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Bauld, L., Judge, K., Barnes, M., Benzeval, M., Mackenzie, M. and Sullivan, H. (2005) *Promoting social change: the experience of health action zones in England*. Journal of Social Policy, 34 (3). pp. 427-445. ISSN 0047-2794

<http://eprints.gla.ac.uk/3338/>

Deposited on: 23 November 2011

Promoting Social Change: The Experience of Health Action Zones in England

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Abstract

When New Labour came to power in the UK in 1997 it brought with it a strong commitment to reducing inequality and social exclusion. One strand of its strategy involved a focus on area-based initiatives to reduce the effects of persistent disadvantage. Health Action Zones (HAZs) were the first example of this type of intervention, and their focus on community-based initiatives to tackle the wider social determinants of health inequalities excited great interest both nationally and internationally. This article draws on findings from the national evaluation of the initiative. It provides an overview of the HAZ experience, and explores why many of the great expectations associated with HAZs at their launch failed to materialise. It suggests that, despite their relatively limited impact, it is best to consider that they made a good start in difficult circumstances rather than that they failed. As a result there are some important lessons to be learned about the role of complex community-based interventions in tackling seemingly intractable social problems for policy-makers, practitioners and evaluators.

Social programs are complex undertakings. They are an amalgam of dreams and personalities, rooms and theories, paper clips and organisational structure, clients and activities, budgets and photocopies, and great intentions. (Weiss, 1998: 48)

Introduction

Health Action Zones were one of the products of New Labour's first flurry of enthusiastic activity after the landslide victory at the 1997 general election. They were established in relative haste as high-profile pathfinders that were intended to modernise health care and reduce health inequalities in the most disadvantaged parts of England. But they quickly lost their place in the limelight as the policy agenda filled with an ever-expanding list of new initiatives to transform public

services and promote social justice. By the beginning of 2003, after most of them had been active for half or less of their intended seven-year lives, they were to all intents and purposes wound up. Nevertheless, the main purposes for which they were established remain important. So what can be learnt from their experience? Is there a useful tale to be told about policy failure? Or is there perhaps a story of progress in the face of adversity? The answer turns out to be a bit of both. In the telling there are important lessons to be learned about the design, implementation and evaluation of complex community-based initiatives that seek to tackle social problems such as health inequalities.

The aims of this article are to:

- examine the background to the HAZ initiative and its evolution over time;
- introduce key features of the framework adopted for the evaluation of HAZs;
- review what progress was made in relation to three critical areas: planning for whole systems change, building collaborative capacity, and tackling health inequalities;
- reflect on the overall progress made by HAZs during their short lives; and
- consider the implications for policy design, implementation and evaluation of future initiatives.

Getting started

In May 1997, the Secretary of State for Health announced his intention to establish a number of Health Action Zones. These would be pilot projects whose aim would be 'to explore mechanisms for breaking through current organisational boundaries to tackle inequalities, and deliver better services and better health care, building upon and encouraging co-operation across the NHS' (Department of Health, 1997: 145).

In October 1997, the Department of Health (DH) invited health authorities in conjunction with local authorities and other agencies to submit bids to become HAZs. The guidance made it clear that successful zones would create alliances for change by harnessing the dynamism of local people and organisations and 'build on the success of area based regeneration partnerships'. The aim of new-style partnership working would 'provide added impetus to the task of tackling ill-health and reducing inequalities in health'. The guidance also made it clear that HAZ status would provide opportunities for the modernisation and reshaping of health and social services. The three broad strategic objectives of HAZs were: to identify and address the public health needs of the local area; to increase the effectiveness, efficiency and responsiveness of services; and to develop partnerships for improving people's health and relevant services, adding value through creating synergy between the work of different agencies. In addition,

Ministers set out seven underlying principles that HAZs were asked to adopt and to reflect in their plans and activities:

- achieving equity
- engaging communities
- working in partnership
- engaging front-line staff
- taking an evidence-based approach
- developing a person-centred approach to service delivery
- taking a whole systems approach

Among the incentives offered to potential HAZs were new freedoms, flexibilities and resources, although these were not spelled out in great detail. The obligations included requirements: to establish partnership boards; to demonstrate community involvement; to set targets for potential achievements, including early wins; and to set in place performance management systems that would monitor and demonstrate progress with reference to agreed milestones.

Given these expectations, potential HAZs were invited to submit bids by the beginning of 1998, 'which will have significant impact . . . and make lasting change to health and related services in local areas'. In support of these aspirations it was decided that:

- a HAZ development unit would be provided and support networks would be established and facilitated by the Department of Health;
- there would be a commitment to share learning with others;
- a requirement was placed on HAZs to undertake local evaluation of their work; and
- an independent central or national evaluation would be commissioned 'so that a clear assessment can be made of the impact of the strategies adopted by HAZs'.

The DH received 41 bids for Health Action Zone status, from 49 health authorities in total. From these the DH granted Health Action Zone status to 11 areas from April 1998 (DH, 1998a). Of those areas not selected in the first wave, a number were asked to submit further applications, and 15 more areas were granted HAZ status from April 1999 (DH, 1998b).

