PARTNERSHIPS:
COMMUNITY INVOLVEMENT AND PERCEPTIONS
OF HEALTH INEQUALITIES

IPH

CONTENTS

ACKNOWLEDGEMENTS

POLICY CONTEXT

Working in partnership across government departments and their agencies and with the community, voluntary and business sectors and trade unions is central to government policies for tackling complex problems. Several such partnerships have been set up to improve health in deprived communities and address inequalities in health in Ireland and Northern Ireland. For example, in Northern Ireland the *Investing for Health* (IfH) public health strategy led to the establishment of four partnerships as a key mechanism for implementing this strategy. These partnerships all share a common goal of reducing inequalities in health by effectively tackling the wider determinants of health. The involvement of communities and users in deciding and implementing policies is central to their approach.

> **Definition of partnership: where two or more organisations make a commitment to work together on something that concerns them both, develop a shared sense of purpose and agenda, and generate joint action towards agreed targets.**
>
> Health Education Board, Scotland 2001

EVALUATING PARTNERSHIPS

People often assume that collaboration will be more effective than efforts planned and carried out by a single organisation, yet there is little evidence that collaboration has improved health status or impacted on health systems. Evaluating partnerships is difficult for various reasons such as the long timescales for achieving impact, different perspectives on what success means, the complexity and variability of partnership interventions, and the different contexts within which partnerships work.

RESEARCH INTO MEASURING THE BENEFITS OF PARTNERSHIPS

The Research and Development Office for Health and Social Care in Northern Ireland funded the Institute of Public Health in Ireland (IPH) to undertake research into partnerships between 2003 and 2006, as part of their *New Targeting Social Need* programme. The study was a collaboration between the IPH and the Centre for Psychosocial Studies at the University of the West of England. The aim of the research was to identify the impacts of multisectoral partnerships, how they can be measured, and what contribution they make to tackling inequalities in health.

In-depth case studies of four partnerships were carried out with: *Armagh and Dungannon Health Action Zone* (ADHAZ); *North and West Belfast Health Action Zone* (NWBHAZ); *Northern Neighbourhoods Health Action Zone* (NNHAZ); and *Western Investing for Health Partnership* (WIHP). Based on these case studies, the IPH has developed a conceptual model linking the collaborative efforts of partnerships to benefits which impact upon the determinants of health and a set of indicators for use in assessing progress.

The indicators make up a Partnership Evaluation Tool (PET) which has been developed as a web-based resource available on the Institute's website for any partnership to use to support its own assessment and development.

This publication presents our comparative analysis of approaches to community involvement by the four partnerships and perceptions of pathways to reduce inequalities.

1. COMMUNITY ENGAGEMENT IN PARTNERSHIPS

1.1 INTRODUCTION

> Despite its central place in current policy, there is no agreed definition of the concept of 'community'. It can refer to a group of people who share an identity (e.g. belonging to an ethic group), an interest (e.g. political activism), or a locality (e.g. a neighbourhood) (Barnes 2003).

In partnerships for health involving community representatives, the term has been found to be similarly ambiguous and applied in different ways: 'a "community" might be an age-group, people who live in a street or borough, it may mean "non-statutory" or "non-hospital", or may refer to the "public at large".' (Jewkes and Murcott 1998:852). When we discuss 'community' in this chapter we mean those population groups with whom the partnerships are concerned.

The ways in which the concept of community have been interpreted and applied in social policy has varied over time. In the 1960s, collectivism and the common good were emphasised. Throughout the 1980s, active citizens and communities were encouraged to be involved in executing both their rights and responsibilities. Since the mid-1990s 'community' is increasingly seen as securing social cohesion, creating trust and establishing the networks and relationships necessary to tackle breakdown of democracy and morality (Taylor 2003). This concept of community has been embraced by the New Labour Government, who has made community one of its central policy themes (Marinetto 2003). Policies and strategies commonly include community involvement in area based partnerships as central implementation mechanisms (MacKian 2002). Indeed, the criteria for eligibility to government schemes, such as *Health Action Zones* (HAZ) and *New Deal for Communities*, included demonstrable community involvement.

The focus on community involvement through partnership has opened new opportunities for community participation in the policy process. Such involvement has long been called for. Within the health promotion and the new public health movements, community participation was identified early on as fundamental to health improvement.

> The Alma Ata Declaration of 1978 states that 'people have the right and duty to participate individually and collectively in the planning and implementation of their health care' (quoted in Jewkes and Murcott 1998:846).

The *Ottawa Charter* of 1987 goes further and asserts that the community should be accepted as 'the essential voice in matters of its health' (quoted in Jewkes and Murcott 1998:849). A range of arguments have been proposed on how involving the community will result in better health. For example, it has been described as leading to better use of resources, as having the potential to impose public accountability on those in power, and as empowering people to take more responsibility for their health, leading to healthier choices (Jewkes & Murcott 1998). Those who have campaigned for community involvement for the past two decades have generally welcomed the public health policies of New Labour with their strong emphasis on local partnership working.

There is now a growing body of research and evaluation of the impact of community participation in local partnerships for health. The level of engagement and commitment of partners, including community representatives, commonly forms part of how success in partnership working is conceptualised (Dowling *et al*. 2004). Community participation is described as essential in order to ensure that real needs are being met and that the

decisions reached are acceptable to local communities (Jones 2000; Katz *et al*. 1997). The representation of communities in strategic decision-making has been described as particularly important (Pickin *et al*. 2002). Conversely, lack of community involvement and ownership is frequently identified as a major flaw in local strategies to improve health (Pickin *et al*. 2002; Lasker and Weiss 2003).

According to Stern and Green (2005), the current empirical evidence suggests that local partnerships have limited potential for making significant change in their areas. Despite this lack of evidence, the way in which partnerships are portrayed in the literature and by practitioners is often marked by a 'rhetoric of optimism' (ibid.:273). Emphasis is commonly placed on celebrating that a wide range of organisations agree on an agenda, rather than on the limited evidence for structural change, which is often a priority on such agendas. Given the long wait for community involvement in partnerships for health and the strong emphasis on such involvement in government policy, there is understandably a strong desire for these partnerships to be successful.

There is, however, considerable scepticism in the sociological literature as to the wider implications of community involvement in partnerships for health. For example, Crawshaw and Bunton (2003) argue that the way in which the concept of community is applied in 'third way' politics has re-invented the relationship between individuals and society. Responsibility is no longer located in the relationship between the individual and the state, but in the relationships between the individual and those he or she cares most about such as family, neighbours or colleagues. Community development approaches provide access for individuals to become involved in projects which encourage them to take responsibility for their own health. Since community development more often than not fails to tackle structural inequality and instead uses existing resources while working within the status quo, the concept of community may be convenient and non-threatening for Government (*ibid*.). Nettleton (2003:239) argues that as community development is becoming integrated into statutory provision, there is a danger that:

> Community development may become appropriated by those whom it seeks to challenge. As it becomes absorbed into the professional structures of formal health care it thereby loses its political potential. This is compounded by the fact that community development projects may be dependent on the state for funding. If they successfully mobilise communities to challenge authority they run the risk that they bite the hand that feeds them.

Involvement in partnership working and policy processes may therefore be interpreted as an incorporation into the state (Craig *et al*. 2004) which may impact on the ability to challenge and oppose government action.

