Assessing the role of housing association activity in tackling health inequalities in Greater Manchester

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Contents

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List of acronyms and abbreviations

ALMO: Arm's Length Management Organisation

CCG: Clinical Commissioning Group

CIH: Chartered Institute of Housing

DHSC: Department of Health and Social Care

EHS: English Housing Survey

GM: Greater Manchester

GMCA: Greater Manchester Combined Authority

GMHSCP: Greater Manchester Health and Social Care Partnership

HA: Housing Association

HACT: Housing Associations Charitable Trust

HCA: Homes and Communities Agency

HHSRS: Housing Health and Safety Rating System

HIAP: Health in All Policies

HOOP: Housing Options for Older People

HWB: Health and Wellbeing Board

LHA: Local Housing Allowance

LSOA: Lower Super Output Area

MHCLG: Ministry of Housing, Communities and Local Government

NHF: National Housing Federation

NPPF: National Planning Policy Framework

PHE: Public Health England

PRS: Private Rented Sector

RP: Registered Provider

RTB: Right to Buy

SES: Socio-economic Status

SDOH: Social Determinants of Health

STP: Sustainability and Transformation Partnerships

TCPA: Town and Country Planning Association

UK: United Kingdom of Great Britain and Northern Ireland

VCSE: Voluntary Community and Social Enterprise

WHO: World Health Organisation

Abstract

This thesis examines the role of housing associations in relation to health inequalities. Many housing associations in England are diversifying their business activities, and taking an increasingly active role in providing non-housing support services. Such services may function as either a direct or indirect determinant of health, yet empirical data on these activities is lacking. By investigating the experiences of housing providers in Greater Manchester, which is the only city-region in England to have had its budget for health and social care devolved from central government, the research assesses the interaction between housing association services and the city-region's population health approach. A group of Greater Manchester Housing Providers (GMHP) sits formally within the city-region's devolution structure, presenting a research opportunity that makes a contribution to both housing studies and the social determinants of health scholarship.

Using a multi-level case study of Greater Manchester and data from elite interviews with housing and health sector professionals, this research considers whether housing associations, as independent businesses that have retained a public service function, can offer a suitable, sustainable solution to housing-related health inequalities. A critical realist approach to population health is employed to demonstrate the interdependencies and complexities between housing association services and the wider populations, governance structures and policy contexts they operate within.

In this thesis, housing association activity is shown to be diverse, variable and inconsistent, and susceptible to numerous external pressures. As a sector, housing associations offer only a fragmented solution to the pervasive and entrenched health inequalities which disadvantage whole social gradients. In one sense, the diversifying housing association offer is shown to be more comprehensive, and to be engaging with health in an increasingly holistic way. Yet against the backdrop of continued statutory retrenchment, austerity and welfare reform, the activities of housing associations are shown in this thesis to be increasingly exclusionary, contributing to regressive gaps in the safety net and social contract, which are ill-suited to tackling the universal issue of health inequalities.

Declaration

No portion of the work referred to in this thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning.

Copyright statement

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Chapter One
Introduction

Context to the study

The relationship between housing and health is a well-established one that has long been recognised in the research literature. The relationship between housing and health is multi-faceted. A 'decent', health-affirming home is not just one which is free from hazards, though this is recognised to be important (Housing Act 2004). Healthy homes provide not only physical shelter, but also safe refuge, therefore acting as a source of physiological and psycho-social support (Hiscock et al., 2001; Kearns et al., 2000; Shaw, 2004). The Health Foundation has identified the features of a healthy home as one that: is affordable, stable and secure; can appropriately provide for the needs of all the household's members; makes us feel safe and comfortable, and is connected to the wider community, services, and work (de Sa, 2017). The World Health Organisation decreed in 2010 that guidelines on 'healthy housing' should be promoted recognising that decent housing functions to prevent illness (Braubach, 2011; Lawrence, 2017). Recognition of the features of a healthy home has led to a growing number of studies which ask to what extent such housing is provided, and what its direct relationship is to the prevalence of illness and health inequalities (Allen, 2000; Gibson et al., 2011; Thomson and Thomas, 2015). Housing, and its uneven distribution, has therefore been recognised as a tool by which policymakers might effectively reduce health inequalities (Howden-Chapman, 2002; Howden-Chapman and Chapman, 2012).

Health inequalities, however, are a stubborn and persistent phenomenon that even governments which have made tackling them a specific priority, have struggled to reduce (Mackenbach, 2010, 2012). The causes of health inequalities, and the substantial differences faced in (healthy) life expectancy, are widely understood to be social in origin (Marmot, 2015; McGovern et al., 2014). Strategies which are focussed on improving social and environmental contexts, increased income and wealth equality, and equitable access to education or employment opportunities, are likely to have a more substantial impact on health equity than programmes which focus more narrowly on medical treatments within a clinical, curative health service (Baum et al., 2009; Golden and Wendel, 2020; Marmot, 2015). As such, the

role of housing has also been identified as increasingly important social determinant of health by researchers. *The Marmot Review* (2010) identified housing as an important influence on health, but the authors acknowledged in their 2020 update that 'at the time [housing] was considered less of an issue than in the years that have followed' (Marmot et al., 2020, p.93). The intersection of housing and health inequalities is a growing area of academic interest, and this study attempts to contribute to multiple strands of this research agenda.

As housing studies continue to explore the health benefits (or otherwise) of housing interventions (Holding et al., 2019; Kearns et al., 2020), and the health inequalities research pays closer attention to the potential of housing (Marmot et al., 2020), this is an opportune moment to present this thesis. Housing associations play an increased role in addressing health-housing intersections, yet the role of housing associations in health has not been thoroughly investigated. Policymakers from across the United Kingdom (UK) have deemed housing associations to be a 'health-related service' and encouraged social housing providers to take a more involved role in their local health strategies (Care Act, 2014; see also NHS Health Scotland, 2016). This is in the context of localism, and encouragement for devolved governance over the past decade in England, including the strengthening of city-regional structures (Smith and Wistrich, 2014). Devolution to city-regions, and the creation of combined authorities and city-region mayors, has been said to offer 'new possibilities for addressing social inequalities' through more effective targeting of policies and resources, as well as opportunities 'to address issues and integrate policies and services at sub-national levels' (Lupton et al., 2018, p.1). This thesis presents new primary data which sheds light on the experiences of housing associations that have been involved in this process. Focusing on Greater Manchester, these data reveal a group of invested housing associations adopting an increasingly diverse, health-focussed role as part of their activities. This more expansive role, extending beyond the core landlord function to embrace the provision of health-related services, is regarded by some as a natural extension of these organisations' social purpose, and a manifestation of their role in the community (Jabbal, 2016; Simpson et al., 2015). Yet the ability of housing associations to influence the causes of health inequalities, and work effectively with health sector partners, is influenced and restricted by variable local and national contexts.

The development of housing-health research takes place in the context of several other, related research agendas. Numerous studies have considered the role and function of a public housing sector, and its relationship with the state (Malpass, 2005; Mullins and Jones, 2015). In welfare states, a statutory housing system is likely to accompany some degree of provision of publicly run healthcare, social services, and wider social determinants of health such as education and recreation. Yet this relationship is especially fragile during periods of austerity and state retrenchment, as has been evidenced in America (Peck, 2012) and in Europe (Crouch, 2011; Davies and Blanco, 2017). Davies and Blanco (2017, p.1521) argue that 'urban governance in the UK is a scalar mess', and that the different levels of operation and control experienced by various departments, including housing, health, education and police, is complicated by the fact that 'UK municipalities are compelled by law to deliver austerity and they have no control over welfare reform'. The relationship between central and devolved powers in the UK provide important context for this research, which considers the extent to which the expanding involvement of local housing providers in health and social care services can function successfully with such straitened resources.

Devolution of health and social care responsibility to Greater Manchester, however, is seen by its advocates as a means to potentially challenge, or alter, the wider restrictions placed on the city-region by central government. It is argued by the Chair of the Greater Manchester Health and Social Care Board that it is 'better to have decisions made locally, because local people understand what local problems are and what Greater Manchester needs. We need to work together' (Smith, 2016, quoted by GMHSCP). The Greater Manchester Health and Social Care Partnership claims that 'thanks to devolution, we now have the freedom and flexibility to do things that benefit everyone in Greater Manchester' (GMHSCP, 2020). The vision for the Greater Manchester Model of Unified Public Services is one of better integration between sectors, including housing, delivering more holistic services to local populations (GMCA, 2019; Leng, 2015). This research is important because it has been suggested that the Greater Manchester experience could provide 'a strong case study for other areas looking to develop and pursue their own devolution agendas' (New Economy, 2016, p.4). Beyond the city-region's devolution agenda, this research provides insight into the relationship between housing associations' activities and health inequalities, and the potential implications for both the sector more generally, and for the pursuit of population health systems (Buck et al., 2018).

This thesis offers a contribution to the timely issue of the relationship between housing and health. It does so by considering the evolution of housing associations and the ways in which they are adapting to function as more explicit health actors in the context of austerity and a shrinking state. There is a growing body of literature considering the changes in the function, purpose and identity of the social housing sector (Manzi and Morrison, 2018; Mullins, 2016; Murie, 2018). A longstanding, transdisciplinary research interest has emerged exploring the relationship between health and housing, and how housing functions as a social determinant of health (Lawrence, 2017). This thesis brings together these threads of interest and provides new data and insights into the ways such housing association activity relates to, and interacts with, the issue of health inequalities.

The arguments presented here will demonstrate the ways in which many housing associations are increasing their health-related focus and role, diversifying their business activities and providing in many cases a more holistic, multi-level approach to health and wellbeing for their residents. However, the study also identifies some of the hidden risks and gaps in universal service provision, left by a retrenching state. The thesis will argue that not only are the activities of such housing associations too varied and inconsistent to offer anticipated benefits to their own tenants, a more expansive role when ineffectively executed may actually risk contributing to increased health (and other) inequalities across the communities they operate within.

Research aim and objectives

This thesis explores a broad range of literature relevant to both housing studies and health inequalities research. The links between the areas of scholarship are often explicit, but sometimes only implied, so the themes identified in chapters two and three, which form the basis of the later analysis and discussion, represent an attempt to look more holistically at housing-health relationships, using empirical data collected from housing associations which are playing an active part in their city-region's devolution. The aim and associated objectives below frame this research, underpinned by the conceptual framework set out in chapter four.

Aim

The aim of this research is to critically assess the changing roles and activities of housing associations in addressing health inequalities. The research will inform better understanding of housing associations' experiences of policies and practices operating in a context of devolved governance, as well as their possible implications. Insights generated from housing providers will establish links with the wider issues of equality, and health equality, that arise from the expanding remit and role of third sector organisations' involvement in policymaking, and delivery of public services.

Objectives

To realise this aim, the objectives of the study are:

- to critically review the existing research and policy literature which explores the link between housing and health inequalities;
- to examine the roles played by social housing providers in addressing health inequalities in Greater Manchester;
- to identify the drivers and influences on this activity;
- to explore the relationship between social housing providers and the health service commissioning bodies in Greater Manchester;
- to examine the experiences of health-housing relationships and devolution between the different boroughs of Greater Manchester; and
- to synthesise the key research findings and relate the insights from Greater Manchester's housing associations to the wider phenomenon of health inequalities.

This thesis makes an original contribution to an increasingly important topic. The relationship between health and housing is acknowledged ever more widely as crucial, so this marks an opportune moment to think carefully and critically about the ways the housing sector might contribute to this agenda. The empirical research involved a programme of interviews to assemble a rich seam of primary data. As more cities, regions and nations attempt to design preventive population health systems, with 'health in all policies', the inclusion of housing considerations will be a strategic priority for any comprehensive public health agenda.

Thesis structure

Chapter two considers the relevant literature and some of the key arguments that relate to the broader field of study. It explores the relationship between housing conditions and health outcomes, as well as discussing critical perspectives that consider how health inequalities are created and addressed. The literature review highlights research that has attempted to bridge the gaps between housing studies and health inequalities research, to pinpoint the areas of intersection and assess the role of housing association activities.

Chapter three identifies significant policy trends in the UK that have attempted to advance the housing and health inequalities agenda. It tracks the history of closely linked policy traditions in housing and health, as well as moments when reducing health inequalities was an explicit government priority. The chapter considers the associated successes and challenges of these approaches. It goes on to address current policy trends, where they continue and diverge from historical traditions, and identifies policies that are likely to impact on the research agenda linking health inequalities and the activities of housing associations.

Chapter four details the methodology, and the conceptual background that informs both the research process and subsequent analysis. The conceptual framework outlines the critical realist approach that underpins this attempt to consider holistically the relationship between housing association activity and health inequalities. It outlines why a case study approach was chosen, and why Greater Manchester was identified as a suitable site for the research. This chapter explains the qualitative methods selected, and thematic approach to data analysis that form the basis of the discussion and conclusions.

Chapter five considers the city-region of Greater Manchester and explores primary data collected from interviews with stakeholders working across the city-region's ten boroughs. The data presented in this chapter was collected through semi-structured interviews with managers, chief executives, board members and other senior members of housing and health organisations, exploring the views of those tasked more with strategy than delivery. The chapter considers the ways housing associations have adapted their business priorities

and strategic objectives to work collaboratively, including their collective voice in Greater Manchester's devolution experience. This chapter outlines in detail the strategic priorities for the city-region and considers the perspectives of senior housing association staff as well as policy actors from Greater Manchester's local authorities and Combined Authority, and data collected from senior members of the Greater Manchester Health and Social Care Partnership.

Chapter six presents evidence from two of Greater Manchester's boroughs, Oldham and Trafford, which were selected for further intensive research. The two areas were chosen due to their differences in demographics and political history, as well as their approach taken to the city-region's health-focussed agenda, thereby illustrating some of the heterogeneity between Greater Manchester's ten boroughs. The chapter analyses primary data assembled via interviews with both senior policymakers and frontline staff. The analysis considers perceptions and experiences of service delivery, and the 'on the ground' realities and challenges associated with implementing the emergent policy agenda.

Chapter seven considers the evidence from Greater Manchester in the context of three separate areas of research: the relationship between health and housing (associations); experiences of changing functions for housing providers in the context of devolution and localism; and efforts to reduce health inequalities in a shrinking welfare state during a period of austerity and retrenchment. Exploration of each of these themes demonstrates how the research complements the existing evidence base and their implications for wider scholarship.

Chapter eight concludes the study and explains the contribution to knowledge, outlining the evolution of housing associations' role and function and highlighting the wider implications for a policy agenda focussed on reducing health inequalities.

Chapter Two
Literature Review

Introduction

This chapter explores existing literature linking health and housing. It considers the relationship between housing and good or bad health outcomes, which in populations and societies worldwide manifest as large health inequalities. Engaging with wider health inequalities research, the chapter takes into account critical perspectives on their creation, and the relevance of this literature to housing studies. It highlights areas of intersection between the research agendas, and draws attention to scholarship which highlights the ways certain actors, specifically housing associations, have garnered academic and policy attention.

Healthy housing and healthy environments

The relationship between housing and health outcomes has long been acknowledged. Public health and housing conditions have been the focus of study for almost two centuries, including work by Victorian social reformers such as Edwin Chadwick in his study of the *Sanitary Conditions of the Labouring Population of Great Britain* (1842) and Friedrich Engels's *The Housing Question* (1872). The link between healthy environments and thriving populations inspired the work of early 'social landlords' such as Joseph Rowntree and Octavia Hill. John Snow's efforts to trace the source of the 1854 Soho cholera outbreak to the Broad Street water pump is still celebrated for its 'tremendous contribution' to environmental public health (Ruths, 2009, p.470). As subsequent sections of this chapter demonstrate, the association between cramped, squalid living conditions and the spread of disease has been the subject of a rich and detailed strand of research, exploring both the dangers of an unhealthy living environment, and the potential for well-designed homes to promote better health and reduce inequalities.

Designing homes for good health

Variable housing circumstances have played an important role in determining the uneven susceptibility to ill-health and disease. Relatively advantaged groups and individuals are less vulnerable to illnesses that thrive in overcrowded, poorly designed homes and neighbourhoods. Cholera, for example, 'was one of the most socially graded diseases and intimately related to housing circumstances' (Shaw, 2004, p.399). Residents of overcrowded, poorly designed, unsanitary neighbourhoods have historically been most exposed to disease. Architects, planners and urban designers have for many years sought to create environments to counteract this, and this practice has evolved in societies whose biggest threats now include non-communicable diseases (NCDs) which predominantly have individual rather than infectious risk factors.

The European Modernists and Avant-Garde theorists used medical metaphors to frame their attack on unhealthy designs. In *City of Tomorrow*, Le Corbusier called for 'Physic or Surgery' to treat the symptoms of a failing city, either by cutting away the infected tissue (demolition) or applying localised, curative treatment (refurbishment) in a more piecemeal way (Le Corbusier, 1929). His recommendations favoured the knife, declaring that 'Surgical Solutions Resolve!' as opposed to the less effective and more expensive 'physic' (Le Corbusier, 1991, p.172). This was the architects' radical remedy for the overcrowding, dirt and germs that were believed to spread disease. In medical terms, this could be understood as 'prevention is better than the cure'. To purify and cleanse the decayed city, the Modernists required the dark, filthy buildings of the past to be torn down, and for a bright, light new space to replace them (Wigglesworth, 2000). The mid-century architect played a role of 'active participation in the affairs of the community' (Newman, 1961, p.15) and expected their designs to be used by residents in ways that would improve their health and wellbeing. Modern flagship projects included the *Unité d'Habitation* in Marseilles, designed by Le Corbusier as 'a machine for living in' (completed 1952). This housing complex was designed to foster good health, and its communal rooftop space was intended for exercise and relaxation, reflecting the important modernist notion that 'fresh air, exercise and, most importantly, play, were tools for societal improvement' (Sambrook and Sutton, 2015, p.14). Creating a healthy living environment was a powerful architectural motivation, and in the chaotic years after the world wars, those faced

with the challenge of rebuilding European towns and cities turned to these remedies in the hope they could physically and emotionally rebuild their societies.

In Britain, continental models of deck-access homes and 'Streets in the Sky' were adopted in the post-war vernacular of New Brutalism, favoured by architects and local authorities tasked with developing mass housing on a grand scale (but at modest cost). Architects such as the Smithsons, who designed Robin Hood Gardens in Poplar, London, wanted to use architecture to effect behavioural change in a sanitary environment. Their designs drew on modernist principles as well as Classical and Georgian ideas about healthful planning. Plans for redeveloped flats built all over the UK presented shared gardens and sweeping lawns to recreate the Palladian use of spaces such as the Circus for 'the exhibition of sports' (Summerson, 1993, p.361). The combination of light, air, landscaping and tree planting for new, high rise municipal redevelopments was vital for the creation of 'stress-free space' that architects were promoting as a healthy way of living in Britain (Smithson, 1970). This vision has been criticised for its paternalistic attitude and the degree of control designers have sought to exercise over the inhabitants of their creations (English, 1992, p.95). Homes and neighbourhoods can act as either empowering or oppressive spaces, with a clear relationship to residents' wellbeing. In the same way that demolition of 'slum' terraces in the inter-war years was partly intended to prevent civil unrest and protests (Hollis, 2009), these housing schemes were designed to induce behavioural change that would have positive impacts on health.

In the UK and internationally, however, many of the post-war mass housing projects came to represent a failed experiment (Finnimore, 1989; Gardiner, 1986). The estates that were intended to signify health and modernity came to represent squalor, fear and residualisation. Blame was variously apportioned to the architects, builders, local and national governments, as well as to the residents, who in some cases were held responsible for the pervasive damp and condensation by drying their clothes indoors and making love too energetically (Green, 1993). Some combination of these factors, accelerated by a lack of investment in maintenance, led to the transformation of the 'New Jerusalem' into the New Slums as they came to be viewed by the 1980s. Their decline, and the failure of late twentieth-century remedial efforts, was since attributed to a lack of understanding about the interaction of

these housing estates with wider problems, and the macro-economic causes of deprivation and inequality (Kintrea, 2007). These housing designs were also losing favour across the Atlantic. Postmodernist Charles Jencks described the famous and well documented 1970s demolition of the Pruitt-Igoe housing complex in St Louis as 'the day Modern architecture died' (Jencks, 1984). This period witnessed a change in the research agenda of housing and health, as it came to be accepted that this paternalistic approach to housing – designed for, and not with, its residents – had failed to provide people with the tools necessary to empower them to take control of their own health (Shapely, 2004, 2006).

Since the 1990s, researchers have paid increasing attention to the explicit relationship between housing conditions and ill health. Burridge and Ormandy's collection of work on *Unhealthy Housing* (1993) catalogues the main research areas identified at this point as having a bearing on health. The list of factors demonstrates a focus on the physical aspects of buildings including 'coldness, dampness, mould growth, crowding, high-rise buildings, dangerous design and infestations' (Burridge and Ormandy, 1993, p.xviii). Of this collection, only Freeman's study considered mental rather than physical health factors (Freeman, 1993), and there is a notable absence of work interrogating the structural factors that are now much better understood as drivers of deprivation. Lawrence made early calls for a more social understanding of this problem, defining 'homes' as separate to 'houses', and advocating a human ecology perspective that integrated the work of 'experts' with the know-how and experiences of lay people (Lawrence, 1993). Housing and health are areas of universal interest and experience, with much insight to be gleaned from everyday encounters. The potential of housing to play an active physical and psychosocial role in creating, or constricting, good health has become an active area of scholarship, which has developed its acknowledgement of the complexities within and between the factors involved.

The preventive and protective power of housing against illness

Numerous studies and interventions have attempted to define the relationship between poor housing characteristics and poor health (Gibson et al., 2011; Thomson et al., 2001; Thomson and Thomas, 2014). Particular attention has been paid to the impact certain physical attributes (often those that can be isolated), or features of the home might have on the health

(or more accurately, illness) of inhabitants (Allen, 2000). Such features commonly include levels of damp, mould, overcrowding, vermin, ventilation and other measures that are relatively simple to observe and measure. Thomson et al. (2001) found evidence in their systematic review of the relationship between conditions such as coldness and dampness, and respiratory problems. Gibson et al. (2011) also found evidence of this relationship, and a systematic review of 130 interventions studies showed that overall, the clearest positive impacts on health came from warmth and energy interventions. Programmes which include rehousing, refurbishment, and energy efficiency measures have often been difficult to evaluate due to the inevitable confounding factors that impact a household's living situation but lie outside the narrow boundaries of such studies (Holding et al., 2019). More broadly, 'observational studies have also shown strong independent associations between poor housing and poor health, but their results remain open to debate and interpretation' (Thomson et al., 2001, p.187). Thomson and Thomas (2014) reported limited progress in articulating a theory that directly explains the impact of housing improvements on health, but sustained the argument that improvements in general health, respiratory health and mental health are possible with interventions in warmth and energy. The material quality of the home is generally agreed to offer some protection against illness if it meets a basic standard, notwithstanding unavoidable complexity in measuring or theorising this, and 'the quality of the home environment is directly related to income' (Wilkinson and Pickett, 2009, p.111). It follows, therefore, that the potential of housing conditions to impact on illness is also closely related to financial security, and the myriad factors associated.

It is possible to differentiate between the 'hard' and 'soft' factors which impact on health through housing. The 'hard', or direct, impacts on physical health are those such as mentioned above which relate to the 'material conditions of housing affecting physical health, and in the extreme, the impact of homelessness' (Shaw, 2004, p.397). The 'soft' factors relate to wellbeing, and psychosocial factors such as belonging, and security. Prochorskaite et al. (2016) catalogued stakeholders' preferences for 'soft' features of sustainability and healthy housing design in the UK and identified the following features as important: suitable indoor space; private outdoor space; adaptability; compatibility with architectural heritage; features for informal socialising; accessible public greenspace; attractive views to outside; opportunities to get involved; security features; compact neighbourhood; proximity to

amenities. These represent less tangible, harder to measure features than damp or mould, yet still intervention studies have focussed on individual dwellings and households rather than the wider societies that homes are experienced within.

Research on the health-housing relationship has inherent challenges. The scope of intervention studies illustrates how uncommon the randomised control trial (RCT) is in housing studies, despite being the 'gold standard experimental model to show the effects of interventions in medicine' (Thomson et al., 2001, p.187). The research acknowledges, however, that health is determined by myriad social determinants (of which housing is just one) that intervention studies are unable to control for. In regard to other important environmental factors and social determinants of health, Schrecker argues that adopting 'what has been called a tobacco industry standard of proof' for social factors 'means the evidence may never be strong enough' (Schrecker, 2013, p.743). RCTs of complex social policies are rare, and are also unlikely to assess the impacts of health affecting policies on different socioeconomic groups (Petticrew, 2007; Holding et al., 2019). A more 'holistic approach is needed that recognises the multifactorial and complex nature of poor housing and deprivation', and which investigates the wider social context of housing interventions (Thomson et al., 2001, p.187).

Good housing can also be psychologically protective, and offers 'more than shelter; it can provide personal safety and ontological security' (Madden and Marcuse, 2016, p.12). Housing can offer both protection from the elements and 'provide refuge in a social and psychological sense – a home can confer safety and privacy' (Shaw, 2004, p.408). Psychosocial factors have been shown to relate to security of tenure, appropriateness of dwelling, affordability and degree of choice or autonomy over one's living situation. Constancy, privacy, and a space to both be in control of one's life and construct an identity are argued to provide the basis for this ontological security (Dupuis and Thorns, 1998). This gives a sense that the stability of the world can be relied upon, and therefore a stable home provides a secure launchpad for a healthy and prosperous life (Hiscock et al., 2001; Laing, 1965).

Robinson and Walshaw (2014) found that greater security of tenure is related to higher wellbeing, and Tunstall et al. (2013) have demonstrated the interdependence of housing and

poverty, with tenure specifically highlighted as a health influencing factor (Gibson et al., 2011). In many countries, security of tenure is stronger in the public (or social) housing sector than the private sector, and some evidence suggests a correlation between health outcomes and moving to a more secure tenure. For example, in New Zealand, evaluations of hospital and social housing administrative data 'have found that there is a one-third reduction in hospitalisations when families are re-housed from the private sector to the public sector' (Howden-Chapman and Chapman, 2012, p.417). Poverty levels can alter drastically once housing costs are taken into account (Francis-Devine, 2020), and therefore 'housing may also have a preventative or ameliorative impact on poverty where, for example, high quality social housing reduces living costs and contributes to positive health and wellbeing' (Crisp et al., 2016, p.10). Policies to redistribute housing resources therefore have the potential to mitigate some of the impacts that low income can otherwise have on material poverty and lack of access to decent housing.

Relationships between the state and the housing sector

Although an extensive scholarship exists examining the possible relationship between housing circumstances and health outcomes, the research does not always incorporate the wider context and systemic causes of health and socioeconomic inequalities. The housing sector has not received academic attention equivalent to other recognised contributors to poor health. As Thomson and Thomas argue, 'unlike health service interventions, the primary aim of housing improvement is not to improve health. Rather…that by improving socio-economic determinants of health, such as living conditions, health will subsequently improve' (Thomson and Thomas, 2014, p.207). Poor health is an indicator of material deprivation (Pierse et al., 2016), and research on behalf of the Joseph Rowntree Foundation suggests that 'the significance of the links between housing, poverty and material deprivation deserves greater recognition, both from those interested in housing and those interested in poverty' (Tunstall et al., 2013, p.8). For housing researchers, there is much to learn from work that seeks to explain the causes and consequences of health inequalities and relate these theories to study of the built environment.

Like the health and education services, the housing sector is a 'cornerstone' of the welfare state, although it is accepted as such to varying degrees (Lowe, 2004; Malpass, 2005). Increasingly, the role of the state is perceived as an alternative to the market in allocating housing: as a provider of last resort (Boughton, 2018). Yet there are possible health benefits from a larger sector of public tenure, or a state that intervenes in the private sector more heavily via regulation. Madden and Marcuse (2016, p.142) argue that the question will always be how the state is involved in housing, not whether it should be, as 'the housing system [public or private] is inextricably tied to the state, law, and public authority'. Much attention has been paid to the consequences of the 'roll back' of the state and the 'roll out' of neoliberalism and marketized provision of services (Peck and Tickell, 2012). Historically, the expansion of private renting sectors, subject to less regulation, has been shown to lead to problems. As Murie (2018, p.492) argues, 'rather than a less regulated market releasing enterprise and relieving shortages there was a concern about housing supply, standards and management practices that affected economic growth, health and well-being'. Much research has been dedicated to the relationship between housing and the state, particularly in England, where the social housing sector has begun to occupy a relatively new space (see, for example, Anderson, 2004; Boughton, 2018; Malpass, 2005, 2008; Malpass and Murie, 1994; Mullins and Jones, 2015; Murie, 2007; Tunstall, 2015). A growing third sector forms a crucial component of this research area, and its relationships and comparisons with other elements of the welfare state such as the health services remain important (Harloe, 1995; Malpass, 2008; Pawson and Sosenko, 2012; Rees and Mullins, 2016).

Some housing associations have been shown to have actively distanced themselves from the UK welfare state, during a period in which the state has become more liberal and the voluntary housing sector has been encouraged to embrace commercial goals and private sector working practices (Blessing, 2013; Moore, 2012; Tang et al., 2017). Yet this is a complex area. There is evidence of housing associations diversifying their portfolios and pursuing commercial business activity at the same time as state subsidies have been reduced, and this has been termed a 'critical juncture in the housing sector's history' (Manzi and Morrison, 2018, p.1926). Mullins (2000) noted 'the ability of some housing associations to draw on accumulated surpluses…to indicate their growing independence from the state' and their emergence as a third sector is consistent with 'a shift from [a] social democratic to liberal

model' (Mullins, 2000, p.268). Research since the late 1990s recognises that housing associations increasingly perceive their role as a public housing service evolving into a charitable organisation. Currently it is common for third sector housing providers in the UK to offer many socially focussed services 'above and beyond their basic function of providing housing' (Clarke et al., 2014, p.6). Mullins's (2000, p.270) interviewees framed the scale of sectoral change as "changing the course of a sea tanker…we've pulled the organisation around from being 'bricks and mortar' led to face in the right direction, towards social investment". Housing associations have begun to encompass more diversity in their businesses, and social landlords have been found to employ a variety of both practical and social support services 'in order to affect their tenants' disposable incomes and help mitigate the effects of poverty' (Clarke et al., 2014, p.4). The impact of this activity is deserving of further attention, providing part of the rationale for this thesis.

There is an extensive research literature examining the purpose and function of the social housing sector in the UK (Gregory et al., 2016; Pawson and Mullins, 2010) as well as internationally (Harloe, 1995). Researchers have argued that the housing sector should work in closer partnership with other parts of the welfare state to facilitate a more holistic influence on health. Holding et al. (2019) suggested that social housing departments offering holistic support, alongside their traditional housing officer functions, may have a significant impact on mental health issues faced by their tenants. In the UK, the 'smaller but still significant degree of public sector involvement and an expanded voluntary sector' suggests that the housing sector still has a role to play in carrying out public sector priorities (Lobao et al., 2018, p.404). Manzi and Morrison (2018, p. 1924) highlight the 'stark dilemma' faced by social landlords about 'whether to continue a strategy of "profit for purpose" or to embrace an unambiguously commercial ethos' as the state retreats from housing activity.

The development of commercial practices to sustain these businesses, such as building housing at market rates rather than social rates, is likely to alter the face and function of the housing sector as a publicly funded service. Housing associations are expected to have increased exposure to financial risk, and examples from the Netherlands in the 1990s (when housing associations entered the private market) may serve as a warning. The 'exposure to risk amongst Dutch housing associations…resulted in systemic failure, requiring state

intervention and a return to the core social functions of managing and developing housing for low income groups' (Manzi and Morrison, 2018, p.1925; see also Nieboar and Gruis, 2014; Van der Kuij et al., 2016). Regardless of the size of the state, however, it might still be possible to design a healthy housing system regardless of the political economy and governing ideology. Smith (2012, pp.44-45) suggests that a healthy housing system could incorporate physical and psychosocial considerations in any tenure, and that 'the real challenge therefore is to imagine what a health-sensitive society could and should look like: how we would recognise it, what kind of housing system might sustain it, and what steps must be taken to achieve it'.

An under-explored area of research is consideration of changes in the roles and responsibilities of certain social housing providers which are responding to market influences and pressures. Murie (2018, p.492) argues that 'in spite of sustained financial and political pressures it is inaccurate to portray housing associations as having become private landlords', and that it is premature to predict they will do so in future. Instead this 'diversification into other activity could form part of various contingent strategies to sustain social lettings' (p.499), thereby continuing to offer a possible health benefit. How, then, does this relate to health? Despite the consensus that housing impacts on health, no sustained research attention has been devoted to charting the effects, or potential effects, of the changing focus of housing association functions or public housing activity on health (inequalities) and wellbeing. There is scope to consider changes in the roles and responsibilities of certain social housing providers which are responding to market influences and pressures. The role of housing associations has yet to be explicitly considered in terms of the housing sector's influence on health, and health inequalities.

Critical perspectives on health inequalities

Despite medical advances in wealthy countries that have largely eradicated the infectious diseases that used to foreshorten life, health inequalities remain a pervasive feature of contemporary society. Non-communicable diseases (NCDs), diseases of affluence and what Case and Deaton (2020) call 'deaths of despair', linked to suicide, drug overdoses and alcohol-related liver disease, remain hugely threatening to health, and in most affluent countries

these problems follow a steep social gradient. In order to understand which housing-related interventions or policies might reduce these health problems, and the unequal ways they are experienced, it is important to engage with the literature exploring their causes.

The Social Determinants of Health framework and the 'causes of the causes'

It is generally accepted amongst researchers that the primary drivers of ill health are social, rather than medical in origin. Housing is widely recognised by the public health and clinical research community as one of these important social determinants of health (Buck et al., 2018; Swope and Hernández, 2019). This framework for understanding health inequalities has held primacy since the World Health Organisation's 2008 Commission on Social Determinants of Health, chaired by Professor Sir Michael Marmot, published its report, *Closing the gap in a generation: health equity through action on the social determinants of health* (2008). Some researchers argue that 'health comes first, and income growth and social equality follow' (Canning and Bowser, 2010, p.1255), but these views are in the minority. Although 'attributing causation is complex' (Marmot et al., 2020, p.13), and debate exists over the most effective strategies to combat them, non-medical factors are likely to be responsible for between 80 and 90 percent of health outcomes (Magnan, 2017, McGovern et al., 2014). Health determinants (whether social, structural, individual, political or commercial) can be broadly categorised into 'upstream' or 'downstream' factors (Braveman et al., 2011). The further 'upstream' factors, such as housing, are the most likely to work preventatively, to create, or protect good health, rather than treat or cure illness. While health services and medical interventions have a critical role in the treatment of those who are sick, 'acting alone, the health sector cannot tackle health inequalities' (Marmot and Bell, 2012, p.5).

Dahlgren and Whitehead's (1991) 'Rainbow Model' illustrates the several layers of individual, social and structural interrelated factors that impact on health, and the overarching importance of upstream influences (Fig. 2.1). Housing is specifically identified as one of the important 'socio-economic, cultural and environmental conditions' that affects health outcomes, and its interplay with the other SDOH is clear. It is well documented that housing quality has a direct relationship with income (Fusco, 2015; Tunstall et al., 2013; Wilkinson and Pickett, 2009), and income and wealth have a direct impact on the majority of other health

influences. Relative consensus exists that these numerous 'social factors are powerful determinants of health', and considering the complexity of causal pathways including those that are situated far upstream, such as income and education, researchers have noted that 'it is indeed remarkable that there are so few exceptions to the general rule' (Braveman and Gottlieb, 2014, p.27).

Fig 2.1: The **Dahlgren-Whitehead Rainbow** of Health Determinants

Source: Dahlgren and Whitehead (1991)

These social factors, however, are not distributed similarly or fairly across society, and the global presence of large inequalities in both mortality and morbidity illustrate substantial, preventable health injustices. Link and Phelan (1995) articulated a theory of 'fundamental causes' to explain the enduring association between socioeconomic status and mortality, despite medical advances, concluding that the fundamental cause of health inequalities is 'inequalities in social position' (Douglas, 2016, p.110). This is understood by several researchers as the identification of the 'causes of the causes' (Marmot, 2008), or individuals who are at 'risk of risk' (Link and Phelan, 1995). Libman et al. (2012, p. 6) describe the scenario 'where contextual factors that put people at risk for risk are stacked highest in communities already struggling with other life and health consequences of low socioeconomic status'. In relation to housing, a correlation has been demonstrated between disadvantaged housing

conditions and higher prevalence of injuries, infectious, and chronic diseases (Jacobs et al., 2009). Social position is strongly related to income and wealth, and The Marmot Review (2010) along with much subsequent work has made the case that stubborn income inequalities are the main cause 'of the failure to reduce relative health inequalities in Britain' (Howden-Chapman, 2010, p.1242).

The likelihood of suffering from health injustice is determined prior to birth. Research that focusses on life-course reiterates that 'inequality is cumulative over an individual's lifetime' and that privilege and inequalities are passed between generations (Howden-Chapman, 2010, p.1242). Intergenerational transmission of inequity has been found to influence numerous health-affecting risk factors including levels of education, nutrition and social protection (which includes decent housing) (WHO European Region, 2014). As the evidence base on cumulative disadvantage grows, 'we learn more and more about the futility of trying to change individual behaviour, and more and more about the importance of influences in the womb and early childhood' (Pickett and Dorling, 2010, p.1232). Although the effectiveness of different interventions is subject to debate, 'everyone seems to agree on the importance and key ingredients of a comprehensive ECD [Early Child Development} policy' (Lynch et al., 2010, p.1245). Giving children 'the best start in life' by improving healthy development of children under 5 was the number one recommendation of the Marmot Review (2010). A safe and secure home is an essential feature of this. There is a growing evidence base highlighting the involvement of housing associations in programmes or interventions specifically targeting the health and wellbeing of children and teenagers (see for example Aston et al., 2010; National Children's Bureau, 2016).

(Proportionate) Universalism

Health interventions are recommended by Marmot et al. (2010) to be most effective when applied using the principles of 'Proportionate Universalism'. The concept of proportionate universalism has not yet been extensively applied in housing studies. It can be understood as 'the resourcing and delivering of universal services and a scale and intensity proportionate to the degree of need' (NHS Scotland, 2014, p.3). So, services that are not exclusionary, but are to some degree targeted towards those that have the most need of, or the most to gain from

them. This approach is broadly supported by other work, although debate continues over the best way to apply it, as universalism itself can be either 'general' or 'specific' (Carey et al., 2015). Universalism which confuses 'impartiality' with 'uniformity', and 'equality of treatment' with 'sameness of treatment' does not account for differences in ability to access services, or different needs (Carey et al., 2015, p.3). Proportionate universalism instead 'balances targeted and universal population health perspectives' and takes proportionate action depending on the levels of need or disadvantage within populations (Lu and Tyler, 2015, p.3).

Universal approaches are argued by many to be a matter of social justice. The 2008 WHO Commission on SDOH report began with the powerful statement that 'Social Injustice is Killing on a Grand Scale' (CSDH, 2008, p.26). Rawls's Theory of Justice states that a fair allocation of resources would take place behind a 'veil of ignorance' in a society in which all beneficiaries are free and equal (Rawls, 1971). Universalism is argued by many to be the best approach to avoid stigmatising individuals (Lynch et al., 2010), and also to be more efficient than selectivity (Danson et al., 2012). However, as Carey et al. (2015, p.6) argue, 'a value free assessment of need in political terms does not exist'. It is also possible for 'the commonly recognised public health goals of improving health and reducing health inequalities' to be 'in tension with one another, and deciding which to prioritise is a normative decision' (Smith and Katikireddi, 2013, p.198). Some researchers have related this to housing issues, and suggest that a more universal approach to housing might challenge 'the extent to which the operation of housing and housing finance systems in market societies has become incompatible with an ethic of care' (Smith, 2012, p.42).

Health inequalities impact across the whole social gradient, and disadvantage everybody who is not at the very top (Marmot, 2010). The Marmot Review explicitly 'identified the condition to be addressed – the disease – as inequality itself: the unfair, unjust, and (to Marmot and his colleagues) unacceptable inequalities in health between those at the top of the social scale and everyone else' (Nathanson and Hopper, 2010, p.1237). Therefore, it is necessary for a combination of upstream and downstream measures to tackle the issue and impact on the gradient as a whole. A small number of countries have provided examples of holistic strategies that target the entire social gradient. Norway's health inequalities strategy

explicitly combines universal and selective measures at all levels, covering 'upstream social reform, mid-stream risk reduction and downstream effect reduction' (Whitehead and Popay, 2010, p.1235). In Sweden, 'special attention has been paid to limiting social inequality as a way of reducing health inequalities' (Daniels, 2013, p.178). As Marmot and Bell argue, 'focussing on the bottom 5-10% of the population is necessary but not sufficient' (2012, p.5). More universal welfare strategies are not only correlated with shallower social gradients and better opportunities for social mobility and meaningful employment, but also with higher public support for welfare policy in general (Larsen, 2008).

Individual vs. population health: inequities or inequalities?

Given the complex interplay between structural and individualistic determinants of health, there is debate over the distinction between 'inequality' and 'inequity'. To consider housing determinants or housing interventions in light of health inequalities, it is necessary to question how far they seek to redress the unequal distributions of resources that are either unjust or avoidable. Marmot uses the term 'health inequities to refer to those systematic inequalities in health between social groups that are judged to be avoidable by reasonable means' (Marmot, 2015, p.48). While some inequalities (or 'disparities') might be unavoidable, for example talent, or individual characteristics, Sennett (2002, p.262) argues that we should work to removes those inequalities that are unjust, or avoidable – those that are social in origin. Some egalitarians (such as Temkin) consider luck to be a crucial factor in determining inequalities, and do not necessarily see this as an injustice, because bad luck cannot always be prevented by reasonable means. However, the moral cause for action can still be made. Hausman (2013, p.110) argues that 'beneficence provides a simpler reason to be concerned about the grotesque health equalities that characterise our era than does egalitarianism: millions of people have unnecessarily stunted lives. What more reason do we need for action?'. Tawney made the case in 1931 that despite unavoidable differences in individual abilities, character and intelligence, it is 'the mark of the civilised society to aim at eliminating such inequalities that have their source not in individual differences but in its own organisation' (Tawney, 1952, p.49). Daniels (2013, p.79) also uses 'inequities' to refer to health inequalities that are the result of 'socially controllable factors', but notes that

'unexpected complexity faces policy makers when they aim to reduce inequalities in this way', i.e. through social policies.

Interventions that have demonstrated improvements to health outcomes (such as lower rates of smoking or increases in life expectancy) do not always have a positive influence on health inequalities. Rather, campaigns based, for example, on educating whole societies (non-targeted programmes) about tobacco harms have been taken up to a greater degree by more advantaged groups, so have a 'negative equity impact' (Hill et al., 2013). This has the effect of benefitting health outcomes overall, but actually worsening health inequalities. The pursuit of health justice as well as health improvement can present challenging contradictions between those who advocate the egalitarian approach and those who favour maximisation (Nord et al., 1995). At what cost to aggregate health gains is it acceptable to reduce unjust health inequalities? Daniels (2013, p.180) asks, 'does the answer depend on the type or degree of injustice? Or, the relative gains and losses to the different groups? In either case, reasonable people are likely to disagree about the fairest policy'. Most societies have limited resources at their disposal, and therefore disagreement over where investment is best targeted can lead to unforeseen or unwelcome consequences. Extreme views, such as zero or total priority to those worst affected 'are implausible' yet 'we are woefully ignorant of the actual magnitudes of the trade-offs that are involved in one type of intervention rather than another' (Daniels, 2013, p.194). These population wide considerations are also frequently overlooked in housing-health studies, highlighting the need for qualitative, holistic studies that explore such unavoidable complexities and trade-offs.

Housing associations increasingly provide targeted, rather than universal, help for the neediest in terms of housing, and latterly health and other services too. Academic clinicians have written about 'frequently observing confusion about the difference between "health improvement" initiatives to improve the population's health and "health inequalities" initiatives to reduce the gap and/or gradient' (Douglas, 2016, p.112). It is possibly easier to focus on individualised solutions, despite the fact that all groups are not equally able to take advantage of them. This tension is reflected in the ways social housing has come to be seen increasingly as a safety net for vulnerable people, rather than fulfilling general needs, reflecting a focus on downstream action. An English Public Health Director argues that

'disproportionate coverage' is often given to 'solutions oriented in individual behaviours [and] personal responsibility, often at the expense of changing the context in which people live' (Fell, 2020). The evidence-policy cycle represents a challenge to this goal. Perhaps 'it is simply harder to establish an evidence-base for the impact of social or fiscal policies on health inequalities than it is for more individual (e.g. lifestyle-behavioural or healthcare) interventions' (Smith and Eltanani, 2014, p.13). The case for effective Proportionate Universalism is strengthened here, as 'action to reduce health inequalities must be proportionate, with more intensive action lower down the social gradient, but action must also be universal, to raise and flatten the whole gradient', by impacting on structural, contextual and environmental factors (Marmot et al., 2020, p.15). It is insufficient to focus on one or the other.

Some critics of redistributive policies or more interventionist welfare regimes argue that individuals are responsible for their own 'lifestyle risks' or health 'behaviours', and therefore health inequalities that result from these risk factors are not necessarily unjust. Studies have identified persistent attitudes and perceptions that some households are 'workless largely through choice' and happy to 'languish on benefits', even amongst practitioners who work with unemployed people (Shildrick et al., 2012, p.8). Research from a centre-right think tank has argued that it is possible to incentivise unemployed people into work by reducing benefits, as well as suggesting that 'the Government should consider ways to incentivise and encourage appropriate housing associations to run employment and skills programmes as part of their duty to "empower" their residents' (CSJ, 2018, p.19). But this does not reflect the reality of the structural forces which dictate employment and housing markets. As Bambra argues, 'the relationships between work, worklessness and health inequalities are influenced by the broader political and economic context…[these] are not the discrete activities of individuals, but are essential parts of the way in which the totality of society is politically, socially and economically organised' (Bambra, 2011, p.746). Pierson argues that poverty itself is the 'ultimate indicator, signalling that some people are on the receiving end of broad social and economic inequalities' that ultimately result in reduced capacity to make the kind of choices available to those above the poverty line (Pierson, 2016, p.10). The risk of overt focus in research and policy on individual choices and behaviours is that it

disconnects the effects of systemic, macro-level injustices (i.e. health inequalities) from their upstream causes.

Conceptualisations of population health systems are concerned with both structural and individual health determinants, and recognise their interactions (Fink et al., 2016). Housing is identified as a key determinant by The King's Fund (2018) in *A vision for population health*. The explicit references to housing in this vision, however, focus on individual level hazards, such as children's accidents, or deaths related to low temperatures (Buck et al., 2018, p.23). Many studies have criticised the 'lifestyle drift' in public health research, which responds to policies that have more emphasis on individual health, behaviours and personal responsibility, as opposed to focussing on structural and systemic causes of health inequalities (Douglas, 2016; Mackenbach, 2012; Whitehead, 2012). The 'inverse evidence law' means that 'it is much easier for traditional forms of research to generate evidence on individual ('downstream') interventions compared with social ('upstream') policies' (Smith et al., 2016, p.298). Interventions targeting downstream individual behaviours can only impact on health disparities to a limited degree (Daniels, 2013). Researchers have argued for designing healthier environments and policies, to establish societies that are health creating benefiting whole populations and not just small, targeted groups. Efforts to create or move towards population health systems present a challenge to the dominant paradigm of 'medical-individualist models of health' (Lynch, 2017, p.653) that persist, despite the slimness of the evidence base on the efficacy and effectiveness of specific interventions (Petticrew, 2007). Compounding this challenge are 'efforts to ensure policies are only pursued when they are "evidence-based" [which] may be contributing the much-discussed problem of "lifestyle drift" in health inequalities' (Smith and Eltanani, 2014, p.6). This creates an imbalance between the problem and the cause, and 'policies enacted with an eye to reducing health inequalities tend to target individuals and their behaviours rather than the structures within which these behaviours take place' (Lynch, 2017, p.656). Population health systems require more action on the causes than the effects of inequalities. Mair and Jani (2020, p.128) argue that 'continued attention for individual behaviour change strategies without equal emphasis on upstream determinants of health' cannot hope to challenge 'the epidemic of chronic illness, multimorbidity, and health inequality that we face'.

Challenges of individualism are documented in housing research as well as other areas of public health. Gibson et al.'s (2011, p.181) systematic review of 130 publications on housing interventions found that the 'majority of the interventions included in these reviews could be considered to address health inequalities by tackling disadvantaged groups'. Criticism of targeted approaches also apply in both fields, such as the paternalistic or stigmatising attitudes towards those deemed 'needy'. Researchers note the particular difficulties for early child development services, and getting the balance right between 'accurate targeting of services, greater outreach and uptake by those who would benefit from greater support, potentially more efficient use of limited resources and the need to properly support rather than stigmatise young, disadvantaged mothers' (Lynch et al., 2010, p.1246). Nathanson and Hopper relate this 'to the lady health visitors of the late Nineteenth Century…as the means of bringing light to the heathen' (Nathanson and Hopper, 2010, p.1238). Others have argued that it might be possible to achieve a degree of 'justifiable paternalism' in supportive housing services if this results in improvements to the lives of disadvantaged people (Parsell and Marston, 2016). It is necessary to ensure adequate help and support is given to those who need it, but that this support empowers individuals and does not patronise, exclude or residualise. A proportionately universal approach might achieve this balance.

Empowerment matters at the community level as well as individual, and 'a sense of community control is also important to overall community health' (Marmot et al., 2020, p.98). To successfully design or deliver locally appropriate solutions to health inequality, 'local delivery requires effective participatory decision making at a local level' which will 'only happen by empowering individuals and local communities' (Subramanyam et al., 2010, p.1222). Neighbourhood characteristics, and neighbourhood-level socioeconomic status has been shown in the US to be 'the strongest and most consistent predictor of health outcomes' (Yen et al., 2009, p.458) and housing is an important feature of any neighbourhood. Matheson argues that 'local geographic area has proven singularly important in the reproduction of health inequalities' as the site of multiple systemic disadvantages that compound in unequal health outcomes. These complexities have 'led to frameworks that incorporate local context like socio-ecological and political economy perspectives' (Matheson, 2020, p.4).

As has been suggested at the national scale, it has been argued that relative inequalities *within* cities and regions are more influential on health outcomes than overall levels of deprivation. Walsh et al.'s (2010, p.493) study of Glasgow, Manchester and Liverpool found that 'areas with higher levels of income inequality experience correspondingly poorer health outcomes at equivalent areas of average wealth'. The importance of local conditions for citizen empowerment and improving health has also been acknowledged by researchers analysing devolutionary agendas and processes. Rae et al. (2016) argue that successfully overcoming deprivation and disconnection at a neighbourhood level requires an approach that is sensitive to local conditions. This is necessarily a complex process, likely to be affected by place-specific sensitivities and not suited to a one-size-fits-all approach.

Analysis that seeks to understand the impacts of specific factors (and in this research the focus is housing) on health inequalities must be informed by, and aware of, these political and social contexts. Health inequalities are extremely complex in their origin and therefore any efforts to reduce them must be considered in light of the relationships and interdependencies between health influencing factors.

Complexity in the health-housing relationship

The intersection of health inequalities and housing research informs a holistic interpretation of the social model of health, with its inherent complexities. The social model 'acknowledges other viewpoints, knowledges and discourses beyond the medical profession' in terms of 'understanding, interpreting and experiencing health and illness' (Yuill et al., 2010, p.11). Health is increasingly understood not to be simply a medical issue. Yet, like housing, the consequences of this system are experienced by whole populations, along gradients that vary in steepness depending on government policy, and the roles of relevant sectors. Although an awareness of 'structurally determined health risks' has existed for decades (Laverack and Labonte, 2000, p.255), the research has illustrated a trend in research and policymaking to apply interventions at an inappropriate scale. Rather, health inequalities have their foundations in the deeply rooted social injustices that have a negative effect on the health of all but the most privileged members of society (de Leeuw, 2017; Libman et al., 2012; Marmot,

2015). Health interventions must be considered in the context of these structural, interrelated causes, rather than as isolated or individualised events.

Intersections between the research agendas and breaking down silos

Intervention studies spanning both the health and housing fields are frequently individualistic in nature, concerned with isolated factors such as dampness. This is similar to the way clinical interventions and medical trials are carried out, targeting the symptoms and effects of illness, rather than the wider structures and systems that are understood to cause perpetuating and inter-generational inequalities. In housing studies, this has led to conclusions such as 'interventions carefully targeted at those in greatest need may hold the most promise for improving health' (Gibson et al., 2011, p.182). Such arguments do not necessarily differentiate between population and individual level health, but to reduce health inequalities the action needs to be at the aggregate level. Studies that do not take account of the causal complexities of health inequalities cannot control for wider contributing or confounding factors. Therefore 'instead of looking at individual risks associated with housing, the housing and health community must accept and tackle new, larger, and more general challenges that will force each actor to consider housing and health in holistic terms' (Braubach, 2011, p.580). It might be easier to tackle health influences associated with behavioural and lifestyle factors, but structural, 'upstream' factors such as education, employment conditions and welfare systems have a stronger influence on health, and their uneven distributions contribute to and maintain health inequalities (Acheson, 1998; Graham, 2004). These determinants need to be considered in relation to each other, particularly given that the cumulative impact of exposure to risk factors may lead to the largest health inequalities.

Understanding has improved regarding the cumulative impacts of factors affecting health, which are often structurally rooted. For example, in 2010, the Marmot Review was criticised for the fact that 'ethnicity and its intersections with religion and social class are usually treated as confounders in the analyses', which risks underplaying its importance, and 'there is little discussion of the effect of possible pathways of socio-economic deprivation such as political disenfranchisement, systematic discrimination and institutionalised racism' (Howden-Chapman, 2010, p.1243). More recently, the intersectional relevance of such

factors has been more thoroughly examined (Bauer, 2014). It is recognised that inequalities simply categorised by broad indicators such as housing tenure may not 'recognise the heterogeneity of experience within groups' (Rahman and Whittaker, 2019). Hill (2016, p.100) argues that intersectionality 'offers a useful framework for understanding the multiple layers of advantage and disadvantage relevant for health and wellbeing'.

Housing is a particularly complex health determinant, because it functions as both a symptom and a cause of other health-affecting factors. However, housing is often grouped with other 'underlying health determinants' such as poverty, environmental threats or social discrimination (Laverack and Labonte, 2000, p.255). This risks overlooking the particular ways in which housing can function as a health determinant to either alleviate or compound related health disadvantages, as well as how housing disadvantage may be a manifestation of other social injustices. These factors can interact at the wider neighbourhood level in order to impact more broadly on population health, and individuals' experiences of place are relevant throughout the life course (Pearce et al., 2016). Baba et al. (2016, p.1622) argue that 'places are residential psychosocial environments that can affect individual and collective wellbeing through factors such as environmental quality and relative social position'. The implication, they argue, is that analyses of how particular housing circumstances might impact health in a positive or negative way need to be informed by an awareness of this interplay.

Understanding housing as both a symptom and a cause provides a useful lens through which researchers may develop their understanding of health inequalities. A whole system challenge to the status quo of large health inequalities and unevenly distributed housing has the potential to act as a positive force, improving population health "through better and equally distributed housing conditions' (Braubach, 2011, p.580). However, such challenges are likely to be more difficult within neoliberal frameworks which emphasise 'individuality over collective social responsibility' (Libman et al., 2012, p.4). Smith describes the way that 'health inequalities flow from a suite of discriminatory practices bound together by the institutionalisation of carelessness…[these practices] may thrive within neoliberalism', but they do not have to (Smith, 2012, p.42). Instead, she argues that 'health discrimination and institutions such as ingrained carelessness could thrive in any political setting or any kind of market' (p.44) but practices and policies could work to either exacerbate or alleviate some

manifestations of this, and of other fundamental causes. In order to address such systematic issues, it is necessary to make links between traditionally siloed research agendas.

The complex interplay and interdependencies between the various determinants of health indicates that silos in research are unlikely to help tackle the issue of health inequalities. Linking housing studies with health and economic research is important, particularly given the economic roots of health injustice. Chandra and Vogl (2010, p.1229) argue that 'economists would do well to read epidemiology literature for new ways to improve population health, while epidemiologists would benefit from taking causality more seriously and being humble about the difficulty of designing smarter policy'. Some epidemiologists have argued that the Marmot Review uses 'the language of economics, not social epidemiology or progressive public health', for example by focussing on 'maximising the "capabilities" of children and young adults' (Pickett and Dorling, 2010, p.1233). A cross-disciplinary approach to health justice could also be informed by Nussbaum's '10 Central Capabilities', which she argues are the foundations for a good life (Nussbaum, 2011; see also Johns et al., 2020). Others suggest approaching the issue in terms of 'healthy and unhealthy economic growth strategies' (Whitehead and Popay, 2010, p.1236). Research by Lupton et al. (2019, p.19) has argued that inclusive growth strategies may work in two ways to impact health: through 'economic structures and activities that are more inclusive by design' with inherently fairer systems that 'support health, wellbeing and community life'; and by 'making sure that local people are connected to [existing] economic opportunities' through physical and social infrastructure. Murie (2018) makes the link between successful economic development and a housing system that reproduces a healthy workforce. These research agendas touch on several of 'the sectors that have been identified persistently' as having an impact on individual and population health, including education, housing and urban planning, transport, welfare support and sustainable development (de Leeuw, 2017, p.334).

Researchers pursuing a more sensitive and comprehensive agenda have embraced theoretical frameworks such as Social Ecology to better examine political economies and 'the more complex and interactive nature of the determinants of health and the need for a more holistic approach if these are to be addressed' (Beck et al., 2010, p.129). The social ecological perspective when applied to the 2007-08 United States' foreclosure crisis presented 'a

context that enables us to examine the impacts of the USA's neoliberal financial and health care policies on the intersections of health and housing' (Libman et al., 2012, p.2). This approach emphasises the 'multi-level cumulative and reciprocal relationships' between housing and health (Libman et al., 2012, p.3). Lawrence has also advocated socio-ecological approaches, arguing that individual factors related to housing or health must be considered in relation to each other, in order to understand their compounding impact. The 'multiple components of housing units and their surroundings need to be considered in terms of their *potential* and *effective* contribution to the physical, social and mental well-being' (Lawrence, 2011, p.577). Matheson uses complexity theory to describe how the whole is greater than the sum of the parts, where 'health inequality is viewed as emergent, and causes are systemic and compounding' (Matheson, 2020, p.1).

Integrating policy agendas, housing-health interventions and working in partnership

Scholarship that considers 'Healthy Public Policy', or health-in-all-policies approaches, makes connections between these relevant areas of action. Healthy Public Policy, characterised by an explicit concern for health and equity in all areas, 'makes healthy choices possible or easier for citizens…[making] social and physical environments health enhancing' (de Leeuw, 2017, p.333). This applies not just to *health* in all policies, but health *equity* in all policies too. Integrating concerns about health equity is necessary at multiple levels, requiring action from national and local governments: 'National policies will not work without effective local delivery systems focussed on health equity in all policies' (Subramanyam et al., 2010, p.1221). In some places, devolution agendas have been directed explicitly towards this, which highlights the importance of the locus of power and decision making for health outcomes.

Devolutionary policies and processes echo some of the health inequalities narratives of empowerment and emancipation. It has been suggested that 'empowered communities could have the capability to undertake a more active role in the provision of services such as healthcare, with the associated potential for impacting a range of health issues' (Baba et al., 2010, p.1623, see also Woodall et al., 2010). In some places, devolutionary agendas have

explicitly included the housing sector. For example, in devolved areas in the UK such as Greater Manchester, housing has been recognised as an 'enabling' priority to support the devolution of health and social care services. The 'immediate priority is to reduce demand for health care through the integration of housing interventions at the points of hospital admission and discharge' (Leng, 2015, p.487), but the wider policy agendas are more ambitious (Chevin, 2014). The housing sector is viewed as an important partner for the health and social care sector, and suggestions have been made that, in the UK, partnership working will be 'key to the way housing would do its business in the future' (Richardson et al., 2014, p.26). This requires attention from researchers as the housing sector takes a more explicit role in the task of reducing health inequalities.

Evidence presented in The Marmot Review revealed the extent of the 'massive gap between knowledge and implementable policy' (Chandra and Vogl, 2010, p.1229). Smith and Eltanani (2014, p.7) also illustrated this gap, arguing that 'although health inequalities research is often depicted as fractured…there are clear areas of consensus among researchers as to the kinds of policies likely to reduce inequalities'. Areas of consensus include: a more progressive distribution of wealth and income; better investment in targeted interventions for disadvantaged groups; and improved regulatory policies to limit the effects of behavioural and lifestyle risk factors. The economic causes of health inequalities are understood to require economic solutions, yet the political sensitivities of tackling 'the top end of the social hierarchy, as well as the bottom' are challenging (Pickett and Dorling, 2010, p.1231). These 'translation gaps' from evidence to policy to practice 'have increasingly been seen as major impediments in many areas of health research' (Lynch et al., 2010, p.1245).

The health inequalities that pervade our societies are rooted in macro-level factors, and in the structures of the political economy, yet the impacts are felt at an individual and household level. Atkinson (2013, p.33) identifies the 'major contribution' of the 2008 WHO Commission on SDOH as enlarging 'the scope of the policy debate: we have to move beyond the medical care/health status link' and 'consider tax policy as well as health spending, and this means income tax and not just health-related taxes such as those on cigarettes. Individual doctors should be concerned not only with prescriptions and hospital referrals, but also with employment services and family relationships'. It has been suggested that a multiple

pathways approach to healthy housing is crucial, and that 'ecological interventions, which target multiple levels (e.g. individuals, households, housing and neighbourhoods) are most likely to be successful' (Gibson et al., 2011, p.181). It is possible, therefore, that a housing sector which is broadening its focus may be able to also influence health outcomes, if the scale of the response to health inequalities takes into consideration the scale of the causes.

Formative life experiences, such as infancy and early childhood, are influenced by numerous determinants, of which a stable and healthy home environment is just one, and this continues throughout the life-course. No single factor or intervention operates in isolation from other influences, and a sensitive, contextual understanding is always necessary. Housing itself 'is a complex intervention applied to a heterogeneous group for a range of reasons', therefore 'different aspects of residential change for particular types of household' are unlikely to result in uniform impacts (Kearns et al., 2011, p.597). Housing is identified by Braubach (2011) to be both a 'social' and an 'environmental' determinant of health, and the range of disciplines that directly relate to this topic include: 'housing, engineering and construction, public health, environment, social welfare, urban planning, and building management…[action] from all these sectors is necessary to provide healthy housing and shows the complexity of the subject, as well as its great potential to increase the quality of life of citizens through providing adequate and safe homes' (Braubach, 2011, p.579). Housing as an 'intervention' is applied throughout the life-course and particular attention is often paid to the housing needs of children and the elderly. In keeping with a universal public health perspective, however, housing needs can be viewed as of perpetual and equivalent relevance at every age.

The complexity of the issues has led to researchers making 'repeated calls for intersectoral action' (de Leeuw, 2017, p.333). Sectors that are more aware of the impact of their decisions in other areas may be better able to avoid some of the unintended consequences and unacceptable trade-offs that have accompanied well-meaning but poorly informed action. The Marmot Review urged local areas to 'integrate planning, transport, housing and health policies to address the social determinants of health' (Marmot, 2010, p.134). The Planning sector, for example, is crucial to the integration of health, social care and housing agendas, and numerous researchers have recommended that personnel be recruited to span such departments, to 'break down silo barriers and greatly assist the integration of health into

planning policy and decisions' (Chang and Ross, 2015, p.70, see also Carmichael et al., 2012). Recommendations such as these alone, however, are unlikely to present a strong challenge to the existing causes of spatial health inequalities. A risk remains that 'areas of poor health are likely to be areas with marginal development viability' (Chang and Ross, 2015, p.73) therefore consideration of benefits to other areas and sectors is needed during the planning process. Interventions that lead to residualisation or other unintended consequences that indicate poor health equity are undesirable (and theoretically avoidable). It is necessary to tackle housing and planning practices that are likely to increase the spatial and health inequalities that result from singular, insensitive agendas that do not take account of the fragile ecology linking these factors and relationships.

Increasing international interest is emerging in research that explores how health care resources can be deployed in new ways, to complement more conventionally place-based services targeted at deprived neighbourhoods. In the United States, Rosen et al. (2018, p.1) found that success in health-related outcomes of the Comprehensive Communities Initiatives in California required 'an enabling local government context'. This recognised the complex challenges related to implementing holistic, multi-strategy place-based interventions designed to tackle spatial inequalities and injustices, particularly in contexts where government funding has declined. The resultant increase in reliance on the private or voluntary sector to provide services in these contexts (Marwell, 2004), is argued by Rosen et al. (2018, p.2) to still be more successful in communities that have comprehensive and fruitful engagement with local government, which retains 'essential public authority'. This may prove an influential factor for housing associations working across local authorities in England.

