at the same time, in no doubt that ‘speaking out’ might negatively affect their careers.

### **Central – local tensions**

The roles of medical advances, public health interventions and individual behaviour change in population health improvement were discussed from a historical perspective in chapter 2 of the thesis. The *Saving Lives* policy (DoH, 1999) represented a synthesis of perspectives concerning mechanisms for health improvement. It balanced the desire not to behave as a ‘nanny state’ with the aspiration to not blame individuals for all their health problems. The policy emphasised the ‘wider determinants of health’, such as income inequalities and the need for public involvement in the issues that affect people’s health. This draws on the principles of the Ottawa Charter, as well as community development and social capital theory, described in chapter 2. This combination of upstream policy and local participation has been a focus of the research and, in particular, the work has been interested in the links between the two issues.

*Saving Lives* was regarded in this research as giving a clear message that distinguishes national government responsibilities, from the responsibilities of local workers. The problem with this approach was considered to be that connections between the local

and the national are not referred to. The same criticism applies to the famous 'social determinants of health' diagram (Dahlgren and Whitehead, 1991) and to the Acheson report (Acheson, 1998). Acheson's report was regarded, independently by two senior academic commentators (private information), as 'typical of a civil servant'. This was because it has a 'top-down' approach, that is, it simply states that income redistribution is necessary, without considering social and political structures that might further the cause of redistribution. In particular, the influence of the trade union movement is ignored. Acheson's (1998) report did not mention the possibility that union organisation might support lower income groups by encouraging income redistribution, supporting health and safety at work and encouraging social solidarity. If it had, then there is a possibility that reference to trade unions would not have been deleted in the move from Green to White public health paper. This, in turn, may have led to some more local work in the area of trade union support. But without any official backing, local workers did not use local autonomy to do what, individually, they generally supported.

Over the last six years institutional changes in the NHS organisations of Lambeth, Southwark and Lewisham have been substantial and have delayed the implementation of public health policy. The formation of primary care trusts (PCTs) was based on an understanding that changed structures would alter power relations. Family doctors would gradually come under greater state regulation and control, and would, at the same time, have more power to influence hospital services through directly influencing the contracting process. However, from the public health perspective the way the move to PCTs was constructed was also affected by central government relations with local government. The Health of the Nation assessment (LSHTM, 1997) suggested the need to keep under review where the public health function should be placed. It was known in 1998 that the move to PCTs would mean co-terminosity with borough boundaries. It was nevertheless decided by the DoH to keep Health Improvement Programme (HimP) development at the Lambeth, Southwark and Lewisham Health Authority level until the first borough HimPs were produced in the autumn of 2002. Giving lead responsibility for the HimP instead to the local authority and requiring them to involve the NHS, would have speeded-up the process of planning to reduce health inequalities. However, this would perhaps not have sat well with Labour's wider policy towards local government, which demonstrates

tensions and disagreements. Labour appeared to be more trusting of a health authority that was about to be disbanded, than of a borough council that was to continue. The council, in practice, became the administrative lead for the first borough HimP. Given that staff felt the NHS did not have the strongest of roles in health inequality reduction, because of the importance of the wider determinants of health, this was quite acceptable to all local partners.

Compared to local *distortion* of national policy, *delays* in implementation are not traditionally seen as so important in studies of the local responses to national policy. In this case study, delays are of greater significance. This is because the government staked political credibility on being seen to bring in NHS improvements before the 2001 election. As has been seen, the lack of support given by the DoH in providing a framework for local work to address health inequalities led to delayed implementation. Again, the HOTTN assessment (LSHTM, 1998) found that a lack of guidance had also been an earlier problem for local managers. The local aspects of recommendations in the Acheson report were not developed into clear recommendations for local area work and no outline of work that was thought to be most useful for local areas to pursue was provided. It was not until 2003 that the Department of Health released a concise précis of the key interventions required of the local NHS (DoH, 2003,b). Primary care commissioners and indeed public health consultants may have felt inundated with requirements to report on targets provided by the DoH on other areas of work. But small numbers of public health and health promotion staff were left without any framework for local work to address health inequalities. The mantra of the 'need for local autonomy' therefore worked against swift progress (Audit Office, 2002).

The way that public health issues were managed during the disbanding of health authorities and the move to PCTs caused unnecessary delays in public health work. Nevertheless, the move of public health departments to borough level and the resulting boundaries - coterminous with local authorities in London at least - may, in the long run, result in a more efficient integration of public health into local authority and primary care work.

The need for central support in public health work is demonstrated by various examples of broad successes and failures in the field. Firstly, local areas were initially required to produce their own targets for health inequalities reduction. Whilst local target production had been a recommendation of the HOTTN assessment, it was anticipated that this would take place within a framework of national targets, national support and institutional stability. Local health inequalities target setting was untenable between 1997 and 2002, given local staff resources, the vague and vast possibilities for local work, lack of national support and institutional changes. Secondly, Health Action Zone work was required to be locally planned and driven. Here, evaluations were found showing poor overall performance and value for money. Thirdly, however, within the area of the National Service Frameworks and the Sure Start initiative there is more evidence of local support and success. These two initiatives were provided with more appropriate support from the centre and recognised the limits of local capacity, but at the same time did not set up entirely new organisations side-stepping local structures, as did the HAZ.

#### **The partisan state and income inequalities**

The increased role of NHS staff in public and user involvement work around health improvement, coupled with their beliefs about the impact of income inequalities on health inequalities, led to an investigation of how NHS and other staff understand the role of public involvement in influencing income inequalities. State bureaucracies have been charged with strengthening community involvement in issues that affect health. But at the same time they are unable to be politically partisan and find it easier to encourage non-party methods of public involvement. The reluctance to endorse a party-political framework for local public involvement in national political issues was evident from individual opinions scattered between the Labour Party locally, civil servants and community workers.<sup>171</sup> Although it was not the majority opinion, it was the one that held sway. The low profile of party politics and representative democracy meant that staff did not necessarily consider that local people would gain influence over income inequalities via party involvement. At the same time a vicious circle was

<sup>171</sup> Reporting here is not intended to support or decry this perspective.

set up, in that local professionals did not signpost the public towards locally elected representatives to take up their grievances on a range of issues.<sup>172</sup>

The issues of bureaucratic neutrality were considered in chapter 1. The possibility that the state might play a partisan role, siding with the interests of particular groups in the population, needs to be considered when looking at state implementation of health inequalities policy. However, it is also the case that the state bureaucracy's inability to play a partisan role may adversely affect outcomes in situations where partisan politics might help those whom policy is attempting to assist.

The key concept of 'power' and the possibility that elites might be able to construct agendas in the way portrayed by Lukes (1974) has been taken into account in analysis of the data. The distancing of public involvement work from local party political systems of public involvement has found some sympathisers among community development workers. However, the findings suggest that the Labour Party elite was prepared to 'go along with' and indeed, encourage this development. This was demonstrated in interviews with local councillors. The deletion of reference to the labour movement in the move from Green to White public health paper, mentioned previously, also provides further evidence of this phenomenon.

At the national level media interviews with senior Labour Party officials corroborate the view that Labour the elite has deprioritised party involvement.<sup>173</sup> At the local level there was a lack of funding, support and awareness of the labour movement's potential role in health inequalities reduction, when compared to the role of other groups, such as 'faith groups'. Historically this was not the case, for example, with the funding of trades councils by local authorities having been widely accepted practice in

<sup>172</sup> MORI found that one fifth of voters would approach a councillor if they needed help on an issue, such as, dealing with a noisy neighbour. However, the figure was lower in London (13%) (MORI Social Research Institute, 2002). The issue is, how should this data be interpreted and what policy recommendations might be drawn from it? The current consensus developed between Labour officials and voluntary and statutory workers appears to be geared towards finding new local institutions for residents to access, rather than reinvigorating representative democracy.

<sup>173</sup> For example, in a radio interview it was put to the chair of the Labour Party that New Labour did not want and could manage without an active Labour Party membership. To which he replied that Labour, as in the Labour Government, was investing heavily in inner-city communities. This again demonstrates the substitution of partisan political formations for state-led 'non-political' community involvement. (Ian McCartney interviewed by John Humphrys, The Today Programme, BBC radio 4, May 2<sup>nd</sup>, 2003).



the 1970s. The reason why the party elite was prepared to endorse less membership participation was because they wanted to maintain control of upstream policy issues, particularly around redistribution (Rose, 1984; Mulé, 2001). The Labour mayor of Lewisham agreed with this reasoning in interview. Electoral success was not seen to be dependant on an active grass-roots membership (Epstein, 1980). Although the mayor was concerned that low turnouts might allow BNP (British National Party) successes.