Community involvement, which is central to both the HAZ and IfH initiatives (DHSSPS 2002), therefore presents clear opportunities and challenges for the partnerships in this research. Community involvement was high on the agenda of all partnerships, and strategies for community involvement, included at the highest level of decision making, were in place. Strong emphasis was placed on the necessity of connecting with the community for the partnerships to be successful. Before returning to some of the overarching issues, this section briefly outlines how communities were involved in each of the partnerships at the time the research was carried out.

1.2   COMMUNITY INVOLVEMENT IN THE PARTNERSHIPS

1.2.1   North and West Belfast Health Action Zone (NWBHAZ)

Three local Belfast Area Partnerships were invited to sit on the NWBHAZ council as a proxy for community representation. These partnerships are three out of five such partnerships covering the greater Belfast area and funded by the Department of Social Development to stimulate economic and social regeneration in their local areas. The rationale for having three Belfast Area Partnerships as part of the Council was that they would bring with them relationships and connections to a wide range of community organisations and networks. These links, in addition to detailed knowledge of local needs and the ability to advocate on behalf of the community, were seen as placing these partnerships in a powerful position within the NWBHAZ. The Belfast Area Partnership representatives were, however, very clear that they did not, and could not, represent the community and resisted the ascribed role of community representatives. While they did recognise the potential of their Partnerships to connect HAZ with local organisations and networks, at the time of the interviews they did not have the resources to adequately carry out this role.

A strategy for maximising existing resources was, however, in place. The Eastern Health and Social Services Board had recently provided funding for two permanent community development posts to be located within the NWBHAZ to progress their agenda under IfH. The North Belfast Partnership, who already had short term funding for a community worker, agreed to share that resource with the other partnerships and NWBHAZ. This meant that the three community development workers could work as a team, facilitating the community involvement process for the HAZ agenda. It was envisaged that they would work 'close to the ground' across the areas covered by the three Belfast Area Partnerships. This process would then enable the Belfast Area Partnerships to mobilise the communities they serve, inform them of what the HAZ was doing and engage them in the work.

At the time of this research, the NWBHAZ was establishing a HAZ community engagement group. This group was described as providing direct communication between the HAZ and the community it serves.

Although this process took a long time, it was seen as having provided sustainable community involvement, and at the time of the interviews (2003), the community engagement group had broad representation from across the area. The group met separately from the NWBHAZ council but their discussions 'were fed into council meetings'. This was described as allowing different 'cultures' and ways of working within the two groups. This parallel process between the two groups was described as working well.

Levels of community involvement were also described as being associated with the overall HAZ strategy, in particular, the decision not to focus primarily on projects. As one partner said, 'you know, projects aren't really going to change the world'. The advantage of projects, however, is that they can produce 'quick wins', they may be easier to understand, funding may be more readily available for them, and they give partners more tangible results. This may be particularly important for community representatives who were described as concerned with practical outcomes and less interested in the conceptual discussions which took place at the HAZ Council, perhaps viewing meetings as 'talking shops'.

> Levels of community involvement were also described as potentially sensitive to provision or withdrawal of services. Community representatives were described as not always appreciating that the partnership agenda may only represent a small proportion of what a large statutory organisation does and they may interpret closure of services by a partner organisation as a betrayal of trust.

1.2.2   Armagh and Dungannon Health Action Zone (ADHAZ)

In the strategic alliance, community representation involved partners from umbrella community organisations in Armagh and South Tyrone and locally elected political representatives. The political representatives commented that their involvement in HAZ was a good way of representing their constituents.

Community representatives were described as having knowledge of local issues and the ability to involve local people in the agenda of the partnership:

> Their strength is based on the fact that they represent people who are actually in their communities and they are bringing forward their views. Very often they are bringing forward the views of people who do not get a chance to articulate those views in any other way.

The HAZ was described as fortunate in having very skilled and sophisticated community participation. Community representatives were seen to bring different perspectives and ideas to the partnership. Their independence from Government was considered valuable as it enabled them to provide a challenge function, holding the statutory sector organisations accountable for delivering on their commitments. One partner from the statutory sector expressed how participating on the ADHAZ has convinced him of the value of community development and of involvement of people from the community, stating this had led him to change his organisation's strategy.

During partnership meetings emphasis was placed on facilitating everyone's participation. The Chair actively encouraged all partners to speak and ensured that a variety of views were aired. It was also suggested that in the early stages of the partnership, the Chair and the Manager had confronted some of the tensions that could have derailed the partnership by ensuring that contested issues were openly discussed. This was seen to have played an important role in gaining the trust of community representatives.

Initially, the commitment of statutory organisations had been questioned by some community representatives. For example, in the early days of the partnership, statutory partners had on occasions left meetings before the end. This was interpreted as a lack of commitment. After being challenged by a community representative, statutory partners were now described as more committed. Yet, community representatives would from time to time remind the statutory partners of the values and principles underpinning the partnership. Some community representatives were described as having adopted some of the conventions of the statutory sector, demonstrated in their comfortable negotiation in the partnership arena.

There were other processes of community involvement in the ADHAZ. The demonstrator projects, around which the HAZ activities centred, were based on community development principles. At the time of the research the *Home is Where the Heat is* fuel poverty project was being carried out. Reference was frequently made to how community involvement had been excellent on the project steering group and a key success factor in the high uptake of energy efficiency measures achieved by the project.

Several partners expressed that the ADHAZ simply would not have been established had they not had community involvement from the start. One statutory agency partner said that 'it's all very well having a community development approach with all the professionals, but unless the community is actually at the nucleus of what it is you are doing, well then, you are nowhere ... So there the community people are very powerful'. A community

representative, however, pointed out that their power within the HAZ is not rooted in their appointed positions, which is the case for the statutory partners, and that this makes the power base of community representatives more fragile and potentially transient.

1.2.3   Northern Neighbourhoods Health Action Zone (NNHAZ)

When developing the proposal for the NNHAZ it was agreed that the HAZ should target community needs in small neighbourhoods with particularly high levels of deprivation and place emphasis on enabling communities to take an active part in the identification of needs and in the design and implementation of solutions. Communities were therefore approached very early in the process because 'if the communities were not for this it wasn't going to go anywhere and we weren't going to pursue it'. Throughout the project, the HAZ support officers have remained in very close contact with the local residents groups, providing support and assistance.

Partnership working in the NNHAZ operates at different levels. Each of the 14 neighbourhoods has a local inter-agency group tasked with implementing a Community Action Plan. These plans are developed by the local residents groups with assistance from HAZ development officers and the local interagency groups which, in addition to the residents groups, consist of the local councils, the education and housing sectors and other relevant public sector bodies. All 14 HAZ neighbourhoods are members of the NNHAZ Strategic Group which also has representation from community and voluntary organisations. There are also a number of community representatives on the HAZ Management Group, which is a subgroup of the Strategic Group.

At the time of the interviews the Strategic Group met quarterly. Meetings usually followed a workshop format where the group was divided into subgroups to enable 'everyone to have their say'. To further maximise the participation of community representatives at the strategic group, the HAZ team provided support and advice prior to meetings about the issues that were on the agenda and they arranged transport when needed.

