

Health Development Agency

Tackling health inequalities:
turning policy into practice?

David J. Hunter and Amanda Killoran

Authors

Dr David J. Hunter, Professor of Health Policy and Management, School for Health, University of Durham
Dr Amanda Killoran, Public Health Specialist, Health Development Agency

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Health Development Agency
Holborn Gate
330 High Holborn
London
WC1V 7BA

Email: communications@hda-online.org.uk

Website: www.hda.nhs.uk

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About the Health Development Agency

The Health Development Agency (www.hda.nhs.uk) is the national authority and information resource on what works to improve people's health and reduce health inequalities in England. It gathers evidence and produces advice for policy makers, professionals and practitioners, working alongside them to get evidence into practice.

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Summary

The government is firmly committed to tackling health inequalities and seeing its inequalities targets met. This report summarises the key issues in achieving these policy goals, which emerged from a series of seminars organised by the Health Development Agency (HDA). The seminars were designed to explore how government policy gets, or does not get, translated into practice, and to identify the factors that help or hinder implementation as well as the criteria that lead to success or failure. The seminars brought together an invited audience of policy makers, managers and practitioners from across the health policy field, as well as academic researchers.

National policy has a range of routes to tackling health inequalities. The focus of the seminars was on narrowing the health gap, particularly through addressing area inequalities in health, and health disadvantages of the poor. Securing sustainable change in health inequalities is now the priority. A set of background papers was commissioned for the seminars. These sought to distil the lessons from existing evidence and experience on local implementation of policies aimed at tackling health inequalities, and to identify gaps in the evidence. This report draws on their analyses and findings. It is in four parts, focusing on:

- The process of policy development and implementation
- The nature of the evidence, and how it informs policy and practice
- Effective interventions and gaps in the evidence
- Managing system change.

Policy development and implementation

The ability to get policies and decisions implemented effectively has become a key concern in the delivery of the government's reform programme in health. Implementing policy and delivering improved health poses a significant

challenge. The complexity and breadth of the health inequalities agenda, at both national and local levels, are not in doubt. If progressive policies are to succeed, there needs to be a shift from hierarchical and command-and-control modes of operating to more lateral network models. An optimal balance between the top-down approach and bottom-up translation is required. This is not solely a management process – politics and power are fundamental. Power imbalances and powerlessness must be addressed if the needs of the most deprived communities are to be given due attention.

Stakeholders' views of implementation and tackling health inequalities at local level are critical to the success of policies. Stakeholders' views are shaped by their differing conceptions of the local system, and may include seeing the local system as:

- Geographically bounded, with change as a developmental process targeted at the most deprived communities
- A network of relationships, with collaboration sought in the politics of partnerships
- The hierarchy of national–regional–local defining a 'rational' process of implementation and performance.

These perspectives are not necessarily incompatible, but tensions exist which may undermine implementation.

The nature of public health evidence and its application

Evidence-based policy is desirable to ensure public policies and interventions optimise benefits and minimise negative outcomes, and use scarce resources effectively. There are gaps in the evidence, and further research is necessary – but there is an equal challenge in *implementing* what has been proven to work. In some cases research exists, but is not exploited. There may be a case for shifting the balance in 'research and development' in favour of development, to

provide a greater understanding of the process of change. This may mean a more prominent role for action research. Those seeking to prioritise initiatives to address inequalities on the basis of the evidence face several challenges:

- The need to define the intended policy outcome and focus of interventions precisely – in particular, interventions that focus exclusively on the most deprived groups and areas will not necessarily reduce the health gap between the most deprived and the more affluent, or the overall health gradient across socio-economic groups of the population
- The evidence base on measures to tackle health inequalities is limited, and what evidence there is does not match the traditional requirements in evidence-based medicine for randomised controlled trials
- Focusing on the individualised interventions that typically populate the evidence base potentially ignores the more important macro-level determinants of health, and the degree to which inequity is tolerated and sustained through policies at national and local levels
- Interventions need to reflect theoretical approaches to understanding social and environmental sources of structural inequalities in health, how they interrelate, how they are mediated, and how they are constructed over an individual's life history
- A focus on identifying new, effective interventions for addressing health inequalities may divert attention away from a critical analysis of how current policies, priorities and ways of working may confirm disadvantage; or from developing ways of ensuring new policies are critically assessed for their impact on health inequalities.

Effective interventions and gaps in the evidence

The example of neighbourhood renewal illustrates the issues that can arise in putting policy into practice. The evidence that inequalities in health have a strong spatial dimension is well established. There is growing understanding of the role that 'place' plays in influencing individuals' and families' levels of exposure to health risks, as well as their opportunities for being healthy. There are good reasons why an area-based approach to tackling health inequalities, as part of a wider policy for community regeneration, is an appropriate and important part of a national response to the health gap between rich and poor. A sizeable evidence base already exists on effective approaches to regeneration and reducing health inequalities at neighbourhood level.

Key features of the Neighbourhood Renewal Strategy are:

- Local strategic partnerships providing the framework for effective development and implementation of multi-agency neighbourhood renewal strategies
- Focus on changing mainstream programmes and services, rather than spending ring-fenced monies in isolation from the bigger picture
- Emphasis on putting into practice 'what works'
- Local learning action plans that identify and develop skills and resources
- A Neighbourhood Renewal Fund to pump prime change
- Emphasis on involvement of local communities
- Establishment of the Neighbourhood Renewal Unit to support implementation efforts.

Research shows that regeneration can make a positive contribution to improving health and reducing health inequalities. But there is potential for negative health impacts and a worsening of health inequalities. An assessment of the health consequences of schemes must be an integral part of their planning and design. Rapid health impact assessment can be used early in a regeneration scheme, contributing to plans for implementation.

There is evidence to inform the effective design and implementation of health-related interventions (such as preventive screening, and treatment of coronary heart disease) but care must be taken in its interpretation. Interventions can be considered successful only when they are at least as effective for the lowest socio-economic group as for the highest. Interventions that are effective in general terms may be ineffective in reducing health inequalities. The avoidance of a variant on the 'inverse care law' – the 'inverse prevention law' – is required.

Primary care trusts (PCTs) have a key role in improving population health and addressing health inequalities. Yet many barriers to implementation exist, including lack of commitment, experience and incentives among some practitioners; organisational prioritisation; and the resources and capacity to implement effective programmes. Health improvement drops down the agenda for PCTs when set against the 'must dos' related to the acute sector. Reinforcing the problem has been an uncertain shift from a medical model to a broader, population-based approach.

Studies on social capital suggest that strengthening community involvement in decision making, governance and democratic renewal may be viewed as possible ways of building social capital to improve the health of deprived communities. But there is little research available that

examines the relative effectiveness of such interventions, including the impact on health inequalities.

Experience of applying the theory of change demonstrates that local strategies for community regeneration should be viewed as multi-faceted and complex community interventions. The potential of traditional evaluation methods (including randomised controlled trials) for explaining how or why such strategies or programmes work is weak, and there is a case for a more flexible evaluation framework.

Managing system change

Ability to manage change and to adopt a systems perspective were viewed as a principal factors in achieving effective implementation. These factors are acutely tested in a context where disjointed government persists despite the government's aspiration for joined-up policy, organisation and management. Review of the early experiences of implementation of the Neighbourhood Renewal Strategy revealed that there remain long-standing obstacles to managing change to address inequalities and deprivation. For example, the Audit Commission's research showed an absence of organisational capacity to realise the strategy, and slow culture change in respect of partnership working. The overload of initiatives diverted attention from the need to bring activities and resources into the mainstream. However, many local agencies recognise these problems, and many are working to find solutions to them.

Effective leadership and management are required to ensure effective joined-up policy and organisation. Future leaders and managers will need to think and act by:

- Seeing inter-relationships rather than static structures
- Understanding how systems evolve over time
- Focusing on issues where impact is likely to be maximised
- Avoiding symptomatic 'solutions' such as short-term fixes.

Equipping managers with the skills they need to operate in this challenging environment – characterised by the need to balance stakeholders' interests, understand complex accountabilities, and manage for social outcomes – will be critical. Public health goals cannot be achieved without a serious partnership across the disciplines of public health and management.

Conclusions and recommendations

Analysis of the seminar discussions and background papers

gave rise to conclusions and recommendations concerning the implementation gap in respect of policies aimed at tackling health inequalities and deprivation.