The view of some, but not all, Labour Party councillors was that people should join the Labour Party if they wanted to play a role in influencing income inequalities. However, this view was coupled with a weak if not hostile message in relation to recruitment. No efforts had been made to recruit active members, and recognition that the activist base had melted away over the 6-year period in which the research took place was coupled with the suggestion that this was not necessarily a loss. It was clear that Labour Party councillors were uncertain as to what their role in relation to membership recruitment should be. It was also found that there was a potential for state-funded public involvement tools to compete with party and partisan self-organised groups. This was especially since, for example, some, but not all, community development workers were hostile to any form of party politics.

Since power can be accrued via the use of resources, it follows that groups with greater access to resources will gain less benefit from democratic rules that drive down the costs of participation. To take a crude example, those without financial resources would have more control over transport policy in a situation where car use was determined by general voting, rather than by ability to purchase a car. Thus, different democratic rules imply different outcomes for different groups. This makes these rules an important component in consideration of health inequalities policy. Some community development workers appeared to believe that easily accessed community development groups and consultation are more democratic because they don't require party political membership commitments. However, this ignores the fact that the political parties can wield power in the form of controlling local and national government. Other community workers however, believed, along with one Lewisham MP, that real influence lay in party organisation. As a result of the drift away from

participation in an organised labour movement, lower income groups appear to have less power to influence the 'wider determinants of health' than they did in the 1970s.

The involvement of local councillors in influencing provision of health improvement work was minimal within the research period. However, the development of local government 'scrutiny committees' might increase their input in the future. The scrutiny process involves reviews of issues such as "public health, health promotion and health improvement (including tackling health inequalities)" (Hamer, 2003:4). It is not concerned with managing "the performance of the NHS but [will] concentrate on ensuring the health needs of local communities are being met." (Hamer, 2003:4). The distinction between these two areas has the potential to cause confusion. Within the process it is suggested that: "local councillors can speak on behalf of local people, raise local concerns, challenge the rationale for decisions, and propose alternative solutions." (Hamer, 2003: 4). This thesis has identified deep-seated problems with the role of local councillors, in that their base in active party structures has been eroded.<sup>174</sup> They are not held to account by the population, except through the three-yearly voting process, which contains no active dialogue and involvement. It therefore remains to be seen whether the new roles given to them in scrutiny will have a substantive impact on the difficulties local people have in playing a part in influencing the upstream, wider determinants of health.

Respondents appeared surprisingly confident about being unrestrained by the need for political neutrality. Staff generally did not appear to feel that there was anything that they couldn't do because of the limits of their unelected office. However, when the question of the NHS supporting trade union organisation was raised, some respondents did say that this might be difficult. There seemed to be confusion about the rules surrounding this kind of work. Similarly, NHS staff expressed uncertainty as to when and how to involve elected members. Some voluntary sector staff saw these councillors as a useless and malign group. One or two interviewees also mentioned that careers could be affected by the voicing of opinion counter to the mainstream orthodoxy. Thus, the NHS had a problematic relationship with organisations that support lower income groups, particularly those that might affect income inequalities,

<sup>174</sup> Scrutiny could also weaken partisan politics. Leach and Copus (2004) look at the relationship between party group behaviour and scrutiny committees.

such as trade unions. For some managers, internal dealings with trade unions representing staff interests also made them weary and sense that if they encouraged growth in union membership they might be supporting their adversaries.

A cumulative process of filtering out organised labour movement input took place. Central government did not endorse TU input and unions did not grasp opportunities to further their interests in this context. For example, the union Unison had developed a policy supporting trade union representation on local strategic partnerships (LSPs). However, staff at the local level did not know of this, and therefore even if they had been able to influence LSP membership they were not encouraged to. It is remarkable that a Labour government should have constructed policy in which trade unions were not represented on Local Strategic Partnerships despite employer membership, especially given the fact that the partnership's role was to support regeneration and play a part in the reduction of health inequalities. No local criticism of this situation was encountered outside of the interview settings. Generally, trade unions, particularly the public service union Unison, did not capitalise on the role they could have played in influencing policy implementation and the formation of structures for public involvement. From the senior union official's perspective, this was partly because they were locked into disputes with NHS management in its widest sense, for instance over the issue of PFI (the Private Finance Initiative).

To recap: one factor in the future success of the policy to reduce health inequalities, set out in *Saving Lives* and backed up by the Acheson report, is said to be the involvement of local people in the 'wider determinants of health' or upstream measures (Whitehead, 1992a: 438). Here are found unresolved problems. Increased NHS and local authority spending on public and service user involvement is coupled with declining active participation in the local Labour Party and trade union movement. In the case of the Labour Party, falling membership levels are also apparent. Between 1997 and 2002 there seems to have been no enthusiasm for addressing this situation among the local and national party elite. Certainly no work to encourage local recruitment was found. NHS staff and local authority officers are not in a position to address this issue, since it would mean entering into a politically partisan role. Local employees of state institutions find it much easier to support the development of local public involvement in regeneration projects, community groups, or even in religious organisations, basing their work on social capital theory.

Staff often did not know how local people should get involved in national issues, so even if unrestrained by instincts to preserve the neutrality of the bureaucracy, they are not in a position to influence this kind of involvement. Like Acheson, they ignored the issue. The thesis suggests that this combination of state support for non-partisan involvement and its unwillingness to support partisan involvement, backed up by, at best, a lack of interest from the Labour Party itself in membership participation, all feeds party-partisan dealignment. Social capital theory sits well with systems that might encourage this partisan dealignment. Indeed new studies on social capital and health ignore partisan political organisation (Swann and Morgan 2002; Coulthard, Walker and Morgan, 2001).

The Local Strategic Partnership (LSP), according to some interpretations, is a further development moving power away from elected councillors<sup>175</sup> and the labour movement. In Lewisham's case the majority of councillors are Labour. Their diminished power means that, even if ordinary members had more intra-party power, it would not be of such significance in the new framework. Such bypassing of political institutions can have a partisan impact. The thesis argued in chapter 1 that the function of the Labour Party for lower income groups is different from that of the Conservative Party for better off sections of society. And, as has been suggested earlier, with less money and bargaining power to buy political influence, lower income groups can benefit more from mass organisation representing their interests (chapter 6).<sup>176</sup> The system being developed and assisted by the Labour government and state may not be best suited to increasing the power and influence of lower income groups. For example, the inclusion of business representation on Local Strategic Partnerships and the exclusion of trade union interests is an extraordinary display of bias.

This research is now in a better position to respond to a question posed by Exworthy: "Can the intent and spirit of the Acheson report be maintained across the whole of

<sup>175</sup> One interviewee stated that this was the opinion of the Local Government Association.

<sup>176</sup> The reasoning here draws on a variant of 'rational choice theory', this has been enhanced to take account of interests in collective action (Ward, 1997).

government in the long term?"<sup>177</sup> The thesis has taken the view that party politics and especially the ability of lower income groups to influence the Labour Party's policy on redistribution, will be a factor in the long term drive to reduce income inequalities. It has worked with the assumption, although this is a disputed point, that health inequalities are affected by income inequalities. The response to Exworthy's question, based on this reasoning, would be that at least three conditions are needed. Firstly, use of focus groups for political purposes develops to the benefit of lower income groups. A clarification of this point is needed. Given a strong Labour Party elite and a low and inactive membership, it still might be possible for lower income interests to be represented in the party via the findings of focus groups. However, this would require at the very least that group participants be asked unbiased and published questions and for the answers to be open to scrutiny. Secondly, membership levels could be driven up by various inducements and campaigns. This, according to Scarrow (2000), would require the strengthening of intra-party democracy. Thirdly, council seats could be reserved for non-party representatives so that those disillusioned with parties could still have access to a central site of power. The research points towards option two being the best to concentrate on, with elements of access to focus group research and the use of other opinion testing methods. Non-party representation should be increased only within this context. Option 2 with elements of 1 and 3 would allow more grassroots control and democratic accountability over issues affecting health and income inequality.