There is a strong consensus that much more focus is needed on preventing, rather than treating, poor health outcomes, in order to avoid social inequalities becoming life-limiting or life-shortening injustices. It is recognised that sectors such as public housing, working in social, rather than medical settings, have an increasingly important role to play in the prevention of illness. Housing is viewed as a site of prevention, and as a means of protecting good health and prosperity. In England, although preventing illness 'has traditionally been the responsibility of the NHS…a more holistic view of the challenge is needed, putting prevention in the context of the social determinants of health (Marmot and Bell, 2012, p.9).

This is the launchpad for this research. Research on housing interventions requires closer engagement with conceptual framings of health inequalities, in order to better understand the possible impact and potential of the housing sector to reduce them. Housing associations in the UK may have a valuable role to play in the fight against health inequalities, through their provision of both 'hard' and 'soft' housing-related determinants of health. As social housing providers take an increasingly active role in health concerns beyond the bricks and mortar of their homes (particularly in regions that are experiencing devolution in relevant areas of decision and policy making), this thesis will examine their activities in the context of this scholarship.

Summary

This chapter has outlined the developments in scholarship concerned with the relationship between housing and health, both at the individual level (housing and health/illness outcomes) and at the population level (health inequalities). It suggests that by considering concepts and frameworks that are prominent in health inequalities research, such as proportionate universalism and the social determinants of health framework, it may be possible to offer richer, more comprehensive analysis of housing issues. The role of housing associations has been shown to be related on multiple levels to the joined-up, intersectional agendas of public and population health. It forms a crucial element of health-in-all-policies approaches, which confront the complexities inherent in such health-housing relationships. Research in both health and housing studies has become increasingly aware of this relationship, and it has been suggested that growing engagement with, and involvement in, health issues by housing providers may operate as a public health tool, as a way of addressing inequalities. There is scope for an in-depth empirical assessment of the ways housing associations are changing and adapting their function, and working in partnership with other health-influencing sectors, with potential relevance for both theory and policy. The following chapter will analyse the policy landscape in the UK that is relevant to this research agenda.

Chapter Three
Policy Review

Introduction

Understanding the evolution of housing and health policy, and their interrelationships, is important to contextualise the subsequent investigation of the role of housing associations in addressing health inequalities. This chapter identifies the areas of intersection between these implicit or explicit policy areas, and considers the implications of contemporary policy for health inequalities.

An historical link between housing and health policies

As a health determinant, housing has considerable potential to influence health outcomes preventatively, encouraging good health rather than treating ill health. At certain periods, particularly during the years immediately following both the First and Second World Wars, public health, housing and planning intersected as part of the same closely linked policy agenda. The 1919 Housing and Town Planning Act (Addison Act) had far-reaching consequences for public health, given that it sought to eradicate the 'slum' living conditions which had been responsible for proliferating illness and infectious diseases. Dr Christopher Addison, the author of the Act, was also the government Minister for Health, and this legislation framed housing as a national responsibility, rooted in health concerns. The interdependencies of these policy areas have been apparent to varying degrees subsequently, and at key moments have created some of the most radical and progressive changes to policy, and gains for social equalities. Following Lloyd George's commitment to provide 'Homes fit for Heroes' and the 1919 Act, further Acts in the 1920s reframed and extended the duty of local councils to make housing available as a form of social security (Clarke, 1924). By 1933, the public housing stock in Britain had grown by more than half a million homes.

In the years of rebuilding after the Second World War, the UK established its welfare state and social contract, alongside a period of enthusiastic and vigorous intervention of the state in public housing. Britain was motivated to tackle William Beveridge's 'five giants on the road

to post-war reconstruction': Want, Disease, Ignorance, Squalor and Idleness (Beveridge Report, 1942). Beveridge envisioned a social security system that took care of its citizens 'from cradle to grave', and these principles are still considered to be the foundation of the modern welfare state. The NHS was founded in 1948, when both the Department for Health and the Department for Housing were led by the minister Aneurin Bevan, whose vision for the welfare state was universal. His policies and legislation, such as the 1947 Town and Country Planning Act and the 1949 Housing Bill, obliged the burgeoning welfare state to deliver previously unmatched levels of housing, that would no longer be designated only for working class citizens.

In the subsequent decades, this social contract in Britain, and the welfare state itself, have evolved. As knowledge and technology have advanced beyond recognition since the 1940s, political and popular forces have shaped the way that the principles of universalism, social security and equality are applied in policy terms. For the relationship between housing and health inequalities, these policy developments are of critical importance, and while progress has been made in several areas, such as increased life expectancy for the majority of citizens, the larger goals of health and housing equity remain elusive (Raleigh, 2020).

Public housing and planning

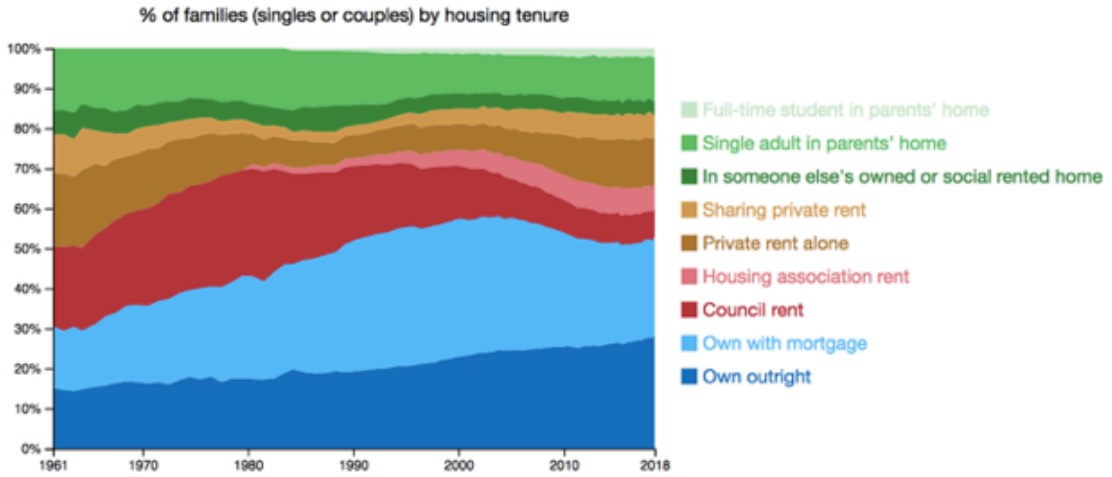
The high levels of public housebuilding in the mid-Twentieth Century were a continuation of the 'mass upliftment' principles of the interwar years, enabled by the prevailing sense of social solidarity, national pride and community spirit. The state's responsibility in delivering social housing was accepted across the political spectrum, and in their winning 1951 manifesto, even the Conservative Party named housing as 'the first of the social services'. The housing projects led by local authorities were informed by the Modernist goals of improving health and reducing social inequalities, and strict design standards (with a health function) were introduced. All social housing from 1961 was expected to meet the 'comprehensive, evidence-based' Parker Morris standards as a minimum requirement (Park, 2017, p.3). These were primarily standards for minimum space, but also included the requirement of a flushing toilet, adequate storage space and sufficient heating to keep the dwelling at a temperature of at least 18 degrees Celsius.

These standards were informed by a less sophisticated evidence base than could be assembled today. It has been argued that although the 1960s represented 'the zenith of formal building standards in this country…health issues were implicit rather than analysed and avoided' (Burridge and Ormandy, 1993, p.411). In spite of the laudable aims, public housing development of this period 'was sometimes poorly designed and, more particularly, badly built' (Boughton, 2019). The health and safety failures of the mass housing schemes in the years after they were built, as well as the abandonment of Parker Morris standards in 1980 under the Thatcher administration, led to a policy environment far less focussed on developing universal, health-enhancing housing. Instead, the designs of the post-war homes, and the residents who lived in them, were targeted by a government which viewed council housing estates as social ills, and regulatory standards as barriers to free-market development and home ownership.

Policies such as RTB embodied the Conservative priorities of creating a smaller state and constraining the scope for public sector involvement in the market. Introduced in the Housing Act of 1980, RTB gave council tenants the statutory right to buy their home at a substantial discount. Since RTB was introduced, social housing levels have remained in decline, and between 1980 and 2019, approximately 2.6 million public homes were sold into private ownership (Homer, 2019). This has impacted on social and health inequalities, leading to further residualisation of neighbourhoods and segregation of residents (Cole et al., 2015; Murie, 1998). Researchers have found that 'RTB can improve the aggregate welfare of low-income households only if the council housing quality is sufficiently low such that middle-wealth households have no incentive to exercise RTB' (Disney and Luo, 2017, p.51). In England, the higher quality housing stock was bought by those with the means to do so, leaving the tenants who could not afford to buy with a lower quality and poorer choice of home. The long-term effects of this policy have led to growth in the home-owning and private rented tenures (now 64% and 19% respectively) and a reduced proportion of households living in socially rented accommodation (17%) by 2018 (English Housing Survey, 2019). These shifts in tenure are important in understanding how the role of housing associations have developed alongside that of local authorities, (see Figure 3.1). By 2019, within the social

rented sector, 2.4 million English households were renting from housing associations and 1.6 million from local authorities (EHS).

Fig.3.1 Housing Tenure in the UK 1961-2018



Source: The Resolution Foundation (2018)

The role of housing associations in the UK has evolved dramatically, from fringe providers of homes for people that neither the free market nor the state catered to, to the majority provider of all social housing. The Thatcher government promoted housing associations as the new providers of social housing, but in 1992 they made up just 4% of the total housing stock. It was also observed at the time that 'large housing association estates, which are being built as a result of government encouragement, are housing seriously disadvantaged tenants, creating unbalanced communities and the likelihood of future expensive social problems' (Arblaster and Hawtin, 1993, p.42). Housing associations have since become responsible for the entirety of public housing in some local authorities. In an attempt to tackle unhealthy housing conditions and achieve a 'Decent Homes Standard', the Blair administration prioritised the formation and growth of new and existing housing associations to undertake a process of stock transfer of housing from the state. As the Blair government's first health secretary Frank Dobson phrased it: "Anyone with a shred of common sense knows that housing affects people's health" (cited by Fotheringham, 2002). This scheme allowed local authorities to transfer their stock to independent housing associations or ALMOs (Arms-Length Management Organisations), who could then access government grants as well as raising money through Private Finance Initiative (PFI) to improve the housing quality and fund

new developments. The standard was updated in 2006 to account for regulations in the 2004 Housing Act, including the implementation of the Housing Health and Safety Rating System (HHSRS) which identifies risks and hazards to physical health. More than a million social rent homes were made 'decent' under this programme between 2000 and 2010, and the social housing sector remains the tenure with the highest proportion of stock that meets these standards (MHCLG, 2019b).

By 2010, 90% of social rented homes (both local authority and housing association) met the Decent Homes Standard, and by 2015 only three per cent of social housing was considered 'non-decent' (Crisp et al., 2016). However, the Conservative government reduced and then ended this programme of subsidy in 2015 when half a million social rent homes still required improvement. The quality of housing in the private rented sector has been reported to be even lower. Shelter argued in 2016 that four in ten private rented sector properties failed to meet the 39 standards they deemed necessary for residents' wellbeing (Osborne, 2016). Given the rapid growth of the PRS as a sector, this presents a significant challenge for those working to improve the relationship between housing and health inequalities. There is also a significant cost associated with maintaining these decent standards in existing social homes, which must be borne by either the local authority or housing association that owns them. The introduction of a 1% annual rent reduction for social landlords for four years may have made their routine costs more difficult to meet or budget for, given that the majority of these organisations' income is from rent payments (see MHCLG, 2016). Evidence suggests that the majority of UK housing associations are pursuing a cost-efficiency agenda (Hollander, 2019).

A Joseph Rowntree Foundation report from 2014 concluded that the long-term link between poverty and poor housing conditions had been at least partly broken by 'good quality, low-cost housing', although 'housing costs-induced poverty' has risen due to a higher cost of living and rising house prices (Clarke et al., 2014, p.3). Increasing numbers of households in poverty after housing costs are taken into account is now a larger concern for health and wellbeing than the physical home environment, particularly in social housing (Pinoncely, 2016). As well as varying levels of physical standards, there are 'significant tenure differences in the risk of poverty', with the most vulnerable tenants living in the social or private rented sector (Crisp et al., 2016, p.i). Clarke et al. (2014, p.3) identified the growing role of the private rented

sector in housing poor households, including many households that would have qualified for social housing had there been enough available. This could have material and non-material consequences for households who are excluded from the tenure with the lowest and most stable rents. 'Affordable' housing, which is let at 80% of market rent, has replaced 'social' rent as the government's preferred form of social housing. This results in increasing variation in the rents that housing associations are charging for their newly built properties, with particularly high rents in London and the South East (JRF Analysis Unit, 2018). Benefit and welfare reforms have left many households with a growing financial gap to meet in order to rent either these 'affordable' properties, or within the PRS (Crisis, 2019). These rental policies, and the ongoing prioritisation of homeownership (for example the introduction of 'starter homes' as alternatives to affordable housing) has meant that state intervention often benefits those least in need of it and remains inaccessible to many (Emmett and Van Lohuizen, 2015). Initiatives such as 'Help to Buy', introduced in 2013, demonstrate 'the focus of government policy since 2010…on helping households unlikely to be experiencing poverty, in particular prospective homeowners' (Crisp et al., 2016, p.7). The extension of RTB means that former social rented stock is likely to be replaced (when it is) with properties rented at 'affordable' levels, significantly changing the landscape of that tenure.

There remains more to the role and function of social landlords than the provision of bricks and mortar, however. Beyond encouraging housing associations to become providers of physically decent homes, subsequent policies have attempted to use the links that have long been reported between social landlords and the provision of additional social support, such as 'Housing Plus' (Power, 2017). The UK's Public Health bodies included a range of housing partners in the 2014 Memorandum of Understanding to utilise their 'shared commitment' to improve 'health through the home' (DHSC and PHE, 2014). Signatories include the Chartered Institute of Housing (CIH), the National Housing Federation (NHF), the Homes and Communities Agency (HCA) and the Housing Association Charitable Trust (HACT). By including housing organisations in their strategies to tackle priorities such as providing more specialised or supported housing and reducing delayed transfers of care (or 'bed-blocking'), the function of housing associations in the eyes of policymakers has become explicitly focussed on health and social care. Reducing delayed transfers of care is an area where housing providers can make a strong offer to acute trusts (Copeman et al., 2016). Confusion has been reported over

funding for these 'extra care' functions, however, suggesting uncertainty over the expectations and responsibilities for housing associations. With funding for supported housing in particular, problems arose because housing benefit 'covers the cost of providing the building, providing housing management and delivering landlord services – not care and support' (Stacey, 2017). The National Housing Federation estimated that by 2016 almost 2,500 sheltered units that were due to be built by housing associations had been shelved or scrapped due to financial constraints.

Evidence has emerged to suggest housing associations are undergoing a period of sustained diversification in role and function, and in the activities they fulfil. Examples of initiatives pursued by housing organisations that might impact on health have included: assisting community groups to set up and run social enterprises; furniture recycling; healthy eating and behavioural programmes; tackling domestic violence and anti-social behaviour; social prescribing and community navigation (finding non-medical solutions to health problems) (Simpson and Henry, 2016). Changes to the benefits system have also contributed to a 'greater responsibility placed upon local government and housing organisations as the communicators of information about welfare reforms and what they mean for individuals' (Jackson and Nixon, 2012, p.5). Contemporary housing officers are now expected to have a 'social heart and commercial head' (Richardson et al., 2014, p.2). This suggests a further expansion of housing associations' function, though it has been highlighted that currently a lack of evidence exists regarding the effectiveness of social landlords' support services in reducing poverty (Tunstall et al., 2013). Similar concerns may apply to increased health or social purposes for housing associations.

Housing associations have evolved from community-based groups that often provided a specialised alternative to the state's supply of mainstream council housing, to much larger organisations, not necessarily rooted in the communities they serve (Manzi and Morrison, 2018; Mullins, 2000). There is some evident uncertainty regarding the degree to which housing associations do or should function as either a public or private service (Murie, 2018). Several recent policies have encouraged housing associations to follow a market logic when it comes to who they house. Yet their tenants are often framed as, or perceived to be, those who will require additional health and social care support services. If housing associations

need to maximise their rental income to meet their commercial and development aims, as well as offset losses from reduction in housing benefit, can their activities be compatible with 'the traditional goals of a social landlord, such as addressing poverty and homelessness?' (Clarke et al., 2014, p.4). This question has resulted in ambivalence about the role for these organisations and indicates a space for further research in regard to their influence on health and their involvement in health-related services.

Attempts have also been made to use planning powers to improve standards and equitability. Planners and policymakers have identified the disparities in the quality of housing between and within housing tenures, and the difficulty of regulating for, or enforcing, basic standards. The Town and Country Planning Association (TCPA) launched their call for a Healthy Homes Bill in 2019, the centenary of the Addison Act. This reflects the difficulty that has persisted in enacting Article 25 of the Universal Declaration of Human Rights (1948) and ensuring that: *Everyone has the right to a standard of living adequate for the health and wellbeing of himself and his family, including food, clothing, housing and medical care and necessary social services*. Only in March 2019 did legislation come into force for the first time to ensure that homes in England and Wales should be 'fit for human habitation' (Homes Act 2018). It remains to be demonstrated whether local authorities have the resources to ensure these regulations are observed.

Ensuring and enforcing housing conditions, standards and rights that are beneficial to health requires a level of regulation and intervention that has been unpalatable to Conservative-led governments since 2010. The extension of Permitted Development Rights, and the contraction of the regulatory ambit of local planning authorities, has increased the number and broadened the type of conversions from commercial to residential premises (Garton Grimwood and Barton, 2019). Some of these developments, such as office-block to residential conversions, represent hazards to health and have resulted in accommodation that is a long way off meeting standards of decency (Clifford et al., 2020), yet the 2020 white paper, *Planning for the Future*, outlines government intentions to liberalise this even further (MHCLG, 2020b). Critics have berated the failure of central government to 'provide a strong, coherent and relevant planning agenda', and accuse the National Planning Policy Framework (NPPF) of ignoring the major issues of social inequality and environmental sustainability

(Rydin et al., 2015, p.2). Liberalisation and deregulation characterise the 2012 and 2018 revisions to the NPPF. Encouraging neighbourhood planning at a time of financial cutbacks and without addressing inequalities in neighbourhood resources may exacerbate socio-spatial inequality (Bailey and Pill, 2014). Recommendations for equality and inclusion in planning were removed from the NPPF in 2013, replaced instead with references to 'wellbeing', and 'the words "poverty", "equity" and "social justice" do not appear' (Ellis and Henderson, 2013, p.8).

It is perhaps inevitable that the work of housing organisations would become more diverse, as more gaps in neighbourhood supports and services are opening up, but they are determined by local contexts – organisations will have local conditions and local partners to respond to if they wish to expand their remit further, and step into the roles and spaces that the statutory bodies are retreating from. This research will consider more of the ways housing (and housing organisations) function as determinants of health, through the home itself, and through non-housing (but health-affecting) wider services e.g. social or clinical support to their residents. Housing remains a public health issue, which is now more widely understood, but policies that are specifically targeted at health can help to explain why the upstream causes of health inequalities (including housing) are often overlooked in this context.

Health inequalities (reduction) policies

The policy link between health and housing in the UK has weakened in the years since ministers such as Addison and Bevan had responsibility for both agendas. Internationally, progress was made during the 1980s through initiatives such as the World Health Organisation's series of targets for member states (1984-1985), intended to reduce health inequalities both globally and within individual nations. Some of these targets specifically related to healthy environments, including housing, such as accelerated programmes for housing construction and improvements, and development of health criteria for housing (Thunhurst, 1993). These criteria included adequate space, heating, lighting, waste disposal, noise control, safety and recognising special needs. The UK participated in the WHO Europe Healthy Cities Programme of 1986, and the UK Health for All Network was created for British towns and cities to join the programme. In the quest for these 'healthy cities' and the

attempts to tackle housing-related illnesses, however, the Department of the Environment, with responsibility for housing and planning, was far less involved that the Department of Health, raising questions about the efficacy of a public health function buried within a curative health service (Burridge and Ormandy, 1993). In the British practice, policy and scholarship of this period, the weakness of the link between housing and medical research is evident in the greater importance accorded to individuals and disease than to epidemiology and the social or environmental impacts on health (Byrne and Keithley, 1993). Yet the scale of the uptake by numerous towns and cities of the targets and ideals of Health for All did go some way to establish the link between health and housing, and 'challenged as far as the intersectoral coalitions of local and health authorities can, any denial by central government that such a link exists' (Green, 1993, p.427).

Although they have been given varying degrees of prominence, health inequalities have remained important to the political agenda, whichever way the ruling government has attempted to tackle them. Over the 1970s, the Labour governments commissioned a series of research projects to identify the causes of health inequalities and make recommendations to reduce them (Townsend et al., 1992). This collection of reports became the Black Report, which was eventually published in 1980. It found large inequalities in mortality and morbidity between the social classes, which were not being properly addressed by the health or social services (Howden-Chapman, 2010). The incoming Thatcher government, however, attempted to suppress these uncomfortable findings, which proposed radical change in health and care policy, and the Black Report 'disappeared into a desk drawer' (Mackenbach, 2010, p.1249), while the Conservative government shifted the policy and research focus away from the social and structural determinants of health (Thunhurst, 1993). Rather than collective, society-wide action, Conservative policies were targeted towards the individual.

With regard to housing standards, there was a withdrawal of enforcement and regulation during the 1980s, and individual subsidies transferred the responsibility for housing conditions from landlord to owner-occupier, leading 'toward a legal response to unhealthy housing conditions which is individual, private and fragmented' (Burridge and Ormandy, 1993, p.401). These principles were also reflected in the 1988 Green Paper 'Care in the Community' (also known as the Griffiths report). This report explicitly disconnected health

from housing, defining the role of housing in community care as 'bricks and mortar with no social or interagency significance' (Griffiths, 1988). Housing departments rejected Griffiths' claims, however, on the grounds that it made 'the false assumption that there is a clear dividing line between responsibility for bricks and mortar and the provision of social support' when 'in practice the two are inextricably linked' (Arblaster and Hawtin, 1993, p.28). This Green Paper became the 'Caring for People' White Paper in 1989, and then the Community Care Act in 1990. Its emphasis on community, rather than statutory services reflected the reliance of the government on philanthropy and charity, assuming that others will step in where the state will not. The Act required local authorities to produce community care plans in partnership with carers', housing and voluntary organisations. Several new housing associations were subsequently established, or expanded, during the 1990s to help deliver support services to residents with specific needs, for example in 1993 the East London Housing Association set up a new subsidiary, Care and Support Services (L&Q, 2018).

During the 1980s, 'health, except implicitly in its very broadest sense of physical, social and mental well-being, did not figure much on either [central government or local authority] agenda' (Green, 1993, p.426). The Government's White Paper in 1992, The Health of the Nation, was a fresh attempt to address health inequalities and drew on the WHO's findings and targets for improvement. Whilst this paper was welcomed by many in the medical profession as a departure from laissez-faire approaches, it was criticised for focussing more on better clinical treatment of public health concerns, than on the WHO's proposals to address the causes of these conditions, such as inequality and other socioeconomic problems (The Health Foundation, 1992). By 1997, despite some successes with Community Care, the UK was suffering nationally from cuts to social spending and too many people were left waiting in hospital beds because care was inadequate at home (Edwards and Kenny, 1997).

Towards the end of the Conservative administration, housing's potential to improve health outcomes re-emerged as an area of interest. The New Public Health represented an attempt to look beyond the physical aspects of the environment and understand the social and psychological elements (Burridge and Ormandy, 1993). It recognised that the scale of the health problems, and the lack of progress that was made by treating inequalities as individual issues, as well as dissociating housing policy from health policy, had seriously impeded the

potential for improvement. Instead, recognition 'that housing is a health promoter rather than a source of illness, reverses the emphasis and encourages positive intervention' (Burridge and Ormandy, 1993, 18.8). Researchers recommended policy interventions that could tackle health and social problems more holistically (Lawrence, 1993). These approaches encouraged more multidisciplinary and inter-sectorial work, picking up where the Black Report had left off, over a decade before. By the late 1990s and the 'end of the period of three Conservative governments, inequalities were at the highest ratio last century' (Howden-Chapman, 2010, p.1241). The Black Report was dusted off by the incoming Labour administration, and reducing health inequalities by targeting socioeconomic injustice was back on the agenda.

Under Labour (1997-2010), several studies into health inequalities were commissioned. The Acheson Report was published in 1998 and it identified a number of health indicators by which to measure inequalities, alongside 39 recommendations for how to improve them, which were directed broadly towards the societal and structural causes of poor health (Macintyre, 2008). 1998 also saw the publication by the Social Exclusion Unit of *Bringing Britain Together*, which led to the National Strategy for Neighbourhood Renewal (SEU, 1998). Connecting health and neighbourhood policies was a priority for Labour. The 2001 Policy Action Team (PAT) report, *Joining it up Locally*, stated ambitions for Local Strategic Partnerships (LSPs) between local authorities and other statutory agencies, the VCSE sector, local residents and community actors, to bring 'a deprivation focus to local strategic working' (SEU, 2001, p.226). Actions directed at health, crime, education and housing were intended to '[narrow] the gap between deprived neighbourhoods and the rest of the country' (SEU, 2001, p.226).The recognition of health inequalities between neighbourhoods and the programmes designed to tackle them, which included the Employment Zones, Health Action Zones and New Deal for Communities (NDC), constituted 'a radical shift in the approach of central government to tackling social exclusion compared with all previous administrations' (Ginsburg, 1999, p.281). However, Watt and Jacobs' (2000, p.25) analysis has argued that this Labour Government's focus on social exclusion was, for reasons 'of pragmatism and expediency', insufficiently focussed on the 'redistributionist', (or upstream) structural and macro-level policies, that could tackle root causes of social injustice and exclusion, but require far greater levels of state intervention.

The targets set out in the Department of Health's 2003 strategy, *Tackling Inequalities: A Programme of Action*, adopted the Acheson recommendations (including more partnerships and 'joined-up' working) and established targets for England to achieve by 2010. These targets included reducing the gap between the poorest areas and the rest of the country in infant mortality and life expectancy by 10%. The Acheson Report also helped establish the Sure Start programme and the 2008 National Equality Panel, chaired by Professor John Hills, which was set up by the Government to provide recommendations on 'action to tackle inequality…based on the most robust and sophisticated analysis of its roots and how it affects people's lives' (Harman, 2010, p.iii). This was followed by the WHO report *Closing the Gap in a Generation* (2008) and *The Marmot Review* (2010), which were important in providing both a call to action and a framework of policy recommendations. These reports 'synthesise[d] over 30 years of accumulated research on social factors relevant to health inequalities' (Lynch et al., 2010, p.1244). A more detailed understanding of the role social circumstances have in producing health inequalities emerged, although the complexity of housing and 'the built environment' as a risk factor was often under-acknowledged. Writing in 2020, Marmot and colleagues recognised that the 2010 Review 'touched on housing, but at the time it was considered less of a health issue than in the years that have followed' (Marmot et al., 2020, p.93).

A 2009 House of Commons Review into the impact of the Acheson Report found that there had been measurable decreases in infant mortality, the gender gap and ethnic educational inequalities. It reported an increase in life expectancy generally and a slowing rate of relative inequality increase (Howden-Chapman, 2010). However, these gains were not shared equally among the population. The results suggested 'that despite more than ten years of systematic policy action health inequalities [had] not narrowed' (Mackenbach, 2010, p.1249). While Mackenbach (2010, p.1249) was disappointed because 'it is difficult to imagine a longer window of opportunity for tackling health inequalities', even thirteen years is relatively short-term in comparison to the cumulative and intergenerational ways that health inequalities become embedded. The 'complexity and multiplicity of the relevant causal pathways' (Schrecker, 2017, p.293) that lead to large health inequalities require massive upstream action rather than targeted interventions on a short-term or small-area scale. Despite the

goals of reducing health inequalities, any redistribution of wealth under New Labour was achieved mainly through providing welfare and benefits to those on low incomes (such as working tax credits), rather than creating a more equitable earning system (Hirsch and Miller, 2004).

Although programmes such as Sure Start (which utilised a proportionate universalism approach) appeared to improve health outcomes for a number of families (Torjesen, 2016), this service was made vulnerable after the ring-fence around its budget was removed. As cash-strapped councils have faced urgent needs for funds, in the wake of the credit crunch and then austerity, more than 350 Sure Start centres have closed between 2010 and 2016 (Rigby, 2017). The limited progress achieved has not been sustained and health inequalities have not remained so high on the agenda post-2010, despite some (though arguably not the most important) of the recommendations from the Marmot Review being accepted by the government (Marmot et al., 2020). It is acknowledged that 'developing the required cross-sectoral and social determinants approaches is a complex and long-term task; these approaches take time to show impacts, often on timescales way beyond the life of political cycles' (Marmot et al., 2020, p.130).

The more recent rhetoric has been focussed on prevention and health creation, and awareness that social factors can protect and provide contexts for healthy living. The NHS Five Year Forward View (2014) recommends 'New Models of Care' to create a sustainable health service focussed on prevention, early intervention and more support outside of clinical settings (NHS, 2014). This is a long-term ambition that signals a desire to create good population health, as part the wider agenda in several places to incorporate health-in-all-policies (HIAP) (Greszczuk, 2019). It will require work with partner organisations, and this vision, 'coupled with the pain of unprecedented pressure on the NHS is causing CCGs [Clinical Commissioning Groups] and others to look more widely for solutions' (Simpson et al. 2015, p.6). The New NHS Alliance's 2015 report, *Housing: Just What the Doctor Ordered*, makes the case for the health sector and CCGs to engage the housing sector, particularly housing associations, in their search for alternative models of care provision (Simpson et al., 2015). The 2019 Green Paper, *Advancing our health: prevention in the 2020s* 'acknowledges prevention is everyone's responsibility, from the NHS to employers, schools, local authorities

and individuals' (Selbie, 2019). This suggests a growing reach from health departments into the wider social determinants of health.

Investments in social programmes and public services (including but far beyond housing) have been shown to be necessary to improve population health, and reduce health inequalities. Better education, transport and connectivity, sustainable employment and fairer distribution of income and wealth are all necessary for better and more equitable health outcomes. Policies that introduce cuts to these public service budgets, therefore, may be expected to impact on health inequalities negatively. Policy recommendations have frequently and consistently been made to encourage more partnership and intersectoral work between organisations and sectors (public, private and voluntary) that influence health. However, as public services try to exist with fewer resources, this dependence on other sectors 'could be seen as the "only" option, rather than a positive choice' (Coleman et al., 2015, p.382). This point of tension, and its consequences, is one that this research will explore in more depth.

Welfare reform and austerity

Universal policies and services that improve both public housing and public health require substantial amounts of financial support and political buy-in, for the necessary redistribution of resources. Historically this has been more feasible at particular moments. In the Nineteenth Century, '"a cross-class political alliance" made viable by rapid expansion of the franchise was responsible for advances in public health in England' (Szreter, 1999, quoted in Schrecker, 2017, p.297). Similar social solidarity was perceived after the Second World War (Harris, 1992). Universal buy-in and universal benefit are necessary for the success of such collective endeavours such as establishing a health service that is free at the point of use for all citizens and funded through general taxation. The same principle applies to support large-scale public house building. The support for a large welfare state has been shown to be stronger in societies where the middle classes get more back from the state (McKee and Stuckler, 2011) as well as when risk and deprivation affect separate groups (Rhem et al., 2012). Since the 2010 UK Coalition government's welfare reforms, the policy changes have been argued to 'further erode the effects of earlier interventions and create a more difficult context for social and economic success' (Murie, 2012, p.482). Housing and benefit systems

have become more residualised, and what are deemed to be scarce resources are available less universally, via stricter means-tests, gatekeeping and eligibility criteria.

This reflects a neoliberal paradigm that has persisted for several decades and across governments, which has altered relationships between the state, business and civil society in ways that impact on health and housing. While purposely weakening local government and attempting to roll-back the state more generally, the Thatcher administrations also oversaw the growth of the voluntary and charity sectors. Thatcherism embraced the 'Victorian Values' of restrained state spending, enhanced individual responsibility, encouragement of philanthropy, and the lionisation of 'family values' (Samuel, 1992). Her critics, however, denounced these 'values', and the shadow minister of education in 1983, Neil Kinnock, told party members that 'Victorian Britain was a place where a few got rich and most got hell' (Samuel, 1992, p.13). What was said to be the ineffectiveness of the benefits system in supporting people in need led to an increasingly residualised welfare system with a lasting legacy. While some indicators of wellbeing improved during this period of government, such as greater levels of home and car ownership and central heating, the most vulnerable groups in society did not share these benefits. Those most likely to have inadequate income were pensioners, lone parents, households without earners and families with children (Shaw et al., 1999). Gradual reforms to the social contract in the UK have led to a welfare system that has significantly departed from the collective ideals of Bevan and the Attlee administration. While the Blair Labour government was elected in 1997 on a platform promising social investment and renewal, their policies retained elements of the individualism and conditionality that had previously undermined universalism and social solidarity. Instead they offered 'compassion with a hard edge', and a commitment that 'the new welfare state must encourage work not dependency' (Blair, 1997).

In the context of the Coalition and Conservative governments that have been in power in the UK since 2010, the welfare state has been further stripped back. Benefit sanctions characterise welfare for people in poverty, as well as 'increasingly conditional, interventionist and enforcement-based elements' of social policy, 'particularly in relation to ASB [anti-social behaviour], social housing and homelessness' (Watts et al., 2014, p.17). This is most acute for certain groups, demonstrated by the negative impact of cuts to housing benefit and

increased welfare conditionality on single homeless people (Reeve, 2017). This undermines both universal benefit from, and therefore the likelihood of universal support for, the modern welfare state, reducing buy-in from the middle classes, including the 'squeezed but basically safe' (Schrecker, 2017, p.297). Critics argue that the result of these reforms is that the 'undeserving' poor are frequently targeted. The Centre for Social Justice, founded by Iain Duncan Smith, Secretary of State for Work and Pensions from 2010 to 2016, published a report, *Rethinking Child Poverty*, in 2012. As well as suggestions that the government implemented, such as a redefinition of the term 'child poverty' to exclude any measure of income (Mack, 2016), their report painted 'a picture of UK poverty that is tied up with bad parenting, highlighting the cases of alcoholic, crack-addicted parents who abandon their children to play bingo', but much less focus on families whose poverty is due to unemployment or low-paid work (Gentleman, 2015). By confusing behaviour with 'lifestyle', policymakers can frame certain health inequalities as matters of individual 'choice', ignoring the 'fundamental causes' that lead to some choices being more likely or possible. (de Gruchy, 2019). There is an ideological motivation behind the austerity choices that impact mostly on 'the poor and marginalised' who 'have less political power and penalising them is consistent with narratives that their plight is their own fault' (Lobao et al., 2018). Social solidarity, and therefore support for more generous, interventionist state activity such as widespread public housebuilding to improve population health, has been undermined.

The Welfare Reform Act of 2012 introduced a number of adjustments to the welfare system and cuts to public expenditure (individuals and local authorities), affecting mostly those of working age that are in low-paid work or unemployed, and people with disabilities. These reforms included various changes to Housing Benefit, such as the Under-occupation or 'Bedroom' Tax, which penalises occupants of social housing with more bedrooms than deemed necessary, as well as more stringent caps on Local Housing Allowance (LHA) payments and limitations on eligibility for support. The reforms introduced by the Coalition were wide-reaching and this austerity has been targeted specifically at certain spending areas. Within local government, the Institute for Fiscal Studies has calculated that the levels of cuts by department from 2009-10 to 2019/20 stand at 59% for planning departments and 52% for housing (Harris et al., 2019, p.28). The NHS, however, has seen its budget protected, though it is anticipated that the impacts of cuts in other areas such as social care, as well as

an ageing and expanding population, may increase the strain on the health service, even if the budget is maintained (Stoye, 2018). The austerity context has been acknowledged as a driver of increased partnership working as 'housing associations understand the financial pressures facing the health sector' and are therefore 'very well placed to engage successfully with the health sector and are reaping the rewards through commissions and partnership working' (NHF, 2016, p.12). Others have suggested that the financial challenges faced by both the health and housing sectors may encourage clinical organisations to show more 'interest' in the ways housing interventions might help alleviate pressures on their systems (Simpson et al., 2015).

Of interest to this research are the measures affecting housing, and the significant loss of public health funding. As established, these two areas are closely related. The relationships between housing, poverty and health are complex and operate on multiple levels, 'but there seems little doubt that current national policies undermine the extent to which housing policy can reduce or mitigate poverty through access to low cost, secure or good quality housing in the right location' (Crisp et al., 2016, p.1). Cuts to the LHA are likely to exacerbate this pressure. One study by a local authority-funded think tank argued that cuts to housing benefits could destabilise communities 'by forcing movement to low rental areas' (Jackson, 2012, p.4). The health impacts of this could be physical, as 'healthier', greener environments tend to command higher house prices and rents. Uneven economic growth can increase housing-related poverty by driving up housing costs in particular places and forcing households to live further from key centres of employment (Crisp et al., 2016). The impacts of housing benefit reforms have been most drastically felt in high rent areas, such as London, as well areas with large numbers of private renters (Hudson-Sharp et al., 2018). While households with lower incomes often live in the PRS, private landlords 'do not face the same constraints as social landlords in setting rents though there are limits to the amount of housing benefit that may be paid', meaning cuts to LHA 'may increase poverty if tenants fail to find accommodation within the new limits' (Clarke et al., 2014, p.4). This weakening of the safety net creates potential physical and psychological health risks for many households on low incomes.

Welfare reforms and austerity measures have impacted unevenly across geographical space (Barford and Gray, 2018). Cuts have not been experienced evenly among the population as 'national austerity policies can have local consequences that, if not entirely unsurprising, were certainly neither thought through not articulated in advance' (Beatty and Fothergill, 2014, p.63). The impacts are likely to be felt harder in communities that can least afford to cope with them (e.g. northern ex-industrial towns, including some in Greater Manchester, as Etherington and Jones, 2016, note). Schrecker (2017, p.294) argues that these 'policy changes have hit not only the poorest people but also the poorest and least healthy places hardest'. The worst-affected English region is the North West, and several of the Greater Manchester boroughs included Salford, Manchester, Oldham and Tameside are in the top eighth of the most-affected places (Beatty and Fothergill, 2014, p.72). These policies may impede efforts to reduce health inequalities within those disadvantaged populations, or at least create a more challenging context to work in. Non-statutory local partners such as housing associations are therefore taking on an increased role in the wake of welfare reform, partly because they have assumed responsibilities ceded by a retrenching state, but also because the rationalisation of public services has fuelled the demand on the voluntary sector. This activity is likely to be influenced by the priorities of, and powers available to, the local authorities they work in.

Localism and local devolution

Austerity and devolution emerged in tandem, as part of a wider strategy to reduce the role, responsibility and expenditure of central government. Findings from reports such as the Marmot Review were expected to have wide-reaching impacts on policy and therefore health inequalities, through the actions of local authorities. The onset of austerity measures in Britain allowed those pursuing an agenda of increased local responsibility and interagency working to use devolution as a vehicle, and partial compensation, for much larger budget cuts. Despite differing agendas, central and local actors have supported devolved powers, yet although local leaders 'might object to austerity…by playing the devolution game they are bound-up in agreeing to and implementing austerity' (Etherington and Jones, 2016). Responsibility for much of this integrated working is now at the local level, with an expectation that non-statutory, local partners will take an increased role in this 'community

localism' (Hildreth, 2011, p.709). This includes housing associations. The formation of the CCGs has expanded the purchasing role, and decreased the provider role, of local authorities. Joint Strategic Needs Assessments (JSNAs) were originally expected to direct local authorities towards services and interventions that would decrease inequalities and encourage partnership work between the health service and local communities, education and housing (Department of Health, 2007). The 2010 White Paper, *Equity and Excellence: Liberating the NHS*, indicated the increased role intended for the private or third sector in the provision of these services. The 2012 Health and Social Care Act transferred the responsibility for carrying out JSNAs to the newly formed Health and Wellbeing Boards in several areas, in order to identify the 'bigger picture' in terms of the health needs of a local population (Geddes et al., 2011, p.2). Much of this localism is characterised by the delegation or relocation of existing functions, with funding levels still set by central government. Instead of an emancipatory gesture, these localised transferals of responsibility, particularly to areas with high deprivation such as Greater Manchester, risk exacerbating poverty and inequality by placing an 'unequal burden of austerity measures on northern local government' (Coleman et al., 2015, p.381).

Localism creates challenges for those seeking to reduce inequalities. Local authorities since 2011, have more autonomy over decisions about who, for example, is included in their eligibility criteria for public housing, in spite of the 'reasonable preference' that legislates for the compulsory inclusion of certain groups. This agenda, and variation in its implementation, also poses a threat to the universalism of the NHS, and it is common to speak of a 'postcode lottery' when referring to the level and standard of health and social care services available to the populations of different areas (PHOF, 2016; Woods, 2016). Yet the 2012 Act 'removed from national government the responsibility to ensure provision of a universal standard of health care to all regardless of income, age, or postcode' (Dorling, 2013). There is a delicate balance to be struck between strategies that are locally appropriate but do not unwittingly disadvantage other areas. England may be 'too diverse for a one-size fits all care model to apply everywhere. But nor is the answer to let a thousand flowers bloom' (NHSE, 2014, p4). Reducing health inequalities in the context of such uneven distribution of resources will place some regions at a disadvantage.

The potential gains of devolution could be impaired by the restrictions that will operate alongside the freedoms. The autonomy offered to individual areas is limited, as policies such as welfare reform are national, and devolved authorities do not have the choice to 'opt-out' of them (Beatty and Fothergill, 2014). Ensuring accountability remains at the relevant level may also become more challenging as further levels of governance are introduced, for example at city-region level. The New Local Government Network highlighted the limitations of relying on restricted central government funds to boost economic performance without financial freedom, arguing for cities to be given greater powers 'over key economic levers such as skills and worklessness policy' to help them tackle the huge challenges they face (Townsend, 2010, p.15). The lack of autonomy over such crucial areas as education and skills, which are known to heavily influence long-term health outcomes (Bibby, 2017), has also been highlighted in Greater Manchester, where there is no education 'system' covering the city-region (Lupton, 2017). A whole systems approach with equity at its heart is crucial to ensuring that the benefits and opportunities of devolution can be evenly shared.

Meaningful partnership working and public participation have been identified as necessary for real and lasting success in regeneration projects (Baba et al., 2016). Policies that involve the principles of empowerment, or increasing community control, are also hoped to address some of the causes of health inequalities. These causes are often illustrated by the behavioural risk factors that are more prevalent in communities with reduced capacity to make the healthy choice the easy, or default option. Housing associations have been increasing their involvement in these community-based, social interventions (Bagnall et al., 2016), yet the commissioning frameworks have changed since the 2013 establishment of Clinical Commissioning Groups (CCGs). The member-led CCGs were intended to involve more clinical insight and be more 'bottom up' and 'democratic' than the Primary Care Trusts, but have also had to operate with significantly reduced management resources in the context of austerity (Naylor, 2012). Nevertheless, they remain crucial partners for housing associations who wish to get involved in their locality's health issues. The National Housing Federation has provided advice to its members who are seeking commissions for their housing services from their local CCGs, highlighting the restrictions created by lack of available finance and the challenges of receiving approval for non-clinical interventions (NHF, 2016).

Localism, and local devolution, is argued by contemporary policymakers to locate decision-making at the most appropriate level to ensure good health (Hope and Barwick, 2020; Thraves, 2012). Action to implement the recommendations of the Marmot Review has been more forthcoming at the local level. By 2013, three quarters of local authorities were applying at least some of the Review's recommendations (Allen, 2013). When considering the report's implications for spatial planning, the basis for the paper was 'the overwhelming evidence that health and environmental inequalities are inexorably linked and that poor environments contribute significantly to poor health and health inequalities' (Geddes et al., 2011, p.3). The successes of local approaches, and effective integration of their services, are related to the degree of collaboration and partnership working between numerous stakeholders (Ham, 2018). Since the reforms of 2012, most Public Health functions in England have been transferred from the NHS to local government. This recognises the fact that prevention of illness is a social, rather than a medical endeavour. Such HIAP approaches are in line with recommendations that localities should fully integrate planning, transport, housing, environmental and health systems to deliver health equity (Geddes et al., 2011).

Some of these recommendations for local action are specifically targeted towards housing. The 2014 Memorandum of Understanding to support joint action on improving health through the home 'recognises the importance of housing and sets out some broad principles of joint working to deliver better health and wellbeing outcomes, and is accompanied by an action plan signed by various partners including health and housing organisations (Simpson et al., 2015, pp.6-7). The policy language suggests greater intersectoral awareness. For example, the 2014 Care Act states that 'housing is therefore a crucial health related service which is to be integrated with care and support and health services to promote the wellbeing of adults and carers and improve the quality of services offered' (Care Act 2014, Section 15.48). However, integration of services (successfully) requires significant upfront investment (Parkin, 2019), so devolution at a time of austerity is likely to be a great challenge. In Greater Manchester, to continue delivering the same level of services there is a £2 billion deficit expected to appear in the health budget after just five years of devolved health care (Checkland et al., 2016).

Possibly as a result of having inadequate resources and the consequent need to 'target' them effectively, this localism is rooted in the principles of individualism. It illustrates the 'lifestyle drift' to which critics of UK policies attribute rising health inequalities. The focus of these policies has been increasingly targeted at the 'worst offenders' rather than on universal principles. Initiatives such as the Estates Regeneration Fund, which offered the relatively meagre sum of £100 million to the 100 'worst' estates, on a competitive, loan basis, demonstrates this targeted but under-resourced action. The more generously funded Towns Fund (announced September 2019) invited 100 deprived places to apply for up to £25million each for investments in transport, urban regeneration, skills, enterprise infrastructure and digital connectivity, but is also allocated on a competitive basis and its five-year duration is relatively short-term (Cox, 2019). Individualised policies such as the Troubled Families programme also 'conflate[d] families experiencing multiple disadvantage and families that cause trouble', which further stigmatises those in poverty (Levitas, 2012, p.12). Such downstream, behavioural interventions do not address the root causes of social and health inequalities. Local administrations that embraced these policies, however, were able to utilise central government's own rhetoric to secure additional resources to deliver such programmes. The growth in activity of the Behavioural Insights department reflects the reality that 'most government policies are concerned with influencing behaviour' (Hallsworth et al., 2016, p.11). Yet this activity also needs to focus more on prevention. As argued by the Behavioural Insights Team, 'if behavioural and lifestyle factors increasingly drive the majority of years of healthy life lost, then isn't it time we attach these issues at their causal roots, not just the symptoms?' (Hallworth et al., 2016, p.3). Improving environmental factors such as housing will therefore be instrumental in establishing a population health system that is focussed on creation of good health, rather than treatment of illness.

It is becoming increasingly clear that although local factors are important and influential for health inequalities, this can consist of an overly individualised focus, 'at the expense of marginalising and minimising the influences of macro political and economic structures on both place and health' (Bambra et al., 2019, p.36). This relationship between micro, meso and macro level causes of health inequalities have a complex and cumulative impact that is felt and experienced in neighbourhoods and communities. It has been argued that it is necessary to 'scale up' the analysis of policy, which supports the assertions of the thesis's

literature review that there is value in taking a more population-wide, or 'political economy approach to understanding geographical inequalities in health' (Bambra et al., 2019, p.36). This is particularly important in order to learn from devolved administrations, when considering the higher-level contexts that they operate within and the spaces where upstream causes of health outcomes are determined. This research into housing associations (as key stakeholder organisations) will take care to include observations and consideration of this bigger picture, and consider household and neighbourhood level activities and health outcomes in the context of society-wide socioeconomic inequalities.

Summary

This chapter has charted the historical relationships, and interdependencies, between health inequalities, housing, and planning policies. At times in the UK's history, this link has been an explicit government priority, and strategies to reduce health and social inequalities have taken into account the influences of wider social determinants. More recent English policies have pursued a strategy of localism as well as austerity. This has involved scaling back the level of investment from the central state but also encouraging more local and non-statutory actors to play an active part in community-based population health efforts. A crucial social determinant of health, and key delivery partner, is the social housing sector. The following chapter will outline the conceptual framework and research methodology of this thesis. These have been developed as a way to interrogate the relationship between health inequalities and housing associations, and are informed by the issues identified in this policy review and the previous literature review chapter. Case study research on housing associations and health inequalities in Greater Manchester, which is the first city region in the UK to have devolved control over its health and social care budget, as well as having to follow national policy directives, can shed more light on these issues.

Chapter Four
Methodology

Introduction

This chapter explains how the study was conceived and designed, as well as the process of data collection and analysis. The methodological approach and conceptual framework were formulated in response to the literature and policy reviews, which highlighted some uncertainty regarding the form and extent of health-focussed work of housing associations, for which empirical data is lacking. It is timely to explore the issue in more depth, drawing upon case study evidence from an area, Greater Manchester, which is suggested by some to be particularly advanced in reforming and clarifying the role of housing associations in respect of health inequalities (Barratt, 2019; Norman, 2017). Conceptually, this study considers this particular 'housing and health' relationship in a broader context than individualised, dwelling-specific research has tended to do (Gibson et al., 2011; Ige et al., 2019), and it has utilised the social determinants of health framework to inform the analysis. In this way, the lessons gleaned from the data have wider implications for research aiming to advance population wide health equity, as well as insight into the relationship between housing providers and devolution, localism, retrenchment of public services and their replacement by non-state actors.

The aim and objectives

The aim of this research is to critically assess the changing roles and activities of housing associations in addressing health inequalities. The research will inform better understanding of housing associations' experiences of policies and practices operating in a context of devolved governance, as well as their possible implications. Insights generated from housing providers will establish links with the wider issues of equality, and health equality, that arise from the expanding remit and role of third sector organisations' involvement in policymaking, and delivery of public services.

To realise this aim, the objectives of the study are:

- to critically review the existing research and policy literature which explores the link between housing and health inequalities;
- to examine the roles played by social housing providers in addressing health inequalities in Greater Manchester;
- to identify the drivers and influences on this activity;
- to explore the relationship between social housing providers and the health service commissioning bodies in Greater Manchester;
- to examine the experiences of health-housing relationships and devolution between the different boroughs of Greater Manchester; and
- to synthesise the key research findings and relate the insights from Greater Manchester's housing associations to the wider phenomenon of health inequalities.

The research questions:

1) How and why is the role of housing associations evolving in attempts to reduce health inequalities in Greater Manchester?
2) What are the implications of this housing association activity in relation to critical health inequalities scholarship?

These questions were formulated in response to the gaps and limitations of the existing literature relating to housing association activity and health inequalities (see p.28). Research which has tracked and examined the function and role of the housing association sector has highlighted the increasing diversification of their activities (Clarke et al., 2014; Mullins et al., 2017; Pawson and Mullins, 2010; Murie, 2018). This thesis therefore extends and contributes to this strand of research. Previous studies have explored housing association activity in terms of poverty interventions or social responsibility (Manzi and Morrison, 2018; Mullins, 2000; Richardson et al., 2014; Tunstall et al., 2013) (see p.54), but there has been no concerted attempt as yet to explore the relationship between their activities and health, or health inequalities (see p.29).

Previous research has assessed the activities and services of housing providers in relation to particular health conditions, such as mental illness (Holding et al., 2019). This thesis extends previous research studies by considering the Greater Manchester housing associations in

terms of health *inequalities*, linked to a series of concepts in the literature which have been under-utilised in housing research. In this sense, the thesis responds to calls from other researchers for housing studies to take a more holistic view of its relationship with health (Lawrence, 2017; Libman et al., 2012b). The thesis also responds to the case developed by some researchers that theories widely utilised in the health sciences, such as complexity theory (Rutter et al., 2017), should be employed as a way of understanding inequality as the 'emergent' result of elements interacting within a social system (Matheson, 2020). Yet a 2016 study which analysed housing renewal programmes in relation to proportionate universalism noted that 'no previous study has explored the effects of proportionally allocated investment in housing-led renewal on health inequalities' (Egan et al., 2016, p.42). Concepts such as the social determinants of health framework, the social gradient, the social model of health and proportionate universalism are therefore recognised as important academic concepts to incorporate in this research and apply to the issue of housing associations' relationship with health inequalities.

The conceptual framework

The conceptual framework builds on the well-established social determinants of health model and applies the relevant components to this study of housing. Taking the conclusion from Chapters 2 and 3 that housing is frequently under-assessed by health researchers, or only examined in simplistic terms, the goal of this thesis is to assess the activity of housing associations as a way to think more critically about the ways housing interacts with, and is interdependent to, the other social determinants of health. The framework is supported by a critical realist approach, which considers context and contingencies. Part of the contribution to this field of study is to bridge some of the conceptual gaps that have separated, or siloed, these research agendas in the past, despite their numerous areas of commonality and intersection. For example, concepts such as Proportionate Universalism and its critical position in health inequalities research have been applied to the issue of social housing allocation policies in order to think more holistically about what such targeted action might mean for population-wide health. The analysis is necessarily focussed on the processes and mechanisms of housing association activity, rather than outcomes, but the health inequalities context is an essential component of this.

Fig.4.1 The **Dahlgren-Whitehead Rainbow** of Health Determinants:

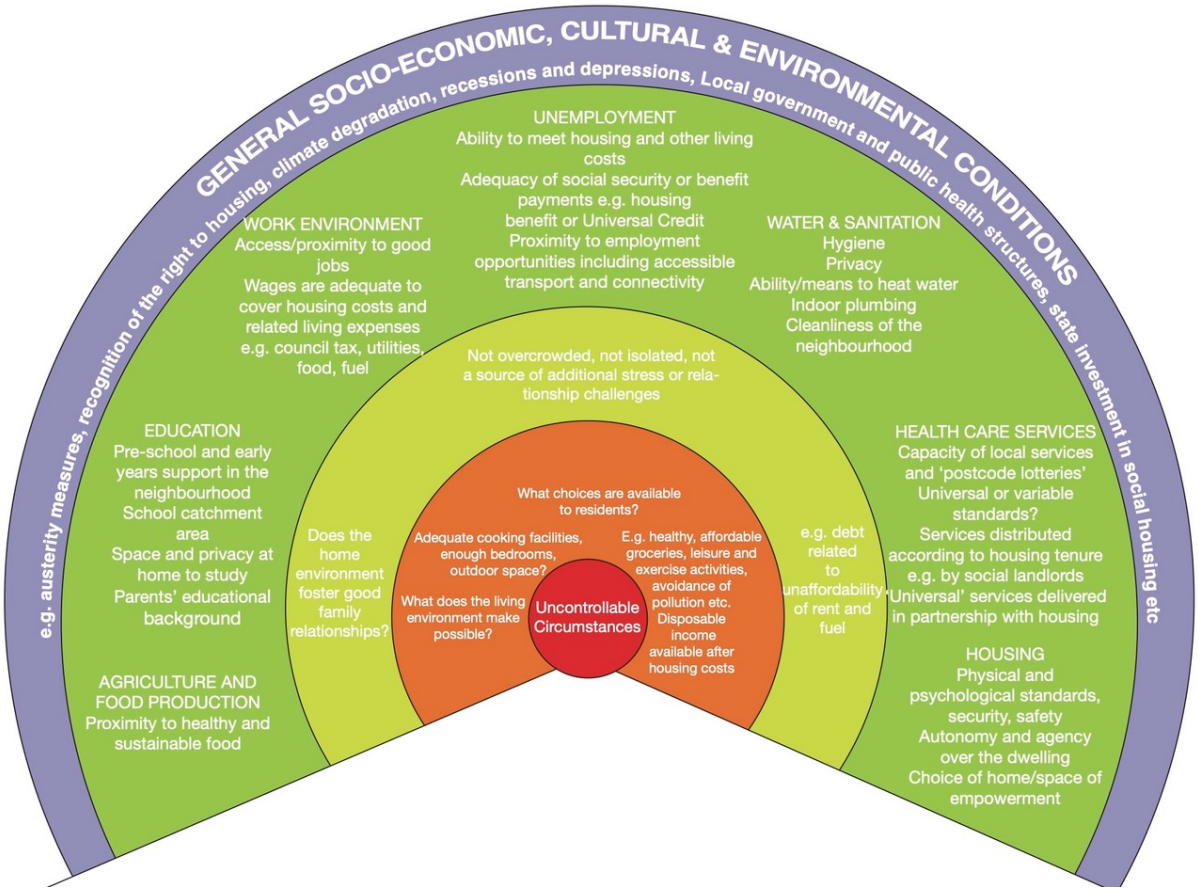
Source: Dahlgren and Whitehead (1991)

The determinants illustrated in the Rainbow Model (Fig.4.1) do not function in isolation. 'Housing' impacts on health alongside, and in conjunction with, the other social determinants of health, as illustrated in the diagram below (Fig.4.2). This highlights the importance of taking a more holistic, socio-ecological approach to these issues of public health, which challenges more individualistic research approaches (found in both housing and health inequalities research) that are rooted in the biomedical paradigm (Golden and Wendel, 2020).

The conceptual framework embeds a series of concepts identified in the review of health inequalities literature as important for housing studies. For example, use of the Dahlgren-Whitehead Rainbow (Figures 4.1 and 4.2) in formulating the interview topics during data collection facilitated a more holistic, whole-system understanding and analysis of the ways housing association activities are adapting and evolving to affect health. Such analysis is able to go beyond the identification of clinical, or social care support services which contribute to individual models of health. Other research has highlighted the limitations of linear, rather than holistic perspectives, and challenges the ways 'our conceptualisation of the relationship between housing and health has been "medicalised"' (Baker et al., 2017, p.3). Considering

the Rainbow model aided the identification in the primary data of more housing services which fit a 'social' model of health. For example, interventions as far reaching as library services, childcare and nurseries, energy efficiency measures and debt advice can all be understood through this model to influence health inequalities.

Fig.4.2: Housing intersections with the Rainbow Model



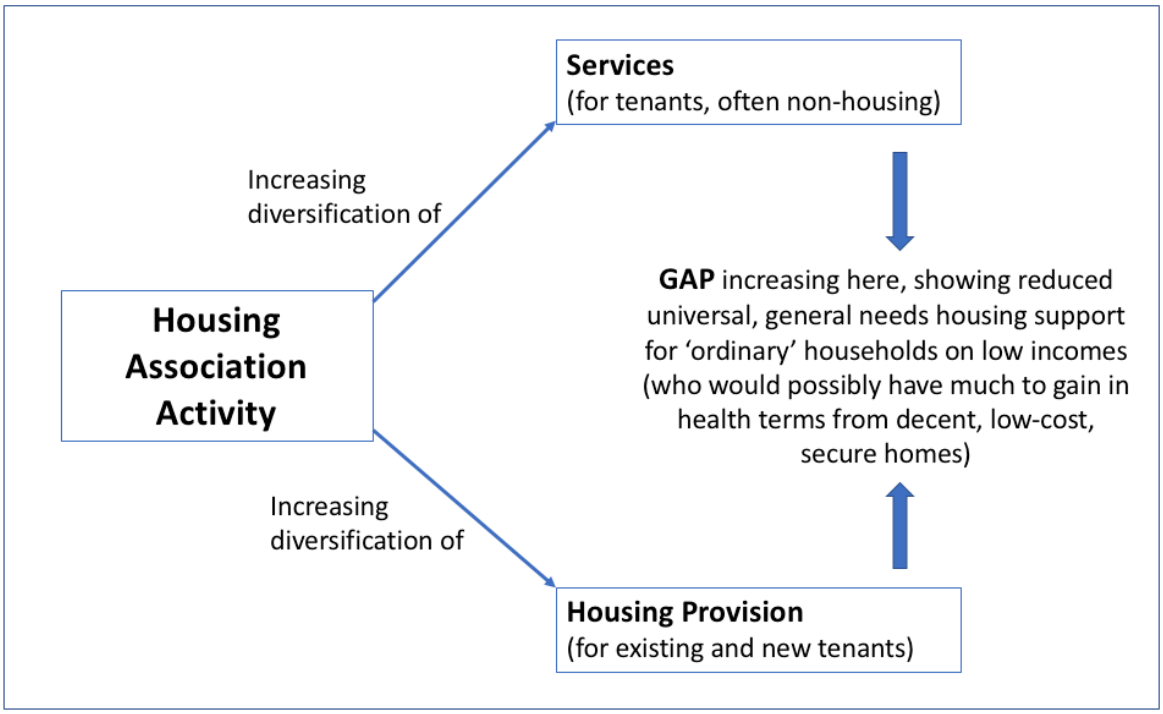
Source: Author

In Fig.4.2, the areas of interest on which this research focuses have been mapped onto the social determinants model, showing some of the multiple and often overlooked ways that housing interacts and intersects with other determinants of health at meso and macro levels, as well as the individual level. These multiple feedback loops frame the research objectives in the context of health inequalities, and are a visual reminder of the importance of context and almost infinite variety of ways these factors may interact to produce individualised health outcomes. When studying structural issues such as health inequalities, it is useful to consider

the factor under investigation (in this case housing association activity) against the wider, systemic framework in order to draw conclusions that have the broadest and most relevant reach and impact.

Attention to context provides further insight into the research aims. These SDOH frameworks are applicable across whole populations, which in turn raises the question of how housing association activity sits as part of wider 'housing' circumstances given that social housing as an 'intervention' is only applied to certain portions of the population at any given moment. It is important that the conceptual framework also includes the wider population who are excluded (or at least not directly affected) by housing association activity in order to make judgements about its effectiveness in tackling health inequalities. The findings of this study, for example in Fig.4.3, have thus been critically considered against the context of the frameworks above. These health inequalities concepts are complementary, and a social determinants of health approach gives a clearer understanding of proportionate universalism, particularly when applied to the housing association data (see Fig.4.3). The 'non-housing' services offered by housing associations are growing in number, and increasingly targeted towards improved health and wellbeing for their tenants, for example debt advice, employment support, food banks and mental health services. However, the demographic of tenants these services are available to, based on the increasing involvement of housing associations in 'Affordable' or market rents, shared ownership, private sale, sheltered and extra care units, is decreasing in universality.

Fig.4.3: Increasing diversification of housing association activity



Source: Author

The starting point for this study is that the relationship between housing and health is not a simple dichotomy, despite its seemingly obvious link. Rather than a straightforward 'cause and effect' between housing conditions or circumstances and health inequalities, this research takes a more holistic, ecological perspective in order not to overlook the complexity of different contexts. Housing is part of the social model of health, and its relationship to those other determinants is influential and important for health inequalities. However, the experiences of disadvantage, which have been argued to contribute to inequalities in health, act cumulatively (Ferraro and Kelley-Moore, 2003). This thesis takes a broader, more holistic view of the critical perspectives surrounding health inequalities than might be expected in housing studies (Egan et al., 2016). Looking outwards from the housing scholarship, this research incorporates the discourse and debates influencing population health. This is necessary to understand the possible consequences and context of the housing association activity that is investigated here, given that the stated aims of the housing organisations, and health-housing policy, is to improve health *outcomes*.

Although this study does not attempt to measure health or illness, critical perspectives on health inequalities have been incorporated throughout the analysis of the housing providers' activities. In this way it is possible to make informed conclusions regarding the likelihood, or the tendency, of this housing activity to contribute to either a reduction or increase in health inequalities, while still taking into consideration the larger, complex, more cumulative system of causation that makes health inequalities so variable and challenging to predict. This thesis uses 'tendency' in the critical realist way, to mean a causal mechanism that may only possibly be activated, depending on the contingent conditions (Fitzpatrick et al., 2020, citing Sayer, 2000). As an advocate of critical realism in housing studies, Hastings (2020, p.17) argues that this philosophical position 'justifies and encourages researchers to look outside their own discipline' and can contribute to the Epistemic Emergence of 'the production of knowledge that it is not possible to reach within a single discipline'.

Accepting that health inequalities are both unwanted and avoidable, and that they are a social construction, it is logical to take the position that social actors and social policies (in this instance specifically in relation to housing associations) have the potential and capacity to impact on them. In this way, the evaluation of housing association activity is more meaningful than previous housing-health studies, because this research takes into consideration many more of the wider determinants that influence health alongside, and in conjunction with, those housing factors. As highlighted in the literature review, the absence of an overarching theory linking housing and health, and the trend towards individualistic studies of the direct relationship between particular housing characteristics and specific health or illness indicators cannot capture or properly address the systemic and structural causes of the wider phenomenon (Gibson et al., 2011; Thomson and Thomas, 2015).