Effective interventions and gaps in the evidence

- There is substantial opportunity to apply existing evidence of what works in relation to areas of health and access to health services
- The evidence on the potential for reducing health inequalities through wider regeneration measures is much less well developed, and could be improved
- The prospective use of health impact assessment can be an important way to engage a range of stakeholders in making decisions about different interventions, taking account of the evidence
- The concept of social capital appears relevant to investigating how community cohesion and social relationships could improve health
- Programmes that combine a range of approaches appear to offer the best prospects for changing health inequalities
- The 'theory of change' approach provides important lessons for managing change.

Managing system change: issues of governance

- Studies employing a theory of change approach show that locally a culture of logical planning for achieving long-term health and social outcomes is generally absent. Technical support in planning is required
- Introducing a culture of evaluation, learning and development is critical, given the limits to evidence on effectiveness
- Partnership arrangements are viewed as the most appropriate mechanism for managing the system changes required to deliver policy
- Bringing efforts and interventions to reduce health inequalities and deprivation into the mainstream of partner organisations' core business is a fundamental challenge
- Primary care trusts are new players within the health system and are expected to make a major contribution to tackling health inequalities and improving health – although the pressures on them to deliver on other priorities, as well as constrained capacity, may restrict their potential to deliver
- Too little use is made of the insights on implementation failure and success available from political and organisational sciences.

Introduction

In the Labour government's second term, its policy on tackling health inequalities appears to have reached a critical point in its development. *The Cross Cutting Review on Health Inequalities* (HM Treasury, 2002) reiterates the government's commitment to reducing health inequalities, and acknowledges that sustained action on the wider determinants of health is demanded if the intergeneration cycle of health inequalities and poverty is to be broken. An *All-government Delivery Plan* to tackle health inequalities is planned (Department of Health, 2003). It promises to articulate the contribution on which each government department's performance is to be judged. The key challenge focuses on turning policy into practice at all levels of government.

In 2002, the HDA organised three seminars that aimed to explore how government policy gets, or does not get, translated into practice. It aimed to identify the factors that help or hinder implementation, as well as the criteria that lead to success or failure. The seminars brought together an invited audience of policy makers, managers and practitioners from healthcare organisations, local government, central government departments and academic researchers.

Graham (2002) points out that national policy shows a range of interpretations of what is meant by tackling health inequalities. At one end of the continuum, addressing the *health disadvantage of poor groups and communities* is the focus. The focus widens at the mid-point to *narrowing the health gap* between those in the poorest groups and those who are better off. At the other end of the continuum, the focus is on *reducing the health gradient across the socio-economic hierarchy*. While these definitions are complementary, each raises important implications for policy development and interventions. The seminars were primarily concerned with how to narrow the health gap, particularly

through addressing area inequalities in health, and health disadvantage of the poor (rather than ethnicity, gender or other aspects of health inequalities).

This report provides a synthesis of the papers discussed at the seminars and listed in the box on page 5, as well as noting other relevant bodies of work. The papers sought to distil the lessons from existing evidence and experience about local implementation of policies aimed at tackling health inequalities, and to identify gaps in the evidence that need to be filled. This report will be of interest to those concerned with tackling health inequalities and deprivation, and who wish to have an overview of the issues and challenges involved in turning policy into practice. The papers provide a rich source of information and analysis, and can be accessed via the HDA's evidence base at www.hda.nhs.uk/evidence

The government has acknowledged that the health debate has 'for too long been focused on the state of the nation's health service and not enough on the state of the nation's health' (Milburn, 2002). The government regards much of the policy framework for improving health and tackling health inequalities as established, and the emphasis now must be on effective implementation.

Traditionally, governments propose policy then look to their agents to dispose of it, so that the process follows a clear, rational, linear progression. In practice, however, the transmission of policy into practice is complex and cyclical rather than linear, with the very act of implementation influencing the nature and content of policy in all kinds of ways – some very visible, others less so.

Among the key issues and dilemmas evident in decision making and implementation are:

- Whether, and how, national policy can be effectively implemented locally, and what needs to be in place for this to occur
- The risk that a plethora of national initiatives from various departments, which appear disconnected rather than joined-up, are dysfunctional and disabling rather than productive and empowering
- Who should be taking action locally to implement national policy, eg the NHS, local government, regional agencies, agencies in the independent sector, or some combination of these?

In a context where there exists considerable uncertainty, policy overload and major organisational turbulence, the processes for implementing policy and reaching sustainable decisions are likely to become more difficult to put in place successfully. Sustainability is of particular concern when it comes to addressing inequalities in health, given the accumulation of disadvantage across the life course, and the time required to demonstrate changes in health outcomes.

It is important to acknowledge that the government is endeavouring to transform the way in which policy is developed and implemented. There is an acceptance of the need to shift from the command-and-control, top-down model of policy to a new approach that involves transferring power and responsibility to local communities and those providing public services. The government is committed to what has been termed 'real localism' (Milburn, 2003). The uniformity of provision and monolithic public services have failed to tackle health inequalities, with the poorest services still to be found in the poorest communities. The government wishes to achieve a better balance between national standards and local autonomy so that public services can be reconnected directly to the public.

The report is in four parts:

- Part 1 examines the process of policy implementation and delivery, and the stakeholders responsible for it
- Part 2 considers the nature of the evidence and how it informs policy and practice
- Part 3 reviews the experience of putting policy and evidence into practice, and offers the national strategy on neighbourhood renewal as an illustrative example
- Part 4 explores the issue of managing system change; issues of complexity and joined-up organisation; and management approaches needed to implement policies that cut across government and other agencies both vertically and horizontally.

A final concluding section draws together the key themes and offers some recommendations addressed to policy makers, practitioners and academic researchers.

Seminar papers

Bauld, L., Judge, K., Mackenzie, M., Mackinnon, J. and Truman, J. (2001) **Health Action Zones in transition: progress in 2000.**

Bauld, L., Mackinnon, J. and Judge, K. (2002) **Community Health Initiatives: recent policy developments and the emerging evidence base.**

Blamey, A., Judge, K. and Mackenzie, M. (2002) **Theory-based evaluation of complex community-based health initiatives.**

Chinamasa, C., Edwards, R. and Heller, D. (2002) **A report of synthesis of literature on the public health role of primary care in addressing health inequalities.**

Cropper, S. (2002) **What contributions might ideas of social capital make to policy implementation for reducing health inequalities?**

Curtis, S., Cave, B. and Coutts, A. (2002) **Regeneration and neighbourhood change.**

Ferlie, E. (2002) **What is known about effective approaches to managing strategic systems change and what are the implications for mainstreaming inequalities?**

Fordham, G. (2002) **Implementing neighbourhood renewal: experience and lessons so far.**

Gillam, S. and Florin, D. (2002) **Reducing health inequalities: primary care organisations and public health.**

Heller, D. *et al.* (2002) **Needs assessment of PCTs: supporting the public health and primary care agenda.**

Hunter, D.J. and Marks, L. (2002) **Decision-making processes for effective policy implementation.**

Killoran, A. and Popay, J. (2002) **Stakeholders' perspectives of local systems for tackling health inequalities. An exploratory study.**

Stewart, M. (2002) **Systems governance: towards effective partnership working.**

Seminar papers can be accessed via the HDA's evidence base at www.hda.nhs.uk/evidence

1 Policy development and implementation

This section considers the process of policy development and implementation for tackling health inequalities. The arena of health inequalities demands recognition of the complex nature of the system, and the interdependence of factors operating to influence health and efforts to improve health. There needs to be a better balance between the top-down, command-and-control style of policy making and a local, bottom-up approach based more on lateral partnerships and networks. Policy delivery is more likely if local stakeholders are fully engaged. The experiences of local stakeholders are explored.

Complexity and interdependence

Implementing policy and delivering improved health is difficult work, especially in complex political and organisational settings. Stewart (2002), for example, argues that while 'whole systems models are useful in recognising the interdependence of parts of the system of governance, [they] are less helpful in deciding precisely where to intervene ... Holism is desirable in principle, difficult to achieve in practice'. Some observers consider policy implementation to be a problem that seems to be getting worse (Pfeffer, 1992). The ability to get policies and decisions implemented is, in Pfeffer's opinion, becoming increasingly rare. Why should this be so?

