Healthy public policy: factors driving the regional agenda

BROWN, JEAN,STEWART

ABSTRACT

Jean S Brown.

Healthy public policy: factors driving the regional agenda.

Throughout New Labour's term in office, from 1997 to 2010, the Government placed increasing emphasis on both healthy policy and regionalism. No longer was health merely part of the National Health Service agenda. Instead, *all* policies had to take health into account, to address the wider determinants of health, such as housing, employment and poverty. New regional agencies were created to aid policy development and implementation at the regional level. This study considered the way healthy public policy reached and climbed the decision-makers' agendas within these regional structures.

The North East region of England was chosen as a case study. A series of interviews took place with those most heavily involved in policy-making in the region. Documents from the regional agencies and other organizations playing a part in the decision-making process were examined. Along with general policy, four specific policy areas were investigated: tobacco control, housing, worklessness and climate change. These were chosen to allow comparison of influential factors, particularly those factors identified in the agenda-building literature.

Several agenda-building models proved helpful, suggesting factors shown to influence agendas, although many related to national agendas. The most significant factors were the people and organizations involved and the ways they worked together, formally and informally, across departments and across organizations. Informal joint working was also particularly useful in enhancing decision-makers' awareness of health issues so that health would be considered in all policy.

The recently elected Government plans to move away from regionalism towards localism. The North East currently has an ethos of joint working and a commitment to healthy policy. Losing the supportive regional structures could well mean losing the capacity to make all policy healthy policy.

Healthy public policy:
factors driving the regional agenda.

Jean Stewart BROWN

Thesis submitted for the degree of
Doctor of Philosophy.

School of Medicine and Health
Durham University

Year of submission: 2012

CONTENTS

List of tables

List of figures

Glossary and abbreviations

ANEC	Association of North East Councils
ASH	Action for Smoking and Health
BECON	Black Minority Ethnic Community Organisations Network (a North Eastern regional organization)
BERR	(Government) Department for Business Enterprise and Regulatory Reform
CABE	Commission for Architecture and the Built Environment
CBI	Confederation of British Industry
CEC	Commission of the European Communities
CLG	See DCLG
CMPS	Centre for Management and Policy Studies
CPPIH	Commission for Patient and Public Involvement in Health
CPRE	Campaign to Protect Rural England
CRC	(1) Churches Regional Commission (2) Commission for Rural Communities
CSIP	Care Services Improvement Partnership
CURDS	Centre for Urban and Regional Development Studies (at Newcastle University)
DCFS	Department for Children, School and Families (took over from DfES in 2007)
DCLG	Department for Communities and Local Government
DCMS	Department for Culture, Media and Sport
DEFRA	Department for Environment, Food and Rural Affairs
DETR	Department of the Environment, Transport and the Regions
DfES	Department for Education and Skills (became DCFS in 2007)
DH	Department of Health
DPH	Director of Public Health
DTI	Department for Trade and Industry

DWP	Department for Work and Pensions
EA	Environment Agency
EEF	Engineering Employers Forum
ERA	Elected Regional Assembly
EU	European Union
FOREST	Freedom organisation for the right to enjoy smoking tobacco
FRESA	Framework for Regional Employment and Skills Action
FRESH	Fresh Smoke free North East, the regional tobacco office
GO(R)	Government Office (for the Region)
GONE	Government Office for the North East
HDA	Health Development Agency
HIA	Health Impact Assessment
HO	Home Office
HPA	Health Protection Agency
HSE	Health and Safety Executive
IAWG	Inter-Agency Working Group (involving the region's government departments and agencies, set up by GONE)
IA	Impact Assessment
IB	Incapacity Benefit (paid to non-employed working age adults unable to work because of health problems or disability)
IIA	Integrated Impact Assessment
IPA	Integrated Policy Appraisal
IPPR	Institute for Public Policy Research
IRF	Integrated Regional Framework (related to ensuring that sustainability was built into all regional strategies and policies)
IRS	Integrated Regional Strategy
JC+	JobCentre Plus (government agency, part of the DWP)
JSA	Jobseeker's Allowance (for people demonstrating they are available and looking for work)
LA	Local Authority
LAA	Local Area Agreement