Ontological and epistemological assumptions

The ontology and epistemology of critical realism offer a useful framework to consider and explain the relationship between the activities of housing associations and health inequalities. This realist ontology takes the position that actual housing circumstances have a real consequence for health outcomes. However, the variety evident in these experiences makes understanding causation very challenging. For this reason, the positivism of the biomedical

model, and the notion of 'hard, secure, objective knowledge as both attainable and singularly valid' (Golden and Wendel, 2020, p.3), can be rejected. Critical realism avoids some of the 'pitfalls' associated with 'empiricist theories of causality', which are better suited to 'closed' systems (such as laboratories), or linear, single level explanations of 'cause' and 'event' (Roberts, 2014, p.1). Instead, there is a need to think holistically, and ecologically, about the interrelationships and trade-offs between multiple health-affecting factors and their contexts, for example how housing affordability is related to employment and education opportunities, connectivity and public transport, and the existence and accessibility of public services. Housing researchers have frequently recommended these broader approaches (Lawrence, 1993; Libman, 2012). An 'affordable' home, even one that meets high health and safety standards, is not likely to act as a health asset if it is positioned in a neighbourhood with poor or non-existent links to wider opportunities for material well-being and security. Chapter Two highlighted how much of this disadvantage is cumulative, and therefore the importance of interventions to act on multiple levels, as well as for evaluations of such interventions and policies to take into consideration these layered or interlaced impacts.

Some of the critical realist tools and concepts have been utilised when thinking about the scope and scale of this complex social phenomenon of health inequalities. This framework allows researchers to 'approach causation critically' and recognises that the structures and processes which create health inequalities are 'complex, layered and contingent' (Archer et al., 2016). Byrne argues that critical realism is therefore 'wholly compatible with the complexity perspective' (Byrne, 2005, p.100). Health inequalities exist in the social world, an 'open system' which is impossible to reduce to positivist, general rules of empiricism due to the infinite possibility of concurrent contextual factors and causes, that may be both part of, and independent of, housing circumstances. In order to understand causality, realist research considers the way numerous causal mechanisms, 'in certain contexts…will work together to produce a specific phenomenon' (Hastings, 2020, p.11). Collier (1989) describes the interaction and coalescence of emergent properties as 'lamination', and by recognising the depth of this lamination, and interconnected layers of a social system, it is suggested that the facts and values which make up reality cannot be neatly divided (Porpora, 2016).

The ontological and epistemological positions adopted are informed by the review of the research literature spanning different academic fields. Housing studies, health inequalities research and the work examining the relationship between housing and health (or housing and illness) have effectively used the tools and positioning of critical realism to try to grasp and explain the complexity and interdependencies of the relationship and causal mechanisms that link housing factors and health outcomes. Barr et al. (2016, p.261) suggest that such a realist framework may have 'great potential for generating evidence to determine what works, for whom, and in what circumstances for reducing health inequalities'. In housing research, authors including Allen (2000), Fitzpatrick (2005) and Hastings (2020) have applied critical realism to better explain and understand the complex and interplaying mechanisms that work to cause phenomena such as homelessness. Allen (2000) applies this perspective to the relationship between housing and illness in order to give more nuance and consideration to the variability of health outcomes that cannot be uniformly determined by a standard experience of housing circumstance. Acknowledging complexity and variation is a key component of health inequalities theorising, and critical realism may 'deliver enriched explanations for complex social phenomena relevant to social policy' (Hastings, 2020, p.9). It is also necessary for researchers to be able to say something about the 'likely' effects of a policy intervention, while accepting that there is unlikely to be a blanket 'covering law model' or 'general law' of social policies that will predict invariable outcomes. As in complexity theory, the whole is more than the sum of the parts, and in this study of the relationship between a causal mechanism (housing) and a phenomenon (health inequalities), the compounding effects of either disadvantage or protective factors are of supreme importance.

Previous research has recommended a more holistic understanding of the housing and health relationship (Lawrence, 2004 and 2006; Swope and Hernández, 2019). 'Holism' has two definitions, and both are appropriate in the context of this research. As a philosophical concept, holism is 'the theory that parts of a whole are in intimate interconnection, such that they cannot exist independently of the whole, or cannot be understood without reference to the whole, which is thus regarded as greater than the sum of its parts'. In medicine, holism refers to the treating of a whole person, considering social and mental factors rather than just symptoms of an illness (online dictionary). In response to these research objectives, it was possible to extract maximum meaning from the data by considering these complex

mechanisms from more than one perspective. An analysis that evaluated the health-focussed activities of housing associations in isolation, without considering those holistic relationships between the causes of health inequalities, and the importance of what is happening contextually, may have drawn very different conclusions to those of this thesis. Critical realist perspectives go some way to explain the intra- as well as inter-sector variability and experiences of health-targeted work by housing associations. In this study these activities are understood in conjunction with several of the other necessary tendencies that work together to cause health inequalities.

The study design

The qualitative case study

This thesis embarks on a detailed, multi-level nested case study of Greater Manchester. Such a methodological approach is defined by Yin (2014, p.16) as 'an empirical inquiry that investigates a contemporary phenomenon (the "case") in depth and within its real-world context'. A case study was selected as the most appropriate methodology here because it allows research on a complex set of phenomena (health inequalities) within a specific and appropriate context (Greater Manchester), while ensuring 'that the issue is not explored through one lens, but rather a variety of lenses which allows for multiple facets of the phenomenon to be revealed and understood' (Baxter and Jack, 2008, p.544). As the relationship between housing and health has been shown to operate on numerous levels of intersection, and because the ways health inequalities are created are so complex, this type of in-depth, multi-level case study is considered to be 'robust and reliable' (Baxter and Jack, 2008, p.550). Case study methodology is appropriate for this research, which took place in stages and was iterative in its design. The wider 'case' (Greater Manchester) was explored in the initial stages of the research, and the study design was refined and redirected during its subsequent stages to focus on two individual 'cases' in more depth (Oldham and Trafford) (see Fig.4.5). The more cases that can be included, 'the more robust are the research outcomes' (Rowley, 2002, p.21). The nested design supports this approach, allowing for additional depth of analysis through the cases of Oldham and Trafford, which could explore in more detail the intra-metro contrasts which have often been overlooked when treating Greater Manchester as a homogeneous entity. Given the conditions set out by Yin (2003),

the case study approach is suitable for studies such as this, which aim 'to answer "how" and "why" questions', as well as research which aims 'to cover contextual conditions because you believe they are relevant to the phenomenon under study' (Baxter and Jack, 2008, p.545).

In response to the research questions, the overall research strategy was designed to incorporate holistic perspectives on the issue of housing associations and health inequalities, which, as demonstrated in Chapters 2 and 3, have been limited in previous studies by an over-reliance on the positivism of the medical model, and linear approaches to the relationship between isolated housing interventions and specific health outcomes (Allen, 2000; Baker et al., 2017). The research is thus framed by the social determinants paradigm, which forms the backdrop for the data collection and analysis. A 'social determinants approach' is recommended by Marmot et al. (2020, p.10) for cross-sectoral and place-based working, and sustained efforts in delivering 'a programme of action on health inequalities and inequalities in social determinants'. Greater Manchester declared itself a 'Marmot City Region' in 2019 (Price, 2020).

A critical realist perspective also shaped the study design in response to the research questions, and critical realism allows for flexibility in methodological approach (Scott, 2005). The case study approach embodies critical realist thinking regarding the importance attached to temporal and spatial context in understanding social relations. The study is therefore focussed on a group of actors working within and across institutions in a particular place, at a particular time, in order to explore the interplay of structure and agency in shaping and limiting both individual and institutional actions. Easton (2010, p.119) argues that critical realism is well suited to case study research, particularly if the 'process involves thoughtful in-depth research with the objective of understanding why things are as they are'. Critical realism also supports research on 'open' systems, where relationships are context dependent (Haigh et al., 2019), as is demonstrated in this research via the multiple, interdependent factors and mechanisms that comprise Greater Manchester's approach to health inequalities involving housing providers.

Why Greater Manchester?

Fig. 4.4: Greater Manchester, England

Source: Nilfanion – Ordnance Survey OpenData (2010)

Fig. 4.5: The ten boroughs of Greater Manchester

Source: GMHSCP (2017)

Greater Manchester provides an enlightening case study of the social, political and institutional dynamics of housing associations working as agents of 'health'. The city-region was selected as the site for this study because of both its active and engaged group of housing

associations (Greater Manchester Housing Providers (GMHP)) and also the city region's position, unique in England, of having responsibility for health and social care spending devolved since 1st April 2016. While both these factors make Greater Manchester a place of particular interest and rich research material, the lessons from this study can provide insight more broadly to the issues of devolution, retrenchment, austerity, and the changing roles and relationships between statutory and non-state actors who are increasingly providing essential services, in the UK as well as further afield. Greater Manchester was selected precisely because it is not representative of the English experience, although it is, however, a potential template for other city-regions hoping to apply a similar devolved model (Ward et al., 2016). In cases where the 'objective is to achieve the greatest possible amount of information on a given problem or phenomenon, a representative case or a random sample may not be the most appropriate strategy' (Flyvbjerg, 2006, p.13). Those typical cases do not often yield the richest information, but rather 'atypical or extreme cases often reveal more information because they activate more actors and more basic mechanisms in the situation studied', and a 'few cases selected for their validity' will produce more insight than random or representative samples (Flyvbjerg, 2006, p.13).

Greater Manchester offered an opportunity for a kind of 'natural experiment', an approach that is appropriate for studies of policy that are outside the control of the researcher (Barr et al., 2016; Leatherdale, 2018). As part of its transformation plans, Greater Manchester had stated its explicit local goals of reducing health inequalities, radically upgrading population health prevention, and of involving more housing stakeholders in the process (GMCA, 2015). Devolution in Greater Manchester offered a potentially unique supportive policy environment for these goals, enhanced by unprecedented health and social care powers for England. The Greater Manchester Combined Authority (GMCA) and the Greater Manchester Health and Social Care Partnership (GMHSCP) both offer possible vehicles for more effective governance and delivery of the 'healthy public policy' which is stated to be their aim. Each 'public service in GM – from housing and transport to health and justice, and employment – has better health as one of its aims' (Benbow et al., 2020, p.318). The multi-level approach taken here, which considers the city-region as a whole as well as some of its individual boroughs in further depth, allowed for a rich and layered process of data collection. The city-region has been a site of academic interest for many years due to its supposed success in

promoting policy innovation and building supportive governance structures (Deas et al., 2020). This thesis builds on those insights, and contributes to the growing literature on Greater Manchester in light of its continuing socio-spatial inequalities.

The CASE Partner

The study was supported from its inception by a Greater Manchester housing association with an explicit 'intention to create improved health and well-being for residents' (Trafford Housing Trust, Call to Action, 2018). This organisation has significantly diversified its business to include more health-related activities of the sort that this research intended to examine. Contacts at the housing association were able to provide an extremely valuable source of insight and information. In order to achieve high standards of academic rigour and as much impartiality as possible when researching these issues, the Case Partner was not involved in the study design process, nor the analysis of the data. They were not intrusive in this respect and have asked only that conclusions are shared with them at the end of the project. However, once the review of the literature and policy surrounding the subject were completed, the organisation was approached and support was requested in beginning the data collection process of elite interviews, as well as some direct observation. The partner organisation consented for several members of its senior staff, as well as staff members who are directly involved in service delivery, to be interviewed. An invitation to a meeting of the Greater Manchester Housing Providers' (GMHP) Health Steering Group in January 2018 was also secured, which proved to be a crucial part of the research process, and instrumental in providing access to many of the participants that were interviewed for this study.

The choice of research methods

The study was designed to capture the experiences of housing associations in relation to their health-related activities, and to develop a critical interpretation of them. The literature review and policy review have highlighted the complexity of this relationship between housing and health, and suggested the benefits of adopting a holistic, critical realist ontology to approach and analyse these heterogeneous organisations. A qualitative research strategy was most appropriate here, given the strength of such methodologies to 'celebrate richness, depth, nuance, context, multi-dimensionality and complexity' in topics such as this (Mason,

2002, p.1). These qualitative methods lend themselves most appropriately to the kind of complexity and subtlety that are characteristic of an intensive case study research design (Kvale, 1994). Qualitative approaches are suitable for research questions that require 'textural data' as part of 'a holistic approach that involves discovery' (Williams, 2007, p.67) as well as for studies with an exploratory nature (Elliott and Timulak, 2005). Research objectives such as these, which anticipated some complexity and nuance in the findings' implications, therefore required close and consistent involvement and engagement with study design and data collection. These were ongoing and iterative processes of investigation, rather than being fully predetermined.

Some of the initial ideas for data collection were rejected, such as the possibility of sending a survey to all of the housing associations operating in Greater Manchester. The likelihood of receiving enough data of sufficient depth to meaningfully answer the research questions was limited. A large survey (if it received a high enough response rate) may have provided useful data to demonstrate 'what' housing providers are doing in regard to health inequalities, but in order to understand 'why' this activity is taking place, a semi-structured, in-depth interview process would go further to satisfactorily address the study's objectives. However, it was important to try fully to incorporate the broad scale of the city-region, given that the devolved powers reside at the Greater Manchester level, which incorporates ten boroughs. The fieldwork was tackled in separate stages. An initial round of interviews was conducted first, with a broad range of housing providers and other stakeholders that spanned each of Greater Manchester's individual local authorities, as well as interviews with professionals working at the Greater Manchester level, for example at the Greater Manchester Combined Authority (GMCA) and the Greater Manchester Health and Social Care Partnership (GMHSCP). The interviews covering the city-region were an important tool in designing the subsequent part of the study, which focussed on the experiences of housing providers in Oldham and Trafford, and their in-depth insights regarding delivery of some of the activities and services highlighted at the first stage.

The pace of this process of interviews allowed the study design to evolve, and line of questioning to adapt, as information came to light. As Hochschild (2009) suggests, one of the benefits of conducting elite interviews is that 'the interviewer can carefully triangulate among

respondents' and it is sometimes possible to 'use information gleaned from a previous interview to question or push a current subject a little more deeply'. This was particularly useful when moving from the broader phase of interviewing across the city region to the borough specific interviews focussed on particular health-related projects. The opportunity to attend GMHP meetings throughout the research process, and perform some direct observation, provided a further means of data triangulation, as well as the possibility to situate and contextualise some of the interview findings in a broader dynamic.

Trafford and Oldham

Two local authorities were selected for detailed examination, in order to better understand the experience of Greater Manchester, recognising that it cannot be understood as a homogeneous or uniform territory in either political or socio-economic terms. The boroughs selected for further attention were determined by both pragmatic considerations, and the data from the initial round of interviews (spanning all ten Greater Manchester boroughs and the members of the GMHP group). The first stage of interviews generated insights from the housing providers' peers into which organisations may have had the most experience to learn from, and who had made the most progress in their local authorities in furthering this health agenda. These studies were complementary rather than comparative, given that the initial round of interviews highlighted the extreme variability and heterogeneity between these organisations. Oldham is a historically more deprived borough than Trafford. Oldham has previously been able to attract centrally allocated regeneration funding, for example via the Housing Market Renewal Pathfinder scheme which allocated £90 million to Oldham-Rochdale between 2008 and 2011 (Wilson, 2013). Trafford, on the other hand, is overall the most affluent of Greater Manchester's local authorities but experiences significant inequalities (Gray and Barford, 2018). Conducting interviews within these two boroughs was an opportunity to consider how some of the activities and trends highlighted by senior managers and policymakers were experienced by the housing staff members responsible for their delivery.

Oldham was repeatedly referred to in interviews as the borough where the housing association and local authority had a particularly fruitful partnership with the local authority

and CCG. The pursuit of such partnerships in Oldham is part of a locally distinctive approach, related to Oldham's status as a member of the Cooperative Councils Network, and its efforts at innovation in recent years, particularly since the onset of austerity (Shafique el al., 2012). The stock transfer housing association, First Choice Homes Oldham, had a series of four projects that were jointly funded and commissioned by their CCG and interviews were conducted with the housing staff who delivered each of them, whether in their housing-based or clinical settings. This housing association was responsive to the goals of the research and the personnel interviewed were given the time to participate by the senior managers.

The housing association based in Trafford was the CASE partner organisation, and their original engagement with the study was driven by their flagship health and wellbeing project. This is an Extra Care housing development which also houses a community centre, health facilities, an optician, pharmacy, nursery, a hair salon, a café and the public library. This site offered the opportunity to view one particular housing project holistically, and by interviewing several stakeholders working in the same site it represented a unique place in Greater Manchester to explore the work of a housing association and its partners in one spot, from numerous perspectives.

Ethical approval

The University of Manchester granted Ethical Approval for the study on 13th October 2017. The primary issues requiring ethical consideration related to the security and anonymity of the data collected. This research was concerned with health issues, but care was taken not to stray into questioning that would have breached issues of confidentiality. Any evidence relating to specific circumstances of an individual, even when medical conditions were part of the interview, was anonymised during both its reporting and recording. No information was sought that might have revealed patient-sensitive data or compromised any professional and ethical obligations to stakeholders' patients or tenants. Time was taken before each interview to explain the parameters of the research, and to remind participants that their participation was voluntary and could be withdrawn at any time. A secure data management plan was drawn up in accordance with university and ESRC guidelines.

(See Appendices 1, 2 and 3 for sample consent form, participant information sheet, and sample interview guide)

The data collection process

The primary data for this research was collected between January and December 2018, with follow-up direct observation in 2019.

Semi-structured interviews

Elite interviews were determined to be the most suitable way of generating data to address the research objectives. Elite interviews 'can give substance and meaning to prior analyses of institutions, structures, rule-making, or procedural controls' such as those identified in the literature and policy review chapters (Hochschild, 2009). The majority of the fieldwork took the form of semi-structured interviews, with professionals in the housing sector as well as stakeholders in local government, clinical practice and public health. The selection of participants was informed by their experience related to the research topic, which is deemed to be of vital importance (Cameron, 2005). Key actors in the field were identified, supported by the CASE Partner, who issued an invitation to one of the quarterly Health Steering Group meeting of the GMHP in January 2018 and made an introduction. Thus, a combination of criterion and snowball sampling were employed to access specific participants for this research who possessed specialised knowledge in this field, whether from a housing, public health or governance (Greater Manchester devolution) perspective. The anticipated number of interviewees was forty (twenty across Greater Manchester and ten in each of Oldham and Trafford), although this number was adjusted throughout the research period. As Malterud et al. (2016, p.1754) note, having an 'approximation of sample size is necessary for planning, while the adequacy of the final sample size must be continually evaluated during the research process'. The actual number of interviews conducted was thirty-seven (see Table 4.1 below).

The semi-structured interviews employed a predetermined framework for questioning, which comprised a mixture of specific and broad themes and issues to consider. The interviews began with ice-breaker questions to allow the participants to 'warm up', such as questions about their current role, how long they had worked for the organisation and their professional

background and experience. The questions asked in the first phase of the interview were designed to get participants thinking about their current activities and experiences, describing the ways their organisation, their team or their own role is working in connection with the health-housing agenda. As recommended by Longhurst (2016, p. 107), the 'more difficult, sensitive or thought-provoking questions are best left to the second half of the interview or focus group when participants are feeling more comfortable'. Towards the end of the interview, the participants were asked to think about broader issues, such as the sustainability and viability of this work, barriers to progress, and the identity of their organisation or sector. To reduce both researcher and participant bias where possible, the questions were simple, non-leading and open-ended, varied as much as possible in their language and vocabulary, and anonymity was assured (Shah, 2019). Interviews predominantly took place in private rooms at the workplaces of participants. This was anticipated, as 'in most cases if you are talking to business people or officials from institutions and organisations you will have no choice but to interview them in their own offices' (Valentine, 2005, p.118). Workplace interviews had the benefit of ensuring participants felt at ease in their surroundings, and securing private spaces to conduct the interviews allowed the interviewees to speak confidentially.

The data collection itself formed part of the iterative processes of both the study design and the analysis. As the areas of fieldwork interest became more focussed, moving from Greater Manchester to the case study boroughs, the approach was continuously adapted and clarified. Some initial familiarisation and data analysis were undertaken at the transcription stage, which took place between the phases of interviews. This informed and refined both the lines of questioning and the individuals approached to participate in the interviews. The process became more streamlined in an effort to reduce superfluous data that would not have been possible to utilise. For example, the number of participants interviewed in the second case study borough (Oldham) was significantly fewer than those involved in the first (Trafford). Although Oldham involved the fewest interviewees, it yielded the least amount of irrelevant (or surplus) data, that had little or no bearing on the specifics of the research questions (though were of course somewhat useful in terms of enlightening context). In accordance with the concept of 'Information Power', as an alternative to the commonplace but frequently arbitrary use of 'saturation' (O'Reilly and Parker, 2012), when the 'attained

and projected information power appears to be unexpectedly strong', the 'number of participants needed may be adjusted downward' (Malterud et al., 2016, p.1757). Rather than 'a complete description of all aspects of the phenomenon we study', which in qualitative research would be likely to stray far from the aims of the project, 'we are usually satisfied when a study offers new insights that contribute substantially to or challenge current understandings' (Malterud et al., 2016, p.1759).

Direct observation

The opportunity was presented via the Case Partner to attend several of the Greater Manchester Housing Providers (GMHP) 'Housing and Health Steering Group' meetings. These quarterly meetings are mostly attended by a designated individual from each of the twenty-five GMHP organisations, usually the Chief Executive or another senior manager or director (although full attendance was unlikely). Many of these meetings were also attended by 'guests' from the health sector or local government, usually on a one-off basis. The meetings discussed how to further the aims of the GMHP to 'connect health and housing', so were a useful platform for following this agenda and becoming familiar with the individuals responsible. During the course of the fieldwork, having interviewed several members of the group individually, it was possible to build relationships and trust with these members of the housing sector. There was some risk that the positionality of the researcher, as a guest of one of the members, might have led to subsequent invitations being issued because participants saw the process as uncritical, or felt that building a personal relationship might act as a way of deflecting potential criticism. Yet, a degree of insider status has been suggested to have its advantages, including for access, rapport and analysis (Hayfield and Huxley, 2015). As argued by Mason-Bish (2018, p.264, p.275), elite interviews undertaken by a well-informed and knowledgeable researcher can demonstrate 'the dynamic nature of interviewing' and balance, which is part of the 'joint construction of a narrative' between interviewer and interviewee (see also Harvey, 2011). These participants subsequently issued invitations to observe several follow-up housing-health meetings in local authority/combined authority settings after the interviewing process was complete, which was extremely helpful during the analysis stage of the research. It also provided the opportunity to stay up to date with the

ongoing issues and developments of the GMHP agenda, and to ask any follow-up questions with interviewees which were emerging during close readings of their transcripts.

These meetings were attended as a non-participant, in order to ensure the minimum influence or disruption to the proceedings from the presence of a researcher. One of the advantages of observation such as this is to enable the researcher to access 'backstage activities' that are not usually visible, giving the opportunity 'to provide rich, detailed descriptions of the social setting in your field notes and to view unscheduled events, improve interpretation, and develop new questions to be asked of informants' (Kawulich, 2012, p.153). Direct observation is recommended as a valuable pairing to other qualitative methods. For example, semi-structured interviews 'can be a good complement to observation, as interviews allow you to ask questions one-on-one with people who are part of the ethnography' (Turner, 2018; see also Kawulich, 2012). It is also helpful when identifying the relevant individuals to interview, which often 'involves some participant observation to identify the most interesting respondents' (Turner, 2018). As recommended when doing case study research, 'each data source is one piece of the "puzzle", with each piece contributing to the researcher's understanding' and this 'convergence adds strength to the findings as various strands of data are braided together to promote a greater understanding of the case' (Baxter and Jack, 2008, p.554).

Table 4.1: Data collection calendar - Interviews

Date of interview	Anonymised reference	Professional position	Stage of fieldwork
18/01/2018	GM1	Housing Director (local authority) Strategic lead (combined authority)	GM (Greater Manchester)
08/02/2018	TD1	Director (HA)	Trafford
14/02/2018	GM2	Chief Executive (HA)	GM
16/02/2018	GM3	Chief Executive (HA)	GM
19/02/2018	GM4	Executive Director (HA)	GM
22/02/2018	GM5	Assistant Director for Homes (local authority)	GM
23/02/2018	GM6	Strategic Lead (combined authority)	GM
26/02/2018	GM7	Senior Health and Wellbeing Lead (HA)	GM
05/03/2018	GM8	Executive Director (HA)	GM
05/03/2018	GM9	Director of Health and Housing (HA)	GM
08/03/2018	GM10	Deputy Chief Executive (HA)	GM
23/04/2018	OD1	Customer First Director (HA)	Oldham
04/05/2018	GM11	Senior Manager, Housing and Health (GMHSCP)	GM
04/06/2018	GM12	Housing and Health Officer (VCSE)	GM
05/06/2018	GM13	Chief Executive (VCSE)	GM
14/06/2018	TD2	Clinical Employee (HA)	Trafford
20/06/2018	TD3	Senior Director (HA)	Trafford
27/06/2018	TD4	Centre Manager (HA)	Trafford
29/06/2018	TD5	Volunteer Manager (HA)	Trafford
29/06/2018	TD6	Extra Care Manager (HA)	Trafford
29/06/2018	TD7	Managing Director (VCSE)	Trafford
09/07/2018	TD8	Senior Manager (VCSE)	Trafford
10/07/2018	TD9	General Practitioner (GP Surgery)	Trafford
12/07/2048	TD10	Sales Officer (HA)	Trafford
17/07/2018	TD11	Senior Manager (HA)	Trafford
17/07/2018	TD12	Senior Member of CCG (Clinical Commissioning Group)	Trafford
20/07/2018	GM14	Chair of CCG	GM
25/07/2018	GM15	Tenant Representative (Sheltered Accommodation)	GM
25/07/2018	GM16	Sheltered Accommodation Scheme Manager (HA)	GM
19/09/2018	GM17	Senior Manager, Public Health (GMHSCP)	GM
03/10/2018	GM18	Head of Independent and Community Living (HA)	GM
05/10/2018	GM19	Managing Director (HA)	GM
19/10/2018	OD2	Hospital based housing officer (HA)	Oldham
24/10/2018	OD3	Programme Manager (HA)	Oldham
06/11/2018	OD4	Senior Manager, Health and Housing Needs (HA)	Oldham
06/11/2018	OD5	Neighbourhood Manager (HA)	Oldham
12/11/2018	OD6	Hospital based housing officer (HA)	Oldham

Dates of GMHP 'GM Health Steering Group' meetings attended (quarterly):
15/01/2018
19/04/2018
16/07/2018
08/10/2018
14/01/2019

Dates of follow-up meetings attended:
31/01/2019 – Greater Manchester Strategic Housing Group (GMCA)
26/03/2019 – Greater Manchester Housing and Health Programme Board (GMHSCP)
18/04/2019 – GMHP Health Steering Group

Recording and storing data

A secure data management plan was drawn up in accordance with the University of Manchester's guidelines, and submitted for ethical approval. The semi-structured interviews were recorded on a portable device and uploaded to secure University network storage at the earliest opportunity. The data was not stored on any other portable or removable storage device. All data storage devices (including hard drives, laptops and transcription files) were encrypted and password protected. Data will be stored for a minimum of five years, as stipulated by the University's ethics requirements. The data collected will not be transferred to any individual or party outside the immediate members of the research team. All storage file names have been kept anonymous, according to the researcher's cataloguing system. Audio recordings were not made of the large group meetings, but field notes were taken, and the official minutes of these meetings were provided by the Chief Executive of the hosting organisation.

Approaches to data analysis

The analysis took the form of both inductive and deductive reasoning. The line of questioning was informed by the knowledge gathered from the literature and policy review processes, and was regularly reviewed as data were collected. Some analysis was conducted after each phase of interviewing in order to rigorously inform the subsequent stages. The insights that emerged during the fieldwork were not predetermined, but they did align with some of the preconceived themes that were expected to be found, based on the relevant scholarship. These themes and insights have formed the framework for the analysis.

As part of the critical realist process, deduction is helpful to 'identify the phenomenon of interest' and suggesting causal mechanisms, as well as providing links with existing literature and research, while induction provides the 'data to be explained and tests the explanations' (Easton, 2010, p.124). During the analysis process, critical realism shaped the way the data from interviews were approached, in particular in recognising the importance of the 'real' and 'existing' material phenomena which relate to health inequalities, rather than purely subjective conceptions and perceptions. Critical realism also allows for a qualitative understanding of causality, as was necessary in analysing the Greater Manchester data, enabling the various causal mechanisms to be examined in the social world where they take place. Such mechanisms in 'real' contexts will 'interact with one another in often contingent and unpredictable ways' (Roberts, 2014, p.2). This aided interpretation and understanding of the wider forces and contextual social factors which interact as part of the case study. Other approaches which are more commonly applied to evaluations of health interventions, such as the positivist approaches associated with the medical model (Baker et al., 2017), do not allow for adequate consideration of the contingent factors which social determinants of health models emphasise are so important. Utilising the concepts from critical health inequalities literature in combination with interview testimony contributed to the holistic interpretation of this evidence.

The transcription process was an important stage in becoming familiar with the data, and all audio transcription was undertaken independently. Time was taken between different stages of the research to transcribe and reflect on the data collected at each point, in order to take those insights forward into subsequent interviews to remain informed and keep the semi-structured conversations focussed. The questions put to participants in the Oldham and Trafford case study boroughs (the second and third phases of fieldwork) were thus informed by the insights gained during the broader, scoping interviews. This ensured that the data was most likely to remain relevant and useful. The experience reflected that of other researchers who have reported that 'the process of developing themes and arguments out of transcripts of intensive interviews is endlessly iterative' (Hochschild, 2009). The first stage of transcription, and the initial insights generated by the first stage of reading and familiarisation, formed the basis of the approach taken to coding and theming the data. This

process followed the six-step process of thematic analysis as recommended by Braun and Clarke (2006):

1) Familiarisation
2) Coding
3) Generating themes
4) Reviewing themes
5) Defining and naming themes
6) Writing up

By using a combination of multiple readings, outlining an initial framework, reflecting on unpredictable insights, returning to literature on the subject and numerous drafts, the final argument emerged in the form of three significant themes.

Thematic analysis

Table 4.2: Sample interview transcript demonstrating codes and themes

Interview Extract	Codes
We, as an organisation, are actually somewhat ambiguous about the extent to which we should be playing in this space. I'm not personally, I think that it is impossible for a social landlord not to be a significant player in this space, and that stems from the fact that we house, disproportionately, older and more vulnerable people in society. They are, by default, [it's a] dreadful term, 'frequent fliers' into the health and social care services. And those services, for the next decade, I cannot see doing anything other than withdrawing from those people's needs. Therefore, we are going to be left with the problem. So, we've got this problem and we can't get rid of it, unless we really shift who we allocate to and what we do, and all that kind of stuff, and that takes us away from our social mission. So for me it's almost a no-brainer that, the health and social care gradient, we need to get further and further up it. The question then becomes, 'how do we do it?' And we've tried taking little steps. We employ [an Occupational Therapist], we've got a Dom [Domiciliary] Care team, we do Extra Care, and we've now got it so our Dom Care team provides the extra care in the Extra Care, that wasn't easy…So, we continue to progress from here. Or, we do what we've done with our development world. So [we] in a different world, we were building at the rate of a hundred, hundred and fifty homes a year, then we refinanced which meant that we would do a bit more, two hundred a year. And then we partnered with a housing association in the South, who are investing through us and we're investing with them, and between us we're building now at the rate of five hundred a year. So, we've more than doubled the rate at which we're building. And we're having really hairy talks with them about building huge, thousands of numbers of housing, massive. And that has transformed the way we approach development. Because we've got a partnership with somebody that is very different from us. So, back to health and social care, who is that partner that we need to find, who will radically transform the offer that we are able to make?	Confusion of identity (T1) Individually determined values of CEOs and Boards (T1) Necessity vs. desire (T1) Demographics of tenants (T1) Austerity/cuts (T3) Diversification and changes in purpose (T1) Partnership working (T1 and T2)

Table 4.3: Turning codes into themes

Examples of codes	Themes (T1, T2 and T3)
• Purpose/priorities of HAs • Necessity vs. desire of interventions • Variability within the sector • Substitution of statutory services • Role (and recruitment) of HA staff • Partnership working with local authorities and the health sector • (Changing) demographic of tenants • Relationships and communication • Two-tier health and housing service • Medical vs. social model of health • Mission drift • Identity crisis/confusion • Commercial vs. social priorities	1) 'Healthy' housing associations
• Inherited deficit and budget cuts • Governance and policy structures (e.g. GMCA and GMHSCP) • Public Health reforms • Variability between boroughs • Relationships within and between boroughs • Political priorities (local) • Partnership working with local authorities and the health sector • The medical model • The social model • Lifestyle drift • Long-term vs. short-term approaches • Limits of localism • Upstream vs. downstream approaches • Reach (or limit) of devolved powers • Relationship between devolved and centralised powers • Accountability	2) Housing and Devolution
• Austerity measures • Driving forces of HA activity • Public sector retrenchment • Holes in the safety net • Welfare reform • Universalism • Proportionate universalism • Individual vs. collective action • Priority afforded to housing compared to other welfare state services e.g. clinical services • Two-tier health and housing service • The social contract • Charitable, deficit model	3) Housing and the Welfare State

The coding process formed a crucial part of the analysis, and several codes (such as universalism, individual vs. collective action, lifestyle drift etc.) illustrated familiar links with scholarship that spans both housing studies and health research. The coding was facilitated using NVivo software. Some of the codes aligned closely with each other, such as 'relationships and communication' and 'partnership working with the health sector', so during a process of simplification the codes were regrouped within the themes, giving more clarity to the analysis process. This process was repeated several times. Chapter Seven is structured under these three themes, giving richer meaning to the implications of these data in those areas of research.

Summary

This methodology process has delivered rich, valuable data that goes a long way to better explain and understand the relationship between housing associations and health inequalities. The methodological approach therefore advances the housing-health discourse to include explicit consideration of health *inequalities*. In order to critically assess the role of housing associations (without the means to measure individual health outcomes), this research utilises the social model of health framework and both social-ecological and critical realist approaches to produce a nuanced, holistic account of this complex relationship. By taking a more holistic view it is possible to anticipate likely consequences of housing association activity (changes in their function, focus, and purpose) in light of population-wide or aggregate health outcomes. Policy measures may have unintended consequences, so engaging with the widest possible literature will inform more detailed and critical judgements. A case-study approach (focussing on the population health of Greater Manchester in its devolutionary context), has thus prevented the study from becoming an evaluation of housing association activity on the likely health outcomes solely of their *tenants*, (though that remains an important part of the analysis), as that might have failed to give appropriate weight to the structural and systemic issues that are the root causes of inequalities in health, and the steep social gradient. The subsequent chapters will share the insights and implications for these data in detail, and in this context, considering the ways these housing association activities may contribute towards the ultimate goals of improved population health and reduced health inequality.

Chapter Five
The changing health role of housing associations in the devolved Manchester city-region

Introduction

Chapter Five discusses key findings from the research on the form and extent of housing associations' involvement in health activities at the city-region scale. In much of Greater Manchester, housing associations are increasing their focus on health and wellbeing, although the experiences of those involved varies widely. The devolution agenda is a strong influence on several of these organisations. Housing providers that are most actively involved in health issues are closely connected to their statutory partners in the city-region, such as the individual borough councils they work within, the Greater Manchester Combined Authority (GMCA) or the clinical bodies (NHS Trusts and CCGs). This, however, is not the case across the full range of social housing providers, nor are they a homogeneous group. The statutory bodies in Greater Manchester have identified the potential of housing associations to contribute to a population-based health system, through both housing and non-housing services.

Analysis of primary data highlights several ways housing associations are adapting their ways of working to fulfil this agenda, as well as the challenges associated with this activity. The participants in this stage of the research were senior actors operating at both the combined authority level and within the ten individual local authorities, representing housing associations, the health sector and local government. The housing association interviewees were senior staff, either directors or chief executives, or the managers responsible for their organisation's health activities. The data presented in this chapter provides an overview of the relationship between housing and health actors across Greater Manchester, and acts as a precursor to the granular analysis of Chapter Six, which draws on the perceptions and experiences of actors involved in delivering housing and health services in Oldham and Trafford. This chapter will explore the diversification of the services provided by Greater Manchester housing providers with a health focus, and some of the forces which are driving their expanding role. Links will be made between the housing association activities and the

austerity and devolution policy context, as well as implications of these findings for housing staff, the people of Greater Manchester, cross-sector partnerships, and the growing uncertainty regarding the purpose and sustainability of an increasing remit for housing associations.

Diversification of housing association activity into health

During the course of the research, senior housing professionals operating across each of Greater Manchester's ten boroughs were interviewed in their various capacities. One characteristic observed amongst all the participating housing providers is the increasing diversification of the services they are offering, above and beyond their core landlord function. This tendency has been identified by previous studies (Hickman and Robinson, 2006; Richardson et al., 2014; Smyth et al., 2020; Tang et al., 2016), but this chapter's findings explore this diversification specifically in relation to health. The activities of housing associations are increasingly varied, and include interventions targeted at the medical or clinical problems of their customers, as well as initiatives designed to target the wider social determinants of health. Examples of this work include: supported and sheltered housing; aids and adaptations; extra care schemes and in-house teams of carers; employing clinical staff such as mental health practitioners and occupational therapists; food banks and community pantries; employment and skills training; debt and financial advice and support; accommodating GP surgeries and pharmacies; counselling; food and nutrition; holiday kitchens for children; nurseries; volunteering, training and apprenticeships; running community centres and libraries. As one interviewee put it: 'I couldn't even begin to tell you how much stuff we do' (Interview, GM9).

Housing professionals accepted that the provision of decent, stable, affordable and non-hazardous homes is paramount, and that 'if you've got a secure home that's warm, that's probably one of the biggest things that [we] can do in terms of addressing health inequality' (Interview, TD1). It was commonly noted, however, that for residents encountering the biggest health challenges, more support is needed. Interviewees stated that 'you've got to get the housing right, so we'll never move away from that' but they 'recognise that just providing the roof is never going to be enough, and it's very complex, particularly when you're

dealing with people that are economically and socially and health deprived' (Interview, GM4). In terms of the housing association's primary role, 'number one is providing a house but pretty close second is somebody needs a purpose after that' (Interview, TD1). Housing associations argued that 'if we're looking at changing the focus of health from hospitals, from institutions, into community settings, [then] we're in a good position to do that' (Interview, GM3).

These housing organisations form an important component of Greater Manchester's ambition to move to a 'population-based health system' (Interview, GM11). The city-region is embarking on a period of public service reform and health and social care devolution, which is intended to focus on 'a stronger prioritisation of wellbeing, prevention and early intervention' (GMCA, 2019c, p.29), leading to a 'radical upgrade in population health prevention' (Walshe et al., 2018, p.25). The 'non-landlord' functions of housing associations are shown in Greater Manchester to be diversifying and developing at a previously unmatched pace. The contribution of these activities to the city-region's goal of improved population health is recognised by those working in Greater Manchester's devolved health and social care partnership, who have found 'more areas of work where there's value in us having longer term partnerships' with the housing providers (Interview, GM11). To increase their impact and amplify their voices within the city-region, several housing associations in Greater Manchester are working 'collaboratively…across GM on a whole range of things. Building new homes, public service reform, planning issues, and now increasingly, on health' (Interview, GM3). The fieldwork participants on which this thesis is based are drawn from this group of housing organisations.

The Greater Manchester Housing Providers

Much of this activity in Greater Manchester is led by a group of approximately twenty-five housing associations, forming the Greater Manchester Housing Providers (GMHP) who provide a collective voice to external stakeholders. Their combined stock amounts to more than 250,000 homes across the city-region, housing one in five of Greater Manchester's citizens (GMHP, 2018). These housing providers have been formally incorporated in the city-region's governance structures by signing a Memorandum of Understanding, setting out 'how

GMHP will work in partnership with the GMCA, in the context of the GMCA Devolution Agreement' (GMCA and GMHP, 2016). The strategic objectives of this partnership are to implement the Greater Manchester Growth and Reform Plan, signalling an expectation that the social landlords will play an increased role in delivering public policy objectives. The Plan involves 'closing the gap between the tax that is generated through growth and the cost of delivering public services', so that the city-region becomes financially self-sustaining (GMCA, 2014, p.4). This agenda is also reflected in the MoUs that have been signed with other non-statutory bodies, such as the Voluntary Community and Social Enterprise sector which outlines how the 'transformation programme will depend on the work of VCSE organisations, given their critical role in supporting people to look after themselves and each other in a collective way' (Salford CVS, 2016). The group of housing providers has several workstreams operating simultaneously, including the specific ambition of 'connecting health and housing' (GMHP manifesto). The Housing and Health steering group is attended by chief executives or senior housing professionals with responsibility for their organisation's health concerns.

In addition to the individual health and wellbeing-related services delivered by these housing associations, such as employment services, financial advice and healthy eating projects, the group have worked together to design three collaborative interventions. The breadth and scope of the discussion regarding ways housing providers might work with clinical commissioners 'got too diffuse, really…so we said let's focus on these three priorities' (Interview, GM3). Each programme is intended to be viewed as 'an investable proposition for health' funding, based on 'a compelling business case' (Interview, GM3). These investable propositions are:

HOOP (Housing Options for Older People)

The HOOP service is intended to work preventatively, offering a range of housing choices and services in order to ensure older people have the option to live in, or adapt, the most appropriate housing for their needs. Designated staff members 'have a conversation with an older person before they end up in A&E or a hospital bed and can't go home because the home's no longer suitable for them' (Interview, GM3). HOOP workers will 'ask people to think about their housing needs and aspirations going forward', offering tailored advice and support to ensure their clients are in suitable, sustainable housing. One housing provider

estimated that in their borough, 'in the first year, for forty thousand which is the cost of employing someone, it saved about £850,000 for health, through a mixture of advice and support and adaptations, and a number of people moved to more appropriate accommodation' (Interview, GM3). Some people will stay in their homes and some will move, but the purpose of this intervention is to increase and facilitate a wider range of options for individuals, in order to prevent their homes becoming hazardous or unsafe. In 2018, HOOP had been trialled in five of the ten boroughs, including Oldham.

Affordable Warmth

This scheme was piloted in Oldham, offering a range of services, adaptations and advice to households experiencing energy poverty. The 'social housing providers put a sum of money into that, so did the council, and then the CCG paid by result. For every person that comes out of fuel poverty, because of the potential health benefits, the CCG will pay over money, so it's a kind of recycled fund' (Interview, GM3). This range of services, such as retrofitting to improve energy efficiency, solar panelling, advice on utility bills and debt, is designed as a holistic, mutually reinforcing housing-health partnership. The intention is that by 'making homes more energy efficient, putting renewable heating systems in there which people can afford more, surprise surprise, it reduces fuel poverty which is good for your health' (Interview, GM3).

Hospital Discharge

Some of the housing associations have employed staff to work inside hospitals, either in A&E or on long-term wards, to deal with any housing-related issues that might prevent patients' discharge. In some boroughs the housing providers have been 'funded [by the CCG] to deliver that on behalf of the council' (Interview, GM10). This service is intended to be used by patients whose housing circumstances may have contributed to their hospital admission (such as falls caused by trip hazards, unmanageable staircases or hoarding issues), as well as those who are no longer able to return to their previous housing as a result of their medical issues (such as deterioration in mobility caused by long-term inactivity, surgery or amputation). In A&E, housing officers are able to offer advice and interventions to homeless individuals, whose lack of secure accommodation or experience of rough sleeping may be a contributing factor to their presentation at a hospital. On longer-term wards, housing staff

are intended to reduce the delayed transfers of care, sometimes referred to as 'bed-blocking', for people who are clinically well, or no longer receiving hospital treatment, but whose home is unsafe or unfit to be discharged to.

Some of the smaller housing associations operating in Greater Manchester are not part of this group, however, and some members are only involved in health-focussed work to a very limited extent. 'The core of GMHP is the stock transfers, the ALMOs and the specialist or very much locally based' organisations, whereas the larger but more thinly spread, national organisations are reportedly 'not really that engaged' in the health agenda (Interview, GM3). The stock transfer housing associations, and those that are bound to the communities they operate within, are more heavily invested in the Greater Manchester goals of population health improvement. The larger, national housing associations have joined the GMHP but were reported by interviewees to have taken a less active role, and were rarely in attendance at the quarterly GMHP health steering group meetings. From a local authority perspective, those national organisations are observed to be 'disinvesting without a doubt…they're not a strategic partner for us at all, so none of the big nationals in that way really are playing a big role in Manchester' (GM1). There is some diversity in prioritisation of this work, with the business interests of the larger organisations spread across much wider areas and a larger, more disparate group of potential health sector partners. Insights generated from this evidence of diversification, demonstrating 'how' housing associations are shifting their activities, are helpful for answering research question one. Even amongst the heavily invested organisations, the experiences of this work remain varied.

Driving forces and justifications behind the evolving housing association role

Some housing providers see this activity as a natural extension of their role. It maximises the potential of the position and proximity of community housing officers to work more directly with residents. Scheme managers of housing association properties 'often advocate for people who are trying to access health and social care' (Interview, TD1) as well as being well-placed to identify concerns before a tenant reaches crisis. One director stated that they could 'think of loads of stories where a scheme manager might spot something that somebody is

struggling with, or spot somebody struggling and encourage them to go and see a GP, so rather than ending up in A&E, things are a bit more planned' (Interview, TD1). The GMHSCP has recognised the potential of housing association partners, given that 'the housing providers are out there, they're a huge part of communities and how people live their lives', so as part of moving towards a 'population-based health system…that's where those links need to be made, at that community level' (Interview, GM11).

The Third Sector status of housing associations as separate from the statutory services is identified as a strength for this role, when 'as a brand, we do have a trusted relationship with the community, so that would get them through the door' to a housing association that is 'seen as non-threatening…not social services either, and all the stigma that goes with social services and some of the medical professions, we're not them' (Interview, GM4). Clinical stakeholders acknowledge the potential of the housing providers to 'really help as one of our key partners' (Interview, GM14). The housing associations' position, intelligence and networks, their relationship with the VCSE sector and the way 'they are mapped into that network in a slightly different way' to the CCG, is recognised as 'a huge resource' for the health sector and one that is very important to them (Interview, GM14).

Much of this activity is framed as a response to local 'need'. Housing professionals demonstrated empathic understanding of the everyday health challenges experienced by people in poverty. For many social housing tenants, their financial situation has become increasingly strained during the ongoing period of austerity in the UK. Housing staff recall that they 'suddenly got hit with welfare reform, the comprehensive spending review had come out, and it was like "oh my god", we understand what is going to happen to people, we can't stop it' (Interview, GM9). Housing staff also recognise that the health sector is stretched by non-medical concerns, for example 'frequent fliers at the GP surgery' who are 'presenting health symptoms to the GP, but actually the underlying cause isn't health, ill health is the evidence of the symptoms of what the social causes are' (Interview, GM3). Interviewees highlighted limitations in their ability to tackle these challenges:

> One of the issues is poverty. Poverty means people don't eat very well, they don't make the best decisions about their lifestyle…it's genuinely true, if you're really struggling in every part of your life, having a fag sometimes is the thing that gets you through the day. Buying the cheapest food,

> means somebody has a full stomach, whether it's the right things or the wrong things, is not your worry, your worry is, are they fed? Alcohol is so cheap, again, if you're feeling a bit crap and you can't get to the GP or you don't want to go to the GP, and a drink takes the edge off, then you're going to drink…So I think that's where we fall, because we can't stop poverty (Interview, GM4).

There is a sense amongst providers that their decisions to diversify have been forced by the policy context they are operating in, and 'a direct response to welfare reform' (Interview, GM4). Necessity, rather than desire, has driven much of this work, particularly the debt, welfare and employment support services. Interviewees remarked that 'what the cuts have done is really disproportionately affected the people who are less able to help themselves' (Interview, GM10), and expressed concern about the ongoing impact of Universal Credit:

> That's really bad. We're expecting [increased rent arrears] when the full service is rolled out, we're preparing for that, we're restructuring our income team for that…and they're putting measures in place to try and prevent that, because we really don't want to evict people (Interview, GM7).

Local authorities identify this as a particular issue in the private rented sector because 'landlords don't like UC claimants' (Interview, GM5), which in turn adds pressure to the long waiting lists for social housing in Greater Manchester, which in 2018 was 54,000 households (GMCA, 2019, p.19).

Interviewees considered many of their interventions that target the social determinants of health to be direct responses to social issues. One housing association provides holiday activities for children and holiday kitchens 'because kids don't get fed in the summer holidays when they're not at school, and the DV [domestic violence] kicks off in the summer, because families are under loads of stress…it's so much stuff like that' (Interview, GM8). Another has started to 'run a food bank' for their community 'because kids don't have a hot meal at weekends, or during holidays, because parents simply can't afford it' (Interview, GM19).

Medical issues are also highlighted by senior staff, with reports of frontline officers facing unexpected requirements for care, that may demand an immediate response and cannot be disregarded:

> I'll give you an example of something that happened. A guy was discharged from mental health ward in his pyjamas, without anything else, to one of our step-up step-down facilities…we [also] have guest rooms in our independent living scheme, and the housing officer went to get some of her brother's clothes so that he had some clothes to wear. He was discharged without his medication, his taxi arrived before his medication had come from the pharmacy…and you've got a

> housing officer and a scheme manager to deal with that, when they're not trained to do that (Interview, GM7).

The support offered by housing associations may be understood as an unavoidable reaction to the situations they find themselves in. These services are seen by some as an imperfect necessity rather than a positive option. Rather than meeting the high standard of a specialised intervention, 'you would never, ever make that choice at all' to design housing-health services from scratch in this way (Interview, GM11).

Housing sector responses to cuts in public service provision

The housing association response to the 'need' they have identified amongst their residents is often directly related to the loss of services and support that were provided by other sectors, or the local authority. Housing officers 'are dealing with some incredibly stressful cases, and we're seeing a withdrawal of some services and just struggling to see, where do I refer this person to?' (Interview, TD1). While housing staff recognise that the boroughs they work within 'have had to make an awful lot of cuts' (Interview, GM7), this has meant the backdrop for their housing services is becoming increasingly threadbare and challenging. Interviewees see their organisations as the 'last man standing' or the 'provider of last resort in some areas' (Interview, GM6).

Housing associations are independent organisations, separate from the statutory services, but many interviewees 'feel that we are being left to plug more and more gaps' (Interview, GM7) and that 'we are, absolutely, we are the safety net' (Interview, GM4). Much of this work represents substitution, rather than additionality in this local authority context:

> We're just trying to fill a gap. What you'll find with housing associations is we're filling a gap, that actually the council used to do years ago, and it's just because they've had cuts, it's not because they don't care or don't want to do it, they just can't do it (Interview, GM10).

For example, one housing association took over a care leavers' service, that 'wouldn't exist if we hadn't done that, because the existing provider was stepping away from it, they couldn't make it work' (Interview, GM9). In numerous cases, housing staff are 'genuinely not sure, without social housing providers doing a lot of that support work, what would happen to those individuals' (Interview, GM4).

The GMHP members are reluctant to take on this role long term, stating that 'we're not just here to plug gaps' (GMHP group). However, the relationship between housing providers and statutory partners has become more closely linked during austerity:

> A lot of the GM housing providers started doing [more] at around the same time local authorities and CCGs were starting to talk to housing providers, as one of the few social providers with services that hadn't been decimated by cuts…we had [lost money] but we haven't lost money on the scale of the local authority, or the health service, or charities (Interview, GM6).

Statutory partners experiencing a 'huge financial deficit' while responsible for allocating their drastically reduced budgets, recognise that there is a need 'to work differently, and not see housing providers just as cash cows to support these things', because 'sometimes we've seen the resources some of these organisations have as a way of trying to plug some gaps' (Interview, GM14). The housing providers are aware of this perception, reporting that they are 'seen as maybe some kind of cash cows around having lots of money, when maybe they don't necessarily see how we reinvest that in property and in the community' (Interview, OD4).

Attention was drawn to particular programmes or sources of funding that have been lost, such as the Supporting People Programme, which had its funding ring fence removed in 2009. Interviewees reported that 'back in the days when Supporting People was around there were groups of housing providers who would meet and talk about some of the social care and health issues in the borough…that infrastructure has gone' (Interview, TD1). Staff in the health sector also lament the loss of this service, and 'the end of programmes like Supporting People when there was all that capacity and resource to do that nicer stuff, the lower level support level stuff' which enables people to 'live independently for longer and keeps them out of the health and care system, it's just gone…almost overnight, stripped out of that system' (Interview, GM11). The possibility was raised that budget priorities in Greater Manchester's devolution arrangements 'could be Supporting People round two, which started as a ring-fenced allocation but then the ring fence was lifted and local authorities had to dip into it because they were just in such dire straits' (Interview, GM3).

Interviewees also noticed rising thresholds of 'need' that individuals are required to meet before a statutory intervention will be made. Housing associations could, in principle, offer a level of additionality in services to households who are under-served by formal support. Housing staff encounter people who 'haven't met some criteria that has been set by health and social care, yet they still live in a building that we own and they're presenting to us with issues', making some level of involvement inevitable (Interview, TD1). However, statutory support has been reduced for 'people that have got ongoing, complicated mental health issues but are stable-ish…people that were being picked up before, but now aren't', so these individuals are reported to be 'falling through the net, in worse situations' and the housing staff 'seem to be in more of a crisis management situation than a planned situation' (Interview, GM18). One deputy chief executive noted that 'people coming into temporary accommodation now, their needs are far greater than five years ago…I think years ago they would have been sectioned, some of the people that are coming in' (Interview, GM10). Interviewees report difficult dilemmas when faced with tenants who do not meet 'a threshold for social services…the thresholds for their involvement is reduced' (Interview, GM10), but whose actions or symptoms create a situation that cannot be ignored:

> Our safeguarding numbers are up. We've had one where a gentleman thought the lady in the next-door flat was his wife, so kept touching her. And so, the family's going, what's going on here? We're going, oh blimey, but we can't just turf him out of his house…It is a minefield. So, then you bring in the council's adult social care safeguarding team, they assess him, this is a real-life example, they assess him as…okay. Might be early signs [of dementia], but he's okay. So, then he's allowed to stay in his home, we can't evict him, but the family of Marjorie or whoever is going, I don't feel safe for my mum anymore (Interview, GM2).

Housing professionals voiced concerns about the wider impacts of these rising thresholds for 'triggering an intervention' which may not occur 'until a crisis happens, and by then of course so much damage has been done, in lots of different ways, to the individual, to their relationship with their neighbours, their relationship with their family…it's much harder to pull somebody back from that situation' (Interview, GM4). The withdrawal of many preventative, early intervention services, has led to more individuals being 'out of services longer, just because of the different thresholds' (Interview, GM11). It is becoming increasingly important to many social landlords to support these tenants, particularly when alternative support cannot be found elsewhere. Housing association staff perceive that there are 'a lot of people being sustained to live relatively independently in the community because

of housing association interventions', which prevents them from being 'admitted to mainstream hospital…[or] perhaps they would have found themselves in a treatment centre for mental health' (Interview, GM4). Interviewees reported that many people they encounter 'previously might have had [statutory] care and support, and now they don't. So, when those individuals do live in a housing association…that safety net that's offered by the housing provider is invaluable' (Interview, GM11). This and the previous subsection have generated many additional insights regarding both 'how' and 'why' this work is being done by housing providers, to answer research question one.

Changes in expectations for the roles of housing staff

Alongside rising thresholds for statutory services, the increasing health and support needs of tenants have placed new demands and expectations on housing officers. Interviewees highlighted particular issues encountered by their staff, including mental health conditions, dementia and domestic violence. Senior managers report that 'if you were to ask our frontline officers what's changed in recent years, they would say that mental health issues have just gone through the roof' (Interview, GM7). Services that traditionally housing officers might refer individuals to have been heavily affected by local authority budget cuts. Several boroughs reported 'a real shortage of mental health services' as well as 'drug and alcohol, which is another service that's been reduced' (Interview, GM10). For others, the reduction of financial support available via the welfare and benefits system has impacted their ability to support tenants with money problems. These issues are likely to be impacting cumulatively on some people:

> One of the things I hear from the housing team and the money support team is that for some people life is getting really, really difficult, and people who used to chase our tenants to pay money said there always used to be a way they could find some way to help people pay their rent, and increasingly with the welfare reforms that we've got, they don't have those options. So, I suspect that financial pressure will have an impact around mental health…it's going to see an increase that way too (Interview, TD1).

Particularly in cases where housing staff are replacing cut services, the adequacy and quality of the substitution is a cause of concern. Where capacity has been removed from the mainstream services, 'housing providers, to be fair, have continued in a lot of cases to deliver that support. Not necessarily to the same level, but certainly to the best of their abilities, and they should be commended for that' (Interview, GM11). It is recognised, however, that

housing officers encountering individuals with mental health problems 'are spending longer trying to deal with those things, without the skills to do it very effectively' (Interview, GM7). Recruiting frontline staff has 'been quite a challenge' for some housing associations, because 'the people that we're employing now have to have so many different skills…are we asking too much? Sometimes I think I'm asking too much because the role's really changed' (Interview, GM2). Some interviewees consider this involvement in welfare and wellbeing to be 'an inevitable part of the role, if you're going to do your job well' (Interview, GM18). A widely held view is that:

> Anyone who works in housing would say that you are far more than somebody who takes rent and does repairs…it's far more complicated than that…often we've done it to ourselves because we want the best outcome for our customers, so, if you think something isn't right, we employ people that take notice, and care, and think, what's happening here? (Interview, GM18).

However, many organisations feel that they and their staff do not have the resource or the expertise to support people with these unmanaged conditions. This is also potentially harmful for other residents and members of the community who must cope with the stress and anxiety of living with unsupported people who have complex needs.

> We've started to have some complaints in our sheltered schemes actually. Where people feel like they've been left to manage dementia, because they've got a neighbour with dementia, who's wandering the corridors at nights. And there's nobody else there at night. And that's kind of another level of issue to deal with, isn't it, because it's still probably the best place for that person, but if other people are picking up the care requirements, that's not right either (Interview, GM7).

Some examples were provided of housing staff 'going the extra mile in a risky way' and offering tenants support in ways that are inappropriate.

> We did have a member of staff…she'd had some contact with one of our customers, who hadn't managed to have a bath for a really long time, and really wanted to have a bath. So, between her and another member of staff from a different organisation, they physically helped this woman to have a bath. Which for me, puts the person at risk, it puts the staff at risk, and it puts the organisation at risk (Interview, GM9).

Interviewees reported concern that 'we're getting to a place that's quite dangerous to be, because not only have we had all this reduction in services, we've also had changes in legislation that mean we've got more duties than we've had before' (Interview, TD2). The Care Act (2014), for example, obliges local authorities to safeguard from self-neglect, but housing staff observe that 'it's not generally understood what that means' and 'everyone's

kind of scratching around in the dark' (Interview, TD2). Housing providers are unsure of their role and responsibility here, arguing that 'surely there should be some guidance, and better application of that law, because of that grey area we find it really difficult to hold the council accountable' (Interview, TD2). The lines become increasingly blurred with regard to who ought to fill the support roles in situations such as these.

> It's all well and good saying everyone's got all these rights and we have these responsibilities as a decent landlord to do all these things, but if the backup services aren't there for people, it puts us in a very difficult spot (Interview, GM19).

Variability of experiences within Greater Manchester

The GMHP's collective approach to expanding the health remit of housing associations comes with inherent challenges given the lack of homogeneity across the ten Greater Manchester boroughs. Some of these disparities have been highlighted by the inability of the devolved city-region to take independent decisions regarding the centralised policies of austerity and welfare reform. The 'impact of public funding cuts within GM is not even', and has had significant impacts for the affluent, as well as the poorer authorities. Some boroughs 'have been hit much harder than others, and these are the same authorities which did not benefit over the years from national investments i.e. Bury, Trafford and Stockport' (Damm et al., 2017, foreword). In affluent areas, with high housing demand, 'the levels of deprivation in some of our estates compared to the general population…is significant' and housing professionals 'feel really strongly about this, it's worse…being poor in an affluent area, I think you just see the differences more and it can be harder' (Interview, GM10). 'Lean' local authorities that 'have also taken the view that they wouldn't put council tax up' have 'kept their income low as well and they've been hit by austerity just like every local authority' (Interview, TD1).

Reflecting the individual characteristics of each borough, those working at the city-region level have noted that 'one of the things you learn in GM very quickly is you're not going to end up with one model across all ten boroughs…[although] I think that's what a lot of people wanted originally' (Interview, GM6). Some of the housing associations want more alignment, stating that 'we've got to start working like one area rather than ten authorities' (Interview, OD4), but interviewees at the Greater Manchester level argue that 'the purpose of the whole

devolution was about us drawing power down from Westminster, not us taking power from the localities' (Interview, GM11). Some of the housing associations have expressed ambitious expectations that the 'Greater Manchester' umbrella might have reduced some of this variation:

> They have got very strong identities, and sometimes I feel like … some of the housing providers try to utilise the GM umbrella to navigate around those locality issues, and actually it's about having better relationships in your local area, with your local authorities. That might be difficult, working in partnership sometimes really is, but there's not a mandate from us, we can't go out to the CCGs and say, you need to go and talk to housing, you need to spend your money on this from housing, that is not how the partnership operates (Interview, GM11).

Tensions are reported between the ambitions of the Mayor's office and the combined authority, and the visions of the different boroughs, whose local authorities also hold a democratic mandate:

> Each district is managing its transition process in the way the district wants it to. There isn't a blueprint that everybody must do it this way across GM…in that way lies disaster which is what the Mayor's problem is. If he tries to do one thing in the same way across the whole of GM, he'll lose (Interview, GM1).

Similar concerns are expressed by those who work across both the sectors: 'One issue that I do encounter…is almost an expectation [from the housing associations] that the partnership, or me, or whoever it may be, could come in and rectify all of that. And that we have a mandate with health in the localities that we absolutely do not have. This is a partnership' (Interview, GM11).

In addition to resources, the priority afforded to this closer working relationship between the health and housing sectors is also uneven. The housing associations that have come the furthest with HOOP, Warm Homes and hospital discharge, report frustration at the progress of social landlords in other boroughs:

> Sometimes it's not felt like everybody's moving at the same pace, or giving it the same priority, or willing to put in the same level of commitment, in time, and funding. And then you tend to move at the pace of the slowest, and I've found that quite frustrating at times…when we committed to deliver the three investable propositions, I would've thought three years on, in every borough, we would've had something of the three propositions going [but]…Some haven't got anything at all…on those three investable propositions, and some have got some of those things (Interview, OD1).

The initiatives that have been replicated across the boroughs, have not necessarily been structurally consistent, with variations in their impacts also reported. For example, several of the housing associations have provided 'Step-Up, Step-Down' transitional accommodation for people in need of additional care and support but not hospital treatment. These short-term housing units are aimed at relieving the pressure in hospitals caused by delayed transfers of care, and are funded by various sources. One housing association has an ambition 'to support the NHS to save a million quid by 2021…[and] every day somebody spends in one of those beds saves the NHS three hundred and fifty pounds' (Interview, GM2). In this borough, the health sector pays the rent, up-front, for a year in advance, 'but it took them about three or four months to get a body in it…you think, why? When we've got this bed-blocking?' (Interview, GM2). Elsewhere, two 'step-up step-down' beds, funded by the CCG, have remained empty for three years. This 'waste is replicated, all over the place', and is often attributed to the fact that too many people, or levels of management and delivery, are involved in any new project: 'the more people involved in that ladder, of getting something off the ground, the more chances to fall off it' (Interview, TD11). Another borough's step-up step-down programme is viewed as a liability by the housing provider as the health services rent the beds on a use-by-use basis:

> We've done an evaluation of the pilot…we did one that looked at how great it was for the health service, but then I thought, hang on a minute, I think this might be losing us money…it was completely jammed, for quite a long time, [but] then we moved into a position where we got a lot of vacancies suddenly…we had quite a lot of deaths and people moving into residential care…the impact of that has been that the step-up, step-down accommodation has been empty for long enough that over the year we've made a net loss on it, which is not really what we were planning for (Interview, GM7).

The ability and willingness of the housing associations to absorb the risk associated with such programmes is inconsistent.

The degree to which different housing associations have diversified into non-landlord services is largely attributed to the values and priorities of their board members and governance bodies. For example, one senior manager's 'view is that we should primarily be a landlord', but 'what [their] executive management team are more interested in is the regeneration…the employment opportunities for people in the town centre, that's a very important part of our

new corporate strategy' (Interview, GM7). Others are using their reserves for housing schemes that are less stable financially:

> This board…as someone that worked under the old regime and into this one you can absolutely see the difference in the mind-set, and what we're prepared to do and how far we're prepared to go to support people…the extra care scheme was done before any of the supported housing funding was sorted out. They just took the view that, if we're going to make a loss, it's the right thing to do, it's the right product in the right place at the right time, we're going to do it anyway (Interview, GM8).

Organisations directly providing clinical services recognise that they are 'quite unusual in terms of a housing association providing home care…we've got involved in another load of regulation with the CQC [Care Quality Commission]' whereas other housing providers 'don't do that, and shy away from that' (Interview, TD1). The increased risk and responsibility that accompanies diversification into these services is a deterrent for some, with one chief executive reporting that 'one thing that we're not is Extra Care, and that's been a strategic decision by the board [because] it's very expensive' (Interview, GM2). Organisations considering an Extra Care role say: 'we'll end up doing it when we're ready…we have this thing about controlling the quality, and if we're providing it, we know we're going to do it appropriately, properly' (Interview, GM9). Increasing the health service or clinical provision of a housing organisation is resource intensive:

> If we went down a route of looking at nurses or physios…what risk in terms of regulation does that bring for us, would our board be comfortable with that? And there are the issues around funding, it's really tight in all of that, could you successfully get the funding to employ everybody? (Interview, TD1).