> HAZ staff emphasised that meaningful participation must entail actual and equal participation: 'you can tell people that they have an equal voice, but if they don't have the confidence to voice it, then they are not heard'.

The impression was that at this stage, few had difficulty speaking out. This was echoed by community representatives, though some had found participation challenging, particularly at the outset when they were new to this type of working. Reference was made to 'office talk' and the way in which a whole raft of abbreviations were used which for some only made sense when they received the minutes after the meeting.

It was commented that the size of the Strategic Group, consisting of nearly 60 members, prevented some of its strategic function. Instead, meetings served as a means of updating members, seeking agreement, and for partners to meet, forging new or maintaining existing relationships. According to one senior manager, working directly with the local communities through HAZ meant that: 'we are now working more with communities as opposed to directing things onto them. This gives better, more sustainable solutions'.

One community representative suggested that the Strategic Group meetings may represent the main method for statutory agencies to feed into the development of HAZ. The local residents groups, on the other hand, had a much more hands-on involvement and the opportunity to impact via their continuous interaction with the HAZ support workers and the local inter-agency groups. Some community representatives were described as very clear about what they wanted from HAZ and were described as 'drivers for action'. As a result, it was argued, some tangible benefits were emerging at local level. In one neighbourhood,

for example, the effort by the local group to stop vandalism had improved community spirit and made it possible for the Northern Ireland Housing Executive to invest in properties that had been destined for demolition.

There were concerns that community representation on both the Strategic Group and the Management Group was not as good as it should be. Some mentioned that community groups were sometimes set up as issue groups to address particular concerns which would dissolve once these issues were resolved, or initial enthusiasm and energy exhausted. This was perceived as part of 'real life', resulting in a lack of continuity in community representation. Other 'real life' issues also impact on ability to participate. Some community representatives, for example, took time off work to participate in meetings and training organised through HAZ. While HAZ reimbursed travel expenses, time off work had to be borne by the individuals.

1.2.4   Western Investing for Health Partnership (WIHP)

The WIHP partnership consists of 30 partners, roughly half of which come from the community and voluntary sector and half from the statutory sector. There are also two private sector representatives. The partnership is co-chaired by a statutory and a community sector representative. Community and voluntary sector representatives were initially invited to apply for a place on the partnership and places were allocated by a selection panel.

The main focus of the partnership at the time of the research was on pilot projects and action research, intended to inform future action. This was perceived as a useful approach, which also contributed to increased local knowledge and capacity. At the time of the research, HAZ subgroups were being established to address target groups at different stages of life such as children, young people, adults and older people. Community representation on the subgroups was perceived as widening community participation. One interviewee commented that partners from the statutory organisations may feel more at ease with the partnership meeting format: '[the statutory partners] are very good but they do tend to come in and say things. A number of the voluntary groups would be a wee bit slower to come forward and they'll react by all means but it tends to take them to 12.30 to do it and then we're rushing through'.

> Others attributed the constraint on community representatives speaking out in full meetings of the partnership to their position in power hierarchies. For example, a community group might be reluctant to raise critical views of the Health and Social Services Board if much of their funding is received from the Board.

Representatives from all sectors made reference to the benefits of forging new relationships and gaining new experiences. Partners from the community and voluntary sectors discussed the value of learning 'how the system works' and how to gain influence. They also thought that the partnership helped statutory sector organisations to gain a better understanding of the contribution of the community and voluntary sector and how it fits into 'the bigger picture'. However, the vulnerability of the newly developed relationships were alluded to by one community representative who commented that lack of commitment from even one statutory organisation can send a very negative message to partners from community and voluntary organisations. Community representatives did not believe partners from the statutory sector necessarily appreciated the constraints on their time and resources.

While community groups were seen to play an important role in communicating the views and needs of local communities, the concept of 'community representation' was problematised in a number of interviews. For example, as many of those on the partnership from community sector represent community networks, they may find it difficult to

communicate directly to the community or to be sure that feedback from other network members to the communities is accurate and comprehensive.

The community and voluntary sector in the Western area was described as well developed, and this may paradoxically contribute to a contested concept of community representation. As one partner said, 'sometimes, you know, you are seen as if you are the authority in one area and you're not because there are so many organisations that work in that specific area'. Another community representative was concerned that there is a danger of the community and voluntary representatives being considered 'semi-dispensable' because there are so many of them.

Others referred to how participation in the partnership could lead to tension and differentiation within the community and voluntary sector. For example, there was recognition that the City of Derry has greater population density and better capacity in terms of community infrastructure compared with other areas. This can make it easier for the statutory organisations, many of which are located in Derry, to develop joint working with community organisations based in the city compared with those based elsewhere. Participation on the partnership by the stronger and more accessible community and voluntary groups may serve to widen the gap between the more successful groups and the rest.

1.3   FEATURES OF SUCCESSFUL PARTNERSHIP WORKING
The four partnerships have applied different methods for involving their communities, some of which correspond with what Lasker and Weiss (2003) describe as essential features for successful collaborative problem solving in the field of community health. Based on research conducted over a number of years, Lasker and Weiss describe these features as:

- Empowering individuals by getting them directly and actively involved in addressing problems that affect their lives
- Creating bridging social ties that bring people together across society's dividing lines, build trust and a sense of community and enable people to provide each other with various kinds of support
- Creating synergy, that is the breakthroughs in thinking and action that are produced when a collaborative process successfully combines the knowledge, skills and resources of a group of diverse participants (Lasker and Weiss, 2003:21).

The ways in which the four partnerships have involved their communities provide many examples of empowerment, creation of bridging ties and creation of synergy. For example, with regards to empowerment:

- WIHP appointed a co-chair from the community sector. This created substantial learning benefits for the person holding the position and signalled commitment to empowerment
- NNHAZ provided training, support and advice to individuals in local community groups to enable them to participate in the partnership, to create local Community Action Plans and to implement these together with their local interagency groups
- Partners in ADHAZ emphasised how careful planning of partnership meetings facilitated the contribution of all. Support and communication between meetings also contributed to an atmosphere where people felt that they could contribute
- NWBHAZ emphasised how it was necessary to take the time needed to create an atmosphere of trust and build capacity among community members to enable them to participate. They did not wish to push representatives to participate in an arena where they might not feel comfortable.

For all partnerships the benefits of the creation of connections or bridging ties were pointed out:

- In NNHAZ, members of residents associations were able to discuss their issues and work with senior officials in the statutory organisations with responsibility for health, education and housing
- In NWBHAZ several senior statutory representatives commented that the HAZ provided an opportunity to meet at regular intervals with a range of senior representatives from other agencies, which, had it not been for HAZ, would not have happened
- In ADHAZ, the inclusion of locally elected representatives was seen as contributing to improved relationships between the health sector and local councillors
- WIHP was the only one of the partnerships to have the business sector represented directly, which was seen as providing partners from other sectors with novel perspectives.

Synergy in a partnership is ideally the result of negotiations where consensus is reached without requiring anyone to 'give in', but where all participants jointly create something new they can all support. The ability of a partnership to achieve a high level of synergy relates strongly to its non-financial resources (Weiss *et al*, 2002).

