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Version: Accepted Manuscript

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Wicked Comparisons: Reflections on Cross-national Research about Health Inequalities in the UK

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Abstract

This article discusses a comparative study of how local actors tackle health inequalities in England, Scotland and Wales. The main method used in this study was a thematic analysis of 200 interview transcripts. Its main focus was on how health inequalities are framed for intervention by performance assessment systems and the challenge for these systems that their nature as a 'wicked issue' presents. The three different national contexts are described, including organisational structures and the use of targets, and the difficulty of making evaluative comparisons is considered. Reflecting on results from the study, it is concluded that both divergence and convergence in themes across the three countries reveal narrative patterns that draw on discourses rather than evidence. The nature of national performance audit regimes appears to play an important part in shaping these discourses, which are themselves evolving, partly in interaction with local feedback.

Key words:

Health inequalities; performance assessment; national comparisons; UK; discourses.

Introduction

Socio-economic inequalities in morbidity, mortality and access to health care have been recognised by most European countries for over a decade as a priority for government action (WHO Regional Office for Europe, 2002). However, progress has been disappointing, with health inequalities having an intractability shared with other 'wicked issues'. This term, first coined by Rittel and Webber (1973) to describe difficult planning issues, describes the complexity of problems that often have no definite shape, can evolve and mutate, elude clearly right or wrong solutions and often have many causal levels.

Performance assessment and wicked issues: the case of health inequalities is a project funded under the first phase of the ESRC's Public Services Programme, involving researchers from the Universities of Durham, Cardiff and Aberdeen. It aims to compare how a complex issue like health inequalities is constructed as a problem for intervention at a local level within the contrasting national policy contexts of England, Wales and Scotland, especially their varying degrees of top-down performance assessment.

This article focuses on the difficulty of making these comparisons when the performance assessment regimes are different. One of the aims of the ESRC programme was to learn from the cross-national laboratory of different policies in each of the three countries of the UK, but we found it virtually impossible to do this in an evaluative sense because there were different targets and policy priorities, and few common reference points. This difficulty was further compounded by the time

dimension as governments changed and organisations were restructured over our period of research.

There have been few studies of performance assessment regarding health inequalities or its application to other wicked issues. Exworthy et al. (2002) explored the implementation gap between English policy on health inequalities and local action, identifying a series of obstacles to progress, including the dominance of waiting lists in performance management and a lack of engagement among local authorities. Hunter and Marks (2005) identified similar problems with targets in the NHS and their extension into the complex arena of health improvement and health inequalities. The evaluations of the English Health Action Zones also revealed this complexity, with the HAZs taking different approaches to inequalities and their goals and targets varying according to local context (Benzeval, 2003). These and other studies, such as from the ESRC Health Variations Programme, show how decision-making for addressing inequalities in health typically takes place in a context of uncertainty and competing priorities (Barnes, Matka and Sullivan, 2003; Benzeval, 2003; Graham, 2000; Hunter and Killoran, 2004).

Our study, therefore, sought to address the gap in research on performance assessment and wicked issues by seeking to understand the influence on local actors of national audit regimes and policies. An interesting question, which we explore in this paper, is whether this is evaluative research; whether we can make claims about 'what works' regarding these different national contexts when the way that issues are framed for intervention varies significantly.

Institutional context

Performance assessment developed extensively as a method of implementing national policies under New Labour governments from 1997 (Travers, 2007). The idea for our research project came from seeing performance assessment extend to health inequality. We saw health inequality as presenting a challenge in this respect, given its complexity and the long timescales over which changes in population health may occur. A wicked issue of this nature intensifies what can be thought of as a 'black box' problem: the problematic relationship between an action and an outcome because of difficulties of causal attribution and complex interdependencies (Hudson and Henwood, 2002; Kavangh and Richards, 2001; University of Birmingham, 1999). A command-and-control approach to performance managing such issues seems unlikely to relate well to their nature as 'a constellation of linked problems embedded in the fabric of the communities in which they occur', and this is compounded by stakeholders who grapple with wicked issues often bringing to the issues different interpretations, values and goals (Kreuter et al. 2004, p. 441).

