Tackling health inequalities and social exclusion through partnership and community engagement? A reality check for policy and practice aspirations from a Social Inclusion Partnership in Scotland

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In the contemporary UK policy context, multisectoral partnership initiatives and community participation are increasingly viewed as appropriate mechanisms for tackling health and social disadvantage. Such initiatives are often put into practice in contexts of industrial and economic decline, fragmented neighbourhoods, hard-pressed public services, and sustained under-investment in voluntary and community sector organisations. This paper draws on ethnographic fieldwork in a Social Inclusion Partnership (SIP) in Scotland to suggest that policy-makers and public health practitioners need a better understanding of the difficulties involved in implementing partnership and participation initiatives in this kind of context. The East Kirkland SIP was set up to tackle social exclusion and health inequalities within the most deprived neighbourhoods of a Scottish town, yet community engagement remained elusive. Partnership proved to be risky territory for all involved, marked by rivalry and suspicion between SIP members, rather than co-operation, whilst health promotion and social inclusion priorities conflicted with those of community development and regeneration. In sum, this paper presents a reality check for some contemporary policy and practice aspirations.

Keywords: community; health inequalities; participation

Introduction

Contemporary UK policy explicitly links social exclusion and poorer health with 'lower' social classes and disadvantaged communities (Scottish Executive 1999a, 1999b, 2002; National Assembly for Wales 2000a, 2000b; Department of Health 2001). At the policy level, local partnership and community engagement in area-based initiatives are increasingly viewed as pathways to healthy people and places, with many public sector organisations now having a requirement to work in partnership as a condition of government funding (Department of Health 1998). Collaborative partnerships between different professional groups concerned with promoting health is not a new phenomenon (Milewa *et al.* 2002). What is relatively recent is government recognition of intersectoral collaboration and partnership as an

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effective strategy for promoting the nations' health, to the extent where this emphasis has been described as 'enshrined' in both rhetoric and policy (Scriven 1998).

One of the consequences of the contemporary focus on joined-up health and social policy is to encourage the engagement of individuals (who are perceived as responsible for self-improvement) and communities, largely through the medium of multi-sectoral partnerships, which then become responsible for local improvements in health and the social fabric. Partnerships of many kinds thus play a pivotal role in the new modernisation agenda of the UK government, supported by financial incentives to bring potential partners together (Balloch and Taylor 2001). The fundamental assumption underpinning the drive towards greater community participation, and partnership arrangements at all levels, is that this will improve the chances of an intervention's success and, potentially, its sustainability. It is also believed to offer the prospect of better policy-making, fostering better relations between the state and society and promoting the formation of social capital (Burton *et al.* 2006).

Assumptions about the benefits of partnership and community engagement have been challenged within the general literature on health and regeneration partnerships (Kings Fund 2001; Scottish Executive Central Research Unit 2001) as well as the broader literature around community and education policies (Milbourne 2002) and urban regeneration (Hastings 1996). Difficulties around the partnership/community participation approach to health and social policy problems have also been well documented (Ewles 1998; Gillies 1998; Popay and Williams 1998; Scriven 1998; Taylor 2000; Balloch and Taylor 2001; Pickin *et al.* 2002).

One of the key characteristics of contemporary partnerships for health is the focus on public participation, reflecting ideals of participatory democracy and equality between partners (Aspen Institute 2002). Yet this is arguably the most challenging aspect of partnership work, as power differentials are at their greatest between professionals and lay people and between formal organisations and community groups (Popay and Williams 1998), both of whom may draw on very different levels of resources/networks, etc. Reviews of partnership work argue that these arrangements often leave existing power relations intact: communities remain on the margins of decision-making and smaller partners lack the resources to engage effectively with better-resourced and larger organisations (Hastings 1996; Balloch and Taylor 2001). Critics have also noted that the emphasis on partnership and community engagement enables government to devolve responsibility for action to the community and individual level (Carlisle 2001; Crawshaw *et al.* 2003). Community-based initiatives are often judged to have failed (Zakus and Lysack 1998).