A Cabinet Office report published in 1999 acknowledged the need for policy making to be modernised:

'The world for which policy makers have to develop policies is becoming increasingly complex, uncertain and unpredictable ... Key policy issues, such as social exclusion and reducing crime, overlap and have proved resistant to previous attempts to tackle them, yet the world is increasingly inter-connected and inter-dependent. Issues switch quickly from the domestic to

the international arena and an increasingly wide diversity of interests needs to be co-ordinated and harnessed ... Government is asking policy makers to focus on solutions that work across existing organisational boundaries and on bringing about change in the real world.'
(Cabinet Office, 1999)

But in order to look afresh at how traditional approaches to policy and implementation might be modified or replaced, a new intellectual underpinning for policy is required (Chapman, 2002). In addition to a reformulation of the intellectual basis of policy, the organisational systems used to deliver policy on the ground also need to be rethought. As many commentators have argued, if progressive policies are to succeed in complex arenas, then moving from hierarchical and command-and-control modes of operating to more lateral network models is a prerequisite (Benington, 1997; Bentley, 2002). In particular, mechanistic command-and-control systems are unsuited to the complex, unpredictable demands of contemporary organisational life. There can be few areas where this is more true than in tackling health inequalities and improving health. We return to the management challenge arising from these different approaches to policy implementation in part 4.

Policy failure can result from bad execution, bad luck, or bad policy. It may also result from too much policy that simply overwhelms those charged with its execution. Ineffective implementation tends to be viewed by policy makers as an example of bad execution. Or external circumstances may be so adverse that bad luck is identified as the reason for failure. A reason that is less commonly advanced to explain policy failure is that the policy itself may be defective, in the sense of being based on inadequate information, poor reasoning, or hopelessly unrealistic assumptions about what is possible with the human and financial resources available.

The point about policy failure is that it suggests there can be no sharp distinction between formulating a policy and implementing it. But studies show that the likelihood of a successful outcome will be increased if thought is given to potential problems of implementation at the policy design stage. For instance, policy failure can result from policy being imposed from the centre, with no thought given to how it might be perceived or received at local level. It is not a case of bottom-up approaches to policy and action being preferable to top-down ones. An optimal balance between the two is necessary. Problems can arise when there is evidence of an imbalance.

Only those who subscribe to a model of perfect rationality in policy making would consider that perfect implementation was possible. In fact, implementation involves trade-offs, compromises, and operating with often poor or no information. Understanding implementation, as well as securing its effectiveness, is likely to entail a number of approaches – structural, procedural/managerial, and behavioural. The seminars considered all of these. A fourth approach, and perhaps the most fundamental, though often ignored or understated, is political. If implementation of a policy takes insufficient account of the realities of power, then the policy is unlikely to succeed. A political approach may also challenge the assumptions on which other approaches are based, eg those of behavioural analysts or management consultants. For example, implementation failure often results in regrets about the absence of leadership. But it could be that problems of implementation are, in many instances, problems in developing political will and expertise (Pfeffer, 1992). Problems of performance and effectiveness are problems of power and politics – power imbalances, powerlessness, and the inability of some groups or causes to get their ideas or policies taken seriously. Therefore a political strategy for implementation is as important as a strategy for agreeing more technical factors, such as targets or performance indicators. ‘Unless and until we are willing to come to terms with organisational power and influence, and *admit that the skills of getting things done are as important as the skills of figuring out what to do*, our organisations will fall further and further behind’ (Pfeffer, 1992: 12; emphasis added).

The complexity and breadth of the health inequalities agenda at both national and local levels are not in doubt. They are reflected in a wide range of decision-making processes and complex partnerships spanning different decision-making and performance-management systems. As noted, the various moves to tackle inequalities resemble a complex adaptive

system. Such a system has been described as ‘a collection of individual agents with freedom to act in ways that are not always totally predictable, and whose actions are interconnected so that one agent’s actions changes the context for other agents’ (Plsek and Greenhalgh, 2001: 625). In complex systems, unpredictability and paradox are ever-present and some things will remain unknowable. Furthermore, the interactions within a complex adaptive system are often more important than the discrete actions of the individual parts (Plsek and Wilson, 2001).

A principal theme to emerge from studies of the policy process is that policy formulation and implementation are interdependent activities, and policy initiators should consider them in combination. If policy is to be successfully implemented, then those stakeholders who have responsibility for its implementation should be involved in its design from the outset.

Stakeholder views of the local system: implications for implementation

Stakeholder views of implementation and tackling health inequalities at local level are critical to the success or otherwise of policy, and have a clear impact on how policy implementation might be conceptualised. In their exploratory study of the perspectives of various stakeholders, Killoran and Popay (2002) were concerned to investigate the nature and dynamics of local systems within which policies aimed at reducing health inequalities are being implemented. Stakeholders’ views are shaped by their different conceptions of the local system. For some stakeholders, the local system is geographically bounded, with particular emphasis placed on neighbourhood renewal and area-based initiatives such as the New Deal for Communities and Health Action Zones, which target the worst areas nationally and locally. The emphasis is placed on a developmental approach characterised by learning, evidence and technical support, promoting experimentation and innovation to inform and influence mainstream change. In such a context, a command-and-control approach to policy and its delivery, pursued through vertically organised performance management and inspection arrangements, may be wholly inappropriate and run counter to the developmental ethos.

For other stakeholders, the local system is depicted as a network of relationships. Partnerships are seen as a defining feature and the key delivery vehicle, with local strategic partnerships (LSPs) and neighbourhood management models variously highlighted as having a pivotal role. Issues of

governance, politics and accountability are important in this conception of the local system, as well as the power imbalances between the various stakeholders engaged in the process. Local strategic partnerships are not only bringing together the health and regeneration agendas, but also bringing the democratic decision-making structures of local authorities together with different models in business and health organisations. Research into understanding LSPs is needed in order to discover how to render them more effective, or to disseminate more widely the successes of some and the constraints operating on others. Critical to such a view of the local system is a belief that devolution and democratisation are fundamental to establishing genuine relationships with local people, which could allow effective solutions to complex problems to be explored. Again, such a view of the local system based on horizontal or lateral linkages and networks is at odds with a system of policy and implementation that is vertically organised in hierarchies.

Finally, and related to the notion of governance, is the importance attached to the various levels of policy and implementation – national, regional and local. Some accounts present policy implementation as a rational process of local delivery within national frameworks of strategy and accountability. The system is portrayed as a command-and-control one, but with increasing degrees of devolution permitted and more promised. As noted earlier, this is in keeping with the recent thrust of government policy that seeks to emphasise local choice and diversity, with services becoming people-centred and responsibility for them devolved to enable local communities to influence the shape and impact of policies and services.

Within this context of stakeholders' overlapping understandings of the local system for delivery and implementation, a number of barriers to implementation may be identified, operating at macro- and micro-levels (Killoran and Popay, 2002). At a macro-level, eight themes were identified:

- Questioning of the emphasis on local delivery, eg through area-based initiatives, when there was more visible national action on issues such as income redistribution
- Tension generated by a top-down emphasis on performance management conflicting with local autonomy
- Turbulence and continuing instability in the local system arising from modernisation and organisational change
- Conflicting timeframes at national and local levels to build sustainable relationships between agencies and local people

- Tension between the focus on, and priority attached to, a downstream as distinct from an upstream health agenda, and their respective contributions to tackling inequalities
- Different perceptions of leadership roles, commitment and accountability of various government departments, eg perceived lack of connectivity between Department of Health priorities and other central departments' commitment to neighbourhood renewal
- Confusion about accountability and responsibilities in exercising a leadership role in inequalities
- Lack of understanding of public health and a preoccupation with acute hospital services among the public.

At a micro-level, other tensions were identified that had an impact on implementation:

- Emphasis on partnership working in a context where capacity is limited
- Emphasis on planning where capacity was also limited and community planning in particular underdeveloped, eg evidence from health action zones and New Deal for Communities showed that plans were generally 'hopelessly unrealistic, badly set out and unspecified'
- Emphasis on need for evidence in a context where it was difficult to 'prove' that change was happening at a community level, especially within a short timescale
- Concern with structural change versus the importance of people as drivers of change – too much focus on structural fixes, and neglect of developing and rewarding people
- Fundamental difficulties in influencing or 'bending' the mainstream, and a preponderance of short-term initiatives and/or projects.

These stakeholders' perspectives are derived from a small exploratory study; other sources of evidence about stakeholders' experiences of the policy process may provide contrary views. Nonetheless, the stakeholder interviewees were selected to provide diversity in terms of their views and roles and location within the system. While it may be possible to challenge some statements, the study indicated how these stakeholders perceive their working environment and challenges to tackling health inequalities. Other studies suggest the views expressed by the respondents do not appear untypical or exceptional (eg Cabinet Office, 2001a,b).