England's public services managerialism has used targets as a key delivery mechanism across all policy areas, in contrast to both Scotland and Wales where targets have been less comprehensively deployed and are often more about dialogue between levels of government than 'command-and-control' from the centre (Greer, 2004). These differences reflect the ability of each country to follow distinct policy approaches since the introduction of devolved government in Wales and Scotland in 1998. Health inequality, however, has been a clear policy priority in all three countries, creating an opportunity to investigate the difference that each country's

distinct approach to applying targets and performance assessment has made to tackling the issue.

At the time that our research proposal was submitted, new 'joined up' and 'outcome focused' performance assessment arrangements were being developed across the National Health Service (NHS) and local government in England, including Local Area Agreements and Comprehensive Area Assessments (Bundred, 2005; Healthcare Commission, 2004). Cross-cutting issues such as health inequality had been spared the full gaze of performance assessment because of the difficulty of attributing change to any single organisation (in contrast to, say, hospital waiting times). The new approach aimed to establish joint accountability for these issues and their performance measures, and in doing so has promised that health inequalities will be 'seen to matter' (Department of Health, 2004). A key question, therefore, was whether they were seen to matter more in England than in Wales and Scotland, where there has not so far been the same thrust in policy of 'what matters is what's measured' (Gwyn and Hood, 2006, p. 517).

The Government in England introduced quantified national targets for reducing health inequalities in 2001, focusing on narrowing by 10% social class differences in infant mortality and an area-based 'health gap' in life expectancy (which compares the fifth of local authority areas with the worst health and deprivation indicators to the national average). These targets were expected to be met by 2010. Performance assessment accompanied them: there were reporting requirements for both local NHS Primary Care Trusts (PCTs) and local partnership bodies (Local Strategic Partnerships, or LSPs) and an expectation that there would be corrective action if progress was off

target. At the time of the first phase of our study in 2006, these targets had been extended beyond just life expectancy and infant mortality to include circulatory diseases, cancers, smoking and teenage pregnancies.

Scotland took a different approach and focused on health *improvement* rather than *inequality* targets, with these targets applying to Scotland's most deprived fifth of local areas (using statistical areas rather than England's local government areas). Introduced in 2004, these were quantified targets for reducing over the period 2003 to 2008 smoking prevalence, premature mortality for circulatory diseases and cancers, and teenage pregnancies. Although there were no arrangements for top-down performance measurement equivalent to the English national target regime, progress with improved health in the most deprived areas was the subject of discussion and follow-up in the annual reviews of local NHS boards conducted by the Scottish Government.

Wales introduced national targets at the same time as Scotland, but with a different approach again. Quantified *nationwide* targets were put in place for reducing premature mortality from circulatory diseases and cancers, with the health inequality targets being established as a *faster rate of improvement* than the national average for the most deprived groups, but with no measures. These were complemented in 2006 with three health inequality targets relating to children and aimed at a *quantified* narrowing of the gap between the most and least deprived fifths of the population in infant mortality, low birthweight and teenage pregnancies. Wales had the least performance assessment of these types of target, with neither the local NHS boards nor local authorities required to account for progress.

Responsibility for reducing health inequalities lay primarily with local NHS bodies in each country, although partnerships were emphasised, especially with local government (Smith, Hunter *et al.*, 2009). Our early organisational mapping work raised an interesting issue as to what the UK's 'National' Health Service is, as there were striking differences in both structures and the processes for delivering services between each country. The main difference was the existence in England of a split between the parts of the NHS that commission local health care services (primary care trusts or PCTs) and the organisations that are commissioned to provide these services, mainly hospitals and community health care organisations. This is meant to strengthen local planning by separating it from operational matters and increase the accountability of providers, including exposing them to competition.

Wales had a similar split - although without the commitment to competition - until October 2009, when the Welsh Assembly Government merged the two functions into enlarged local health boards meant to improve integration across services, trailed as 'an opportunity to do something different to the rest of the UK' (West, 2009, p. 8). The Scottish Government integrated its NHS in 2004, with its health minister at the time saying, 'We are doing things differently in Scotland. We want an approach that is more rooted in partnership and integration, rather than competition' (quoted in Christie, 2003).