Area-based initiatives are underpinned by the logic that a variety of strands of social improvement can be pursued at the same time, for a reasonable period of time and with a sufficient level of funding (Burton *et al.* 2006), although the health inequalities literature suggests that such initiatives will exclude the majority of poorer people and those with the worst health (Pantazis and Gordon 2000; McLoone 2001). Such initiatives are invariably highly complex, in terms of both their ambitions and the ways in which they are conceptualised. Because they exhibit features of both the 'old left' area-based health and social policies and features of 'new right' politics of competitive bidding exercise, they may represent a 'third way' for policy, focusing on the poverty of places rather than people (Powell and Moon 2001). As Burton *et al.* (2006) note, area-based initiatives can be expected to do things differently as a result of greater involvement – but what those things might be cannot be predicted. At the

broadest level, this kind of thinking reflects policy aspirations towards a re-invigorated sense of citizenship and social involvement for marginalised/excluded peoples and communities. More narrowly, it also provides both diagnosis and prescription of 'the problem'.

Partnership and participatory work at community level, then, is subject to enduring tensions, notwithstanding its popularity at the policy-making level. This paper draws on ethnographic fieldwork in one of the Scottish Social Inclusion Partnerships (SIPs) funded to tackle local health inequalities and social exclusion using a health promotion, partnership and community-led approach. Given that detailed accounts of how national policies aimed at addressing health and social problems are implemented at local level still remain relatively rare, the purpose of this research was to examine the 'fine grain' of one such initiative. This paper adds to the existing literature by detailing the sheer complexity of implementing a participatory initiative aimed at tackling health inequalities within a disadvantaged community, giving an account of the substantial and unanticipated problems encountered by both professional and community participants. This paper contends that policy-makers and public health practitioners need a better understanding of the real difficulties involved in implementing such initiatives. Although based in a single initiative within part of Scotland, the problems described in this case study are unlikely to be unique to one particular town, region, or even country.

Methods

This paper is based on ethnographic fieldwork with the East Kirkland[1] SIP over some 20 months. The SIP was organised around regular, committee-style management board meetings. Attendance at these and other SIP events, combined with interviews and numerous *ad hoc* discussions with different SIP members, enabled me to trace the development of the partnership and the difficulties encountered by and within this group. Detailed fieldnotes of meetings and events were taken and eleven SIP members from the statutory, voluntary and community sectors were interviewed. These semi-structured, 'conversations with a purpose' (Burgess 1993) were tape recorded and transcribed.

Analysis of the different types of data generated was conducted as an ongoing process both during and after the fieldwork period (Hammersley and Atkinson 1993). Analysis focused on explicating the social processes of partnership work through 'rich' or 'thick' description of events and interactions, and participants' understandings of those experiences (Denzin 1994). Data were coded according to emergent themes and checked for accuracy of interpretation in the process of ongoing refinement which an extended period of fieldwork permits (Lofland and Lofland 1995; Stake 1995).

The East Kirkland SIP: context and origins

In Scotland, the context is one where health boards and local authorities are obliged to collaborate, although specific policy imperatives can differ. Health boards are required to address health improvement, whereas the social justice and inclusion agenda dominates the work of local authorities: strategies for social inclusion include

the reduction of health inequalities (Scottish Office Department of Health 1998; Scottish Executive 1999a, 1999b, 2002). Forty-eight Social Inclusion Partnerships (SIPs) were established in the 1990s, some of which were funded for 10 years. Led by local authorities, health board representatives have been key partners. Most SIPs have had at least a partial focus on improving health within their communities, within the 'new' regeneration agenda. This aims to tackle the degradation of the built environment, reclaim excluded people and reintegrate a fragmented, polarised society (Furbey 1999).

Kirklands is one of many towns hit by the demise of heavy industry and therefore has much in common with other former industrial communities across Scotland. The area has a history of Irish immigrant labour, resulting in a sectarian division into Catholic and Protestant elements. According to the local benefits agency, unemployment is up to 57%. The town's worst areas of social housing have been demolished and re-built but room for improvement remains. The Health Board reports Kirklands as the most deprived population in its area.

In August 1999 a senior local authority officer (who later became the SIP chair) submitted a bid to the Scottish Executive for SIP status to be awarded to ten neighbourhoods within Kirklands, the so-called 'East Kirkland' SIP, covering a population of roughly 20,000. The worst areas of tenement housing were concentrated in these neighbourhoods, which scored higher on deprivation indices and had a poorer health record than other parts of the town. Drug and alcohol misuse was perceived as a particular problem amongst younger people in the area. The theme of this new SIP was that of tackling health inequalities, with a particular focus on children and young people.