There were examples of such creation of synergy in all the partnerships:

- NWBHAZ was able to assist a community in crisis through the *Shankill 21* initiative. A wide range of agencies was ready to get involved at short notice
- Interviewees in ADHAZ referred to the success of their fuel poverty project as an initiative that was very successful due to the combination of skills, knowledge and resources of the project subgroup
- Within NNHAZ community groups from different sides of the sectarian divide engaged in joint working. This was described as a breakthrough by those involved
- Within WIHP, the action research projects carried out in the early stages of the life of the partnership were considered to have helped identify community needs, secure community engagement and to give rise to some innovative and successful initiatives.

Based on Lasker and Weiss' framework, is seems clear that the four partnerships were implementing essential features for ensuring that the involvement of the community leads to successful joint working, although there are variations between the partnerships as to where the main strengths and challenges lie. All partnerships recognised that community involvement could and should improve. Continuing to build trust and mutually beneficial relationships between representatives from the community and statutory sectors was seen as an important on-going goal, and we turn to this next.

1.4   TENSIONS BETWEEN SECTORS

People in all the partnerships studied described how the relationships between statutory and community organisations or representatives had improved as a result of participating in the partnership. Real or potential tensions between those from the statutory and community sector were, however, reported. The trust that had been built up was by some described as shaky, and could be threatened by, for example, statutory representatives leaving meetings early, the withdrawal of local services, or not properly attributing credit to local communities for their contribution. Such examples seemed to allude to a suspicion among community and voluntary representatives that statutory organisations were not fully committed to the partnership or to taking on board 'bottom up' messages and that they wanted to hold on to the power of their position.

This view finds support in the literature on intersectoral partnerships which suggests that traditional divisions and power relations between sectors tend to be maintained within partnerships (Stern and Green 2005). The power of the various sectors in this research was described as manifesting itself in different aspects of the partnership process. While statutory representatives were frequently described as the most vocal and forceful at meetings, community representatives, in particular in NNHAZ, were seen to display most of their influence between meetings. The power of community representatives was explained by statutory partners as residing in their connectedness to the local community. If the partnerships are there to address local issues, then those 'close to the ground', who can talk with and on behalf of local communities become gatekeepers to development and success.

Representatives from the statutory and community sectors thus described the ultimate power of the other sector as their potential withdrawal from the collaborative process. In the view of some community representatives, statutory partners could exert significant power on the partnership by taking unilateral decisions about service provision or allocation of resources. According to statutory representatives, those representing the community provided legitimacy to the partnership by grounding it in local communities. Without this, the purpose of the venture would cease.

1.5   REPRESENTING THE COMMUNITY

Each partnership had a different strategy for securing community representation. While NNHAZ had representatives from local residents groups on their strategic group, ADHAZ and WIHP relied to a greater extent on larger organisations or community networks. NWBHAZ sought representation from the three Belfast Area Partnerships. In a study of how the community was represented in the steering groups of *Healthy Cities* initiatives in England, Jewkes and Murcott (1998) noted that community representatives were generally 'appointed' by the partnership, not elected by the community. A 'good' representative would be able to represent a variety of groups by being 'in touch' or being 'knowledgeable' about them. For practical reasons those in community development posts were often selected as they had access to facilities such as phones and computers and were able to discuss issues at the 'right' level. Umbrella organisations from the voluntary sector were those most often selected. This led to a situation where communities were represented by a small section of the voluntary sector consisting of the largest, funded organisations. Moreover, representatives often did not have the time or the means to consult or get a clear mandate from those they represented, and there were limited mechanisms for accountability. Jewkes and Murcott conclude that this way of representing the community means that the assumed benefits of individual participation, such as empowerment, changing attitudes and actions, in reality was denied to the majority of community members.

Similar issues may occur in the partnerships in this study. With the exception of the residents groups in NNHAZ and the local elected representatives in ADHAZ, the majority of community representatives had not been elected by the community they represented. Many community representatives work for networks or umbrella organisations, some of whom recognised the difficulty of feeding back or consulting with the community. Some stated clearly that they represented a network and not the community.

> Selecting organisations to represent the community in partnerships may impact on the internal power relations within the community sector. Jewkes and Murcott (1998:855) found that consistently selecting stronger organisations could 'accentuate differences and inequalities between organisations'.

By inviting community and voluntary organisations to apply for a place on the partnership, WIHP attempted to ensure that all the organisations in the sector had an opportunity to join. The process was in general considered to have been robust, open and fair. Still, the selection was made by the partnership and not the community. One of the community representatives in WIHP felt that others in the sector initially queried why she had been selected to sit on the partnership and that she had been subject to a degree of scrutiny. As described above, other comments were made about how being part of partnerships could increase some groups' access to statutory resources and, as a result, increase the differences between successful and less successful community organisations.

While most of those representing the community worked in the community sector, some, like those from the NNHAZ residents groups, participate on a voluntary basis often on top of a full time job. This may impact on the ability to stay engaged, and Sullivan and Skelcher (2002) identify the potential for burn-out of community representatives as a barrier to full community participation in collaborations. Again, the result may be that the communities are not represented. These issues were recognised by the research participants, and similar to the *Healthy Cities* initiative, there was recognition that 'the people whose health was to be promoted were not around the table' (Jewkes and Murcott 1998:856).

1.6   COMMUNITY INVOLVEMENT: BOTTOM-UP OR TOP-DOWN?

Perhaps as a result of this recognition, in all four partnerships parallel pathways of influence or impact on the partnership have evolved, all which are actively used by community representatives. In ADHAZ, the steering groups for the demonstrator projects had strong community representation; in NNHAZ, community representatives were heavily involved in the work of the inter-agency groups on the local Community Action Plans and in frequent contact with HAZ support staff; in WIHP the subgroups developed at the time of the research provided opportunities for community groups to contribute; and in NWBHAZ, the community engagement group met separately from the HAZ's council. Following Lasker and Weiss' points set out above, these processes may be seen as a means of empowering individuals to get involved and it may create bridging ties. For example, in the steering group of the ADHAZ demonstrator project on fuel poverty, such ties were created and recognised as beneficial to the project and to representatives from all sectors (Rugkåsa *et al*. 2007). In other cases this may be less likely. For example, NWBHAZ was running their community engagement group separately from the partnership council. While partners described that the groups 'feed into one another', they did not believe the groups were ready to have joint meetings. These various parallel processes were described as appropriate ways of seeking community involvement. One could, of course, argue that they serve to make community participation peripheral to the partnership, and that instead of tackling the issue of inadequate community participation, it is allowed to happen at the margins of the partnership.

The parameters for community involvement are also shaped by the reasons behind setting up the partnerships in the first place. There are reservations that partnerships, despite the rhetoric of active citizenship and community involvement, are, in fact, 'top-down' and at a fundamental level serve the needs of Government. Marinetto, for example, comments that the current modernisation agenda may lead to top-down approaches in which 'institutions such as the state and local authorities feature prominently in shaping the context of community participation' (2003:110), though he emphasises the interdependence between the state and civic society in initiatives such as partnerships. He warns that community consultation and involvement is not the same as

delegation of power. The focus on community involvement under Labour, he claims 'has not been accompanied by a substantive transfer of executive power from the centre to local institutions and people' (*ibid*.:116).