Housing providers that do choose to dedicate more resources to this kind of activity are therefore likely to have a reduced ability to invest elsewhere, including in core business functions, such as housebuilding. There is fear that investing in a new initiative 'means switching something off somewhere else, and there's a reluctance to switch off somewhere else, because of the fear factor of what's the impact going to be?' (Interview, OD1). For housing departments within local authorities, balancing budgets across different departments might reduce spending power overall, but increase their ability to view investments holistically, and assess the ways housing services might reduce costs elsewhere. In one borough, the housing director stated that 'we will build a scheme that maybe wouldn't stack up for an RP, because of the saving to adult social care…we built a scheme a couple of years ago for adults with learning difficulties and additional needs, and on paper that didn't

stack up', but the 'massive saving' in the 'cost of care…made it stack up financially' (Interview, GM5). If a housing association, however, approached their local authority and said, '"but that's not stacking up for me, will you underwrite it?" I don't think a council would' (Interview, GM5).

There is variation in both the financial resources and independence of these housing providers, which influences how extensive their intervention into health-related concerns is likely to be. The ALMOs must operate with the approval of their local authority, 'so that's a level of decision making that is taken out of us, we have to get things approved by the council' (Interview, GM10), whereas organisations with their own resources can make decisions according to their individual business priorities. For providers that 'weren't affected as strongly as some others were in the rent cut', they have been able to invest in more diverse, income-generating business activities, such as telecare (Interview, GM2). For another senior director, however:

> I feel like we've got less people working on non-housing issues that most places. We're quite a recent stock transfer organisation, and I think we actually are less well-off than a lot of the others (Interview, GM7).

There exists considerable range in the extent, type and standard of health work provided by even the most engaged housing associations.

Balancing social and commercial expectations

The government definition states that housing associations in England 'are independent societies, bodies of trustees or companies established for the purpose of providing low-cost social housing for people in housing need on a non-profit-making basis. Any trading surplus is used to maintain existing homes and to help finance new ones' (MHCLG, 2019). It is a difficult balancing act for these independent housing associations to ensure they achieve both commercial viability and meet their goals of social responsibility. The 'housing providers firmly acknowledge that…they are a business at the end of the day. They have social responsibility, but they also have a bottom line' (Interview, GM11). This has created some confusion amongst interviewees regarding the role their organisations ought to take.

The income of independent housing associations comes almost entirely from rent (some of which comes via Housing Benefit, or the housing element of Universal Credit). Housing professionals recognise that paying this rent might be more difficult for many of their tenants, 'with the changes to welfare benefits, there may be a real push on them, the benefits may be being stopped or they're being re-evaluated' (Interview, GM4). The housing providers 'really recognise that we need, for tenancy sustainment reasons, to be supporting some of our more vulnerable customers better' (Interview, GM7). Supporting households to sustain their tenancies, for example by offering financial advice or mental health services, contributes to a more stable income for these housing associations:

> We're doing it as a business, there's definitely a business argument about more sustainable tenancies, people then pay their rent, but you know, we've all got a social conscience; we're all in social housing for a reason (Interview, GM10).

Providing employment services that support tenants to pay their rent is one such activity that spans both their social and commercial purposes. Several GMHP members are 'trying to help our tenants and their families get into training and employment' (Interview, GM3), reporting that they 'understood the social determinants of health, and the job side there, so we started doing employment and skills which we had never done before on any serious footing', and that if they were 'going to do anything it needs to fill gaps…so we started understanding what that space looked like, and what our communities would need to even get them thinking that they could have a job, and then came with the careers and the support and the signposting' (Interview, GM8). One housing association reported that they 'got 450 people into jobs last year, which is a tremendous amount' (Interview, GM4), and 'if you're in employment you're not subject to the vagaries of whatever the [welfare] policy is' (Interview, GM9).

To justify their changing role, some housing organisations propose that more market level involvement will generate returns that can be re-invested for a social purpose. The Guinness Partnership's 2018 Business Plan states that they have 'placed more emphasis on diversification because we need to generate financial returns that will enable us to build more homes and develop better services'. This raises questions about the core function and purpose of these organisations, and how far their efforts on non-landlord services impinge on their ability to continue providing health-improving homes. Reflecting this uncertainty, chief executives and directors of organisations studied for this research expressed variable

interpretations of the role they expected their companies to fulfil. For example, one chief executive argued that 'in my head we're not a housing association, we're an organisation that combats poverty, inequality and injustice' (Interview, TD3). For others, however, the view was that their organisation 'should primarily be a landlord because I think that's where we've got most to offer' (Interview, GM7). There is acknowledgement that 'it's really nice to do all this sexy stuff, but if you can't manage your properties properly then it's not right' (Interview, GM10).

> I think fundamentally the basis of that is a crisis of who we are as an organisation. I keep trying to say, as a social landlord, is this something we would do? Not as a hero to everybody, but as a social landlord (Interview, TD2).

Many organisations share the view that although housing itself is critical for health, and ought to remain a key priority, they feel that now some of the extra services have 'kind of become must-haves now…we could never not do this anymore' (Interview, GM4). Health inequalities and the gaps in healthy life expectancy faced by some of the communities they work with are a moral cause for some organisations, who 'as a housing association…can't live with that, we need to do everything we can to reduce that gap' (Interview, GM8).

As well as for individual tenants, the housing associations themselves have experienced strain and pressure on their financial resources due to austerity. To reduce the UK's housing benefit bill, the 2016 Welfare Reform and Work Act obliged social landlords to reduce social rents by 1% per year from April 2016 for a four-year period (MHCLG, 2016). The resultant reduction in housing association's capital receipts has had consequences for their business models and social investments:

> With the one percent rent reduction, we reduced the amount of money that was available for community grants. I'm sure most people did. And we closed community centres, which we didn't think were viable (Interview, OD1).

The question of funding for such non-housing services is a cause for concern for social landlords who recognise that 'if we can support individuals to live on their own then that's good, but it comes at a cost, it's quite an expensive cost' (Interview, GM4). Housing associations are operating in an environment of reduced resources of their own, against a backdrop of further and dramatic funding cuts to local authorities. The services provided by

housing associations may prove financially unsustainable. One interviewee refers to their 'prescription responder service', part-funded by the CCG:

> It's an excellent service, but it's costing us a lot of money, and we're at the moment about to review that service, and our independent living service with a view to making them financially viable. Because they're not at the moment, there's quite a big gap between what it costs us and what we get in (Interview, GM7).

There is a risk that these health-focussed services, even if they meet a high standard, are not necessarily viable long-term. The housing providers are generally willing to invest in new ways of working on a pilot, or short-term basis in order to demonstrate the value of an intervention, but their expectation is that commissioning bodies will then pay to continue these services. In some community services which 'as a housing association we just put money in [because] we knew it was the right thing to do', the goal is that 'it might attract further funding if we can demonstrate the value' (Interview, GM4). Interviewees stated in the 'longer term we've got to show what sort of evidence that might have in terms of health and wellbeing and then maybe have a conversation with those funding bodies' for activities that 'at the moment we've just done because we've seen issues' (Interview, TD1). This is less likely in a context of straitened public budgets:

> So, then you start to go down conversations around, well, actually you should be commissioning us to do this, whether that's health commissioning, commissioning from a health organisation or from a local authority. Yeah, in an ideal world, absolutely. But there's not infinite resources to be able to, which is why we're in the position that we're in (Interview, GM11).

These services are at particular risk, then, particularly within organisations that still perceive health or social support as 'extra' rather than 'core' business. Concern exists around staffing costs, for example 'the money for the two roles [HOOP and hospital discharge] has come from the local authority and [our] reserves, not from health…I'm very conscious that they're two years fixed term, so it's about demonstrating the value with the view to bring in some funding' from the CCG (Interview, GM4). For one provider, considering what would happen to their services if they were deemed unaffordable: 'the alternative is that we just start saying no' (Interview, GM7).

Implications of health-focussed housing association activity for non-tenants

Housing Associations are impacting on the social determinants of health in at least two capacities. 'Housing' is a social determinant on its own, but housing providers are now also taking action on several other social determinants. Additionally, some of their services are directly targeted at health and medical issues. However, instead of complementing existing universal services, available to all, they are potentially compensating for a lack of them, or offering them on a smaller scale, and to a reduced group of people, than might previously have been the case when they were provided within their local authorities. Stakeholders ask: 'Where are the people who are in the awful, lower end of private rented sector accommodation? Where are the people who haven't got that safety net of living in a housing provider property?' (Interview, GM13). The experiences of private tenants compared to social tenants is increasingly determined by more than just the quality of the housing, however. 'Once you're a [social] tenant, you've got health initiatives, you can have counselling, we do employment services, you can get a wealth of different services that we can provide, but if you're private sector you can't' (Interview, GM10).

In programmes such as Warm Homes, which are targeted at reducing energy poverty, the majority of houses that require interventions have been in the private sector (owned and rented). Some social landlords have been reluctant to deliver this programme, reporting 'we've got enough on our plate, how and why would we invest in that?' (Interview, GM3). For some interviewees, this is a cause for concern:

> I think that in some senses it's creating a two-tier system of access for people. If you've got a social landlord, you can access through these routes, but if you haven't…we had it with things like adaptations, that we paid the council a sum of money to priorities fitting adaptations for our customers. And that's interesting because actually, is that fair? Is that equitable? (Interview, TD2)

The activity is likely to be targeted, if not towards individual residents then by area, determined by the location of housing stock. This is partly for pragmatic reasons, for example when working with health sector partners, in order to get 'that network operating locally…if you're a housing provider and you've got a GP on your estate, that's where the link is made' (Interview, GM18). One provider 'actually employ[s], on behalf of the council, medical visitors

who will go out and see people, assess their need and level of priority either for rehousing or advice in terms of helping them to get an adaptation to their home' (Interview, GM3). In theory, services provided for the council are open to all residents of a borough, but in practice the housing providers do not have access or knowledge of private sector tenants in order to approach them proactively. As housing associations often 'pick up tenants just because they have staff who are quite good at knowing individual tenants…that's obviously a barrier if you're rolling services out to people who aren't your tenants, you don't have that knowledge' (Interview, GM12).

Some housing associations are directly providing social and health support to their tenants as a way of bypassing the long waiting times, or rising thresholds, required to access mainstream services. One organisation has 'provided counselling, working with Relate…we've got a contract with them to provide free counselling because we found that our customers were waiting three or four months if they went to the GP to get counselling', but if their tenants approach the housing association for counselling 'they can get it this week' (Interview, GM10). Some housing provider services are tenure blind, but the housing associations are not necessarily recording this information when it comes to their users, or do not have the capacity to do so, making it difficult for them to evaluate whether they are having successes beyond their customer base. There is also less of an appetite for maintaining some of these services for residents outside their sector, and a sense that if they do, they may be letting bad landlords 'off the hook' (GMHP group).

To improve standards, some housing providers have employed clinical staff who previously worked in (or were trained by) the statutory services. One organisation has paid for nurses to consult with their tenants 'who have cited ill health as a reason why they're not in work or training' (Interview, GM4). Housing associations have also recruited psychiatric nurses and occupational therapists to respond to particular challenges faced by their organisation, such as hoarding. For landlords, there is arguably a practical as well as moral reason to help and support people with hoarding disorder, given the increased risks of fire, accidents or vermin infestations, and in some housing organisations the condition is increasingly treated as a wellbeing issue, rather than a breach of tenancy conditions (Molyneux, 2016). However, 'hoarding as an issue is so resource intensive' and the siloed ways of working and 'passing the

buck' has made tackling it challenging, particularly if 'nobody thinks it's their duty…social services say no, it's mental health, and mental health say no, it's housing' (Interview, TD2). The experience of one occupational therapist employed by a housing provider has been very positive:

> What we were doing wasn't working. We were pretty much going down the tenancy enforcement route with people, whereas I've come and said, that's not going to work, these people are already likely to be quite distressed about their environment, and quite fearful of other people's judgement about this environment. So, sending a letter saying, "your house is a mess, clean it up", isn't going to work, you're just going to get people's backs up. So, I said no, let's change that to say, "we're concerned about you and your welfare, we'd like to come and see you and see how we can support you". So, we've changed it to that sort of approach…and on reflection actually feel that we've been more successfully than I initially thought we had (Interview, TD2).

However, interviewees voiced some concerns regarding this trend which may have unintended consequences for (in)equality of access to specialised support:

> When you're getting to the point as a housing provider you're asking if you need trained mental health professionals as part of your staff, you think, really? Because that's the only way we could be confident we would get a service. That's worrying (Interview, OD5).

Housing association activity needs to address concerns of equity, universality and fairness, if it is to effectively challenge the growing problem of health inequalities. The danger of creating an extra tier of service provision poses a risk to the principles of equality of access to support, and a universal right to good health. In examples where housing associations are funding health and social care services from rental income, rather than local authority or centralised funding that could be raised from taxation of the wider community, it is the social housing tenants, likely to be on low incomes themselves, who are effectively paying for services that they may or may not need:

> Because you spend all of your time dealing with the people who have got issues…I suppose the unfair thing is that they all pay the same rent. And the people who don't ever need you, could in theory be paying less money if they didn't have to pay for the extra service (Interview, GM7).

Due to the lack of statutory funding, housing associations 'have to be really careful, because obviously the only income we get is from rent', so if their interventions do not add value, or have significant positive impact, 'conceivably people would be, quite rightly so, [asking] why are you spending rental income on this?' (Interview, GM4). This evidence of variability and lack of universality, when considered alongside the concepts of proportionate universalism, and the social gradient in health, are valuable for answering research question two.

Working in partnership

Housing associations that are trying to have more impact on health issues want to be seen as equivalent stakeholders to the mainstream services. Much of the health-focussed activity of these housing associations is delivered in (or dependent on), partnership with various members of the health sector. External partners must be 'bought in' to the health functions of housing associations. Much of the 'success' that has occurred in particular boroughs is determined by the individuals involved, 'it's partly the relationship with health and it's partly down to the local personalities' (Interview, GM6). For example, in one borough where the CCG has paid for a HOOP worker, the local authority's housing director attributed that to one person: 'fortunately we had one enlightened CCG commissioner…who totally got that, so she persuaded the CCG to fund a post' (Interview, GM1). The importance of individuals was repeatedly highlighted by interviewees, who stated that 'things happen because people work together on them, not because you have a process or procedure. It's about relationships, built on trust' (Interview, GM3).

For such a multi-agency approach to work, however, these relationships require stability and consistency. One housing professional who sought involvement with their Health and Wellbeing Board, identified the chief officer of their borough's CVS as instrumental, as 'a really good broker, because quite often [he] will invite me in and say "look, housing are a key player here"' (Interview, GM4). The housing providers and the VCSE both feel as though they are 'holding back the tide for the NHS' (Interview, GM13). These partners are also both crucial components of Greater Manchester's devolution strategy. The growing and diversifying role of the housing providers and the VCSE (both signatories of Memorandums of Understanding) is in keeping with Greater Manchester's ambition to move to a preventive health system, which focusses on public health, community services, social prescribing, and the Local Care Organisations. However, there are doubts about whether some of those in the health service view these initiatives purely as cost-saving measures, rather than transformative services that require long-term investment to survive. As pressures grow in the VCSE, its ability to relieve the same pressures on the health and social services is reduced. The third sector is perceived to be 'saving the public sector a fortune, but not being thought about or talked about, because

the culture of the institutions that is doing all the planning [such as the CCGs] is so far removed from that small community' (Interview, GM13). In boroughs that reported partnership working to be 'more challenging…the voluntary sector is completely crumbling', particularly with regard to coordination, or large, influential organisations that have ceased operating since 'they ran out of resources (Interview, GM7).

For housing associations, these partnerships have been variable across the boroughs. With HOOP, 'we got the whole project at a Greater Manchester level, yes, everybody is up for that and doing it, [but] have we got it funded from Health across Greater Manchester? No.' (Interview, GM1). The Health and Wellbeing Boards (HWBs) indicate the extent of these partnerships. For housing associations who have not established strong working relationships with the health sector, the HWBs are viewed as important gatekeepers:

> We asked could we be a part of the Health and Wellbeing Board…we did a presentation, and they all went, well, that's lovely, thank you very much, but no. No, I don't think, it's not for housing partners…I mean that was probably the most direct saying no…people like the CCGs, I think they just, I feel like at one level they appreciate housing, but I think they just, I don't know if they think that we're just all about money, because I know it is about commissioning (Interview, GM10).

Much attention is drawn to the perception that health sector partners have of the housing sector, and the gap between the housing providers' ambitions and the working realities. From the housing sector's point of view, they 'don't think there's necessarily an understanding of everything that we do' (Interview, OD4). The provision of support services that surpass their obligations as landlords, is something that housing associations have 'always done…and for us, it's no big deal, as a housing professional it feels like we're doing what we're meant to do' (Interview, OD3). However, they are still waiting for the health sector to fully 'embrace' them, and 'that's where the work is needed…I feel like we're doing as much as we can, but we need a little bit more from them, some more buy in' (Interview, OD2). Some interviewees 'still think there's a branding issue for housing…it's felt to me like we've had an open door with health for the best part of ten years on this issue' (Interview, GM9), but senior health partners have 'viewed [the housing providers] with a bit of suspicion' (Interview, OD1).

The housing sector 'complains continually that health doesn't listen to it and doesn't take on board the value it brings' (Interview, GM18), and housing professionals feel that 'we keep

proving our worth' (GMHP group) yet still are excluded from important conversations. One housing provider reported being asked by their public health director: 'What's housing got to do with health?' (Interview, GM7). When explaining their organisations' motivation behind being 'so much more than a landlord', housing professionals reported that explaining the commercial justifications for this activity gets a better response from health stakeholders than talking about their social conscience, 'because they see us as a business' (Interview, GM10). The GMHP group is viewed as crucial for amplifying this message, through 'having those talks with key people [and] getting them to realise the contribution we can make' (Interview, GM10).

Embedding this joined-up, cross-sector approach to issues of housing, health inequalities and population health, however, is still perceived as piecemeal and fragmented. Whilst many of these relationships are reported to be becoming more productive in relation to the development of strategy, there is still progress to be made in creating a systemic, consistent experience of integrated partnership working at an operational level. Some interviewees suggested that the gap between the strategic decision making, and the frontline experience of working in partnership, is too large for these kinds of housing interventions, and devolutionary pilot programmes, to really infiltrate or challenge established ways of working:

> It's the middle treacle of everything. So the top get the idea, the bottom get the idea, not to use that in any derogatory way but, in delivery, the people who are there know their stuff, and the treacle of finance gets in the way, of assurance gets in the way, of territorial rights, starts to get in the way. And there's this institutional fear of stepping outside what you know you need to do (Interview, GM14).

The differences in scale between organisations, for example a CCG or NHS Trust, and a housing association, are also identified as challenges. It is 'difficult for a small provider like us, who's spread across Greater Manchester, to have any clout with the CCGs that we operate within, because we're [comparatively] so small' (Interview, GM18). Some of the health sector's requirements for partnership working are deemed inappropriate by those working in the third sector, such as the 'information governance toolkit the NHS uses, which is just horrendous, and they impose on some very small organisations needlessly in my view' (Interview, GM13). The speed and pace at which the housing associations want to progress

this agenda is also not matched by the larger, statutory partners. Although they have 'moved light years…it doesn't move quickly enough' for some of the housing providers (GMHP group).

The different approaches to change, and transformation, are culturally and organisationally embedded in very different ways between the sectors, and the medical community's approach to risk and regulation is not always shared by housing partners. The social landlords voice frustration that 'we still have nonsense that we have to have an epidemiological study over three years before we can prove the value of something, when everyone knows it bloody works' (Interview, GM3). This makes working in partnership, or securing funding from clinical partners for housing interventions, more challenging. One interviewee, who has worked professionally for both the housing and health sectors, remarked that 'when I first came in [to the NHS] I was quite surprised at almost how far back we were starting the conversation with people', regarding housing's impact on health, but 'I'm part of an organisation which has a huge element of it which is clinical and medical, and those wider social elements probably aren't considered as much' (Interview, GM11). Several interviewees working in housing felt that the health sector simply does not 'get' what they are trying to offer:

> One [health partner] said, and it was really insightful, she meant it really positively, she said: "Why do you bother? Why, as a landlord, are you interested in health?" And in some respects, it really threw me, because it was so basic. It's such a basic question, [but] it really enlightened me about how far back they are (Interview, GM10).

This cross-sector work is felt to be more challenging because of difficulties in communication and understanding. There is 'a massive frustration in the housing world that we've so much to offer and it doesn't get taken up by health and social care', despite 'so much talk from the health and social care side about what we should do' (Interview, GM1). The size of the health sector can make it difficult for a housing professional to identify 'who I need to speak to…I've spoken to quite a few people, but I still don't feel like I've met the right person' (Interview, GM7). Operating as independent, private businesses, the health sector is not necessarily obliged, or even permitted, to share sensitive information about individuals with housing associations. In Wigan, the only Greater Manchester borough that has the majority of its social housing both owned and managed by the Council, a senior housing director is able to bypass some of those challenges:

> If I could share with other people in GM, the biggest difference for me and my staff [since re-joining the council], it would be that closer working with health and adult social care…the issue you might have in other places. We don't have an issue with data sharing, we're the same organisation. And obviously it is on a need-to-know basis, so we're not sharing data inappropriately, but if you were [a housing association] we couldn't give you our data without that person's permission (Interview, GM5).

The fragmented nature of the social housing tenure in Greater Manchester, as in the rest of the UK, means that implementing cross-sector working practices is not necessarily a universal experience. It is recognised, however, that this is a crucial barrier to overcome in order for this agenda to make meaningful progress:

> As we're talking about the roles of the voluntary sector, and housing, and education…assisting with that very local commissioning, we're going to have to get much better at doing those very basic things, like sharing information with each other…If you want a voluntary sector organisation to respond to this, then you are going to have to give them the information to allow them to respond to that, otherwise it all falls apart as a principle (Interview, GM11).

Changes to housing association demographics

Interviewee testimony demonstrates diversification of housing associations in not just the services they are providing, but the demographics of tenants that are increasingly moving into their newer housing developments, targeted at the more affluent end of the rental and buyers' markets. This compounds, and further concentrates, the impacts of a 'two-tier' system of health and housing support services. One national organisation, with significant stock in Greater Manchester, is seeking a new customer base for their 'Affordable' rent housing, or shared ownership options, including 'more people, in particular those on middle incomes, younger people and families with children [who] are locked out of home ownership and ineligible for social rent' (Guinness Partnership, 2018, p.3). Another states that they 'probably still see ourselves as an alternative to private renting' but that they have 'tried to diversify around who we house, so for instance in tower blocks we have open allocations policies, we advertise on places like Right Move which is alongside what the private rented sector would do' (Interview, TD1). The almost non-existent building of new housing at social rent levels, combined with the ongoing loss of existing homes through the right to buy policy is viewed as 'nothing but stupid' by the chief executive of Salix Homes (Sugden, 2018). The new schemes, whether offered at affordable rent or for shared ownership 'won't replace in terms of numbers the amount sold through right to buy' (Interview, GM3). This shift in

customer demographics suggests many prospective housing association tenants with low incomes are increasingly housed in the growing PRS, which is supported by evidence from other researchers (Bailey, 2020; Power et al., 2018).

The growing emphasis on more affluent tenants also explains why several housing providers reported feeling unable to appropriately tackle the issues of homelessness and rough sleeping, without significant additional resources. Housing associations reported increasing aversion to providing homes for those with additional support needs, during a period of reduced external or mainstream support. One local authority (which still has some provision of council housing, owned and managed by the council) noted that the housing associations operating in their borough 'will all take the best people, so the residual people, with ASB, long-term debt, complex dependencies, dual diagnosis, stay in the [council] housing', if the borough has any (Interview, GM5). The willingness to provide homes for those in challenging situations is determined by both the priorities and the resources of the organisations:

> We have to be very careful who we take on, because we're very small…if they have mental health issues, we don't have a huge amount of resources to deal with that, so if they're not paying their rent, or they don't have support workers, or don't understand things, if they have no financial awareness, it's going to be very difficult, they're going to be very difficult as tenants. And managing that…would take up way too much of our time (Interview, GM19).

For homeless households with support needs beyond simply shelter, housing providers do not always feel able to meet the needs of individuals adequately, and are increasingly risk-averse towards challenging tenants. Interviewees recognise the issue's complexity, that 'no-one sleeps rough on the street if their mental health is the way it should be' (Interview, GM10) and 'it's really hard [because] homelessness isn't a housing issue, if you take it back to the fundamentals of it, people don't become homeless just because they haven't got a house' (Interview, GM11). For individuals who 'aren't homeless just because they don't have somewhere to live' but due to 'much more complicated causes' such as 'mental health…substance abuse and addiction', then securing a home without additional support will not be enough (Interview, GM3). Simply providing a house is viewed as 'fine for people who are homeless because they might have mild issues, or no issues…if it is just poverty…but the vast majority in Manchester have got drug and alcohol, or mental health issues' (Interview, GM10). These services specifically have been vulnerable to budget cuts and

underinvestment, and housing professionals voice frustration with the level of support offered by mainstream services. Given that 'the two things are so closely linked, health and homelessness', there is a need to 'develop some working between the two, because I don't think there's a huge amount at the moment even though a lot of people come directly to us from mental health wards' (Interview, GM7).

Some housing associations have shown significant ambition regarding homelessness. The Social Impact Bond, which is a partnership between some members of the GMHP and the Mayor's office, to provide homes and holistic, wider support to rough sleepers, 'has got the potential to be one of those big game changers…I think we could take rough sleeping on the streets of Manchester largely away' (Interview, OD1). Others are more sceptical about the potential of this programme to be transformative, given the lack of capacity in the statutory support services needed for holistic support:

> The first stage is to refer people…that have been accepted onto the programme. Then from acceptance, there's the move into settled accommodation…If there's a drug and alcohol problem in there then that needs to be addressed first, and in some cases there's also a mental health problem in there. Then there's the case of moving from settled, into paid employment. Again, drug and alcohol and mental health issues are particularly pertinent. The progress of moving people from the street into accommodation is just about on track. The progress of referring people into those health interventions is, yeah, you can refer, but, 18 month wait for CBT. Oh great. Some really interesting questions about whether actually the SIB needs to employ [health and social care staff] to provide that response, because the state just isn't there to do it. And that's GM-wide (Interview, TD3).

This programme is targeted at the 'entrenched' rough sleepers, intended to tackle only the extreme end of the homelessness spectrum. The potential to work preventatively, or provide an early intervention, remains small. Housing associations are clear that while LHA benefits are frozen, and do not reflect the cost of private rents, new homeless households, including those in temporary accommodation or 'sofa-surfing', will continue to be created at a rate faster than they are able to offer support.

These changes in the demographic characteristics of new housing association tenants mean that their housing provision is now focussed at opposite ends of the spectrum of housing need, rather than across the whole social gradient. This provides significant insight for research question two. Housing associations, like health and social care mainstream services, are struggling to work preventatively for 'at risk' individuals, who may be under the radar of

certain services, or unlikely to receive an intervention before a crisis hits. The structures are not in place to tackle these wider housing issues at their root causes, despite efforts in Greater Manchester to target the symptoms. Housing associations are becoming less able to provide the security of a healthy, decent home to households simply experiencing poverty, reducing their ability to function as a universal, public housing service.

Housing and DevoManc – collaboration within the 'GM Family'

Devolution has encouraged Greater Manchester housing organisations to cooperate with each other and to develop links with other sectors. The quarterly meetings of the GMHP 'Housing and Health' sub-group have demonstrated consistent alignment in the messaging, goals, and cross-organisational learning between social landlords, as evidenced by interview data. For example, the GMHP was felt by some interviewees to offer an opportunity for shared learning and a 'peer-support' infrastructure (Interview, GM18). Members of the group made comparisons with the 'siloed approaches' they had encountered in other regions and showed appreciation for the GM group 'because the partners are so willing' in their efforts to share their work, experience and even resources (Interview, GM2). A similar group in Sheffield is described as 'miles behind' the GMHP in terms of progress (GMHP group). Some interviewees attribute this relative momentum to the devolution processes, stating that 'the housing providers have really worked together for many years, but in this format, it really came together with devolution', and was driven by the signing of the MoU (Interview, GM10). However, it is important to highlight, as discussed earlier in this chapter, that this group represents the interested parties and excludes some housing providers also operating in Greater Manchester who have chosen not to engage, or feel unable to because of lack of resources. Housing providers are not homogeneous, and their efforts are not uniformly replicated for all social housing tenants.

The GMCA and GMHSCP have invited input from housing providers in numerous formats. An ALMO chief executive sits on the Population Health Programme Board, which 'was really important' to the health and social care partnership, 'because when we started that board…it was overly clinical' (Interview, GM17). The 'collaboration of the [Registered Providers] is

proving really beneficial' in providing a collective rather than fragmented voice for the individual housing associations. The GMHP 'are having that conversation at the Greater Manchester level, so you get [more] traction and lobbying' with the broader stakeholders (Interview, GM4). The appointment of a Strategic Relationship Manager for Housing at the Health and Social Care Partnership is significant for a clinical organisation, and those working at the GMHSCP remark on the fact that 'it does feel quite radical', and 'the fact that the partnership have acknowledged that housing has a part to play in all of this transformation is fantastic' (Interview, GM11). This suggests efforts to embrace a more social model of health. The GMHSCP has recruited staff from diverse public service backgrounds, including local government, policing, and education, which interviewees perceived as 'a deliberate attempt…to broaden the gene pool beyond the traditional health colleagues, [and] we were given an implied mandate to be disruptive and challenging' (Interview, GM17).

Housing's inclusion in the Greater Manchester Population Health Plan (GMHSCP, 2017), and the inclusion of health concerns in the Greater Manchester Housing Strategy (GMCA, 2019), demonstrate the increasing awareness at the city-region level of the relationships and interdependencies between the two main areas of interest for this research. Interviewees from Population Health Transformation are conscious that 'the work around inclusive growth is as important' as any other elements of the public health focussed work, and that 'making sure [they're] influencing the industrial strategy, making sure [they're] putting an inequalities lens over that' strategy, is crucial for influencing those wider health determinants (Interview, GM17). The Housing Strategy is ambitious, but whether its implementation will be feasible is not yet certain, and by the end of 2019, the majority of the 'Healthy Homes' outcomes were marked as 'delayed' in the Implementation Plan (GMCA, 2019b, p.7).

There is recognition at senior levels that the health sector in Greater Manchester, and their evolving policies, could be making more progress in the inclusion of housing as a protective force for the whole population:

> Where I think we are at the moment is, we accept that housing is a driver of ill health. Our focus to date, though, has been the role that housing can play in supporting those who are ill, or at greatest risk of ill health…I think at the moment we're missing the point about population health and the role of housing (Interview, GM17).

The activities of the housing associations can be understood in the context of Greater Manchester's HIAP ambition, which recognises housing as an important social determinant of health. However, investment in housing programmes and other structural determinants of health, from the £30 million allocated to Population Health (out of £450 million transformation funding), has only amounted to 'five grand on housing and we've funded 17 other programmes' (Interview, GM17). This small investment paid for an assessment of the home improvement and adaptations services that operate across Great Manchester. The 'view for the future might be that we fund a smaller number of programmes, but that are more aligned to the wider determinants of health' (Interview, GM17), but in the immediate period following the transfer of health and social care budgets, the priority has been given to reactive, traditional programmes that have not departed in any dramatic way from standard public health programming. The housing providers have voiced frustration at being simply a delivery partner for these traditional approaches. They 'want to influence strategy…we don't just want to have a conversation about what we can do together' (GMHP group).

The framework of the Greater Manchester population health approach is modelled on that of the King's Fund, which is 'centred on four pillars: the wider determinants of health; our health behaviours and lifestyles; the places and communities we live in; an integrated health and care system' (Buck et al., 2018). However, interviewees recognise that the powers devolved so far do not necessarily reach into all those four pillars. This has encouraged some of the housing associations to focus more energy on relationships and projects in their individual boroughs:

> The only way I think you're really going to step that momentum up, unless Andy Burnham and the GMCA come along and give us a magic wand and a lot of money to deliver on this, is you've got to deliver it locally (Interview, OD1).

The individual programmes operating at city-region level are also recognised not to go far enough upstream, and interviewees noted 'this isn't a population health plan, this is a list of how you change people's behaviour' but 'population health is wider determinants, it's housing, it's environment, it's education, it's poverty' (Interview, GM11). Some of 'the thinking behind devolution pushes the responsibility for health and wellbeing back to the individual person' (Interview, GM3). The behavioural and individual focus of much GMHSCP

activity illustrates the limitation of the city-region to take action on the structural causes of health inequalities:

> I think we're doing some really important stuff here in the Population Health Plan, and the programmes that we're doing will make a difference. They just won't make the step change difference that tackling some of this stuff [social determinants] will. So, for all the work we do on work and skills, on keeping people active, people being more moderate drinkers, using less drugs, smoking less cigarettes – until we deal with childhood poverty, they all offer slightly marginal gains…those who are more interested in these causes of the causes, they're not as bought into the plan as we would want them to be (Interview, GM17).

As with the lack of other upstream powers, housing professionals have criticised the extent to which housing has specifically been included in the Greater Manchester Population Health Plan, arguing that the work they do already exceeds the ambitions of the strategy. The housing programme is part of the 'Ageing Well' strategy, and interviewees stated that 'it's great that there's something in there, but I'm not sure that it necessarily would have been how I would have wanted to put it together' (Interview, GM11). While they felt 'it was really helpful to see that housing had a home in that…it was poor housing, it was damp, it was things that have been eliminated [in the social rented sector], so it wasn't low wellbeing' (Interview, GM8).

The lower end of the private rented sector, however, is fraught with health and environmental concerns, from the quality of the housing stock to the insecurity of the tenure. The PRS is growing as a proportion of tenure nationwide, but social landlords observe that 'probably the vast majority of their stock is of a poorer quality than ours' (Interview, OD1). The experience of this issue varies across Greater Manchester, but is reported to be more 'acute' in authorities with high housing demand such as Stockport or Trafford. In Stockport, for example, 'the only people who get [social] housing are in real high need…if you're just someone on low wages then it's really difficult' (Interview, GM10). Given the long waiting lists in boroughs where 'there is quite a jump between social housing and private sector rent' (Interview, TD1), increasingly large groups of people are not catered for by housing options in the most appropriate tenure. Choice-based letting systems, which most Greater Manchester boroughs use to manage their waiting lists, are frequently over-subscribed to a huge degree. This leaves many people who qualify for social housing, but who do not have the most acute needs, languishing on the waiting list almost indefinitely:

> The highest I've seen one week was 487 [people] on one property…What chance have they got?...You're competing with the wider populous, but you're also competing against the massive push, quite rightly, that Manchester's on about getting people off the streets. There's massive priority for one-bedroom properties to be offered to roofless, entrenched rough sleepers…and there's a housing crisis (Interview, GM18).

Other boroughs with lower demand have their own particular problems too. In one low-demand area: 'Even round here we could have a hundred [bids] for some properties…and at the moment the stock of available housing is actually diminishing as well, through the impact of right to buy' (Interview, GM3). The under-occupation penalty has also challenged the ability of landlords to be more flexible in their allocations, and Greater Manchester has not been able to 'opt-out' of the centralised housing and welfare policies that have impacts which resonate locally. For example:

> Bedroom Tax was a big issue for us. We've got a lot of, what I'd call low demand homes…two- and three-bedroom flats…that historically would have been let to guys who said they had access to their children…for their children to stay at the weekend, and bedroom tax meant that we couldn't do that anymore, because they wouldn't be able to pay the rent, if they were on benefits….Because our one bed flats are in short supply…we met that need by putting people in two and three bed flats, and then suddenly overnight you couldn't do that anymore (Interview, GM7).

The security and stability that a social rent sector property offers, as opposed to private renting, is recognised by housing staff as one of the foremost health benefits of housing association homes. However, the (growing) gap between demand and supply of social housing is increasing pressure on the existing resources and creating challenges for allocation policies. Housing staff recognise that for individuals who qualify for support, but whose needs are less acute than others, 'you could wait for years, [but] if you haven't got enough points you'll never get a property…it's just the insecurity of it all…people are aspiring to a council house compared to private rented', yet only a fraction of those on the waiting list will be allocated a social rent home (Interview, GM10). Social housing staff 'hear from people that walk in through the door' that 'private renting is a nightmare…there's absolutely no stability, that's the main things, they want to be in a house where they know they're not going to get thrown out' as well as expectations that repairs and maintenance will be carried out: 'they don't have high expectations, it's just decent living' (Interview, GM19). This context is vital in understanding how housing association activity is able to impact on population health, because 'the private rented sector is growing, daily, and so is the lower end. It's not

something that is going to go away' (Interview, GM11) but most of the interventions made by housing associations are utilised within their own sector.

The data relating to devolution is of relevance to both research questions, providing much evidence of 'how' and 'why' the housing actors are acting on health, but also directly informing the insights related to health inequalities concepts, such as health in all policies, lifestyle drift, upstream and downstream approaches, and the individualism of the medical model compared to the social model of health.

Summary

The evidence in this chapter has demonstrated that many housing associations are diversifying their attempts to support the health of their residents at a pace and scale that is enhanced by their status as formal partners in Greater Manchester's devolution and population health ambitions. Although this activity is argued by some interviewees to be a logical extension of the housing sector's role, this activity is also perceived to be necessary due to the impacts of austerity, welfare reform and public sector cuts. The housing providers liken their role to 'filling a gap', which has created challenges for these organisations in terms of expectations placed on housing staff, the variability in the extent and quality of services they provide, and the difficult balance between their social purpose and commercial viability. Evidence of such challenges is found at both the combined and local authority levels, particularly where housing providers have embarked on partnership working with the health sector. Some housing providers have made more progress than others in their localities, for example by securing invitations to their Health and Wellbeing Boards. This variability has led to some concerns about the long-term sustainability and viability of this role for housing associations. Not all organisations have the same appetite for risk, nor are the housing providers committed to this expanded role indefinitely, at least not without external investment. In addition, the activities of housing associations are taking place within a housing market that cannot meet the demand for social housing, nor ensure that everyone in Greater Manchester finds a home in the most appropriate sector. It has become clear that the extra services and support provided by housing associations for their residents are not usually available to people living in other tenures. The next chapter will argue that even when

housing associations are commissioned to work across tenure, the reality of this experience is challenging and unreliable. The evidence suggests that many people are likely to be falling through the gaps in both housing and support provision, meaning that this shift in housing association activity has potentially large implications for Greater Manchester's pursuit of improved population health, and better health equity.

Chapter Six
The delivery experience of housing-health services in Oldham and Trafford

Introduction

This chapter considers in further depth some of the issues raised by interviewees in the previous chapter, providing additional detail to support answers to both research questions. The delivery experiences of two case study organisations and their flagship health and wellbeing interventions are analysed here. In Trafford, the housing association's flagship project is an extra care housing scheme and community centre, with 81 apartments and numerous on-site services. In Oldham, it is a partnership with the CCG that has led to the commissioning of four jointly funded interventions. The interview participants are staff working at all levels within the two housing associations, including decision makers, managers, and those responsible for service delivery. The frontline staff offer valuable and detailed insight into the operational realities of some of these high-level priority changes. These views complement the strategic policymaker perceptions that feature in the previous chapter. The contrasting socioeconomic and political contexts of these two boroughs provide the foundation for an analysis of Greater Manchester that does not view the city-region as a single, homogenous entity. Rather, this chapter will argue that even when facing similar challenges in this population health agenda, local contexts have a sustained and important influence. Variability across the local authorities and between individual organisations was highlighted in Chapter 5 as a significant feature of this increased housing association involvement in health issues. In addition, however, the experience of devolution and austerity across the city-region as a whole, highlights some common themes and shared experiences that resonate in both boroughs. This chapter will argue that in two housing associations that have made health and wellbeing an explicit and extensive priority, the task of developing these practices into part of an efficient and sustainable population health system remains extremely challenging, and susceptible to both internal and external pressures.

Health, social and political context for the case study boroughs

Oldham and Trafford differ in several ways, particularly in terms of the health, wealth and prosperity of their residents. The significance of these boroughs for research on Greater Manchester has been highlighted by Deas et al. (2020, p.9), who identify Oldham as 'a borough characterised by widespread poverty, interrupted by some more affluent neighbourhoods', and Trafford as 'an area of relative wealth but containing pockets of marked deprivation'. Trafford, according to the 2019 Indices of Multiple Deprivation score, is the least deprived borough in Greater Manchester overall. It ranks 191st of 317 English districts. However, this aggregate pattern conceals significant localised deprivation, which appears to be increasing in its extent. The proportion of LSOAs in Trafford that fell into England's most deprived decile was 5.1% in 2019, an increase from 2.9% in 2015 (Trafford JSNA, 2020). Regarding health, these inequalities are pronounced, and average Healthy Life Expectancy is sixteen years older in Trafford's wealthiest neighbourhoods than in the neighbourhoods of its most deprived deciles. The stated 'overarching priority of Trafford's Health and Wellbeing Board' is reducing this inequality (Trafford JSNA, 2020). Oldham is more deprived overall than Trafford and has a larger share of deprived LSOAs, 22.7% of which fell in the top tenth of England's most deprived areas in 2019 (Oldham JSNA, 2019). Average life expectancy is lower than Trafford: females in Oldham can expect to live 80.5 years compared to 83.7 years in Trafford; males in Oldham have a life expectancy of 77 years in Oldham and 79.8 years in Trafford. Life expectancy in the least deprived parts of Oldham is 11.5 years longer for men and 11.2 years longer for women than for those in the most deprived neighbourhoods, and Oldham's Healthy Life Expectancy is shorter than the English average (Oldham Council, 2019).

Trafford is often 'seen as an affluent borough' (Interview, TD5), but there are large income and health inequalities between neighbourhoods. The wealth in some of the borough 'masks the fact that we've got some areas of quite acute deprivation' (Interview, TD6). This creates financial challenges because Trafford Council 'is rewarded based on what's perceived to be great wealth: you don't need much because you're a really wealthy area' (Interview, TD3). Significant pressure therefore falls on the resources available for public services. Trafford

Council, as something of an outlier compared to the rest of Greater Manchester, has spent fourteen years under Conservative control since 2004, followed by periods of No Overall Control and then a Labour majority after 2018 and 2019 respectively. Trafford is a 'lean' local authority; historically reluctant to raise council tax and is 'reliant on profits generated from commercial activities to run its services' (Interview, TD1). It has also pursued partnerships with private contractors to deliver basic services such as waste collection, in contrast to Oldham's strategy of in-sourcing contracts (Deas et al. 2020). This asset and property-dependent approach represents a 'phenomenal risk' to Trafford's income, and concerns were raised by interviewees that 'if the property market slumps, their profits will slump, what happens to the services? It's just mind blowing how short of money they are' (Interview, TD3). In the build-up to devolution, the members of Trafford Council were enthusiastic early proponents of localism and of replacing public services with voluntary sector provision. The role of the third sector is increasingly important in Trafford, and housing staff report being 'quite lucky in Trafford that we do have quite a lot of third sector services, low level intervention services' (Interview, TD2), but these are delivered on a voluntary basis and unlike in Oldham, the local authority has not yet engaged the housing provider in a formal delivery partnership.

The approach in Trafford has been termed one of 'Libertarian Pragmatism', in contrast to the 'Cooperative Council' model seen in Oldham (Deas et al., 2020, p.10). In Trafford, the approach of the council has placed much decision making about priorities and how to deliver them into the hands of communities. This 'pragmatic approach' meant that 'all council services were reviewed, but without imposing a preferred delivery model' (Deas et al., 2020, p.13). Several services such as leisure, libraries and parks have been transferred (with encouragement) to community groups. One of the services now run from Limelight, the flagship housing association development, is the library, supported by a team of volunteers recruited and trained by the housing provider.

Trafford's strategic plan is delivered through the council-led, cross-sector 'Trafford Partnership', which encompasses GPs and hospital services, community health service providers, pharmacists, homecare services and residential homes, the VCSE sector and active citizens. Its vision is: 'A sustainable health and social care system which aims to help local

people to be healthy and enjoy living in Trafford [which] is everyone's responsibility; it may mean changes to behaviour, culture and lifestyle' (Trafford Plan, 2016, p.8). The context which the housing provider is operating in, therefore, is one that has significantly bought into the idea of personal responsibility, demonstrating a 'lifestyle drift' rather than sustained focus at a borough level on the structural determinants of health inequalities. The plan acknowledges the health implications of poverty and inequalities, but is passive in its recognition of the causes of this, reflecting the (hitherto) libertarian tendencies of this authority's leaders. Third sector organisations have been encouraged to take an increased role in community services, without formal incorporation into the borough's public health and governance bodies. In Trafford, there is no housing representation on the HWB, which is viewed as 'quite a big omission, locally' (Interview, TD1). Despite a lack of invitation to participate at this level in health discussions, the housing association's view of itself is an organisation that just 'gets on and does stuff' (Interview, TD3). This is reflected in the extent of the services that the housing association now provides, such as establishing their own social care company.

In comparison, Oldham as a local authority has been vocally anti-austerity, and its Council leaders have been consistently critical of the cuts and strategies pursued by central government. The 2019 announcement of the Stronger Towns Fund was described by the leader of Oldham Council, as an 'insult to the people of the town who have been the victims of Tory cuts for almost 10 years' (Jackson, 2019). Oldham is much more dependent on public sector employment than Trafford, and has also suffered proportionately higher levels of funding cuts. Between 2009-10 and 2016-17, the real terms cut to local government service spending was almost 30% in Trafford, but in Oldham these cuts amounted to more than 40% (Gray and Barford, 2018). Unlike Trafford, Oldham council has sought to use its public sector to build social value within the borough, retain the financial benefits of public spending, and utilise local anchor institutions. Their approach to community wealth building and inclusive economies is extended to the Voluntary and Community Sector as detailed in the Oldham Social Value Charter and the Social Value Procurement Framework (Oldham Council, 2016). An invitation was issued to the housing association to sit on Oldham's HWB, to contribute to the Locality Plan 'when most other [housing associations] couldn't get a mention of housing in there' (Interview, OD1), and to participate as one of the borough's Integrated Care

Organisations (ICOs). The Oldham housing association recognises that 'our experience has probably been different, because our council and our CCG in particular were open to us being part of that partnership' (Interview, OD1).

In both boroughs, the majority of social housing is provided by a single housing association, each set up to manage the large-scale stock transfers of council housing. As such, they are geographically rooted to their boroughs and visibly connected to the communities they operate within. The two organisations were incorporated in 2002 and 2003 and now both operate as 'profit for purpose' housing associations with increasingly diversified business activities. They are also similar in size. The Trafford housing association manages approximately 9,000 homes, and the Oldham provider manages approximately 11,000 homes. Each organisation has a 'flagship' health and wellbeing initiative. In Trafford, the housing association has built a health and wellbeing 'hub' which includes 81 extra care apartments. This development illustrates the extensive and growing role of the third sector in Trafford, which has expanded its role in the areas of health and wellbeing without formal incorporation into the statutory population health agencies. In Oldham, however, the flagship health and wellbeing programmes have been established as a direct result of the housing association's relationship with the borough's Department of Public Health, CCG and HWB. The housing provider in Oldham has been commissioned by the CCG to deliver some of their local priorities.

The following sections of this chapter will demonstrate that this local context is an important influence on the delivery experiences of housing providers. It will also argue that despite the different approaches of the two case study boroughs, the challenges of expanding the role and reach of housing associations as part of devolution, during an ongoing period of austerity, reduced resources, and retrenchment in the statutory services have created common experiences in the challenges faced by those working on the frontline. The challenges inherent in cross-sector partnerships are exacerbated by this context. While interviewees believe that the expansion of the housing association role makes some sense in principle, the difficulty of delivering this successfully, over a short period of time and with dwindling resources, has compromised their ability to make strategic, or pro-active choices regarding housing's role in a wider population health system.

Limelight Old Trafford – a wellbeing 'hub'

Fig 6.1: Limelight Old Trafford

Source: Trafford Housing Trust (2020)

The flagship project of Trafford's housing association is a £20 million facility called 'Limelight' in Old Trafford (Fig. 6.1). This housing and community centre complex opened in October 2017, comprising apartments, the public library, a GP surgery, pharmacy, opticians, nursery, hair salon, community café, as well as spaces for hire that are used by third sector organisations, corporate clients, or for social functions. Social care is also provided directly to the tenants of the apartments. They 'are quite unusual in terms of a housing association providing home care', as other providers have a tendency to 'shy away' from this role, and its accompanying regulation and risk (Interview, TD1). This centre was built with far-reaching ambitions for health and wellbeing, to facilitate and inspire 'flourishing lifestyles' within the local community (Teasdale, 2017). It was designed as a site for the housing provider to consolidate its socially focussed health promotion role and to expand its partnerships with other health and community partners, while reducing direct public sector involvement. The provisions within Limelight are designed for 'models of social prescribing [and] local area coordination…taking pressure off that statutory system and linking in people and

communities' (Interview, TD11). Cross-sector partners with influence on wider determinants of health have been involved in the design and delivery of Limelight. Moving to preventative, population-based public health systems requires action to be taken further upstream, including more stakeholders that influence social health factors. The clinical organisations in Trafford recognise the potential of the housing trust to build a social model of health and 'provide that greater stretch around sense of place, so it doesn't just become a clinical conversation' (Interview, TD12). This is a primary imperative behind the housing provider's diversification, and of 'shifting the focus away from what the original core parts of the business were' to work on wellbeing (Interview, TD6).

This community centre and housing scheme also reflects the importance of area-based public health interventions for this borough. Trafford does not have an acute hospital, so public health, primary care and community-based support are crucial. Housing associations and the VCSE are instrumental parts of the 'new models of primary care' that reflect one of Trafford's transformational priorities. The *Trafford Plan to 2020* (2016, p.6) states that 'to encourage independence and self-reliance' as part of this move to non-clinical settings, their residents 'will be part of a thriving and supportive community and less reliant on public sector services'. The Limelight project is intended to encapsulate, in built form, much of what Trafford's CCG sees as its ambition:

> For us, it's thinking beyond the surgery, but also what are the links between the surgery and those other organisations, so how can we design a system that enables the GPs who are on the front line to [know]…what are the resources within the housing sector, with the local community and voluntary sectors, it's trying to knit that whole system approach together (Interview, TD12).

The housing association, and the staff working within Limelight, visualise the centre as a 'one-stop-shop' for health and wellbeing, offered in a holistic, non-clinical fashion. Interviewees argued that the housing association's position within the community, and their understanding of the borough's residents and history, makes them ideally placed to fulfil this role. The community centre is viewed by some staff as a site of 'triage', through which they can act as a first point of contact, supporting residents to access the appropriate facilities and services.

The hub replaced a community centre that was closed and demolished in 2014. Interviewees highlighted the importance of this facility for local residents, and managers felt that 'as much

as [the housing association] own it, for me, it belongs to the community' (Interview, TD4). A sense of continuity with the old centre has been sought. Several members of staff from the old centre have been reemployed at Limelight, so that 'every time somebody comes through that door, they see somebody that they know, they see somebody that they have a relationship with, they see somebody that is just a big, smiling, friendly face', which 'puts people at ease [and] improves health and wellbeing immediately' (Interview, TD6). The businesses operating from the premises were also selected precisely for their established links to the neighbourhood:

> What works here, I think, is that we've got a pharmacist that is a local person, selected partly because of that. We've got the GP, who is from Old Trafford, passionate about Old Trafford. We've got our hairdressers who are really passionate Old Trafford residents, opticians, the nursery provider, so they're all committed to the community. And that is something that you cannot get in a contract, you can't buy, you can't ask someone to do it if they don't really feel it (Interview, TD11).

Visitor numbers to the centre during its first year were 'better than expected, we've never had to sell it to the community' (Interview, TD6). The majority of events and activities take place in the open, public spaces of the centre rather than in the private residents' space, so are universally accessible.

Interviewees reported unexpected levels of openness and disclosure from community members regarding health or wellbeing issues. The staff in Limelight feel trusted, 'and that means that people talk to us about all sorts of things…three women now have come in and disclosed domestic abuse to members of staff, I had somebody that came in and talked to me about addiction issues…That's slightly unexpected' (Interview, TD4). However, staff recognised that 'we're not experts' (Interview, TD6) in the majority of cases they encounter, and that their role is better suited to doing 'that job of the missing link' (Interview, TD2), directing and signposting individuals to specialist, tailored support services. Some staff felt that 'the thing about housing is, I don't think we're particularly skilled about asking some of those quite difficult questions about what's going on', for example if somebody discloses suicidal thoughts to a housing officer, 'we don't gather enough information sometimes to be able to say, this is why we feel we're at risk, this is what the person feels about the situation' (Interview, TD2). Concerns were raised by interviewees of a lack of resources in secondary care, or long waiting times for specialist services to refer individuals to. This means that

instead of acting as a 'link', the housing association staff are left trying to help individuals, but often without the resources to do this effectively.

> So, people are coming back to me and saying "oh, can you help me again because I really like you helping me?" and I think no, I can't, I really can't because it's not my job, I need to move you on (Interview, TD11).

There is a strong sense amongst interviewees that the community is responding positively to the housing association's initiatives, but that frequently this means 'filling the gap' (Interview, TD1) in a space where a specialist service or statutory organisation would otherwise be.

Transformation for health, wellbeing and partnerships?

Interviewees reported doubts that the health and wellbeing activities developed in Trafford were transformative to the anticipated degree. Limelight was designed to support, or increase, the existing services in the community and the voluntary sector organisations already in operation:

> Something that I'm really passionate about is that we don't come in, and take things away from other centres, or other projects that are taking place in Old Trafford, because that is not what we should be doing. We should be adding capacity, regenerating community support in other organisations. We shouldn't be coming in and thinking that we can do everything ourselves, that's not community development (Interview, TD11).

As well as the VCSE, this project was intended to create new, and strengthen existing, working relationships between the housing and health sectors. The on-site GP surgeries are an important part of this agenda, the GP is 'the key player in that health space' (Interview, TD4) and the cultivation of good relationships between individuals is identified as crucial. The surgery leases the clinic's space from the housing association 'so, we have no control over what happens in there, which means that we have to try and broker a really good relationship with the lead GP…and make sure that she understands and that she is really engaged in that wider health and wellbeing offer' (Interview, TD11).

These partnerships have not grown as quickly as hoped. Staff at the housing association reported that the Limelight development 'really tells you everything' about the 'inability of the health and social care system to properly understand the social determinants of health' (Interview, TD3). Early discussions with stakeholders initially committed to involvement with

Limelight included 'a group of thirty health and social care professionals from across Trafford and Greater Manchester' who 'bought into the vision of making every contact count, about the integration of services, about it being much more than a delivery of GP services from that space' (Interview, TD3). This reflects the housing provider's experience with cross-sector working on other projects, and their attempts to engage health professionals 'who will give you all the spiel about moving resources upstream', but once the project is finished, 'bugger all changes' (Interview, TD1). The housing staff showed disappointment that 'all these grand ambitions…have funnelled down into something which is, whisper it, quite ordinary' (Interview, TD3). The health partners recognised this tendency of 'the system' to 'always just go back to what it knows best, its corporate DNA', which does not fundamentally change as a result of new partnerships 'because at the moment, what we do is have an idea and then we try to make the system work around it, and it won't' (Interview, TD12).

The 'important' is often compelled to give way to the 'urgent' when services are overstretched. It has proved difficult to use the GP surgery space in the innovative ways hoped for, because of the need to prioritise the basic functions of the service. Whilst the Limelight management 'would love to have art sessions and all sorts of things upstairs' in order to offer something non-clinical, wellbeing-related for patients, in reality 'during peak times [the waiting room] is rammed' (Interview, TD4). Instead, 'what is actually delivered on the ground, now, is not much more than the basic GP service' (Interview, TD12). The GPs expressed interest in more holistic services but drew attention to the demanding nature of their immediate priorities and commitments to their patients. The reception desk for the community centre 'should be triaging' in order 'to peel away a lot of the things we [the GPs] don't need to see' (Interview, TD9). Clinical staff recognised that the centre was not yet effectively redirecting patients to non-medical resources:

> How can we change this? To not just have a traditional GP surgery, where you go upstairs into a reception room…sit down, and wait to see the doctor. That really could be anywhere in that environment. It doesn't even have to be in Limelight. So, it's not adding, really, a great deal more value. So, the question is how do we change that? What are the links that can be made beyond the GP surgery, but using the proximity of it, into some of those other things that are operating in and around the Limelight centre? (Interview, TD12).

GPs, however, raised concerns that redesigning their services in more innovative ways was difficult in the context of austerity, welfare reform, and their current levels of demand. The

'GP is seen as being the person who can sort everything out' (Interview, TD9). A 'lot of patients will come, time and time again, with a problem in front of their GP…and they're not really presenting about the condition that they're talking about' (Interview, TD12). For surgeries in neighbourhoods with high health inequalities such as Old Trafford, their patients have been disproportionately impacted by cuts to social security and services:

> I'm not a counsellor…[but] in deprived areas it's a case of social issues, and that's affecting what comes in through the GP door. So, when housing issues change, like the single rooms [Bedroom Tax], the payments, how they've started giving people Universal Credit. That's just messed up (Interview, TD9).

It is proving difficult for both the housing staff and their health sector partners to properly integrate their services, innovate and intervene upstream, in the face of so much urgent, downstream demand.

These attempts to work more closely together, intersectorally, have highlighted some fundamental organisational differences between health and housing. Some housing association staff have clinical training, or a professional background in health services, so are attuned to the cultural differences that accompany cross-sector working. One interviewee argued that 'there are improvements that can be made on both sides' (Interview, TD1), and that better alignment of professional values would improve outcomes for their service users:

> I think there are things that we [housing] could do, to improve our information sharing and our professionalism when it comes to addressing these kinds of issues. Also, our risk level, and tolerance, is totally different and we need to acknowledge that…Other things, like issues around capacity and consent, we could do with having a more developed working knowledge of, for all our staff. I think that if we got those things right, we would be better able to say, actually, you're not holding up your end of the bargain. But I do think there are failings on their side as well. (Interview, TD2).

The agenda of closer housing and health work is being pursued in the context of some entrenched ways of working. A senior housing executive reported his 'pet hatred of commissioners' who he perceived to be invested in preserving the system's status quo, 'even if they believe they are being altruistic and doing the right thing, they are just captured by the system…and I think housing has to have some recognition that we do exactly the same thing' (Interview, TD3). The clinical partners recognise that it is difficult to overcome the structural challenges to making these transformations. The strategic decisions, and agreements on collaborative working, can be far removed from the reality of those tasked with the operation.

There is often 'a disconnect between the institution and the reality of what you actually get, on the shop floor…and I can tell you that [the CCG] isn't yet having that level of conversation that it needs to' (Interview, TD12). Commissioners recognise that 'what we have is a transaction gap, between strategy and transaction and making something real, is this palpable gap', which is even more pronounced in 'gargantuan' sectors such as the NHS (Interview, TD12).

Housing partners observed the vast difference in scale between organisations such as theirs, and the scale of NHS trusts or commissioning groups. Limelight represented an enormous investment for the housing association, at £20 million, and 'we think, wow, it's absolutely brilliant, how can it be that the health and social care and public health world has not noticed it, and is not flooding into it? Well, because it's tiny for them' (Interview, TD3). Health sector interviewees recognise these limitations:

> It's that dichotomy beyond doing something at scale, which we need to do, but being able to do something that in its confidence and credibility isn't just a tiny little pilot, involving one GP practice and a few willing people around the edges. It's got to be something that's scalable and that's the challenge for us at the moment' (Interview, TD12).

Examples of successful partnerships in Trafford are frequently attributed to the individuals involved, whose integration is often perceived to be 'in spite' of the system, 'they find ways round it' and one housing association has 'stopped talking to the local authority and the CCGs, they're now talking to clinicians in hospitals' directly, having determined that 'you don't need all this bureaucratic stuff, sitting there trying to make sense of the system, you just need two people to have a good relationship and make it happen' (Interview, TD1). This individualised, rather than systematic approach, was repeatedly raised by interviewees as a source of frustration when working across sectors.

The semi-public status of the building's owners, and the boundaries between the communities it serves also create barriers to achieving the larger strategic goals. Devolution to Greater Manchester has not removed the separation in resources and duties between individual boroughs, but Limelight is situated very close to the Trafford-Manchester border and is frequented by residents of both. The centre has an office providing housing advice, or support with welfare and social security to Trafford residents, and the GPs highlighted issues

with fairness and universality. Patients 'with housing and debt problems could go to Trafford Housing, but, as I understand, they can't advertise that because this is a public building, and if you live in Manchester, not Trafford, they can't help' (Interview, TD9). The medical services on offer to tenants as opposed to non-tenants is also a source of some tension. Some of the residents 'expect home visits now' and the GPs 'think part of the way the building was sold to them was, "you've got a GP on site"…and the carers have got this very strong belief that that's people right here' (Interview, TD9). For the GPs, however, this is unfair to other local patients:

> Our policy is, if you're housebound, or terminally ill, you qualify for a visit. If you can get out, to go to a hospital appointment, or to get your hair done, then you can come here. Purely because, we've got a big block of flats over the road and we say no, you're not housebound, you come in. They say, but my friend who lives in your building isn't housebound and you visit them. It's not fair. The carers don't see that. (Interview, TD9).

Communication between the community centre staff, the medical team and the public services housed in the building has also been identified as a potential problem. An example where communication had 'broken down' (Interview, TD5), was an incident when a GP patient who is well known to the surgery, and suffers from mental illness, was arrested while sitting in the waiting room. The community centre staff had called the police when she entered the premises, as she is banned from all Trafford libraries. Housing and clinical staff report communication to be an issue. One housing employee recalls 'issues with things not being communicated properly to GPs, letters going missing, emails not being received…even though it's the GP that's got the duty of care to assess and make the decision, you have to chase it all the way' (Interview, TD2). Similar issues are reported with social services, in examples 'where I have rung twenty or thirty times before I've got an answer out of them' (Interview, TD2). The lack of faith in the mainstream services' responsiveness for supporting individuals creates a challenging environment for the housing staff when, once a support need has been identified, 'you can't do something practical with them' (Interview, TD3). Although Limelight has brought together a wide range of willing partners, there remain several gaps and shortfalls in the capacity they can build with the available resources.

Balancing health, social and commercial demands – building in sustainability

The services in Limelight, which include a pharmacy, opticians and hair salon, fulfil a health and wellbeing function, but also operate as commercial businesses. The centre as a whole is expected to 'break even' and 'pay for itself' after three years (Interview, TD4). Interviewees stated the difficulties of achieving a 'fine balance of sustainability and community development practice, and saying "no" as much as you say "yes"' (Interview, TD11). This equilibrium between social value and long-term financial stability is made more challenging by the austerity context they are working in, and the impact this has on a poor neighbourhood in an affluent borough. The 'original justification' for developing Limelight was a social return on investment report, which argued 'that there is a social reason to do this, not necessarily a financial reason' (Interview, TD4). Interviewees noted the lack of 'a real, clear, business plan' before the building was opened, and that the decision to 'break even' within three years was taken retrospectively (Interview, TD4). Managers argued that 'we should have done that the other way' and considered 'how would we achieve that' before the earliest decisions were made (Interview, TD11). Limelight needs to offer a service to the community and generate income, and the revenue it needs to balance its budget cannot be raised 'just through having tenants' but by having 'viable business opportunities', such as renting the space to corporate clients (Interview, TD11).

The social context of the centre's location presents numerous health challenges. The investments made in one area have been accompanied by cuts in others, and one manager likens this to 'filling up the bath with the plug out' (Interview, TD3). Limelight represents a large investment by the housing association, but some interviewees perceived it to have taken priority over other, more established community services, which require longer-term revenue support but have seen a reduction in resources. A neighbouring community centre in Old Trafford had worked for years with a strategic youth worker who was first employed by the housing association before being made redundant along with several other 'outreach staff'. His salary was paid for six more months from a 'pot' of money the housing association had made available for community groups before the housing provider 'said they're not going to fund it' any longer (Interview, TD8). His colleagues were disappointed because 'he's of the

community, he knows everybody in the community, he's trusted and he's really good at what he does' (Interview, TD8). However, the housing association can no longer justify funding him 'because they've said that they've got their own worker who does that capacity building, but they actually don't…it [doesn't work] for Old Trafford' (Interview, TD8). Such approaches to health and wellbeing can work to either consolidate or weaken the cumulative impact of individual community services.

The CCG understands this difficult and delicate balancing act faced by public, private and third sector organisations:

> We're not fully there in terms of understanding that ecosystem, and what the interdependencies are within it, and what is our role within all of that to try to provide the stretch to do things differently, so that we're not just cutting our noses off to spite our face, which is what happens when, on a line-by-line basis, you take decisions to reduce funding (Interview, TD12).