Referencing back to the core literature sources used in building the thesis's arguments has been carried out and additions made, based on the research data, to that theory. The thesis makes an original contribution to research on the implementation of policy to reduce health inequalities because much of the literature has hitherto focused on the uptake of project work led by the NHS and the immediate effectiveness of measures to improve health or to engage with the public at a local level. The research has tried to step behind these developments to look at the local structuring of wider political involvement, which is likely to have long-term effects on the upstream wider determinants of health. The study has established that it is legitimate to examine party political and trade union involvement in the context of NHS policy to involve the

<sup>177</sup> Health Equity Network (HEN) conference, 2002 ([www.jkhen.org](http://www.jkhen.org)).

public. The subject of ‘inbuilt biases against party political involvement’ has been neglected in discussions of public involvement relating to health improvement and yet, as has been demonstrated by previous research, Labour voters tend to have poorer health (Davey Smith and Dorling, 1996). The perspective adopted also highlights the need to take into account internal party incentives because these can shape policy instructions given to state bodies. The work has also considered the problem of public involvement in issues which are outside the control of single local authority areas, but which nevertheless are thought to have a real impact on health outcomes. In taking into account a wider political science framework the thesis has added to the mix of theoretical approaches that may be used to look at the subject. This study’s contribution has been different from others because a link has been established between Labour Party and trade union involvement and the work of the NHS in this policy area.

Briefly, a review of ‘policy learning’ by government since 1997 is now conducted and then recommendations arising from the findings are discussed.

## **Learning through implementation**

The production of *Tackling Health Inequalities: a programme for action* (THI) (DoH, 2003) shows adaptability in the government’s approach to the policy and its implementation. At the outset there was no indication that further support, in any form, would be provided to local implementers. Indeed, at mid-point in the years of this research a number of staff felt the policy was being allowed to ‘fizzle out’ in the drive for reduced waiting times.

The later introduction of national targets for health inequality reduction, when none had formerly been planned, marked a change of policy that was quite momentous. Ministers specifically argued against national targets and then climbed down. The change of direction demonstrated a genuine ability to digest, interpret and react to mounting evidence and academic lobbying. The result was widely welcomed in public health circles.

A desire to learn from the past is evident in the use made of *The Health of the Nation: a policy assessed* (LSHTM, 1997). As the tables show, recommendations were not always taken up (Appendix 7.1). However, the key question of performance management was addressed and its impact on implementation of aspects health inequalities work was noticeable at the end of the research period. That is, central requirements to, for example, improve the uptake of breastfeeding were taken seriously at the local level, and staff time was allocated to them, in a way that had not happened previously.

An apparent temptation to propagandise and introduce irrelevant issues into policy programmes because they chime with other areas of current health planning did not diminish over the years of the research. This is a ‘downside’ of the generally successful drive for ‘joined-upness’. References to other issues the government wished to address become mixed up with clear ‘independent’ policy in one area. This is detectable in *Tackling Health Inequalities* (DoH, 2003), where it is apparent that the issues of ‘foundation hospitals’ and ‘choice’ are driving some of the text. This leads, for example, to the following comment, presumably relating to acute services: “Apparently uniform national services, what’s been called a “one-size-fits-all” approach to health, education and local government, have failed to combat health inequalities.” (DoH, 2003:1). However, within the academic literature on health inequalities, provision of services such as childcare is prioritised over issues of choice between similar levels of provision and services.

Thus, it is possible to demonstrate areas of learning that led to significant progress and development in the successful implementation of the policy. At the same time, inconsistencies between public health policy and wider government policy, noted by staff in relation to the Conservative’s Health of the Nation programme, never entirely disappeared from Labour’s strategy.

## **Policy recommendations**

Here are listed various recommendations that emerge from the findings of this investigation. Given the production of *Tackling Health Inequalities* (DoH, 2003) and the earlier introduction of national targets for reducing health inequalities, some of the

recommendations that would have been made have been addressed. This demonstrates the evolving nature of the policy. Thus, the following point has in many ways been dealt with by the publication of THI (DoH, 2003):

Core NHS work on reducing health inequalities may be more successful if national support is felt at the local level. Local public health departments do not simply require greater local freedom and autonomy. While they will obviously not want to be restricted in unhelpful ways, nevertheless, a great deal of local time can be saved by appropriate national input. The format and status of the Acheson report meant that it remained an extremely influential document at the local level in the years of this investigation. However, local areas needed the report amended and tailored to meet their specific needs – a ‘customized’ Acheson. This has now been provided by THI (DoH, 2003).

Whilst the remaining recommendations are numbered they are not in order of importance and may, to an extent, overlap. Suggestions are considered stemming from the question ‘what could be different?’.

1. The HAZ provided welcome additional resources for public health and health promotion. However, the attendant additional organisational structures were a distraction. The fact that more money for health improvement was not allocated to *existing* local government, NHS and voluntary sector departments and organisations suggests that there was an underestimation of the effect of *pre-1997* budget restrictions on the efficiency of these departments. In national policy development existing structures should not be blamed for shortcomings, without a proper assessment of the effect of previous budget reductions.

2. There is an impasse for the NHS and local government because, with considerable justification, they do not feel able to support partisan political formations. Public health practitioners should appreciate that statutory NHS and government systems are biased against granting trade unions and Labour Party members a role in influencing national income distribution policy. Also, Labour Party elites may have an interest in dampening public participation in the party.



Local authorities should review their support for trade union organisation and should develop methods for informing the public about party political structures. Business representation on Local Strategic Partnerships should be balanced with a trade union perspective, particularly from those unions representing the less well off, such as shop workers. Local statutory and voluntary sector staff need to be kept up-to-date and informed about developments in party activity. The role of local councillors needs to be clarified for staff, particularly for NHS staff who are not used to working with them.

Public health departments should make closer, routine and systematic links with locally elected members in order to hear the issues that residents have raised with them, to voice the concerns of NHS service users and to share evidence on the importance of issues relating to the wider determinants of health.

3. The possibility of set-aside places for elected non-party councillors drawn from various community interests should be investigated further. This is because the system currently allows parties ultimate control of all council votes, but at the same time, parties have lessening membership involvement. (As reported, there was some local hostility to elected party councillors, particularly from community development staff.) Referral of Primary Care Trust decisions to borough councils for comment and ratification should be considered.

4. Historically, those classes most likely to gain from redistribution have played a role, even if in conjunction at times with the middle classes, in organising for improvements. In order for the recommendations of the Acheson report to be implemented, more consideration needs to be given to assisting those agents, such as party members and trade unions, who might be able to support this. NHS and state employees are not in a good position to comment on changes in the internal structure of the Labour Party. At a local level since 1997 public involvement in the party has very significantly diminished. At the same time state investment in public involvement has increased. The cost-effectiveness of state-led public involvement initiatives should be researched further. Following Rose (1992), it should not be assumed that low participation is normal. In different situations

there might be far more participation by lower income groups in labour movement structures and a far greater knowledge of how to influence national policy.

5. It appears that elite power is being consolidated by developments at the local level. The power of local residents to influence national policy has diminished. The Labour Party should recognise the part it might play in combating party-partisan dealignment by investing in higher profile member recruitment campaigns. These should be linked to more accountable methods of party member involvement. The party should aim recruitment campaigns at minority ethnic groups, younger people (15-30) and lower income groups. Focus group testing should not be taken as a substitute for efforts to recruit members; rather, accounts of focus group questions, methods and results should be available for the membership to use to form political judgements. While partisan dealignment may be taking place all over Europe, the process is not being challenged by the British Labour Party.

6. If Trade Unions wish to support a reduction in health inequalities, for the purposes of clarity, they need to publicise policy on income inequality aimed at public health staff, local authority officers and lower income groups, for them to take-up at work. Health unions should review their role in co-ordinating the local staff constituency that supports redistributive policy. The Labour elite should use its media access to promote the benefits of TU membership.<sup>178</sup>

To answer 'what could be different?'- Labour could aim to increase citizens' understanding of, and their belief in, the social disadvantages of increasing income inequalities. This would entail recognition of the problem in a way that does not take place in THI (DoH, 2003), coupled with permission for democratic debate over fiscal policy change. However, local staff employed to support public involvement to reduce health inequalities should be alert to the possibility that New Labour's interpretation of the political and economic demands of capitalism requires it to

<sup>178</sup> More recommendations might be added. Whilst not addressed in this thesis, environmental issues were also neglected in *Saving Lives* and subsequent NHS work has largely ignored the links between public health and environmental standards and sustainability. The wisdom of this sidelining will no doubt be questioned in the future. Similarly, the role of market pressures in influencing health inequalities is a subject worthy of research, but it has not been feasible to cover it here.

restrain certain forms of public involvement.<sup>179</sup> These forms, e.g. trade unions, are those that are most effective in challenging income inequalities.