> Craig and colleagues (2004:221) warn that as community and voluntary organisations gain access to the policy-making process, 'they face difficult strategic decisions in balancing the opportunity to gain influence with the need to maintain their independence and autonomy. They also face important issues about disparity of resources and power between themselves and more powerful partners'.

Based on research with a wide range of community and voluntary organisations, they identify ways in which participation can be problematic for community representatives. For example, there were experiences of there being 'peripheral' and 'core insiders', with community groups often at the margins. Some express that they are 'widely consulted but not influential'. Others are sceptical to aligning themselves too closely to funders because it may limit their capacity to challenge or criticise statutory partners. There may also be a danger that in partnerships established by Government, community representatives are 'co-opted into governmental agendas and at the same time losing touch with constituents without great gains to demonstrate' (*ibid*.:228).

Similar concerns have been raised with specific reference to Northern Ireland. McVeigh (2002) argues that the top-down initiative of the Government's community relations policy over the last decades has had negative effects as it identified the 'problem' as being between groups within the community, thus eliminating the state from the equation. McVeigh argues that there has been a shift in community organisation in Northern Ireland from one that included alternative education and/or policing, to one that is resourced and shaped by the state. Today, community organisations operate in a competitive funding environment moulded by the state. A similar argument is presented by Collins (2002) in relation to the Social Partnerships set up in the Republic of Ireland in the 1990s. The inclusion of the community organisations in these partnerships has meant, he argues, subscribing to the agendas and mechanisms of the state: 'Bottom-up mobilisation which underpinned the partnership process was essentially a sophisticated process of State building' (*ibid*.:99). Similar to Crawshaw and Bunton (2003), who argue that community development initiatives frequently work within the 'status quo' and may therefore be convenient and non-threatening for governments, Clarke (1996) argues that 'community' can be employed as a mechanism for social control where the rhetoric masks the power relations that prevent change.

1.7   THE PRAGMATICS OF COMMUNITY INVOLVEMENT
Taylor (2003) presents three views as to the likelihood of community development processes being successful: firstly, a pessimistic view sees community regeneration as 'rearranging the deck chairs on the Titanic'. Such a view has been raised in relation to area-based initiatives, including HAZ (Crawshaw and Bunton 2003) and there are concerns that while the Government establishes such initiatives it does not sustain them or allow them sufficient power to develop to their full potential.

Secondly, an optimistic view would argue that the participation of communities as equal partners provides an opportunity to redress the balance of power. This may reflect the view from some parts of the health promotion movement, for whom community control has perhaps become a 'holy grail' (Jewkes and Murcott 1998:857). Perhaps the rhetoric of optimism (Stern and Green 2005) regarding the opportunities afforded to communities by partnerships reflects the long wait since the movement first called for community involvement. In any case, as shown, there are many issues surrounding the involvement and

representation of communities that need to be addressed before this potential may be realised.

Thirdly, Taylor sets out a pragmatic view which would accept that 'power flows through privileged pathways' (2003:14) and that it may be unrealistic to hope for fundamental change in the power relations underpinning policy-making. There may still, however, be potential to exploit policy making processes for the benefit of the marginalised. This position seems best to reflect the overall view of the partners in our research. While seeing the potential of community participation and working hard to maximise it, the partners recognised that fundamental change was unlikely to happen. Their view echoes how Stern and Green (2005:275) describe the position of those involved in *Healthy Cities* initiatives: they 'had a dual obligation to be both sophisticated about the limitations of partnership working, and committed and optimistic about its potential'. Partnerships found compromises and solutions 'that were "good enough" if not optimal, and that adopted an explicitly incremental approach that enabled a level of progress whilst not "rocking the boat".' (*ibid*.:274). Partners in these partnerships stayed on board due to the added value to all partners, however marginal. Again this seems to reflect views in our research where community involvement was identified as providing tangible benefits to communities that albeit limited, was better than no change at all.

The four partnerships studied in our research expressed their commitment to community involvement and awareness of many of the barriers to maximising its potential.

> This section has flagged up some issues that may be particularly pertinent for future development of community involvement in partnerships such as:
>
> - How community representatives are selected
> - How community representatives are accountable to their constituents
> - How to ensure that community voices are not marginalised
> - How existing power relationships may impact on how partnerships are set up and function
> - How the community and voluntary sectors can retain their challenge function while working in partnership with statutory partners
> - How health improvement and reducing health inequalities must not be interpreted as simply the responsibility of communities and individuals, and that engaging in partnership with the community should not be the end of the Government's responsibility.

How these issues should be addressed will depend on the purpose and remit of each partnership and on the context in which it exists.

2. PERCEPTIONS OF PATHWAYS TO REDUCING HEALTH INEQUALITY

2.1 INTRODUCTION

The IfH and HAZ policy initiatives, which constitute the policy context for the four partnerships studied, are based on a social determinants model of health, explaining health as an outcome of a range of social and economic factors. Although not the only depiction of this model, the Dahlgren and Whitehead (1991) 'rainbow' is the one most generally applied. Determinants of health are represented as a set of concentric arcs around the individual with his or her hereditary factors, age and sex at the centre. Outside are layers of determinants as follows: individual lifestyle factors; social and community networks; living and working conditions; and general socio-economic, cultural and environmental conditions. The layers closer to the individual are seen as more immediate, while those further away are more distal determinants of health.

Figure 1
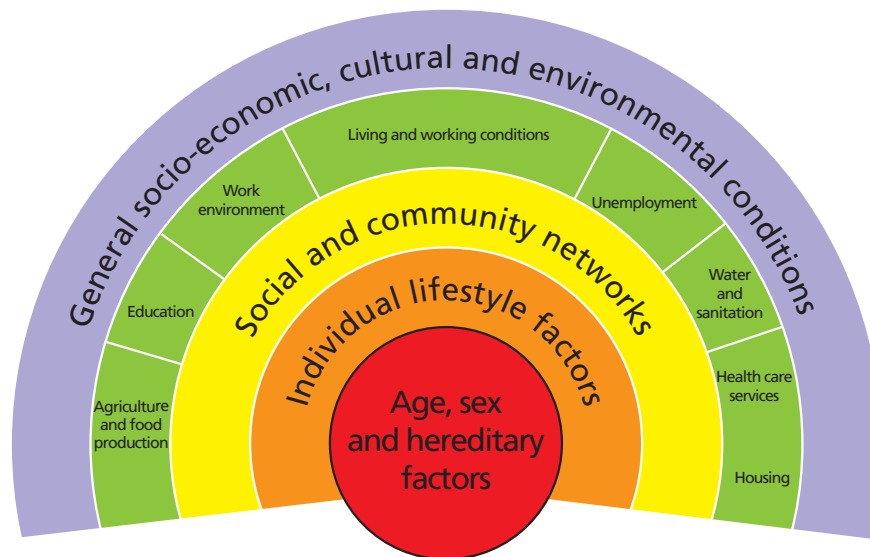
(Dahlgren and Whitehead 1991)

A focus on the social determinants of health emerged among health researchers in the 1970s (Graham 2004a). In 1974, the Lalonde report promoted the idea of a public health policy agenda focusing on preventative, 'upstream' determinants (Raeburn and Rootman 1998), and a social determinants model formed part of the *Health For All 2000* initiative, the *Alma Ata* Declaration, and the *Ottawa Charter* (Graham 2004a). Following the social model, health inequalities are commonly understood as emerging as a result of the uneven distribution of social determinants of health (DHSSPS 2002). In Northern Ireland, as in other countries, there are systematic differences between socio-economic groups, with those less wealthy carrying a disproportionate burden of ill-health compared with those better off (Balanda and Wilde 1999).