Staff in Limelight reported that working in this context of cuts to funding and wider services means they 'never feel like I've done anyone justice' (Interview, TD9). Some of these experiences might have been unforeseen, yet when 'the tap gets turned off, somebody comes up and says "well, actually, have you seen the damage that's been caused by that?"…We need to be having a smarter conversation about what is in the resource pot' (Interview, TD12). The long-term strategy is not necessarily supported by the short-term actions, and staff working for this housing association voiced frustration at the statutory services that have 'taken out all of the low level and preventative work [which] is extremely short-sighted because it just means that in years to come we'll have bigger problems' (Interview, TD2). The housing association expects that working with health will ultimately generate additional income for them, but so far, embedding these ways of joint working throughout both the health and housing structures has proved to be inconsistent and unreliable:

> This has to operate at two levels. It has to operate at the ground level, it has to have people who are prepared to break all the rules, and just make things happen, and some of that does go on. Slowly, [we] are starting to build good relationships with people, and so long as they stay there those relationships do become profitable. Business for us, cost savings for the NHS, and good outcomes for the patients. So that kind of works. But what kind of system do we have where that's what it relies on? When the strategic intent is not joined up at that level? That's what we have, no joining up (Interview, TD3).

Staff at Limelight 'don't want to…put an asset into the community that in three years' time [the housing association] decides, this isn't financially viable; we don't want to be involved

anymore. That isn't good for the community. I want to make sure that it's as sustainable as it can be so that the community are guaranteed that this is here, for a long time' (Interview, TD4). This requires a long-term guarantee from the housing association that community services such as Limelight will remain a funding priority. The pursuit of a break-even budget reflects the sense that they 'don't want to become the [permanent] funder' of these public, universal services, and 'if they change their strategy, the funding isn't going to come back at a local authority level', so accountability for cutting services would then likely lie with the housing provider (Interview, TD11). This kind of diversification involves significant capital spend and upfront investment but does not guarantee ongoing revenue support.

The extent to which Limelight represents a change in the fundamental purpose of housing associations provokes differing opinion within the same organisation. While the board of this housing association is reported to be 'somewhat ambiguous about the extent to which we should be playing in this space' (Interview, TD3), interviewees expressed a range of perspectives regarding the identity of their organisation, and other housing providers. Some asked, 'are we having a bit of an identity crisis?' (Interview, TD16). Others felt 'it is impossible for a social landlord *not* to be a significant player in this space, and that stems from the fact that we house, disproportionately, older and more vulnerable people in society' (Interview, TD3). For one housing officer, 'what you hope is that social landlords stay social landlords, not move away to be commercial, because then you're forgetting about the people' (Interview, TD6). Reflecting the imperative on their organisation and their staff members, these housing associations are therefore likely 'to be left with the problem…we can't get rid of it, unless we really shift who we allocate to, and what we do, and that takes us away from our social mission' (Interview, TD1). However, this lack of clarity regarding the breadth and limitations of their services may cause some safeguarding concerns:

> I think housing associations are having a bit of a crisis of identity…we struggle with not knowing what our boundaries are here. So, we articulate about going the extra mile, and we don't really give good guidance about what that is, or what that should be. And I think sometimes we get it wrong, and we don't realise that we've got it wrong, we don't realise how much danger we put ourselves in by going that extra mile (Interview, TD2).

The housing staff, and staff of Limelight, reported that they do not always feel comfortable or capable of providing adequate support to individuals, but the lack of preventative, early

intervention services to refer onto means that many of the tenants they work with 'go under the radar for so much longer, and then it escalates until it is at the point of risk' (Interview, TD2). Senior managers within Limelight have observed that their staff, despite the lack of external services to refer onto, 'through their own commitment and passion, will get that person sorted out' (Interview, TD11). This is not, however, matched by ongoing support or investment in training or supporting staff members. As discussed in the previous chapter, customer facing staff in Limelight reported that their jobs have evolved to 'cover all bases' (Interview, TD6) and that, 'as a housing officer you're not just looking after a house' but 'actually looking after a tenant, and a tenant's welfare' (Interview, TD5). This role is felt by staff to involve some personal risk:

> What you'll find with a lot of housing officers, we often find ourselves in a situation where we've been in a property with someone and they've shown erratic behaviour…it's like, "you've got to be careful with lone working" etc. [but] we will go and support that person because we are worried about that person (Interview, TD6).

Staff acknowledge, however, that the role of a housing association employee 'isn't to provide long term, sustainable services for people, because I have no resource for that, I'm only one person' (Interview, TD5). They may able to bridge that gap in support for their tenants, but they do not have the capacity to replace or supplement a failing wider mental health support system. In the context of devolution, leaders in Trafford acknowledge that 'in this borough…I don't think we've made anywhere near as much use of public health as we could have done' (Interview, TD12). Austerity cuts, however, are perceived to have led to 'the emasculation of public health' which has led to housing leaders feeling 'kind of doomed at the moment' and 'deeply pessimistic' about their capacity to work together proactively in the near future (Interview, TD3).

Interviewees were concerned about the long-term effects of austerity, and pressure on community services. By 'allowing it to carry on we are being complicit' and the cuts to preventive services are 'costing the system a huge amount of money', which is 'going to have massive legacy effects' (Interview, TD12). Limelight staff observe that 'when other systems are under pressure, we get swamped' (Interview, TD9). There is a lack of robust mainstream services in Trafford to refer individuals to, even if housing staff identify a support need. Interviewees highlighted the gap between the extent of the primary care services' reach

(which are heavily supplemented by VCSE organisations) and the health issues, particularly mental health issues, that they encounter in the community:

> The thing I find really missing is secondary care services…the squeeze is here, where you aren't able to access primary care services independently, because your needs are a little bit higher, but not high enough to reach the criteria for secondary care services (Interview, TD2).

In terms of how well Limelight represents a sustainable model for health and wellbeing developments elsewhere, for other housing associations, interviewees were cautious in drawing conclusions. The need for locally appropriate interventions is highlighted by this:

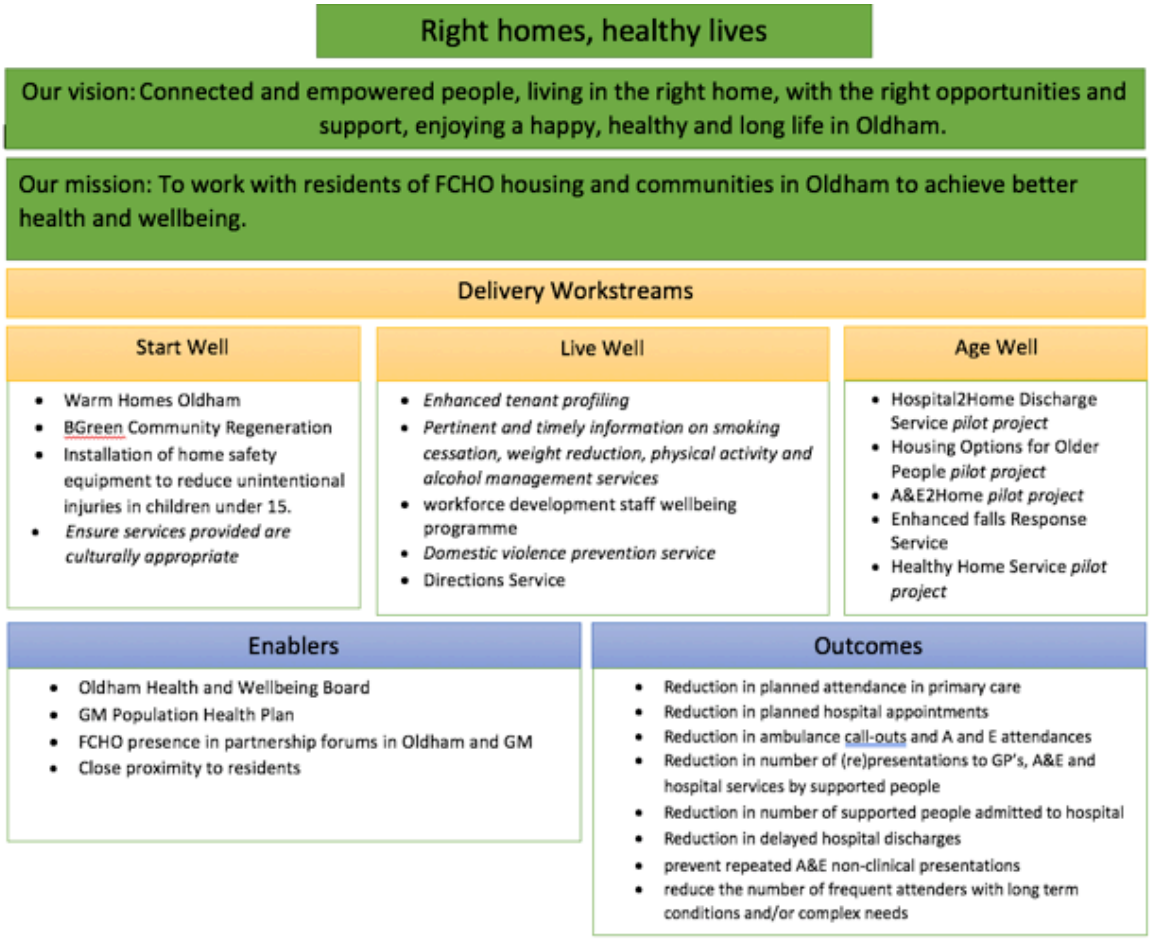
> Look, this is Limelight, which is about the only thing we can shout about at the moment…come and have a look, we'll tell you all the things that went well, we'll tell you the things that we wouldn't do again, in a million years. It's not a prescription, it's a solution for this time and place which has been reasonably well executed and fairly successful, take it. Steal with pride but don't replicate blindly, because it won't work in your context (Interview, TD3).

As with several of the pilot, or short-term interventions offered by housing associations, Limelight represents a stand-alone project, of supreme importance to the housing provider but with limited impact in the health sector. Limelight represents a state-of-the-art facility that works well in its own right, but that primarily functions as a downstream intervention, offering space (and services) to a community that will benefit from them, without impacting on the structural causes of the inequalities they experience. Limelight's operations do not match the scale of 'transformation' which would determine population health, or health inequalities, the causes of which remain further upstream.

Commissioning and partnerships between housing and health in Oldham

In the Oldham case study borough, the housing provider offers several of the type of non-housing support services to its tenants as identified in chapter 5. The organisation's strategic vision is ambitious, and its health-focussed activities are organised into the categories of the Greater Manchester Population Health Plan: 'Start Well', 'Live Well' and 'Age Well' (Fig. 6.2).

Fig 6.2: Strategic Framework, First Choice Homes Oldham



Source: First Choice Homes Oldham, Strategic Framework (2017, p.6)

In addition to the services provided solely by the housing association, and as part of its business strategy, this organisation has established four specific health-focussed pilot projects, joint-funded with their CCG: A&E to Home; Hospital to Home; Housing Options for Older People; Healthy Homes (Table 6.1). These flagship programmes represent the partnership between the housing association and the health sector, illustrating the housing association's 'venture into something that we weren't already doing', as interviewees would 'argue we've already done loads of health and wellbeing things as part of our core service' (Interview, OD1). The hospital discharge services, and HOOP, are two of the 'investable propositions' that GMHP offer across the city-region, but are not yet fully established in all ten boroughs. Oldham is perceived by housing actors across Greater Manchester to be particularly advanced in this housing-health relationship. The impression elsewhere is that 'in Oldham they've done wonders' as a result of the joint commissioning (Interview, GM10).

This housing association therefore occupies a valuable site of experience, as well as offering insights that might be applied elsewhere, as housing providers continue to pursue this agenda of closer relations with health partners.

Table 6.1: Jointly commissioned health-housing programmes in Oldham

	Hospital to Home	A&E to Home	HOOP	Healthy Homes
What the service involves	Housing officer based in the hospital to support patients with housing-related barriers to safe discharge e.g. aids and adaptations, essential repairs, clearance and cleaning, thermal comfort, liaising with landlords.	Similar to Hospital to Home, for patients with housing issues but who aren't admitted onto the wards, including people experiencing homelessness.	Specialist advice and practical support provided by housing officers to older people, explaining and facilitating alternative or appropriate housing 'options' e.g. house moves, assistance with financial claims, aids and adaptations, help accessing social care.	Team of five full-time staff tasked with early intervention and prevention, tackling the causes and non-clinical drivers of hospitalisations in a non-prescriptive way e.g. house moves, improvements to warmth and insulation, personal support/care, referrals to other services.
Target population	Medically well patients unable to be discharged (delayed transfers of care)	Frequent fliers to A&E and avoidable admissions	Older people	Over 75s and frequent fliers in NHS services
Community or clinical setting?	Clinical	Clinical	Community	Community
Preventative or reactive service?	Reactive	Reactive	Preventive	Preventive
Challenges reported	Slow pace of building relationships with the clinical staff in the hospital in order to generate referrals, getting housing to be viewed as a separate need to social care.	Lack of a data sharing agreement, referrals slow to come through, hospital staff unaware of A&E officer's presence/role.	Building trust and relationships with service users took a long time relative to the funding period, making the service difficult to evaluate. Difficulty reaching some private sector occupants.	Lack of data and intelligence sharing. Inability to reach target populations, so relied on HA records and contact details. Too short-term to observe or evaluate whether it was successful.
Funding continued?	Yes	Yes	No	No

Staff members responsible for delivering these services were confident of achieving significant improvements for their clients. The HOOP service 'just seemed to take off from the start' and the number of referrals indicated 'a real need for that service without even promoting it' (Interview, OD4). The service was utilised in the wider community and by Oldham's VCSE organisations. It was 'a matter of popping up to Age UK and introducing yourself, and that's it, the floodgates opened' (Interview, OD5). During the eighteen-month pilot approximately 350 people accessed the service, and more than 120 older residents were helped to move into homes that were more likely to support better physical and mental health. Staff perceived that 'the reason HOOP was so successful' was the intensive support and relationship building it offered individuals, which is not simply to say 'right, you're moving house, crack on', but recognising that 'it takes multiple conversations, it takes reassurance'

(Interview, OD5). The Hospital to Home officer reported that 'over that first twelve months, she helped about a hundred cases to be discharged' (Interview, OD1).

Some wider, holistic benefits from these services were also identified. Financially, there were 'some absolutely unbelievably positive outcomes' for Healthy Homes service users (Interview, OD3), who were advised by housing staff on the full range of benefits and social security payments they were entitled to. Within the team 'there was a vast amount of knowledge which we could use and share' to help 'people to understand what they were missing out on' (Interview, OD3). One of 'the best outcomes we had was [gaining] an increase for an elderly couple, to their finances, by fifteen thousand pounds a year…it was like a complete new lease of life' for them (Interview, OD3). These services produced in the 'vast majority…good outcomes, and people are sustaining tenancies for longer', increasing 'financial viability, not just for the customer but for us' (Interview, OD4).

These four programmes all included some degree of support for residents to relocate, if it was likely to benefit their health and wellbeing. This was reported to have addressed some of the imbalance in Oldham between housing supply and demand. For example, the HOOP programme 'had benefits for the housing strategy team' as it identified suitable tenants for 'some of the sheltered accommodation that they'd struggled to let before' (Interview, OD5). HOOP and Healthy Homes were 'win-win' projects designed to address the lack of family accommodation available, and support 'older people who may be struggling to heat a large home, mobilise around a large home, so are more at risk of injury and poor health' as a result of their housing (Interview, OD3). In some instances, 'the difference we've noticed with us having this post in place', has freed up larger, family-sized accommodation, which housing staff could then offer to younger, larger households (Interview, OD4).

Cross-sector coalitions and communication

For these four programmes to succeed, cross-sector collaboration is necessary, with significant buy-in from housing, health, local government and community organisations. In order to deliver both social value and value for money, the housing provider recognises that 'you do rely heavily on partnerships' (Interview, OD1). The housing staff attribute the

formation and funding of these programmes to the fact that they have 'such good connections with our CCG' (Interview, OD2). To set up HOOP, for example, their established working relationship meant they were able to make a direct phone call asking for fifty-fifty funding, and 'within 24 hours, there was no grant application, or consideration, [the CCG] just came back and said "yeah"' to an eighteen-month pilot (Interview, OD5). Healthy Homes was created at the health sector's request, who 'had asked whether [the housing association] could assist them in reducing the number of elderly patients that were using NHS buildings' for avoidable reasons (Interview, OD1). In Oldham, the health sector is making proactive use of the housing sector as a partner, which is in keeping with its co-operative council model and community wealth building approach (Lupton et al., 2019).

Inclusion of the housing association on the HWB was identified as crucial. The hospital discharge programmes 'came about because there were discussions at that board' (Interview, OD2).

> I think we were quite lucky. Because we were invited onto the [HWB], from its inception. And we weren't aware of anybody else in Greater Manchester that was given such an invitation…that came about probably as a result of a couple of enlightened people. One being the director of public health, who could see that if we're really going to improve health in this borough and reduce those inequalities, housing had a significant role to play. In particular not just housing conditions but in terms of that community engagement, communities doing it for themselves (Interview, OD1).

This relationship was seen by the housing provider as an opportunity to prove their commitment to this agenda and ability to deliver a high-quality service, and was 'one of the reasons why we were successful in getting some of our health projects off the ground', as 'none of them were a hundred percent funded by the CCG' (Interview, OD2). The Hospital to Home service was originally fully funded by the housing association, whose offer to the CCG was 'if you give us a chance to actually get into the environment, we'll fund the post for twelve months' (Interview, OD1). The fifty-fifty funding arrangement was navigated after the service had already proved beneficial, 'because the [hospital] integrated discharge team were actually the biggest advocates for the service going forward' (Interview, OD6). This partnership building is an area in which Oldham is perceived to have made significant progress compared to the other Greater Manchester boroughs, changing the standing and status of the housing association.

> Relationships, I think have blossomed. Not saying it's perfect…But at the strategic end, those relationships are really being built. And I think…we are, now, seen as being an anchor institution in the town, with something to offer here. We're no longer something that's viewed with a bit of suspicion…people have seen we're willing to put our money where our mouth is and do something. So…the relationships are a heck of a lot better than they were three or four years ago, when we were an unknown in the world, in the room, and probably treated with some suspicion. A lot of that has gone (Interview, OD1).

However, while there were many reports of successful relationship building at a senior, strategic level, the challenges of cross-sector working, communication and intelligence sharing were still acutely felt by those charged with service delivery. As reported in Trafford (where the housing provider is not a member of the HWB), those working in Oldham felt there was a 'transaction gap' between the strategic priorities of clinical commissioners and housing executives, and the experience of this collaboration by frontline staff:

> Sometimes the levels aren't right. So, when we look at the health services, I think at a high-level people have bought in, the commissioners were like, this is brilliant, go off and deliver it. But at an operational level, well, you can't have the data. Or, what's housing go to do with anything? (Interview, OD5).

The 'on the ground' relationships between the housing and health staff at the hospital, which generate referrals, are necessary for the success of these roles. The first months of the Hospital to Home officer's posting 'was just walking wards, trying to get people to understand, why are housing doing anything?' (Interview, OD4). The housing officer reported having 'some quite negative comments put to me when I first started, from some of the [hospital] staff…who are you? Why are you here?' (Interview, OD2). They needed to make personal links with the medical staff 'just to get people to have a conversation', and recalled following doctors on ward rounds, in order to intervene and speak to patients and families directly, saying 'I can help you with this' as a way of promoting the service (Interview, OD2).

The housing staff identify that moment, 'once [they] got the communications and built relationships with the staff', as the 'point when the referrals started to come through' (Interview, OD2). Discharge officers note that 'when there is a specific housing need that we are able to help with, you can see a lightbulb going off in people's minds' (Interview, OD6). Further referrals are generated 'because key members of staff have worked with [us] and have then shared their experience with other colleagues' (Interview, OD6). These relationships have taken longer to embed than the housing staff anticipated. While they

'have been there for some time now, I still feel like there is so much more to do in terms of changing attitudes and getting ourselves established' (Interview, OD6). One interviewee reported feeling 'like you're really taking steps forward, and then you'll get a comment like [are you a social worker?] and I feel I'm back to square one again' (Interview, OD2). What the discharge officers 'wanted to achieve, still want to achieve, is that [clinical] staff are considering a person's housing need as a separate need from social care' (Interview, OD2). For the programme to be a success 'and the possibility of ever changing anybody's attitude towards it' the staff report a constant need to stay 'visible', 'just reminding people of who we are, and reminding people that housing need is not a social care need, we're here for a specific reason' (Interview, OD6).

Being dependent on individual relationships, rather than structural consistencies, means that the success of these healthcare-based services is vulnerable to changes in staffing, personnel turnover and organisational restructures. Interviewees reported 'frustration' that the hospital staff 'change so often', and once 'you get familiar with some, get to explain what you're about, what you're there for' and get them 'really on board… you never see them again' and the 'next person who comes along [is] not quite on board', so progress is hindered (Interview, OD2). This has been amplified by the changes to staffing and governance that have come with devolution:

> The biggest setback we've had recently is all in one go there's been a massive change in the strategic level of the CCG, the council, in terms of the personalities. So, a lot of those really close relationships we'd formed with the leaders of twelve months ago, have gone, because the leaders have changed. So, we're having to rework, rebuild relationships (Interview, OD1).

The challenges of delivering universal services

The difficulties for third sector providers in reaching the wider population, even when commissioned to provide a universal service, risk exacerbating the emergence of a two-tier system of access to health and housing support. The majority of the organisation's non-housing services are interventions that 'we just do…for our own, we only do it for our own tenants' (Interview, OD4), which has been identified as a cause for concern across the GMHP. Effective partnership working can go some way to combat this challenge. Staff reported that HOOP could successfully use its network of referrals and VCSE partners to provide a cross-

tenure service. Unsurprisingly 'some of the main concerns were around the private sector', but accessing those residents 'was fine, because we had those referral sources such as Age UK, there was no problem' (Interview, OD5). Healthy Homes, however, which was 'directed at the private sector' (Interview, OD1), struggled to make impact outside of their own tenant group, despite being a commissioned, cross-tenure service. The lack of access to information meant that 'the vast majority, in the end, of customers, were [our] customers' (Interview, OD3). The hospital discharge officers also that noted that when the referrals they receive are for patients that live in their properties 'it is so much easier…I wish they were all our tenants' (Interview, OD6).

The services that received CCG funding were intended to be tenure-blind, yet it has proved challenging to deliver equitable services. Much of the private rented sector stock in Oldham is 'of a poorer quality' than the housing association stock, 'therefore we're finding that a bigger and bigger percentage of our interventions are going into the private sector' (Interview, OD1). Hospital housing officers reported expecting most referrals 'to be from the private sector, because there's that lack of support there for them. Whereas for social housing tenants, they should know who to contact when they've got a problem' (Interview, OD5). However, tackling housing problems outside their own tenure, without easy access to information and working relationships with the private landlords, created barriers for the interviewees. The 'problems where we really struggle to resolve tend to be from owner occupiers and private sector' tenants (Interview, OD2). Regarding accessibility, interviewees also noted that tenants 'who are most likely to respond are probably the ones who least need the service' (Interview, OD1).

This also causes a dilemma for the housing association when their own resources, which are almost entirely derived from rental income, are required for interventions in other sectors. When delivering these services across the private sector, the housing association 'created a small fund to enable us to do things quickly…but the idea would be you'd recover those costs from, if it was a private landlord, from them, and if it was an owner occupier then ultimately from the owner occupier'. This is 'easier said than done in some cases', but possible when working in partnership with the council 'to enforce landlord conditions on the PRS' (Interview, OD1). After funding for HOOP and Healthy Homes was discontinued, housing officers voiced

concerns about the lack of support available to people with housing and health problems, living outside the social housing sector. To some degree, elements of the commissioned services continue to be provided by the housing association for their own tenants, who 'could have been supported anyway' (Interview, OD3). Yet the wider need still exists 'without a shadow of a doubt, definitely. And the people who are not receiving that service are either your private renters or your owner occupiers, and more needs to be done in that area' (Interview, OD3). However, 'we don't work across tenure unless we're commissioned to work across tenure, because why would we?' (Interview, OD4). Housing-related support for the community members in the private sector is 'non-existent, as far as we can tell. If there's any support out there, it's self-created support' (Interview, OD3), which is unlikely to be equitable in either standard or accessibility. This contributes to the uneven system of access to these wellbeing support services, so is unlikely to support reductions in health inequalities.

A gap is identified between the original intentions of these programmes, for example their target populations, and the reality of implementation which is often constrained by pragmatic possibilities. The Healthy Homes programme was commissioned for a specific demographic: the over-75s who frequently use NHS services for preventable reasons. However, the housing association has not been able to reach them. The 'biggest obstacle that we're getting is around data sharing' (Interview, OD1) and the lack of data sharing agreements meant that once the service was launched, the health partners (GPs) were unable to share the patients' personal information or contact details with the housing association. The housing staff were 'baffled, because when they commissioned us, it was on the understanding that we were getting the data' (Interview, OD3). This service was commissioned, and five full-time members of staff were employed to deliver it, with a crucial misunderstanding about how it would work.

Although the staff believed that their programme was successful, the people they supported 'weren't the target that they'd identified, for whom the funding was given' (Interview, OD5). Due to the relatively short pilot length, staff were anxious 'to try and get as many customers through as possible, but also aware that we needed to provide a good service' (Interview, OD3). To identify clients, the housing association's own records became the source of information for the majority of service users. Their 'database of every person that's ever tried

to apply for housing, and the reasons why' contained contact information, so, 'we went into the list, we broke it down and identified anybody over the age of sixty and we did cold calling' (Interview, OD3). Although the team would have preferred to design their outreach differently, they felt as though they 'sold it really well' and they did attract a high volume of clients (Interview, OD3). Nevertheless, the project did not reach its targets, and staff questioned whether the ambition of the programme 'might have been too big for the funding' (Interview, OD3).

The lack of intelligence sharing is reported as a hindrance in the hospital-based services too. More than a year after the role was established, the A&E officer still did not have a data sharing agreement. Staff argue that an agreement is necessary for the 'freedom of sharing information right from the outset, because otherwise you've got no chance' (Interview, OD3). This is particularly challenging for programmes that have been established to support a specific demographic:

> I immediately found that it was very difficult to get any sort of information about anything…how am I supposed to do my job if you can't share any information with me? Especially to prevent frequent attenders, can I get a list for the frequent attenders? Oh, I can't give you a list (Interview, OD6).

The housing association identified a reduced likelihood in recommissioning these universal services as a result of this inability to share data. It 'becomes a problem when you're evaluating' the service and are tasked with demonstrating the value to both the health sector's commissioning bodies and 'to our regulator and our board that everything we do offers value for money and that the interventions are working' (Interview, OD1). This is increasingly challenging when trying to prove the success of a preventative service:

> We're…trying to stop unnecessary service demand upstream, on adult social care and health. So, our interventions going in there should lead to less demand for their services in the future. Except, we don't get to see that, because they're not coming to demand those services from us, they're going to the health services and adult social care. So, we can't get the data we need to be able to evidence the impact that we're having, we can't prove that viability (Interview, OD1).

This reinforces the views of interviewees that the housing association's health interventions seem logical in essence, and the goals are supported by the staff. However, without significant commitment and resources given to more joined up working, at multiple levels within both the housing and the health sectors, housing association staff are compelled to

respond to the circumstances they find themselves in, in a reactive, ad hoc way, rather than being able to confidently plan, deliver and evaluate their services as intended.

Increasingly complex demands on housing interventions in a context of austerity

As reported in the previous chapter, housing associations are working in an increasingly challenging financial context, making preventative work and improving population health more difficult. The housing provider 'has felt the pinch over the last number of years', and the impact of their services is reported to be lessened due to the weaker universal support available (Interview, OD4). 'Eligibility to get somebody into a service ten years ago compared to now is completely different', and the client groups that housing associations traditionally dealt with 'ten years ago, [they] just don't pick them up at the moment' (Interview, OD5). The tailored programmes that the housing association developed with the CCG do not have the capacity to address some of the wider, pervasive concerns. It remains 'near on impossible to get into mental health services, or to get on a drug and alcohol programme', yet the housing association work is operating in a 'kind of void', witnessing their tenant base 'struggling to cope with austerity measures and cuts to services' (Interview, OD5). Instead of supporting and enhancing a universal system of support that can meet the community's basic needs, the housing association are witnessing the squeeze on Oldham's residents 'two-fold'. Not only are 'more people accessing social housing and support who are working, and struggling', but also more people are 'coming through with quite complex needs, where it's hard to get a solution for them because they're not eligible for a service, and really, they're not able to manage their tenancy' (Interview, OD4). This reflects experiences across the city-region, where housing providers reported feeling like 'the last man standing'.

Housing officers, therefore, are facing increasingly complex medical and social issues within the communities their programmes are designed to serve. To some degree, this justifies the housing association's attempts 'to gear our services up' and direct them towards support for their tenants who are living in poverty or accessing food banks, of which they have had 'a real spike in the numbers' (Interview, OD5). The rising number of people struggling 'goes hand in hand with the numbers we've got on Universal Credit' (Interview, OD5). However, challenges

created by ongoing austerity measures and cuts to public services mean that these health and wellbeing services, often ostensibly targeted at prevention, are increasingly operating against a chaotic background of health and social crises. Cuts to mental health services are 'without question' impacting on the housing association and highlighting the inadequacies of support on offer (Interview, OD3). The rise in mental health problems 'is just touching all our services, and the threshold for mental health intervention is just unbelievable' (Interview, OD2). Housing officers expressed disbelief that patients who might have attempted suicide, are 'a day later…accessing homelessness services' (Interview, OD4), in spite of the limited ability of housing staff to support a suicidal person. Social difficulties accompanying mental health problems are also increasing, and the effects of this are encountered by the housing staff. The 'barriers' they face 'trying to get people to a stable point where [they] can do meaningful engagement' are exacerbated by drug and alcohol use which are often used as 'self-medication for mental health issues' (Interview, OD3). Officers working with individuals who are homeless suggest that 'pretty much everyone who's come in has got some level' of mental health problem (Interview, OD4), so pressure is felt to be mounting on both their tenants and the wider population:

> We see it from our end, from our tenant base who are struggling to cope with austerity measures and cuts to services. But we manage the homelessness services as well, and temporary accommodation for the local authority, and the pressure on that service over the last three years particularly has spiked (Interview, OD5).

The senior managers of the housing association recognise that 'some of our neighbourhood officers and support staff are acting like social workers were a number of years ago, before the cuts came into force', and they expressed concern that 'there's maybe not an understanding of how much is being picked up' (Interview, OD1). Housing officers are increasingly responding to social and health issues with knowledge that is 'just not in people's skill sets, nor should it be' (Interview, OD5). However, as in Trafford, a lack of faith exists in the availability and quality of the mainstream services. The gaps in support should be met 'from a statutory service, not just a support worker allocated by a housing provider…it's the access to statutory services, mental health services, that are needed' (Interview, OD4).

The range of issues dealt with by housing officers, particularly in urgent care settings, is considerable. These staff members report extreme examples of mental illness, collapse in

social care, homelessness and addiction issues, which are related to the patient's accommodation needs but cannot be wholly addressed by them. The housing staff doubted their ability to support these patients. While the hospital officers might be able to assist with a small-scale discharge problem, such as adapting a property for someone with declining mobility, they are not equipped to fill the support requirements of a patient with more complex issues. For example, a patient who is homeless, admitted to hospital with trench foot, is not likely to sustain their recovery when sleeping rough:

> There's something happening before they even come in. It's surprising, but people actually get trench foot. So, there's something going on before they even get to the point that they've got trench foot and they're treated for trench foot and then they're going back out where there's no hygiene (Interview, OD6).

Insufficient levels of vacant, suitable accommodation in the borough means that the housing officers cannot address this problem far enough upstream. Despite increasing their interactions with people in acute housing need, the ability of the housing staff to respond using their core function, i.e. accommodation, is rarely feasible. Housing officers have had to adjust their expectations of how far they would be able to go in supporting people. 'Very quickly', one interviewee 'realised it's not about them coming in, and we're giving them a house and that's all sorted, that sometimes isn't even an option' (Interview, OD6). However, there is little long-term value in ameliorative treatment for medical issues that are caused or exacerbated by rough sleeping, if an initial intervention is not made to ensure safe and secure accommodation. As the Marmot report argued, 'why treat people only to send them back to the conditions that made them sick in the first place?' (Marmot, 2008). The degree of intervention possible represents surface-level solutions rather than an ability to address the fundamental causes of health problems and inequalities faced by those who are well known to hospital services. It is recognised that 'what we really needed to resolve these problems is accommodation, and there is a lack of that across the board…so there [are] some real frustrations' (Interview, OD2).

The introduction of these housing-focussed health services has taken place at the time of increasing demand on the health and social care system. The discharge roles were created to respond to existing pressure, yet staff have expressed doubts in their ability to continue meeting the additional rise in duties and obligations since the Homelessness Reduction Act

(2017) came into force. This legislation has made the hospital posts 'more crucial than ever' and the staff report that there has 'been an increase in referrals' during the Act's first six months (Interview, OD6). One discharge officer highlighted the 'duty to refer' and 'only since then, everyone's been a bit interested and gone, oh, we need to refer to housing' (Interview, OD6). This increase in obligation without corresponding funding has led to a shortage, or overstretching of staff within the housing organisation, who run the homelessness service on behalf of the council. They are 'having conversations with the authority at the minute…the Act's brought through new responsibilities that then need to be managed' and 'we're still looking to get an increased resource because we do need it' (Interview, OD5).

Working across organisations and cultures

Much of the joining-up agenda, which housing interviewees supported and recognised the potential value of, is frustrated not only by shrinking resources for public services, but also by the differences and variability in cross-sector working cultures. The urgent priorities of the health sector are perceived as a barrier to gaining support for the preventative rather than reactive housing services. CCG funding was continued for both hospital discharge officers, but the HOOP and Healthy Homes services were cut at the end of their pilot periods. The housing services were felt to have made an 'impact and certainly opened eyes for some of the clinical people about the impact non-clinical interventions could have' (Interview, OD1). Yet commissioning bodies are 'caught in the moment' of short-term challenges 'and they're measured, ultimately, on things like A&E waiting times and delayed discharge cases, all those things which are at the urgent end of the care spectrum, rather than those at the other end' (Interview, OD1). When faced with the budgeting decisions, the housing association has 'been more successful with continued funding on the reactive services than the prevention ones', in spite of the fact that 'we actually believe there was more working in the prevention' (Interview, OD4). Interviewees recognised that the hospital-based 'services that are alleviating pressure on the acute' areas, such as A&E, are able to demonstrate 'a more immediate result…it's immediate pressure, so actually putting something in there is an immediate relief and you see it' (Interview, OD5). The clinical sector's priorities are therefore located further downstream than the housing provider's, with more funding allocated to:

> The urgent care [services], the ones that get the immediate result, not the ones that are actually going to give you the long-term solutions. When it should be the other way around in my opinion. Because if you're getting the long-term solutions you shouldn't need those short-term fixes (Interview, OD1).

Housing association staff felt that the experiences and feedback of the voluntary and community sectors were not given equivalent recognition to those of the clinical stakeholders. The HOOP service was widely lauded by the VSCE organisations that 'could feel the benefit' (Interview, OD5). Groups such as Age UK, for example, 'were really on board with those services' and asked, 'what would we have done without [them]?' (Interview, OD4). However, the housing provider suspected that the VCSE did not have the same 'clout' in influencing funding decisions at the CCG as the medical staff did. The hospital-based services, which both had their funding renewed, were championed by the consultants who had benefited from them. Housing officers have attended the Urgent Care meetings and noted that 'all the talk is around the reactive, A&E' services (Interview, OD2). The doctors, who have benefitted from the immediate relief provided by a discharge officer, are in those meetings, 'going "where is she? I need her, this [service] is great"…I think it's just about who has the most influence' (Interview, OD5). Interviewees suggested that 'maybe it's a lack of appreciation or understanding, short term thinking' that leads to money 'going about the clinical side, and the pressures on A&E, reducing the sixteen hour trolley waits…rather than on prevention services and adult social care' (Interview, OD1). Housing officers understand that clinical staff are 'extremely busy and they're thinking that's another day's problem, let's get today's problem solved and we'll deal with that [housing] problem on another day' (Interview, OD2).

In the context of austerity, despite significant cross-sector buy-in in Oldham, the ambition for GM's Public Service Reform is felt by interviewees to be unattainable. The reality of these efforts to improve and integrate public services has not matched its ambition, and housing staff have encountered familiar problems when pursuing this transformation:

> Everybody talks about prevention, community, community engagement. Actually, if you're going to invest in community services you've got to put the early help into place, you've got to do those preventative things if you're going to reduce demand and reduce cost at the acute end. So, they all talk about it, but actually when it comes to the real energy in the room, everything is going into resolving the urgent care crisis by putting sticking plasters onto it, by trying to resolve it at the end point. And all the effort's going into that and virtually all the money's going into that. We need to change the narrative into how we stop that downstream demand, but actually talking about the

> things we need to do upstream before then, and starting to invest in it…resolving it at source is a real issue (Interview, OD1).

Housing staff found the 'completely different environment' between a hospital and housing organisation to be a big challenge, stating 'if you think housing's bad, the NHS is just different, it's alien to us if you've not worked in it' and therefore takes some time to adjust to (Interview, OD6). Those working in housing, who are more familiar with the social context of health inequalities, have difficulty aligning with the clinical mindset. Housing staff report that the health partners are 'so engrossed in their own issues and they think about it in medical terms, or…their whole focus is on solving the urgent care crisis rather than, well, I say solving it, making it go away in the immediacy rather than solving it' (Interview, OD1). Their evaluation processes also differ, and the qualitative nature of assessing social, preventative, housing interventions does not necessarily suit clinical traditions. Although the health sector 'accepted that we had done really good work on HOOP', the evidence 'was more on case studies about how somebody had felt after the service, rather than, it's made "X" amount of savings' (Interview, OD2). Interviewees felt that the housing and health sectors need to work harder to 'speak the same language', or 'sing from the same hymn sheet' if they want to make progress on these issues together (Interview, OD4). Health and housing is viewed as 'such an obvious partnership' in theory, but in practice 'it's not, on the ground' (Interview, OD5). In order to get effective joint working in place, both a significant amount of resource is necessary, as well as the commitment, and patience, to align different working cultures and practices.

A short-term view of a long-term issue

The four Oldham pilot programmes are characterised by a short-termism that frustrated many of those involved. The 'transformation' period, as with devolution, is one of trial and experimentation. However, the initial timescales and allocated funding were perceived to be inadequate for establishing these programmes sustainably and evaluating them. Healthy Homes was funded for twelve months, but the lag between commissioning, designing and recruiting for the service, plus winding the service down when funding was stopped, meant that in reality it was fully functioning for only five months. The staff 'were really disappointed' that the service was not recommissioned, as they believed that with a little more time they

'could have got to thousands of people' and 'if we would've had more referrals then it would have worked' (Interview, OD3). Interviewees argued that it takes time 'to nurture what we've created…and keep that going, even though sometimes it brings frustrations, it is special what we've got' (Interview, OD2). The success of these programmes requires sustained and ongoing effort. The delivery timescales are not necessarily suited to the scale and root cause of the problem. The scope to tackle the issues presented in A&E, particularly for patients who might be homeless for myriad, complex reasons, often goes beyond the possibility for intervention available in a setting where the officer is 'lucky if [they've] got a couple of hours' with a patient (Interview, OD6). Resource imitations mean that 'we have to accept that we can't immediately meet everybody's housing need' (Interview, OD2), especially when 'the priority is…those immediate results', such as reducing waiting times (Interview, OD1).

While the actions of the hospital discharge officers may work to prevent readmission, their responses to a patient are triggered by an admittance to hospital that has already happened.

> We're doing things too late, we're being very reactive here, but I'm from [housing] and we're used to being proactive, but the hospital staff are not…they're more reactive than proactive (Interview, OD6).

The Healthy Homes service, when it was 'getting bigger numbers with the preventions', was the kind of intervention that housing officers thought 'would have had a long-term impact', but they recognised the difficulty of registering and proving that benefit (Interview, OD3). Housing staff expressed a desire to embed these projects more systemically, and on a longer-term basis, into Oldham's multi-sector approach to public health:

> We know our [health services] are fragile because they're relying on funny monies rather than mainstream monies, and that's the big stepping-stone…how do we turn these projects, pilots, into mainstream services? (Interview, OD1).

The HOOP service illustrates this lack of sustainability. The 'shame is, then, all of a sudden, all these community-based services had bought into the service and were relying on it, and then they've withdrawn funding', which was 'disappointing' for all involved (Interview, OD4). It also risks a loss of expertise and experience amongst the staff involved, employed on a short-term basis but who 'gained so much knowledge and fed it out there to these people it was really positive…the entire team, including myself loved the role, and it's a shame that it's not ongoing' (Interview, OD3). The short-term nature results in a lack of job security, low

levels of staff retention and high turnover. Programmes which attributed their success to the diverse knowledge and expertise of their team (particularly those from non-housing backgrounds), saw their employees disbanded after funding was withdrawn, and the staff who were not deployed elsewhere in the organisation left, taking their experience and know-how with them. Interviewees reported feeling frustrated by this context, and were adamant that 'there's got to be an understanding that you can't continue firefighting in A&E' while trying to create a sustainable system that actively prevents illness (Interview, OD1).

The insecurity of funding such pilot programmes impacts on both those delivering and those using the service. Interviewees felt that their ability to invest in their clients, and commit to an adequate timeframe for support, was reduced by funding cycle timings. Healthy Homes staff reported the 'shock when they said there wasn't going to be anymore funding' and voiced concerns for 'all those people that are going to miss out' (Interview, OD3). The fund which pays for these commissioned services is 'only ever allocated annually' so the housing sector's offer is 'still not seen as a mainstream service' (Interview, OD5). This is both 'annoying for the staff' who have 'no security around their post or what they're delivering', as well as damaging for the efficiency and quality of the service while it is 'in that constant cycle of business cases which is also frustrating' and wastes a lot of time that could otherwise be spent providing support to individuals (Interview, OD4).

The ability to plan service delivery over a prolonged, secure period, is felt to be important for delivering preventative, rather than reactive services. Longer-term funding would increase their ability to work preventively, in a way that might proactively improve population health. Senior managers recognise that 'there needs to be some permanency, some commitment, to establishing that', and when 'it's wishy washy about how long you're going to be around…when they just don't know what the future holds, it's really difficult, to be honest…so you find yourself just responding to things on a day to day basis, rather than forward planning' (Interview, OD2). Although the housing provider states that 'we've never really been after money' (Interview, OD1), the commercial viability of these services as part of the wider business remains a concern.

> We've said in all those cases we're willing to fund fifty percent of anything, but our view is once it starts to become mainstream it should be a shared resource and shared funding that's going in there, not just us. We're willing to pilot stuff and put money in…but ultimately, if there's value to it, we should all be [contributing] (Interview, OD1).

The pilots, trials and short-term programmes are seen as a way 'to try and get a foot in the door' with the health sector, but these activities are not necessarily sustainable in their own right and 'there are bigger conversations to have around how we make longer term savings' (Interview, OD4). The housing provider has 'a responsibility to our board and to our tenants' to justify their use of resources (Interview, OD5). The ambitions that have accompanied devolution in Greater Manchester are felt by some staff to be unrealistic and unsuited to the fundamental causes of health issues in their communities. While some of the social landlord's activity 'does mask the need' (Interview, OD2), or at least masks the full extent of some problems, it is described as a 'plaster' and not suited to the structural causes of health inequalities. In some cases, these programmes have revealed to a fuller extent the hazards of many people's housing circumstances:

> We've opened these cans of worms with the older people of Oldham. You're thinking "Jesus Christ", there's so much more that needs to be done. And if we're just doing it here, no-one else is seeing anything, unless they've got an organisation like us in place (Interview, OD3).

With 'the best will in the world, the housing providers can offer individual services, housing first and things like that, but unless there's a large scale policy change and some improvements in terms of supply, and the services that are there to support people out of the problems that they're having, it doesn't work' (Interview, OD1). There is 'also an assumption that we'll do it, and [we] see this probably at a GM level, everything's happening at the GM level with the housing providers and…you're seen as a bit of a bad egg if you don't. I think there's an assumption that you'll do it, and if you won't do it, it's kind of like, "what do you mean you won't do it?"' (Interview, OD4). Future plans for the housing association include joining Oldham's integrated care alliance. This is 'putting us in the position of being potentially a health service provider and care service provider in the future' (Interview, OD1), suggesting further diversification, demand on resources and therefore possible implications for the housing association's 'core function'.

This programme of co-operative work in Oldham, and the strategic intention to use a housing association for health and wellbeing purposes, is based on the assumption 'that all that can

be done to provide good quality housing in sufficient quantity for people in Oldham is being done' (Higgins, 2017b, p.2). The Director of Public Health recognised the value of this core function, and suggests that any additional health interventions are only beneficial if the housing need is met first:

> 'Housing associations like [the case study organisation] are able to set the foundations for good health by ensuring residents live in a home environment that is of sounds quality and supportive of good health. This is the fundamental purpose' (Higgins, 2017b, p.2).

However, Oldham has 'just got an absolute shortage of accommodation…a crisis around affordable and suitable accommodation' (Interview, OD5), both for the ageing population in the borough and for younger residents. Staff reported that 'quite often there will be a rehousing need, but we have so many people on the housing register that are living in risky, unsuitable situations, that have got priority to move' (Interview, OD2). The pressure is increasing on the social landlord twofold, as they have 'more and more older people trying to find suitable accommodation…[which is] a real issue' alongside 'more people who are working and in poverty, who, historically, would have been able to meet their own needs, that are coming through social housing' (Interview, OD4). The housing association is feeling 'a pinch from both sides' (Interview, OD5), and despite Oldham being a borough with typically lower demand for housing, and a slower PRS market than boroughs such as Trafford, the supply of housing is not easily meeting the demand. The lack of housing resources in Oldham reduces the influence of these health interventions, no matter how successful they are individually, on overall population health.

Summary

The case study borough data reveal some of the practical and operational challenges that have arisen for housing associations pursuing more diverse, health-focussed business activities and cross-sector partnerships. In Trafford, the housing association has expanded of its role without a formal commissioning arrangement from the public health or clinical partners. Oldham's co-operative model has commissioned the housing association, as a significant anchor institution, to function as a formal partner in public service delivery. The two organisations' different flagship health initiatives, provided by otherwise similar stock transfer housing associations, demonstrate some of the variability that is present across the

ten boroughs of Greater Manchester. While the evidence suggests that this expansion of the housing association role makes some sense in principle, interviewees reported difficulties in achieving their ambitions, and barriers to making progress on the determinants of health that sit furthest upstream, where preventive and population wide health interventions might be felt most. The reactive, downstream, nature of their interventions is demonstrated in this chapter.

Despite these different approaches to an enlarged health role, the overarching similarity between their experiences has been one of diminished resources that are not well matched to the scale of the task they are undertaking. The constraining role of austerity, on both local government spending and individual citizens, is significantly impacting on the work done by housing associations. Staff members showed enthusiasm and passion for the social purpose of their work, yet reported spending much of their time engaged in piecemeal firefighting of urgent crises, and struggling to cope with the failings evident in the shrinking welfare state, and pressures on health and social care. Their response is therefore as much an unavoidable and expedient reaction to the challenging circumstances as it is a pro-active or strategic choice. These challenges are compounded by ongoing housing and accommodation shortages that leave housing staff frustrated by their inability to fulfil their core function, which is recognised by Oldham's Director of Public Health to be a pre-requisite of any expanded role for housing associations to meet. The analysis presented in Chapters 5 and 6 will form the basis of the discussion in Chapter 7, which will consider how these findings relate to the wider literature.

Chapter Seven
Discussion

This chapter discusses findings from the empirical data in the context of the wider research literature and in light of the earlier exploration of the policy context. It does so in relation to three themes: the changing identity and role of housing associations; the devolution process in Greater Manchester; and the restructuring of the welfare state.

Healthy Housing Associations?

This section considers the role and identity of housing associations and questions the changing function of the housing sector with regard to health inequalities. It identifies some of the driving forces behind the increasing diversification (and variation) in the sector, as well as some of the possible consequences of this activity. The data collected from housing associations and their health partner organisations illustrate the inherent challenges (as well as some successes) of cross-sector, more holistic approaches to health and wellbeing. The financial and political contextual factors are identified as instrumental to the housing and health experience at both an organisational and city-region level, and the findings here are considered in the light of the ongoing politics of austerity.

The purpose and priorities of housing associations

To some degree, housing associations are still providing 'healthy' homes in physical terms. The principal case study organisations featured in this research have consistently attained a 100% Decent Homes Standard and have satisfied other basic safety measures such as complete Gas Safety Certificates (First Choice Homes Oldham, 2018; Trafford Housing Trust, 2018). The mission statements of housing associations in Greater Manchester have, however, become significantly more ambitious and far-reaching. Their goals are as broad as achieving 'a society transformed, free from poverty, inequality and injustice' (Trafford Housing Trust), to creating 'thriving neighbourhoods, filled with opportunity and purpose' (Mosscare St Vincents) and 'the conditions in which customers and colleagues can enjoy life and realise their potential' (Irwell Valley). Chapter 5 presented evidence of these telling differences in the ways housing associations view their role in society (see p.120). The ex-president of CIH

challenges these 'increasingly complex – or, even worse, "edgy" descriptions of purpose, mission, values, [and] objectives' that significantly depart from the role they were created to fill (Inman, 2020). The exposure to 'mission drift' is a recurring theme in these data, suggesting that organisations might 'lose sight of those core services' which is 'not good for anybody' (Interview, TD4). As argued by Ebrahim et al (2014, p.97), in order for social enterprises to 'realise their potential' they must 'establish organisational processes and systems that enable them to sustain themselves without compromising their missions'. Housing staff remain convinced that they have 'got to get the housing right, so [they'll] never move away from that', but this can prove difficult when they also 'do a huge amount of stuff that really isn't what you would think of as social housing' (Interview, GM4).

Any new activity operates in the context of the traditional role of housing associations in providing and maintaining housing, particularly in the case of the stock transfer organisations whose 'primary and only purpose was to improve the existing stock' (Interview, GM1). *Inside Housing* analyses annually sector-wide maintenance and repair housing association spending. Their most recent figures show a nationwide increase in budgets during 2018-2019, 'after several years of belt tightening'. However, they are cautious in concluding this represents anything more than 'a blip', possibly in response to the Grenfell Tower disaster, as 'most larger associations [are] apparently still pursuing a cost efficiency agenda' (Hollander, 2019). This suggests that housing providers are still treading a delicate line in terms of the balance of their 'landlord' and 'non-landlord' investments, and reiterates that the sector as a whole is not homogenous when it comes to form or function. During any analysis of the potential for housing associations to influence health inequalities, this lack of homogeneity is crucial.

These services – what one interviewee called 'much more than just being a landlord' (Interview, GM10) – have always played some part of the function of social housing, and the historical roots of housing associations are in charitable social enterprise (Czischke et al., 2012). However, the evidence presented here raises questions about the stability, sustainability and quality of the expanding services provided by housing associations. Barr et al. (2016) highlight the importance of understanding these 'natural experiments', taking the form of 'complex social policies that are likely to have an impact on health inequalities [but] are introduced without any evaluation of this impact' (p.255). In the case of this study, the

expanding remit of housing associations in a context of diminishing resources has population-wide significance. The growing provision of support services offered by housing providers that exclude people who otherwise qualify for, or would benefit from, additional support, could have negative implications for health inequalities. As outlined in the conceptual framework, health inequalities are created along social gradients, in whole populations. These effects are also exacerbated by corresponding cuts to the statutory and universal support services, reducing the strength and size of the public sector safety net.

Variability *within* the housing association sector

The experience of this diversification is felt in different ways across the sector, and housing association activity has been variable and inconsistent. While most members of the Greater Manchester Housing Provider group have made some commitment to providing HOOP, Warm Homes and Hospital Discharge services (see Chapter 5), the implementation of these programmes is delivered and funded through a variety of means. Those involved are 'learning to accept that some of the housing providers will invest more in terms of their money and resources…which is inevitable' (Interview, GM6). Some attention has been paid elsewhere to the broad range of possibilities open to 'the future social housing provider' (Scanlon et al., 2017), which this data from Greater Manchester demonstrates a specific and significant focus on health. The level of involvement is often (although not always) influenced by the type of social landlord, or by the demographics of its community. This makes it difficult to predict the value of this work, or its likely wider impact. Social landlords may have an opportunity to design and tailor services responding to local need, including services for women, elderly residents, or young people who are out of employment. Others direct a significant amount of their resources into employment and skills training, as a way of connecting their communities to jobs. They are able to secure some central funding via 'the skills funding agency [that] will pay for a certain amount, but we know that some of our customers need more'. The housing association 'will plug that gap, to make sure that those programmes have the best outcome, for our residents, into employment' (Interview, GM8). While the purpose of the independent housing association sector has historically been understood as one that is able 'to "fill the gap" where the state or market was unable to provide for households in need'

(Manzi and Morrison, 2018, p.1927), this 'gap' is increasingly taking the form of services and support that go beyond housing provision.

Not all housing associations have the capacity or the desire to take such a prominent role in relation to health-related services. Given the persistent health inequalities both within and between Greater Manchester's boroughs (MCC, 2016), such disparities in the capacity of organisations that ostensibly exist to fulfil the same function could have unwanted impacts on health equity. The housing providers share concerns about spreading themselves too thinly, 'and they're saying, well, we've got enough on our plate, how and why would we invest in that?' (Interview, GM3). Unintended consequences for equity may result from ignorance of the costs of trade-offs between health priorities (Daniels, 2013), and health inequalities researchers consistently advocate for universal (or at least proportionately universal) interventions over piecemeal or inconsistent efforts (Carey, 2015; Lynch et al., 2010; Whitehead and Popay, 2010).

The provision of additional 'non-landlord' services is not obligatory for social landlords. Therefore, the values and priorities of an individual housing association's governance bodies exert significant influence over the level of involvement they have in this field. Interviewees reflected on the GMHP organisations as 'twenty-five separate businesses, each with their own boards and their own governance structures and their own business plans' (Interview, GM6). The reclassification of housing associations as private entities in 2017 was praised by the National Housing Federation as 'welcome recognition of their position as independent social businesses' (Orr, cited by Apps, 2017). However, confusion and 'lack of clarity about the status of housing associations' who are only accountable to the Homes and Communities Agency (Birrell and Gray, 2016, p.135), creates additional challenges for those who seek to argue that, as a sector, social landlords might offer a solution to a lack of health equity.

More pressingly, organisations must satisfy the expectations of their boards and governance bodies, and interview data highlighted the wide range of priorities evident in these settings. While most Greater Manchester housing associations paused or cancelled the building of new Extra Care accommodation during the 'daft fiasco' of high funding uncertainty over whether supported housing would be subject to LHA rates (Norman, 2020; Riverside, 2017), some

went ahead regardless at the insistence of their board, using their organisation's reserves. Others have shied away from such resource-intensive services as extra care (see p.117). This represents a high level of individually determined values and priorities. Manzi and Morrison (2018, p.1933) have argued that increased diversification on large, national housing association boards, to include more members with corporate expertise, 'implied that Board members were likely to be recruited on the basis of their private sector, financial management experience, rather than as local community representatives'. This was not consistently reflected in the organisations canvassed in Greater Manchester, however, several of which continue to prioritise their community roots and connections.

The Savills report, *Challenging Governance* (2015), examines the makeup and values of the boards of different housing associations. These organisations' structures are defined by three typologies: 'those that are Customer and Constituency based, those following a Federal approach and those that work to Functional groupings' (p.20). The data here suggest an extensive degree of variation in values and priorities even between the 'Customer and Constituency based' stock-transfer organisations. This is in line with the deregulatory strategies and polices introduced in the 2016 Housing and Planning Act (HCA, 2017). Numerous provisions in this Act were aimed at 'reducing the regulation of housing associations', and changes to the constitutional consents regime have meant that housing associations no longer need permission from the regulator to restructure their businesses, sell their stock, merge with other organisations or otherwise make changes to their status (Wilson et al., 2018, p.11). This reflects the increasing variety and inconsistency within this housing tenure.

Critical realism allows for this significant variability to be understood as meaningful, because of its inherent understanding of context and contingency. In a social, or open system, the concept of causation is stratified, making a great deal of variety possible (Vincent and O'Mahoney, 2018). The context that housing associations are operating in, for example austerity with its associated cuts and limitations to universal services, is driving the housing associations' health-focussed activity, if and when those other contingencies are met. The importance of the 'bottom line', and the need to stay commercially viable, demonstrate the necessary tendency of housing associations to prioritise their survival. Yet the evidence from

Chapters 5 and 6 clearly suggests that this tendency is mediated in some cases, particularly in the stock transfer organisations where community roots and municipal histories give the social purpose of housing associations more importance than might be expected of a larger, national organisation or a for-profit provider. The causal effects of these mechanisms are thus mediated through agents' intentional actions (Moghadam Saman, 2019), making the impact on health inequalities likely to be equally inconsistent. The contexts that influence these mechanisms mean that by understanding the relativism that is inherent in critical realism, it is possible to make more nuanced judgements about the likely impact or implications of this work, depending on numerous other entities. The remainder of this chapter considers this issue further.

Consistency, universality (relative to need), and equality of access to high quality public services have been shown as crucial for achieving just social and health outcomes (Hermann, 2016; Marmot, 2015). The 'unjustifiable variation' in public health provision and outcomes, given the strength of the evidence supporting preventive action, has been raised 'as a core issue' at the House of Commons Health and Care Committee (Buck, 2020, p.8 and p.45). The variation evident in the degree of both statutory and housing association services across Greater Manchester's boroughs makes it difficult to gauge the size of the gaps in public sector provision overall, given that housing associations report that many people are 'being sustained to live relatively independently in the community because of housing association interventions' (Interview, GM4). The result of these interventions is to support people at a level above the threshold that would qualify them for the mainstream services, which are increasingly reserved only for moments of crisis. Housing providers are 'not trying to overtake what's already there, we just know the thresholds for [statutory] involvement is reduced, and we're just trying to fill a gap' (Interview, GM10). This supports findings by Hastings et al. (2015, p.21) in their research on the impacts of cuts to local authority funding on poorer communities, which found that 'a tightening of eligibility thresholds for some social work interventions' has led to people in some communities being 'picked up' by voluntary or housing sector organisations. While housing associations with the means and motivation to do so are able to provide some level of replacement support for their tenants, the risks of dropping through the safety net remain acute for communities in which non-landlord services are less well developed. This evidence illustrates the unevenness of the social housing

sector's response to a universally challenging context. Risks are generated from the fact that non-landlord activities are in many examples a replacement of public sector support, offering substitution, rather than additionality, to what remains of universal provision.

An (in)adequate substitution?

A notable aspect of the changing role of the housing association is the transformation of the kind of work undertaken by, or expected of, frontline housing workforces. Customer-facing staff in Greater Manchester reported that their jobs had evolved to 'cover all bases' (Interview, TD6) and that, 'as a housing officer you're not just looking after a house' but 'actually looking after a tenant, and a tenant's welfare' (Interview, TD5). The extent and challenges of these changing demands on housing staff have been discussed in *Frontline Futures: New era, changing role for housing officers* (Richardson et al., 2014), but this thesis's evidence draws attention to concerns about the health issues of housing association tenants. The evidence presented here reinforces concerns that the involvement of such a variety of non-statutory actors, in a field as broad as health, can pose challenges for accountability and quality assurance (Buchs, 2009). Lobao et al. (2018, p.400) argue that 'failures in private sector provision of public services are increasingly common, as successful bids for contracts are often low cost – but come with a high price of reduced standards'. In order to assure both equality and quality in the services individuals can expect, debate is needed about what is expected from the housing sector front line (Richardson et al., 2014). The services offered by housing associations respond to a necessity because 'a lot of that safety net stuff just isn't there anymore' (Interview, TD1). The resulting system is felt by many interviewees to be inadequate.

These responses from housing providers are being driven by widespread financial cuts, but 'while the bottom-line in business markets is price, in education or health, cost alone is no measure of quality' (Sennett, 2002, p.186). Even well-meaning organisations face difficulties when tackling health issues in ways that go far beyond providing the protective force of a stable home. Housing staff are expected to build trusted relationships with individuals in order to refer or guide them to the appropriate universal or statutory services. When those services to which they would usually refer have, 'almost overnight, [been] stripped out of that

system' and the housing associations 'have continued in a lot of cases to deliver that support', it is unsurprising that this is 'not necessarily to the same level' (Interview, GM11). In examples where housing association support is a direct response to a lack or loss of specialist provision, particularly regarding mental illness, or for those working with dementia sufferers, the data assembled for this research suggest that the offer from the housing association is not likely to meet the same standards. One housing association's 'safeguarding numbers are up', but they 'can't just turf out' a tenant who they fear has dementia, who is acting in a distressing way towards their neighbours but has been assessed by the local authority as healthy and suitable for mainstream unsupported housing (Interview, GM2). Yet they also need to protect the other residents. The lines become increasingly blurred with regard to who ought to fill the support roles in situations such as these. As highlighted by Tunstall et al. (2013) with regard to anti-poverty interventions, there is no clear evidence to suggest that housing providers are the best choice for providing such services, especially where they go beyond housing associations' traditional areas of expertise.

Concern exists amongst housing staff over where accountability and responsibility lie for safeguarding their tenants. Despite a rise in safeguarding concerns, a lack of clarity regarding roles and expectations risks some housing staff 'going the extra mile in a risky way' (Interview, TD2). Duties brought in under the 2014 Care Act include obligations to tackle self-neglect, 'where someone demonstrates a lack of care for themselves and/or their environment and refuses assistance or services' (Department of Health, 2014) and these have caused some confusion and anxiety amongst housing providers. Technically, the duty to help an individual (if identified by a housing professional) would end with their referral to either the health service, social services, or appropriate place of support, but, as discussed, the growing gaps in the statutory provision have led to housing staff taking matters into their own hands (see p.113). This has implications for health inequalities. An increase in people receiving support for their health issues outside the NHS (or local authority) from well-meaning but unqualified staff is likely to challenge the ambition of achieving better equality in outcomes, and may risk doing more harm than good.

In housing organisations where the staff felt their efforts were able to meet, or even exceed, the clinical standard, this was often achieved by employing clinical staff who previously

worked in (or were trained by) the public sector. Home Group housing association report that they have been 'investing in clinical infrastructure and clinicians' in their services (King's Fund, 2019), and several of the GMHP provided similar recruitment examples. There may be far reaching consequences from this activity. If housing associations employ clinical staff, it could further reduce capacity within the universal sectors, especially in the context of the workforce challenges in England which 'now present a greater threat to NHS services than the funding challenges' (King's Fund, 2018, p.3). The social housing workforce remains ostensibly part of the quasi-public sector, yet their organisations are also impacted by commercial concerns. This evidence is illustrative of the sometimes strained 'precarious partnerships' between state and non-state actors that are a result of actions taken in the UK since 'government responsibility for addressing inequality was decollectivised' (Williams and Fullager, 2019, p.20). Housing associations have, to varying degrees, taken on some of this responsibility. These approaches create a subdivision of service delivery that is contributing to a 'two-tier' system and adding to the challenges for health equality.

Partnership work with the health sector

The evidence presented in this thesis suggests that while housing associations may have a valuable contribution to make towards improving health outcomes, there is not yet consensus about how this ought to work in practice. UK policymakers have advocated more partnership working and better integration between the housing and health sectors (Connolly, 2018). This thinking was embodied in the 2014 MoU between a range of health and housing partners, intended to demonstrate a 'shared commitment to joint action across government, health, social care and housing sectors on improving health through the home' (DHSC and PHE, 2014). The CIH paid particular attention to partnership working as 'key to the way housing would do its business in the future' (Richardson et al., 2014, p.26). Although interviewees confirmed that this national MoU 'didn't really make any major breakthroughs' (Interview, GM10), the different Greater Manchester boroughs (whose health organisations and housing partners have signed up to a separate Greater Manchester agreement) have, to varying degrees, experimented with partnership working between the sectors. Chapter 6 illustrated some of the examples of this in practice, and the gaps between expectation and experience demonstrate the challenges of increased integration.

Part of the rationale underlying the increased role for housing associations in a health context is that they are able to be drivers of prevention (NHF, 2010). Universal provision of decent housing may work as a macro factor in this realm. But at a micro level, the justification for partnership work between housing providers and CCGs, such as in Oldham, was due to the potential of housing associations to provide targeted prevention through specific, person-centred services for individuals. Partnership working of this kind recognised that the housing provider 'workforce is…a huge part of communities and how people live their lives' (Interview, GM11). However, the 'preventive' services that frontline staff felt were the most beneficial or transformative (HOOP and Healthy Homes) have been side-lined, despite promising pilots. Instead of prevention, attention has focussed on services that alleviate pressure on the acute priorities of the health sector (see p.169). This has typically involved hospital discharge officers working on a case-by-case basis. While health inequalities might be understood in terms of material or psychosocial factors, 'these social determinants of health are themselves shaped by macro-level structural determinants: the economy, the state, the organisation of work, and the labour market' (Smith et al., 2016, p.11). Interviewees that have transferred from the housing sector to a clinical setting noted 'surprise' that 'those wider social elements probably aren't considered as much' by the health workforce (Interview, GM11).