The SIP fund

The East Kirkland SIP was awarded a SIP fund of roughly £750,000 for each of its 10 years of operation. The SIP fund was intended to raise community awareness of the SIP's existence and its health improvement aims, and to pilot a range of intentionally short-term initiatives. The aim was 'to find out what works' and persuade relevant service providers to adopt the initiative. Improving the lifestyles and life circumstances of local people was the ultimate aim, but doing this solely on the basis of the SIP fund was regarded as impossible by statutory sector partners. The long-term sustainability of initiatives in *any* sector was viewed as beyond the SIP remit. This is significant, because local voluntary and community sector projects formerly funded under the Scottish Urban Programme were now expected to compete for SIP funding in the short-term but to achieve self-sustainability through other routes.

Managing the SIP

When this research began, the SIP had been in existence for well over a year as an Interim Management Group (IMG) with no community representation. Statutory sector partners included the local authority, health board, primary care trust, local health care co-operative, benefits agency, Scottish Homes, Scottish Enterprise, and the police. This group was chaired by a senior local authority officer. Applications for SIP funding were submitted by statutory service providers and community groups to the IMG for consideration. During its first year the IMG funded many

health-promoting initiatives, most of which were delivered by local statutory sector providers.

Why no community representation?

Funding decisions during this early stage had taken place in the absence of community or voluntary sector representation on the interim board for two reasons. It had proven difficult to agree funding priorities: some partners wished to draw on SIP funding to supplement services they already provided, whereas the Scottish Executive had directed that it should provide 'additionality'. Achieving consensus and shared understanding around themes and goals took considerable time. The second reason was the lack of a dedicated staff member with time to establish mechanisms for securing community participation. A secondment to the post of SIP manager accelerated this process but also served to concentrate local government influence within the SIP leadership, a cause of particular resentment to the community, which had a history of poor relations with the authority. The chair, vice chair (drawn from the health board) and manager formed the core of the partnership and drove its health promotion agenda.

Launching the SIP, engaging the community

The East Kirkland SIP was publicly launched 18 months after inception at a community conference. This first interaction between SIP leaders, other key service providers and members of the community provided early indication of differences in priorities between major elements of the partnership. The health board's chief executive spoke of tackling lifestyle issues and specific diseases (heart disease, cancer and stroke), drawing on the policy agenda that shapes health board work. The SIP manager focused on problems of poverty, unemployment and poor housing - issues central to the work of local government. Questions and concerns from community residents centred on drug and alcohol use amongst young people and mental health problems amongst long-term unemployed men.

The outcome of this event was that one place on the SIP board was allocated to an umbrella organisation for the local voluntary sector, and six reserved for community representation, including a young person. At the same time, 12 community workers/residents were recruited to form an interim community sub-group of the SIP and work with the chair and manager to devise a process for selecting 6 community representatives. Three of the interim community representatives were in the process of negotiating with the IMG future funding of their own community projects from the SIP fund. The community group expressed worries that the 10 neighbourhoods would be in competition with each other for SIP resources and that community representatives would be partisan in respect of their own area. They foresaw problems of engagement, suggesting that it only an interested minority who would seek involvement and that young people would not be among them.

Achieving community representation: a contested process

The process of securing community representation on the SIP board proved fraught with difficulty. The community sub-group agreed on direct nominations to the

board, to be followed by a public election conference only if insufficient nominations were received. The community project leaders referred to above were thus nominated and co-opted onto the board shortly before the election conference. At that event, held to elect the remaining three community representatives, no young person came forward. However, vociferous objections were made by residents from neighbourhoods lacking representation and the event ended in some hostility.

'East Kirkland' had emerged as a bureaucratic construct with little meaning for the community with which it was required to engage and whose health it purported to improve. SIP boundaries were contested by local people who pointed to areas of deprivation excluded from this initiative. 'Community' proved a potentially misleading term, as most local people identified with their own neighbourhood, but sharp divisions existed between age and sectarian groups across the broader area. Some people held hostile attitudes to others *within* their own neighbourhood (e.g. 'kill all the junkies').