The social model of health and a concern with health inequalities gradually made its way into the thinking of governments (Graham 2004a). In the UK, a report into inequalities in health was commissioned by the Labour Government in 1979. The report, referred to as the *Black Report*, identified materialist/structuralist explanations as those with most potential for policy (Williams 2003). The report had, however, little impact on policy at the time. The New Labour Government commissioned a second report into health inequalities in 1997. Of the 39 recommendations in the *Acheson Report*, only three were within the direct remit of the NHS, reflecting how a wide range of perceived determinants were seen as impacting on health (Acheson 1998). Since then, devolution of power, as part of New Labour's agenda, has led to publication of country specific public health strategies for the four countries in

the UK, each making reference to a social model of health (DHSSPS 2002). In Northern Ireland, the IfH public health strategy makes explicit its commitment to a social model of health (*ibid*.). The overall aim of such policies, in common with other such policies in the western world, is to improve health and reduce health inequalities by tackling the determinants of health (Graham 2004a).

The social model of health lends itself easily to a partnership approach, which is a common feature of New Labour's policy initiatives. The coming together of partners from different sectors with responsibility for different social determinants provides an opportunity to align services and initiatives related to the full range of determinants. The importance of cross-sectoral working, and in particular the involvement of communities so that they can define their own agenda and become active in the political process, is often seen as an important part of the application of the social model (Kelly and Charlton 1995).

Both the HAZ and IfH policies are firmly embedded in the social model of health and have reducing health inequalities as a key objective. Specifically referring to HAZ, the Department of Health, Social Services and Public Safety states that they were 'set up to target areas of disadvantage in the community where there was greatest need to address public health issues and an opportunity to make significant improvements' (DHSSPS 2006). Both initiatives recognise the impact of social deprivation on health and the need to tackle the root causes of ill health. Locally agreed strategies would be identified and implemented, and 'innovative action should provide impetus to the task of tackling persistent health inequalities' (*ibid*.).

In various applications of the social model of health, the relative causal efficacy of social structure and individual are given different emphasis. In some instances emphasis is placed on the lifestyle and health behaviours of individuals as the most important determinant, while in others the way a society is structured (such as a rigid class system) is seen as the key driver. A focus on lifestyle or structural determinants for health may indicate differing views as to the casual powers of individuals and structure respectively. It is common, however, that both perspectives are incorporated into one policy or initiative (Graham 2004a), and this is the case with IfH and HAZ, both recognising the full range of health determinants.

'Policy' can be understood as the combination of policy frameworks (for example the IfH document) and how the mechanisms for change implicit in these frameworks are interpreted and acted upon in policy implementation (for example through partnerships) (Pawson 2002). The ways in which policy strategies or mechanisms are interpreted by practitioners may therefore be crucial for policy outcomes. Discrepancies between the understanding of health inequalities in policy and among practitioners could represent a difficulty in achieving policy aims. In this section we explore how partnership members in the four partnerships understand health inequalities, how they think such inequalities can best be remedied, and how they see the role of partnerships in reducing inequalities in health.

Given that many partners came from a background where they might not have been exposed to the social model of health, we originally thought partners' understanding of the key concept upon which the policies were based could be a cause for misunderstanding. As shown below, however, partners seemed overall to have a good understanding of the concept, but there were discrepancies as to whether emphasis was placed on individual or structural factors in explaining and seeking to tackle health inequalities.

After exploring the views expressed by partners in the next two sections, we discuss some potential weaknesses in the social model of health and finally its implications for policy.

2.2 PERCEPTIONS OF HEALTH INEQUALITIES AND HOW THEY CAN BE REDUCED

2.2.1 Location of inequalities

All partnerships focused their work on deprived communities. This may explain why partners tended to discuss health inequalities as an issue limited to poor or deprived segments of the population. Many expressed that to tackle health inequalities, one needed to focus on those 'at the bottom', that is the most deprived people or areas. Some even referred to inequality as an entity existing within areas or people:

'It's something about understanding what inequalities are all about, and in some way, having a concept of need and the context in which the unequal actually live.'

'Especially by working in areas where we have identified health inequalities.'

Inequality was thus described as if residing 'within' an individual or a community, and not as a relational concept that involves differences 'between' sections of society. It may be that respondents, had they reflected on this further, would have expressed themselves differently. What these and other comments highlight, however, is that health inequalities are largely understood as the problem of ill health among the poor. The effect of inequality across the social gradient, as described in the literature, is lost in such an approach.

2.2.2 Focus on individuals

Some interviewees emphasised the role of individuals when describing the causes and solutions to health inequalities. Material or non-material individual resources, or lack thereof, were portrayed as producing inequalities which impact on health.

'For me, inequalities in health is that gap area, which is defined by those who have and those who have not. And I don't mean have in financial terms even, I mean have in capacity to understand, or to be aware of, or to have the confidence, or the ability to actually gain.'

This respondent illustrated her view with an example of how she had been involved in setting up a playgroup facility in a deprived area where this service was lacking. It soon appeared, however, that the people using the service were from outside the area, people who knew 'this is a good investment in my child', whereas local people, for whom the service was intended, did not use it: 'No one had actually thought about how they would build up the confidence and the knowledge in the community that this facility was for their child's future'.

A need for increased knowledge or individual empowerment was highlighted as essential for reducing health inequalities, and by some this was seen as more important than material issues:

'I think the problems of access, problems of funding are overstated, personally, and that it is lack of knowledge usually in a particular group of people, regarding the damage to their health of their diet, their lifestyle etc.'

People's ability to take responsibility for their own health was also described as hampered by social and economic circumstances. The NWBHAZ partnership applied the concept of 'developmental pathways' which represents how, through life, health is shaped by the decisions people make on the basis of the options open to them. If the available pathways are unfavourable, this will impact on people's health.

'The sorts of inequalities of life opportunities that young people have, or the mistakes they can make that then cause further inequalities, by inappropriate pregnancies, for example … [it] breeds its own inequalities, as a consequence, but it's got its root in another set of inequalities.'

Some, including several community representatives, described health inequalities primarily as a result of unequal access for individuals or communities to health care services. This could be due to poor public transport or lack of financial resources. Unequal access to services was also described as a result of lack of confidence or 'know-how':

'The better off and the better educated can get health care, because they know how to do it and they have the confidence to do it.'

Among those who emphasised the role of individuals when discussing health inequalities, many expressed that people will, and should, make their own decisions, but that they may need support and help to increase their knowledge and confidence to make the right choices. Empowerment and information were described as key ingredients in an approach by which people could take control over their lives, and that this would provide a pathway to reduced health inequalities.

'It's equality of opportunity, really is the key. You can't force people to select a proper diet […] to take the right amount of exercise, but what we want to do is give them the knowledge and the accessibility to be able to do it.'