The 26 Health Action Zones were located in diverse areas of England. They were mainly concentrated in the North and Midlands, with four zones in London, one in the Home Counties and two in the South West. In total, HAZs included 34 health authorities and 74 local authorities. However, the specific organisational configuration varied tremendously between zones (Judge *et al.*, 1999). The population covered by HAZs varied from 200,000 (Luton) to 1.4 million (Merseyside), with an average size of about 500,000. The total amount

of resources made available to HAZs is difficult to estimate precisely because money was available in a variety of different forms for various purposes. For example, a DH press release in 1999 reported that 'total HAZ funding that will be available over the three years 1999/2002 is made up of programme funding of £152 m, £21 m innovations fund, £90 m deprivation uplift and £30 m smoking cessation funding' (DH, 1999). Our best guesstimate is that on average HAZs received funding of approximately £4–5 million per year at 2004 prices. This represented a very modest injection of additional funding in relation to the size of mainstream health and local authority budgets, but it was intended to provide a change management fund that would promote changes in existing services.

A framework for evaluation

In the spring of 1998, at the same time as the first wave of Health Action Zones was being selected, the Department of Health invited applications to undertake the national evaluation of HAZs. The research brief highlighted the fact that Health Action Zones were expected to have a life of five to seven years and that the central evaluation would need to be capable of assessing interim achievements as well as the longer-term impact. Beyond this, the DH recognised the very wide scope of what HAZs might try to do. Even so, it was expected that the evaluation should be concerned with assessing processes, as well as outcomes and impact, to ascertain how, as well as whether, objectives were achieved.

Within this general framework, the DH indicated that the evaluation should address a number of key strategic themes:

- improving health and reducing health inequalities;
- restructuring and integrating services for improved health outcomes;
- securing improved value for money from all available resources;
- building and sustaining partnerships;
- involving and empowering local communities to achieve sustainable development; and
- exploiting freedoms available to HAZs, forging innovation, bringing together policy and implementation, and influencing central policy development.

Given the uncertainty about the development of the HAZ initiative and the type of national evaluation that was required, the commissioning process was considerably protracted and it was not until the end of 1998 that a contract was agreed for a modest first phase of national evaluation. One of the key requirements was to 'undertake a scoping exercise to map and to categorise the different approaches that HAZs are adopting in relation to the community health improvement process and their own local evaluations'. At the same time, considerable effort was expended on seeking to promote the evaluability (Wholey, 1983) of the HAZ initiative by taking every opportunity to promote a 'theory of

change' (Connell *et al.*, 1995; Judge and Bauld, 2001) approach to development and learning, which, with the benefit of hindsight, met with only modest success.

As a result of a consultative process following the production of an initial scoping report (Judge *et al.*, 1999), a modified set of key requirements was agreed with the DH.

- The primary emphasis of the evaluation would focus on a whole-systems perspective on the management of change within HAZs to promote the modernisation of health and social care and to reduce health inequalities.
- A key aspect of the change process would investigate the extent to which HAZs were able to build effective capacity for collaboration - through inter-agency partnerships and community involvement - to produce tangible outcomes of value to policy-makers and other stakeholders.
- It was recognised that detailed research on the management of change might be possible only in a sample of HAZs. Nevertheless, there was a general requirement to maintain contact with all 26 HAZs, to establish effective links with regional performance management arrangements, to synthesise and to co-ordinate the work of local evaluators, and to invest in dissemination efforts of various kinds.

As a result, the main phase evaluation was organised around four key modules:

- *monitoring and mapping* changes over time in all 26 Health Action Zones;
- *whole systems change* in eight case study HAZs;
- *building collaborative capacity* in five case study HAZs;
- *tackling health inequalities* in three case study HAZs.

Fieldwork began in the summer of 2000 and was completed in the autumn of 2002. This delay meant that the substantive elements of the evaluation began after first wave zones had been in existence for two years and second wave HAZs for just over a year. This limited the extent to which the research could develop any baseline measures to track change over time.

Monitoring and mapping

The monitoring module aimed to assess the development of all 26 HAZs through time. This included providing a basic description of overall change strategies, the way in which these developed during the three years of the main evaluation, and the broad impact they achieved within this time frame. Data were collected from all HAZs in four primary ways (Bauld *et al.*, 2001).

- By making an annual visit to each HAZ in the autumn of each year and interviewing the HAZ director/co-ordinator. These visits were supplemented with telephone interviews in the late spring of each year.

- By collecting and reviewing all relevant documentation – such as revised plans, progress reports, newsletters and briefings and so on – produced by each HAZ.
- By reviewing high-level statements in each HAZ.
- By seeking every opportunity to meet informally with HAZ personnel at different events.

Case study work

The whole systems change, building collaborative capacity and tackling inequalities work was conducted using customised case study designs. The objective was to seek to answer a series of research questions by working intensively in a small number of HAZ areas. A detailed outline of these research questions and the methods for each module can be found elsewhere (Barnes *et al.*, 2004; Benzeval, 2003; Mackenzie *et al.*, 2003). All three used a theory of change approach to evaluation as a guiding framework for the research. Data were collected through surveys and face-to-face (via interviews and focus groups with key stakeholders), via local evaluators and through the collection of documentary and visual evidence. For each module, some details of the research design and approach to data collection had to be modified in the face of a rapidly changing policy context and the response of HAZs to this (Barnes *et al.*, 2003)

The evolution of health action zones

The national and local policy context affected the development of the HAZ initiative and the progress made by each zone (Bauld *et al.*, 2001; Bauld and Judge, 2002). Initially, there was considerable enthusiasm for HAZs both nationally and locally (Denham, 1999; Jowell, 1999), and there was a significant dialogue between HAZ leaders and civil servants about policy developments, with HAZ leaders feeling they were really able to influence change. Initial interviews with project managers in the first wave of zones identified a tremendous sense of optimism that HAZs had a real opportunity to improve the health of their local population (Judge *et al.*, 1999). The early emphasis on partnership and community involvement was welcomed, as was the opportunity to focus on health inequalities. Alongside this initial enthusiasm, HAZs faced a number of early pressures, which created particular challenges.