2 The nature of public health evidence and its application

The place of evidence in decision making

Partly as a result of a preoccupation with evidence-based medicine, there is a tendency to overstate the importance of evidence as a driver in decision making (Hunter and Marks, 2002; Marks, 2002). Evidence on effective interventions forms part of the decision-making process for addressing inequalities in health. But it is rarely a starting point at local level. Priorities for implementation more often emerge out of the planning process, and in response to funding opportunities. The evidence base is itself the product of decision making in relation to methods for synthesis and criteria for inclusion of research studies. It informs part of the decision-making process for addressing inequalities in health, but is inadequate (and sometimes inappropriate) in meeting an agenda which is also driven by values of social welfare and equity, and where effectiveness may lie in how decisions are reached as well as an assessment of the evidence which underpins them.

The evidence base for tackling health inequalities

Those seeking to prioritise initiatives to address health inequalities on the basis of the evidence face a number of challenges.

First, the intended policy outcome and focus of interventions need to be defined precisely. As pointed out above, there are different understandings of what health inequalities can mean (Graham, 2002). In particular, interventions that focus exclusively on the most deprived groups and areas will not necessarily reduce the health gap between those who are more deprived and more affluent. Unless such interventions improve the health status of those living in poor socio-economic circumstances at a faster rate than improvements in health of the better-off, the gap will not be narrowed.

Such interventions are unlikely to reduce the overall health gradient across socio-economic groups.

Second, the evidence base for tackling health inequalities is scanty. Evidence-based medicine has traditionally been based on systematic reviews of controlled intervention studies. This approach does not always fit well with appropriate research strategies to evaluate measures to address the social and economic determinants of health. Consequently there is limited evidence about interventions designed to improve the health of particular disadvantaged communities; to assess the effectiveness of health service interventions; or in relation to specific topics (such as housing) associated with inequalities in health. There are strong arguments for a more inclusive approach to the evidence base. The importance has also been demonstrated of drawing on decision-making models that reflect different notions of evidence, and different approaches to weighing up evidence in order to reach judgements in situations of extreme uncertainty. These include, for example, impact assessments, forecasting, scenario-building, public inquiries and the legal process.

Third, it is argued that focusing on the evidence base and the individualised interventions that typically populate it has the effect of ignoring the more important macro-level determinants of health, and the degrees to which inequity is tolerated and sustained through policies at national and local levels. Inequalities in health reflect wider inequalities (and therefore decision making across a wide policy spectrum). At a micro-level, too, reliance on the evidence base works against a recognition or assessment of the effects of synergy, and also underestimates context-specific aspects of achieving change within local communities.

Fourth, interventions need to reflect theoretical approaches to understanding social and environmental sources of structural inequalities in health status, how they interrelate,

how they are mediated, and how they are constructed over an individual's life history. Just as inequalities in health emerge from an accumulation of different forms of disadvantage across the life course, so interventions that are appropriate for tackling these inequalities are often complex, operating on a number of different levels over a long period, and involving multiple professions and organisations each with their own values, cultures and priorities. Following a social-ecological model of health, Smedley and Syme (2000) argue that for maximum effectiveness interventions need to be carried out simultaneously across a wide range of sectors. They state that research is needed into multi-level intervention approaches 'to contribute to our understanding of how best to create linkages between levels of influence and how to sequence or co-ordinate interventions across levels', as well as on the increased cost effectiveness of intervening at additional levels. Such an approach to generating evidence implies challenging the prevailing orthodoxy in favour of randomised controlled trials and an essentially biomedical view of what constitutes credible evidence.

It is important to appreciate that the type of evidence useful in tackling health inequalities and change management is likely to differ significantly from that which can guide clinical practice (Iles and Sutherland, 2001). When investigating such areas, research methods are needed that allow for the process of change to be explored and understood, rather than those that concentrate on measuring the outcome. It is not a case of opting for one or the other – both types of evaluative research are needed. A better balance between them is also needed.

Fifth, a focus on identifying new and effective interventions for addressing health inequalities may divert attention away from a critical analysis of the ways in which current policies, priorities and ways of working contribute to disadvantage, or from developing ways of ensuring new policies are critically and prospectively assessed for their effects on health inequalities. The so-called 'inverse care law' remains much in evidence (Wanless, 2002).

A development focus

While the overall evidence base is limited, in some cases more could be achieved by applying what is already known. There is a need for a greater focus on *development*, rather than on acquiring additional knowledge [as referenced in the Public Health R&D Strategy (Department of Health, 2001)]. There is a case for shifting the focus to understanding and

evaluating the *process* of change, and how it occurs, as well as its *outcomes*. A sharper focus on action research might assist in bringing the two activities closer together in ways that enable research to influence practice.

As Fulop *et al.* (2001: 9) state, 'those undertaking action research suggest that the inevitable effect a researcher will have on an organisation or individuals while undertaking research should be harnessed for positive benefits within the organisation. In action research, implementation and research occur iteratively, and the researcher is part of the change process'. Meyer (2001) suggests that action research can also be used in a number of ways to generate different types of knowledge:

- When no evidence exists to support or refute current practice, or when poor knowledge, skills and attitudes exist to carry out evidence-based practice
- When gaps have been identified in service provision, or services are under-used or deemed inappropriate
- When new roles are being developed and evaluated and there is a need to work across traditionally conflicting boundaries.

3 Effective approaches to regeneration and reducing health inequalities at neighbourhood level

The evidence is well established that inequalities in health have a strong spatial dimension (see eg the Acheson report: Department of Health, 1998). Research indicates increased polarisation, with growing contrasts between poorer and better-off areas (Hills, 1996). The Social Exclusion Unit identified 4,000 neighbourhoods that are 'pockets of intense deprivation where the problems of unemployment and crime are acute and hopelessly tangled up with health, housing and education'. The *National Strategy for Neighbourhood Renewal* (Social Exclusion Unit, 2001) is viewed by the government as an important part of its response to deprivation and inequalities. Box 1 (page 12) summarises the strategy as an example of policy and evidence into practice.

There is growing understanding of the role that 'place' plays in influencing individuals' and families' levels of exposure to health risks, as well as their chances and opportunities for being healthy. For example, research funded under the Health Variations Programme by the Economic and Social Research Council has advanced knowledge in this area (Graham, 2000). Analyses have shown that, while individual factors are the primary cause of spatial inequalities in health, areas also have an effect. Poorer people may have poor health in part because they have to live in places that are health damaging (Macintyre, 1997). People have higher exposure to physical hazards such as environmental pollution, traffic volume and rates of road accidents (Department of Health, 1998). People have poorer access to public services, including primary care, public transport, shops and recreation facilities (Macintyre, 1986, 1997). Macintyre and colleagues studied the influence of home – and specifically tenure – on health. They confirm that renters are both poorer, and in poorer health, than owners; and suggest plausible physical and psychosocial mechanisms through which features of the home and the area in which it is located might have health-promoting or health-damaging effects on physical and mental health. They also suggest that influences of housing and area on health

are likely to be more direct than the more generalised effects of income and social class (Macintyre *et al.*, 2000).

The notion of social capital has growing currency in helping to explain how psychosocial pathways could operate to influence the health of individuals and families. Lupton and Power's (2002) work on social exclusion and neighbourhoods goes some way to positioning such health risks and opportunities within a cycle of neighbourhood change, decline and potential renewal.

There are thus good reasons why an area-based approach to tackling health inequalities, that is part of a wider policy for community regeneration, is an appropriate and important part of a national response to the health gap between rich and poor. But reviews of the evidence indicate that few evaluation studies of interventions have focused on economically disadvantaged areas as the unit of analysis, so there is very little robust UK evidence on how effectively to improve the health of such communities (eg Bauld *et al.*, 2002).

The seminar papers were primarily concerned with identifying and assessing the evidence, albeit limited, on how the health of deprived communities might be improved. The focus on deprived communities will not necessarily close the health gap unless the health of those in poorer areas improves at a faster rate than in more well-off areas. The overall health gradient across socio-economic groups is unlikely to reduce without wider, population-based policies.

Interventions addressing the root causes of ill health

Curtis and colleagues (Curtis *et al.*, 2002) draw on structured reviews of the evidence to identify the health impact of particular types of interventions: where the primary aim has

Box 1 Case Study: Evidence into Practice – The Neighbourhood Renewal Strategy

The strategy aims to *narrow the gap* between the most deprived neighbourhoods and the rest of the country, so that 'within 10–20 years no-one is seriously disadvantaged by where they live'. Evidence and learning about previous attempts to address deprivation informed the development of the strategy (Social Exclusion Unit, 2001). Variable success in the past was attributed to flaws in the policy framework, and also to the process of implementation. The Neighbourhood Renewal Strategy is intended to build on previous learning and address previous weaknesses.