## Conclusion

In 1997 “palpable excitement” was reported among public health professionals. This was generated by the prospect of ditching Conservative health policies and the ushering in of Labour programmes, seen to be more supportive of public health measures (Butler, 1997). Between 1997 and 2003 the response, in Lewisham, to British Labour government policy to reduce health inequalities, came in the form of both opinion and action. Opinions were fairly consistent across a range of staff charged with implementing the policy in the NHS, local government and the voluntary sector. They held that income inequality affected health inequalities. Support also existed for trade unions, which were accepted as contributing to income inequalities reduction. However, these opinions did not appear to result in specific actions and only affected implementation in as much as they contributed to the slowing down of work.

An answer to the research question has been provided, in that it may be concluded that broad political considerations, issues and tensions in the party and government do indeed appear to have affected the pattern of local implementation of policy to reduce health inequalities. This is especially evident if a longer-term perspective is taken and the involvement of local people in issues affecting their health is understood to be a key component of the public health programme.

The thesis stakes a claim to have developed the literature in this area by showing the relevance of an analysis that takes into account pressures within the labour movement and government, coupled with the higher import the policy to reduce health inequalities has for Labour-voting, lower income groups. The ‘neutral state’, in the form of the NHS, is designed to avoid conflicts over redistribution and is ill equipped to enable effective public involvement in this area.

<sup>179</sup> It is not clear if New Labour concurs with the IMF’s prescription for Sweden – that it increase its income inequalities (Artus, 2000).

A number of recommendations have been listed. These are directed at the Labour Party, the trade unions and the NHS. The labour movement itself should address democratic involvement and participation issues if it is to increase the voice of lower income people and their power to influence issues affecting health. It is not possible for the neutral state on its own to effectively facilitate involvement on important upstream issues that are identified in the academic and policy literature as essential for health improvement. Whilst the NHS and local state may successfully move away from purely consultative forms of involvement and undertake valuable work, democracy is diminished if questions of income inequality are not also open to public control via democratically accountable, rather than purely consultative, labour movement arrangements. It may be that over the next few years the Labour Party attempts to revise its internal democratic processes to try to win back lost members, but the direction these developments will take is unclear given the Labour elites' consolidation of political power over the last seven years. This is certainly not to say that the labour movement should be viewed as the only route to participation and control, there is a role for the development of non-party involvement within this model. It is recommended that planned reforms of the Labour Party explicitly plot the way in which members might affect redistribution. Labour councillors and trade union leaders have a role to play in politicising the experiences of lower income people and in raising a collective awareness of shared problems. Change is less likely if issues remain at the level of individual experience and are not turned into issues of political choice. Grassroots pressure needs to be directed in such a way as to ensure that politicians have to 'do something' about issues. Political pressure can ensure that issues of crime, drugs, inadequate services and increasing income inequality are addressed. Access to political power cannot be ignored in any consideration of health improvement among different sections of society.

Trade unions should also promote their role in supporting the involvement of people on lower incomes whose health tends to be worse and in advocating explicitly redistributive economic policies. Aside from the development of 'scrutiny committees' it is recommended that the NHS pay more attention to developing links with elected councillors. Formalised systematic dialogue should be piloted and evaluated.

Action on health inequalities was also slowed down by an apparent confusion at central government level about the proper balance between central and local functions. Small public health departments were given technically and managerially difficult tasks, such as developing local targets for health inequality reduction. At the same time, and in the context of NHS institutional upheavals, health improvement programme planning did not make use of local government capacity to lead the process at the borough level. Maintaining NHS control over the process at this juncture wasted time.

Local state-led public involvement programmes increased, while at the same time active membership of labour movement organisations, that might affect both local and national policy, declined. Thus, local community influence over national income inequalities became even remoter, and the power of government elites to control this upstream policy was strengthened.<sup>180</sup>

Thus, it was found that the wider concerns of the Labour Party elite, namely income inequalities and central versus local control, affected the public health policy's implementation at the local level. A number of recommendations flowed from these findings. However, these are not all actions that can be addressed by government. Instead the conclusion is that the labour movement itself, in the form of both the trade unions and the Labour Party, could do more to support collective activity affecting health inequalities.

<sup>180</sup> Similar processes are reported internationally (World Bank, 2002).

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## Appendix 1.1

**Going through Wolman's (1981) stages in order, a critique is provided of issues relevant to this study.**

Within his early 'conceptualization and theory evaluation' and 'selection' stages the role of those who will also play some part in later stages is absent. This is a criticism made by Hill and Hupe (2003: 475), although not specifically towards Wolman's article. Regarding the health inequalities policy looked at in this research, early involvement from the policy community (Marsh and Rhodes, 1992) was evident and may have helped to support later developments. For example, academics and senior Department of Health officials subsequently came to speak to local players at a borough based health inequalities conference reported on in this research. In doing this they continued to 'sell' the policy, albeit to a receptive audience.

Wolman believes that unspecified objectives can be the result of programmes requiring 'support from diverse elements'. This does not apply to the policy considered here since in its initial stages, post-1997, it did not appear to significantly interest either diverse bodies or generate any hostile opposition. Rather, it is suggested here, tensions within one element, namely the party of government, affected implementation.

This thesis also highlights a gap in time between 'conceptualization' and the clarification of technical elements within 'programme design'. 'Authority leakage' occurred not because 'subordinates' did not wish to do what their superiors wanted, but because they did not know or understand what was required. Wolman's example of vague instructions is extremely pertinent to the present study, and is replicated in *Saving Lives* (DoH, 1999). He cites an American regeneration programme, which he says called for: "widespread citizen participation".

Wolman's concern that instructions may be "so complex and prolific that they conflict with each other or simply are so unwieldy that they are unusable in day-to-day decisions." is applicable to the findings of chapter 4 of this thesis (Wolman, 1981: 452). Also relevant is the observation that 'subordinates' actions will be detrimental to the programme if they "believe their superiors are not pursuing these objectives vigorously enough or in the most effective manner or if they believe their superiors are not themselves committed to the program's stated objectives." (Wolman, 1981: 453). The need to balance programme control with a nurturing of employee morale and creativity is also a stress evident in the NHS 'targets culture' (Wolman, 1981: 454). It is, nevertheless, important not to jump to too rapid a conclusion about the factors affecting employee morale. Careful observation and analysis is required to assess key pressure points.

We should also be alert to the dangers of too ready an acceptance of Wolman's suggestions without due consideration as to whether the correct circumstances apply. This is evident in his hypotheses that:

“Programs placed in new agencies are more likely to succeed (hypothesis 13); programs placed in existing agencies are more likely to fail if they represent major deviations from programs previously administered or if they require the agency to change its perception of its mission or its traditional clientele groups (hypothesis 14).”

The Lambeth Southwark and Lewisham Health Action Zone was introduced as a discrete agency, in a context of great organisational turbulence, where existing and relevant structures already existed with similar values. The findings of this research suggest that this was an unnecessary move.

Wolman's points on 'program funding' are apposite to debates witnessed locally on whether to target funds to the most deprived of the borough's wards or to target in other ways, for example by client group. However, this thesis suggests that there is more to be said on the impact of funding. For example, it is of relevance to know the extent to which funds are non-recurring, are ring fenced, or are allocated within a context of - previous under funding, current budget cuts in other related services, or skills shortages in the labour market.

Wolman's view that “Inadequate feedback is probably one of the more common reasons for program failure.” is also relevant to this thesis. The findings suggest that feedback did occur at particular junctures and that this helped to keep the programme on track. However, it is also true that other feedback initiatives appear to have been started too early in the process, before 'lack of knowledge' and 'technical feasibility' problems were resolved, with some serious implications for the programme.