Early pressures

One of the most prevalent issues to emerge early on was the tension between the need for ‘early wins’ to demonstrate that HAZs were ‘making a difference’, and the longer-term investment required if changes in population health were to be realised. The speed of reform and the time frame in which HAZs were expected to develop and deliver were also described as challenging in terms of organisational capacity. There was a sense that the emphasis upon working to tight deadlines was counter-productive and could stifle creativity within HAZs.

An additional challenge that emerged was that of communication problems between the centre (in the form of the regional and central offices of the Department of Health) and the zones themselves. Project managers and others reported that they were failing to receive clear messages from the centre, or that these were not being disseminated properly (Bauld *et al.*, 2001). Throughout the lifetime of HAZs, beginning in the very early days of the initiative, the issue of whether central government was conveying clear and consistent messages to HAZs, and adequately supporting local efforts, was raised time and time again by project managers.

Finally, an additional early pressure on HAZs was the need to carefully plan and then implement their activities within an extremely broad and ambitious remit. Initially, HAZs were given a great deal of freedom regarding the types of programmes in which they could invest. The result was a proliferation of early plans that aimed to achieve very ambitious objectives within a relatively short time frame, with little relationship between their stated goals and the activities intended to achieve them (Judge, 2000; Judge and Bauld, 2001). This lack of convincing planning is discussed in more detail below. It meant that HAZs got off to a shaky start in terms of their ability to focus time and effort appropriately on selected activities that stood any chance of achieving positive change.

Uncertainty in 2000 and 2001

HAZs entered a period of transition at the end of 1999, when policy shifts at the national level had a considerable impact on the development and direction of the zones. First, continued concern within central government regarding the ability of HAZs to plan and implement activities resulted in the introduction of a performance management framework specifically designed for the zones. In line with other parts of the NHS (that were subject to different frameworks but with similar objectives), HAZs were expected to demonstrate on a quarterly basis how they were making progress towards specific longer-term objectives. This was to be achieved by the submission of 'high level statement' documentation to the HAZ Central team in the Department of Health. High level statements were based on a logical framework approach that asked HAZs to summarise their key goal, activities, milestones, indicators of success and targeted resources for each of their work programmes. Secondly, and more substantially, a new Secretary of State for Health, Alan Milburn, began, towards the end of 1999, to introduce a number of significant reforms into the health service. He was particularly determined that the constituent parts of the NHS should work together to tackle leading causes of death such as heart disease and cancer, as well as addressing long-standing problems such as winter pressures and waiting times.

HAZs were required to modify their programmes to address these issues. For some zones this involved only minor changes to their programme. For others the shift was more significant. Almost all project managers (25 out of

26), when interviewed in the autumn of 2000, pointed to ministerial priorities as a significant cause of a shift in direction for their HAZ. For all HAZs, it was clear that their original remit of developing local solutions to address local health problems had been broadened to embrace a wider NHS agenda.

An additional element of uncertainty for HAZs revolved around the issue of future funding. Although the zones had originally been launched with the promise of a seven year life span, funding was never guaranteed. The initial budgets announced were only for three years and resources were allocated to HAZs on a yearly basis. The shift in ministerial priorities created considerable concern among project managers that the profile of the initiative at a national level had been diminished and that the future was more uncertain. This unease was exacerbated in the spring of 2000 by cuts – both apparent and real – to HAZ budgets (Hansard, 2000).

Neighbourhood renewal and NHS reform

The HAZ programme was the first area-based initiative established by New Labour. It was, however, quickly followed by a plethora of other ‘zones’ aiming to address a range of social issues such as crime, unemployment and teenage pregnancy, to name just a few. At the same time, extensive research into the causes and nature of social exclusion in Britain culminated in the recognition that a new approach to reviving ‘failing’ communities was required. The result was the development of a national strategy for neighbourhood renewal, launched in 2001 (Social Exclusion Unit, 2001). The strategy aimed to develop a more integrated way of reducing a range of inequalities across England’s most deprived communities. At the heart of the strategy is the development of Local Strategic Partnerships (LSPs) (DETR, 2001). These bodies, led by local government, are intended to consolidate existing partnership structures, including HAZs.

In addition to the changes heralded by neighbourhood renewal, HAZs were affected by reforms within the NHS in England. These structural changes were first outlined in the NHS Plan and subsequently developed in the document *Shifting the Balance of Power* (DH, 2001). They amounted to a complete restructuring of key components of the health service. Perhaps most significantly for HAZs, they included the abolition of health authorities (through which HAZ funding was originally distributed) and the creation of larger Strategic Health Authorities and, at the local level, the formation of Primary Care Trusts (PCTs). *Shifting the Balance of Power* stated that ‘HAZs are to be reabsorbed with mainstream health funding through primary care trusts’ (DH, 2001).

Thus, by 2002, the structure of key partner organisations for HAZs within local government and the health service had been transformed. In addition, key functions of HAZs became the focus for these emerging organisations, most notably partnership working for LSPs and addressing inequalities in health for PCTs.