In England, the health inequality targets should be one of the main priorities shaping commissioning decisions by PCTs in the 20% of local authority areas with the worst health and deprivation indicators – the so-called 'Spearhead areas'. Since 2005/06, the

performance of these PCTs against the targets has been performance assessed by Strategic Health Authorities. In Scotland, the integrated model includes community health partnerships (CHPs) that bring together NHS and local authority representation with the aim of improving the coordination of health and social care services and establishing joint leadership for tackling health inequalities, including delivering national targets. In Wales, the local health boards and local authorities jointly produce health, social care and well-being (HSCW) strategies that include health inequality objectives but not national targets for health inequality.

Partnership bodies formed part of the local delivery system for tackling health inequalities in all three counties. In England, these were Local Strategic Partnerships (LSPs) and in Scotland the Community Planning Partnerships (CPPs). In Wales there were no nationally prescribed partnership bodies like LSPs or CPPs but joint health groups and alliances that included among their work preparing the HSCW strategies.

Conceptualising and designing the study

Our interest in local particularities, but explored in their national contexts, meant that we decided we needed a case-based approach with comparison of cases across countries. We therefore needed to define our 'cases'. In one respect, many types of case were possible - particular professional roles, organisations or localities - and our data coding enables these different views of the data to be used to explore and investigate themes using the software package NVivo. Our main case definition, however, was the organisation in its local context.

We sought to achieve some comparability of geographical context by selecting one regional centre and one mining/manufacturing industrial hinterland in each country, and then mapped the organisations responsible for local policy delivery and the key post-holders in these organisations whose strategic responsibilities included health inequalities. These organisations were the local authorities, the local NHS and local partnership organisations. Key post-holders were chief executives, directors of finance, performance managers, health strategy managers, and lead officers and chairs for the various partnerships. Anonymity was guaranteed.

Our data are mainly from 200 interviews with these senior professionals carried out in two phases during May-August 2006 and January-June 2008. Results from the first phase of the study can be found elsewhere (Blackman *et al*., forthcoming) and from the second phase are currently under review. The purpose of this paper is not to present our results, although we summarise them below, but to reflect on some of the challenges involved in comparing different policies and organisations across the three countries and over time.

We were concerned with what Nutley, Walter and Davies (2007) describe as the 'meso-level' of service actors, where local service delivery organisations are managed and shaped. This meso-level focus brings into view what might be regarded as a local policy system, and this system is our black box of 'collective processes, practices and cultures' (p. 8). It is a black box precisely because there is no mechanical input-output relationship between cause and effect, but a self-organising system of interacting agents with their own local organising principles. Plsek and Greenhalgh (2001, p. 625) define such a 'complex adaptive system' 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'.

This behaviour gives rise to important features of such systems: context dependency, feedback loops, emergent non-linear change, and unintended consequences (Chapman, 2004). Plsek (2001) has applied these ideas to improving health care management, Byrne (1997) discusses their application in social policy, and Blackman (2008) has recently applied them to explaining smoking as an adaptive behaviour in different neighbourhood, employment and income circumstances.

Blackman's example can be used to contrast what Plsek (2001) calls mechanical thinking with adaptive systems thinking. A mechanistic approach to missing a target for narrowing the social class gap in smoking prevalence would be for the PCT to increase funding for smoking cessation services. This reflects a linear model of change: more spending on these services is expected to produce a decline in smokers. However, there is now considerable evidence that the contexts in which smoking rates are highest are where people are coping with worklessness, very low incomes or poor neighbourhood liveability such as dereliction or crime. Higher spending on cessation services may have the unintended consequence of widening the gap in smoking rates between people living with these conditions and others who are more motivated to respond to health promotion messages (there is no evidence of a social class gap in understanding of the effects of smoking on health but considerable evidence about social class effects on receptiveness to health promotion programmes). A more successful strategy may be to focus the resources of both the PCT and local authority on reducing levels of worklessness and crime in the most deprived areas, creating the

conditions in which people consider it worth investing in their future health by giving up smoking.

Plsek (2001) and Chapman (2004) propose a number of principles that can inform this kind of adaptive systems thinking, including learning 'what works' from local innovation and experimentation; sharing information and making connections; using simple rules that move the system in the right direction, such as avoid actions likely to widen inequalities even if these are likely to improve health for some; and evaluating overall system performance with stakeholders as co-evaluators.

These principles sit very uneasily with command-and-control managerialism, so again we might expect to see them less in evidence in England than the other two countries. More generally, we were interested in how local actors operationalised the policies of their respective national governments towards health inequalities and where targets fitted into these constructions. If, as Stacey (2006) argues, professionals act through complex responsive processes, we might expect to see targets given meaning in the particular choices made by local actors; choices about how to define the issue, ways of working, types of intervention and how to evaluate success.