## Appendix 1.2

### Held's Models of Democracy

In summary, Held's models of democracy are: 1. the classical democracy of Athens 2. protective democracy (citizens requiring protection from each other and from governors) 3. developmental democracy, type a (citizens have equal political and economic freedoms); developmental (or representative) democracy, type b. 4. direct democracy 5. competitive elitism (a skilled elite is selected) 6. pluralism (governments mediate between demands of diverse interest groups. Neo-pluralism is more circumspect.) 7. legal democracy 8. participatory democracy 9. democratic autonomy (mixes direct participation and election of representatives. Equal rights and bill of rights. Overall investment priorities set by government, but extensive market regulation of goods and labour.) (Held, 1987).

The four forms of particular importance for the thesis (see chapter 6) are: (i) representative (Held's type 3b); (ii) direct (Held's type 4); (iii) legal (Held's type 7); and (iv) participatory (Held's type 8). In (i) representative democracy, "Participation in political life is necessary not only for the protection of individual interests, but also for the creation of an informed, committed and developing citizenry." (Held, 1987: 102). The key features of the model include - popular sovereignty with a universal franchise, representative government (elected leadership, regular elections, secret ballot etc.), clear demarcation of parliamentary assembly from public bureaucracy, citizen involvement in the different branches of government through the vote, and extensive participation in local government, public debates and jury service. Moving to (ii) direct democracy, this includes the principle that "...only equality can secure the conditions for the realization of the potentiality of all human beings.." (Held, 1987: 136). In this model public affairs are to be regulated by ...councils organized in a pyramid structure, public officers are to be paid no more than workman's wages, and, in the communist variant of the model, consensus is the 'decision principle on all public questions'. For (iii) legal democracy: "The majority principle is an effective and desirable way of protecting individuals from arbitrary government .... Majority rule....must be circumscribed by the rule of law." (Held, 1987: 251). The core features and general conditions of the model include - rule of law, minimal state intervention in civil society and private life, effective political leadership guided by liberal principles and minimization of the threat of collectivism. In (iv) the participatory model the following principles apply: "a society which fosters a sense of political efficacy, nurtures a concern for collective problems and contributes to the formation of a knowledgeable citizenry capable of taking a sustained interest in the governing process." The key features Held lists for this model are: "Direct participation of citizens in the regulation of the key institutions of society, including the workplace and local community, reorganisation of the party system by making party officials directly accountable to [the] membership, operation of 'participatory parties' in a parliamentary or congressional structure, and maintenance of an open institutional system to ensure the possibility of experimentation with political forms" (Held, 1987: 262).

### **The Black Report's Explanations for Health Inequalities**

#### **Artefact**

"This approach suggests that both health and class are artificial variables thrown up by attempts to measure social phenomena and that the relationship between them may itself be an artefact of little causal significance" (Townsend et al, 1992: 105).

#### **Selection**

"Occupational class is here relegated to the status of a dependent variable and health acquires the greater degree of causal significance. The occupational class structure is seen as a filter or sorter of human beings and one of the major bases of selection is health, that is, physical strength, vigour or ability." (Townsend et al, 1992: 105).

#### **Cultural or behavioural**

"These are recognisable by the independent and autonomous causal role which they assign to ideas and behaviour in the outset of disease and event of death. Such explanations, when applied to modern industrial societies, often focus on the individual as a unit of analysis emphasizing unthinking, reckless or irresponsible behaviour or incautious life style as the moving determinant of poor health status. Explanation takes an individual form....Others see behaviour which is conducive to good or bad health as embedded more within social structures; as illustrative of socially distinguishable styles of life, associated with, and reinforced by, class." (Townsend et al, 1992: 110).

#### **Materialist**

"Occupational class is multifaceted in "advanced" societies, and apart from the variables most readily associated with socio-economic position – income, savings, property and housing – there are many other dimensions which can be expected to exert an active causal influence on health. People at work for instance, encounter different material conditions and amenities, levels of danger and risk, degree of security and stability, association with other workers, levels of job satisfaction and physical and mental strain. These other dimensions of material inequality are also closely associated with another determinant of health, -education." (Townsend et al, 1992: 109).

### Confidential, anonymous interviews

All of the local interviewees were presented with letters, to keep, confirming the confidential nature of the interview. Two exceptions to this were that the mayor of Lewisham's letter stated that he would be identified in the thesis. The letter to Sir Donald Acheson about the PhD research did not say that the interview was to be confidential. These exceptions were made because, firstly, it was thought it might be of value to identify their individual opinions and, secondly, it was not judged that they would be likely to say more important things if the interviews were confidential. It was considered that interviewees' greatest fear might be gossiping with other staff members over what the interviewees had said. Therefore, aside from the letter, a verbal reassurance was given that no disclosure of this nature would take place. The researcher did not reveal who the interviewees were to anyone, although interviewees themselves may have told others they were interviewed.

An example of the letter text is provided in the box below:

Dear \*\*\*\*\*

**Confirmation of anonymised data**

Thank you for agreeing to take part in an interview for my research on health inequalities policy.

I confirm that I will ensure that you will not be identified by name or be identifiable in the text of the PhD, in any published articles resulting from the research, or in any discussions.

Yours sincerely

Jane Thomas

All the interviewees have been anonymised in the thesis text (aside from the one discussed below, plus the mayor and Sir Donald Acheson). Because a broad indication of job role is relevant to an interpretation of the data, where necessary, in order to both indicate job role and maintain confidentiality, job titles have been substituted for broadly similar titles. The details of this substitution are provided in table 3.1. Mustapha Bello, referred to on page 5, is a pseudonym.

Three of the interviewees said that they did not feel the need for what they said to be treated confidentially. These interviewees were 2 community workers and 1 councillor. In writing the findings chapters it was decided that there was no advantage to be gained from identifying the community workers and that, in fact, this might be a distraction from a reading of the text. However, the councillor, Ian Page, said that he felt that what he said *ought* to be public information as he was democratically elected and Lewisham residents should have access to his opinions. He was one of two Socialist Party councillors elected in Lewisham at the time, and the other councillor was a woman, therefore to describe him in the text of the thesis as the Socialist Party councillor was to, in effect, identify him. (The sex of some other interviewees was changed in the text of the thesis as an extra insurance against recognition).



## Appendix 3.2

### Interview schedule

Adapted for councillors, trade unionists and some voluntary sector staff.

1. Firstly, would you briefly outline the main responsibilities of your job?

Do your responsibilities cover work on health inequalities? (or did your responsibilities cover this when the latest public health policy was first introduced?)

Is it possible to say roughly what proportion of your time you would spend working on issues directly related to reducing health inequalities in an average month?

Would you say, in general, that you now spend significantly more time addressing this issue (than before 1998 when the new public health policy came out) or is it about the same?

2. In implementing the government's strategy to reduce health inequalities locally, what do you think the most important local actions have been so far?

And what have the difficulties been?

3. Could you describe how targets and priorities were set for the Health Improvement Plan/HimP at the health authority level, and at the borough/PCG level?

In your view were targets not included that should have been? What were these?

One PCG set a target around low birth weight babies – do you have any views on that?

How likely is it that the targets will be achieved?

Who is really signed-up to the targets in a personal and professional way?

What are the barriers to achieving the goals?

What would be needed to raise the profile of health inequality in the local policy and professional community?

4. Do you think that local areas should set their own targets to reduce health inequalities (in terms of topics and expected improvement) or do you think that more direction should be given by the centre?

Prompt – how much.

(The review of the Health of the Nation strategy suggested that more freedom should be given to local areas to set targets, but that does not seem to have worked and now the government is looking at a more central target, do you have any views on this?)

5. The public involvement agenda is now seen as important; do you think there is anything more that could be done locally about how local people might influence national policy? (prompt for problems on this)

Do you think the Lewisham Citizen's Panel could be asked to say what they think about income differentials in this country?

Is it important for the NHS to be seen to be politically neutral?

6. Some academics think that there is really very little that can be done locally to improve health inequalities because national social policy affecting income differentials is the sole cause of health inequalities; while others would say there is a lot that we can do that will have an effect outside of this national economic framework – where would you think you stand?

(How would you rank the impact that local health policy work has had on the strategy compared to national social policy, for example benefit changes. Say on a scale of 1-100, where would you rank the impact of national social policy, and local health policy?)

7. How much effective local work to reduce health inequalities would you say lies within the scope of the NHS?

8. The Lewisham inequalities sub-group of Healthier Lewisham is going to be drawing up a programme of work and terms of reference for the group. What do you think that the group should include in its remit? (could this include using the media and statutory publications to inform Lewisham residents about the developments in income inequalities and the links between health and wealth inequalities?)