Rivalries and contested legitimacy

At every meeting of the full SIP board, the newly elected community representatives challenged the SIP leaders and other partners on most agenda items and contested the legitimacy of prior funding allocations. Large quantities of complex paperwork were waded through, with comparatively little time for discussion, and the community representatives became frustrated with the lack of any obvious progress beyond sitting at the partnership table 'discussing policy' – an activity that would fail to impress their community constituents.

Interviews showed that they believed that their late involvement on the SIP, and the fact that much of the SIP fund had already been allocated, meant they were 'tokens' on the board. They feared the contested election processes had undermined their legitimacy in the eyes of the community. As months passed, they remained dissatisfied with the continued pattern of funding distribution between statutory and voluntary : community bids (roughly 60 : 40), resented the considerable allocation of funds to support new or existing posts within major agencies, and viewed the SIP as unaccountable to the community. Although a role description had been provided, they were uncertain about what was expected of them but were keen to provide 'a united front', vigilant with regard to perceived 'underhanded behaviour' by more powerful partners.

Conversely, statutory sector partners expressed scepticism, during interview, about the 'representative' status of their new partners. This group felt that the SIP brought diverse agencies together, 'forcing us all to work, in a positive way, with partners', but also spoke of this as 'artificial' as agencies sometimes had little in common, and partnership added to existing workloads. Despite sympathy for their community partners' predicament, they perceived capacity for dissent within the SIP as limited: having received funding to support their own initiatives, few could 'afford to rock the boat'. SIP leaders, on the other hand, privately saw themselves as carrying the responsibility for the SIP, with insufficient contribution by others.

Contested priorities and conflicts of interest

The SIP's perceived emphasis on conventional health promotion proved at odds with community representatives' views of what was needed. Those who sought funding for

their community projects from the SIP fund particularly criticised the allocation of funds for health-promoting activities, arguing that community priorities were greater safety and play areas for children. During interview, they spoke of poor health as only one consequence of a broader-based social inequality: all noted links between health, poverty, deprivation, inadequate housing, lack of educational qualifications and unemployment. For example, one said:

> East Kirkland, according to the people wi' the stats, has a massive problem with every bloody illness, regardin' the amount o' people who smoke, the amount o' people who consume alcohol, have coronary heart disease – that's why it was given the SIP. Certainly the housing stock is improving, but they're still puttin' in the same people wi' the same lack of finance. When you move the same families in, you've still got unemployment, you've still got the poor health, you've still got the poor diet, you've still got the lack of money and the poverty trap. (Community Representative)

They argued that low income, insecurity and fear of crime were higher priorities for local people than health issues:

> the day to day struggle, to manage from day to day and week to week on a benefit book takes priority for people round here. (Community Representative)

And as one ironically commented,

> we're gonnae gie ye five pieces o' fruit [a SIP initiative] but ye can sit in yer house an' be terrified tae go out. (Community Representative)

They regarded funding to tackle social exclusion and poor health as 'just a new bandwagon', a label that poorly concealed its substitution by central and local government for previous regeneration funds. Crucially, the perceived shift of government funding from community development and regeneration to health promotion, and the increased emphasis on the self-sustainability of community initiatives, were experienced as threats to local projects.

Crunch point and crisis

Although SIP leaders and community representatives shared an understanding that people living in disadvantaged areas needed more services and facilities than better-off areas, this failed to develop into positive collaboration because of their intrinsic conflicts of interest. As community representatives' struggles with their role became clearer to other partners, it was proposed that they be provided with greater support, in the form of a dedicated worker. Extra funds had been provided by the Scottish Executive to support community engagement.

However, disagreements emerged *within* the community representatives' group: more experienced members wanted a qualified worker whilst others feared that such an individual would 'end up telling them what to do'. They planned an away-day to discuss how best to use funds they regarded as theirs to allocate, but the chair urged them to invite one of the service-providing partners to help ensure that their discussions resulted in feasible proposals as the money 'belonged to the whole SIP'. Some of the community group agreed with her suggestion: others did not.

Acrimonious exchanges resulted in the resignation of the leader of the community representatives, an event perceived by other partners as a substantial blow to partnership relations and a crisis point in the life of the SIP. The chair, fed up with 'constantly being seen as the enemy', handed her position to her

vice-chair, as his relationship with the community representatives had been far less turbulent.

Following a series of tense discussions, the community representatives agreed to receive support from the SIP manager to enable them to develop local 'fun days', starting with those neighbourhoods not represented on the Board. Fieldwork ended at this stage, but the SIP looked set to survive, albeit in a different form.