Our approach to this sense-making was to interpret interviewee accounts as discourses. This means more than simply regarding their accounts as ways of describing the world but also as constructing the world and looking for the rules that establish what is meaningful (Foucault, 1972). We also had a focus on *particularization* in local situations, which meant that we needed qualitative data that would span both geography and time.

We decided that semi-structured interviews were the best data collection method, permitting some standardisation of questions but enough flexibility to capture local particularity. Above all, we wanted to access our interviewees' discourses by giving them the opportunity to talk at some length about their work. The semi-structured interview schedule was therefore designed as a framework for a conversation across linked topics that we then analysed for thematic patterns.

There were some discussions initially about where to focus the research. There were not only many different organisations but many different roles to consider. Some were key roles and were similar across organisations, such as chief executives and directors of public health, but others were less clear, such as people with responsibility for health in local authorities, who could be found in different departments and posts.

We needed to build up a coherent picture of what was happening in the different localities, and decided to do this first by identifying the key organisations that were strategic players in each locality, and then identifying key strategic posts and their nearest fits across the three countries and each locality. For the analysis, we decided to handle the large number of interview transcripts by grouping responses from organisations together and seeing how far the views of individuals were shared or diverged, building up from there how far organisations across a locality shared perspectives. We were then able to construct a picture of how far perspectives were similar within countries. This was an iterative process and included reflecting on differences between roles and organisations across the countries.

Methodologically, 'a focus on discourse …allows us to study shifts in language, practice and relations of power' (Newman, 2001, p. 30). The English HAZs provide an example. When a new Secretary of State for Health reframed the role of HAZs from being substantially autonomous locally to being agents for delivering national priorities, 'HAZs which had based their activities around action to address the root causes of poor health found themselves having to reconstruct their stories in order to demonstrate how they were addressing, for example, targets for reducing the incidence of cancer' (Barnes, Matka and Sullivan, 2003, p. 270). Similarly, current pressure to make a faster impact on the NHS life expectancy target for 2010 is encouraging a conceptualisation of health inequality as concerning the delivery of treatment and screening services for people aged over 50 in manual social groups, which may detract from other strategies and public policy interventions focusing on primary prevention but with a longer timescale (Blackman, 2007).

Discourses are recurring patterns in linguistic constructions that we expect to reveal actors' versions of their worlds of policy and practice and implied relationships between elements of this world. Giddens (2001) describes discourses as 'frameworks of thinking': in shaping how issues are conceptualised they are used to inform and legitimate actions. Rather than seek to measure outcomes over the 24 month fieldwork period, which would be too short to draw any reliable conclusions about performance, we focused on the process of narrative development. Our analysis is concerned with investigating change over time in how 'health inequalities' and 'performance assessment' are constructed; how these constructions are used strategically as arguments; and how these argumentative strategies relate to sources of power. We could hypothesise, for example, that cross-cutting performance assessment

of the type being introduced by England's Comprehensive Area Assessments will move health from a lower order theme to a higher order theme in local government, since there will be an expectation that a local authority demonstrates its contribution to area-wide health improvement.

This conceptual framework enabled account to be taken of the way local actors interpreted and worked with the different performance assessment regimes over time and over a period of political and organisational change. A longitudinal study proved very useful in making such comparisons, going below the surface changes in policy, structures and practice to see how perceptions changed over time, and also revealing some of the long-term underlying themes that persisted through the changes.

Interview data were supplemented with information from local plans, performance assessment reports and statistics relating to health inequalities. This contextual analysis included the wider regional and national policy and performance frameworks. In addition, a review of key policy literature was undertaken (see Smith, Hunter *et al.*, 2009).

Transcripts of interviews and documents were analysed with a systematic indexing of themes using NVivo. Further analysis was guided by the research questions using a thematic framework approach to explore variation in the data by country, sector, locality and stakeholder position. The analysis was conducted through three stages: an initial familiarisation with the transcripts to identify recurring themes and any higher order categories or 'main themes' into which these could be grouped, producing an initial thematic framework; a systematic indexing of the whole dataset,

labelling the texts using index categories and main themes, and refining the thematic framework; and further sorting of the data by theme or concept.