9. Stepping back from your work role – can you say what you really think about income inequalities? (prompt – can they be reduced, how would they be reduced, do you think this would be desirable, why are they lower in say Sweden ...)

10. Some people have said that as part of the process of the NHS addressing health inequalities changes in pay differentials within the NHS are needed, whereas others believe that the current differentials are needed in order to recruit staff. Would you have a view on that?

11. If I was a member of the public and I wanted to join an organisation that was doing something about income inequalities, where would you recommend I go?

How about the local Labour party in Lewisham?

12. Because trade unions have been shown to reduce pay differentials and reduce accident rates, some people think that the local NHS could/should work in partnership with the TUC or the GLA to increase trade union membership. What would you think of that?

## Appendix 4.1

### A chronology of institutional changes and related policy documents

Date	National Policy – publications and Activity	Local Plans, Policy and Activity
Pre-1997	The Conservative government's <i>Health of the Nation</i> policy (DoH)	The Healthier Lewisham partnership Health authority public health dept. and community trust health promotion dept. covering 3 boroughs
1997	Election of Labour government. <i>The NHS: modern dependable</i> (DoH)	
1998	The Green Paper – <i>Our Healthier Nation</i> (DoH)	Community Health South London NHS Trust established (amalgamation of community trusts covering Lambeth and Southwark/Lewisham)  Local responses made to Green Paper  Service and Financial Framework planning starts, LSLHA HimP planning also starts
1999	The Acheson Report and the White Paper- <i>Saving Lives</i> (DoH). <i>National Service Framework for Mental Health</i> (DoH)	Health authority and PCG strategic planning session at Millwall stadium. Divisions on HimP process  DoH acceptance of Lambeth, Southwark and Lewisham's HAZ proposal  First Lewisham health inequalities sub-group of Healthier Lewisham formed
2000	<i>The NHS Plan</i> (DoH) - production of national targets to reduce health inequalities. <i>The National Cancer Plan</i> (DoH). <i>National Service Framework for CHD</i> (DoH)	Morley, A (2000) <i>Strategic initiatives in Lewisham, mapping work on health inequalities</i> , London, H.L.  Formation of North and South Lewisham Primary Care Groups  The Lewisham Health Inequalities Conference – guest speakers include Sir Donald Acheson
2001	<i>Shifting the Balance of Power</i> (DoH)  Re-election of Labour government	Lambeth, Southwark and Lewisham Health Authority (LSLHA) (2001) <i>The Health of Lewisham – everybody's business</i> , London, LSLHA  Primary care investment plans produced (see note 1 below)  Lambeth, Southwark and Lewisham Health Authority (LSLHA) (2001) <i>Health Improvement and Modernisation Programme 2001-2004</i> , London, LSLHA  First Lewisham Mayor elected
2002	Regional Health Authorities disbanded. Creation of South East London Strategic Health Authority  <i>Investment, Expansion and Reform – the next 3 years: Priorities and Planning Framework 2003-2006</i>	Lewisham Primary Care Trust (2002) <i>Health Improvement and Modernisation Programme 2002-2005</i> , London, Lewisham PCT  Lewisham HimP conference containing substantial element of programme on health inequalities  Formation of Lewisham Primary Care Trust Appointment of a Lewisham Director of Public Health. Disbanding of Lambeth, Southwark and Lewisham Health Authority  Local Delivery Plan targets include issues relating to health inequalities (autumn)
2003	<i>Tackling Health Inequalities: a programme for action</i> (DoH)	<i>Community Strategy 2003-2013</i> , London, Lewisham Strategic Partnership.

#### Notes:

1. "...PCTs will be expected to deliver Annual Accountability Agreement targets, play their part in the Health Improvement and Modernisation Programme and deliver Service and Financial Framework Targets." *Primary Care Trusts: open for consultation* (2001) London, Lambeth, Southwark and Lewisham Health Authority.
2. Details of further developments such as 'public-private partnerships' are provided by Harrison (1998) and Appleby and Harrison (2001).

## Appendix 7.1

### A comparison of the key findings of *The Health of the Nation: a policy assessed (LSHTM, 1998)* with findings from the study area

<p><b>The Health of the Nation (HOTN) – a policy assessed.</b> Two reports (1998)</p>	<p><b>Our Healthier Nation (OHN) – local responses.</b> Summary findings within the scope of the thesis – focusing on the policy to reduce health inequalities (2003)</p>
<p><b>1. Investing in Health ? - an assessment of the impact of the Health of the Nation, Universities of Leeds and Glamorgan Principal Findings pp. 13-14.</b></p>	
<p>2.1 “The HOTN was widely welcomed – it was the first attempt to put in place a national health strategy based on WHO’s Health for All. It had an important symbolic role.”</p>	<p>OHN was welcomed by all staff encountered. It was seen as - the first national policy to aim for a reduction in health inequalities and as - recognising the significance of the ‘wider determinants of health’.</p>
<p>2.2 “The HOTN failed over its five year lifespan to realise its full potential and was handicapped from the outset by numerous flaws of both a conceptual and process-type nature. By 1997, its impact on local policy-making was negligible. It wasn’t seen to count while other priorities, e.g. waiting lists, balancing the books, took precedence. The need for a fresh start was stressed.”</p>	<p>Over a five-year period from 1998 to 2003 administrative, or process problems, delayed the local policy response. The introduction of <i>The NHS Plan (2000)</i> refocused attention on waiting times. However, new aspects of the policy were still in the process of being implemented locally in 2003, eg, changes in performance monitoring.</p> <p>As at April 1997 staff anxiety for a change of policy could not easily be disentangled from their general desire for a change of government.</p>
<p>2.3 “The HOTN was regarded as a Department of Health initiative which lacked cross-departmental commitment and ownership. At local level, it was seen as principally a health service document and lacked local government ownership. Shared ownership at all levels both horizontally and vertically was stressed as essential for success.”</p>	<p>Production of a health authority HimP continued this trend (2001). However, the first borough HimP (2002) achieved greater local government ownership.</p> <p>Some increased vertical ownership was noted, particularly from within the voluntary sector.</p>
<p>2.4 “The HOTN did not change significantly the perspective and behaviour of health authorities and did not fundamentally alter the context within which dialogue between health purchasers/providers and other partners took place.”</p>	<p>Some increase was observed in the role of the public health and health promotion perspective at PCT level.</p> <p>Purchaser/provider dividing lines changed, e.g. health visitors entered into employment in the ‘commissioning agency’.</p>
<p>2.5 “The HOTN did not cause a major readjustment in investment priorities by health authorities. There was no relationship between resource use and outcomes and no evidence of a health economics perspective having been adopted.”</p>	<p>Additional ‘ring fenced’ funds were used. Public health and health promotion finances were less restricting to the policy’s local implementation. Although budget cuts to core services were still evident in 5 of the 6 years surveyed, special time-limited schemes such as the Health Action Zone compensated for this.</p> <p>Adoption of a ‘health economics perspective’, defined as “..the extent to which it (policy) has broadened the health agenda beyond the conventional focus that health is the responsibility of the NHS..” (HOTN – a policy assessed: 20), was noted. Outcome measurement was beyond the scope of the thesis.</p>
<p>2.6 “The HOTN reinforced the changing role of</p>	<p>OHN and the introduction of co-terminus</p>