Key features of the strategy are:

- Local strategic partnerships, to provide the strategic framework for effective development and implementation of multi-agency neighbourhood renewal strategies
- Focus on changing mainstream programmes and services to address the needs of the most deprived communities and groups, rather than spending ring-fenced funds in isolation from the larger picture
- Emphasis on putting into practice 'what works', supported by a range of technical assistance to local partners and practitioners
- Local learning action plans that identify and develop skills and resources
- Neighbourhood Renewal Fund to pump prime change in the 88 local authority areas with the most deprived communities
- Emphasis on involvement of local communities through investment in development of the capacity and infrastructure of local voluntary and community groups
- Establishment of the Neighbourhood Renewal Unit to support implementation locally and nationally across different government departments.

Experiences of neighbourhood renewal and early lessons

In principle, local strategies for neighbourhood renewal provide a framework for review and re-orientation of mainstream programmes. Local strategy development and implementation is at an early stage, and limited evaluation evidence is available. The evaluation findings of related initiatives, discussed in this section, provide lessons to guide local strategy development and the design of interventions.

Judge and colleagues applied the theory of change to evaluation of the delivery plans for health action zones and for the health domain of the New Deal for Communities (Judge *et al.*, 1999; Bauld *et al.*, 2001). Overall, the quality of these plans was very variable. Those involved in these local initiatives experienced difficulty in setting out their plans in a logical fashion that linked problems, interventions and outcomes.

The assessment of the health domain of the New Deal for Communities indicated that attention needed to be given to:

- Baseline data collected and their comparable use within and across the New Deal for Communities
- The degree to which local health needs drive the planning agenda
- How far targets are realistic, measurable and meaningful in relation to the goals of the New Deal for Communities
- The extent to which planned activities are well specified, adequately resourced and sufficiently targeted to bring about change.

The evidence shows that the task of developing local strategies aimed at achieving long-term health outcomes is highly challenging (see also Blamey *et al.*, 2001). There is limited expertise and experience available to define the logical pathways linking problems, interventions and outcomes. Substantial technical assistance and support are required. Plans tend to be over-ambitious and wide-ranging, while the complexity and resources demanded to take forward community interventions suggest that a more selective and tightly managed approach is needed. A focus on a small number of priorities is likely to be constructive. Plans and project design need to be linked to performance management frameworks. Experience of the theory of change suggests that local partners and central policy makers (as commissioners) tend to have different expectations of such initiatives. Clearly, work to achieve greater consensus could help implementation.

Both the seminar paper by Fordham (2002) and the Audit Commission's (2002) research on implementing the Neighbourhood Renewal Strategy (page 20) show that many local agencies are struggling with these issues. In particular, the management of change has proved difficult, especially when vertical and separate departmental 'silos' remain intact and partnership working remains largely rhetorical. The plethora of projects and initiatives in recent years has undermined the ability of managers to take a long-term, mainstream view of development. Instead, they are preoccupied with the short term and with a 'bidding' culture. Recruiting and retaining staff, and ensuring they possess the requisite skills, are key challenges.

been to change the economic, social and physical environment in neighbourhoods, with the potential of improving the health of socially disadvantaged groups and communities. Their review focuses on employment, housing and transport, and some of their findings are summarised in Box 2. They show that regeneration can make a positive contribution to improving the health of those in poorer socio-economic circumstances.

But there is also some potential for negative impacts on the health of these groups, and a worsening of health inequalities. It is important that assessment of the health consequences of such schemes is an integral part of their planning and design. Various tools for health impact assessment are being employed at a number of levels. Curtis *et al.* (2002) illustrate how rapid health impact assessment can be used early in a regeneration scheme to inform plans for implementation, monitoring and evaluation.

Health-related interventions for reducing health inequalities

Bauld *et al.* (2002) mapped the range of evidence concerned with the effectiveness of health-related interventions for reducing health inequalities in the context of neighbourhood renewal. While, overall, the evidence base is underdeveloped, their review draws attention to a range of sources that can inform practice.

Arblaster and colleagues' systematic review of the literature identifies a number of *intervention characteristics* that contribute to successful outcomes in improving the health of disadvantaged groups (Arblaster *et al.*, 1996). Petticrew and Macintyre specify a number of intervention areas shown to be effective in reducing inequalities (Petticrew and Macintyre, 2000). Systematic reviews of the evidence in the main intervention categories relevant to neighbourhood renewal are being assembled by HDA. Petticrew and Macintyre make

Box 2 Summary of evidence on regeneration interventions

Employment

The research evidence suggests that unemployment, or employment in jobs with poor working conditions, is generally damaging to health. Changes in employment status have been shown to be linked to changes in health. Re-employment of unemployed people may be beneficial to health, but for those moving into work where conditions are poor, changes in health may be detrimental. Studies of regeneration that has improved the general economic situation in previously depressed areas suggest that economically disadvantaged long-term residents do not always benefit. Active labour market intervention schemes are intended to address this problem by improving the capacity of unemployed people to participate in the labour market. Participation in active labour market intervention schemes has health benefits, but may also have some negative effects on health.

Housing

Poor housing is associated with a range of physical and mental health conditions. In the short term, housing refurbishment can be disruptive and intrusive. In the longer term, improvements have occurred in general self-reported physical and mental health, as well as reductions in symptoms and use of health services. While there is potential for health gains for people moving into improved housing, the health effects for the wider population of rehousing or housing refurbishment may be mixed. Housing regeneration programmes do not always improve housing equally for all local populations. Those with the most severe housing needs, and some marginalised groups, may be further excluded or displaced by housing schemes. Thus neighbourhood improvements may displace social problems rather than solve them, so may not help to reduce general health inequalities.

Transport

Improvements to transport infrastructure are often included as part of urban regeneration schemes. Transport has a number of features that contribute positively to determinants of health, by improving access to a range of services, facilities and amenities, and improving social interaction. Improvements to transport infrastructure such as major roads or airports may also have a negative impact on health through pollution, accidental injury, severance of communities, and a reduction in healthy and sustainable forms of travel such as walking and cycling. Socially and economically disadvantaged communities are particularly at risk of these detrimental effects, so it is important to minimise or mitigate the potential negative health effects of transport development to avoid exacerbating health inequalities.

the point that interventions can be considered successful only when they are at least as effective for the lowest socio-economic group as for the highest. Interventions that are effective in general terms may be ineffective in reducing health inequalities.

Well established evidence on the role of access to health services demonstrates the inverse care law: in areas where the need is greatest, there is often the poorest supply or quality of provision. This pattern of inequity of access is clearest with respect to primary care and prevention services. For example, there are fewer GPs (and attached practice staff) per head of population in more deprived areas compared with more affluent areas (Benzeval and Judge, 1996). Recruitment and retention of staff is problematic, particularly in inner cities. There is less take-up of all types of preventive care in deprived communities, and among black and minority ethnic populations.

Primary care is at the centre of the government's NHS modernisation project. One of the core functions vested in PCTs is to improve population health and address inequalities. Gillam and Florin (2002) examined the types of interventions that PCTs should consider in tackling health inequalities, taking account of the evidence. The three categories of interventions are shown in Box 3.

As Gillam and Florin note, 'the very breadth of activities involved – from individual health advice to organisational forms of primary care organisation to complex community interventions – is itself a stumbling block'. They also point to a variant of the inverse care law – the inverse prevention law – whereby communities most at risk of ill health tend to experience the least satisfactory access to preventive services. Lack of evidence on effective interventions is not the only factor that influences the potential for tackling health inequalities in the primary care setting. Research has

Box 3 Evidence for the role of primary care in tackling health inequalities

Type of intervention

Individual-oriented interventions

Classic preventive activities, eg immunisation, coronary heart disease (CHD) risk factors

Evidence base for effectiveness

Strong evidence for inverse care law, with less access to services for those in poor socio-economic circumstances compared to those who are better off

Strong evidence from experimental studies for certain individual-oriented activities that improve risk factor status at population level, although not necessarily for lower socio-economic groups

Limited evidence for cost effectiveness of certain preventive activities at population level, although not necessarily for lower socio-economic groups

Forthcoming evaluation of CHD National Service Framework will be an important source of evidence on effectiveness of implementation, including coverage of lower socio-economic groups

Organisational interventions

Organisation of care and access for disadvantaged groups, eg increased access of ethnic groups to cervical screening – providing different languages and availability of female doctors

Some experimental studies about access at practice level

Evidence of negative effect of financial barriers (charges), particularly with respect to take-up of services by lower socio-economic groups

Little evidence on PCT-wide organisation and delivery of services that target and reach lower socio-economic groups

Pilots suggest that nurse-led personal medical services address previously unmet needs in deprived locations with insufficient doctors
Forthcoming national evaluation of Sure Start schemes

Community-wide interventions

Including community development initiatives and collaborative initiatives in community settings

Very little experimental evidence

Methodological difficulties in rigorous evaluation

Forthcoming evaluation of health action zones and other area-based initiatives, and healthy living centres

highlighted a range of factors that operate as barriers to implementation of interventions that have proven effectiveness. These barriers include lack of commitment, experience and incentives among some practitioners, as well as organisational prioritisation, and the resources and capacity to implement effective programmes. Nevertheless national tracker studies of 75 PCTs have reported progress by PCTs in establishing an infrastructure for health improvement. Emphasis has focused on addressing inequalities in access to services. Many PCTs have implemented health improvement initiatives in line with the national service frameworks.