Analysis was aided by having members of the project team based within each country and able to contribute insights about the interviews and local political and policy contexts. An important part of the analysis was meetings in each country to discuss emerging themes. In addition, the full team met to discuss emerging findings, and these were also shared in meetings of the advisory group, chaired by Sir Derek Wanless and including key post-holders from government departments. This ensured that the standpoint of each country was reflected in discussions.

Despite contrasting approaches to targets in each country, we found that local discourses about the nature and causes of health inequality had significant similarities. Health inequalities were mainly conceptualised in terms of the effects of unhealthy lifestyles linked to living in deprived communities, rather than emphasising a medical model of access to health care or a wider determinants model of economic and environmental inequalities (although these themes were present).

In England and Scotland, but not Wales, respondents saw national policy as clearly concerned with health inequalities. They supported this and felt accountable for actions believed to be addressing the issue. This accountability appeared to be more systematic in England where there were standard metrics linked to the 2010 targets, but measurement appeared somewhat detached from implementation. In particular, there was no modelling of the effects of programmes as either the best option or on a sufficient scale to meet the targets, although there was some evidence that the

imminence of the 2010 targets was skewing interventions to programmes of case finding and treatment rather than tackling wider determinants, because this was believed to have the required short-term effect.

In both England and Scotland, the priority given to work on health inequalities was said in large measure to depend on having higher political priorities under control, especially waiting times for treatment. In Wales, this and other service-related issues, as well as the absence of any national performance assessment of local work on health inequalities, meant that health inequality was not in the frame for intervention in any systematic way. Welsh policy had an emphasis on *equity* that skewed attention to access issues like waiting times, but inequalities in outcomes rather than access to care had little specific focus. The main way that health inequalities entered into local discourse in Wales was the burden of poor health left by the legacy of past heavy industry and long-term illness. This tended to be seen as a general issue, needing in particular a focus on chronic disease management, rather than an issue of benchmarking one area against another.

The limits of evaluation

Given that there were targets of some sort in all three countries, but different intensities of performance assessment, it would have been interesting to be able to compare progress with these targets in the light of the different audit regimes. In fact, this is very difficult because the targets are so different both in what they measure and how they are framed. It is possible to compare national life expectancy trends, but assessing progress with health inequalities requires measuring 'gaps'. These gaps are

measured differently in each country. Indeed, in Scotland there was no explicit targeting of health gaps, and in Wales there was no explicit targeting of the extent to which these gaps among adults were to be narrowed.

These different national approaches might nevertheless be expected to have some effect on how local actors went about working on health inequalities. In England, the implication of a targeted 10% narrowing of the life expectancy gap by 2010 implies working out what is needed locally to achieve this degree of narrowing and then implementing programmes to achieve this outcome. In Scotland, the targets imply delivering enough interventions in the most deprived areas to achieve at least the given percentage improvements set for a range of specific outcomes. In Wales, the targets suggest different approaches for adults and children. For adults, they imply working out how to improve the health of 'deprived groups' (not necessarily areas) at a faster but unspecified rate than for the country as a whole. For children, they imply working out how to narrow a series of quantified gaps between the most and least deprived groups. All the approaches, therefore, involve various types of measurement and, by implication, some kind of modelling as to what and how much is needed to achieve given amounts of progress.

The timescales for meeting targets in each country varied appreciably. In Scotland, targets with a 2003 baseline were expected to be met by 2008; in England, targets with a 1998 baseline were expected to be met by 2010; and in Wales targets with a 2002 baseline were expected to be met by 2020. If these target regimes are meant to have an effect on local action, we might have expected to hear local actors talk about

interventions expected to have quite a short-term impact in Scotland, somewhat longer in England and over a longer term in Wales.

No such relationship between respondents' discourses and these timescales was apparent, except for some talk of reaching people needing medical treatment as a way of meeting the English 2010 targets. The targets, in other words, were of little importance in establishing what was meaningful. This was not true, however, of other performance targets, which framed the discourse on health inequality in an indirect but very important way. This was most apparent in Wales, where the performance management system for the NHS was described as making policy by default because meeting waiting time targets was rewarded financially and sanctions were imposed for poor performance. Health improvement, therefore, was inevitably a lower priority. A health board director of finance observed:

> 'I'm not saying that we're told not to deliver on health inequalities but you've got to achieve the service targets and they're the ones you'll be criticised on … the number one priorities such as waiting times for accident and emergency, cancer and cardiac ... If you fail to achieve the targets essentially they are imposed on you.'