Critical issues

Throughout the evaluation, efforts were made to chart the progress of Health Action Zones and to critically assess the extent to which they realised their goals and the factors affecting this process. This learning is set out in considerable detail in a series of reports (Barnes *et al.*, 2003; Benzeval, 2003; Mackenzie *et al.*, 2003), which contain many examples of the valuable work undertaken by HAZs. We found it much more difficult, however, to assess the overall impact of HAZs on population health.

Exploring population level impact

Health Action Zones were expected to make a significant contribution to improving population health and reducing health inequalities in their area. However, neither HAZs nor the national evaluation team were commissioned (or resourced) to use traditional evaluation tools (such as household surveys across HAZs) to measure any changes between baseline and follow-up through time. Given that there are no HAZ-specific data for measuring the impact of the initiative, therefore, routinely collected statistics must be used to examine changes in population health through time. One of the best sources of this type of data is the Compendium of Clinical and Health Indicators, which brings together 150 indicators from several data sets including the Public Health Common Data Set indicators, population health outcome indicators, Our Healthier Nation indicators, clinical indicators, cancer survival indicators and others (DH, 2003).

We have described elsewhere (Barnes *et al.*, 2005) how we selected a range of indicators from the Compendium with the objective of identifying whether there was a demonstrable difference between HAZ and non-HAZ areas in relation to changes in health outcomes through time between 1997/98 and 2001/02. Data for local authorities within HAZ areas were compared with those outside HAZ areas with similar levels of disadvantage. The 67 local authorities associated with HAZs were ranked in the most disadvantaged 134 of the total of 354 for England. We compared levels of change in aggregate indicators for these HAZ local authorities with a similar number (67) also in the most disadvantaged group of 134 but not part of HAZs, and with the remaining, more advantaged, group of 220 that were also not associated with HAZs.

Some evidence emerges from the analysis to suggest that HAZs outperformed other areas in relation to a number of indicators that are related to their programmes and national policy priorities. First-wave HAZs, in particular, that had an extra year to make an impact, appear to have seen more positive changes in relation to all cause mortality and CHD mortality than other areas. Findings are, however, not consistent between indicators. Mortality from suicide increased in all areas, for example, with the largest increase in first wave HAZs, despite the existence of some HAZ programmes focusing on this problem, particularly among young men. There are a number of other significant anomalies in the

patterns of change that are identifiable. Overall, we conclude that the data do not support the view that HAZs made greater improvements to population health than non-HAZ areas between 1997 and 2001.

Given the considerable degree of uncertainty, however, about impact on population health, we present three disparate but important examples of areas that illustrate our collective view that HAZs were not able to realise the potential that was expected of them:

- **Planning for whole systems change:** the danger of placing too much reliance on logical planning structures to make progress in alleviating relatively intractable social problems.
- **Building capacity for collaboration:** the relatively unbalanced contribution made by HAZs to developing inter-agency partnerships and engaging communities.
- **Tackling inequalities:** the limited extent to which it is reasonable to expect modestly funded local initiatives to tackle fundamental structural problems, such as health inequalities.

Planning for whole systems change

One of the key assumptions of the HAZ initiative was that local agencies would either already have or be able to develop a capacity to promote whole systems change and that in doing so they would be able to share with central government clear plans against which they could be held accountable. As the national evaluation progressed, it became apparent that this assumption was naïve.

As with many other complex social initiatives (Parry and Judge, 2005), HAZs struggled with the task of planning activities and setting early and intermediate measures of success. They struggled with this during the development of their early plans, and then subsequently as they wrestled with accountability requirements as part of performance management. The following types of problem emerged:

- A lack of existing baselines hampered HAZs in setting the desired level of change that they wished to achieve. Often the choice of target appeared to have been selected without the evidence of either routinely collected data or the identification of a problem through a needs assessment.
- Targets were frequently expressed with a lack of specificity that would make it impossible to determine if the HAZ had achieved its end.
- Selected targets were only a partial representation of the overall strategy.
- Targets were imposed on HAZs by central government and were not necessarily set at a locally realistic level because of a variety of contextual factors.
- Activities and interventions were not conceptualised clearly enough to allow the degree of change to be predicted.

- Process measures were not always plausibly linked to the types of outcomes predicted to emerge from them.

HAZs' initial problems with developing convincing plans were originally attributed, at least in part, to the short deadlines provided for submission of their original plans. Later versions of strategic approaches as captured through performance management did not, however, show that these plans offered much more specificity in relation to their goals and activities. This suggests that initiatives such as HAZs require much more support and guidance to develop an integrated strategic approach.

Given that evaluations of a range of different policy initiatives have reported the difficulty that implementers experience in producing logical plans (that link the central purpose of the initiative to feasible strategies that will touch enough individuals to meet measurable objectives), it is reasonable to ask whether this is a question of capacity and resource or whether it is inherently unrealistic to expect that plans can be developed in this way (Barnes *et al.*, 2003). Is the messy and changing world of policy implementation so contradictory to highly specified planning that it becomes counter-productive to place a huge emphasis on explicitly identifying plausible pathways between means and ends? Of course, this is not to argue that planning, or a sense of direction, are not of paramount importance, but that policy-makers and evaluators need to be more realistic about the process of implementation and planning. Wilkinson and Applebee, for example, have argued that an overly programmatic approach to delivering change places an emphasis on top-down change processes that are to the detriment of 'lateral, cross-agency working' (1999: 77).