Perhaps the most troublesome issue for PCTs is that health improvement drops down the agenda when set against the 'must-dos' related to the acute sector. A contributing factor, as a survey carried out for the HDA of PCTs and their public health roles discovered (Heller *et al.*, 2002), is the paucity of work on the public health role in primary care. There is a need to look systematically at ways of building human resource capacity in public health at the primary care level. Among the themes identified in the survey, and affecting progress, are:

- Pace of change/organisational uncertainty
- Multi-disciplinary working and inter-professional relationships
- Developing guidelines on approaches to public health in primary care
- Developing the public health workforce
- Public health: everybody's business but nobody's priority?

The conclusion reached by Chinamasa *et al.*'s (2002) literature review of the public health role of primary care in addressing health inequalities is that primary care is still trying to come to grips with the concepts involved in public health. The shift from a medical model-based approach to a broader population-based approach has created uncertainty and some confusion among various stakeholders.

Social capital and policy implementation for reducing health inequalities?

The concept of social capital has increasingly been viewed as relevant to helping explain patterns of health inequalities in communities. It is also informing policy and intervention options aimed at reducing health inequalities, particularly through efforts and investment in building social capital in ways that can generate health benefits in socially

disadvantaged communities. More broadly, policy makers increasingly view the potential of social capital for generating economic, social and health outcomes as a reason why working with communities and building social cohesion is a prerequisite to tackling deprivation and inequalities (Cabinet Office, 2002). Social cohesion and community engagement therefore become central for turning policy into practice.

The theory of social capital derives from the work of Putnam (1993), Coleman (1988) and others. It is concerned with the production and use of resources that are embedded in social structures and networks, rather than in individuals. Putnam views social capital as the features of social life – networks, norms and trust – that enable participants to act more effectively to pursue shared objectives. The theory remains subject to debate and development. Cropper (2002), in his seminar paper, states that social capital is a portmanteau term and a highly equivocal concept: 'It bundles together several established concepts – trust, reciprocity/social exchange, networks and sociality, and informal organisation'.

There is an increasing amount of empirical work that tests the relationship between health and measures of social capital. Although positive effects of social capital on health have been identified, there are many questions to be addressed, including the relationship to health inequalities. How does social capital operate? What are the pathways that produce health benefits? Does social capital provide a buffer mediating the effects of (relative) material deprivation, or income inequality on health? Under what conditions does social capital work? Macinko and Starfield (2001) comment that 'there does not appear to be consensus on the nature of social capital, its appropriate level of analysis, or the appropriate means of measuring it. There seems even less clarity on precisely how it might be related to inequalities in health outcomes'.

There is a significant research agenda for understanding and applying the idea of social capital to benefit the health of deprived neighbourhoods. Specific intervention studies may provide a way forward that allows for more precise testing of how health benefits might flow from specific elements of social capital. For example, the spread of information, and the presence of mutual support within networks, can provide levels of protection against infectious disease and HIV/AIDS, and may enable take-up and maintenance of health-promoting behaviours.

Strengthening community involvement in decision making, governance and democratic renewal are also viewed as ways of building social capital to improve the health and wellbeing of socially disadvantaged communities and groups. It is argued that there are opportunities provided within current policies for encouraging and supporting civic engagement and democratic performance. For example, support to voluntary and community groups, and local people's participation in policy processes, could promote social capital formation in neighbourhoods. Community leadership provides a further focus, and changed practices among elected representatives could mediate improved levels of trust between communities and institutions.

Overall, although the literature identifies various ways of building social capital, there has been very little work examining the relative effectiveness of such interventions, including the impact on health inequalities. Work to refine definitions and instruments should support the opportunities for evaluation and strengthen the evidence base.

Complex interventions and the challenges for evaluation

Local strategies for community regeneration and reducing health inequalities are multi-faceted and operate at a variety of levels. 'Complex community interventions' are viewed as offering the best prospects for tackling the problems of deprived neighbourhoods. Technical and methodological difficulties abound for evaluation, and there is considerable debate about the most appropriate evaluation approach. Judge and colleagues (Judge *et al.*, 1999; Bauld *et al.*, 2001, 2002) point out that such interventions do not lend themselves to traditional evaluation methods such as randomised controlled trials. A more flexible evaluation

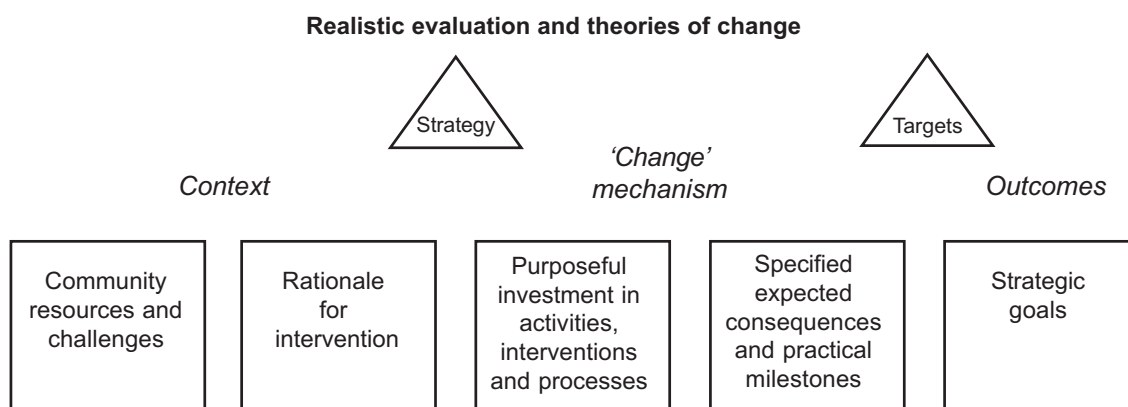
framework is needed if evidence for effectiveness and learning is to be secured. Rigorous evaluation is critical to ensuring that any potential detrimental implications of policies and programmes for health are understood, and harm avoided (Macintyre, 2000).

Curtis *et al.* (2002) highlight the types of evidence required to determine the health impacts of programmes and interventions that focus on improving the social and economic circumstances of poorer communities. The strongest evidence, it could be argued, would be derived from studies that collect similar data for large samples of individuals chosen from a variety of different places, and follow them over time, with complementary qualitative studies to collect more in-depth information. Ideally, quasi-case control methods should be used to compare populations not affected. Cost, practical and ethical reasons have hindered such research in the UK context, but there are examples of such trials in other countries.

In the UK, researchers have adapted Pawson and Tilley's (1997) ideas of 'realistic evaluation'; and a 'theory of change' perspective developed by the Aspen Institute in the USA (Judge *et al.*, 1999). These approaches acknowledge social programmes as complex, open systems. The potential for traditional evaluation methods, including quasi-experimental designs, to explain how or why the programme works is viewed as weak, particularly given that the variety of variables cannot be controlled. Essentially, these approaches are concerned with defining and testing the logic that underpins the relationship between problems, planned interventions and outcomes.

Figure 1 shows the model of the process for health improvement and community regeneration. This was applied

Figure 1 Process of community regeneration and reducing health inequalities (adapted from Judge *et al.*, 1999)



in the national evaluation of HAZs (Judge *et al.*, 1999; Blamey *et al.*, 2002), and the same approach has informed the national evaluation of the New Deal for Communities and local strategic partnerships that are concerned with assessing the effectiveness of neighbourhood renewal strategies.

Macintyre (2001) has argued that the evaluation of initiatives such as HAZ should involve a more systematic approach which considers the possibility of randomised choice of sites in the phased introduction of interventions, and evaluates outcomes as well as process. Perhaps these arguments are not mutually exclusive.