The mismatch between the anticipation and the reality of partnership working is indicative of some of the wider issues at play. Successful service provision by HAs outside their tenant populations is generally reliant on funding and effective partnership working with public sector organisations, such as the NHS. However, the evidence suggests many tensions and 'a fundamental misalignment' (Interview, TD3) between the housing and the health sectors. Much of this can be understood by categorising efforts into 'social' or 'medical' approaches to both understanding and combatting health inequalities. Housing interventions, with their preventive, protective qualities, are a valuable part of a 'social' model of health (Stuart, 2015). They could represent a welcome shift to a focus on the structural causes of health inequalities rather than the established primacy of 'downstream' factors and deeply rooted prioritisation of clinical approaches. However, when funding of the pilot projects in Oldham was reviewed, requests from hospital based clinical consultants to maintain funding for reactive services were perceived as more important than those from the community-based VCSE.

Organisations such as Age UK, who were reliant on the preventive HOOP service, were not in attendance at the Urgent Care strategy meetings or able to influence these decisions (see p.172).

Evidence from Greater Manchester of the challenge of designing and implementing a social model of health echoes problems identified at a strategic policy level in international contexts. Lynch (2017, p.657) argues that those most concerned with reducing health inequalities, 'epidemiologists and public health professionals, are simply not as well-integrated into policy-making in most countries as are medical actors, central banks or lobbyists for multinational corporations', with the effect that 'policy-making structures tend to be organised around…medical, rather than the social determinants of health'. Housing providers in Greater Manchester expressed frustration with the 'nonsense that we have to have an epidemiological study over three years…when everyone knows it bloody works' (Interview, GM3). This demonstrates a tension between the practical experience and realities of day-to-day housing management, and the rational but unwieldy requirements of evidence-based policymaking. The challenges of evaluating the success of housing association interventions is also likely attributable to the fact that clinical approaches to evidence simply do not work in public health settings, nor can they account for the contingencies or complexities across multiple social and environmental health determinants, or 'open' social systems, in critical realist terms. Preventive interventions are tasked with 'preventing what might have happened, but it might not have happened, and [it's] much harder to measure' (Interview, OD4). Thomson et al. (2001) have highlighted the challenge of proving what is such a 'self-evident' and 'intuitive relation[s]' between housing and health (p.189), which may explain some of the difficulties in securing stable, mainstream funding from a *Clinical* Commissioning Group for social-environmental interventions.

Interview data suggests there is a very strong sentiment amongst housing professionals that the health sector simply does not 'get' what they are trying to offer. Housing providers who felt they had made significant progress with non-landlord services tended to attribute it to 'enlightened' commissioners or directors of their NHS trusts or public health departments (Interviews, GM8, GM10, OD1). The absence of these enlightened individuals in other places was referred to as a significant barrier by several interviewees. The challenge of 'joined-up

working' between the health sector and other stakeholders is not a new phenomenon, and was identified as a barrier in research on the New Deal for Communities in the 2000s, a period before austerity compounded the problem (Lawless et al., 2010). Research that factors-in the current 'pessimistic public spending outlook' is cautionary, and highlights that successful integration is likely to cost more money, not less (Hunter and Marks, 2016, p.148). As Chapter 6 discussed, the experiences of partnership working in Greater Manchester frequently fall short of expectations, providing only modest improvements, or 'something…quite ordinary' (Interview, TD3). These examples suggest a significant waste of resources in both the health and housing systems, challenging partnership working that is justified in part by the argument that joined-up interventions with other sectors will save the NHS money (Buck et al., 2016).

The difference in scale between partner organisations represents one of the challenges of institutional asymmetry. Housing associations are proud of their step-up step-down facilities, their desire to use resources efficiently ('we want to save the NHS a million quid by 2021' (Interview, GM2)), and their state-of-the-art community centre facilities. However, the importance of these is questionable, when measured against the more pressing challenges facing the health sector:

> They're operating on a completely different scale aren't they? Those savings that perhaps housing interventions can offer, bed by bed, ward by ward, are significant, of course they're significant, but when you're dealing with millions and billions perhaps that's why they end up falling to the wayside…And sitting empty, forgotten about. Bleeding money, absolutely wasting resources, but that question of scale probably is a key thing (Interview, TD3).

These challenges have been explored by others seeking to understand why promising evidence such as technological innovations in healthcare are either abandoned or left unadopted. Some barriers identified include mismatched economies of scale as well as a lack of long-term vision in order to embed innovations sustainably (Greenhalgh et al., 2017). These less 'hi-tech', housing-based solutions for health experience the same drawbacks. Interviewees had grander ambitions for the housing sector and referred to the necessity of moving beyond their comfort zone, and attempting larger-scale activity. They expressed a desire to focus on 'one or two really big-ticket items to get [their] teeth into', and that would force the health sector to 'sit up and notice' (Interview, OD1). As argued by the UK2070 Commission, the challenge of shrinking the UK's persistent geographical and social

intergenerational inequalities requires ambition on a grander scale: to 'go big or go home' (Kerslake, 2020). Given the size and financial resources of the housing association sector, and the fact that it is the medium-sized housing providers rather than the large national organisations that are most heavily invested in this agenda (Scanlon et al., 2017), this jump in scale is likely to be difficult to achieve without significant policy support and resources.

The evidence in Chapter 6 illustrated the challenging transaction gap between strategic priorities of senior stakeholders and experiences of frontline staff. This was apparent in both case study boroughs, despite the differences in approach and demographics. These challenges are indicative of the broad cultural and sectoral misalignments that must be overcome in order for partnership working to be successful and meaningful.

A two-tier health and housing service

Most of the non-housing services offered by the housing associations canvassed are not available universally. Instead, these services are mainly offered to tenants. For example, one organisation offers a counselling service to residents in order to bypass long waiting lists for statutory support (see p.123). The range of support offered by many housing associations 'in some senses is creating a two-tier system of access for people. If you've got a social landlord, you can access through these routes, but if you haven't', then the services remaining to you are becoming more and more restricted (Interview, TD2). The risk is that those in need of social support, but who are excluded from public housing, are also unlikely to be able to access a wide range of additional services that were previously available universally, regardless of housing tenure. The evidence in Chapters 5 and 6 illustrated the barriers and challenges that can arise when organisations attempt to reach the wider community, or are commissioned to deliver a universal, cross-tenure service. With the withdrawal of CCG funding for the tenure-blind services, interviewees noted the likely difference in impact this would have:

> The fact of the matter is, those people from [our tenant base] could have been supported anyway…and the people who are [now] not receiving that service are either your private renters or your owner occupiers, and much more needs to be done in that area (Interview, OD3).

The social housing sector in Greater Manchester, as elsewhere in the UK, is unable to meet demand (GMCA, 2019). The contrasting socio-demographic characteristics of both housing association tenant bases and waiting lists offers some clues about which groups struggle most to secure or retain access to social housing. Research by Crisis (2019) reached the conclusion that 'housing associations are routinely excluding the poorest tenants' (Butler, 2019). Recent research in Wales concluded that 'eviction from social and supported housing was a significant contributor to youth homelessness' (Shelter, 2019). One local authority in Greater Manchester (which still has some provision of council housing, owned and managed by the council) noted that the housing associations operating in their borough have a tendency to 'cherry-pick' the 'best' prospective tenants, with fewer additional or complex issues (Interview, GM5). Given that the majority of Greater Manchester's boroughs no longer have council-owned housing, and in view of increasing risk aversion in housing associations, it is likely that many people with acute health and housing needs are not being housed in the social sector at all. This supports growing evidence that some homeless applicants to social landlords are rejected and deemed too risky to house because of 'unmet support needs' (Greaves, 2019, p.13). Concern exists for those in housing need, based in boroughs with no other supply of social housing, who may fail the affordability (and other) checks many housing associations perform on their prospective tenants (Preece et al., 2019).

The PRS, particularly at the more expensive end, is also exclusionary and risk averse. Forty percent of private landlords surveyed in 2017 refused to rent to people in receipt of housing benefit, and 'close to one in five private landlords have an outright ban on families with children', further restricting meaningful choice for those with no other tenure option than the PRS (Marmot 2020, p.114). In 2019, 61,800 households with children were recorded as living in temporary accommodation in the UK (MHCLG, 2019). Housing strategists in Greater Manchester asked, 'where are the people who haven't got that safety net of living in a housing provider property? What about the people who are in unsupported temporary accommodation, and living in B&Bs?' (Interview, GM11). If 'some affordable rent properties are now becoming unaffordable to people who are on benefits' (Interview, GM3), particularly in areas of high housing demand, then as argued by Murie (2012), the poorest and newest households are likely to be concentrated in lower quality parts of the PRS. The evidence suggests that the requirements of private tenants are increasingly unaddressed in more ways

than just inadequate housing. The exclusionary nature of this housing association activity is two-fold. Not only are there exclusions from the social rent sector for people in *housing* need, but the housing providers also exclude people in need of support services.

The restricted options in the private rented sector, and the increased frequency in use of temporary or emergency accommodation, support the view of interviewees that social housing is no longer 'the tenure of last resort' (Interview, GM10). This reinforces claims that 'the problems in private renting, increasingly used for poorer tenants, make social housing look an economic, attractive [and possibly healthier] option in comparison' (Power, 2015). Tunstall and Pleace (2018) have highlighted differences in security and satisfaction faced by tenants who live in the social rented as opposed to the private sector. There is a risk that this two-tier system of access (to both housing and health/social support) is contributing to the cumulative (dis)advantage of certain groups and individuals, whose access to support is likely to be determined by luck and location, rather than entitlement or need. While social landlords who are active in this field 'pick up a lot of issues' and 'work quite hard on getting [their tenants] the services that they need, as early as possible', for the 'people that live in private rented, there's not necessarily a mechanism to pick them up' (Interview, GM12).

The evidence presented here for Greater Manchester supports claims that exclusion from one support service (i.e. social housing) can be exacerbated by exclusion from another (preventive or low-level health and social care). As previous research has noted, 'longitudinal cohort studies suggest that disadvantage tends to cluster and accumulate over time' (Smith et al., p.12, 2016). Therefore 'many people experience their housing as just another precarious place in an insecure world' (Madden and Marcuse, 2016, p.54). In several Greater Manchester examples, this insecurity of tenure is now compounded by inconsistent provision or withdrawal of additional, non-housing services. Current practice in the allocation of social housing is becoming both more variable and more exclusionary, contributing to the cycle of disadvantage faced by a growing number of people.

A crisis of identity for housing associations?

Interview data demonstrated a wide range of views and often profound uncertainty when talking about perceptions of the role of housing associations, and what position they ought to fill in the current landscape. Housing professionals asked, 'are we having a bit of an identity crisis?' (Interview, GM16). But only some organisations are ambivalent. Given the reality faced by the organisations and their tenants, some senior executives 'think that it is impossible for a social landlord not to be a significant player in this space' (Interview, TD3). The ambivalence of senior staff compounds the financial disparities and the variable priority given to non-housing interventions (see Chapter 5), further adding to the complexity of this heterogeneous group of organisations. These types of 'case studies and examples can neither be generalised from, nor dismissed as atypical, but indicate real differences' in the markets they operate within (Murie, 2018, p.486). This lack of consistency is likely to have further impacts for health equity. Reflecting this uncertainty, chief executives and directors of the housing bodies featured in this research expressed variable interpretations of the role they expected their organisations to fulfil (see p.120). Housing associations, despite being 'independent', do not operate (and nor do their tenants live) in isolation from the impacts of policy. Rather, 'housing sector organisations have responded to changes in their operational environment' (Murie, 2018, p.486) and their diverse activities are reactions to both national trends and their local contexts, yet are constrained by their organisations' resources and wider agendas.

The ambiguity relates to both the purpose and audience of housing associations. As a landlord, confusion exists over the target groups for whom basic housing services are to be provided. As a non-landlord, there is little consensus on what role they ought to take in supporting people beyond the provision of the home itself. Frontline staff expressed concerns that this 'mission drift' could disadvantage people who rely on housing associations' support: 'What you hope is that social landlords stay social landlords' (Interview, TD5). Changes in their demographics, however, mean that 'the lines blur and blur between Registered Providers who are running private sector rent businesses and social rented stock' (Interview, GM1). This is being driven partly by the lack of statutory funding and reduction in rental income to support their core business activities. Some in the sector have

enthusiastically embraced these opportunities to explore new ways of generating income, but others lament the loss of their original purpose. One chief executive, when asked about increased for-profit activity by his large national housing association, notoriously answered that providing homes for poor households 'won't be my problem' (Slawson, 2015).

GMHP members have expressed concerns about the difficult balancing acts facing their organisations. They must consider their social purpose and their commercial viability, and between their 'core' and their 'extra' services, while acknowledging the risk that 'you can spread yourself too thin' (GMHP group). Other research has highlighted some of the implications of this identity question for housing associations (Ferrari, 2014; Manzi and Morrison, 2018). Some have argued that housing associations are best regarded as 'hybrid' providers (Mullins et al., 2017; Rolfe et al., 2019). The housing providers themselves argue that their commercial activities are intended to sustain their social responsibilities, using 'profit for purpose'. This supports the argument posed by Murie (2018, p.499) that 'diversification into other activity could form part of various contingent strategies to sustain social lettings'. This is not, however, the case for all housing associations operating in Greater Manchester, and the stock transfer housing associations and ALMOs have demonstrated more of a commitment to this activity that some of the larger organisations, without such strong histories of public service or geographical ties to Greater Manchester.

Housing and DevoManc: social housing and population health

Greater Manchester was selected as the research location because of the extent and pace of devolution and its status as the first English city region to gain statutory powers and responsibilities. Most relevant and furthest reaching are the devolution of health and social care responsibilities, which political leaders claim have the potential to 'make fundamental improvements to health and care for the area's people' (Smith, 2018). Devolved responsibility for these budgets has been accompanied by a local political desire to take more action on the social determinants of health, and to improve population health in Greater Manchester through more holistic, joined-up policy action:

> As Secretary of State for Health, you can have a vision for health services. As Mayor of Greater Manchester, you can have a vision for people's health. There is a world of difference between the two (Andy Burnham, Mayor of Greater Manchester, GMHSCP, 2018).

Greater Manchester is viewed by many as 'the de facto exemplar of "devolution" to English city-regions' (Hodson et al., 2018, p.200). The evolution of the city-region has generated sustained research interest (Codling and Allen, 2020; Deas, 2014; Froud et al., 2018; Haughton et al., 2016; Hodson et al., 2018; King's Fund, 2015; Lorne et al., 2020). However, the evidence presented in this thesis reinforces earlier arguments about the need to avoid overstating the transformative potential of governance and policy reforms in respect of health and social care (Walshe et al., 2018). The Greater Manchester health and social care services continue to be regulated by centralised bodies, and their task is to deliver services locally, to meet nationally derived targets. Devolution is said by some critics merely to be the local delivery of national policy, failing to allow 'local autonomy or control over policy' (Walshe et al, 2018, p.6). The long-term and much more challenging tasks of eradicating poverty and deeply ingrained social injustices are, realistically, beyond the immediate scope of the GMCA or GMHSCP. Greater Manchester's health and housing organisations are frequently working more closely together, but interview data reveal frustrations about lack of policy autonomy and a consequent inability to influence deep-rooted factors affecting health. This section will discuss the variability and inconsistency across the different boroughs of Greater Manchester, the limitations of a short period of 'transformation' for the health-housing ambitions, and the disparity between the extent of devolved powers and the scale of the issues the city-region hopes to address.

Ten devolutions: GMHPs and their local authorities

While devolution has occurred at the city-region level, the differences between the ten boroughs and the priorities of their local leaders, including their CCGs, have meant that housing associations working in different authorities have experienced very different contexts, even with the collective voice behind them. In Oldham, the Director of Public Health and the leaders of the CCG 'were open to [the housing provider] being part of that partnership' (Interview, OD1) and to sit on the Health and Wellbeing Board. In other boroughs, the housing association has not been able to match this pace of integrated working,

and some have been flatly denied opportunities to partner with the public health and clinical bodies (see p.126).

Interview data attributed frustrations to the political priorities and difficulties of individual boroughs, which the combined authority umbrella can do little to challenge. In Trafford, for example, the perception of housing association staff is that being for many years the 'darling' council of the Conservative-led governments from 2010, the borough acted as a test-bed for flagship national policies, such as early rollout of Universal Credit. Staff in Trafford felt they 'always get…the shitty end of the stick' (Interview, TD5). Trafford has had a history of political instability, with hung councils or no overall control making action more difficult and frustrating others working in the area. The degree of responsibility for delivering essential services also varies across the housing providers. The Homelessness Reduction Act (2017) confers duties on the local authority that Oldham's housing association was subsequently commissioned to deliver, but without additional or sufficient resources to discharge them effectively (see p.169). Other researchers have warned of 'the problem of an increase in unfunded mandates', particularly where the accountability for decision making and responsibility for policy implementation are located at different levels (Peck, 2014). This illustrates the extent to which local responsibilities multiplied under devolution, but without additional resourcing.

The divisions and geography of the boroughs present challenges, suggesting that the administrative boundaries of the local authorities do not always align with the needs of some neighbourhoods. 'GM' as an entity does not supersede the interests of the individual authorities. For example, some of the community services in Old Trafford are likely to serve many residents of neighbouring Manchester, but are not funded by Manchester City Council. 'It's quite difficult, there's these borough boundaries, oh no, you can't get that because that's Manchester money' (Interview, TD7). Within Manchester itself, frustration is also voiced at the inequality in access to central funds, particularly for community or voluntary groups. Some neighbourhoods in North Manchester are in urgent need of investment, but lacking skills in the community to put together a funding application, 'unlike [wealthy] Chorlton and Didsbury which are full of retired professors who can write excellent bids' (GMHP group). The difficulty of reversing such accumulation of either advantage or disadvantage in different

environments has been highlighted by Pearce et al. (2016, p.200) in reference to inequalities which stem from the fact that affluent individuals can pay for 'residence and participation' in healthy places, navigating markets which offer them more choice. These concerns reflect inherent inequalities in the ways funding and services are allocated. Similar challenges have been identified in the distribution of charitable wealth and resources, which New Philanthropy Capital argues 'is disproportionately concentrated in England's most affluent areas at the expense of the country's most deprived communities' (Butler, 2020). Devolution, and the GMCA, has little ability to change these postcode lotteries or challenge this fragmentation and uneven spread of support systems, which have been exacerbated in both the third and statutory sectors since the reforms of the 2012 Health and Social Care Act (Dorling, 2013).

Relocating public health departments to local authorities since 2012 has had a variable impact across Greater Manchester. The evidence presented here highlights the impacts of political priorities on population health approaches. Interviewee responses suggest that 'one of the things you learn in GM very quickly is you're not going to end up with one model across all ten boroughs' (Interview, GM6), no matter the frustrations of individual housing providers. The variation in the way public health grants are spent, and the uneven capacity of individual boroughs to raise additional resources, is not challenged by these devolutionary measures. As Buck (2020, p.63) has argued, this relocation 'brings high risks especially in those areas that are less able to attract new businesses. These areas are the very ones that are likely to face the greatest challenges for public health,' as well as the highest health inequalities.

The politicisation of public health decisions has been highlighted as a cause for concern. Inequalities in population health systems are therefore not only driven by disparities in resources, but also local politics. This might be nothing new, and 'public health has always been highly political' (Wilkinson and Pickett, 2018, p.4). However, the differences in approach between individual boroughs of the same city-region has driven complaints from those who wish to see a more collective approach to population health, including at the GMHSCP level:

> At the moment there's such variance across Greater Manchester, that it mitigates the potential impact of population or public health functions…you've also got a really wide spectrum in Greater Manchester, of those that have retained very traditional public health teams, delivering the

> expectations under law, and those that have retained a very small public health function, and have embedded public health in all the policies. And that extreme exists in Greater Manchester' (Interview, GM17).

The variability, postcode lottery and unclear accountability structures, however, are concerning for those who wish to see health inequalities reduced (Buck, 2020; Hunter and Marks, 2016). Interviewees expressed confusion and frustration about how best to utilise or communicate with public health departments. Critics of devolution – at a time of austerity and national pressure to maintain private sector delivery of health services – worry that 'accountability will be nowhere to be seen' (Tallis, 2018). Housing staff reported feeling 'deeply pessimistic' that 'public health in this country has been so emasculated over the past thirty years that there is no voice for the public health issues…it is deeply frustrating and deeply depressing' (Interview, TD3). Some local authorities also reflect that they 'don't think [they've] made anywhere near as much use of public health as [they] could have done' (Interview, TD12). A 'system that lacks clear accountability, particularly political accountability, will see action on health inequalities becoming lost as other priorities with clear and demanding accountability mechanisms take precedence' (Marmot et al., 2020 p.138). This is recognised within the system, and for clinical colleagues, 'ultimately what they prioritise is what they're measured on' (Interview, GM17). These measurements of success remain somewhat locally determined.

It has been argued elsewhere that 'localism cannot be viewed as a taken-for-granted progressive model' and that such devolution of decision making has 'a necessary tendency to disadvantage socially marginalised groups' including those who are homeless (Fitzpatrick et al., 2020, p.2). In Greater Manchester, this tendency is exacerbated by the fact that devolution and austerity measures have come hand in hand. Rather than targeting transformation resources upstream, and addressing the structural causes of health inequalities, the experiences of the housing associations delivering individualised programmes have been influenced by the political priorities and values of local authorities and their public health teams. As Jacobs and Manzi (2013, p.41) have highlighted, 'consensus is rarely achieved, particularly [on] decisions…about the availability of scarce resources'. As this evidence has illustrated, these approaches result in individuals falling through gaps in service provision, and unwelcome variation in their experiences of health and housing

services. This supports assertions that Health and Wellbeing Boards remain 'hugely variable in their influence, leadership and impact', as well as how the population health narrative 'risks creating a too strong emphasis on individual, clinical' approaches to prevention, which the NHS can understand, but its record of 'unwarranted variations over thirty years' suggests it is not equipped to tackle (McManus and Fell, 2020).

Transformation in a tight timeframe – a short-term solution?

The Greater Manchester programmes delivered with housing associations and funded through transformation budgets are not yet embedded in everyday practice, nor do they represent business-as-usual. Numerous pilot programmes have been trialled, and 'there's loads of schemes that are really good but they are all quite individual, and they've been individually commissioned, individually set up…it's obviously a barrier, they're not necessarily things that can be rolled out' (Interview, GM12). Several programmes delivered by housing associations felt promising to the staff involved, but the requirement to continually write business cases and evaluate the success of programmes to receive ongoing funding has proved challenging (see Chapter 6). The frequent monitoring and impact assessment required is also problematic in view of the long lag-time between intervention and health outcomes, as Marmot et al. (2020, p.130) notes: 'the long-term nature of investments to improve health, and the complexity of social determinants of health, [which] means that cost/benefit evaluations are difficult'. Being funded by incremental 'funny monies' (Interview, OD1) which are only allocated sporadically means that housing-related health interventions and other non-landlord services are not yet mainstream. The initial three-year period of transformation is likely to be too short to state conclusively whether these piecemeal, rather than systemic, interventions have had any influence on the health inequalities that represent generations of cumulative disadvantage and injustice. MacKinnon (2015) argues that devolution is a process, not an outcome, and the long-term impacts of the transformation period are yet to be felt. They will be unlikely to have a lasting impact, however, if not given time to take root.

While the different boroughs have used various mechanisms to invest in housing association activity, it is commonly felt across the GMHP that the programmes they have been involved

in will only contribute to the long-term solution if they can attract secure funding, from outside their organisation's resources. The pilot programmes therefore represent an opportunity to demonstrate their impact and value, 'with the view to perhaps bring in some funding or some recognition' to put these services on more sustainable footing (Interview, GM4). This short-termism also risks negatively impacting on the quality of the service offered by the housing associations' programmes. The lack of long-term funding means housing staff find themselves 'just responding to things, on a day-to-day basis, rather than forward planning' (Interview, OD2). The resultant job insecurity also causes anxiety for the staff involved. Short-term interventions which are later fundamentally altered or withdrawn have been shown to undermine effective community empowerment and engagement (Whitehead and Popay, 2010), presenting a challenge to these explicit goals of devolution. This is not a sustainable footing from which to encourage secure, stable transformation of services and promote long-term improvement of population health.

Creating a social model of health (as promoted by the GM Population Health Plan) is a necessarily long-term ambition, which challenges urgent priorities. Analysis of interview data demonstrates the sense of frustration among stakeholders with the devolution programmes. A particular complaint from housing sector actors, as Chapter 6 explains, concerns the continuing prioritisation of the medical model, and the insufficient weight attached to upstream transformation necessary to truly improve population health. Interviewees agreed that 'prevention is better than cure' (Interview, OD3) but showed disappointment that targeted programmes continue to take precedence: 'it's all very reactive rather than preventive' (Interview, GM12). Researchers agree that to reduce health inequalities 'we need to focus on population health rather than individual lifestyle' (Watson and Owen, 2020), but those working to achieve this note 'real system barriers to actually transforming the entire system to be focussed on health, not illness' (Interview, GM17). Interviewees working on population health initiatives are encouraged by some of the improvements to Greater Manchester's services, but recognise that the activity would do better in the long-term if focussed further upstream:

> Loads of the stuff that is happening over here improves the lot for people who are ill. So, people who are ill are getting a far better product, because of devolution…[but] my job is to stop any of this being necessary (Interview, GM17).

Housing providers have observed the difficulty of longer-term perspectives from their clinical partners, for whom short-term pressures take priority over transformative, upstream working. For both housing and health sectors, however, the shared view is that it is unacceptable to focus on prevention if that means neglecting those in need of immediate support. Housing professionals opposed to Right to Buy state that 'housing associations should not be forced to part with assets for the benefit of those already housed today at the expense of those needing homes tomorrow' (Murtha, 2019). Clinical morality also prevents this move to drive activity upstream in circumstances where resources are scarce: 'you cannot stop treating the already sick to divert resources to prevention…that is not ethical' (Tallis, 2018). Greater Manchester experienced similar difficulties in the early stages of devolution, when the emphasis of city-regional policy was on the 'Troubled Families' payment-by-results programme. This programme emphasised tackling 'behaviours' rather than the structural causes of compounded disadvantage. The Head of Policy and Partnerships for GMCA in 2013 highlighted the difficulty of delivering results when funding was lacking, and the challenge of shifting 'existing spend – from reactive to preventive services' which 'requires either decommissioning reactive services before the benefit of earlier intervention is felt, or double running and double funding both reactive and preventive services' (Skelton, 2013, cited by McCann, 2013). The Greater Manchester authorities have since backtracked on their support for Troubled Families, arguing that it was merely pragmatic and expedient tactic to be seen to support the narrative of central government in order to procure resources (Rees and Rose, 2015). However, the tendencies towards individualisation and responsibilisation are evident here in relation to devolution of health.

The reality experienced by the housing and health staff who were interviewed does not meet the growing expectation that the focus will be on prevention of illness and improving population health, as advocated by recent studies (Prevention Green Paper, 2019). Instead, the spending decisions continue to reflect a prioritisation of individualistic actions, or 'lifestyle' focussed interventions. As Chapter 6 shows, the consensus among interviewees is that the inability to fundamentally challenge national policy norms, which 'focus less on "public" health and more on "individual" health (Pearce et al., 2016, p.196), is holding back progress. Frontline staff disagree with the strategic vision and priorities that have driven

decisions to focus on the short-term as opposed to the long-term. There is a behavioural focus in much of this work, both at the city region level and the programmes implemented by the housing providers. Some housing professionals refer to this as 'tough love', echoing the perspective of central government and reflecting a view that '…you have to take responsibility for your own health and wellbeing [and]…move away from a dependency culture' (Interview, GM3). Housing staff often use these same narratives to reflect on the health of their communities, where 'people have a whole host of lifestyle illnesses, stuff that's preventable if you improve the lifestyle' (Interview, TD1). Others are critical of the limited potential this has to make transformational health gains, and bemoan a lack of more structural action.

> Just going in and sorting out individuals' problems is just not sustainable. It's incredibly resource intensive, and it doesn't change anything. It changes the outcome for that individual, but there's always another individual to take their place, so what do you do to support the community? (Interview, GM4).

In the same way that accountability for the consequences of national policies is now likely to reside at the city-region level, 'some of the thinking behind devolution pushes the responsibility for health and wellbeing back to the individual person' (Interview, TD1). The conceptual framework made clear that focussing on 'individual behaviour change strategies without equal emphasis on upstream determinants of health will be insufficient' to address the complex causes of health inequalities (Mair and Jani, 2020). More action is required on the 'fundamental causes' of health inequalities (Link and Phelan, 1995), powers related to which have not been devolved in this process.

Limitations of the devolved powers – a mismatch between ambition and ability

Findings from the programme of interviews in Greater Manchester suggest that devolved responsibility for health and social care is perceived not to have been accompanied by the level of resource (financial or political) to adequately tackle health inequalities. This relative powerlessness is a source of frustration amongst those working in Greater Manchester, who express concern over the structural causes of health inequity. 'Public Health funding central to the DevoManc vision has been decimated' alongside social care, and 'DevoManc is the marriage of two massive debts' (Tallis, 2018). Recommendations for large-scale health and social care transformation and integration highlight the need for corresponding large

investment in the early stages (Parkin, 2019) as well as noting that improved, integrated services may reveal unmet needs and cause costs to rise (Mason et al., 2015). The scale of the ambition for reform and transformation has not matched the funding settlement, or deficit, that accompanied these powers. A goal of place-based working in Greater Manchester is to 'harmonise the budgets' but in a period of austerity and scarce funds, 'people start getting twitchy' and protective over their limited resources (Interview, GM6). Experiencing this process alongside a national austerity programme and extensive cuts to public services, represents a 'devolution of fiscal stress' of the kind that in the United States has been argued to reduce 'fiscal transfers to local governments while downloading [increased] expenditure responsibility' (Kim and Warner, 2018). A British journalist reported a coalition government minister saying 'We are all devolutionists now. We will devolve the axe!' at the beginning of this austerity programme (Toynbee, 2020). Housing staff are aware of the difficulties this creates in trying to secure funding for preventative initiatives, which aren't 'going to hit anyone's budget quickly' (Interview, GM4). Devolved cuts are still cuts, and the devolutionary process has involved financial compromise.

The ambitions of Greater Manchester are large. A whole system move to Healthy Public Policy is advocated by the mayor, which is characterised by an explicit concern for equity and health in all policy areas, as well as by clear accountability for the resultant impacts (de Leeuw, 2017). However, the housing providers in the Greater Manchester governance groups feel that their efforts are contributing to a maintenance of the status quo rather than transformation: 'We're plugging service provision, we're not changing service provision…it's not whole-systems change' (GMHP group). Their experience, even when positive, is fragmented and piecemeal rather than structural. This focus on only 'target populations' (see Chapter 6) or individualised factors is problematic for reducing health inequalities across the whole social gradient. Matheson (2020, p.5) argues that in the relationship between complex social systems and health inequalities, 'the whole is greater than the sum of the parts', which implies that 'solutions cannot be piecemeal; they need to be informed by evidence about the "whole system"'. Housing and health sector partners agree that their efforts need to become more radical than current powers allow, and that 'devolution, if only used to reconfigure services and integrate people and places, is not going to lead to the kind of change we need' (Interview, GM17). This supports the conclusions drawn by Walshe et al. (2018) that the initial

experience of devolution has been primarily one of practical implementation and administrative restructuring, rather than transformative innovation. The complexity of sub-national divergence has been highlighted by Hodson et al. (2018, p.203), who recognise that 'central orchestration politically conditions the shape of city-regionalism', even when the devolved areas appear to have priorities that differ from (or extend beyond) the centre's.

The early stages of devolution in Greater Manchester have focussed much energy on governance arrangements, which have included numerous housing voices, such as housing representation on the Population Health Board. At the STP (Sustainability Transformation Partnerships) level 'there is only Greater Manchester that has a dedicated housing resource' (Interview, GM11). The majority of England's STPs have been NHS-led, and while the GMHSCP is under the NHS banner, it has been led during its transformation period by Jon Rouse, who has a background in local government, and evidence suggests that recruitment at the partnership has been diverse and is not dominated by clinical professionals (see Chapter 5, GM17). As Buck (2020, p.42) states, 'it is no accident that in those few [STPs] where local authority chief executives have been in the lead there has been a much stronger focus on the wider determinants of health such as housing, and a stronger engagement with local government public health'.

Those working in housing have argued for this more comprehensive approach, and one of their 'long-term goals would be to get that joined-up thinking between all the stakeholders in an area' (Interview, GM12). While it may be encouraging for those who advocate less siloed, more holistic ways of working towards health equity to see the networks of communication between stakeholders grow, 'joined-up governance is not the same as integral policy, which also is not the same as intersectoral action. Governance is not policy, nor is it action' (de Leeuw, 2017, p.344). The interview findings show the slow pace of tangible action at the city-region level. Interviewees argued that scaling up their efforts is often 'a waste of time at GM level' and projects 'sometimes go nowhere' despite numerous discussions. The housing providers 'are dynamic and get frustrated' (Interview, GM10) by the limited progress and argue that 'the work that we've still got to do is get people to do more, rather than say more' (Interview, OD3). Critics of devolution at the local authority level make similar observations: 'It's all gone on governance for four years and now there's no chuffing money' (GMHP group).

Many of the causes of poor population health and large health inequalities are situated further upstream than the devolved powers reach (Douglas, 2016). Other measures remain at higher levels of government and 'it cannot be left to localism to resolve many modern public health issues' (Hunter and Marks, 2016, p.144). Many of the population health programmes, including those that have directly or indirectly involved housing associations, illustrate the limitations of the devolutionary possibilities. In trying to influence wider determinants of health, those involved in service delivery recognise that: 'what we've [done] is turn some of these into programmes, rather than what actually needs to happen which is wide scale strategic policy or legislative shift' (Interview, GM17). The direct investment from the population health transformation budget on housing programmes is extremely modest (£5,000 of £30million) compared to the scale of some of the larger, resource intensive but more traditional population health programmes such as Making Smoking History. The investments in programmes at the city region level remain further downstream than the national policies, which continue to pursue a cost-cutting, accountability shifting, more localised and fragmented agenda. Greater Manchester may be more accountable for health improvement outcomes, but the level of power and emancipation that devolution provides is relatively modest.

The divergence between the expectation and the reality faced by stakeholders during devolutionary processes has been highlighted elsewhere. For example, the Mayoral agenda and election commitment to tackle homelessness 'even without a budget or clear powers to do so' and related public commitments to increase affordable housing can 'create difficult local politics around raised expectations and limited policy and financial resources' (Hodson et al., 2018, p.212). Some of the housing associations involved in the social impact bond, the initiative to support Greater Manchester's entrenched rough sleepers (see p.131), were disillusioned by the lack of buy-in and wraparound support available from other agencies. These housing associations questioned the extent to which they needed to provide their own health and social care response, 'because the state just isn't there to do it' (Interview, TD3). Not all the commitments of devolution are matched by an ability to deliver.

> In GM, we've taken on an increasing mandate around housing, particularly the harms caused by poor housing or lack of housing, without necessarily having the powers to do much about it. A lot of those powers are still held centrally, through central government. We can't flex from a lot of the national legislation and national models (Interview, GM17).

Peck (2014) uses the term 'scalar dumping' to describe the process of devolving responsibility for service delivery, while denying appropriate resources and retaining central government responsibility for the overall shape of policy (see also Kim and Warner, 2018). This does not empower local populations in the way devolution is intended but 'instead, existing power relationships between policy, professionals and communities have replicated themselves through the new structures aimed at devolution' (Matheson, 2020, p.6). Housing staff view these programmes positively, but recognise their limitations, as 'a plaster to what really needs to happen' (Interview, OD4). These criticisms are shared by policy actors, as demonstrated in Chapter 5 (see p.135).

Devolution is more challenging against the backdrop of austerity, restricting local institutional capacity and the ability to fulfil enhanced remits (Hodson et al., 2018). In Greater Manchester, the 'financial viability of the devolution programme depends on savings, which it is claimed will be made by integrating health and social care budgets, alongside supporting citizens to take better care of their health' (Checkland et al., 2016, p.459). Housing providers, however, recognise the insidious effects that living in poverty has on the health of their tenants, and their ability to make healthier decisions (see p.111). These difficulties cannot be tackled by simply making changes to health services. 'The struggle to make ends meet, including being able to afford…goods and services considered essential to living a dignified, decent and independent life (such as fuel, food and housing) is a major factor explaining inequities in self-reported health between social groups in countries across the WHO European Region' (WHO, 2019) . These are factors that the city-region authorities and the housing associations recognise as important, but are constrained in their ability to address. The case study experiences suggest that while devolution offers the opportunity to develop policy that recognises the interconnectedness of the factors causing ill-health, and the role of housing as part of this, there are insufficient resources to deliver meaningful reform.

The 'in what circumstances' (Pawson and Tilley, 1997) part of the realist formula, and the dependence of outcomes on context (Haigh et al., 2019), demonstrates the limitations of

housing associations' involvement in these health issues, even in a supportive policy environment within a city-region that has prioritised population health approaches and tackling health inequalities. The critical realist approach enhances our understanding of the interplay between sometimes complementary, and sometimes conflicting contextual factors. The case study evidence suggests that although housing associations and their representatives are incorporated at multiple strategic levels, the challenges of delivering successful services in line with the principles of proportionate universalism remain influenced by local priorities, unfunded policy ambitions, and national austerity measures.

Healthy housing in the shifting and shrinking welfare state

Although proponents of devolution in Greater Manchester argue that it presents an opportunity to align the branches of central and local government that influence health inequalities (LGA, 2016), the experience of the transformation thus far has witnessed a predominance of specific programmes targeted towards individuals. The wider relationship between housing associations and the welfare state is illustrative of continued erosion of those collective principles that once underpinned the strategies of both universal health (care) and a state that provided support 'from cradle to grave' (Beveridge, 1942). 'Beveridge systems', a term referring to public services that are distributed equally, by need, such as the NHS, 'can be seen as systems level approximation of the general universalism paradigm' (Carey et al., 2015, p.2). The evidence of the social housing providers in Greater Manchester signals a further departure from these principles, in the forms of increased fragmentation, strengthened gatekeeping and variable service quality and access, raising the prospect that this post-universalist era might accentuate health inequalities.

Driving forces behind housing association activity

The fieldwork suggests some tensions around housing association choices about which services are deemed essential, and which are discretionary. Many of the services discussed in Chapters 5 and 6 represent logical and effective extensions of the housing role, including those that would benefit from more holistic thinking or clinical input and perspective. Examples include the service designed for tenants suffering from hoarding disorder offered by a clinically trained professional at one case study organisation, and the collective effort of

the GMHP to reform and consolidate Greater Manchester's aids and adaptations services. These are uncontroversial initiatives with an obvious relationship to the buildings and traditional landlord role. However, even a 'successful' housing association intervention is hindered by the fact that 'what's still missing is a multi-agency strategy around it', and the lack of statutory services to which housing staff can refer their tenants (Interview, TD2). The cuts and constraints in the public sector are both driving, and limiting the effectiveness of, housing association interventions related to the health and social services.

An important finding from the interviews is that the increased involvement of housing associations in health and social care interventions is attributed by stakeholders to the need to respond to austerity and welfare reform. This has been partly a response to exhortations from government and the statutory services, such as The Care Act (2014) which specifically defines housing as 'health-related service'. It has also reflected a perceived compulsion, for reasons of pragmatism, to deal with the immediate consequences of austerity. Interviewees demonstrated concern for individuals moving onto Universal Credit ('god help the poor bastards'), and rationalised their actions in response to this: 'The imperative for us, as social landlords, and businesses actually, is how to meet welfare reform? We need to do something' (Interview, GM6). The evidence from Greater Manchester shows that welfare reform has negatively impacted the least well-off housing association tenants, as well as private rented sector households, where increasing numbers of individuals and families in housing need are likely to be housed. As research by the Resolution Foundation (Gardiner, 2019) has shown, the uneven nature of cuts to the welfare budgets has disproportionately burdened the poorest households. Various responses from housing associations, such as their employment services, were a direct response to welfare reform (see Chapter 5), designed to mitigate some of its negative effects. It is likely that financial pressures on tenants, and therefore the impetus on housing associations to intervene, will be most acute in the least well-off regions and local authorities, who have been shown in Gray and Barford's (2018) spatial analysis as hardest hit by austerity. As Hastings et al. (2017) have argued, the pattern of austerity cuts in England has been regressive, disproportionately affecting the most disadvantaged communities. This risks compounding disadvantage for districts 'who were very dependent on government grants', but are now 'being left to plug more and more gaps' with housing association interventions (Interview, GM7).

Housing association health-focussed activity is vulnerable to other pressures (mainly financial), both internal and external to the organisations. The result is that the sustainability of even successful interventions is not guaranteed. The case study associations demonstrated reluctance to become the ongoing source of funding for replacement services that have been cut by local government, as they cannot commit to a long-term investment should their organisation's priorities change. This finding supports the arguments made by the National Coalition for Independent Action in their 2016 report, which states that the voluntary sector is, like the private sector, neither democratically accountable nor universal, and not equipped for the task of addressing essential needs. The report's author states that 'when it comes to my rights, health and wellbeing, I don't want to be reliant on the market or on the ebb and flow of voluntary services' as 'there are no protections when they fail' (Waterhouse, 2016). The current housing and health practices, driven by neither the duty nor obligation to provide this public service, are therefore unlikely to be sustainable indefinitely.

Shrunken services: austerity in housing and associated sectors

The social housing sector in Greater Manchester, as elsewhere in the UK, has been affected by austerity and the shrinking welfare state. Housing has become the most commodified branch of the contemporary welfare state (Malpass, 2008; Fenton et al., 2013). The presence of the private market and high numbers of both private renters and owner occupiers mean that the 'public housing sector' as we understand it can likely never be a universal service, at least not to the same degree as health or education. However, universal principles are key for achieving better population health outcomes (although social gradients in health inequalities still exist in more generous welfare regimes, such as Scandinavian nations) (Bambra, 2011). In order to function well, the public housing sector must cater equally to all those who require it, but as the evidence illustrates, many people in Greater Manchester who qualify for housing support are unable to access it. Such a shortage of social housing resource means housing staff 'have to accept that we can't immediately meet everybody's housing need' (Interview, GM3). The protective and preventive power of housing, which could act as a means to combat accumulating health disadvantage (Blane, 2006), is becoming increasingly residualised and inequitably distributed.

Housing remains a crucial point of intersection for the factors determining an individual's experience of either hardship or prosperity. The interdependencies of the sectors most affected by budget cuts mean the impact on health inequalities is cumulative. Changes in the housing sector impact on inequalities, which in turn influence housing itself. Gray and Barford (2018, p.542) argue that 'substantial and sustained' cuts to municipal funds were 'one of the key drivers in restructuring local government and public service provision in Britain'. Indirectly, cuts to Work and Pensions and Justice spending create additional difficulty for individuals. Universal Credit has not been welcomed by the social housing sector, denounced as 'just a punitive policy…[with] that austerity badge sitting on top of it' (Interview, TD3). Housing staff are apprehensive of the effects on their communities as Universal Credit is 'rampaging through GM', knowing that the 'impact of that on health is chronic' (GMHP group). The impacts of 2010-15 policies on individuals have taken time to be felt, 'and we're just now starting to see that all play out in terms of the impact that it's having on the poorest and most vulnerable' (Interview, TD3). This adds weight to claims that austerity's impact on health, and health services, would be felt most by 'those already vulnerable, such as those with precarious employment or housing, or with existing health problems' (Stuckler et al., 2017, p.20). In the context of restrictions on the finance of the housing sector, the capacity of housing associations to halt or reverse this is limited.

The findings of this research raise questions about whether a private, independent business like a housing association has an inherent tendency to prioritise profit making and financial maximisation over the imperative of providing a service for service's sake, such as the NHS or social care might be expected to do. The evidence from Greater Manchester suggests that in some organisations, such as the stock transfers, these tendencies are tempered by the legacies of social responsibility that stem from their place-based nature and municipal roots. Increases in the health-impacting role played by housing associations are (mostly) not influenced by changes to the duties or obligations imposed on the housing sector. The capacity and commitment of housing associations to embrace this activity is variable. To provide services that impact on health is a choice, offered either from a sense of moral obligation and goodwill, or as good business sense, or a combination of the two (see p.119).

The weakness of relying on voluntary commitments from the private sector in matters of public health has prompted concern from other researchers (Collin and Hill, 2016, p.182; Gilmore et al., 2011). Some housing organisations have been reluctant to step fully into this role, questioning whether their income (which is primarily rental) ought to be spent in this way: 'it's the poorest people paying for the adaptations for disabled people, it's all wrong when you think about it' (Interview, GM7). This activity is therefore vulnerable to other organisational pressures and priorities. The organisations' tenants do not have the rights to demand these supports be continued should they be under threat, which must be profoundly disconcerting for anyone using them or depending on them. The combined activities of these housing providers go some way to mask the inadequacies of the public sector, and the extent of the damage caused by funding cuts, but they are unlikely to offer an adequate, long-term replacement for well-resourced, universal provision. There is a high (often hidden) risk of future health and care crises caused by uncertainty about future investment in meaningful prevention services.

The reshaped safety net: undeserving or under-served populations?

One consequence of extensive statutory retrenchment in the sectors that provide early intervention, or preventive health and wellbeing support, is that the third sector, through organisations such as housing associations, charities, and the wider VCSE has, in many areas, become the primary source of service provision. Housing associations lament that they are 'often the last man standing' (Interview, TD1). Some organisations have used this opportunity to demonstrate their ability to deliver this support, with the goal of receiving longer-term commissions from the public sector and therefore income for this work, if it were delivered at a universal scale. However, the resources are unlikely to be forthcoming for this (see p.121). As the Oldham experience illustrated, this is a challenging and complex ambition, and the reality of delivering cross-sector, tenure-blind support services across the community has been underestimated at many stages, particularly at a strategic, commissioning level. Targets for interventions have been 'wildly ambitious, especially when you're starting from nothing' (Interview, OD3). Additionally, the interventions are 'so much easier' to carry out, and 'there's so much more that [they] can do to help' (Interview, OD6) if the patient referred to their service is a tenant of their organisation.

The justification for housing providers filling this support role is often made alongside assumptions that the social housing sector is where individuals with low incomes, health needs or vulnerabilities are likely to be housed. However, the most recent statistics from MHCLG support the argument in this thesis that the tenant base of social landlords does not neatly fit these definitions. Despite social landlord stock increasing by 3% between 2008/09 and 2018/19, the number of new housing lettings at social rent levels decreased by 17% (MHCLG, 2020). To some degree, by diversifying, social landlords are stepping in where the market will not as the relationship between private housebuilding and the welfare state has long dictated (Broughton, 2018), but in order to finance this role, the majority of new housing association stock is offered at private or 'affordable' rents, or for sale. At the same time, 'the stock of available housing is actually diminishing as well, through the impact of Right to Buy' (Interview, TD1). This leaves a large, and growing, gap in provision for households who qualify for housing support at social rent levels. In April 2019, 1.16 million households were on local authority waiting lists for housing, an increase of 4% on the previous year (MHCLG, 2020). The capacity of a safety net like this is far less than needed, in terms of housing, but beyond that too.

As argued in Chapter 3, the relationship between the state and the individual in the UK has fundamentally shifted since 1948, the year of the NHS's foundation and the Universal Declaration of Human Rights. The British Social Attitudes Survey measures the degree to which people understand the influences that individual and society-wide factors have on their health, and found from the 2017 data that 'individual responsibility dominated people's thinking' (Holt-White, 2019). Thirty percent of respondents 'thought individuals were entirely responsible for their own health' compared to just one percent who 'thought the government was entirely responsible for people's health' (Elwell-Sutton et al., 2019). This shows a dramatic underestimation of the structural and social factors which have the greatest impact on health outcomes in wealthy countries. Some housing staff also echoed these sentiments: 'how do you [get more people to] take more responsibility for being fitter and healthier, and smoking less and drinking less and eating better, and all that kind of stuff?' (Interview, GM3). These trends have been partly attributed to narratives in the media, 'reflecting the lifestyle drift in government policies [which] of course also reflects the predominant understanding of

health more generally as an individual rather than societal issue' (Douglas, 2016, p.112). The lack of public interest and political support for strategies and interventions that would influence the structural causes of health (and economic) inequality is part of the current individualistic policy framework in the UK, and this is evident in the housing sector.

Across Europe, shrinking welfare states have been argued to offer safety nets which are increasingly only viewed as a 'last-resort' (Natill, 2020). Housing association activity provides a useful lens through which to determine who might be caught by the safety net of the UK's social security system, and who is at greater risk of falling 'between the cracks…those people who aren't either in social housing or aren't already on the NHS radar…[who] aren't particularly anyone's responsibility' (Interview, GM12). The impact of policies 'that leave populations bereft of needed public services' have been shown to 'increase inequality across geographic areas and sociodemographic groups' (Lobao et al., 2018). In light of this, the evidence from Greater Manchester is concerning, particularly for groups denied access to social housing on the basis of affordability checks, or previous rent arrears:

> What's really tricky is that if we can't make that [tenancy] work then really there's not a lot, I know it sounds dreadful, but there's not a lot of hope for those people (Interview, GM4).

Preece et al. (2019, p.1) have highlighted the nature of this 'greater conditionality' and exclusion in affordability assessments, which 'increase the potential for exclusion from affordable housing on the grounds of ability to pay'. The risk of such trends is that those in need of support, who are excluded from public housing accommodation, are now also likely to be unable to access a wide range of additional services that were previously available universally, and unrelated to housing tenure (see p.166). The public housing sector has become both more residualised and exclusionary, with similar implications for health and social support.

These gaps in the safety net, and weaker social contract, may contribute to longer term 'legacies of austerity', even if public sector funding begins partially to recover. The activities of housing associations, which go some way to mask the larger public expenditure cuts, represent some of the 'hidden' effects of austerity, as emerging research is beginning to explore (see, for example, Gardner and Gray, 2020; Hall, 2020; van Lanen, 2020). Housing

providers liken new national funding announcements, which cannot hope to replace what was lost, as 'filling up the bath with the plug out' (Interview, TD3). 'Austerity will cast a long shadow over the lives of the children born and growing up under its effects' (Marmot et al, 2020, p.5). Other research has highlighted a more general 'hollowing out' of the welfare state and an irreversible (in the short to medium-term) loss of knowledge and expertise that will take decades to rebuild (Malin, 2020).

Housing associations and Universalism

'Proportionate Universalism', as a key component of the conceptual framework, remains the approach to increased health equity that has most support among health professionals, and it is argued to have grown in importance in the decade since *Fair Society, Healthy Lives* was published 'as resources have shrunk and inequalities widened' (Marmot et al., 2020, p.142). In 2019 Greater Manchester signed up to be a Marmot City Region, and other cities and towns in the UK have demonstrated strong efforts to apply the Marmot principles of proportionate universalism at the local level. Coventry is highlighted in the Institute of Health Equity's case studies, as are the school-readiness programmes in Greater Manchester which have closed the gap between GM and the rest of England (Price, 2020). Generally, however, the programmes and support both directly and indirectly related to housing services are offered on a more targeted, and less universal platform. This is perceived to have damaging impacts, both in the way the fewer individuals who are entitled to scarcer support become stigmatised, and to society-wide support for a larger welfare state and more generous redistributive policies, which, particularly given the increased inequality in both wealth and income in the UK, is a pre-requisite for any improvement in health equality (Larsen, 2008; Hills, 2017). As Chapters 5 and 6 show, this perception is echoed in the consensus among interviewees canvassed for this research.

While Greater Manchester's housing associations are familiar with the Marmot Principles and the need for the application of proportionate universalism in their service provision, their identification of the groups in most need of support comes directly from their experiences with their tenants. Their experiences with individuals in need of non-existent support illustrate the departure from proportionately universal approaches in most areas. They might

apply the principles of targeting their actions towards the neediest, and some are critical of this 'tendency to focus on the hardest cases, or the people who have the most difficult needs' (Interview, GM12) at the expense of their wider communities. Even so, this activity takes place within their own contexts. While this work may represent the application of proportionate universalism within the realm of the HAs' tenants, it does not benefit others affected by reductions in service quantity or quality. Housing association actions which are reactive, employing a medical model, and targeting only their tenants, do not benefit those affected by the 'toxic combination of insecure work and insecure housing' (Mayor of GM). Given that in 2018, 54,000 people in Greater Manchester were on the housing register (GMCA, 2019) and that in 2017, 30,000 people were working in jobs on zero-hour contracts (Clarke, 2017), we can assume many people are affected by this 'toxic combination'. Housing associations have neither the capacity nor the desire to become universal providers of non-housing support services, yet universal approaches are almost always argued to be a more effective approach to improving equality than selectivity (Danson et al., 2012).

Carey et al. (2015) highlight some of the disparities in application of these proportionate universalism principles, cautioning against the dangers of means-testing and a market-based approach, which is exclusionary rather than universalist. When interpreted to mean tackling either only those in the greatest need, those that meet a certain criteria (such as existing HA tenants), or those in most acute housing deprivation, it is unlikely that persistent health inequalities can be reversed. The evidence presented in this thesis suggests that the risks of increasing health inequalities are twofold. Not only is the diversification of housing association activity reducing their capacity to act as a universal provider of affordable housing to those in need of homes, but their wider support services are not easily offered universally, to the wider population, who are either ineligible or inaccessible, but may have very little in the way of a statutory support system to rely on.

Applying the critical realist conceptualisation of absences (Bhaskar, 2008) demonstrates the risk to health equity associated with the lack of universalism, and proportionate universalism, in these housing-health services. This concept allows absences to be attributed causal powers (Vincent and O'Mahoney, 2018), giving agency to factors which might not be measured, seen or understood if taking an empiricist or constructionist approach. In the evidence presented

here, there is an *absence*, in several instances, of housing association interventions being applied to non-housing association tenants. This absence, or lack of intervention, can therefore be interpreted as having a causal power, or a tendency, to increase health inequalities. When understood in the context of population health systems, this absence reveals a process lacking in universalism, which will not reach the broader social gradient in the ways that are necessary to reduce health inequalities (Marmot, 2015).

Rising thresholds to access both social housing and associated support services cause concern and frustration to interviewees. The 'cohort of people who are becoming tenants now have got much more needs' than the longstanding, more universal tenant base, which is 'the product of the allocation policy' (Interview, GM10, see also Chapter 6, OD5). While many housing associations are now also housing more affluent households, or particular populations such as elderly residents with care needs, their role in providing *general needs* housing to those on the lowest incomes (whose need for public housing stems mainly from reasons of affordability) is the one that has been most tightly pinched. In addition to this, housing staff struggle to support tenants that have access to social housing but are struggling elsewhere in their lives, without wider support available. The housing providers may intervene on some level, but, as has been suggested here, it is unlikely they are able to offer the same standard or equality of service as that of specialist, universal providers.

A key finding of this thesis, therefore, concerns the variability within housing tenures and the diversified role of social landlords as a potentially significant risk factor, or social determinant of health, in its own right. While housing has been increasingly recognised as an important and complex health factor, recent work on health inequalities (Marmot et al., 2020), continues to focus significantly on the relationship between individuals and their particular housing circumstance. This thesis demonstrates the risks to health equity that arise from a two-tier public housing system (and unwelcome variation even within the social rented sector), and the far-reaching consequences that (un)fortunate local housing association priorities and availability might have on the health opportunities for any given community. The data from Greater Manchester demonstrate that a potential barrier to accessing preventive or early intervention health related support services is living outside the social housing sector, with possible increases in health inequalities as a result of this unequal access,

or two-tier system that has formulated under these arrangements. Those who have attempted to deliver services in both the social and the private rented sectors are pessimistic about resources in the PRS, which is 'growing, daily, and so is the lower end. It's something that is not going to go away, and it's something that is not really tackled in the emerging housing strategy' (Interview, GM11). There is evidence of both inter and intra-sector variability in terms of the priority given by housing actors to health concerns (direct or indirect). This suggests that in an era of post-universalism, what could be occurring is increased inequality of health (and housing) provision but in more complex terms than housing association versus non housing association.

Summary

Chapter 7 has discussed the changing and diversifying role of housing associations in terms of their goal of reducing health inequalities. Rather than being comprehensive, consistent and sustainable drivers of prevention, the housing association services have been shown to be reactive, individualistic and often exclusionary. This chapter has argued that the social determinants of health are made additionally complex by using housing associations to fulfil such a variable health and social role. The austerity context and public service spending cuts have determined much of the health-focussed activity by housing providers, but the response borne of necessity is not one that policymakers in Greater Manchester would have designed, had other resources and powers been forthcoming. The evidence presented here supports research arguing that austerity works regressively, to compound disadvantage and inequality. Lack of resources, combined with the organisational and cultural challenges of inter-sector working have created difficulties for the joined-up, Healthy Public Policy agenda in Greater Manchester, which the devolved approach is limited in its capacity to address. Devolution has encouraged some cooperation across the city-region and between the housing providers, but the powers of DevoManc do not supersede either the centrally determined financial restrictions, or the individual priorities and values of both the independent housing associations and the elected leaders of the Greater Manchester boroughs. This chapter has discussed how the evidence of the GMHP signals a withdrawal and diminishment of universal principles, in the forms of increasing variability and fragmentation in service quality and

access. Such reductions in universalism may have unwelcome and unforeseen consequences for both health inequalities and continued support for a welfare state.

Chapter Eight
Conclusions

This thesis has contributed to knowledge through a critical assessment of the growing health-focussed role played by social housing providers in a devolving city-region. The aim of the research is to interpret the changing role and purpose of housing associations in the context of health inequalities. In doing so, the study has critically reviewed the academic and policy literature on the causes of, and interrelationships between, health inequalities, housing and the role of social housing providers. Chapters Two and Three identified gaps in the research, exploring how, why and to what extent housing association activity is changing to embrace a new role, as well as the potential for housing-health studies to incorporate critical perspectives on health inequalities. The methodology and conceptual framework presented in Chapter Four informed the analysis (Chapters Five and Six) and discussion (Chapter 7) of the primary data assembled, bringing together conceptual and empirical concerns spanning both housing studies and health inequalities research. The findings are documented in this chapter, which discusses the study's main conclusions and contribution to the field of housing studies. The chapter also highlights future research areas that could build upon these findings and further extend the evidence base regarding housing and health interactions.

This study has confirmed that housing associations, to varying degrees and in different ways, are providing an increasing number of services with a health or social focus, in addition to (and sometimes as a replacement of) their established role in letting and maintaining 'public' housing stock. The *raison d'être* of such organisations, and the service provided to tenants and wider communities, is becoming increasingly disparate. The lack of universality, the absence of statutory duty, and the growing number of competing business interests for housing associations, have far-reaching implications for policies and places seeking to reduce inequalities in health outcomes. Housing association activities have become on the one hand more holistic, engaging more with the social determinants of health, and offering some tenants a more joined-up, integrated service linking their housing and health or social service requirements. On the other hand, housing provider services are inconsistent and exclusionary, creating new inequalities in access to support that was previously universal. These inequalities are evident when comparing housing association tenants with those reliant

on other tenures, but the evidence presented in this study shows they also exist within the voluntary housing sector itself. This reflects a broader shift in the UK and internationally, which has seen universalist approaches to public services and social welfare facing increase challenge from marketized models of public services delivery, underpinned by neoliberal thinking, which this thesis suggests will have lasting legacies and impacts.

Summary of the key findings and answering the research questions

1) How and why is the role of housing associations evolving in attempts to reduce health inequalities in Greater Manchester?

Housing associations in Greater Manchester are diversifying the services they offer to their tenants and the areas of business with which they are involved. Many of these activities have a direct or indirect focus on health. Housing association activity is variable – often but not always determined by the type of social landlord role the organisation fulfils, or the socio-demographic characteristics of their tenant base. The findings suggest that beyond providing specialist or supported accommodation facilities, housing association services for those with specific health needs or conditions is not likely to meet the standards offered by trained clinical professionals (and if they do, it is often by employing clinical staff who previously worked in the public sector and have been trained by the state). Findings from the research show that housing associations' activity in health and social care is offered mainly to their tenants, rather than provided on a universal basis, and creating potential for a two-tier system of access amongst those with equivalent needs. Successful work outside their tenant populations is dependent on funding and partnership working with the public sector, such as the NHS, but evidence from the Greater Manchester case study reveals the sometimes profound tensions and cultural misalignments between the housing and health sectors. Primary data assembled for the case study research suggests that isolated success stories in linking housing and health are attributable to individuals, relationships and leadership, rather than systemic support.

Although devolution has encouraged cooperation and dialogue between different Greater Manchester housing organisations, and with other sectors, it has not brought the resource (money or power) to achieve the necessary transformation in health inequalities. The MoU

signed in 2016 by the GMHP and GMCA, and wider ambitions for devolution, do not fundamentally challenge the independent status of housing associations, or the individual nature and priorities of the ten separate boroughs of Greater Manchester. It is evident that local and organisational priorities may represent a fundamental challenge to the provision of services for marginalised groups, which is exacerbated when resources are scarce and particular services are deemed unviable. These findings support recent conclusions drawn on the limitations of localism and devolution for homelessness (Fitzpatrick et al., 2020), which say that localist policymaking has a tendency to disadvantage and deprioritise 'unpopular' spending. Devolution has focussed local actors on shared ambitions, and encouraged closer inter-sector working, but the devolved powers do not encompass all the policy areas that contribute to health and economic inequalities. Stakeholders in Greater Manchester expressed a desire to extend the policy areas they control, but without significant redistributive resources attached there would be little guarantee for citizens that the city-region can deliver a fair, proportionately universal system of support to tackle inequalities.

The findings of the study show that some actors in Greater Manchester perceive devolution as a modest series of attempts to improve existing ways of working, rather than a driver of wider structural transformation. The power to achieve the necessary transformation to upstream causes of health inequalities is not held by either the combined authority or the individual housing associations. Whatever successes they have accomplished are felt to be in spite of the wider system, not because of it. The short-term nature of the pilot programmes, and injections of transformation funding, are not suited to addressing the longitudinal, entrenched reproduction of health inequalities. This is partly a result of variable housing association activity, which is predominantly directed at populations created by social housing allocation policies. But it also reflects contextual challenges to which housing providers are obliged to respond, despite having limited influence over them. In the UK, these challenges have included austerity and reduced funding for local government and public health, welfare reform, and the long-term process of privatisation and marketization of social housing (Smyth et al., 2020). The critical realist conceptual framework took these complex contingencies into account, demonstrating that in spite of the stated ambitions for an enlarged housing association role – a principle which garnered support among interviewees – the wider

contextual factors continue to shape and constrain how far housing (and housing providers) can influence health inequalities.

The context of Greater Manchester's devolution and ongoing austerity measures have been shown to exert a strong influence on the organisations' focus on health. Much of the housing association activity has been driven by necessity, in response to this challenging context, either in replacing health or social services that have been cut, or providing support to their tenants in order to minimise the impacts of welfare reform. This is partly justified as an extension of the housing associations' social purpose and partly as a commercially shrewd response to a more challenging financial climate. The organisations studied justified their actions in terms of finance, stating the need as private, independent businesses to maintain their commercial viability. As a sector, they have mostly followed the policy agenda set by central government, despite criticism by senior professionals of some of the policies' impacts. For example, the extension of Right to Buy policies, the building of affordable or shared ownership properties, and potentially exclusionary allocations policies have become more common as housing associations seek to preserve their viability and longevity as functioning businesses. Their social purpose, and the goal of delivering social value, remain important concerns to many, but their status as independent businesses leaves housing associations compelled to employ coping strategies to remain viable in a context of public sector funding cuts.

2) What are the implications of this housing association activity in relation to critical health inequalities scholarship?

As a social determinant of health, housing association activity is vulnerable to other pressures, particularly reduced spending on public sector services and social security. The diversification of housing association activity is intended to ameliorate the damage caused by public sector cuts, but the Greater Manchester case study shows it is not an adequate, long-term replacement for well-resourced, universal provision. The welfare state continues to be weakened, and housing forms part of a population health model, but is not consistently regarded as a public service, or considered a priority on the same level as 'Beveridge' systems such as the NHS. Housing departments have been some of the largest casualties of cuts

during austerity (Harris et al., 2019), making it difficult for both statutory bodies and social landlords to make long-term spending commitments and investments in the built environment. Unevenness and lack of universality is likely to continue to have negative impacts on health equity. Housing itself (the bricks and mortar) is a crucial component of the preventive services that could reduce health inequalities, and this is now reinforced by the possibility that the local housing association may be an increasingly important provider of additional health and social service. It is not possible, however, for housing providers to improve population health or reduce health inequalities if people with equivalent needs do not get equitable access to housing or other public services.