health authorities, providing a framework within which the commissioning role was to be judged.”	boundaries facilitated partnership working between public health and the local authority. Up to 2003 the policy’s links to PCG/T commissioning were achieved more through individual’s commitment to public health principles rather than being driven by OHN.
2.7 “Some attempt was made to drive progress via the contracting process but it was minimal. The impact upon Trust and primary care teams’ performance has been slight.”	Service change was slow to develop. But clear examples, such as, large increases in provision of smoking cessation support, which included some specific targeting towards disadvantaged communities, can be discerned.  The contracting process was not ‘used to drive progress’.
2.8 “The HOTN did not seriously impact upon primary care practitioners either as commissioners or providers.”	Some specific developments were noted, e.g. community nurses were drawn into the local public health network; GPs were felt by some interviewees to be more open to recognition of the need to address the ‘wider determinants of health’; specific projects were funded, e.g. two linking primary care to voluntary sector support.
2.9 “Community Trusts appear to have been most engaged via involvement in community development activities and health promotion programmes; acute Trusts have been largely untouched by the health strategy. The HOTN has been relevant only where it enabled pre-existing agendas to be furthered and/or as a source of new funds.”	Some developments in the public health role of acute trusts were noted, e.g., involvement of acute trust HR departments in a HAZ employment scheme; the increased health promotion role of the mental health trust. Pre-existing partnerships were important in work to raise the profile of the new policy. Without new ring-fenced public health funds and a diminishing of acute sector deficits, the implementation of the OHN policy would have been very different.
2.10 “Local authorities in general perceived The HOTN to be dominated by ‘medical conditions’ and heavily ‘medically led’. It was a cause for concern among those local authorities which believed that they contributed more to a health agenda in its broadest sense than health authorities.”	No concern from those in the local authority along these lines was noted. Comment was made that jargon and ‘cultural differences’ between services made communication difficult at times. Some differences in commitment to working for ‘health in its broadest sense’ was seen within the local authority, between departments. Those departments with less involvement blamed lack of staff resources rather than lack of commitment in principle. LA involvement tended to be strongest from the ‘health and social care’ directorate.
2.11 “Continual organisational turbulence frequently disrupted management teams and working alliances. It also contributed to lapses of corporate memory which hindered consistent data collection and recollection of events by interviewees.”	Continual organisational turbulence disrupted and delayed planning a local strategic response to the policy. Lack of clear leadership and responsibility for the policy up until the appointment of the PCT Director of Public Health in 2002 further hindered implementation.
2.12 “The different agendas/drivers and cultures of health services and local government were complicating factors.”	Although a difference in ‘cultures’ was noted by some staff, the strongest evidence for this was that some health and some local authority terms needed to be explained in joint meetings. Some evidence of different agendas in anti-poverty policy was also noted (see chapter 5). However, shared agendas in work to improve health and well being and their determinants, were greater than differences. Local authority ‘floor targets’ introduced post-2001 increased this shared agenda.
2.13 Pre-existing structures and challenges	Pre-existing partnership structures did not appear

heavily influenced the starting point for joint working. For example, where local government had responded to WHO's Health for All initiative and had formed relationships with health authorities there was already joint machinery upon which to build. In these circumstances The HOTN had been possibly unhelpful. Where no such activity existed, The HOTN provided a suitable spur to joint action."	to find OHN unhelpful. However, the low integration of new HAZ machinery into existing partnerships possibly wasted resources.
2.14 "National targets were a useful 'rallying' point but local targets would have been welcomed within the national framework to reflect local needs."	There was a significant local lobby for the setting of national health inequalities targets. These were issued in 2000/1, but did not fully arrive on local agendas until 2002/3. There was insufficient national support or local expertise to set local inequalities targets, especially within the context of 'organisational turbulence.'
2.15 "Approaches to the translation of national targets to local level varied considerably. There was a general wish for greater freedom both to add target areas to the menu and to adjust targets in the light of circumstances. There was criticism of the targets on technical grounds."	Mixed, complex and at times contradictory responses were noted regarding local targets. (1) 'targets' generally were associated with other central 'requirements', for example, on reporting. (2) staff made general statements about the desirability of local targets, but at the same time felt a lack of expertise and support in deriving local targets. (3) staff were keen to see national targets on health inequality reduction. (4) the HAZ monitoring process was felt by many staff to be overly bureaucratic. (5) staff were critical of the technical quality of LDP targets for 2002/3.
2.16 "The performance management process was heavily geared to short-term outputs, largely driven by the Efficiency Index/Patient's Charter/financial management agendas and there was no extant performance management for strategic development and achievements for health as opposed to health services."	It was not until 2002/3 that any shift in this pattern, detected by the HOTN policy assessment, was noted locally.
2.17 "Lack of management guidance and incentives at local level were seen to be major failings of the HOTN. Local agencies did not have their roles, tasks and responsibilities clearly spelt out with a timetable to ensure that agreed targets or milestones were met."	Lack of management guidance and early lack of performance monitoring was also a failing of OHN. Local agencies and partnerships, 'did not have their tasks clearly spelt out', at least until 2003. One example of an exception being within the 'National Service Frameworks', but here tasks to reduce inequalities were not explicit. Other clear task orientated work-plans were 'fruit in schools' and Sure Start.
2.18 "Strengthening the capacity to deliver on the health strategy was seen to be a priority."	Public health training on aspects of the strategy was evident, e.g., funds were made available for Health Impact Assessment training. Increased ring-fenced funds also 'strengthened capacity to deliver'. Staff shortages and difficulty in recruitment weakened implementation.

<b>Implications for Future Policy as recommended in The Health of the Nation – a policy assessed: 14-15</b>	<b>Comments on the local response up to 2003</b>
3.1 "There was a widespread desire for a fresh start and for new life to be breathed into the health strategy. The government's commitment to produce a new health strategy, which would both build on The HOTN's overall aims and objectives	In 1997, whilst there was a widespread desire for new public health policies, there was also a stronger and almost universal desire, among the local public health and health promotion community, to see a wholesale change of

<p>and extend and broaden these in an effort to tackle the poverty problem and the evidence of widening health inequalities, was welcomed.”</p>	<p>government. These NHS staff wanted the Conservative government to lose the 1997 general election. Having said this, it is certainly true that the staff wanted OHN to ‘tackle the poverty problem and ...health inequalities’ and they became confused and at times cynical when government action to address poverty, income inequalities and health inequalities was discordant with their understanding of the commitments of the policy.</p>
<p>3.2 “There is a risk of ‘initiative conflict’ and overload as a consequence of a plethora of vehicles for collaboration which now exists. While offering rich opportunities to form and sustain partnerships, it is essential that the various initiatives are nested.”</p>	<p>Some evidence of confusion in the role of partnerships was noted in relation to the formation of the Local Strategic Partnership and local groups working on patient and public involvement. However, generally health improvement partnerships led by statutory agencies were ‘nested’. However, there was still conflict over staff time between health projects and initiatives.</p> <p>As described in the thesis, conflict also was discerned in relation to vehicles for public participation.</p>
<p>3.3 “In particular the government needs to:</p> <ul style="list-style-type: none"> <li>▪ Provide leadership by setting out clear, consistent ‘corporate signals’ and ensuring cross-departmental ownership”</li> </ul>	<p>Some local staff remained unconvinced of the consistency between government policy to reduce health inequalities and macroeconomic policy. Many local staff did not know of the national ‘Cross-cutting Review’. However, there was increased joint ownership of policy to reduce health inequalities between the local authority and health services and this was driven by the requirements of the policy.</p>
<ul style="list-style-type: none"> <li>▪ “establish shared ownership at all levels both horizontally and vertically and ensure that chief executives in health and local authorities are fully engaged and committed.”</li> </ul>	<p>Vertical involvement of staff was hindered by staffing constraints and lack of guidance over explicit tasks. High level commitment within health and local authorities existed and was increased due to the increased public health ‘voice’ and the new performance monitoring arrangements. Some senior public health staff remained sceptical, however, of the long-term impact of health inequalities monitoring given the continued acute sector pressures.</p>
<ul style="list-style-type: none"> <li>▪ “within a performance management framework, spell out as clearly as possible agency expectations, tasks and responsibilities.”</li> </ul>	<p>This recommendation was still being ‘newly implemented’ in 2003. Failure to act on it earlier produced delays in local implementation.</p>
<ul style="list-style-type: none"> <li>▪ “consider carefully whether health authorities should have the lead role for delivering on the health strategy or whether this should not be a shared role between health and local authorities.”</li> </ul>	<p>Given continued NHS ‘organisational turbulence’ granting more responsibility for the Health Action Zone and the Health Improvement &amp; Modernisation Programme to the local authority might have sped up local implementation.</p>
<ul style="list-style-type: none"> <li>▪ “stress the importance of joint targets and joint monitoring with each stakeholder playing to its particular strengths.”</li> </ul>	<p>Some NHS and local authority targets appeared to overlap more towards 2003. However, this was not made explicit. Joint projects, such as the HimP development and the health partnership board did strengthen statutory sector links.</p>
<ul style="list-style-type: none"> <li>▪ “ensure that primary care practitioners are on board with the strategy”</li> </ul>	<p>Local efforts were made in this area, but they appeared to be more ad hoc than strategically led.</p>