LDP	Local Delivery Plan
LGA	Local Government Association
LPSA	Local Public Service Agreement
LSC	Learning and Skills Council
LSP	Local Strategic Partnership
MAFF	Ministry of Agriculture, Fisheries and Food (merged into DEFRA by 2001)
NBF	Northern Business Forum
NDC	Northern Development Company
NEA	North East Assembly (Regional Assembly North East)
NEAT	North East Against Tobacco (regional alliance)
NECC	North East Chamber of Commerce
NECCP	North East Climate Change Partnership
NEHB	North East Housing Board
NEHB PSAF	North East Housing Board Private Sector Advisory Forum
NEHB VSAF	North East Housing Board Voluntary Sector Advisory Forum (later North East Housing Board Voluntary and Community Sector Advisory Forum)
NEHB VSAG	North East Housing Board Voluntary Sector Advisory Group (forerunner to NEHB VSAF)
NERIP	North East Regional Information Partnership
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence (formerly just National Institute for Clinical Excellence)
NSF	National Service Framework (Department of Health)
NTUC	Northern Trades Union Congress
ODPM	Office of the Deputy Prime Minister
ONE	One NorthEast (North East Regional Development Agency)
PCG	Primary Care Group
PCO	Primary Care Organization
PCT	Primary Care Trust

PHG	Public Health Group
PHGNE	Public Health Group North East
PHO	Public Health Observatory
PHRAC	Public Health Research and Action Collaborative
PSA	Public Service Agreement
RA	Regional Assembly
RANE	Regional Assembly North East (North East Assembly)
RDA	Regional Development Agency (ONE North East)
RDPH	Regional Director of Public Health
RES	Regional Economic Strategy
RHB	Regional Housing Board
RHS	Regional Housing Strategy
RPG	Regional Planning Guidance (forerunner to the RSS)
RSS	Regional Spatial Strategy
SHA	Strategic Health Authority
StBOP	Shifting the Balance of Power (DH 2001)
Sustaine	Sustainability North East - partnership tasked with ensuring consideration of sustainability in policies in the North East region
TUC	Trades Union Congress
UKPHA	United Kingdom Public Health Association
VONNE	Voluntary Organisations' Network North East
VSN	Voluntary Sector Network
WHO	World Health Organization

Statement of copyright

Acknowledgements

I should like to acknowledge firstly the highly valued support and encouragement of my supervisory team:

*Professor **David J. Hunter** (Principal Supervisor)*
Professor of health policy and management and Director of Centre for Public Policy and Health, School of Medicine and Health, Durham University
*Professor **Tim Blackman** (Second supervisor)*
Formerly Director, Wolfson Research Institute and Professor, School of Applied Social Sciences, Durham University (now Pro Vice Chancellor (research and scholarship), The Open University
*Dr **Alyson Learmonth** (academic advisor and mentor)*
Gateshead Director of Public Health and honorary lecturer, Durham University

I pay tribute also to the late *Dr **Jane Keithley*** (Durham University), originally a co-supervisor.

My thanks also go to my son, James, and my daughter, Louise, for their patience, support and understanding during the last few years.

For help with proofreading, I thank Miriam Forster, Louise and my Mum, Sheila Blackwood, for giving up their valuable time for me. Their contributions are greatly appreciated.

Dedication

I dedicate this thesis to the memory of my father,

James Eric Blackwood (1915 – 1976),

for showing me the fun, fascination and excitement of searching for answers.

Chapter 1: Introduction – how did that get there?

How does a policy that will benefit the health of a population actually get onto the decision-makers' agenda in the first place? What are the driving influences? These general questions were at the forefront of my mind when I realised I wanted to research the issue of healthy policy development.

Various theories of policy and power offer a degree of explanation and I felt that it would be worth exploring these, to see how well they reflected what appeared to be happening in reality. Inevitably, my own involvement in national and regional policy development in England's Department of Health would affect the way I viewed theories. Indeed, my interest in policy-making processes was first piqued when I held the role of senior policy manager in public health, during which time I was regional lead for tobacco control and for *Our Healthier Nation*. What seemed surprising was how the system actually functioned when two of the major groups of players appeared to hold their roles without necessarily any background in the relevant topic area: the political 'masters' were members of parliament representing constituencies and given departmental responsibilities; the senior civil servants often had careers involving promotions from one department to another. It seemed unlikely that useful policies could arise from a non-expert background (and I would never suggest that no useful policies arose!) so I began to question the

origin of policies, wondering how issues got onto the agenda and where the power was that pushed through their development.

Since much of my work has been concerned with policy development in the North East of England, I wanted to investigate agenda processes at a regional level, rather than at a national government level. Additionally, when the research was first begun, there was an expectation, at least in some quarters, that the region would become the first in the country to have an elected regional assembly, which would have created opportunities to look at a new level of regional decision-making in its early stages. This decision-making level would have had a considerable amount of political power and influence over many organizations within the region. However, in a North East referendum in 2004, there was a resounding vote against an elected regional assembly, following much campaigning from the opposition camp about wasted money, white elephants and bureaucracy. Plans for elected regional government were then shelved. However, policy decisions were still made at a regional level (during my research period) and healthy policy areas still occupied very different positions on the various regional decision-makers' agendas.