Funding health and social care services (and the focus on raising income from new sources such as market rent, shared ownership and market sale) is contributing in Greater Manchester to a reduction in the ability of housing associations to invest in their core activities. This means there is a negative impact on the biggest and most sustainable way that housing is able to influence or improve population health – namely providing safe, secure, affordable housing with stability of tenure. Housing associations' ability to continue providing this is threatened by their growing diversification, shifts in financial priorities, and mission drift. Universal (or at least proportionately universal) provision of decent housing offers the largest potential to impact on health inequalities by reducing housing-related ill health, including poverty induced by housing costs. This study reveals a consensus among stakeholders that housing associations' investment in 'non-landlord' priorities is undermining their ability to maintain and invest in their existing stock, and that it is therefore becoming less easy to say that a social rented home is likely to be good for one's health. Rather than demonstrating proportionately universalist principles, the social housing sector is shrinking, at least for 'social rent' properties, so even high-quality services are only likely to benefit a small number of the people who need them. The housing associations' social determinant offer is in one sense becoming more comprehensive, but may actually contribute to an increase in health inequalities if services are only offered to a diminishing group.

The research findings reveal significant variability between housing associations and across local areas. One of the benefits of a critical realist approach was interpreting and giving meaning to the significant variability that was evident in the data, and applying this

interpretation across the social gradient. The housing associations vary in terms of their capabilities and resourcing, and in respect of the priority they accord to reducing health inequalities. The organisations studied here are evolving at different paces, some working closely in alignment with health partners, but others in isolation. This variability reflects devolution and both the commitment to innovate in relation to joined-up service delivery, but also discretion afforded to individual housing associations and the scarcity of resources at their disposal. Analysis of primary data in Greater Manchester suggested that variability is pronounced, despite the explicit ambitions and attempts by the housing providers to deliver some of the same interventions across the whole city-region.

Several examples of high quality, health-focussed interventions by social landlords were identified, such as specialised support to combat hoarding disorders, as well as the provision of community pantries and kitchens, and counselling services. This experience, however, was inconsistent, and frequently determined by housing association choices, rather than their need to meet duties or obligations. When viewed holistically, across the city-region, housing association activity is not able to do more than mitigate damage caused by other policies. There is no evidence that the housing association sector as a whole in Greater Manchester is likely to be able to address population health inequalities in an upstream, systematic and durable way. A loss of capacity in the core function of housing associations, and therefore a corresponding reduction in the preventive, protective power of the social housing sector, may have damaging future repercussions. The programmes delivered as part of the DevoManc transformation continue to demonstrate 'lifestyle drift', and they remain more individualistic than collective, and more reactive than preventive. In that context, it is difficult to envisage any meaningful contribution from housing associations that are both financially 'independent' yet affected by government spending decisions.

The critical realist approach has enabled a balanced interpretation of the evidence, embodying the specificities of local institutional and actor interrelationships, within a spatial and temporal context framed by evolving national policy on health and housing, against the wider backdrop of austerity politics, local state restructuring and public service reform. In the example of Greater Manchester, it is not so simple as concluding that housing associations are increasing their efforts regarding health inequalities. Such a statement implies a degree

of sameness in the *mechanism* that a positivist reading might expect to lead to sameness of *outcome*. By drawing upon Pawson and Tilley's (1997) argument that equal primacy needs to be given to context, the Greater Manchester case study can be better understood as a relative and conditional series of processes that may lead to a variation in outcomes that are fundamentally opposed to the conditions necessary for improved health equity. While it may be the case that housing associations are increasing their efforts regarding health inequalities, that information by itself does not lead to the conclusion that health outcomes are likely to improve, or health inequalities are likely to reduce.

The contribution of the study

This study responded to gaps in the research literature highlighting the lack of empirical data on the changing roles and responsibilities of social housing providers in terms of health, and health inequalities. The thesis adds detail and depth to the scholarship on the function and purpose of social housing, as well as situating the findings alongside debates concerned with the effectiveness and possibilities of devolution. The empirical data assembled and analysed for this study demonstrates the extent to which housing providers have embraced shifting roles and responsibilities, and their variable experiences in doing so. This research demonstrates the increased likelihood of diversified activity and investment by the stock transfer housing associations and ALMOs. The findings also demonstrate the inherent complexities in the relationship between housing and health inequalities, which are shown to have potentially countering influences on individual versus population health. The evidence presented helps us to understand more thoroughly the current and potential future contribution (and limitations) of social landlords to the goals of reducing health inequalities.

The evidence presented in this thesis has been analysed using a population health approach (Buck et al., 2018). The study developed a conceptual framework that built upon a social determinants and population health model, which are under-used concepts in housing studies. This has enabled the study to draw conclusions that are applicable to large swathes of the social gradient. Beyond identifying the relationship between the home and individual, the conceptual framework underpinning this thesis recognises the multiple feedback loops between intended and unintended consequences, particularly possible chains of events that

'turning the tap off' in one area of health or housing investment might set in motion. The tenants of housing associations are not considered as a discrete, homogenous group, but rather as part of whole populations, whose experiences and needs are not easily categorised by housing tenure. It therefore makes a contribution to both housing studies and health inequalities research, particularly for scholarship that considers how third sector or community-based, non-statutory actors might function as health and social service providers (Blank et al., 2018; Buck and Gregory, 2018; Chevin, 2014; Holding et al., 2019; Rees and Mullins, 2016), and what the implications of this activity might be for population-wide health outcomes.

An important contribution of the thesis is to identify the variability within the housing sector and the diversified role of social landlords as a possible significant risk factor, or social determinant of health, in its own right. This risk factor is applicable to wider populations, beyond simply the tenants of a housing association. The lack of homogeneity and uniformity makes it challenging to predict the impact of housing provider activity, but given the importance placed on universal approaches, this study goes beyond the 'methodological individualism' common in much previous work (Goldberg, 2012). The tendency to focus significantly on the relationship between individuals, and their personal housing circumstances, cannot address the issue of the social gradient. When considering the impact of this housing activity on wider social and health inequalities, this thesis considers population health approaches, health-in-all-policies approaches, and proportionate universalism. The activity of housing associations is shown here to be of significance both to their own tenants, and to those excluded from core housing services. The conceptual framework could be utilised in further housing studies, for research on the relationship between health inequalities and either individual, community or society-wide housing factors and interventions.

The findings discussed in this thesis supports the case for comprehensive housing considerations to be explicitly considered as a public health priority. They also give further weight to calls for universalism, or at least proportionate universalism, to act as the driving principle for achieving better health and housing equity, and strengthening the welfare state (Carey et al., 2015; Light, 2003; Marmot et al., 2020; McKee and Stuckler, 2011). Significant

gaps are identified in the safety net, and social contract, which are magnified by the expanding but increasingly uneven role for housing associations in a post-universal era. The conceptual framework advances our understanding of the activities pursued by, or expected of, social housing providers in terms of what they do not or cannot do, as well as in terms of who they do not or cannot reach. The activities they are able to pursue, when viewed holistically, have as much significance for their exclusions as they do for who and what is included. These absences, in line with critical realist analysis, are understood here to have causal powers for health inequalities, and the limitations of these housing association efforts to affect them.

The critical realist approach has generated a meaningful assessment of what this activity *is*. The conceptual framework could be further developed or used in conjunction with other theoretical frameworks. For example, in addition to what is, a rights-based approach could inform health-affirming housing strategies, based on what *ought to be*. The findings from the thesis support similar arguments by critical realist homelessness researchers that there is a 'moral imperative for policy action' to try to prevent homelessness, which is shown through its complex patterns of causation to be *predictable*, but certainly not *inevitable* (Bramley and Fitzpatrick, 2017, p.18). The results from this thesis reaffirm that a linear or individualistic approach is not suitable for in-depth assessment of the multi-faceted contributing factors to health inequalities. Housing as a health determinant is demonstrated via the multi-level case study of Greater Manchester, to interact with numerous concurrent influences on health, which are experienced at individual, household and community level, even within the devolved city-region.

The results of the research presented in previous chapters also provide insights into legacies of austerity, shedding further light on ongoing scholarly exploration of the regressive, long-term consequences for entrenched inequalities (see, for example, Gardner et al., 2020; Hall, 2020; Hastings et al., 2017; Van Lanen, 2020). Research on the enduring effects on inequalities is of particular interest in countries such as the UK where politicians have deemed their austerity period to be over (at least until the advent of the COVID-19 pandemic in 2020). The evidence from Greater Manchester illustrates the risks associated with the ongoing hollowing out of the welfare state. More comprehensive, well-resourced and universal social

safety nets act as a protective force for citizens when crises occur, and therefore function as a preventive public health investment (Nanda et al., 2020; Stuckler et al., 2017). Findings documented in this thesis reaffirm the conclusion of earlier research that recovery from the cumulative and long-lasting impacts of the erosion of collective, universal principles will be a long-term process. The emergence of two-tier housing and health system identified in Greater Manchester, driven by austerity, could prove difficult to reverse.

Additional relevant literature

The findings reveal some potentially valuable insights that might contribute to knowledge on inter-agency working and collaboration and inform a future research agenda. The effectiveness of inter-agency working is shown in Chapter 7 to have a strong bearing on the maturity of the housing-health agenda. The perceptions of housing professionals regarding their success (or lack of) in penetrating external organisational cultures and practices to influence health, were demonstrated in Chapters 5 and 6 to be determined by the level of co-operation achieved between key stakeholders, and the strength of these interpersonal relationships.

The topic of inter-agency collaboration is represented in an extensive realm of existing international scholarship (for example, Alter and Hage, 1993; Ranade and Hudson, 2003; Pratt et al., 1999), which could form the basis of additional research or analysis using the primary data assembled for this study or other, similar datasets. Research exists in relation to social interventions which attempts to identify those successful features of inter-agency working associated with improved outcomes for service users or recipients of interventions (Johnson et al., 2003; Okato et al., 2020). The evidence generated for this study could therefore be insightful in relation to literature that explores multi-agency partnerships as they related to health or social outcomes (see, for example, Gallagher et al., 1995), or the pursuit of increased inter-agency collaboration in the public sector (Hudson et al., 1999). The successful features of inter-agency working as identified by Johnson et al. (2003) include commitment on the part of institutional actors, the effectiveness of communication between them, the strength of leadership from decision-makers, and the level of understanding of collaborators' organisational cultures. Such features, and research participants' perceptions of them, were

present in the data collected for this study and were attributed by interviewees to the progress their organisations had been able to make on better integration of housing and health issues. Regarding evidence from Greater Manchester, the limitations of the devolution process in promoting increased intergovernmental coordination also contributes to the wider body of scholarship on inter-agency working in respect of health and housing (Ayres et al., 2017; Sandford, 2019).

Several complementary aspects of this literature have a bearing on the findings presented in this thesis. Additional or subsequent work, which is more closely focussed on the changing functions of housing associations per se (and their diversification into a wide range of additional 'non-landlord' sectors and areas of work), and less specifically concerned with these intersections with health inequalities, may therefore benefit from consideration of several areas within this scholarship. It may be useful to engage with, for example, work concerned with institutional imperatives or managerial logics in relation to charitable or non-profit organisations during periods of organisational change and upheaval (Mitchell, 2018). Evidence from non-profit, or 'profit for purpose', housing associations, such as those studied for this thesis, may offer useful insights on this topic particularly in relation to the normative behaviours of their boards and governance bodies which were highlighted by interviewees as instrumental in determining the business priorities. This could offer insight to the concept of managerialism (see, for example, Hvenmark, 2015; Maier and Meyer, 2011), which refers to the 'knowledges and practices of organisational governance and operations…marked by concepts like accountability, transparency, participation and efficiency' (Roberts et al., 2005, p.1849). Of relevance to the data from housing associations presented in this study, 'managerial practices are therefore linked to specific justifications that rationalise organisational behaviour' (Mitchell, 2018, p.1038). These insights may be particularly insightful when exploring some of the differences in philosophy and purpose that arose in the housing association data, at a time of increasingly blurred lines between state, market, and civil society organisations (Bromley and Meyer, 2014). The findings of this thesis could therefore contribute to the literature which explores the 'businesslike professionalisation' of non-profit organisations, and the balancing of perceived increased efficiency and effectiveness with the concern that 'further professionalisation will transmogrify non-profit organisations from authentic sites of civil society mobilisation to corporate bureaucracies that

sacrifice their social functions in the pursuit of businesslike values' (Mitchell, 2018, p.1056, see also Maier et al., 2016).

Implications for policy and practice

The evidence from this thesis provides insights that could prove mutually beneficial for both the housing and health sectors. Health policy, or health inequalities policy, that suggests or dictates a role for housing associations in improving health outcomes will need to be aware of the variability and vulnerability that are inherent in the types of services discussed in this thesis, particularly in the long term. Housing providers making offers of improved health outcomes, or promoting their ability to reduce health inequalities, ought to be aware of the population-wide gradient in health outcomes, and understand that their position in this area and their ability for outreach, are thus fundamentally limited.

Housing association interventions would do better for health inequalities if they were able to offer additionality, rather than substitution, to existing health provisions. Yet this challenge is exacerbated by the English context of ongoing austerity and retrenchment. For universal benefit and health equality to be achieved, the right to good housing needs to achieve equivalent status to the right to health (which is itself limited by an understanding of this right as meaning a right to health services, rather than the right to the conditions necessary for a healthy life). A universal housing service, in the same way as a National Health Service does, could demonstrate a commitment to providing a basic but fair system, from which to build meaningful additional support services, for those who require them. There is a need to guarantee a baseline housing standard that all citizens have a right to access and demand, to provide a foundation for good health. Therefore, the obligation, or duty to ensure this, lies with the state. Housing associations as a sector do not have the means to solve this problem while working in such a challenging context, but in a more supportive environment, some of these organisations could, in principle, offer a valuable contribution.

Considerations for further research

This research provides an in-depth analysis of what, how, and why housing associations have become involved in tackling health inequalities. The priority for future research, drawing upon these conclusions, could be to explore the 'post-austerity' experiences of groups and individuals that have been either purposefully or unintentionally disadvantaged by the changes to housing-health nexus revealed by the findings of this study.

While the conclusions here clearly demonstrate some of the unintended consequences of this evolving role, and the ways the reality of housing providers' experiences have not always matched expectations, the findings have also highlighted far-reaching, fundamental questions about the nature of the housing association sector and its activities. The study considers housing associations in relation to population health inequalities, as part of a wider housing landscape which includes other tenures with lower documented standards. There is scope for further study that assesses how 'healthy' the housing association model is – the paternalism, the inability for tenants to opt-out of paying for 'services', and the degree of autonomy and agency that residents have over their homes. There are some vocal online communities of UK housing association tenants, that express dissatisfaction with their landlords taking what is perceived by some to be an inappropriate and invasive interest in their residents' private lives (Spring, 2020; Snow, 2020). Housing journalists have revealed similar concerns amongst housing officers and growing resistance to the changes in the role they are increasingly expected to perform (Mr Anonymous, 2017). Questions about the fundamental appropriateness of landlords fulfilling social or health roles may warrant further consideration, particularly if housing associations continue to expand their non-housing activities.

Writing-up of this thesis concluded in 2020, amid the COVID-19 pandemic – which has itself revealed a series of health and housing inequalities (Abbs and Marshall, 2020; Bambra et al., 2020). This thesis has not explicitly considered infectious diseases, as the most prominent manifestations of health inequalities are noncommunicable diseases, but the underpinning rationale for this study is that access to a decent home is a pre-requisite, and a springboard, for a good life that can be well lived. As the power of housing to protect from harm is

recognised once more in mainstream circles, it has become clear that 'we are in the same storm, but not in the same boat' (Barr, 2020). The hidden risks and amplified inequalities highlighted here in relation to the social determinants of health are also applicable to the experience of COVID-19, and a strategy for health protection must take seriously the issue of equitable access to decent homes as a population-wide health investment. The report, *Places after the Pandemic*, showed that in providing social care calls, or food deliveries, the housing 'organisations who did not operate in one concentrated geographical area found the period more difficult as support had to be delivered at a hyper-local level' (Heath, 2020). This reaffirms the particular position of the stock transfer organisations, and the need for housing associations to be closely connected to their communities if there is to be a broader, health-focussed role for them.

This will be a valuable starting point for post-pandemic research that seeks to improve understanding of how better health and support can be delivered in community-based, non-clinical settings, taking into account the concerns raised here about the capacity and ability of housing providers. Improving public and population health, reducing health inequalities, and harnessing the protective power of prevention, are significant, long-term investments. Housing and health research and policies ought to consider the holistic, population-wide impacts of policies or programmes that are delivered by a fragmented and heterogeneous group of organisations. While housing associations have significant potential to impact on health inequalities, this is as part of a complex, interconnected social system that depends on shared ambition and sufficient resource to be realised. The conclusions drawn here have shown that the competing and often conflicting priorities faced by housing associations are compromising their ability to provide a public health service which is based on the principles of inclusion, universality and equality.

References

Abbs, I. and Marshall, L. (2020). 'Emerging evidence on COVID-19's impact on health and health inequalities linked to housing', *The Health Foundation*, 14th August 2020. Available at: https://www.health.org.uk/news-and-comment/blogs/emerging-evidence-on-covid-19s-impact-on-health-and-health-inequalities (accessed 22nd December 2020).

Age UK (2017). *Briefing: Health and Care of Older People in 2017*, February 2017. Available at: https://www.ageuk.org.uk/documents/EN-GB/For-professionals/Research/The_Health_and_Care_of_Older_People_in_England_2016.pdf?epslanguage=en-GB?dtrk=true (accessed 11th November 2020)

Allen, C. (2000). 'On the "psychological dope" problematic in housing and illness research: Towards a critical realism of home and health', *Housing, Theory and Society*, Volume 17, Pages 49–67.

Allen, J. (2013). 'The Marmot public health review: how much progress has been made?', *The Guardian*, 1st February 2013. Available at: https://www.theguardian.com/healthcare-network/2013/feb/01/marmot-review-progress-made (accessed 20th December 2020).

Alter, C. and Hage, J. 1993. *Organizations Working Together*, California: Sage.

Anderson, I. (2004). 'Housing, homelessness and the welfare state in the UK', *European Journal of Housing Policy*, Volume 4, Issue 3, Pages 369-389.

Apps, P. (2017). 'ONS confirms reclassification of housing associations', Inside Housing, 16th November 2017. Available at: https://www.insidehousing.co.uk/news/ons-confirms-reclassification-of-housing-associations-53255 (accessed 26th November 2020).

Arblaster, L and Hawtin, M. (1993). *Health, Housing and Social Policy: Homes for Health or Wealth?* London: Socialist Health Association.

Archer, M., Decoteau, C., Gorski, P., Little, D., Porpora, D., Rutzou, T., Smith, C., Steinmetz, G. and Vandenberghe, F. (2016). 'What is critical realism?', *Perspectives*, Volume 38, Pages 4–9.

Aston, E., Thomson, H., Scoular, A. and Kearns, A. (2010). *Evaluation of Glasgow Housing Association's Youth Diversionary Programme*. GoWell.

Atkinson, A. (2013). 'Healthy Inequality, Health Inequity and Health Spending', in N. Eyal, S. Hurst, O.F. Norheim and D. Wikler (eds)., *Inequalities in Health: Concepts, Measures, and Ethics*, Oxford University Press.

Atkinson, R. and Kintrea, K. (2001). 'Disentangling Area Effects: Evidence from Deprived and Non-deprived Neighbourhoods', *Urban Studies*, Volume 38, Issue 12, Pages 2277-2298.

Ayres, S., Flinders, M., Sandford, M. (2017). 'Territory, power and statecraft: Understanding English devolution', *Regional Studies*, 52(6).

Baba, C., Kearns, A., McIntosh, E., Tannahill, C. and Lewsey, J. (2016). 'Is empowerment a route to improving mental health and wellbeing in an urban regeneration (UR) context?' *Urban Studies*. 2017, Volume 54, Issue 7, Pages 1619-1637.

Bagnall, A. M., Southby, K., South, J. and Gamsu, M. (2016). *Housing associations and housing interventions: delivering community-centred approaches for health and wellbeing*. Leeds: Leeds Beckett University.

Bailey, N. (2020). 'Poverty and the re- growth of private renting in the UK, 1994-2018', *PLoS ONE*, Volume 15, Issue 2: e0228273.

Bailey, N. and Pill, M. (2014). 'The potential for neighbourhood regeneration in a period of austerity: changing forms of neighbourhood governance in two cities', *Journal of Urban Regeneration and Renewal*, Volume 7, Issue 2, Pages 150-163.

Baker, E., Beer, A., Lester, L., Pevalin, D., Whitehead, C. and Bentley, R. (2017). 'Is Housing a Health Insult?', *International Journal of Environmental Research and Public Health*, Volume 14, Issue 6.

Bambra, C. (2011). 'Work, worklessness and the political economy of health inequalities', *Journal of Epidemiology & Community Health*. 2011, Volume 65, Pages 746-750.

Bambra, C., Smith, K. E. and Pearce, J. (2019). 'Scaling up: The politics of health and place', *Social Science and Medicine*, Volume 232, Pages, 36-42.

Bambra, C., Riordan, R., Ford, J. and Matthews, F. (2020), 'The COVID-19 pandemic and health inequalities', *Journal of Epidemiology and Community Health*, Volume 74, Issue 11, Pages 964-968.

Barr, B., Bambra, C. and Smith, K. E. (2016). 'For the good of the cause: Generating evidence to inform social policies that reduce health inequalities', in K. E. Smith, S. Hill, and C. Bambra (eds)., *Health Inequalities: critical perspectives*, Oxford University Press.

Barr, D. (2020). 'We are not all in the same boat. We are all in the same storm. Some are on super-yachts. Some have just the one oar', 30th May 2020. Available at: https://www.damianbarr.com/latest/tag/We+are+not+all+in+the+same+boat.+We+are+all+in+the+same+storm. (accessed 16th November 2020).

Barratt, L. (2019). 'Greater Manchester landlords to team up with NHS', *Inside Housing*, 5th April 2019. Available at: https://www.insidehousing.co.uk/news/news/greater-manchester-landlords-to-team-up-with-nhs-60939 (accessed 7th December 2020)

Batty, E., Beatty, C., Foden, M., Lawless, P., Pearson, S. and Wilson, I. (2010). *The New Deal for Communities Experience: A final assessment, The New Deal for Communities Evaluation: Final report – Volume 7*, DCLG.

Bauer, G. R. (2014). 'Incorporating intersectionality theory into population health research methodology: challenges and the potential to advance health equity', *Social Science and Medicine*, Volume 110, Pages 10-17.

Baum, F. E., Bégin, M., Houweling, T. A. J. and Taylor, S. (2009). 'Changes not for the Fainthearted: Reorienting Health Care Systems Toward Health Equity Through Action on the Social Determinants of Health', *American Journal of Public Health*, Volume 99, Issue 11, Pages, 1967-1974.

Baxter, P. and Jack, S. (2008). 'Qualitative Case Study Methodology. Study Design and implementation for Novice Researchers', *The Qualitative Report*, 13(4).

Beatty, C. and Fothergill, S. (2014). 'The local and regional impact of the UK's welfare reforms', *Cambridge Journal of Regions, Economy and Society*, Volume 7, Issue 1, March 2014, Pages 63–79.

Beck, S., Hanlon, P., Tannahill, C., Crawfod, F., Ogilvie, R. and Kearns, A. (2010). 'How will area regeneration impact on health? Learning from the Go Well study', *Public Health*, Volume 24, Issue 3, March 2010, Pages 125-130.

Benbow, E., Crossfield, A., Evison, M., Gilchrist, B., Pike, K., Pilkington, J., Price, S., Wilkins, C., Steer, C. (2020). 'Making smoking history in Greater Manchester', *Public Health Panorama*, Volume 6, Issue 2, June 2020, Pages 317-338.

Beveridge, W, (1942). *Social insurance and allied services: Report by Sir William Beveridge*, London: H.M. Stationery Office.

Bibby, J. (2017). *Healthier lives: Our plans for 2017*, Blog: The Health Foundation. Available at: https://www.health.org.uk/blogs/healthier-lives-our-plans-for-2017 (accessed 16th November 2020).

Birrell, D. and Gray, A. M. (2016). *Delivering Social Welfare: Governance and Service Provision in the UK*, Bristol: Policy Press.

Blair, T. (1997) Leader's speech, Brighton 1997, Labour Party Conference. Available at: http://www.britishpoliticalspeech.org/speech-archive.htm?speech=203 (accessed 20th December 2020).

Blane, D, (2006). 'The life course, the social gradient, and health', in M. Marmot and R. Wilkinson (eds)., *Social Determinants of Health*, Oxford University Press.

Blank, L. Holding, E., Crowder, M., Butterworth, S., Ferrari, E. and Goyder, E. (2019). 'Taking preventative health messages into the wider caring professions: the views of housing staff and tenants', *Journal of Public Health (Oxford)*, Volume 41, Issue 4, Pages 674-680.

Blessing, A. (2013). 'Public, Private, or In-Between? The Legitimacy of Social Enterprises in the Housing Market', *International Journal of Voluntary and Nonprofit Organizations*, Volume 26, Issue 1, Pages 198-221.

Boughton, J. (2018). *Municipal Dreams: The Rise and Fall of Council Housing*, London: Verso Books.

Boughton, J. (2019). 'The rise and fall of housing standards', *Blog: TCPA*, 18th June 2019. Available at: https://www.tcpa.org.uk/blog/the-rise-and-fall-of-housing-standards?utm_source=TCPA+monthly+bulletin&utm_campaign=9488dc3ee3-EMAIL_CAMPAIGN_2017_06_26_COPY_02&utm_medium=email&utm_term=0_6c43bd91d4-9488dc3ee3-107985265 (accessed 11th November 2020)

Bramley, G. and Fitzpatrick, S. (2017). 'Homelessness in the UK: who is most at risk?', *Housing Studies*, Volume 33, Issue 1, Pages 96-116.

Braubach, M. (2011). 'Key challenges of housing and health from a WHO perspective', *International Journal of Public Health*, Volume 56, Pages 579-580.

Braun, V. and Clarke, V. (2006). 'Using thematic analysis in psychology', *Qualitative Research in Psychology*, Volume 3, Issue 2, Pages 77-101.

Braveman, P., Egerter, S. and Williams, D. R. (2011). 'The Social Determinants of Health: Coming of Age', *Annual Review of Public Health*, Volume 32, Pages 381-398.

Braveman, P. A., and Gottlieb, L. M., (2014). 'The social determinants of health: It's time to consider the causes of the causes', *Public Health Reports*, Volume 129, Pages 19-31.

Breysse, J., Jacobs, D., Weber, W., Dixon, S., Kawecki, C., Aceti, S. and Lopez, J. (2011). 'Health Outcomes and Green Renovation of Affordable Housing', *Public Health Reports*, Volume 126, Issue 1, Pages 64-75.

Bromley, P., & Meyer, J. W. (2014). "They are all organizations": The cultural roots of blurring between the nonprofit, business, and government sectors. *Administration & Society*.

Buchs, M. (2009). 'Examining the interaction between vertical and horizontal dimensions of state transformation', *Cambridge Journal of Regions, Economy and Society*, Volume 2, Pages 35-49.

Buck, D. (2020). *The English local government public health reforms: an independent assessment*, The King's Fund. Available at: https://www.kingsfund.org.uk/publications/local-government-public-health-reforms (accessed 16th November 2020)

Buck, D. and Gregory, S. (2018). *Housing and health: Opportunities for sustainability and transformation partnerships*, The King's Fund. Available at: https://www.kingsfund.org.uk/sites/default/files/2018-03/Housing_and_health_final.pdf (accessed 19th November 2020).

Buck, D., Simpson, M. and Ross, S. (2016). 'The economics of housing and health: The role of housing associations', The King's Fund. Available at: https://www.kingsfund.org.uk/publications/economics-housing-health (accessed 11th November 2020)

Buck, D., Baylis, A., Dougall, D. and Robertson, R. (2018). 'A vision for population health: Towards a healthier future', The King's Fund. Available at: https://www.kingsfund.org.uk/publications/vision-population-health (accessed 11th November 2020)

Burridge, R. and Ormandy, D. (1993). 'The legal environment of housing conditions', in R. Burridge and D. Ormandy (eds)., *Unhealthy Housing: research, remedies and reform*, Oxon: Taylor and Francis.

Butler, P. (2019). 'Exclusion of poor tenants highlights fatal flaw in housing policy', The Guardian, 15th May 2019. Available at: https://www.theguardian.com/society/2019/may/15/exclusion-poor-tenants-fatal-flaw-housing-policy (accessed 16th December 2020).

Butler, P. (2020). 'Charities crowded in affluent areas instead of where they are needed, says thinktank', *The Guardian*, 17th January 2020. Available at: https://www.theguardian.com/money/2020/jan/17/charity-gap-highlights-need-to-rebuilt-society-says-thinktank (accessed 16th November 2020).

Byrne, D. and Keithley, J. (1993). 'Housing and the health of the community', in R. Burridge and D. Ormandy (eds)., *Unhealthy Housing: research, remedies and reform*, Oxon: Taylor and Francis.

Byrne, D. (2005). 'Complexity, Configurations and Cases', *Theory, Culture and Society*, Volume 22, Issue 5, Pages 95-111.

Cameron, J. (2005) 'Focussing on the Focus Group', in Hay, I. (ed.), *Qualitative Research Methods in Human Geography*, 2nd ed., Oxford University Press, Melbourne.

Campbell, F. (2008). *Tackling Inequalities: A Programme for Action - final report*, Democratic Health Network, 18th March 2008. Available at: http://lgiu.org/wp-content/uploads/2012/04/Tackling-inequalities-A-programme-for-action-final-report-March08.pdf (accessed 23rd November 2020).

Canning, D. and Bowser, D. (2010). 'Investing in health to improve the wellbeing of the disadvantaged: Reversing he argument of *Fair Society, Healthy Lives* (The Marmot Review)', *Social Science and Medicine*, Volume 71, Pages 1223-1226.

Carey, G., Crammond, B. and De Leeuw, E. (2015). 'Towards health equity: a framework for the application of proportionate universalism', *International Journal for Equity in Health* Volume 14.

Carmichael, L., Barton, H., Gray, S., Lease, H., & Pilkington, P. (2012). 'Integration of health into urban spatial planning through impact assessment: Identifying governance and policy barriers and facilitators', *Environmental Impact Assessment Review*, Volume 32, Issue 1, Pages 187-194.

Case, A. and Deaton, A. (2020). *Deaths of Despair and the Future of Capitalism*, Princeton University Press.

Centre for Social Justice Housing Commission (2018). *Social Housing and Employment: Helping social housing be the springboard to a better life*, London: CSJ.

Chadwick, E. (1842). *Report on the sanitary conditions of the labouring population of Great Britain: A supplementary report on the results of a special inquiry into the practice of interment in towns. Made at the request of Her Majesty's principal secretary of state for the Home department*, London.

Chandra, A. and Vogl, T. (2010). 'Rising up with shoe leather? A comment on *Fair Society, Healthy Lives* (The Marmot Review)', *Social Science and Medicine*, Volume 71, Pages 1227-1230.

Chang, M. and Ross, A. (2015). 'Briefing: Reuniting health and planning in England – reflections from the front line', *Proceedings of the Institution of Civil Engineers: Urban Design and Planning*, Volume 168, Pages 69-74.

Checkland, K., Segar, J., Voorhees, J. and Coleman, A. (2016). '"Like a Circle in a Spiral Like a Wheel within a Wheel": The Layers of Complexity and Challenge for Devolution of Health and Social Care in Greater Manchester', *Representation*, Volume 51, Issue 4, Pages 453-469.

Chevin, D. (2014). *Housing Associations and the NHS: New Thinking, New Partnerships*. London: The Smith Institute.

Clarke, A., Morris, S., Udagawa, C. and Williams, P. (2014). *The role of housing organisations in reducing poverty: a review of strategic and business plans*, York: JRF.

Clarke, J. T. (1924). 'The New Housing Act, 1924', The Town Planning Review, Volume 11, Issue 2, Pages 119-127.

Clarke, S. (2017). *'A-typical' working day in Greater Manchester*, Resolution Foundation. Available at: https://www.resolutionfoundation.org/app/uploads/2017/10/Presentation-for-GM-good-work.pdf (accessed 9th December 2020).

Clifford, B., Canelas, P., Dunning, R., Ferm, J., Livingstone, N. and Lord, A. (2020). *Research into the quality standard of homes delivered through change of use permitted development rights*, MHCLG. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/902220/Research_report_quality_PDR_homes.pdf (accessed 21st December 2020).

Cole, I. and Furbey, R. (1994). *The eclipse of council housing*, London: Routledge.

Cole, I., Green, S., McCarthy, L. and Pattison, B. (2015). *The Impact of the Existing Right to Buy and the Implications for the Proposed Extension of Right to Buy to Housing Associations*, CRESR Project Report, Communities and Local Government Select Committee.

Coleman, A. (1990). *Utopia on trial: vision and reality in planned housing*, 2nd edition, London: H. Shipman.

Coleman, A., Segar, J. and Checkland, K. (2015). 'The Devolution Project in Greater Manchester: Introduction to the Special Issue', *Representation*, Volume 51, Issue 4, Pages 377-384.

Collier, A. (1989). *Scientific Realism and Socialist Thought*, Harvester Wheatsheaf.

Collin, J. and Hill, S. (2016). 'Industrial epidemics and inequalities: The commercial sector as a structural driver of inequalities in non-communicable diseases', in Smith, K., Hill, S. and Bambra, C. (eds.) *Health Inequalities: Critical Perspectives*, Oxford: Oxford University Press.

Committee of Public Accounts (2010). *The Decent Homes Programme*, Twenty-first Report of Session 2009-10, House of Commons Committee of Public Accounts, 18th March 2010, London: The Stationery Office Limited. Available at: https://publications.parliament.uk/pa/cm200910/cmselect/cmpubacc/350/350.pdf (accessed 19th December 2020).

Connolly, A. (2018). 'Improving health and care through the home', *Blog: Public health matters*, 20th March 2018, Public Health England. Available at: https://publichealthmatters.blog.gov.uk/2018/03/20/improving-health-and-care-through-the-home/ (accessed 12th November 2020)

Conservative Party (Great Britain), & Churchill, W. (1951). *The manifesto of the Conservative and Unionist Party*. London: Conservative and Unionist Central Office.

Conway, J. (1993). 'Ill-health and homelessness: the effects of living in bed-and-breakfast accommodation', in R. Burridge and D. Ormandy (eds)., *Unhealthy Housing: research, remedies and reform*, Oxon: Taylor and Francis.

Copeman, I., Edwards, M. and Porteus, J. (2016). *Home from hospital: How housing services are relieving pressure on the NHS*, London: National Housing Federation and Housing LIN.

Corry, D. (2020). *Where are England's charities? Are they in the right places and what can we do if they are not?*, New Philanthropy Capital.

Cox, E. (2019). 'What will be the impact of the Stronger Towns Fund?', *Blog: The RSA*, 5th March 2019. Available at: https://www.thersa.org/blog/2019/03/stronger-towns-fund (accessed 24th November 2020).

Crisis (2019). *Cover the Cost: How gaps in Local Housing Allowance are impacting homelessness*, May 2019, London. Available at: https://www.crisis.org.uk/media/240377/cover_the_cost_2019.pdf (accessed 23rd November 2020).

Crisp, R., Eadson, W. and While, A. (2016). *Tackling poverty through housing and planning policy in city regions*. CRESR and JRF.

Crouch, C. (2011). *The Strange Non-Death of Neoliberalism*, Cambridge: Polity Press.

Crouch, C. (2013). 'From markets versus states to corporations versus civil society', in Armin, S. and Streeck, W. (eds.) *Politics in an Age of Austerity*, Cambridge: Polity Press.

CSDH (2008). *Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health*. Geneva, World Health Organization.

Czischke, D., Gruis, V. and Mullins, D. (2012). 'Conceptualising Social Enterprise in Housing Organisations', *Housing Studies*, Volume 27, Issue 4, Pages 418-437.

Dahlgren, G. and Whitehead, M. (1991). *Policies and strategies to promote social equity in health*, Stockholm: Institute of Futures Studies.

Damm, C., Prinos, I. and Sanderson, E. (2017). *Greater Manchester State of the Voluntary, Community and Social Enterprise Sector 2017: A report on social and economic impact*, Centre for Regional Economic and Social Research, Sheffield Hallam University.

Daniels, N. (2013). 'Reducing Health Disparities: No Simple Matter', in Eyal, N., Hurst, S., Marchand, S., Norheim, O. and Wikler, D., (eds.), *Inequalities in Health*, Oxford University Press.

Danson, M., McApline, R., Spicker, P. and Sullivan, W. (2012). *The Case for Universalism: An assessment of the evidence on the effectiveness and efficiency of the universal welfare state*, The Jimmy Reid Foundation.

Davies, J. S. and Blanco, I. (2017). 'Austerity Urbanism: Patterns of neo-liberalisation and resistance in six cities of Spain and the UK', *Environment and Planning A: Economy and Space*, Volume 49, Issue 7, Pages 1517-1536.

De Groot, L. (1992). 'City Challenge: Competing in the Urban Regeneration Game', *Local Economy: The Journal of the Local Economy Policy Unit*, Volume 7, Issue 3, Pages 196-209.

De Gruchy, J. (2019). 'The lazy language of "lifestyles" – let's rid this from our talk about prevention', *Blog: The Association of Directors of Public Health*, 17th April 2019. Available at: https://www.adph.org.uk/2019/04/the-lazy-language-of-lifestyles-lets-rid-this-from-our-talk-about-prevention/ (accessed 12th November 2020)

De Leeuw, E. (2017). 'Engagement of Sectors Other than Health in Integrated Health Governance, Policy and Action', *Annual Review of Public Health*, Volume 38, Pages 329-49.

De Sa, J. (2017). *How does housing influence our health?*, The Health Foundation. Available at: https://www.health.org.uk/infographic/how-does-housing-influence-our-health (accessed 19th November 2020)

De Sousa, C. A. (2003). 'Turning brownfields into green space in the City of Toronto', *Landscape and Urban Planning*, Volume 62, Issue 4, Pages 181-198.

Deas, I. (2014). 'The search for territorial fixes in subnational governance: City-regions and the disputed emergence of post-political consensus in Manchester, England', *Urban Studies*, Volume 51, Issue 11, Pages 2285-2314.

Deas, I., Haughton, G. and Ward, K. (2020). 'Scalar postpolitics: inclusive growth and inclusive economies: challenging the Greater Manchester agglomeration model', *Cambridge Journal of Regions, Economy and Society*.

Department of Health (1989). *Caring for people: Community care in the next decade and beyond*, London: HMSO.

Department of Health (1998). *Independent inquiry into inequalities in health*. Available at: https://www.gov.uk/government/publications/independent-inquiry-into-inequalities-in-health-report (accessed 11th November 2020)

Department of Health (2007). *Guidance on Joint Strategic Needs Assessment*, December 2007. Available at: https://www.rbkc.gov.uk/pdf/jsna_guidance.pdf (accessed 9th December 2020).

Department of Health and Social Care (2010). *Equity and Excellence: Liberating the NHS*, July 2010. Available at: https://www.gov.uk/government/publications/liberating-the-nhs-white-paper (accessed 19th December 2020).

Department of Health and Social Care (2019). *Advancing our health: prevention in the 2020s – consultation document*, July 2019. Available at:

https://www.gov.uk/government/consultations/advancing-our-health-prevention-in-the-2020s/advancing-our-health-prevention-in-the-2020s-consultation-document (accessed 19th December 2020).

Department of Health and Social Care and Public Health England (2014). *Joint action on improving health through the home: memorandum of understanding*, December 2014. Available at: https://www.gov.uk/government/publications/joint-action-on-improving-health-through-the-home-memorandum-of-understanding (accessed 19th December 2020).

Department of Health and Social Security (1980). *Inequalities in health: Report of a research working group*, London: DHSS.

Disney, R. and Luo, G. (2017). 'The Right to Buy public housing in Britain: A welfare analysis', *Journal of Housing Economics*, Volume 35, Pages 51-68.

Douglas, M. (2016). 'Beyond "health": Why don't we tackle the cause of health inequalities?', in K. E. Smith, S. Hill, and C. Bambra (eds)., *Health Inequalities: critical perspectives*, Oxford University Press.

Dorling, D. (2013). 'Dismantling Universalism: Inequality and Public Health', *Blog: Discover Society*, 5th November 2013. Available at: https://discoversociety.org/2013/11/05/focus-dismantling-universalism-inequality-and-public-health/ (accessed 16th November 2020).

Dupuis, A. and Thorns, D. C. (1998). 'Home, Home Ownership and the Search for Ontological Security', *The Sociological Review*, Volume 46, Issue 1, Pages 24-47.

Easton, G. (2010). 'Critical realism in case study research', *Industrial Marketing Management*, Volume 39.

Ebrahim, A., Battilana, J. and Mair, J. (2014). 'The governance of social enterprises: Mission drift and accountability challenges in hybrid organizations', *Research in Organizational Behaviour*, Volume 34, Pages 81-100.

Edwards, P. and Kenny, D. (1997). *Community Care Trends: The Impact of Funding on Local Authorities*. London: Local Government Management Board (LGMB).

Egan, M., Kearns, A., Katikireddi, S. V., Curl, A., Lawson, K. and Tannahill, C. (2016). 'Proportionate universalism in practice? A quasi-experimental study (GoWell) of a UK neighbourhood renewal programme's impact on health inequalities', *Social Science and Medicine*, Volume 152, Pages 41-49.

Elliot, R. and Timulak, L. (2005). 'Descriptive and interpretive approaches to qualitative research', in In J. Miles & P. Gilbert (Eds.), *A handbook of research methods for clinical and health psychology*. Oxford University Press.

Ellis, H. and Henderson, K. (2013) *Planning out Poverty: The Reinvention of Social Town Planning*, London: TCPA. Available at:

http://www.tcpa.org.uk/data/files/Planning_out_Poverty.pdf (accessed 12th November 2020)

Elwell-Sutton, T., Marshall, L., Bibby, J. and Volmert, A. (2019). *Briefing: Reframing the conversation on the social determinants of health*, The Health Foundation.

Emmett, R. and Van Lohuisen, A. (2015). *Starter Homes: Will they be affordable?*, Shelter. Available at: https://england.shelter.org.uk/__data/assets/pdf_file/0011/1183790/Starter_Homes_FINAL_w_Appendix_v2.pdf (accessed 16th November 2020).

Engels, F. (1872). *The Housing Question*, Der Volksstaat.

English, J. (1992). 'Post-war council housing', in Grant, C. (ed.) *Built to Last: Reflections on British Housing Policy*, London: Roof Magazine.

Etherington, D. and Jones, M. (2016). 'Agreeing to austerity: does signing up to devolution challenge the Northern Powerhouse?', *Blog: Policy@Manchester*, 17th November 2016. Available at: http://blog.policy.manchester.ac.uk/posts/2016/11/agreeing-to-austerity-does-signing-up-to-devolution-challenge-the-northern-powerhouse/ (accessed 16th November 2020).

Fell, G. (2020). 'Marmot 10 years on', Blog: Sheffield DPH, 1st March 2020. Available at: https://gregfellpublichealth.wordpress.com/2020/03/01/marmot-10-years-on/ (accessed 21st December 2020).

Fenton, A., Lupton, R., Arrundale, R., and Tunstall, R. (2013). 'Public housing, commodification, and rights to the city: The US and England compared', *Cities*, Volume 35, Pages 373–378.

Fenton, K. (2015). 'Bringing together housing and public health', *Blog: Public health matters*, PHE, 21st October 2015. Available at: https://publichealthmatters.blog.gov.uk/2015/10/21/bringing-together-housing-and-public-health/ (accessed 24th November 2020).

Ferrari, E. (2015). 'The Social Value of Housing in Straitened Times: The View from England', *Housing studies*, Volume 30, Issue 4, Pages 514-534.

Ferraro, K. F. and Kelley-Moore, J. A. (2003). 'Cumulative Disadvantage and Health: Long-Term Consequences of Obesity?', *American Sociological Review*, Volume 68, Pages 707-729.

Fink, D. S., Keyes, K. M. and Cerdá, M. (2016). 'Social Determinants of Population Health: A Systems Sciences Approach', *Current Epidemiology Reports*, Volume 3, Issue 1, Pages 98-105.

Finnimore, B. (1989). *Houses from the Factory: System Building and the Welfare State 1942-74*, Rivers Oram Press.

Fitzpatrick, S. (2005). 'Explaining homelessness: A critical realist perspective', *Housing Theory and Society*, Volume 22, Pages 1–17.

Fitzpatrick, S., Pawson, H., Bramley, G., Wood, J., Watts, B., Stephens, M. and Blenkinsopp, J. (2019). *The Homelessness Monitor: England 2019*. London: Crisis.

Fitzpatrick, S., Pawson, H. and Watts, B. (2020). 'The limits of localism: a decade of disaster on homelessness in England', *Policy and Politics*, Volume 48, Issue 4, Pages 541-561.

Flyvbjerg, B. (2006). 'Five Misunderstandings About Case Study Research', *Qualitative Inquiry*, Volume 12, Issue 2, Pages 219-245.

Fordham, G. (2010). *The New Deal for Communities Programme: Achieving a neighbourhood focus for regeneration, The New Deal for Communities National Evaluation: Final report – Volume 1*, DCLG.

Fotheringham, D. (2002). 'Room for homes improvement', *The Guardian*, 26th April 2002. Available at: https://www.theguardian.com/society/2002/apr/26/futureforpublicservices.fiveyearsoflabour (accessed 12th November 2020).

Francis-Devine, B. (2020). *Poverty in the UK: statistics*, House of Commons Library Briefing Paper Number 7096, 18th June 2020, House of Commons Library.

Freeman, H. (1993). 'Mental health and high-rise housing', in R. Burridge and D. Ormandy (eds)., *Unhealthy Housing: research, remedies and reform*, Oxon: Taylor and Francis.

Froud, J., Hodson, M., McMeekin, A., Stafford, A., Stapleton, P., Wei, H. and Williams, K. (2018). *From Developer Regeneration to Civic Futures: A new politics for foundational service provision in Greater Manchester*, Alliance Business School, University of Manchester.

Gallagher, R. J., LaMontagne, M. J., Johnson, L. J. (1995). 'Early intervention: The collaborative challenge'. In Johnson, L. J., Gallagher, R. J., LaMontagne, M. J., Jordan, J. B., Gallagher, J. J., Hutinger, P. L., Karnes, M. B. (Eds.), *Meeting early intervention challenges: Issues from birth to three* (2nd ed., pp. 279–288). Baltimore: Brookes.

Gardiner, L. (2019). *The shifting shape of social security: Charting the changing size and shape of the British welfare system*, Resolution Foundation, November 2019. Available at: https://www.resolutionfoundation.org/app/uploads/2019/11/The-shifting-shape-of-social-security.pdf (accessed 16th December 2020).

Gardiner, S. (1986). 'Knock down this disgraceful estate', *The Guardian*, 5th January 1986.

Gardner, J., Gray, M. and Moser, K. (2020). *Debt and Austerity: Implications of the Financial Crisis*, Edward Elgar Publishing Ltd.

Garton Grimwood, G. and Barton, C. (2019). *Permitted Development Rights*, House of Commons Library Briefing Paper Number 485, 17th May 2019, House of Commons Library.

Geddes, I., Allen, J., Allen, M. and Morrisey, L. (2011). 'The Marmot Review: Implications for Spatial Planning', *London: The Marmot Review Team*.

Gentleman, A. (2015). 'Tories have redefined child poverty as not just about having not money', *The Guardian*, 1st July 2015. Available at: https://www.theguardian.com/society/2015/jul/01/tories-redefined-child-poverty-no-longer-finances (accessed 12th November 2020).

Gibson, M., Petticrew, M., Bambra, C., Sowden, A., Wright, K. and Whitehead, M. (2011). 'Housing and health inequalities: A synthesis of systematic reviews of interventions aimed at different pathways linking housing and health', *Health and Place*, Volume 17, Pages 175-184.

Gilmore, A. B., Savell, E. and Collin, J. (2011). 'Public health, corporations and the New Responsibility Deal: Promoting health partnerships with vectors of disease?', *Journal of Public Health*, Volume 33, Issue 1, Pages 2-4.

Ginsburg, N. (1999). 'Putting the Social into Urban Regeneration Policy', *Local Economy: The Journal of the Local Economy Policy Unit*, May 1999, Pages 55-71.

GMCA (2014). *A Plan for Growth and Reform in Greater Manchester*, Greater Manchester Combined Authority. Available at: http://www.oldhampartnership.org.uk/wp-content/uploads/2015/01/GM-Growth-Reform-Plan.pdf (accessed 14th December 2020).

GMCA (2015). *Taking charge of our Health and Social Care in Greater Manchester: The Plan*, Greater Manchester Combined Authority and NHS, December 2015. Available at: http://www.gmhsc.org.uk/wp-content/uploads/2018/04/GM-Strategic-Plan-Final.pdf (accessed 19th December 2020).

GMCA (2019). *Greater Manchester Housing Strategy 2019-2024*, Greater Manchester Combined Authority. Available at: https://www.greatermanchester-ca.gov.uk/media/2257/gm-housing-strategy-2019-2024.pdf (accessed 9th December 2020).

GMCA (2019b). *Greater Manchester Housing Strategy: Implementation Plan*, At end December 2019. Available at:https://www.greatermanchester-ca.gov.uk/media/2653/gm-housing-strategy.pdf (accessed 9th December 2020).

GMCA (2019c). *The Greater Manchester Model: Our white paper on unified public services for the people of Greater Manchester*, Greater Manchester Combined Authority. Available at: https://www.greatermanchester-ca.gov.uk/media/2302/gtr_mcr_model1_web.pdf (accessed 15th December 2020).

GMCA and GMHP (2016). *Greater Manchester Housing Devolution, Growth and Public Service Reform: Memorandum of Understanding*, April 2016, Draft 2. Available at:

http://www.northwardshousing.co.uk/media/134450/12a-memorandum-of-understanding-with-gm-combined-authority.pdf (accessed 19th December 2020).

GMHP (2018). *Manifesto: Our Ambition to Deliver*, Greater Manchester Housing Providers. Available at: https://gmhousing.co.uk/our-ambition-to-deliver/ (accessed 14th December 2020).

GMHSCP (2016). *About Devolution: We're in charge of our own health*, Greater Manchester Health and Social Care Partnership. Available at: https://www.gmhsc.org.uk/about-devolution/ (accessed 15th December 2020).

GMHSCP (2017). *The Greater Manchester Population Health Plan 2017-2021*, Greater Manchester Health and Social Care Partnership. Available at: https://www.gmhsc.org.uk/wp-content/uploads/2018/05/Population-Health-Plan-2017-2021.pdf (accessed 9th December 2020).

GMHSCP (2017b). *Memorandum of Understanding between GM Health & Social Care Partnership & the Voluntary, Community & Social Enterprise Sector*, 27th January 2017. Available at: http://www.gmhsc.org.uk/wp-content/uploads/2018/05/VCSE-MOU-27.01.17.pdf (accessed 9th December 2020).

GMHSCP (2018). *Place-Based Integration and Whole Person Support: the Greater Manchester Model*, Speech by Andy Burnham, Mayor of Greater Manchester, 10th October 2018, Manchester Central. Available at: http://www.dev.gmhsc.org.uk/wp-content/uploads/2018/10/Andy-Burnhams-public-service-reform-speech-2.pdf (accessed 16th December 2020).

Goldberg, D. S. (2012), 'Social Justice, Health Inequalities and Methodological Individualism in Health Promotion', *Public Health Ethics*, Volume 5, Issue 2, Pages 104-115.

Golden, T. L. and Wendel, M. L. (2020). 'Public Health's Next Step in Advancing Equity: Re-evaluating Epistemological Assumptions to Move Social Determinants from Theory to Practice', *Frontiers in Public Health*, Volume 8, Article 131.

Goodair, B., Kenny, M. and Marteau, T. (2020). *Townscapes: England's Health Inequalities*, Cambridge: Bennett Institute for Public Policy.

Graham, H. (2004). 'Tackling health inequalities in England: remedying health disadvantages, narrowing gaps or reducing health gradients', *Journal of Social Policy*, 33, Pages 115-131.

Gray, M. and Barford, A. (2018). 'The depths of the cuts: the uneven geography of local government austerity', *Cambridge Journal of Regions, Economy and Society*, 11(3), 541–563.

Greaves, F. (2019). *Rethinking Allocations*, Coventry: Chartered Institute of Housing. Available at: https://www.thinkhouse.org.uk/site/assets/files/1378/cih0919.pdf (accessed 16th December 2020).

Green, G. (1993). 'Cities 2000 projects: goldfish bowl', in R. Burridge and D. Ormandy (eds)., *Unhealthy Housing: research, remedies and reform*, Oxon: Taylor and Francis.

Greenhalgh, T., Wherton, J., Papoutsi, C., Lynch, J., Hughes, G., A'Court, C., Hinder, S., Fahy, N., Procter, R., and Shaw, S. (2017). 'Beyond Adoption: A New Framework for Theorizing and Evaluating Nonadoption, Abandonment, and Challenges to the Scale-Up, Spread, and Sustainability of Health and Care Technologies', *Journal of Medical Internet Research*, Volume 19, Issue 11.

Gregory, J., Mullins, D., Murie, A. and Redman, P. (2016). *Social Housing and the Good Society*, University of Birmingham.

Greszczuk, C. (2019). *Implementing health in all policies: Lessons from around the world*, The Health Foundation.

Griffiths, R. (Sir) (1988). *Community Care: Agenda for Action*, London: H.M. Stationery Office.

HACT and Placeshapers, (2020), *Places after the pandemic: Exploring social landlords' role in the future of places*. Available at: https://www.hact.org.uk/sites/default/files/PlacesAfterThePandemic_FINAL.pdf (accessed 17th November 2020).

Haigh, F., Kemp, L., Bazeley, P. and Haigh, N. (2019). 'Developing a critical realist informed framework to explain how the human rights and social determinants of health relationship works', *BMC Public Health*, Volume 19

Hall, S. M. (2020). 'Legacies of austerity: rethinking social infrastructures, life-courses and families of the future', Conference presentation, Life on the Breadline, September 2020. Available at: https://breadlineresearch.coventry.ac.uk/resources/mid-project-conference/ (accessed 17th November 2020).

Hallsworth, M., Snijders, V., Burd, H., Prestt, J., Judah, G., Huf, S. and Halpern, D. (2016). *Applying Behavioural Insights: Simple ways to improve health outcomes*, WISH Behavioural Insights Forum.

Ham, C. (2018). *Making sense of integrated care systems, integrated care partnerships and accountable care organisations in the NHS in England*, The King's Fund, 20th February 2018. Available at: https://www.kingsfund.org.uk/publications/making-sense-integrated-care-systems (accessed 24th November 2020).

Harloe, M. (1995). *The People's Home? Social Rented Housing in Europe and America*, Oxford: Blackwell.

Harris, J. (1992). 'War and Social History: Britain and the Home Front during the Second World War', *Contemporary European History*, Volume 1, Issue 1, Pages 17-35.

Harris, T., Hodge, L. and Phillips, D. (2019). *English local government funding: trends and challenges in 2019 and beyond*, The Institute for Fiscal Studies.

Harvey, W. S. (2011). 'Strategies for conducting elite interviews', *Qualitative Research*, Volume 11, Issue 4, Pages 431-444.

Hastings, C. (2020). 'Homelessness and critical realism: a search for richer explanations', *Housing Studies*.

Hastings, A., Bailey, N., Bramley, G. and Gannon, M. (2017). 'Austerity urbanism in England: The "regressive redistribution" of local government services and the impact on the poor and marginalised', *Environment and Planning A*, Volume 49, Issue 9, Pages 2007-2024.

Hastings, A., Bailey, N., Bramley, G., Gannon, M. and Watkins, D. (2015). *The cost of the cuts: The impact on local government and poorer communities*, Joseph Rowntree Foundation.

Haughton, G., Deas, I., Hincks, S. and Ward, K. (2016). 'Mythic Manchester: Devo Manc, the Northern Powerhouse and rebalancing the English economy', *Cambridge Journal of Regions, Economy and Society*, Volume 9, Issue 2, Pages 355-370.

Hausman, D. (2013). 'Egalitarian Critiques of Health Inequalities', in N. Eyal, S. Hurst, O.F. Norheim and D. Wikler (eds)., *Inequalities in Health: Concepts, Measures, and Ethics*, Oxford University Press.

Hayfield, N. and Huxley, C. (2015). 'Insider and Outsider Perspectives: Reflections on Researcher Identities in Research with Lesbian and Bisexual Women', *Qualitative Research in Psychology*, Volume 12, Issue 2, Pages 91-106.

HCA (2017). 'Deregulatory measures for social housing regulation from 6 April 2017', Homes and Communities Agency and Regulator of Social Housing, 31st August 2017. Available at: https://www.gov.uk/guidance/deregulatory-measures-for-social-housing-regulation-from-6-april-2017 (accessed 19th December 2020).

Heath, L. (2020). 'Social landlords' role could be forever changed by pandemic, report finds., *Inside Housing*, 17th September 2020. Available at: https://www.insidehousing.co.uk/news/news/social-landlords-role-could-be-forever-changed-by-pandemic-report-finds-67922 (accessed 17th November 2020).

Hermann, C. (2016). 'The public sector and equality', *Global Social Policy*, Volume 16, Issue 1, Pages 4-21.

Hickman, P. and Robinson, D. (2006). 'Transforming Social Housing: Taking Stock of New Complexities', *Housing Studies*, Volume 21, Issue 2, Pages 157-170.

Higgins, A. (2017). *First Choice Homes Oldham: Draft Strategic Framework for Health and Wellbeing*. Available at:

https://committees.oldham.gov.uk/documents/s90266/Appendix%201%20-%20FCHO%20Strategic%20Framework%20Final.pdf (accessed 17th November 2020).

Higgins, A. (2017b). *First Choice Homes Oldham Strategic Framework for Health and Wellbeing: Evidence review and case for change report*, 11th December 2017, FCHO.

Hildreth, P. (2011). 'What is localism, and what implications do different models have for managing the local economy?', *Local Economy: The Journal of the Local Economy Policy Unit*, Volume 26, Issue 8, Pages 702-714.

Hill, S., Amos, A., Clifford, D. and Platt, S. (2013). 'Impact of tobacco control interventions on socioeconomic inequalities in smoking: review of the evidence', *British Medical Journal*.

Hill, S. (2016). 'Axes of health inequalities in intersectionality', in in K. E. Smith, S. Hill, and C. Bambra (eds)., *Health Inequalities: critical perspectives*, Oxford University Press.

Hills, J. (2017). *Good times, bad times: The welfare myth of them and us*, Revised edition, Bristol Policy Press.

Hills, J., Brewer, M., Jenkins, S., Lister, R., Lupton, R., Machin, S., Mills, C., Modood, T., Rees, T. and Riddell, S. (2010). *An anatomy of economic inequality in the UK: Report of the National Equality Panel*, CASE LSE, Government Equalities Office.

Hirsch, D. and Miller, J. (2004). *Labour's welfare reform: Progress to date*, York: JRF.

Hiscock, R., Kearns, A., Macintyre, S. and Ellaway, A. (2001). 'Ontological Security and Psycho-Social Benefits from the Home: Qualitative Evidence on Issues of Tenure', *Housing, Theory and Society*, Volume 18, Pages 50-66.

Hochschild, J. L. (2009), 'Conducting Intensive Interviews and Elite Interview', *Workshop on Interdisciplinary Standards for Systemic Qualitative Research*. Available at: https://scholar.harvard.edu/jlhochschild/publications/conducting-intensive-interviews-and-elite-interviews (accessed 17th November 2020).

Hodson, M., McMeekin, A., Froud, J. and Moran, M. (2019). 'State-rescaling and re-designing the material city-region: Tensions of disruption and continuity in articulating the future of Greater Manchester', *Urban Studies*, Volume 57, Issue 1, Pages 198-217.

Holding, E., Blank, L., Crowder, M., Ferrari, E. and Goyder, E. (2019). 'Exploring the relationship between housing concerns, mental health and wellbeing: a qualitative study of social housing tenants', *Journal of Public Health*, Volume 42, Issue 3, Pages e231-e238.

Hollander, G. (2019). 'Repairs and maintenance spend tracker, 2019', *Inside Housing*, 17th May 2019. Available at: https://www.insidehousing.co.uk/insight/insight/repairs-and-maintenance-spend-tracker-2019-61428 (accessed 17th November 2020).

Hollis, E. (2009). *The Secret Lives of Buildings: From the Parthenon to the Vegas Strip in Thirteen Stories*, Portobello.

Holt-White, E. (2019). 'Public opinion on the determinants of and responsibility for health', *Blog: The Health Foundation*, 25th January 2019. Available at: https://www.health.org.uk/blogs/public-opinion-on-the-determinants-of-and-responsibility-for-health (accessed 17th November 2020).

Homer, A. (2019). 'Right to Buy homes made £2.8m profit "in weeks"', *BBC Shared Data Unit*, 14th March 2019. Available at: https://www.bbc.co.uk/news/uk-47443183 (accessed 23rd November 2020).

Howden-Chapman, P. (2002). 'Housing and inequalities in health', *Journal of Epidemiology and Community Health*, Volume 56, Issue 9, Pages 645-646.

Howden-Chapman, P. (2010). 'Evidence-based politics: How successful have government reviews been as policy instruments to reduce health inequalities in England?', *Social Science and Medicine*, Volume 71, Pages 1240-1243.

Howden-Chapman, P. and Chapman, R. (2012). 'Health co-benefits from housing-related policies', *Current Opinion in Environmental Sustainability*, Volume 4, Issue 4, Pages 414-419.

Hudson, B., Hardy, B., Henwood, M., Wistow, G. (1999). 'In Pursuit of Inter-Agency Collaboration in the Public Sector: What is the contribution of theory and research?', *Public Management an International Journal of Research and Theory*, Volume 1, Issue 2.

Hudson-Sharp, N., Munro-Lott, N., Rolfe, H. and Runge, J. (2018). *The impact of welfare reform and welfare-to-work programmes: an evidence review*, Equality and Human Rights Commission.

Hunter, D. J. and Marks, L. (2016). 'Health inequalities in England's changing public health system', in Smith, K. E., Hill, S. and Bambra, C. (eds.), *Health Inequalities: critical perspectives*, Oxford University Press.

Hvenmark, J. (2015). Ideology, practice, and process? A review of the concept of managerialism in civil society studies. *Voluntas*.

Ige, J., Pilkington, P., Orme, J., Williams, B., Prestwood, E., Black, D., Carmichael, L. and Scally, G. (2019). 'The relationship between buildings and health: a systematic review', *Journal of Public Health*, Volume 41, Issue 2, Pages e121-e132.

Inman, A. (2020). 'Let's ditch the navel-gazing and stick to the basics', *Inside Housing*, 16th January 2020. Available at: https://www.insidehousing.co.uk/comment/comment/lets-ditch-the-navel-gazing-and-stick-to-the-basics-64741 (accessed 17th November 2020).

Irwell Valley Homes (2018). *Our plan for 2018-2021*. Available at: https://www.irwellvalley.co.uk/media/1996/iv-corporate-plan-a6portrait-webv2.pdf (accessed 22nd December 2020).

Jabbal, J. (2016). Integrating housing, health and care. Blog: The King's Fund, 14th April 2016. Available at: https://www.kingsfund.org.uk/blog/2016/04/housing-health-and-care (accessed 19th November 2020).

Jacobs, D., Wilson, J., Dixon, S.L., Smith, J. and Evens, A. (2009). 'The Relationship of Housing and Population Health: A 30-Year Retrospective Analysis', *Environmental Health Perspectives*, Volume 117, Issue 4, Pages 597-604.

Jacobs, J. (1961). *The Death and Life of Great American Cities*, New York: Random House.

Jacobs, K. and Manzi, T. (2013). 'New Localism, Old Retrenchment: The "Big Society", Housing Policy and the Politics of Welfare Reform', *Housing, Theory and Society*, Volume 30, Issue 1, Pages 29-45.

Jackson, N. (2019). 'Oldham Council leader accuses Prime Minister of "insulting people of town"', *The Oldham Times*, 5th March 2019. Available at: https://www.theoldhamtimes.co.uk/news/17476871.oldham-council-leader-accuses-prime-minister-insulting-people-town/ (accessed 29th November 2020).

Jackson, M. and Nixon, S. (2012). *The Cumulative Impact of Welfare Reform*, Centre for Local Economic Strategies (CLES).

Jencks, C. (1984). *The Language of Post-Modern Architecture*, 4th Edition, Rizzoli.

Johns, M., Lockwood, R., Longlands, S., Qureshi, A. and Round, A. (2020). *State of the North 2020/21: Power Up, Level Up, Rise Up*, Institute for Public Policy Research, IPPR North.

Johnson, L.J., Zorn, D., Tam, B.Y., Lamontagne, M., Johnson, S. (2003). 'Stakeholders' views of factors that impact successful interagency collaboration', *Exceptional Children*, 69(2):195–209.

Jones, C. and Murie, A. (2006). *The Right to Buy: Analysis and Evaluation of a Housing Policy*, Oxford: Blackwell.

JRF Analysis Unit (2018). *Affordable Rents compared to traditional social rent levels*, July 2019, Joseph Rowntree Foundation.