In England and Scotland there was a stronger prioritisation of health inequality locally. This was not so much because these targets were imposed but because they legitimised in general terms what was commonly regarded as the right thing to do. There was sometimes disagreement about the specific measures, especially the life expectancy target in England because it was regarded as too high-level and long-term,

even though for local performance assessment purposes the more tangible proxy measure of all-age all-cause mortality was used.

Using these and other data to plan and manage programmes to improve health was seen to be a challenge, as reflected in this comment by a Scottish health board policy manager:

> 'It's much more amenable to something like sickness absence or waiting times, where it's very good. Where it's much more difficult, but I think still applicable, and the discipline of it is very good, it's much more difficult when you're starting to look at behaviour change and health improvement, which is long term, it's multifactorial.'

As a result, why local health trends were going in the direction that they were was poorly understood. One director of public health remarked about the good progress in his locality that was being made with narrowing inequalities between small areas that:

> 'We don't know why we're doing it right … whether it's due to anything we're doing to the actual incidence of disease or whether it's about accessibility of treatments, we don't know … Our message to the service providers has been to keep on doing what you're doing!'

However, there was some evidence of a more evaluative perspective developing, especially in Scotland. A Scottish health board respondent observed:

'We need to look at how are we actually going to judge whether that in fact
has been a factor or whether it's other factors. We've benefitted hugely from
our collaboration with academics to give us that academic rigour in terms of
the design of the intervention. We've then gone on to implement it and it's
made it easier to know as we go along which bits are working and why.'

The performance assessment regime in England did appear to bias actions in some
important respects. Those who wanted to see more spending on measures believed
likely to reduce health inequalities found it difficult to win their case when there were
competing demands for resources that could demonstrate impact more quickly. So
those health inequality interventions that were up-scaling were, beyond short-term
projects, predominantly concerned with 'case finding' among deprived groups and
bringing people into medical treatment. Importantly, this was also driven by national
policy as a means of delivering relatively quick wins as the 2010 targets approached.

It is tempting to ask which country has the 'best' structures for tackling health
inequality. This is difficult to answer for the same reason as evaluating success with
targets comparatively: the objects of policy (the targets) are very differently framed
and imply different delivery arrangements. All three countries, however, had
introduced local partnership arrangements to develop joint strategies to tackle health
inequalities. This is an interesting example of mimetic isomorphism discussed below,
especially as there is little evidence of organisational partnerships having an impact
on public health outcomes (Smith, Bambra, *et al.*, 2009). Partnership working was
widely regarded in our interviews as a good thing, but did not appear generally to be
embedded in terms of coordinated service delivery or joint performance assessment,

and there was a reluctance to pool or share budgets. One of the areas in England where partnership working did appear to be effective was experiencing reorganisation over our research period that would break up these relationships, and in England especially there was frustration about an apparent national commitment to promoting local partnerships but frequent reorganisations that undermined them.

Indeed, another reason why it is difficult to evaluate the effectiveness of local institutional structures is that they change. Although the study took place over a relatively short time frame between 2006 and 2008, there were a number of restructures during this period. In England, an NHS reorganisation saw PCTs either merged to create larger organisations or grouped under joint managements. When the research began there were four PCTs in the study; by the time of the second phase of interviews three had been merged into a larger PCT and one had been incorporated into a joint management arrangement. In one of the English localities there was also a reorganisation of local government imminent at the time of the second phase interviews.

In Wales, a reorganisation of the local health boards was announced for consultation during the second phase of interviews, proposing a radical reduction in the number of local health boards from twenty-two to seven, and abolition of the commissioner-provider split in favour of integrated planning and provision. One effect of this would be that the local health boards would no longer be co-terminous with the twenty-two local councils. A significant innovation was new Local Service Boards which were being established at the time of Phase 2. These were similar to the Local Strategic Partnerships and Community Planning Partnerships already existing in England and

Scotland. They also had Local Delivery Agreements, which were similar to Local Area Agreements in England and Single Outcome Agreements in Scotland.