Furthermore, if planning in HAZ was to have been taken seriously then local players needed time and training to engage partners and to focus on developing strategic priorities and solutions. Local planners also needed to have a sense that their plans were viewed within a national context as meaningful and coherent, and that they would not be expected to overthrow these plans whenever a new national policy was launched. This required a balance between initiatives developing an overly rigid set of plans and central government viewing the HAZ initiative as the vehicle for taking forward all emerging policy relating to health and inequalities.

The process of planning a complex set of change processes was made even more difficult by the fact that the usefulness of the performance monitoring data required by central government was contested. Some HAZs found it useful as an internal monitoring framework, while others found that it clashed with their own local structures. Once again, clarity of purpose was key. Those designing such information systems both locally and nationally should have been more explicit about what data were for and how they would be used. The collection of data centrally is only meaningful if it is seen to feed into decision-making or accountability processes in a transparent fashion. Locally, more thought needed

to be given to how routine monitoring could help with project development and provide evidence to stakeholders that progress was being made.

Perhaps the single most important lesson to emerge from the evaluation's observation of strategic and operational planning by HAZs confirms Chapman's view of the need to view strategic change as complex and contingent rather than linear and wholly predictable:

One way to visualise the difference between the mechanistic, linear approach to policy and the holistic, systemic approach is to compare the results of throwing a rock and a live bird. Mechanical linear models are excellent for understanding where the rock will end up, but useless for predicting the trajectory of a bird. To the degree that social and organisational systems, like the NHS, show adaptive behaviours they are better regarded as similar to live birds than lumps of rock (Chapman, 2002: 12).

Building capacity for collaboration

The HAZ initiative was intended to be a partnership-based programme, and HAZs were best understood as a collection of agencies, groups and individuals rather than as organisations in their own right. Whatever was achieved by HAZs was achieved through collaboration across organisational and sectoral boundaries. At the same time, HAZs could not be considered in isolation from other partnership initiatives taking place within the same areas. HAZs were not always identified as 'leading' such initiatives (indeed it was sometimes suggested that would have been inappropriate), but they were identified as facilitating the inclusion of the NHS within initiatives such as New Deal for Communities and Sure Start. In addition to working alongside and with other area-based initiatives, HAZs also had to find ways of working with mainstream initiatives which sought to develop governance mechanisms which would support collaboration: in the context of health improvement programmes, Primary Care Trusts and, towards the end of the period, LSPs. It became evident that the strategies HAZs adopted for developing collaborative capacity and, indeed, what HAZs were or meant to different stakeholder, underwent considerable change during their lifetime. Strategies for developing collaboration responded to both local and national changes in a process both of developmental learning and 'forced' adaptation to circumstances.

The picture that emerged was of a predominantly positive reaction to the opportunities the HAZ initiative created for the development of collaborative capacity, both in terms of developing new models of service provision to 'established' as well as previously poorly served groups of service users and in creating a context in which those with boundary spanning skills were supported to develop new ways of working. Community engagement was also a key feature of the new ways of working that were developed and which started to contribute to improved health among those engaged in HAZ initiatives (Barnes *et al.*,

2004). The experiential knowledge of community members was an important contribution to designing projects and developing strategies in many instances.

The experience of HAZs provides evidence in support of the view that, for collaborative capacity to become embedded in local systems, it needs to be present across a range of sites and levels from strategic to operational and in relation to governance as well as community engagement (Sullivan and Skelcher, 2002). However, the particular contribution of HAZs to the development of partnership and community governance reveals a more mixed picture.

At strategic level there is little evidence that HAZs made a major contribution to solving the challenges of partnership governance (see Sullivan and Skelcher, 2002: chapter 8). In part this was because the constitutional basis of HAZs offered relatively little freedom to develop new governance arrangements. While the experience of HAZs suggests that collaboration is essential to developing new ways of delivering services that will more effectively meet the needs of communities and service users, it also presents a number of challenges in terms of good governance. These include: accountability for performance and accountability to the public (Barnes *et al.*, 2004).

HAZs were perhaps more successful in demonstrating the potential contribution of new governance mechanisms and forms of accountability at different levels below the strategic. The experience of HAZs suggests that cross-sectoral partnership is easier to establish within localities than across broader geographical areas. It is also at this level that community involvement in governance processes (such as making or scrutinising decisions) was evident, at least in some areas.

At the operational level, HAZs also made relatively little impact in furthering the application of collaborative mechanisms. While HAZs did make use of contracts, joint appointments and secondments, they did not take particular advantage of the opportunity to explore pooled budgets or integrated services, except where progress on these issues had been made prior to the advent of HAZ. Again this may be related to the constitutional basis of HAZs and/or the fact that the initial enthusiasm for requesting 'freedoms and flexibilities' from central government dried up following central government's limited response to these requests.

Even in those areas where examples were given of community members being involved in processes that shaped the development of the HAZ, there was also an awareness of the limits to this, not least because formal rules constrained the extent to which accountability for health services and policy can be expressed downwards to local communities. Overall, HAZs became more of a top-down initiative than initial hopes and aspirations might have suggested. As highlighted above, priorities were set centrally in a way that was not originally anticipated. In addition, the need to respond to changes in the structure of the NHS and other policy and governance initiatives meant that more energy was expended

in negotiating the place of HAZs in the context of the statutory system than in establishing community objectives and priorities.

Overall there was little evidence that strategic directions were shaped by communities or service users. On reflection, HAZs cannot be so strongly characterised as a community-led initiative as a partnership initiative (Barnes *et al.*, 2004).