Kabisch, N. (2019). 'Transformation of urban brownfields through co-creation: the multi-functional Lene-Voigt Park in Leipzig as a case in point', *Urban Transformations*, Volume 1, Issue 2.

Kawulich, B. (2012). 'Collecting data through observation', in *Doing Social Research: A Global Context*, Wagner, C., Kawulich, B. and Garner, M. (eds.), Pages 150-160.

Kay, L. (2016). 'Government should not rely on charities to run essential services, says Penny Waterhouse', *Third Sector*, 19th February 2016. Available at: https://www.thirdsector.co.uk/government-not-rely-charities-run-essential-services-says-penny-waterhouse/management/article/1384191 (accessed 17th November 2020).

Kearns, A. Hiscock, R., Ellaway, A. and MacIntyre, S. (2000). '"Beyond Four Walls". The Psycho-social Benefits of Home: Evidence from West Central Scotland', *Housing Studies*, Volume 15, Issue 3, Pages 387-410.

Kearns, A., Ghosh, S., Mason, P. and Egan, M. (2020). 'Could "holistic" area-based regeneration be effective for health improvement?', *Housing Studies*.

Kearns, A., Whitley, E., Mason, P., Petticrew, M. and Hoy, C. (2011). 'Material and meaningful homes: mental health impacts and psychosocial benefits of rehousing to new dwellings', *International Journal of Public Health*, Volume 56, Issue 6, Pages 597-607.

Kerslake, B. (2020). *Make no little plans: Acting at scale for a fairer and stronger future*, February 2020, UK2070 Commission. Available at: http://uk2070.org.uk/wp-content/uploads/2020/02/UK2070-EXEC-SUMMARY-FINAL-REPORT.pdf (accessed 17th November 2020).

Kim, Y. and Warner, M. E. (2018). 'Shrinking local autonomy: corporate coalitions and the subnational state', *Cambridge Journal of Regions, Economy and Society*, Volume 11, Pages 427-441.

King's Fund (2018). *The health care workforce in England: Make or break?*, November 2018, London: The King's Fund. Available at: https://www.kingsfund.org.uk/sites/default/files/2018-11/The%20health%20care%20workforce%20in%20England.pdf (accessed 17th December 2020).

King's Fund (2019). 'Integrating housing and health: joining up care', online event, 11th July 2019. Available at: https://www.kingsfund.org.uk/events/integrating-housing-and-health (accessed 18th December 2020)

Kintrea, K. (2007). 'Policies and programmes for disadvantaged neighbourhoods: recent English experience', *Housing Studies*, Volume 22, Issue 2, Pages 261-282.

Kvale, S. (1994). 'Ten standard objections to qualitative research interviews', *Journal of Phenomenological Psychology*, Volume 25, Issue 2, Pages 147-173.

L&Q, (2018). *About L&Q: Our History*. Available at: https://www.lqgroup.org.uk/about-landq/our-history (accessed 23rd November 2020).

Lachowycz, K. and Jones, A. P. (2014). 'Does walking explain associations between access to greenspace and lower mortality?', *Social Science and Medicine*, Volume 107, Pages 9-17.

Larsen, C. A. (2008). 'The institutional logic of welfare attitudes: How welfare regimes influence public support', *Comparative Political Studies*, Volume 41, Issue 2, Pages 145-168.

Laing, R. D. (1965). *The Divided Self: an existential study in sanity and madness*, London: Pelican Press.

Laverack, G. and Labonte, R. (2000). 'A planning framework for community empowerment goals within health promotion', *Health Policy and Planning*, Volume 15, Issue 3, Pages 255-262.

Lawless, P. (2012). 'Can area-based regeneration programmes ever work? Evidence from England's New Deal for Communities Programme', *Policy Studies*, Volume 33, Issue 4, Pages 313-328.

Lawless, P., Foden, M., Wilson, I. and Beatty, C. (2010). 'Understanding Area-based Regeneration: The New Deal for Communities Programme in England', *Urban Studies*, Volume 47, Issue 2, Pages 257-275.

Lawrence, R. J. (1993). 'An ecological blueprint for healthy housing', in R. Burridge and D. Ormandy (eds)., *Unhealthy Housing: research, remedies and reform*, Oxon: Taylor and Francis.

Lawrence, R. J. (2004). 'Housing and health: from interdisciplinary principles to transdisciplinary research and practice', *Futures*, Volume 36, Issue 4, Pages 487-502.

Lawrence, R. J. (2006). 'Housing and Health: Beyond Disciplinary Confinement', *Journal of Urban Health*, Volume 83, Pages 540-549.

Lawrence, R. J. (2011). 'Housing for health promotion', *International Journal of Public Health*, Volume 56, Pages 577-578.

Lawrence, R. J. (2017). 'Constancy and Change: Key Issues in Housing and Health Research, 1987-2017', *International Journal of Environmental Research and Public Health*, Volume 14.

Le Corbusier. (1929). *The City of Tomorrow and its Planning*, London: Rodker.

Le Corbusier. (1991). 'The Voisin Plans for Paris', *Précisions*, Cambridge, MA: MIT Press.

Leatherdale, S. T. (2018). 'Natural experiment methodology for research: a review of how different methods can support real-world research', *International Journal of Social Research Methodology*, Volume 22, Issue 1, Pages 19-35.

Levitas, R. (2012). *There may be 'trouble' ahead: what we know about those 120,000 'troubled families'*, Poverty and Social Exclusion in the UK, Policy Response Series No.3.

Leng, G. (2015). 'Home is where the health is: A Greater Manchester Programme', *Representation*, Volume 51, Issue 4, Pages 485-492.

Libman, K., Fields, D. and Saegert, S. (2012a). 'Housing and Health: A Social Ecological Perspective on the US Foreclosure Crisis', *Housing, Theory and Society*, Volume 29, Issue 1, Pages 1-24.

Libman, K., Fields, D. and Saegert, S. (2012b). 'Towards a research agenda at the intersections of housing and health', *Housing, Theory and Society*, Volume 29, Issue 1, Pages 47-55.

Light, D. W. (2003). 'Universal Health Care: Lessons from the British Experience', *American Journal of Public Health*, Volume 93, Issue 1, Pages 25-30.

Link, B. and Phelan, J. (1995). 'Social conditions as fundamental causes of disease', *Journal of health and social behaviour*, Extra Issue, Pages 80-95.

Lobao, L., Gray, M., Cox, K. and Kitson, M. (2018). 'The shrinking state? Understanding the assault on the public sector', *Cambridge Journal of Regions, Economy and Society*, Volume 11, Issue 3, Pages 389-408.

Local Government Associations (2016). *Charting Progress on the Health Devolution Journey: Early Lessons from Greater Manchester*, March 2016, London: LGA. Available at: https://www.local.gov.uk/sites/default/files/documents/charting-progress-health--d30.pdf (accessed 16th December 2020).

Longhurst, R. (2016). 'Semi-structured Interviews and Focus Groups', in Clifford, N., Cope, M., Gillespie, T. and French, S. (eds.), *Key Methods in Geography*, SAGE Publishing.

Lorne, C., Coleman, A., McDonald, R. and Walshe, K. (2020). 'Assembling the Healthopolis: Competitive city-regionalism and policy boosterism pushing Greater Manchester further, faster', *Transactions of the Institute of British Geographers*, in press 10th October 2020.

Lowe, S. (2004). *Housing Policy Analysis: British Housing in Culture and Comparative Context*, Basingstoke: Palgrave Macmillan.

Lu, D. and Tyler, I. (2015). *Focus on: A proportionate approach to priority populations*, Ontario Agency for Health Protection and Promotion (Public Health Ontario), Toronto.

Lupton, R. (2003). *"Neighbourhood Effects": Can we measure them and does it matter?*, CASEpaper 73, London, CASE.

Lupton, R. (2017). *The Challenge for Greater Manchester: Education and Skills in the Era of Devolution*, University of Manchester.

Lupton, R., Hughes, C., Macdougall, A., Goldwyn-Simpkins, H. and Hjelmskog, A. (2019). *Inclusive Growth in Greater Manchester 2020 and Beyond*, Inclusive Growth Analysis Unit, University of Manchester.

Lupton, R., Hughes, C., Peake-Jones, S. and Cooper, K. (2018). *City-region devolution in England*, SPDO research paper 2, LSE.

Lynch, J. (2017). 'Reframing inequality? The health inequalities turn as a dangerous frame shift', *Journal of Public Health*, Volume 39, Issue 4, Pages 653-660.

Lynch, J., Law, C., Brinkman, S., Cittleborough, C. and Sawyer, M. (2010). 'Inequalities in child healthy development: Some challenges for effective implementation', *Social Science and Medicine*, Volume 71, Pages 1244-1248.

MacIntyre, S. (2008). *Bridging the gap: a health inequalities learning resource*. Available at: https://silo.tips/download/produced-for-the-scottish-government-by-rr-donnelley-b-08 (accessed 22nd December 2020).

Mack, J. (2016). *Social Exclusion*, Poverty and Social Exclusion. Available at: https://www.poverty.ac.uk/definitions-poverty/social-exclusion (accessed 14th November 2020).

Mackenbach, J. P. (2010). 'Has the English strategy to reduce health inequalities failed?', *Social Science and Medicine*, Volume 71, Pages 1249-1253.

Mackenbach, J. P. (2012). 'The persistence of health inequalities in modern welfare states: the explanation of a paradox', *Social Science and Medicine*, Volume 75, Pages 761-769.

MacKinnon, D. (2015). 'Devolution, state restructuring and policy divergence in the UK', *The Geographical Journal*, Volume 181, Issue 1, Pages 47-56.

Madden, D. and Marcuse, P. (2016). *In Defense of Housing: The Politics of Crisis*, London: Verso.

Magnan, S. (2017). 'Social Determinants of Health 101 for Health Care: Five Plus Five'. *NAM Perspectives*. Discussion Paper, National Academy of Medicine, Washington, DC.

Maier, F., & Meyer, M. (2011). Managerialism and beyond: Discourses of civil society organization and their governance implications. *Voluntas*, 22, 731-756.

Maier, F., Meyer, M., & Steinbereithner, M. (2016). Nonprofit organizations becoming business-like: A systematic review. *Nonprofit and Voluntary Sector Quarterly*, 45, 64-86.

Mair, F. S. and Jani, B. D. (2020). 'Emerging trends and future research on the role of socioeconomic status in chronic illness and multimorbidity', *The Lancet*, Volume 5, e128-e129.

Malin, N. (2020). *De-Professionalism and Austerity: Challenges for the Public Sector*, Bristol: Policy Press.

Malpass, P. (2005). *Housing and the Welfare State: The Development of Housing Policy in Britain*, Basingstoke: Palgrave Macmillan.

Malpass, P. (2008). 'Housing and the New Welfare State: Wobbly Pillar or Cornerstone?', *Housing Studies*, Volume 23, Issue 1, Pages 1-19.

Malpass P., and Murie, A. (1994). *Housing Policy and Practice*, London: Macmillan.

Malterud, K., Siersma, V. D. and Guassora, A. D. (2016). 'Sample Size in Qualitative Interview Studies: Guided by Information Power', *Qualitative Health Research*, Volume 26, Issue 13, Pages 1753-1760.

Manchester City Council (2016). *Joint Strategic Needs Assessment: Area Profiles*. Available at: https://www.manchester.gov.uk/info/500230/joint_strategic_needs_assessment/7011/area_profiles (accessed 9th December 2020).

Manchester City Council (2020). 'Mosscare St Vincent's Housing Group', updated 7th February 2020. Available at: https://hsm.manchester.gov.uk/kb5/manchester/directory/service.page?id=ODgjJiZXJqU (accessed 22nd December 2020).

Manzi, T., and Morrison, N. (2018). 'Risk, commercialism and social purpose: Repositioning the English housing association sector', *Urban Studies*. Volume 55, Issue 9, Pages 1924-1942.

Marmot, M. (2015). *The Health Gap: The Challenge of an Unequal World*, Bloomsbury.

Marmot, M., Allen, J., Goldblatt, P., Boyce, T., McNeish, D., Grady, M. and Geddes, I. (2010). *Fair Society, Healthy Lives. The Marmot Review*, Institute of Health Equity, UCL.

Marmot, M., Allen, J. and Goldblatt, P. (2010b). 'A social movement, based on evidence, to reduce inequalities in health', *Social Science and Medicine*, Volume 71, Pages 1254-1258.

Marmot, M., Allen, J., Boyce, T., Goldblatt, P. and Morrison, J. (2020). *Health Equity in England: The Marmot Review 10 Years On*, Institute of Healthy Equity, UCL.

Marmot, M. and Bell, R. (2012). 'Fair society, healthy lives', *Public Health*, Volume 126, Pages s4-s10.

Marwell, N. P. (2004). 'Privatizing the Welfare State: Nonprofit Community-based Organizations as Political Actors', *American Sociological Review*, Volume 69, Pages 265-291.

Mason, A., Goddard, M., Weatherly, H. and Chalkley, M. (2015). 'Integrating funds for health and social care: an evidence review', *Journal of Health Services Research and Policy*, Volume 20, Issue 3, Pages 177-188.

Mason, J. (2002). *Qualitative Researching*, 2nd Edition, London: SAGE Publications.

Mason-Bish, H. (2018). 'The elite delusion: reflexivity, identity and positionality in qualitative research', *Qualitative Research*, Volume 19, Issue 3, Pages 263-276.

Matheson, A. (2020). 'Health Inequality as a Large-Scale Outcome of Complex Social Systems: Lessons for Action on the Sustainable Development Goals', *International Journal of Environmental Research and Public Health*, Volume 17.

McCann, K. (2013). 'Top tips: troubled families – what works?', *The Guardian*, 2nd February 2013. Available at: https://www.theguardian.com/local-government-network/2013/feb/02/top-tips-troubled-families-initiative (accessed 21st December 2020).

McCulloch, A. (2001). 'Ward-level deprivation and individual social and economic outcomes in the British Household Panel Study', *Environment and Planning A*, Volume 33, Pages 667-684.

McGovern, L., Miller, G. and Hughes-Cromwick, P. (2014). 'Health Policy Brief: The Relative Contribution of Multiple Determinants to Health Outcomes', *Health Affairs*, August 21, 2014.

McKee, M. and Stuckler, D. (2011). 'The assault on universalism: how to destroy the welfare state', *BMJ*, 20th December 2011; 343:d797.

McKenna, H. and Dunn, P. (2015). *Devolution: What it means for health and social care in England*, The King's Fund, 11th November 2015. Available at: https://www.kingsfund.org.uk/publications/devolution (accessed 16th December 2020).

McManus, J. and Fell, G. (2020). 'Councils can be trusted with Public Health', *Blog: The Commonplace Book*, 21st January 2020. Available at: https://jimmcmanus.wordpress.com/2020/01/21/councils-can-be-trusted-with-public-health/ (accessed 16th December 2020).

MHCLG (2012). *National Planning Policy Framework* (NPPF). Available at: https://www.gov.uk/government/publications/national-planning-policy-framework--2 (accessed 19th December 2020).

MHCLG (2016). *Welfare Reform and Work Act 2016 – social rent reduction*, 21st March 2016. Available at: https://www.gov.uk/guidance/welfare-reform-and-work-act-2016-social-rent-reduction (accessed 9th December 2020).

MHCLG (2019). *Housing statistics and English Housing Survey glossary*, Ministry of Housing, Communities and Local Government, 15th January 2019. Available at:

https://www.gov.uk/guidance/housing-statistics-and-england-housing-survey-glossary/a-to-z#prp (accessed 27th November 2020).

MHCLG (2019b). *English Housing Survey: Headline Report, 2018-2019*, Ministry of Housing, Communities and Local Government. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/860076/2018-19_EHS_Headline_Report.pdf (accessed 19th December 2020).

MHCLG (2020). *Social Housing Lettings: April 2018 to March 2019, England*, Housing Statistical Release, Ministry of Housing, Communities and Local Government, 28th January 2020. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/861471/Social_Housing_Lettings_in_England_April_2018_to_March_2019.pdf (accessed 19th December 2020).

MHCLG (2020b). *Planning for the Future*, Ministry of Housing, Communities and Local Government, White Paper August 2020. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/907647/MHCLG-Planning-Consultation.pdf (accessed 20th December 2020).

Mitchell, G. E. (2018). 'Modalities of Managerialism: The "Double Bind" of Normative and Instrumental Nonprofit Management Imperatives', *Administration & Society*. Volume 50(7)

Mitchell, R. and Popham, F. (2008). 'Effect of exposure to natural environment on health inequalities: an observational population study', *Lancet*, Volume 372(9650), Pages 1655-1660.

Molyneux, P. (2016). 'Are we doing the right thing to help people with Hoarding Disorder?', *Blog: HACT*, 3rd June 2016. Available at: https://www.hact.org.uk/blog/2016/06/03/are-we-doing-right-thing-help-people-hoarding-disorder (accessed 19th December 2020).

Moore, B. (2012). 'Why housing associations should build commercial property', *The Guardian*, 28th August 2012. Available at: https://www.theguardian.com/housing-network/2012/aug/28/social-housing-associations-commercial-property (accessed 19th December 2020).

Mr Anonymous (2017). 'Housing officers or social workers?', *Inside Housing*, 12th January 2017. Available at: https://www.insidehousing.co.uk/comment/comment/housing-officers-or-social-workers-49564 (accessed 12th December 2020).

Mumford, L. (1961). *The City in History*, San Diego: Harcourt.

Murie, A. (1998). 'Segregation, exclusion and housing in the divided city', in S. Musterd and W. Ostendorf (eds.), *Urban segregation and the Welfare State, Inequality and Exclusion in Western Cities*, London: Routledge.

Murie, A. (2007). 'The social rented sector, housing and the welfare state in the UK', *Housing Studies*, Volume 12, Issue 4, Pages 437-461.

Murie, A. (2012). 'Housing in the welfare state: Partitioning places and people', *Local Economy*, Volume 27 (5-6), Pages 480-485.

Murie, A. (2018). 'Shrinking the state in housing: challenges, transitions and ambiguities', *Cambridge Journal of Regions, Economy and Society*, Volume 11, Issue 3, Pages 485-501.

Mullins, D. (2000), 'Social Origins and Transformations: The Changing Role of English Housing Associations', *Voluntas: International Journal of Voluntary and Nonprofit Organizations*, Volume 11, Issue 3, Pages, 255-275.

Mullins, D. (2006), 'Competing institutional logics? Local accountability and scale and efficiency in an expanding non-profit housing sector', *Public Policy and Administration*, Volume 21, Issue 6, Pages 6-24.

Mullins, D. (2016). The changing role of housing associations. In *The Third Sector Delivering Public Services: Developments, Innovations and Challenges*, Bristol: Policy Press.

Mullins, D. and Jones, T. (2015), 'From "contractors to the state" to "protectors of public value"? Relations between non-profit housing hybrids and the state in England', *Voluntary Sector Review*, Volume 6, Issue 3, Pages 261-283.

Mullins, D., Milligan, V. and Nieboer, N. (2017). 'State directed hybridity? – The relationship between non-profit housing organizations and the state in three national contexts', *Housing Studies*, Volume 33, Pages 565-588.

Murtha, T. (2019). 'Right to Buy round three: the sector must resist the latest attempt to sell off social homes', *Inside Housing*, 2nd October 2019. Available at: https://www.insidehousing.co.uk/comment/right-to-buy-round-three-the-sector-must-resist-the-latest-attempt-to-sell-off-social-homes-63528 (accessed 16th December 2020).

Nanda, S., Thomas, C., Statham, R. and Emden, J. (2020). 'Editorial – Universalism and the Welfare State', Institute of Public Policy Research, 13th July 2020. Available at: https://www.ippr.org/juncture-item/editorial-universalism-and-the-welfare-state (accessed 12th December 2020).

Nathanson, C. and Hopper, K. (2010). 'The Marmot Review – Social revolution by Stealth', *Social Science and Medicine*, Volume 71, Pages 1237-1239.

Natill, M. (2020). 'Worlds of last-resort safety nets? A proposed typology of minimum income schemes in Europe', *Journal of International and Comparative Social Policy*, Volume 36, Issue 1, Pages 57-75.

National Children's Bureau (2016). *Housing and the Health of Young Children: Policy and evidence briefing for the VCSE sector*, April 2016. Available at:

https://www.ncb.org.uk/sites/default/files/field/attachment/Housing%20and%20the%20Health%20of%20Young%20Children.pdf (accessed 9th December 2020).

National Housing Federation (2010). *Health and housing: worlds apart?*, London: NHF.

National Housing Federation (2016). *Health professionals' attitudes to evidence and the influence it has on decision making: Connecting Housing and Health Report*, London: NHF. Available at: https://www.housinglin.org.uk/_assets/Resources/Housing/OtherOrganisation/NHF_Health_report_1_Final.pdf (accessed 19th December 2020).

Naylor, C. (2012). 'CCGs and PCTs – not so different after all?', *Blog: The King's Fund*, 17th July 2012. Available at: https://www.kingsfund.org.uk/blog/2012/07/ccgs-and-pcts-not-so-different-after-all (accessed 18th November 2020).

Nazroo, J. Y. (2003). 'The Structuring of Ethnic Inequalities in Health: Economic Position, Racial Discrimination and Racism', *American Journal of Public Health*, Volume 93, Issue 2, Pages 277-284.

New Economy and LGA. Learning from English Devolution Deals. Available at: https://www.local.gov.uk/sites/default/files/documents/learning-english-devoluti-c09.pdf (accessed 19th November 2020)

Newman, O. (1961). 'International Congress for Modern Architecture, *C.I.A.M '59 in Otterlo*, London: Tiranti.

Nieboar, N. and Gruis, V. (2014). 'Shifting back – Changing organisational strategies in Dutch social housing', *Journal of Housing and Built Environment*, Volume 29, Pages 1-13.

NHS Health Scotland (2014). *Proportionate universalism and health inequalities*. Available at: http://www.healthscotland.com/uploads/documents/24296-ProportionateUniversalismBriefing.pdf (accessed 9th December 2020)

NHS Health Scotland (2016). *Housing and health inequalities*, Inequality Briefing 5. Available at: http://www.healthscotland.scot/media/1250/housing-and-health_nov2016_english.pdf (accessed 9th December 2020).

NHSE (2014). *Five Year Forward View*, October 2014. Available at: https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf (accessed 16th December 2020).

NHS (2017). 'Better Care Fund', Available at: https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/ (accessed 19th December 2020).

Nord, E., Richardson, J., Street, A., Kuhse, H. and Singer, P. (1995). 'Maximising health benefits vs egalitarianism: An Australian survey of health issues', *Social Science and Medicine*, Volume 41, Issue 10, Pages 1429-1437.

Norman, C. (2017). 'Health begins at home', *Blog: Greater Manchester Health and Social Care Partnership*, 28th June 2017. Available at: https://www.gmhsc.org.uk/opinion/health-begins-at-home/ (accessed 7th December 2020)

Norman, C. (2020). 'To truly invest in the future, England needs its own Well-being of Future Generations Act', *Inside Housing*, 8th October 2020. Available at: https://www.insidehousing.co.uk/comment/comment/to-truly-invest-in-the-future-england-needs-its-own-well-being-of-future-generations-act-68109 (accessed 21st November 2020).

Nussbaum, M. (2011). *Creating capabilities: The Human Development Approach*, Belknap Press: Harvard University.

O'Reilly, M. and Parker, N. (2012). 'Unsatisfactory saturation: A critical exploration of the notion of saturated sample sizes in qualitative research', *Qualitative Research*, Volume 19, Issue 2, Pages 190-197.

Okato, A., Hashimoto, T., Tanaka, M., Saito, N., Endo, M., Okayama, J., Ichihara, A., Eshima, S., Handa, S., Senda, M., Sato, Y., Watanabe, H., Nakazato, M. and Iyo, M. (2020). 'Inter-agency collaboration factors affecting multidisciplinary workers' ability to identify child maltreatment', *BMC Research Notes*, Volume 13.

Oldham Council (2016). *Oldham Social Value Charter and Framework 2016*, Oldham Partnership. Available at: http://www.oldhampartnership.org.uk/wp-content/uploads/2016/08/Oldham-Social-Value-Charter-and-Framework-2016.pdf (accessed 30th November 2020).

Oldham Council (2019). *Oldham in Profile*, Oldham MBC Business Intelligence Service. Available at: https://www.oldham.gov.uk/downloads/file/4740/oldham_in_profile_2017_pdf_format (accessed 30th November 2020).

Oldham Council (2019b). *Oldham Joint Strategic Needs Assessment*, Oldham Cares. Available at: http://www.oldham-council.co.uk/jsna/ (accessed 9th December 2020).

Osborne, H. (2016). 'Four in 10 British Homes not up to standard, says Shelter', *The Guardian*, 16th October 2016. Available at: https://www.theguardian.com/society/2016/oct/16/four-in-10-british-homes-not-up-to-standard-says-shelter (accessed 14th November 2020)

Park, J. (2017). *One hundred years of housing space standards: What now?*, Levitt Bernstein.

Parkin, E. (2019). *Health and Social Care Integration*, House of Commons Library Briefing Paper Number 7902, 17th December 2019, House of Commons Library.

Pawson, H. and Mullins, D. (2010). *After Council Housing: Britain's New Social Landlords*, London: Palgrave Macmillan.

Pawson, H. and Sosenko, F. (2012). 'Tenant satisfaction assessment in social housing in England: How reliable? How meaningful?', *International Journal of Consumer Studies*, Volume 36, Issue 1, Pages 70-79.

Pawson, R. and Tilley, N. (1997). *Realistic evaluation*, SAGE.

Pearce, J., Mitchell, R. and Short, N. (2016). 'Place, space and health inequalities', in Smith, K. E., Hill, S. and Bambra, C. (eds.), *Health Inequalities: critical perspectives*, Oxford University Press.

Peck, J. (2014). 'State Failure, Municipal Bankruptcy and the Crisis of Fiscal Federalism in the United States', *Cambridge Journal of Regions, Economy, and Society*, Volume 7, Issue 1, Pages 17-44.

Peck, J. and Tickell, A. (2012). 'Apparitions of neoliberalism: revisiting "Jungle law breaks out"', *Area*, Volume 44, Issue 2, Pages 245-249.

Petticrew, M. (2007). '"More research needed": plugging gaps in the evidence base on health inequalities', *European Journal of Public Health*, Volume 17, Issue 5, Pages 411-413.

PHE (2016). *Public Health Outcomes Framework*, online tool, Public Health England. Available at: https://fingertips.phe.org.uk/profile/public-health-outcomes-framework (accessed 9th December 2020).

Pickett, K. and Dorling, D. (2010). 'Against the organization of misery? The Marmot Review of health inequalities', *Social Science and Medicine*, Volume 71, Pages 1231-1233.

Pierse, N., Carter, K., Bierre, S., Law, D. and Howden-Chapman, P. (2016). 'Examining the role of tenure, household crowing and housing affordability on psychological distress, using longitudinal data', *Journal of Epidemiology and Community Health*, Volume 70, Pages 961-966.

Pierson, J. H. (2016). *Tackling Poverty and Social Exclusion: Promoting Social Justice in Social Work*, 3rd Edition, Routledge.

Pinoncely, V. (2016). *Poverty, place and inequality: Why place-based approaches are key to tackling poverty and inequality*, RTPI.

Porpora, D. (2016). *Reconstructing Sociology: The Critical Realist Approach*, Cambridge: Cambridge University Press.

Power, A. (2015). 'Debt, sanctions and skipped meals: how welfare reform affects social tenants', *The Guardian*, 26th March 2015. Available at:

https://www.theguardian.com/housing-network/2015/mar/26/debt-sanctions-and-skipped-meals-how-welfare-reform-affects-social-tenants (accessed 17th December 2020).

Power, A. (2017). *An Agenda for Housing Plus*, CASE Report 111, January 2019, LSE Housing and Communities.

Power, A., Belotti, A., Lane, L. and Provan, B. (2018). *Private Renting: Can social landlords help?*, CASE Report 113, January 2018, LSE Housing and Communities. Available at: https://sticerd.lse.ac.uk/dps/case/cr/casereport113.pdf (accessed 14th December 2020)

Power, A., Provan, B., Herden, E. and Serle, N. (2014). *The Impact of Welfare Reform on Social Landlords and Tenants*, Joseph Rowntree Foundation.

Pratt, B., Merritt, M. and Hyder, A. (2016). 'Towards deep inclusion for equity-oriented research priority-setting: A working model', *Social Science and Medicine*, Volume 151, Pages 215-224.

Pratt, J., Plamping, D. and and P. Gordon, P. (1999), *Working Whole Systems: Putting Theory into Practice in Organisations*, London: The King's Fund.

Preece, J., Hickman, P. and Pattison, B. (2019). 'The affordability of "affordable" housing in England: conditionality and exclusion in a context of welfare reform', *Housing Studies*, Volume 35, Issue 4, Pages 1-25.

Price, S. (2020). 'Greater Manchester is a "Marmot City Region" – What does that mean and how will it improve our health and reduce inequalities?', GMHSCP, 4th March 2020. Available at: https://www.gmhsc.org.uk/opinion/greater-manchester-is-a-marmot-city-region-what-does-that-mean-and-how-will-it-improve-our-health-and-reduce-inequalities/ (accessed 16th December 2020).

Prochorskaite, A., Couch, C., Malys, N. and Maliene, V. (2016). 'Housing Stakeholder Preferences for the "Soft" Features of Sustainable and Healthy Housing Design in the UK', *International Journal of Environmental Research and Public Health*, Volume 13, Issue 1

Rae, A. (2011). 'Learning from the Past? A Review of Approaches to Spatial Targeting in Urban Policy', *Planning Theory and Practice*, Volume 12, Issue 3, Pages 331-348.

Rae, A., Hamilton, R., Crisp, R. and Powell, R. (2016). *Overcoming deprivation and disconnection in UK cities*, York: JRF.

Rahman, F. and Whittaker, M. (2019). 'To understand inequality, we need to understand its intersections too', The Resolution Foundation, 6th March 2019. Available at: https://www.resolutionfoundation.org/comment/to-understand-inequality-we-need-to-understand-its-intersections-too/ (accessed 26th November 2020).

Raleigh, V. (2020). *What is happening to life expectancy in he UK?*, The King's Fund, 26th June 2020. Available at: https://www.kingsfund.org.uk/publications/whats-happening-life-expectancy-uk (accessed 23rd November 2020).

Ranade, W., and Hudson, B. (2003). 'Conceptual Issues in Inter-Agency Collaboration', *Local Government Studies*, 29:3.

Rawls, J. (1971). *A Theory of Justice*, Harvard University Press.

Rees, J. and Mullins, D. (eds.) (2016). *The Third Sector Delivering Public Services: Developments, Innovations and Challenges*, Bristol: Policy Press.

Rees, J. and Rose, N. (2015), 'New 'new localism' or the emperor's new clothes: diverging local social policies and state-voluntary sector relations in an era of localism', *Voluntary Sector Review*, Volume 6, Issue 1, Pages 81-91.

Reeve, K. (2017). 'Welfare conditionality, benefit sanctions and homelessness in the UK: ending the "something for nothing culture" or punishing the poor?', *Journal of Poverty and Social Justice*, Volume 25, Issue 1, Pages 65-78.

Rhem, P., Hacker, J. S. and Schlesinger, M. (2012). 'Insecure Alliances: Risk, Inequality, and Support for the Welfare State', *The American Political Science Review*, Volume 106, Issue 2, Pages 386-406.

Rigby, L. (2017). 'Sure Start worked. So why is Theresa May out to kill it?', *The Guardian*, 6th February 2017. Available at: https://www.theguardian.com/commentisfree/2017/feb/06/sure-start-children-worked-why-theresa-may-out-to-kill-it (accessed 14th November 2020)

Richardson, J., Barker, L., Furness, J. and Simpson, M. (2014). *Frontline Futures: new era, changing role for housing officers*, Coventry: CIH.

Riverside (2017). '85% less supported housing built due to uncertainty with government's LHA plans', *Riverside News & Blog*, 25th August 2017. Available at: https://www.riverside.org.uk/less-supported-housing-built-due-uncertainty-government-lha-plans/ (accessed 18th December 2020).

Roberts, J.M. (2014). 'Critical Realism, Dialectics, and Qualitative Research Methods', *Journal for the Theory of Social Behaviour*, Volume 44, Issue 1.

Robinson, D. (1998). 'Health Selection in the Housing System: Access to Council Housing for Homeless People with Health Problems', *Housing Studies*, Volume 13, Issue 1, Pages 23-41.

Robinson, D., and Walshaw, A. (2014). 'Security of tenure in social housing in England', *Social Policy and Society*, Volume 13, Issue 1, Pages 1-12.

Rolfe, S., Garnham, L., Anderson, I., Seaman, P., Godwin, J. and Donaldson, C. (2019). 'Hybridity in the housing sector: examining impacts on social and private rented sector tenants in Scotland', *Housing Studies*.

Rosen, J., O'Neill, M. and Hutson, M. (2018). 'The Important Role of Government in Comprehensive Community Initiatives: A Case Study Analysis of the Building Healthy Communities Initiative', *Journal of Planning Education and Research*.

Rowley, J. (2002). 'Using Case Studies in Research', *Management Research News*, Volume 25, Issue 1, Pages 16-27.

Rowlingson, K. (2011). *Does income inequality cause health and social problems?*, Joseph Rowntree Foundation.

Ruths, M. B. (2009). 'The lesson of John Snow and the Broad Street pump', *Virtual Mentor*, Volume 11, Issue 6, Pages 470-472.

Rutter, H.; Savona, N.; Glonti, K.; Bibby, J.; Cummins, S.; Finegood, D.T.; Greaves, F.; Harper, L.; Hawe, P.; Moore, L.; et al. The need for a complex systems model of evidence for public health. *Lancet*, 2017, 390, 2602–2604.

Rydin, Y., Beebeejaun, Y., Bianconi, M., Borowczyk Martins, J., Clifford, B., Colomb, C., Dimitriou, H., Edwards, M., Ferm, J., Gallent, N., Hickman, R., Nataraja, L., The, T., Tomaney, J. and Turcu, C. (2015). *Five Radical Ideas for a Better Planning System*, The Bartlett School of Planning, UCL.

Salford CVS (2016). *Memorandum of Understanding between Greater Manchester Health and Social Care Partnership and the Voluntary, Community and Social Enterprise (VCSE) sector in Greater Manchester*, VSNW Devolution Reference Group. Available at: https://www.salfordcvs.co.uk/sites/salfordcvs.co.uk/files/MoU%20-%20VCSE%20and%20HSC%20in%20GM_0.pdf (accessed 9th December 2020).

Sambrook, J. and Sutton, S. (2015). *The Brutalist Playground*, RIBA: London.

Samuel, R. (1992). 'Mrs Thatcher's Return to Victorian Values', in Smout, T. C. (ed.) *Victorian Values*, Pages 9-29, Royal Society of Edinburgh and the British Academy.

Sandford, M. (2019). 'Money talks: The finances of English Combined Authorities', *Local Economy: The Journal of the Local Economy Policy Unit*, 34(2).

Savills (2015). *Challenging Governance*, CIH and Savills. Available at: https://research.euro.savills.co.uk/pdfs/housing-challenging-governance.pdf (accessed 16th December 2020).

Sayer, A. (2000). *Realism and Social Science*, Thousand Oaks: Sage.

Scanlon, K., Whitehead, C. and Blanc, F. (2017). *The future social housing provider*, Flagship Group and LSE. Available at: https://www.lse.ac.uk/geography-and-environment/research/lse-london/documents/Reports/The-future-social-housing-provider-full-report.pdf (accessed 26th November 2020).

Schrecker, T. (2013). 'Can health equity survive epidemiology? Standards of proof and social determinants of health', Preventive Medicine, Volume 57, Issue 6, Pages 741-744.

Schrecker, T. (2017). 'Was Mackenbach right? Towards a practical political science of redistribution and health inequalities', *Health and Place*, Volume 46, Pages 293-299.

Scott, D. (2005). 'Critical Realism and Empirical Research Methods in Education', *Journal of Philosophy of Education*, Volume 39, Issue 4.

Selbie, D. (2019). 'The Prevention Green Paper: A chance to turn talk into action', *Blog: Public health matters*, PHE, 23rd July 2019. Available at: https://publichealthmatters.blog.gov.uk/2019/07/23/the-prevention-green-paper-a-chance-to-turn-talk-into-action/ (accessed 26th November 2020).

Sen, A. (1999). *Development as Freedom*, Oxford University Press.

Sennett, R. (2002). *Respect in a world of Inequality*, New York: W. W. Norton.

Shafique, A., Kippin, H. and Lucas, B. (2012). *Oldham's Co-operative Council: A social productivity framework*, The RSA.

Shah, S. (2019). '7 Biases to avoid in qualitative research', *Blog: Statement of the Problem*, 3rd January 2019. Available at: https://www.editage.com/insights/7-biases-to-avoid-in-qualitative-research?refer=scroll-to-1-article&refer-type=article (accessed 7th December 2020).

Shapely, P. (2004). 'The press and the system built developments of inner city Manchester, 1960s-1980s', *Manchester Region History Review*, Pages 30-39.

Shapely, P. (2006). 'Tenants arise! Consumerism, tenants and the challenge to council authority in Manchester, 1968-92', *Social History*, Volume 31, Issue 1, Pages 60-78.

Shaw, M. (2004). 'Housing and Public Health', *Annual Review of Public Health*, Volume 25, Pages 397-418.

Shaw, M., Dorling, D. and Davey Smith, G. (1999). 'Poverty, social exclusion and minorities', in Marmot, M. and Wilkinson, R. (eds.) *Social determinants of health*, Oxford University Press.

Shelter Cymru (2019). *End Youth Evictions: stopping the cycle of youth homelessness in Wales*, Swansea: Shelter Cymru. Available at: https://sheltercymru.org.uk/wp-content/uploads/2020/06/End-youth-evictions_ENG.pdf (accessed 16th December 2020).

Shildrick, T., MacDonald, R., Furlong, A., Roden, J. and Crow, R. (2012). *Are 'Cultures of Worklessness' Passed Down the Generations?*, Joseph Rowntree Foundation.

Simpson, M., Parkin, T., Henry, H. and Rayner, V. (2015). *Housing: Just what the doctor ordered*, Sitra & NHS Alliance.

Simpson, M. and Henry, H. (2016). *Closing the health gap – a gap worth closing: How housing can play its part in reducing health inequalities*, Housing LIN.

Slawson, N. (2015). 'Profit or purpose? The fight over the future of social housing in Britain', *The Guardian*, 14th August 2015. Available at: https://www.theguardian.com/housing-network/2015/aug/14/social-housing-britain-future-profit-purpose-genesis (accessed 26th November 2020).

Smith, S. J. (2012). 'Explaining the link between housing and health: All or nothing?' *Housing, Theory and Society*, Volume 29, Issue 1, Pages 40-46.

Smith, K. E. (2014). 'The politics of ideas: The complex interplay of health inequalities research and policy', *Science and Public Policy*, Volume 41, Issue 5, Pages 561-574.

Smith, K. E. and Eltanani, M. K. (2014). 'What kinds of policies to reduce health inequalities in the UK do researchers support?', *Journal of Public Health (United Kingdom)*, Volume 37, Issue 1, Pages 6-17.

Smith, K. E. and Katikireddi, S. V. (2013). 'A glossary of theories for understanding policymaking', *Journal of Epidemiology and Community Health*, Volume 67, Issue 2, Pages 198-202.

Smith, K. E., Bambra, C. and Hill, S. (eds.) (2016). *Health Inequalities: Critical Perspectives*, Oxford University Press.

Smith, P. (2018). 'GMCA backs start of devolution of health and social care services in region', Greater Manchester Combined Authority, 12th December 2018. Available at: https://www.greatermanchester-ca.gov.uk/news/gmca-backs-start-of-devolution-of-health-and-social-care-services-in-region/ (accessed 19th December 2020).

Smith, D. M. and Wistrich, E. (2014). *Devolution and Localism in England*, Routledge.

Smithson, P. and Smithson, A. (1970). 'The Smithsons on Housing', BBC documentary, directed by B. S. Johnson. Available at: https://www.youtube.com/watch?v=UH5thwHTYNk (accessed 26th November 2020).

Smyth, S., Cole, I. and Fields, D. (2020). 'From gatekeepers to gateway constructors: Credit rating agencies and the financialisation of housing associations', *Critical Perspectives on Accounting*, Volume 71, Issue C.

Snow, A. [@kindto_animal]. (2020, September 30th). 'No. I've been a Housing Officer and other professionals were always trying to draw me into giving an opinion on very sensitive matters away from Housing. Children's Services are there to deal with those issues' [Tweet]. Twitter. https://twitter.com/kindto_animal/status/1311342115838980098 (accessed 20th December 2020).

Social Exclusion Unit (1998). *Bringing Britain Together: a national strategy for neighbourhood renewal*, Cm4045, The Stationery Office, London.

Social Exclusion Unit. (2001). *National Strategy for Neighbourhood Renewal: Policy Action Team Audit*, SEU, Cabinet Office.

Spring, L. [@ESpringW11]. (2020, October 2nd). 'It's chilling how housing associations are promoting saviour myths. Tenants pay rent for our homes, not for housing associations to frame our lives. We build our own communities, friendship circles, families, voluntary groups. HA staff must know that, so why make up these myths?' [Tweet]. Twitter. https://twitter.com/ESpringW11/status/1311973945189584896 (accessed 20th December 2020).

Spring, L. [@ESpringW11]. (2020, October 16th). 'If only community-owned, resident-run housing was the norm, the social in public and community housing would still mean social as intended – for good of society – rather than social as in "shut up, lowlife and obey that social worker"' [Tweet]. Twitter. https://twitter.com/ESpringW11/status/1317158996625719296 (accessed 20th December 2020).

Stacey, T. (2017). 'Housing benefit is not intended to cover the cost of care and support', *Inside Housing*, 9th February 2017. Available at: https://www.insidehousing.co.uk/comment/comment/housing-benefit-is-not-intended-to-cover-the-cost-of-care-and-support-49768 (accessed 20th December 2020).

Stoye, G. (2018). *Does the NHS need more money and could we pay for it?*, The King's Fund, June 2018.

Stuart, G. (2015). 'What are social models of health?', *Blog: Sustaining Community*, The Family Action Centre, University of Newcastle, 2nd June 2015. Available at: https://sustainingcommunity.wordpress.com/2015/06/02/social-model-of-health/ (accessed 21st December 2020).

Stuckler, D., Reeves, A., Loopstra, R., Karanikolos, M. and McKee, M. (2017). 'Austerity and health: the impact in the UK and Europe', *European Journal of Public Health*, Volume 27, Issue 4, Pages 18-21.

Subramanyam, M., Kawachi, I. and Subramanian, S. (2010). 'Reactions to *Fair Society, Healthy Lives* (The Marmot Review)', *Social Science and Medicine*, Volume 71, Pages 1221-1222.

Sugden, L. [@leesug] (2018, August 13th). 'Holiday season so signing RTB sales. 4 today at an average sale price [of] 46k. 4 more social homes gone forever. Good luck to the new owners. This policy during a housing crisis is nothing but stupid' [Tweet]. Twitter. https://twitter.com/leesug (accessed 13th August 2018).

Summerson, J. (1993). *Architecture in Britain, 1530 – 1830*, 9th edition, London: Yale University Press.

Swope, C. B. and Hernández, D. (2019). 'Housing as a determinant of health equity: a conceptual model', *Social Science and Medicine*, Volume 243.

Syrett, S. and North, D. (2008). *Renewing neighbourhoods: Work, enterprise and governance*, Bristol Policy Press.

Szreter, S. (1999). 'Rapid economic growth and 'the four Ds' of disruption, deprivation, disease and death: public health lessons from nineteenth-century Britain for twenty-first-century China?', *Tropical Medicine and International Health*, Volume 4, Issue 2, Pages 146-152.

Tallis, R. (2018). 'Does devolution in Manchester move the NHS closer to Nye Bevan's vision for what it should provide?', Live debate, part of the ESRC Festival of Social Science, 6th November 2018, Portico Library and Gallery, Manchester. https://www.eventbrite.co.uk/e/nhs-devo-debate-tickets-50638563306#

Tang, C. P. Y., Oxley, M. and Mekic, D. (2017). 'Meeting commercial and social goals: institutional investment in the housing association sector', *Housing Studies*, Volume 32, Issue 4, Pages 411-427.

Tawney, R. H. (1952). *Equality*, Fourth Revised Edition, George Allen & Unwin Ltd.

Teasdale, D. (2017). *The Limelight Offer*, August 2017. Available at: https://www.housinglin.org.uk/_assets/Events/2018-02/The-Limelight-offer.pdf (accessed 30th November 2020).

Temkin, L. (2013). 'Inequality and Health', in N. Eyal, S. Hurst, O.F. Norheim and D. Wikler (eds)., *Inequalities in Health: Concepts, Measures and Ethics*, Oxford University Press.

The Centre for Social Justice (2012). *Rethinking Child Poverty*, May 2012. Available at: https://www.centreforsocialjustice.org.uk/core/wp-content/uploads/2016/08/CSJ_Child_Poverty_secondversion.pdf (accessed 10th December 2020).

The Guinness Partnership (2014). *Our Strategy*, Available at:

https://www.rns-pdf.londonstockexchange.com/rns/9296U_-2014-10-21.pdf (accessed 9th December 2020).

The Guinness Partnership (2018). *Annual Reviews and Company Reports*. Available at: https://www.guinnesspartnership.com/about-us/company-publications/ (Accessed 22nd December 2020).

The Health Foundation. (1992). *'The health of the Nation – a strategy for health in England' white paper*, The Health Foundation, Policy Navigator. Available at: http://navigator.health.org.uk/theme/health-nation-strategy-health-england-white-paper (accessed 23rd November 2020).

The United Nations (1948). *Universal Declaration of Human Rights*, UN General Assembly, Paris.

Thomson, H., Petticrew, M. and Morrison, D. (2001), '*Health effects of hosing improvement: systematic review of intervention studies*', British Medical Journal, Volume 323, Pages 187-190.

Thomson, H. and Thomas, S. (2015). 'Developing empirically supported theories of change for housing investment and health', *Social Science and Medicine*, Volume 124, Pages 205-214.

Thunhurst, C. (1993). 'Using published data to assess health risks', in Burridge, R. and Ormandy, D. (eds.) *Unhealthy Housing: research, remedies and reform*, Oxon: Taylor and Francis.

Tomaney, J. (2016). 'Limits of Devolution: Localism, Economics and Post-democracy', *The Political Quarterly*.

Torjesen, I. (2016). 'Austerity cuts are eroding benefits of Sure Start children's centres', *British Medical Journal*, Published 19th January 2016. Available at: https://www.bmj.com/content/352/bmj.i335?hwshib2=authn%3A1605543667%3A20201115%253A6af0453a-f02e-4423-82fc-fcdf54534ba1%3A0%3A0%3AK6byy93EW0Rhz4c%2B3%2BTyJg%3D%3D (accessed 15th November 2020).

Townsend, P., Davidson, N. and Whitehead, M. (1992). *Inequalities in Health: The Black Report and The Health Divide*, 2nd Edition, London: Penguin Group.

Townsend, S. (2010). 'Welfare reform "likely to harm cities"', *Regeneration and Renewal*, Pages 14-15.

Toynbee, P. (2020). 'The war on coronavirus should be led by councils. But this government hates them', The Guardian, 28th April 2020. Available at: https://www.theguardian.com/commentisfree/2020/apr/28/war-coronavirus-councils-austerity-local-expertise (accessed 26th November 2020).

Trafford Council (2019). *Trafford Joint Strategic Needs Assessment, Health & Wellbeing*, 19th October 2020. Available at: http://www.traffordjsna.org.uk/About-Trafford/Health-and-wellbeing/Health-wellbeing.aspx (accessed 29th November 2020).

Trafford Directory (2020). 'Trafford Housing Trust', updated 23rd September 2020. Available at: https://www.trafforddirectory.co.uk/kb5/trafford/fsd/service.page?id=Jxe4eVUDpC8 (accessed 22nd December 2020).

Trafford Partnership (2016). *Trafford Plan to 2020*, Trafford Partnership, Trafford Council and NHS Trafford Clinical Commissioning Group. Available at: https://www.traffordccg.nhs.uk/docs/Publications/Trafford-Plan-to-2020.pdf (accessed 27th November 2020).

Tunstall, H., Mitchell, R., Gibbs, J., Platt, S. and Dorling, D. (2007). 'Is economic adversity always a killer? Disadvantaged areas with relatively low mortality rates', *Journal of Epidemiology and Community Health*, Volume 61, Issue 4, Pages 337-343.

Tunstall, R. (2015). 'The Coalition's Record on Housing: Policy, Spending and Outcomes 2010-2015', *Social Policy in a Cold Climate Working Paper*, London: CASE, LSE.

Tunstall, R., Bevan, M., Bradshaw, J., Coucher, K., Duffy, S., Hunter, C., Jones, A., Rugg, J., Wallace, A. and Wilcox, S. (2013). *The links between housing and poverty: an evidence review*. York: JRF.

Tunstall, R. K., and Pleace, N. (2018). *Social Housing: Evidence Review*. University of York.

Turner, D. (2018). 'What is qualitative observation?', *Blog: Quirkos*, 13th June 2018. Available at: https://www.quirkos.com/blog/post/qualitative-observation-direct-participation (accessed 8th December 2020).

UK Government (1990). *National Health Service and Community Care Act 1990*. Available at: https://www.legislation.gov.uk/ukpga/1990/19/contents (accessed 20th December 2020).

UK Government (2012). *Health and Social Care Act 2012*. Available at: https://www.legislation.gov.uk/ukpga/2012/7/contents/enacted (accessed 20th December 2020).

UK Government (2012). *Welfare Reform Act 2012*. Available at: https://www.legislation.gov.uk/ukpga/2012/5/contents (accessed 20th December 2020).

UK Government (2014). *Care Act 2014*. Available at: https://www.legislation.gov.uk/ukpga/2014/23/contents/enacted (accessed 9th December 2020)

UK Government (2016). *Welfare Reform and Work Act 2016*. Available at:

https://www.legislation.gov.uk/ukpga/2016/7/contents/enacted (accessed 9th December 2020).

UK Government (2016). *Housing and Planning Act 2016*. Available at: https://www.legislation.gov.uk/ukpga/2016/22/contents/enacted (accessed 19th December 2020).

UK Government (2017). *Homelessness Reduction Act 2017*. Available at: https://www.legislation.gov.uk/ukpga/2017/13/contents/enacted (accessed 9th December 2020).

UK Government (2018). *Homes (Fitness for Human Habitation) Act 2018*. Available at: https://www.legislation.gov.uk/ukpga/2018/34/enacted (accessed 20th December 2020).

Valentine, G. (2005). 'Tell Me about…:Using Interviews as a Research Methodology', in Flowerdew, R. and Martin, D. (eds.) *Methods in Human Geography: A Guide for Students Doing a Research Project*, Pages 110-127, 2nd edition, Harlow, UK: Prentice Hall.

Valentine, G. and Harris, C. (2014). 'Strivers vs. skivers: Class prejudice and the demonisation of dependency in everyday life', *Geoforum*, Volume 53, Pages 84-92.

Van der Kuij, R., Gruis, V. and Nieboer, N. (2016). 'Exploring congruency within organisational change in Dutch Housing Associations', Paper presented to European Network of Housing Researchers Annual Conference, 26 June–1 July 2016, Belfast

Van Lanen, S. (2020). 'My room is the kitchen': lived experience of home-making, home-unmaking and emerging housing strategies of disadvantaged urban youth in austerity Ireland', *Social and Cultural Geography*.

Vincent, S. and O'Mahoney, J. (2018), 'Critical Realism and Qualitative Research: An Introductory Overview', in Cassell, C., Cunliffe, A. and Grady, G. (Eds.) *The Sage Handbook of Qualitative Business and Management Research Methods*, London: SAGE.

Walsh, D., Bendel, N., Jones, R. and Hanlon, P. (2010). 'It's not "just deprivation": why do equally deprived UK cities experience different health outcomes?', *Public Health*, Volume 124, Pages 487-495.

Walshe, K., Loren, C., Coleman, A., McDonald, R. and Turner, A. (2018). *Devolving health and social care: learning from Greater Manchester*, Manchester: The University of Manchester.

Ward, K., Deas, I., Haughton, G. and Hincks, S. (2016). 'Placing Greater Manchester', *Representation*, Volume 51, Issue 4, Pages 417-424.

Waterhouse, P. (2016). Thinking out loud – The Job of Voluntary Services: What voluntary services should do, not do and might do, National Coalition for Independent Action. Available at: http://independentaction.net/wp-content/uploads/sites/8/2015/12/The-job-of-voluntary-services-final.pdf (accessed 2nd December 2020).

Watson, M. C. and Owen, P. (2020). 'Inequalities in 2020: time for a health strategy that unites the country', *British Medical Journal*, 2020;368:m544. Available at: https://www.bmj.com/content/368/bmj.m544 (accessed 2nd December 2020).

Watt, P. and Jacobs, K. (2000). 'Discourses of Social Exclusion: An Analysis of Bringing Britain Together: A National Strategy for Neighbourhood Renewal', *Housing, Theory and Society*, Volume 17, Issue 1, Pages 14-26.

Watts, B., Fitzpatrick, S., Bramley, G. and Watkins, D. (2014). *Welfare sanctions and conditionality in the UK*, Joseph Rowntree Foundation.

Weaver, M. (2004). 'Government regeneration policy attacked', *The Guardian*, 21st April 2004. Available at: https://www.theguardian.com/society/2004/apr/21/regeneration.communities (accessed 2nd December 2020).

Whitehead, M. (2012). 'Waving or drowning? A view of health equity from Europe', *Australian and New Zealand Journal of Public Health*, Volume 36, Issue 6, Page 523.

Whitehead, M. and Popay, J. (2010). 'Swimming upstream? Taking action on the social determinants of health inequalities', *Social Science and Medicine*, Volume 71, Pages 1234-1236.

Wigglesworth, S. (2000). 'A fitting fetish: the interiors of the Maison de Verre', in Borden, I. and Rendell, J. (eds.) *Intersections: Architectural Histories and Critical Theories*, New York: Routledge.

Wilkinson, R. and Pickett, K. (2009). *The Spirit Level: Why More Equal Societies Almost Always Do Better*, Allen Lane.

Wilkinson, R. and Pickett, K. (2018). *The Inner Level: how more equal societies reduce stress, restore sanity and improve wellbeing*, Allen Lane.

Williams, C. (2007). 'Research Methods', *Journal of Business and Economic Research*, Volume 5, Issue 3, Pages 65-72.

Williams, O. and Fullager, S. (2019). 'Lifestyle drift and the phenomenon of "citizen shift" in contemporary UK health policy', *Sociology of Health and Illness*, Volume 41, Issue 1, Pages 20-35.

Wilson, W. (2013). 'Housing Market Renewal Pathfinders', standard note SN/SP/5953, 30th October 2013, House of Commons Library. Available at: https://commonslibrary.parliament.uk/research-briefings/sn05953/ (accessed 2nd December 2020).

Wilson, W., Bellis, A. and Garton Grimwood, G. (2018). 'Implementation of the Housing and Planning Act 2016', Briefing Paper 8229, 19th February 2018, House of Commons Library. Available at: https://commonslibrary.parliament.uk/research-briefings/cbp-8229/ (accessed 8th December 2020).

Woodall, J., Raine, G., South, J. and Warwick-Booth, L. (2010). *Empowerment and health and well-being: evidence review*, Centre for Health Promotion Research, Leeds Metropolitan University.

Woods, P. (2016). 'Health should not be a postcode lottery', *Blog: NHS England*, 23rd November 2016. Available at: https://www.england.nhs.uk/blog/penny-woods-2/ (accessed 8th December 2020).

World Health Organisation (1985). *Targets for Health for All: Targets in support of the European regional strategy for health for all*, WHO: Copenhagen.

World Health Organisation (1986). *The Ottawa Charter for Health Promotion*, Geneva: WHO. Available at: https://www.euro.who.int/en/publications/policy-documents/ottawa-charter-for-health-promotion,-1986 (accessed 9th December 2020).

World Health Organisation (2014). *Review of social determinants and the health divide in the WHO European Region: final report*, UCL Institute of Health Equity. Available at: https://www.euro.who.int/__data/assets/pdf_file/0004/251878/Review-of-social-determinants-and-the-health-divide-in-the-WHO-European-Region-FINAL-REPORT.pdf (accessed 9th December 2020).

World Health Organisation (2020) 'Social determinants of health', WHO, Geneva. Available at: https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1 (accessed 17th December 2020).

Yen, I., Michael, Y. and Perdue, L. (2009). 'Neighbourhood Environment in Studies of Health of Older Adults: A Systematic Review', *American Journal of Preventive Medicine*, Volume 37, Issue 5, Pages 455-463.

Yin, R. K. (2003). *Case Study Research: Design and Methods*. London, SAGE.

Yin, R. K. (2014). *Case Study Research Design and Methods* (5th edition). London, SAGE.

Yuill, C., Crinson, I. and Duncan, E. (2010). 'The social model of health', in *SAGE Key Concepts Series: Key Concepts in Health Studies*, London, Sage UK.

Appendix 1: Sample consent form

An Assessment of Housing Association Activity in Tackling Health Inequalities in Greater Manchester

CONSENT FORM

If you are happy to participate please complete and sign the consent form below.
You do not need to consent to every element in order to participate. For example, if you do not wish for the researcher to use your real name you may leave option 8 blank.

	Please initial box
1. I confirm that I have read the attached information sheet about the above project and have had the opportunity to consider the information and ask questions. Any questions I had have been answered satisfactorily.	
2. I understand that my participation in the study is voluntary and that I am free to withdraw at any time without giving a reason and without detriment to myself.	
3. I understand that my data will remain confidential.	
4. I understand that the interviews will be audio-recorded.	
5. I agree to the use of anonymous quotes.	
6. I agree to my data being retained for up to ten years and no less than five in an encrypted digital storage device.	
7. I agree that any data collected may be published in anonymous form in the resulting doctoral dissertation of the principal researcher.	
8. I agree to be cited by name as a result of my participation in this interview in the upcoming doctoral dissertation of the principal researcher.	
9. I agree to be cited, if relevant, in the mode specified above (7, 8) in academic books and journal publications.	
10. I agree to be contacted at a later date by the researcher to discuss and set up an appointment for a possible follow-up interview.	

I agree to take part in the above project.

_____	_____	_____
Name of participant	Date	Signature
_____	_____	_____
Name of researcher	Date	Signature

Appendix 2: Sample participant information sheet

An Assessment of Housing Association Activity in Tackling Health Inequalities in Greater Manchester

Participant Information Sheet

You are being invited to take part in a research study in partial fulfilment of the principal researcher's PhD Dissertation. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for taking the time to read this.

Who will conduct the research?
Name of Researcher: Annika Hjelmskog
Email: annika.hjelmskog@manchester.ac.uk
University of Manchester Address: School of Environment, Education and Development, Arthur
Lewis Building, University of Manchester, Oxford Road, M13 9PL, United Kingdom

What is the purpose of the research?
The purpose of this research is to explore the role of housing associations in Greater Manchester in reducing health inequalities. The study will consider the evolving role of housing associations in a devolved city-region, including the increases in service provision (such as health and social care services) as well as health-focussed regeneration strategies. This research will consider the possibilities and challenges of an increased involvement by housing providers in the health and social care services, and discuss whether any of the examples of housing regeneration in Greater Manchester provide a possible template for sustainable development and health promotion in other regions.

Why have I been asked to take part?
Your participation in this study has been identified as relevant due to your professional role in [……], and your involvement in the field of research. The study seeks to incorporate the views of as many individuals as possible from relevant backgrounds within [……]. The researcher, Annika Hjelmskog, has through initial contacts and desk based research, compiled a list of potential participants which has systematically been added to through conversation with other participants who were asked to assist by nominating other important stakeholders. Your name was added to the list during one of these processes and you yourself will have the opportunity to nominate other people whom you consider important for the researcher to include in order for the study to be balanced.

What would I be required to do if I took part?
You will be asked to participate in a face-to-face in-depth/semi-structured interview conducted by
Annika Hjelmskog to discuss your role, views, and experiences of [researcher will choose A, B, C or a combination]:

A) Housing Association regeneration activity related to health.
B) Health and social care services in Greater Manchester.
C) Commissioning services and intersectoral/partnership working in a devolved region.
The interview is anticipated to take no more than 60 minutes to complete. Following this, you may be requested to participate in a follow-up interview or summative focus group if you should agree to it. The duration of this study in its entirety is 12 months (January – December 2018). The interviews will take place in a mutually agreed, convenient venue. This may be in an office or room in the building where you work, or at the University of Manchester.

What happens to the data collected?
Your answers will be used to help understand the key issues associated with the work of various housing associations in a wider context of attempts to shrink health inequalities. They will also contribute to further understanding of the relationship between housing and health. The data will be used in the PhD dissertation. It may be published in a peer reviewed academic journal, edited book, book chapter, or in a conference presentation. You may be approached at a later stage in the research to provide additional assistance and/or to clarify your relationship and views of another participant/organisation/project.

How is confidentiality maintained?
The researcher takes confidentiality and anonymity very seriously. Personal information will be kept safe in a locked location which only the researcher will have access to. The data obtained from any participant will be stored in an encrypted medium which will, in turn, be kept in a secure place. Only the research team [the primary researcher and her academic supervisors] will have access to raw data and this will not be shared with any third parties. Unless the participant grants permission to use their real name, anonymity will be maintained through the use of pseudonyms and omission of defining traits during the process of data analysis as well as in direct quotations in the PhD dissertation and other publications. All data storage mediums (i.e. USB flash/hard drives, laptops, transcription files) will be encrypted thoroughly and will be backed up in a personal password protected device to ensure data safety. Data (anonymised and non-anonymised) will be kept for five years minimum and ten years maximum.

What happens if I do not want to take part or if I change my mind?
It is up to you to decide whether or not to take part. If you decide to take part but change your mind at a later stage (i.e. wish to interrupt, postpone, or cancel the interview altogether) you are free to do so. If you do decide to take part you will be given this Participant Information Sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw up to the time of publication without giving a reason and without detriment to yourself.

What if something goes wrong?
If there are any issues regarding this research you may contact the principal researcher or members of the research team. If there are any issues regarding this research that you would prefer not to discuss with members of the research team, please contact the Research Practice and Governance Coordinator.
Researcher: Annika Hjelmskog
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What if I want to make a complaint?
Minor complaints
If you have a minor complaint then you need to contact the researcher in the first instance (contact information above).
Formal Complaints
If you wish to make a formal complaint or if you are not satisfied with the response you have gained from the researcher in the first instance then please contact the:
Research Governance and Integrity Manager,
Research Office, Christie Building, University of Manchester,
Oxford Road, Manchester, M13 9PL, UK
Email: research.complaints@manchester.ac.uk
Telephone: +44 (0) 161 275 2674 or +44 (0) 161 275 2046.

What Do I Do Now?
If you have any queries about the study or if you are interested in taking part then please contact the researcher (contact information provided above)**.**

Appendix 3: Sample interview guide

Introduction Checklist

- Give interviewee participant information sheet and check if any further questions.
- Participant to read and sign consent form.
- Participant to sign consent form.
- Ensure interviewee is aware that the interview will be recorded.

Questions

Icebreaker and personal questions

- Let's talk a little about you - please could you tell me how long you have worked for [the housing association/health partner/local or combined authority] and what your role entails?
- How has your organisation been involved in the housing-health agenda? Could you describe some of those projects for me?
- What has been your experience of the work between housing and health?
- How has your role changed?
- How have the initiatives at your organisation been funded?

GMHP (Greater Manchester Housing Providers)

- What role has your organisation played in this group?
- How has the group worked with the local authorities/combined authority?
- Which other stakeholders have been involved?
- How has the work of the group developed under devolution?

DevoManc and relationships

• Please could you describe the relationship between your organisation and the combined authority/health and social care partnership/local authority/public health department?

Or

- Please could you describe the relationship between your organisation and the housing providers that you have worked with?

Borough context

- Are there any factors specific to your local authority that influence your work in this area?
- How do you understand the health issues or health inequalities in the communities you work with?
- Who have you/your organisation been able to reach as part of this work?

- How well is the housing need met in your area? Do you know the length of the social housing waiting list/is it actively managed/of any exclusions?

  Sustainability

- How long do you anticipate this role/these projects to continue for?
- How has the work on/with health impacted the other business areas of the organisation?

  Barriers to progress

- What difficulties or challenges have you encountered so far in this work?
- Have these challenges been lessened or overcome in any way?
- What role has joined-up/partnership working had in your organisation's progress?
- What would be required to make your job easier?

  Future form and function of the social housing sector

- What do you see as the priorities for the social housing sector?
- How do you see the role of the housing sector after the devolution transformation period?
- And further in the future?
- What else is required for this agenda to work successfully?
- Is there anything we haven't covered that you think I should have asked?

Interview conclusion checklist

- Ask the interviewee if there are any other issues they would like to address.
- Turn the Dictaphone off.
- Check consent form is signed and interviewee has all the information they require.
- Mention contact details in case further questions/contact is required.