It is evident that there are many obstacles to achieving successful change. While some may have their roots in the policies themselves, others arise from the challenge of bringing about change in complex settings, where there are multiple stakeholders in the shape of professions and organisations each with its own values, cultures and standard operating procedures. Much of the complexity is the product of compartmentalised thinking that is not joined-up, seen in the wide range of projects and initiatives that not only reinforce a fragmented approach to delivery, but also divert managers from taking a strategic, long-term view. Section 4 explores the change management issues, which have become more acute over recent years, and illustrates some of the difficulties with further reference to the implementation of the Neighbourhood Renewal Strategy.

4 Managing system change

A recurring theme throughout the seminars was the persistence of disjointed government, despite much rhetoric extolling the virtues of joined-up policy, organisation and management, and the importance of networks and lateral forms of organisation and management. The problem can best be understood with reference to three strands of literature: central–local relations; implementation; and organisational political sociology (Stewart, 2002).

The history of public policy and management is marked by cyclical shifts between central and local control, and between vertical hierarchies and horizontal partnerships or networks. Finding an optimum balance between these various conflicting pressures has proved illusive. Ferlie (2002) notes that the new PCTs are being encouraged to organise themselves in a different way from traditional, vertically organised NHS organisations centred on command-and-control concepts. The changes ‘suggest the need to develop a more subtle and indirect leadership style, often associated with the leadership behaviours contained within the model of the learning organisation’ associated with Senge (1990, 1996). Here the focus is on the local health system or community as a whole, rather than on discrete NHS agencies. Yet, for all the rhetoric surrounding joined-up policy, organisation and management, the reality is that obstacles to moving away from a silo-based approach remain (Exworthy *et al.*, 2002).

There remains a strong and embedded ‘new public management’ approach that manifests itself in imposing ever more elaborate targets, performance management systems and audits on local agencies that are required to modernise and deliver on targets (Ferlie, 2002). This mode of organisation is vertically structured with a strong command-and-control emphasis and style. This leads to an uneasy coexistence of two apparently distinct modes of organisation,

or intellectual approaches. The outcome is confusion, stress, and greater uncertainty among local organisations. The key question is (McNulty and Ferlie, 2002): will a governance-based mode of lateral organisation reach its potential, or will it remain marginalised by a still powerful new public management movement?

The shift from vertical silos to horizontal, joined-up arrangements is not without historical precedents. There is a long history of joint working in respect of health and social care (Stewart, 2002). A lesson from this is the ‘long-lasting nature of the key obstacles’, including ministerial ambition, departmental survival, rigid boundaries, and inflexibility in public expenditure. There is a substantial evidence base testifying to ‘decades of disjointed working’.

Countering the tendencies to fragmentation and disjointedness requires shifts in both the vertical relationships between centre, region, locality and neighbourhood; and the horizontal links between organisations at different levels of the governance system (Stewart, 2002). For such a whole-systems approach, complex systems need to be understood in terms of the interactions between the different parts of a system and its environment. But while whole-systems models may be useful in acknowledging the interdependence of the various parts of the system of governance, they are inherently liable to failure as disequilibrium sets in. They are as robust as their weakest link, and what may start as virtuous circles can easily become vicious circles (Stewart, 2002).

Securing effective joined-up policy and organisation requires effective leadership and management. If this is absent, for whatever reason, including a culture of systems compliance and poor motivation, it is unlikely that the modernisation of policy and implementation will be realised.

According to Senge's model of a learning organisation, future leaders and managers will increasingly need to think and act systematically by:

- Seeing interrelationships rather than static structures
- Understanding how systems evolve through time
- Focusing on areas of high leverage
- Avoiding symptomatic 'solutions' such as short-term fixes (Senge, 1990, 1996).

Hambleton *et al.* (2002) devised a threefold view of leadership:

- *Designed and focused leadership* – provides a clear vision of future direction, a firm manifesto, a dedicated budget, a high-profile leader
- *Implied and fragmented leadership* – provides a consensual view of direction, operates on an implicit rather than explicit forward plan, puts together packages of resources through joint funding arrangements, invisible leadership
- *Emergent and formative leadership* – relies on implementation to shape policy, reflects pragmatism in guiding future direction, uses *ad hoc* resources to make progress.

Designed and focused leadership can offer a more autonomous leadership, depending on style and representational legitimacy. The fragmented, multi-organisational model, which implies a collaborative approach to leadership, may offer weak leadership that is subservient to external policy influence. Formative leadership reaffirms the fragility of partnership structures and processes to achieve desired ends (Stewart, 2002). Less is known about 'good ways to manage initiatives which cross boundaries between public, voluntary and private sectors, about initiatives which are based in communities and involve networks of different agencies, or about management outside the rules' (Parston and Timmins, 1998: 14–15).

Equipping managers with the skills needed to operate in this challenging environment – one marked by the need to balance stakeholders' interests, understand complex accountabilities, and manage for social outcomes – is being addressed by the NHS Modernisation Agency, the NHS Leadership Centre, and the NHS University, among others. The leadership modernisation programme is informed by three key components: successful care delivery systems; successful improvement science practitioners; and successful leaders. But the focus of activity is still on the primary and

secondary care delivery system, rather than on public health. The notion of *public health management* as a topic meriting dedicated attention is beginning to attract attention, not only in the UK but globally (Hunter, 2002). Public health goals cannot be achieved without a serious partnership across the disciplines of public health and management. Studies of managing change in health systems can provide useful insights for managing change in public health. In their study of strategic change in the NHS, for example, Pettigrew *et al.* (1992) identified eight factors accounting for receptivity and change, derived inductively from their studies of change at district level:

- Quality and coherence of policy generated locally
- Availability of key people leading change
- Long-term environmental pressure
- Supportive organisational culture
- Effective managerial–professional relations
- Cooperative inter-organisational networks
- Simplicity and clarity of goals and priorities
- Fit between district's change agenda and its locale.

The factors offer 'a linked set of conditions which provide high energy around change' (Pettigrew *et al.*, 1992: 275). Importantly, 'this energy and the capabilities which underpin it cannot be conjured up over a short period of time through the pulling of a single lever'. Receptive contexts for change are dynamic, and can be created by attention to the factors listed above. They are also reversible, by the removal of key individuals or by some other act which serves to create disequilibrium in the local setting.

Arguably, those engaged in improving population health have not been exposed to such ways of thinking and bringing about change. Experience of implementing the National Strategy for Neighbourhood Renewal illustrates a number of the points made above. Commenting on previous programmes and the lessons to be learned, Fordham (2002) suggests that 'inadequacies in programme implementation' were responsible for many of the weaknesses identified. These include:

- Failure of local partnerships to exert significant influence over partner behaviour
- Lack of inter- and intra-agency coordination
- Project-driven mode of operation which focuses on spending special funding rather than influencing main programme budgets
- Inadequate project development and appraisal technology.

The Neighbourhood Renewal Unit (Social Exclusion Unit, 2001) identified some further important weaknesses, including:

- Lack of relevant skills and experience on the part of those involved in programme implementation
- Frequently faulty analysis of the relationship between problem diagnosis, underlying cause and proposed remedy
- Failure to take sufficient account of what has worked, or not worked, elsewhere.

Drawing on early evidence of the operation of the Neighbourhood Renewal Strategy introduced in early 2001, Fordham (2002) observes that 'implementing the national strategy will prove challenging'. Among the critical issues to be considered are:

- *Securing cultural change* – the Neighbourhood Renewal Strategy's insistence on joint working and a more focused use of main programme resources requires a process of cultural change within all the implementing agencies
- *Skills development* – new ways of working are called for, within and across disciplines, in ways few staff have experienced – but the promised national skills strategy is still being developed, and in any event it will count for little if local agencies do not respond to it, as seems likely; LSPs have yet to produce local learning action plans that indicate how skills gaps are to be dealt with
- *Project-based culture* – the focus on projects remains, rather than influencing main programme budgets, which could prove dysfunctional if the long-term aim is to become mainstream
- *Using evidence* – the reluctance to seek or use evidence survives, as those recruited to the Neighbourhood Renewal Strategy tend to subscribe to an experiential view – 's/he who does, knows'.

In a study of 88 areas prioritised for neighbourhood renewal, the Audit Commission (2002) was concerned with identifying barriers to change, and strategies that appear to be overcoming the barriers. The Commission's study revealed that 53% of LSP members are concerned about inconsistencies in the approach of central government departments to neighbourhood renewal. Departments still adopt a vertical, silo-based mentality, each setting targets for local agencies that reflect their particular priorities. Greater consistency would provide local agencies with a coherent central steer, and remove some of the confusion which is evident. On the other hand, if local commitment to change

things is weak, progress will remain poor regardless of how the centre responds.