Reducing health inequalities

HAZs had dual roles in relation to reducing health inequalities (Benzeval, 2003). First, they were meant to improve health outcomes and to reduce health inequalities in their areas and, given that they were mainly located in disadvantaged communities, this was expected to reduce both local and national inequalities (DH, 1998a). Secondly, they were expected to develop new ways of tackling local health inequalities (DH, 1998b). To achieve this they had both to invest in innovative initiatives and to establish effective ways of learning from them. They were expected both to mainstream successes internally and to disseminate good practice more broadly to the health community.

There is evidence from the national evaluation that HAZs' activities were felt to have pushed health inequalities as a priority up the local agenda and made them more visible. HAZs increased awareness of the problem of health inequalities, and particular manifestations of it, at the local level. For example, HAZs supported initiatives aimed at improving the health of excluded groups such as travellers, street drinkers and prostitutes, who were often hidden or ignored in the local policy arena. Similarly, by investing in prevention, health promotion and community development, HAZs helped to place these activities more firmly on the agenda than they had been before. More broadly, HAZs were felt to have promoted a greater understanding of the determinants of health and gained ownership of the range of partners necessary to address health inequalities.

Despite these positive perceptions, it is important to consider whether a HAZ was an appropriate vehicle for addressing health inequalities. First, was it helpful, or not, to have a separate identifiable policy space. Secondly, were area-based initiatives appropriate ways of addressing complex social problems such as health inequalities.

Being a HAZ was felt by most of the key actors involved to have created new opportunities to begin to address health inequalities. However, Stewart and colleagues (1999) suggest that, while issues often need a specific organisational unit to raise awareness of them, this can also marginalise them. Perversely, though, success in drawing issues into the mainstream may have the detrimental effect of reducing their visibility. The policy space that HAZs gave health inequalities was broadly welcomed as it provided an opportunity to focus and think about the problem that would not otherwise have been possible. However, it was also acknowledged that it had proved difficult for HAZs to influence mainstream

services in relation to health inequalities. Moreover, as other policy studies of health inequalities conducted at similar points in time have noted, the reality for mainstream agencies was that other ‘must dos’ had greater priority (Benzeval and Meth, 2002; Exworthy *et al.*, 2002; Evans, 2003).

When HAZs were initially established, there was considerable criticism of them as a way of tackling health inequalities because they were based at the local level (see, for example, Shaw *et al.*, 1999; Mitchell *et al.*, 2000). It was argued that the structural causes of health inequalities could not be addressed locally, and it was only through changes in national taxation and benefit systems, for example, that health inequalities could be reduced. It is clearly true that major reductions in poverty require such fiscal reforms, and should in time reduce health inequalities (Benzeval *et al.*, 2000). However, it does not necessarily follow from this that local investment across the range of complex determinants of health cannot contribute to reducing the health divide. While it requires national changes in policy to increase benefit levels, for example, local initiatives can be very effective in ensuring greater uptake of such benefits in ways that improve the incomes of the worst off. Moreover, complex social problems require a flexible policy framework that allows for differential response locally in relation to differing needs.

A related argument advanced against the concept of HAZs, and ABIs more generally, is that most ‘poor people’ do not live in ‘poor areas’ (Shaw *et al.*, 1999) and hence targeting disadvantaged areas will not reach a sufficiently large number of disadvantaged people. However, Powell and colleagues (2001) argue that as well as tackling ‘people poverty’ governments also need to address ‘place poverty’: that is, areas with inadequate services in relation to their needs. The strong emphasis that was placed on modernising services in HAZs suggests that this kind of thinking was part of the rationale for the initiative.

With the benefit of hindsight, the concept of a Health Action Zone that could reduce health inequalities in a short time scale with limited resources and a patchy evidence base about how to do so was overoptimistic. Nevertheless, HAZs do appear to have been an effective local voice for raising awareness of health inequalities. A key lesson from the HAZ experience is that there is no single blueprint for addressing the complex causes of health inequalities at the local level. This does not mean that there should be no further action. There are good reasons for believing that progress can be made by small steps and by learning from different attempts in specific contexts to promote change. To achieve this, there is a continuing need for a dedicated policy focus on health inequalities at the local level. At the very least, HAZs have undoubtedly led the way in this direction.

Reflections on the HAZ experience

Health Action Zones were encouraged to set themselves ambitious goals. Very few of them were accomplished in any very clear or convincing fashion. In one very

simple sense, therefore, there is no escaping the fact that they did not do what they set out to achieve. But it would be wrong to judge them on this basis alone. The truth is much more complex. There is, unfortunately, no simple calculus that facilitates the sound-bite message that Ministers might prefer to hear. The nuggets of learning that lie within HAZs have to be mined and cleaned and studied with care. It might appear evasive, but the experience of evaluating HAZs has led us to believe that most 'findings' of real value are context-specific, and the nature of the question or setting is critical to the learning that can be generated.

In the short period of time that Health Action Zones were able to make a direct contribution, they engaged in an incredibly diverse range of activities. During the three to four years that most of the zones existed, they sponsored hundreds of workstreams and thousands of projects (Judge *et al.*, 1999). It is astonishingly difficult to capture the complexity of this activity and to aggregate it in any meaningful way to make possible an overall evaluative judgement. HAZs were not substantial enough and did not survive long enough to make any real impact on conventional indicators of population health or health inequality, but they cannot be dismissed as failures on this basis. At their best, HAZs built local capacity and demonstrated change possibilities. They did this in innovative and sustainable ways that will continue to be useful for many years to come. What is important to remember is that the complex myriad of partnerships that constituted Health Action Zones, involving hundreds of organisations and thousands of individuals, means that many different stories can be legitimately told. The result is a mosaic that does not lend itself to easy or brief summary or to unambiguous judgements about success or failure. The simple truth is that we cannot answer the question – what difference did HAZs make – without narrating elaborate stories laden with many qualifications.