<p><b>The Health of the Nation – a policy assessed. Evaluation of the Implementation of the Health of the Nation, London School of Hygiene and Tropical Medicine. Conclusions: 147.</b></p>	<p><b>The local response</b></p>
<p>“Seven key factors emerged as influencing the implementation of HOTN:</p> <p>1.1 Lack of resources as a barrier to HOTN implementation was indicated by: (a) it was cited by one-third of interviewees as a barrier to implementation; (b) an analysis of individual health authorities’ patterns of expenditure suggested that population-based health promotion may be a ‘soft target’ and may be reduced to achieve savings; (c) an increase in the share of total population-based health promotion funding spent on HIV/AIDS prevention activities, suggested that some HAs are using this ring-fenced budget to cross-subsidise other health promotion activities.</p> <p>1.2. This raises the issue of the importance of ring-fenced resources in the implementation of a national health strategy</p>	<p>Lack of financial resources for local public health project work was not a top concern of staff throughout the period.</p> <p>This was because of, what was in effect, the ring-fencing for funds via schemes such as the HAZ. However, wider concerns over the long-term funding of core council and NHS services were raised.</p>
<p>2. Structural features of local agencies can support or impede HOTN. Those which facilitate partnership working, which strengthen the importance of health improvement within agencies and which protect it from (the) resource demands (of) other functions of health authorities and local authorities are particularly important.</p>	<p>Turbulence in the structures of local agencies hindered implementation. Whilst the HAZ ensured that public health funds were ring-fenced it also created a new bureaucratic structure of its own. However, existing partnerships supported the work.</p>
<p>3. Interviewees saw a national strategy as giving some support to implementation by giving legitimacy to action. However, many called for a statutory framework to enable key local participants to work intersectorally for health, and to protect the strategy from the demands of other functions and the loss of key staff.</p>	<p>The national strategy did not offer local staff enough support with respect to the tasks that partnerships should invest in.</p>
<p>4. The quality of partnership is viewed as important for implementation of a health strategy, and can be reinforced by a supportive culture and incentives to partnership such as those provided in the Single Regeneration Budget.</p>	<p>Staff took advantage of existing partnerships. However, ‘technical difficulties’ over deciding on the most effective tasks, staff shortages and organisational turbulence lessened the support partnerships could offer.</p>
<p>5. Committed individuals can be important catalysts, and can be influential if they are in a senior position. Competing pressures from other responsibilities of organisations can account for lack of commitment by some organisations, or for commitment not being translated into action. A statutory framework for the health strategy would encourage development of commitment of individuals and organisations at every level.</p>	<p>Committed individuals drove and sped-up aspects of the policy’s implementation, for example, the borough HimP development.</p>
<p>6. Socio-economic features were reported as influential in strategy implementation. A health strategy needs to acknowledge the importance of the socio-economic determinants of the health of the local population if it is to be credible with those responsible for implementation locally.</p>	<p>There was some dissonance between staff views of what central government <i>should</i> do and views on what it <i>was</i> doing with regard to macro-economic policy to support health inequality reduction. This in turn led to increased confusion at the local level as to what public health staff should do locally regarding the wider-determinants of health.</p>



<p>7. Local authority culture and political features may affect implementation of HON, although this was a stronger factor in some districts than in others. Local authorities which had a tradition of commitment to health promotion had better relations with their health authorities.</p>	<p>The thesis develops the theme that political features may affect public health policy implementation.</p>
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<p><b>The Health of the Nation – a policy assessed, Lessons learned for implementation of a national health strategy: 83.</b></p>	<p><b>The local response</b></p>
<p>1. A range of models of implementation of OHN should be supported to allow for variation in local circumstances and previous developments in health strategy.</p>	<p>The disestablishment of the health authority and creation of PCGs and then PCTs disrupted local circumstances and rendered out-of-date elements of previous developments in health strategy. The new HAZ bureaucracy did not anticipate future structural changes.</p>
<p>2. OHN should address underlying determinants of health and inequalities. A matrix model has many advantages, enabling explicit consideration of both disease and population-based models in health.</p>	<p>Local staff had difficulty in discerning their role in addressing the underlying determinants of health and inequalities. While senior public health staff recognised the contribution of different services to the policy's main aims, a strategy spelling out tasks in a matrix model had not yet been developed for local use by 2003.</p>
<p>3. There is an unresolved issue about where responsibility for the strategy should rest and the placement of the public health function should be kept under review in the light of changes in the NHS.</p>	<p>Overall responsibility for the strategy stayed with the health authority and then the PCT. Joint working on the health improvement strategy between the LA and the NHS improved with the formation of the PCT.</p>
<p>4. Regardless of the detailed arrangements within the NHS, communication needs to be improved to widen ownership of the OHN outside the NHS.</p>	<p>Communications were improved, but there was still scope for increased joint work.</p>
<p>5. If the momentum of the strategy is to be sustained, it needs to be firmly embedded in a performance management framework. This should include monitoring the process of implementation as well as the outcome, and should enable resources connected with the strategy to be identified, isolated and monitored.</p>	<p>Developments in performance management, supportive to implementation, were finally initiated in 2002/3.</p> <p>Identification of resources allocated for specific schemes, such as fruit-in-schools was achieved. However, a proliferation of special schemes increased administration work. Monitoring of mainstream public health funds was complicated by the introduction of a new financial coding system in the same year as PCT and strategic health authority inauguration.</p>
<p>6. Targets are a necessary tool for prioritisation, but must be credible and local development of local targets should be encouraged.</p>	<p>Insufficient support was offered for the development of local targets to reduce health inequalities between 1998 and 2003. Local staff resources and expertise was not available to undertake this work to a high standard. The production of national targets 3 years after the policy was first released was welcomed although at the time the renewed focus on acute sector targets generated by <i>The NHS Plan</i> dampened enthusiasm.</p>
<p>7. There is a need for a statutory framework to encourage key local agencies, particularly local government, to work in partnerships for health. Other incentives for partnerships should be considered to support the commitment of individuals and organisations necessary for</p>	<p>Explicit policy statements and communications indicating the increased responsibility of the local authority towards health and well being helped to increase a sense of shared agendas. Co-terminosity between the PCT and borough also improved joint working. However, partnerships</p>

implementation.	were functioning before the policy arrived.
<p>8. Central government has a key role to play but it is essential that there is a consistent message across government that is in support of OHN. Central government should also foster the development and dissemination of an evidence base.</p>	<p>Little effective technical support was provided from the centre and there was a sense of a lack of co-ordination as to whose responsibility it was to support local public health services. For example between the DoH, the strategic health authority, the London Health Observatory and the Health Development Agency (H.D.A).</p> <p>Staff detected an inconsistency between policy to reduce health inequalities and government policy on income distribution. The cross-cutting review had little local impact (up to 2003).</p> <p>The H.D.A.'s publications began to provide helpful reference sources for local public health work by 2002.<sup>181</sup> Although, there was little effective involvement of local staff in recommending research and publications programmes that would be useful for the H.D.A to undertake.</p>
<p>9. It will be important to increase the role of key stakeholders, in particular the public, the private sector and those working in primary care.</p>	<p>Initiatives to involve the public were integrated into regeneration schemes which in turn also had health components. Public involvement in influencing the wider-determinants of health is a theme of this thesis.</p> <p>Little work was undertaken to involve the private sector at departmental level, excluding small initiatives such as 'shopping for health' (food awareness activities involving dieticians and diabetes patients.).</p> <p>Primary care staff were key partners involved in areas of work relating to health improvement, for example in initiatives concerning sexual health, patient involvement in 'healthy heart days' and smoking cessation work. However, work was somewhat determined by individual staff and practice interests and commitment. It was noted by health promotion staff that those practices in most need of support in health improvement work, tended to be those least able to make use of such support.</p>
<p>10. Consideration should be given to ring-fenced funding for the implementation of OHN in order to give priority to this activity.</p>	<p>Ring-fencing of funds was effective in providing a dedicated financial stream for public health improvement. However, it was not necessary for the ring-fenced funds to be tied to new and distinct administrative and monitoring structures, as was the case with the HAZ.</p>

<sup>181</sup> The reduction in leaflet supplies formally provided by the Health Education Authority (HEA) was a source of annoyance to local primary care staff.