Implications for policy and practice

This study has highlighted conflict across sectors rather than collaboration, within a local context of industrial and economic decline, hard-pressed public services, sustained under-investment in voluntary and community sector organisations, and sectarian, territorial and other divisions. Public health practitioners and policy-makers need to be aware that partnerships in similar contexts may face considerable difficulties in working to empower disadvantaged communities and improve their health, and may unintentionally ensure continuity of insecurity and dependence for community-led initiatives forced to compete with each other for vital resources.

As all public-sector organisations are dominated by the constant competition for funds to improve service delivery, tackling health inequalities locally may be in danger of becoming a politically expedient label for existing activity. This suggests the potential for fundamental conflicts of interest between national policy imperatives and local priorities around specific issues.

Consulting with and involving local communities may be mandatory for key public sector agencies but the agenda for change may have been pre-determined to a considerable extent by these larger agencies through the initial process of bidding for funding in accordance with government-determined guidelines (Mayo and Taylor 2001). This arguably reflects pressures on large public-sector agencies to respond rapidly to policy initiatives in order to lever in additional funding for areas perceived as particularly deprived, but scarcely makes for community confidence in democratic decision-making. It seems that one of the central paradoxes of social inclusion partnership work is that establishing boundaries and choosing a particular focus can operate as processes of *exclusion*.

Key agencies may be criticised for any delay in public participation but gaining community representation or involvement is an inherently complex, convoluted and contestable process (Jewkes and Murcott 1998; Boyce 2001; Morgan 2001). The outcome of contemporary policy imperatives may result, as in East Kirkland, in 'forced' partnerships, contests for legitimate representation and fundamental conflicts of interest, even when all partners believed themselves to be acting in the best interests of 'the community'. And as the East Kirkland experience demonstrates, partnership work can be a risky business for both more and less powerful participants.

Although project leaders felt victimised (with some justification), they never-theless held far greater power than their community-based colleagues. In the Bourdieuan sense, 'social capital' as a property of powerful *individuals* with good social connections and other resources (such as educational capital) was clearly in evidence within the partnership (Bourdieu 1984). However, the different formulation of social capital developed by Putnam (1995), i.e. as social relations of trust,

reciprocity and respect, was demonstrably absent. As others have noted, social capital of the latter type may take years to develop (Cropper *et al.* 2007).

In sum, this paper demonstrates the complexity of implementing, at the local level, policies aimed at engaging 'the community' or its representatives in health and social improvement initiatives. It also implies that the apparently benign move towards joined up policy imperatives may work towards privileging agency over structure, in terms of what needs to be changed. Both health promotion and the contemporary policy context assume a voluntaristic construction of human agency. However, this is a type of agency that is constrained to work within prescriptive structures. Although devolution in the UK has arguably provided for closer working relationships between policy-makers and practitioners, it may also have had the effect of muting critique: partly because of the inherent difficulty of 'biting the hand that feeds', and partly because of conviction that those in positions of power and influence are genuinely making an effort to tackle the problems.

It seems that the contemporary rhetoric of partnership and community involvement, as a key strategy in tackling 'wicked issues' such as health inequalities and social exclusion, is fed by conflicting ideologies and involves deep ambiguities of policy and practice. In particular, unresolved and undiminished tensions between professional prescription and lay empowerment still exist at the level of local implementation. Although disadvantaged communities may welcome external funding and additional services, this research suggests that for representatives of dissimilar social worlds to learn to work together may take years, that learning to listen to communities remains a significant challenge, and that local conflicts of interest and disparities of power and influence may thwart policy intent and make participation in partnerships a risky business.

A broader conclusion is that, whilst some success may be achieved by committed people working at the local level, inequalities in health and social exclusion remain deeply embedded within the unequal structures of society and are unlikely to be dramatically affected. Attempts to tackle them may not be resolvable within a contemporary policy paradigm that prescribes both problem and solution. At worst, local initiatives may, unintentionally, have been set up to fail. The paper therefore presents a reality check for some key policy and practice aspirations, with potential implications not just for similar projects within the UK but also for other nations or regions tempted by the assumptions and rhetoric of partnership and community engagement.

Note

1. 'East Kirkland' is a pseudonym, as are all proper names given in this paper.

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