A recurrent question in our minds concerns whether or not HAZs were given a fair opportunity to demonstrate what they might have been able to achieve. From the outset they were encouraged to outbid each other in the scale of their ambitions. Most of them tried to tackle too many seemingly intractable problems simultaneously, and they were further hampered by regular attempts by Whitehall to increase and or to change the focus of their activities. During the period 2000/01, in particular, it would have been easy to conclude that Health Action Zones had been an expensive mistake (Bauld *et al.*, 2001). Many valued leaders became dispirited and moved to other jobs. Those that remained had to deal with the disappointments associated with reduced expectations about funding and the perception that HAZs were yesterday's news. But the very change processes being set in train that seemed to endanger HAZs carried within them the seeds of renewal and opportunity. As things have turned out, the Health Action Zone 'badge' will probably be seen to have had a very short shelf-life. But HAZs have shown themselves to be capable of making many significant and lasting contributions to the development of local strategic partnerships and primary

care trusts. There is considerable optimism that valuable lessons from HAZs are being transferred to other organisations. There is every reason to believe that the spirit of HAZs, if not the name, will live on.

Implications for policy and research

In many important ways HAZs were victims of the complexity that they set out to address. The biggest obstacle of all, to which no clear solution has been found by practitioners or researchers, is what Pawson describes as ‘the utter and appalling intricacy of social interventions’ (2003: 472). What is now badly needed is a new body of theory about what it is reasonable to expect community-based social programmes to deliver in the face of the bewildering scale of the complexities that they face. A central aspect of this general point is that the initiatives and interventions that are the subject of evaluation have to be organised and implemented in a way that enables them to address answerable questions.

For example, our experience of evaluating Health Action Zones strongly reinforces the importance of some of the comments made by Derek Wanless in his second report, *Securing Good Health for the Whole Population* (HM Treasury, 2004). He points out that, although ‘there is often evidence on the scientific justification for action and for some specific interventions, there is generally little evidence about the cost effectiveness of public health and preventative policies or their practical implementation’ (p. 5). One of the consequences of this central weakness in the evidence base for promoting population health and reducing health inequalities is that policy initiatives are often not thought through with sufficient care at the time when they are conceived and announced.

This has led to the introduction of a very wide range of initiatives, often with unclear objectives and little quantification of outcomes and it has meant it is difficult to sustain support for initiatives, even those which are successful. It is evident that a great deal more discipline is needed to ensure problems are clearly identified and tackled, that the multiple solutions frequently needed are sensibly co-ordinated and that lessons are learnt which feed back directly into policy (HM Treasury, 2004: 5).

Nevertheless, Wanless goes on to emphasise the huge potential value that would be realised by strengthening the evaluation of many existing and new programmes. But in order to take full advantage of following the injunction that ‘every opportunity to generate evidence from current policy and practice needs to be realized’, there are important lessons to be learnt about the design and implementation of substantial community-based social interventions such as HAZs. There is a need to think more carefully about the focus of such initiatives, their objectives, their timescales, the support that they need, both locally and nationally, and the space and trust and time that is required to make any kind of sustainable change possible. Yet, in our view, it would be wrong to zero in on

HAZs or any other recent initiative in isolation. Health Action Zones were part of a large body of area-based initiatives, and any real learning will come from reviewing some or all of them in combination. In fact, what is badly needed is a critical review of the design, implementation and achievements of the many complex social interventions introduced in the UK in recent years.

Acknowledgements

This article is based on research funded by the Department of Health. The views expressed are those of the authors and not necessarily those of the Department of Health.