Scotland was by comparison reasonably stable, although its Community Planning Partnerships and Community Health Partnerships were quite new at the time of our fieldwork. Single Outcome Agreements, however, were a new innovation which, like England's Local Area Agreements introduced a few years earlier, aimed to establish jointly agreed priorities between national government and local partnerships.

Political change was a further dimension of variability. At the start of the study, the Labour Party was in government in all three counties, although in coalition with the Liberal Democrats in Scotland. By the time of the second phase, Labour and the Liberal Democrats were out of government in Scotland, with the Scottish Nationalist Party forming a minority administration. Plaid Cymru, the Welsh nationalist party, entered government in Wales in coalition with the Labour Party. Labour remained in power in England but there was a change of Prime Minister and many Cabinet posts. So when in our interviews we asked how serious interviewees felt the government to be about narrowing health inequalities compared to other priorities, the answers were referring to different governments in 2008 compared to 2006.

Conclusion

While the project was conceived as a comparative study that would seek, in particular, to investigate the influence over time of new performance assessment frameworks, in reality it was impossible to make like-with-like comparisons or control for the number

of dimensions of variability. The research could therefore not be *evaluative*. While it is sometimes argued that since devolution the UK presents an interesting comparative policy laboratory, there is no research design to these arrangements, so making valid comparisons is far from straightforward. Differences in policy are also more politically driven than evidence driven, undermining an approach that might regard good evaluative evidence from Scotland as implying the policy should be adopted in England. A policy that 'works' in Scotland or elsewhere does so within a particular context of political priorities, objectives and organisational structures and processes.

Despite this, when we look at organisational structures and processes there is some evidence of what Newman (2001) describes as 'mimetic isomorphism'. This occurs 'where organisations voluntarily copy each other in order to be identified with prevailing norms of "best practice" and so win external legitimacy' (p. 27). Examples include the development of local partnerships, outcome agreements between local public services and national government, and larger local NHS organisations, all of which – with very little by way of an evidence base – have been legitimated in part as a better approach to tackling health inequalities.

This was also evident in the interview discourses, such as the common emphasis given to healthy lifestyle issues and their link to deprivation, and the conditional priority that health inequalities had compared to waiting times and balancing budgets. The research evidence is at best mixed for justifying an emphasis on encouraging healthier lifestyles, especially within a context of deprivation. We did not probe deeply into the reasons for this theme being so prominent and speculate that it is indeed a 'discourse' shaped by government policy documents keen to promote

individual responsibility, and by local professional interests keen to be seen to do something about the issue that is plausible, if not actually capable of achieving the change needed. The emphasis on waiting times and budgets is an example of a clear-cut top-down political priority, with no evidence base for the waiting time targets, and budget cycles biasing spending against larger health improvement programmes because of the lack of short-term paybacks.

Although there were divergent approaches to performance assessment in each country, the first phase of the study revealed many similarities in how working on health inequalities was prioritised (after waiting times and financial balance) and what this work involved (largely projects aimed at encouraging healthier lifestyles in deprived areas). There was also little modelling of how the interventions in play would reduce inequalities, even in the English localities where quite detailed performance monitoring was undertaken. These Phase 1 results are discussed in detail in Blackman *et al.* (forthcoming). We attempted an evaluation but had to be very cautious about this, concluding:

> 'Given the different national targets, measures and reporting arrangements it is difficult to make like-with-like comparisons ... In England, progress against the life expectancy and infant mortality targets was off-course in 2006, while Scotland had not adopted targets for these indicators. Despite both these countries investing significant resources in supporting people in deprived areas to stop smoking, England's inequality gap was not narrowing while the gap was narrowing in Scotland (although the gap is measured in different ways). Reflecting the lower priority of health inequality targets in Wales, no

data were reported at the time of the study on progress against the Welsh

targets. Data on teenage pregnancy rates can be compared across the three

countries and are interesting given the different national policy priorities

accorded to this issue … the extent of targeting in either policy documents or

as described by our interviewees did not show any obvious relationship with

trends in rates.'

There were some significant developments and shifts in narratives two years later.