The Commission's research also discovered a strong desire on the part of local agencies for fewer initiatives and projects. These detract from the message that mainstream budgets and services are the keys to change. In such a fragmented context, learning the lessons in order to encourage mainstream approaches becomes a hit-or-miss affair. Fewer initiatives would encourage the use of mainstream programmes.

The research explored the workings of LSPs, and discovered considerable variation in the ways they function. Numerous problems were identified, including the absence of communication strategies in half the sample, and the absence of monitoring arrangements in half the sample. The ways in which meetings of LSPs are run can reduce efficiency and effectiveness.

The Audit Commission research examined the skills and culture in local agencies to determine their fitness for purpose with respect to neighbourhood renewal. The absence of organisational capacity to realise the strategy is an issue for many agencies. It was also apparent that many senior managers and frontline practitioners lack understanding of the aims of the Neighbourhood Renewal Strategy. Lack of 'ownership' of the policy is therefore a serious issue for many. Slow culture change in respect of partnership working was identified. The rhetoric of partnership is evident – but not its practice. The prevalence of 'initiativitis', and the fatigue resulting from it, may be a factor as it can create a style of management and delivery focused on the short rather than the long term. A 'bidding' mindset can divert attention from the need to bring activities and resources into the mainstream. Learning from previous experience is also patchy, and rarely permeates the mainstream. Professional boundaries could also militate against effective partnership working and reduce the possibility of encouraging flexibility around roles. However, many local agencies recognise these problems, and many are working to find solutions.

Conclusions and recommendations

Based on the papers prepared for the seminar series and the subsequent discussions, the potential remains for a gap between policy and practice in tackling health inequalities and deprivation. This may be attributed to inadequacies both in policy development (policy failure), and in implementation (implementation failure). In reality, the system for developing and implementing policy is dynamic and complex. The government recognises the need to adopt new, more appropriate forms of governance in place of the traditional command-and-control style of delivery through 'departmental silos'. Hence the emphasis on joined-up government, partnership working and the 'new localism'. But, as the seminars and the exploratory study commissioned for the series (Killoran and Popay, 2002) demonstrate, stakeholder groups occupying different parts of the policy and delivery system regard the task facing them from different perspectives. The dominant task for some is responding in a rational, sequential fashion to achieving national targets and 'must dos'. They see themselves as having little choice, as they can expect to be performance-managed against these targets. Others believe the processes of cooperation, partnership working and alliance-building to be the focus of attention. And a third group subscribes to a developmental process that is geographically focused on communities. Understandably, tensions exist in respect of these multiple (potentially conflicting) perspectives, presenting barriers to implementation.

The National Strategy for Neighbourhood Renewal represents a key opportunity to tackle health inequalities and deprivation. Its development, implementation and evaluation can be viewed as a case study for turning policy into practice (Box 1). In particular, its policy formulation sought to learn from previous experience and shortcomings. As a consequence, there is an emphasis on bringing about changes in mainstream strategies, and on applying evidence

of 'what works', although there is still some way to go in achieving these aspirations and developing the necessary skills among public health practitioners.

Reviews of the evidence of what works, together with feedback from early experience of local implementation, have identified gaps in the evidence base as well as providing lessons for policy and practice.

Effective interventions and gaps in the evidence

From the background papers and seminar discussions we highlight the following points, in no particular order.

- There is substantial opportunity to apply existing evidence of what works in relation to areas of health and access to health services. The inverse care law has operated, especially with respect to preventive programmes, but can be addressed through efforts targeted specifically at deprived groups and communities. Although the implementation of such interventions with respect to deprived groups and communities has not been well researched, the evidence provides clear principles of working with such groups.
- The evidence on the potential for reducing health inequalities through wider regeneration measures is much less well developed. More research on the health consequences of specific regeneration programmes (eg New Deal for Communities) is required. In particular, understanding is needed of the pathways whereby changes in economic, social and physical circumstances influence health. Evidence must be easily accessible by different audiences and meet their particular perceived needs.
- The prospective use of health impact assessment can be

an important way to engage a range of stakeholders in making decisions about different interventions, taking account of the former evidence. It is important to assess both the negative and positive health consequences.

- The concept of social capital appears relevant to investigating how community cohesion and social relationships could improve health. But the pathways defining how social capital might improve health remain unclear, and are subject to debate. There is no substantive empirical evidence about effective ways of building social capital that achieve health benefits. There are significant methodological difficulties in measuring social capital and evaluating approaches aimed at building social capital.
- Programmes that combine a range of approaches appear to offer the best prospects for an impact on health inequalities. Such complex community interventions pose significant challenges for evaluation. Orthodox evaluation approaches, such as randomised controlled trials or systematic reviews, have their uses, but are not always appropriate. There is a need to review more flexible evaluation frameworks and accord them equal legitimacy, to ensure learning is forthcoming.
- The theory of change approach has been used to evaluate a number of major initiatives, and has merits. The experience in applying it provides important lessons for managing change.

Managing system change: issues of governance

- A finding from studies employing a theory of change approach is that, locally, a culture of logical planning for achieving long-term health and social outcomes is generally absent. Technical support should be made available, and such initiatives need to be much more tightly managed and focused to yield sustained changes that can be evaluated with limited research resources.
- A move towards a culture of evaluation, learning and development is critical, given the limits to the evidence on effectiveness. The necessary infrastructure and capacity for sharing learning nationally, regionally and locally needs to be put in place. Technical support is required to enable local stakeholders to access and apply the evidence and learning.
- Partnership arrangements are viewed as the most appropriate mechanism for managing the system changes required to deliver policy. There is a growing evidence base on the nature of partnership working and what makes for effective partnerships. In particular, the literature on leadership, transaction costs, social capital, trust and

power, as well as on how best to maximise collaborative advantage and minimise collaborative inertia, is important in understanding key aspects of partnerships and how to strengthen capacity (Huxham, 1993).

- Process evaluations of a number of collaborative initiatives and early experiences of neighbourhood renewal indicate that bringing efforts to reduce health inequalities and deprivation into the mainstream of partner organisations' core business is a fundamental challenge to achieving real, sustained impact.
- Primary care trusts are new players within the health system that are expected to make a substantial contribution to tackling health inequalities and improving health. The evidence shows that a range of community-oriented preventive programmes can have a real impact. However, the role of PCTs at organisational level, and their contribution in wider community interventions, have not been researched. Evidence assembled for the seminars suggests that the capacity of PCTs to take effective action on health inequalities is variable. A comprehensive review of the role of PCTs in tackling health inequalities is needed to inform future policy and practice.
- A number of streams of literature from political and organisational sciences are relevant to informing effective policy implementation. For example, research on the type of leadership and skills needed to enable community-level change is required to understand which leadership approaches work best in which circumstances.
- We have drawn on some of this material in this report, but too little use is made of it in understanding both implementation failure and success. A range of specific reviews of the policy analysis and academic literature could usefully assess their relevance and the implications for public health.

The focus of this report is on delivery, and on creating the optimal conditions to ensure delivery occurs. But delivery for what? At the same time, *what* is being delivered cannot be separated from *how* it is delivered. The process is both dynamic and iterative, rather than a passive, purely technical exercise. It is shaped in all kinds of ways by how policy is implemented by particular groups of stakeholders, operating within quite diverse contexts and possessing different values, cultures and mixes of resources, including power, money, knowledge and skills. Local stakeholders experience considerable tension and ambiguity in trying to implement policy in a context where they feel constrained and disempowered by the strictures and limitations of central diktats, and a preoccupation with centrally devised and imposed targets.

The government is alert to this criticism, and believes that by devolving responsibility and resources to local agencies and communities it will empower them to act in ways best suited to local circumstances. As the health secretary put it, 'we now know that finger-wagging from Whitehall can not deliver public service improvement' (Milburn, 2002).

If local stakeholders are to make best use of the opportunities being bestowed on them through the devolved arrangements being put in place, then they must gain an appreciation of politics and the play of power – and become skilled in handling these to their best advantage. It is not simply a case of applying the evidence, even where it does exist. As studies have shown, evidence is rarely applied to decision making in accordance with a rational, linear model. In practice, evidence is often generated through doing – in the enactment of policy. Evidence may be only one component of any decision-making process, but it can be made an integral part of a culture of inquiry based on continual learning and development.

Leaders and managers need to appreciate the complex relationship between research evidence and practice, and to ensure the right conditions are created to allow practitioners to reflect on, and learn from, the practice of what they do and how they do it. In this way, learning becomes a supply of evidence to be drawn on as practitioners continue to implement and reshape policy. Managing change can be undertaken on a sustainable basis only if it is informed by the process of securing change as it occurs. This is the true meaning of the learning organisation.

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