References

- Barnes, M., Matka, E. and Sullivan, H. (2003), 'Evidence, understanding and complexity: evaluation in non-linear systems', *Evaluation*, 9: 3, 263–282.
- Barnes, M., Sullivan, H. and Matka, E. (2004), 'The development of collaborative capacity in Health Action Zones', A final report from the national evaluation, University of Birmingham.
- Barnes, M., Bauld, L., Benzeval, M., Judge, K., Mackenzie, M. and Sullivan, H. (2005), *Health Action Zones: Partnerships for Health Equity*, London: Routledge.
- Bauld, L. and Judge, K. (eds) (2002), *Learning from Health Action Zones*, Chichester: Aeneas Press.
- Bauld, L., Judge, K., Lawson, L., Mackenzie, M., Mackinnon, J. and Truman, J. (2001), 'Health Action Zones in transition: progress in 2000', Health Promotion Policy Unit, University of Glasgow, Report submitted to the Department of Health, June 2001. Available at: www.haznet.org.uk.
- Benzeval, M. (2003), 'Tackling inequalities in health module: the final report of the national evaluation of health action zones', London: Queen Mary College, University of London.
- Benzeval, M. and Meth, F. (2002), 'Health inequalities: a priority at a crossroads', Final report to the Department of Health, London: Queen Mary College, University of London. URL: www.geog.qmw.ac.uk/health/inequalities.html.
- Benzeval, M., Taylor, J. and Judge, K. (2000), 'Evidence on the relationship between low income and poor health: is the government doing enough?', *Fiscal Studies*, 21: 3, 375–399.
- Chapman, J. (2002), *System Failure: Why Governments Must Learn to Think Differently*, London: Demos.
- Connell, J., Kubisch, A., Schorr, L. and Weiss, C.H. (1995), *New Approaches to Evaluating Community Initiatives: Volume 1: Concepts, Methods and Contexts*, Washington: The Aspen Institute.
- Denham, J. (1999), 'Health Action Zones in 78 million pound trailblazing "money for modernisation" Zones will lead the way in modernising services and tackling inequalities', DH Press Release 1999/0034, Department of Health, London.
- Department of Environment Transport and the Regions (DETR) (2001), 'Local strategic partnerships government guidance', DETR, London. URL: www.local-regions.detr.gov.uk/lsp/guidance/index.htm
- Department of Health (DH) (1997), '“Health Action Zones” envisaged as co-operative NHS partnerships', DH Press Release 97/145, Department of Health, London.
- Department of Health (DH) (1998a), 'Frank Dobson gives the go-ahead for first wave of health action zones – new action zones will be trailblazers, leading the way in modernising services and tackling inequalities', DH Press Release 98/120, Department of Health, London.
- Department of Health (DH) (1998b), 'Fifteen new health action zones to tackle health inequalities', DH Press release 98/329, Department of Health, London.
- Department of Health (DH) (1999), 'Funding of £74 m allocated for 2nd wave Health Action Zones', DH Press release 98/0302, Department of Health, London.

- Department of Health (DH) (2001), 'Shifting the balance of power within the NHS', The Stationery Office, London. URL: www.doh.gov.uk/shiftingthebalance/.
- Department of Health (DH) (2003), 'Compendium of clinical and health indicators 2001–2002', Department of Health, London.
- Evans, D. (2003), 'Implementing policies to tackle inequalities at the local level', in A. Oliver and M. Exworthy (eds), *Health Inequalities: Evidence, Policy and Implementation. Proceedings from a Meeting of the Health Equity Network*, London: The Nuffield Trust, pp. 37–42.
- Exworthy, M., Berney, L. and Powell, M. (2002), "'How great expectations in Westminster may be dashed locally": the local implementation of national policy on health inequalities', *Policy and Politics*, 30: 1, 79–96.
- Hansard (2000), 'Adjournment debate: Health Action Zones 12 July', Hansard, Col 179WH-199WH, London: House of Commons.
- HM Treasury (2004), *Wanless Review: Securing Good Health for the Population*, London: The Stationery Office.
- Jowell, T. (1999), 'Health action zones are in the frontline in the war on health inequalities: trailblazers to report to Ministers on action to drive up local standards of health', DH Press Release 1999/0038, Department of Health, London.
- Judge, K. (2000), 'Testing the limits of evaluation: Health Action Zones in England', *Journal of Health Services Research and Policy*, 5: 1, 3–5.
- Judge, K. and Bauld, L. (2001), 'Strong theory, flexible methods: evaluating complex community-based initiatives', *Critical Public Health*, 11: 1, 19–38.
- Judge, K., Barnes, M., Bauld, L., Benzeval, M., Killoran, A., Robinson, R., Wigglesworth, R. and Zeilig, H. (1999), Health action zones: learning to make a difference, PSSRU, University of Kent, Canterbury. URL: www.pssru.ac.uk
- Mackenzie, M., Lawson, L., Mackinnon, J., Meth, F. and Truman, J. (2003), *National Evaluation of Health Action Zones. The Integrated Case Studies: A Move Towards Whole Systems Change*, Glasgow: Health Promotion Policy Unit, University of Glasgow.
- Mitchell, R., Dorling, D. and Shaw, M. (2000), *Inequalities in Life and Death: What if Britain were more Equal?*, Bristol: The Policy Press.
- Parry, J. and Judge, K. (2005), 'Tackling health disparities in England: the role of neighbourhood renewal', *American Journal of Public Health*, in press.
- Pawson, R. (2003), 'Nothing as practical as good theory', *Evaluation*, 9: 4, 471–490.
- Powell, M.A., Boyne, G. and Ashworth, R. (2001), 'Towards a geography of people poverty and place poverty', *Policy and Politics*, 29: 3, 243–258.
- Shaw, M., Dorling, D., Gordon, D. and Davey Smith, G. (1999), *The Widening Gap: Health Inequalities and Policy in Britain*, Bristol: The Policy Press.
- Social Exclusion Unit (2001), *A New Commitment to Neighbourhood Renewal: National Strategy Action Plan*, London: The Stationery Office.
- Stewart, M., Goss, S., Gillanders, G., Clarke, R., Rowe, J. and Shaftoe, H. (1999), 'Cross-cutting issues affecting local government', Final Report, Department of Environment Transport and the Regions, London. Available at www.local-regions.odpm.gov.uk/cross/ccpps/index.htm
- Sullivan, H. and Skelcher, C. (2002), *Working Across Boundaries: Collaboration in Public Services (Government Beyond the Centre)*, Basingstoke: Palgrave.
- Weiss, C. H. (1998), *Evaluation*, 2nd edn, Englewood Cliffs, NJ: Prentice Hall.
- Wholey, J. S. (1983), *Evaluation and Effective Public Management*, Boston, MA: Little Brown.
- Wilkinson, D. and Applebee, E. (1999), *Implementing Holistic Government*, Bristol: The Policy Press.