Some patterns emerged of divergence in the policy priority given to tackling health

inequalities in England and Scotland compared to Wales, and convergence in some of

the approaches to ways of working that were described by interviewees. None of these

appeared to be influenced by cross-national learning or exchanges, and the main

driver was national policy development, especially a desire for a more systematic

approach and focus on outcomes as the position of health inequalities on policy

agendas matured. In England, for example, the greater preoccupation with targets

meant that interviewees talked of scaling up interventions thought to be effective over

quite short timescales, and this was very influenced by the national audit regime and

medical model thinking. In Scotland, work on health inequalities became linked with

the new concordat between the SNP Government and local authorities, which

promised more autonomy for the latter in exchange for agreeing a set of national

outcomes as priorities for local partnerships. The more systematic approach to

planning that this started to engender meant that logical models of broad causes and

effects were talked about, using proxy measures to bring the issues into focus over

shorter timescales, and with more of a 'trial and error' attitude than in England. In

Wales, the Health, Social Care and Well-being Strategies were in their second phase

and were expected to have a more systematic approach to baselines and objectives. A lack of strong steer or involvement from national government, however, meant that there was little meaningful monitoring or modelling, and often an attitude that health inequalities were intractable without many years of work.

What was clear from using interview data was that a reading of local policy documents would give a very partial picture of similarities and differences across the localities. Generally, the policy documents give an impression of greater differences than the interviews because national policy rhetoric tends to exaggerate the impression of difference. On the other hand, some policy innovations – notably Local Area Agreements and Single Outcome Agreements – appear very similar when described by the written word in policy documents but were talked about quite differently by our interviewees because they were seen in different contexts. This seemed to be especially influenced by the distinct national audit regimes and how much dialogue there was felt to be between local and national government, and meant that there were different attitudes towards essentially the same policy instrument. Even in the same locality, a change such as a reorganisation was described quite differently as either damaging or enabling work on tackling health inequalities, depending on organisational standpoints. Attitudes to using and reporting on targets also varied across countries, professional roles and organisations; in ways largely to be expected given national political and policy cultures but begging the question of whether there is a 'right' use of targets.

In the opening section to this paper we described our 'cases' as local policy systems. It is possible in this respect to consider national policy priorities – translated to a

greater or less extent into targets - as addressed by this local system: the network of local agents who come together and are interconnected to fulfil a purpose (Plsek, 2001). Outcomes from this system might then be regarded as a reflection of the purposeful design of services, the nature of interactions between agents, and contextual attributes (Wrede et al., 2006). For example, services may be reactive or proactive, interactions between agents may be more or less aligned to common goals, and contextual attributes such as organisational leadership, aspirations and demographic, ethnic and socioeconomic factors may have a wide range of states. The need to take a whole system perspective follows, and is reflected in recent policy developments in the UK towards area-based outcome agreements.

Our findings are leading us to re-think this systems account. Barnes, Matka and Sullivan (2003) discuss theoretical approaches to evaluating complex interventions, specifically Health Action Zones. They argue that a realist perspective with its systems approach does not sufficiently account for the significance of (contested) meanings. Insights from new institutional theory are suggested as useful in this respect, recognising that shared values create 'logics of appropriateness' that guide organisational and individual behaviour. This is more plausible as an explanatory framework for our results.

There is also little evidence from our interviews of a local policy system as something existing outside the individuals that comprise it. What we have found is more akin to Stacey's (2006) notion of 'widespread narrative patterns emerging in local interaction' (p. 9). He describes this more fully in a way that echoes many of our findings:

'We understand organizations to be the widespread patterns of interaction between people, the widespread narrative and propositional themes, which emerge in the myriad local interactions between people, both those between members of an organization and those between them and other people … Any statements that the most powerful make about organizational designs, visions and values are understood as gestures calling forth responses from many, many people in their local interactions. The most powerful can choose their own gestures but will be unable to choose the responses of others, so their gestures will frequently produce surprising outcomes' (pp. 8-9).

Entering into these interactions are not 'bodies of evidence' but 'bodies of discourse', to a greater or lesser extent based on evidence, values and resource availability. The rise of demands for 'auditable organizations … framed by discourses of accountability and transparency – against the suspicion of "producer domination" of organizational choices' is a one example (Clarke, 2006, p. 212). So are, we have found, local partnerships, lifestyle projects for deprived communities, scaled-up organisations and single outcome agreements, all of which have little by way of an evidence base but appear as major – and intriguingly common – themes across what some have argued are now three separate national health systems in Great Britain.

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