2.2.3   Focus on structure

Health inequalities were also described as a result of structural inequality. Some placed emphasis on macro-economic issues such as unemployment, deprivation or poverty, which leads to an uneven distribution of determinants for ill health.

'The employment characteristics of an area is probably the biggest single issue in my view that affects the health of a population … The incidence of factors adversely affecting health are greater in the lower social classes.'

For others, health inequalities were part and parcel of wider equality issues shaped by social structure. The social organisation of society, in particular historic and political contexts, were described as crucial in producing health inequality. To illustrate this view, one participant stated:

'Now, if you live in a predominantly Catholic area, you will have a poorer health-education-literacy profile and … the inequalities of health from the norm will be greater.'

Health inequality was thus seen as an outcome of inequality more generally and the respondent continued:

'People don't understand inequality [...] They don't know the difference between the equality of input, equality of output, equality of outcome. And if we're talking of inequalities in health, we're talking about inequalities of outcome.'

If health inequalities are a result of economic or equality issues at macro level, partners argued, eradicating them would require fundamental structural and cultural change. The pathways to reduced health inequalities were described as redistribution of wealth and power, resulting in more equal outcomes in education and equal opportunities for decent jobs, which in turn would reduce health inequalities.

2.2.4   Interconnectedness

Many of the interviewees expressed views which implied they understood health inequalities as a result of interaction between structurally and individually based causes. For example, alluding to the interplay between social status and health behaviour, one statutory representative emphasised how behaviours with negative impact on health are much more common among deprived population groups, 'whether it's smoking, whether it's drugs, whether it's obesity, whether it's malnutrition, whether it's exercise'. Another participant used her own mother as an example of how, behind mortality statistics, she believed there is an interplay between lifestyle issues and social circumstances such as the links between health and place:

> 'You know, my mummy was dying, smoking, and telling me it was the only pleasure she had. And yet if you were to look at the statistics, she should have been dying then, because she came from [name of area] and they don't live to 65, so she was only playing out a standard mortality rating.'

Social psychological explanations were also expressed, emphasising how living in poverty and experiencing the negative effects of inequality can lead to a shared mindset, which impacts on experiences and behaviour and perpetuates inequality. Specifically, the situation of the deprived and politicised context in which some protestant communities find themselves were described as having developed such a mindset.

> 'In addition, [health inequalities] are tied to a whole psyche, which is to do with politics with a small 'p', if you want, and a large 'P' as well, and the experience of inner city, working class, Protestant communities.'

2.3   PARTNERSHIPS AS SOLUTIONS TO HEALTH INEQUALITIES

Despite different views as to how health inequalities are shaped, addressing health inequalities through working in partnership was, not surprisingly, strongly supported throughout the interviews:

> 'We know that inequalities in health are the result and are driven by a complex set of factors, coming from a range of different directions that are within and without the control of individuals and organisations … then the only way to actually tackle some of those root causes, is to get those factors lined up and working together.'

2.3.1   Structural pathways for reducing health inequalities

The partnership approach was described by many as the best way of aligning local services and strategic thinking, thereby creating the opportunity for changing the structures which cause health inequalities. However, partners expressed different views as to the likelihood of the success of this approach. Some argued that a partnership such as a HAZ is not in a position to significantly shift the structures that produce health inequalities, and it would be unrealistic to expect reductions in health inequality unless this was part of a high level progressive policy initiative by the Government.

One NNHAZ partner holding such a view noted that the partnership would not be able to address all root causes of inequality since 'the only way in which you're going to address inequalities in health is by adjusting the social divide'. Another of the NNHAZ partners was more optimistic and believed that the partnership approach could impact on health inequalities by putting in place connections that could benefit those most in need:

'We are starting to put in place linkages and connections that should help to reduce inequalities … It's very difficult to see shifts in the inequalities in health but you can see things like communities having more connections with health providers, with health therapists, with other agencies who can affect the issues that they have identified as impacting on the health and well-being.'

A similar difference in views was expressed by two WIHP partners. One emphasised that even if there was some good work ongoing in the action research and pilot projects, 'you can't feasibly say you are tackling inequality if you can only ever deliver the project in Derry and Strabane and the other three council areas will never have it'. The other partner however, expressed a much more optimistic view of the potential for having successful projects mainstreamed and as a result, impacting on health inequalities.

2.3.2   Individual pathways for reducing health inequalities

Others placed emphasis on how partnerships could impact on the lives of individuals and that the cumulative effect of this would represent a pathway for reducing health inequalities. Bringing a range of organisations together was seen has having huge potential for better meeting the needs of individuals:

'So if you come with a view that an individual is an experience in a set of relationships then you must try to engage at that level, you must try therefore to bring your support services or your developmental services or whatever, draw them out through tweaking your agency.'

It was pointed out that since this approach depends on the participation of individuals, the partnership could only impact on issues which local people deemed important to them.

'HAZ can only provide what people want … So you can only really address the issues that the people in the local community want to have addressed. Otherwise you are throwing money away.'

Several respondents commented that although providing huge benefits for the individuals involved, focusing on individuals may leave the overall partnership approach vulnerable. For example, people who have increased their skills through participating in partnership initiatives may leave the community in search of better employment and thus the effort of the partnership may not impact on the community or on levels of health inequality.

2.3.3   Community participation as a pathway for reducing health inequalities

The involvement of local people in identifying and addressing local needs was seen as essential to ensure sustainable pathways for reducing health inequalities. The majority of partners are from professional and/or middle class backgrounds. This was seen as making it difficult for them to fully understand and appreciate the issues and problems faced by those living in deprived communities, which in turn could lead to issues not being addressed. One statutory partner expressed a view that,

'So inequalities in health or whatever they are, will not be addressed because the message from the ground is not reaching the policy people … Because we're all middle classed civil servants who have never been unemployed … we rarely go to the hospitals, because we're all in good health and all that sort of thing, we don't smoke and we eat well and all, you know, because of our incomes and all of that: then we won't get that message.'

Another statutory partner reported how a community representative had expressed very clearly to him that people from statutory organisations did not have the necessary insight to tackle local issues:

> 'I don't mean to be unfair to you because you are all members of your own communities and different communities, but you haven't a clue, you haven't got a clue about our community and what we need, nor are you going to find out through this, sitting around these six or seven tables that you have here. You are going to have to get much closer to our community.'

The solution to these issues was seen as the participation of local communities in the partnerships. All four partnerships had developed strategies for community participation at all levels. Indeed, meaningful community participation was described as an essential part of the logic of partnership working. Some expressed this in a manner that appeared to argue that if communities got involved in the partnerships, reductions in inequality would necessarily follow. In fact, when asked about the way in which the partnership would lead to reductions in inequalities, a common answer would be 'by engaging with communities to find ways that may be effective', perhaps reflecting the community representatives' unrealistic expectations of the partnership.

2.4   DISCUSSION

2.4.1   Individual or structural pathways to reduce health inequalities?

Published policy documents on IfH and HAZ emphasise that health inequalities must be addressed by simultaneously enabling individuals to lead healthier lives and by tackling structural determinants, in particular poverty (DHSSPS 2002). There is close correspondence between these initiatives and views expressed by partners in this research. The practitioners charged with implementing parts of these policies are therefore largely operating with the same interpretation of the problem of health inequalities and identify very similar solutions to those expressed in the policies. Many of the partners however, expressed more radical views on how to eradicate inequality than current government policy does. Many believed the Government does not go far enough, and that to prevent the partnerships' work being limited to 're-arranging the deck chairs of the Titanic', more wide-ranging redistribution of wealth is needed. Whilst recognising this, the practitioners were committed to the work and approach of the partnerships.

There was no uniform view, however, as to whether the most efficient approach to reducing health inequalities would be individually oriented or through structural pathways. This may be a reflection of debates among those involved in academic studies of health inequalities. Scholars have claimed that the relative impact of individual behaviour and social structure, that is the relative causal efficacy of agency and structure, has never been resolved in the way in which medical sociology, health promotion or the 'new public health' think about health. According to Davison and Davy Smith, a largely asocial notion of behaviour and a firm focus on 'lifestyle' has led to an oversimplification of disease causation, and with specific reference to health education they argue that it 'has never come to terms with the complex relationship between the individual and the collective in the field of health and illness' (Davison *et al*. 1991:16-17 quoted in Davison and Davy Smith 1995:93). More recently, a similar concern about the need for the study of health inequalities to deal with the relationship between the individual and society is made by Frolich and colleagues (Frolich *et al*. 2001:781) arguing that '[w]hat is missing is a discussion of the relationship between agency (the ability for people to deploy a range of causal powers), practices (the activities that make and transform the world we live in), and social structure (the rules and resources in society)'. In an article reviewing how the concept of social structure has been

deployed within medical sociology, Williams (2003) emphasises how the discipline in its early development only made brief reference to the concept. During the latter part of the 1980s (after the publication of the *Black Report*), however, this changed, and a sociology of health and illness with a more independent position and an agenda more in line with classical sociology has emerged. Today social structure is part and parcel of the discussion of health inequalities within the context of the social model.

The social model of health fails, however, to fully account for the causal relationship between social factors and individual health. Williams (2003) argues that while it has been established that health inequalities are associated with, for example, race, class and gender, what exactly it is about these features that contributes to chronic disease is largely unknown, and there is still a need to 'explore either the generative mechanisms that produce the indicators of social inequality in the first place, or the complex intersection of structure and agency within the material world of everyday life' (*ibid*.:139). Kelly and Charlton (1995) identify the risk that the social model of health may reify - treating something abstract as if it is concrete - social systems: in applications of the model, disadvantage or unemployment are described as causing disease. Kelly and Charlton warn that this may be relying on an ecological fallacy, that is, drawing conclusions from aggregated data and applying them to individual characteristics. What is needed are explanations of the pathways by which distal social determinants impact on individual physiology. This view is echoed by others, and work by Marmot and Wilkinson is currently at the forefront of exploring the biological pathways by which social conditions impact on health (Marmot 2004; Wilkinson 1996; 2000; 2005).

The differences in the views expressed by the research participants regarding individual and structural solutions to health inequalities may therefore be interpreted as a reflection of lack of clarity on the issue in medical sociology, health promotion and public health.

2.4.2   How to construct effective policy?

Graham (2004b) classifies policies aimed at reducing inequalities into three types along a continuum: (i) those focusing on improving the situation of the worst off; (ii) those focusing on closing the gap between the poorest group and the richest; and (iii) those focusing on addressing the gradient in socio-economic position and health across all population groups.

Both the IfH and HAZ initiatives fall largely into the first type of policy, which focuses on improving the health of those worst off. This approach, Graham argues, is unlikely to reduce inequalities in health unless it somehow prevents the health of the rich from improving too. Focusing on the poor is still a common strategy in policies as health inequalities are frequently interpreted as a problem of ill health among the poor (Marmot 2004), as was the case among our respondents. Policies commonly take the shape of 'area-based initiatives' attempting to improve services and opportunities for people living in deprived areas. Area-based initiatives to reduce inequalities have some weaknesses. Taylor (2003) outlines three common criticisms. First, low income and exclusion are not confined to particular areas and area-based approaches can be interpreted as simply drawing boundaries around problems. Second, area-based policies tend to 'cream off the most able in the locality'; achievers may leave and as a result the area is more impoverished than before. This issue was raised by participants in our research and may be a particular weakness if interventions focus on individuals. Third, area-based initiatives, focusing at neighbourhood level, cannot tackle the macro-structural issues that produce much of the disadvantage in the first place.

The second type of policy described by Graham focuses on narrowing the gap between those at the 'top' and those at the 'bottom' of the social hierarchy. Such strategies may simply swap the relative position of the individuals towards the bottom and hence not

address overall inequality in society. The policy approach with most potential for reducing health inequalities is, Graham concludes, that which takes into account the gradient of health inequality and encompasses all socio-economic groups. One reason why this focus rarely occurs in policy may stem from how such policies connect social determinants of health and health inequality. As shown, the IfH policy defines health inequalities as the result of uneven distribution of determinants of health. It applies the same model to improving health and to reducing health inequality. Graham (2004a:109) argues that this approach of applying the social determinant model to health inequalities may be problematic because:

> Using the model to explain both health and health inequalities can blur the distinction between the social processes that influence health and the social processes that determine their unequal distribution. The blurring of this distinction can feed the policy assumption that health inequalities can be diminished by policies that focus only on the social determinants of health.

Researchers have failed, Graham argues, to communicate this significant difference to policy-makers and, as a consequence, policies commonly seek to reduce health inequalities by 'tackling' the determinants of health. If researchers have not communicated this successfully to policy-makers, it may not be communicated to practitioners either, through strategies or policies. As a consequence, the views expressed by many partners about reducing health inequalities by tackling the immediate determinants, might have been expected. As shown, many believed that the most efficient approach to reduce health inequalities would be to empower individuals to take responsibility for their own health. Others, however, expressed views in agreement with Graham's analysis, maintaining that unless policies address the structural issues that produce the gradient across socio-economic groups, one cannot expect to significantly reduce inequalities in health.

Despite such differences among the partners, however, an overall view was that even if the partnership approach could not fully solve the root causes of health inequality, doing something for those worst off was still better than doing nothing. Several partners explained that it was a moral issue and important for social justice. One partner, who expressed strongly that the root causes of inequality can only be solved by fundamental changes, added that even if the partnership could only address the symptoms of inequality, 'that doesn't mean that we shouldn't try to address those symptoms because they are so blinkingly awful that morally you can't just sit there and say right, well, we're not doing anything because it is too difficult'. Whether 'doing something' which may prove ineffective is better than doing nothing is questionable if one takes into account the opportunity costs involved. The statement does, however, reflect that partners may feel that helping those worst off is a moral duty and maybe it is more an expression of their personal value base than of any attempt to describe a rational strategy on how to reduce health inequalities.

There may be weaknesses in the social model of health and health inequality which forms the basis for the IfH and the HAZ initiatives. Much of the literature which identifies problems with such approaches, only touched on above, was published after these initiatives were designed. If these new theoretical developments, some of which are contested, are supported by further evidence, it may be the case that the theoretical and epistemological foundations upon which the IfH and HAZ partnerships are based could represent a barrier to progress. As policy-makers and practitioners rely on evidence and theories from a range of fields, the limitations of those fields when it comes to understanding health inequality and how to address them, may form part of the external constraints for successful partnership working.

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