This introductory chapter outlines the context of the study, in terms of both the development of healthy policy and the regional role in policy-making (from 1997 to 2008). It then describes the research aims and objectives, offering also the rationale for the study. Finally, it outlines the structure of the thesis.

The healthy policy context

From 1997 to the end of the Labour government in 2010, there was a continually increasing emphasis on healthy public policy at government level. As Orme *et al.* commented,

> Improving the public's health and well being is now a high profile feature of government policy. (Orme *et al*. 2003:1)

It is useful to define what is meant by healthy policy and to look briefly at the ways in which international and national policies began to develop from the middle of last century, before considering the development of policy-making at the regional level.

> Healthy public policy is characterized by an explicit concern for health and equity in all areas of policy and by an accountability for health impact. ... In the pursuit of healthy public policy, government sectors concerned with agriculture, education, industry and communications need to take into account health as an essential factor when formulating policy. These sectors should pay as much attention to health as to economic considerations. (WHO 1998a: 2)

Healthy public policy differs from both health policy and health promotion in several ways (Coombes 1998, 3: 10.2), although it could be said to encompass both of them: it is 'multisectoral'; it is 'multilevel'; it is 'participative'; and it is 'based on a positive concept of health'. It is multisectoral because it deals with a wider range of issues than those dealt with in or for the health sector, addressing factors that might affect health but are generally regarded as the business of other departments. Examples include worklessness, which is strongly related to health status but for which policy-making generally falls under the remit of the Department for Work and Pensions, not the Department

of Health. This feature of healthy policy does create some problems: so many factors affect health that almost any policy is likely to be relevant! The 'multi-level' nature means that it is not restricted to government level policy but applies to all tiers of policy-making. This could include local authorities as well as regional government. The participative aspect means that community participation is an integral component and that policy should not simply be top-down (imposed by national government). Community participation is often a localised geographical activity, but can also mean participation from a community of people suffering from the same condition, such as those with smoking-related diseases.

The concept of healthy policy has grown over many years, with perhaps its most significant roots in the World Health Organization, whose Constitution of the World Health Organization (WHO) was adopted by the Member states in 1946. Stating that 'the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being' (WHO 1946: 2), the constitution also stated that

> governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. (WHO 1946: 2)

Historically, even in 'health policy' as opposed to 'healthy policy', health care rather than health has tended to dominate the agenda (Evans and Stoddart 1990; Hunter 2003; WHO 1978). However, as the following sections show,

recent years have seen a change in this and a growing recognition of health improvement (rather than just illness-curing) as a prime mover in health policy. During the 1970s, individual countries were beginning to accept the WHO's statement of the need to address social aspects, rather than concentrating on medical healthcare. Canada's influential 'Lalonde report', acknowledging McKeown's work in identifying the effects of several influences on health, commented that

> there is little doubt that future improvements in the level of health of Canadians lie mainly in improving the environment, moderating self-imposed risks and adding to our knowledge of human biology. (Lalonde 1974: 18)

The need to address health inequalities was also becoming widely acknowledged during the 1970s, adding to the call for healthy policy. The statement of the WHO constitution was reaffirmed in the Declaration of Alma-Ata (WHO 1978), with the launch of the *Health for All* policy. The Declaration referred to 'gross inequality' both within countries and between countries and suggested that public involvement, primary care and collaborative working were key to the success of the policy. Beaglehole and Bonita (2004: 255) commented that the Lalonde Report came under criticism 'because of the perceived emphasis on victim blaming and the neglect of the social and economic determinants' but that, in contrast, the *Health for All* proposal 'was rejected as being too ambitious'.

In the UK, in the 1970s, various policies to improve health under the NHS included emphasis on individuals helping themselves (DHSS 1976; 1977).

Attempts were being made here to ‘shift attention from an exclusive focus on curative medicine’ (Hunter 2003: 47). The need to address health inequalities was also being recognized. Inequalities were the subject of a 1980 report (known as the Black Report) commissioned by a Labour Government but whose recommendations were rejected by a Conservative Government because of expense (Townsend, Whitehead and Davidson 1992: 4). There have been criticisms of the way the findings were rejected. Oliver and Nutbeam said it ‘bordered on attempted suppression’ (2003: 281), although they also pointed out that this might have increased the amount of publicity it received.

During the 1980s, progress was again seen on the international stage. The Ottawa Charter for Health Promotion identified five health promotion action areas: build Healthy Public Policy; create supportive environments; develop personal skills; strengthen community action; and reorient health services (WHO 1986). The WHO later reflected that ‘these actions are interdependent but healthy public policy establishes the environment that makes the other four possible’ (WHO 1998a: 1). The healthy public policy statement (of which an extract is shown in Appendix 1) stressed the multi-agency nature of healthy public policy. It also emphasised the need for joint action and consideration of a range of social actions to create healthy environments and enhance health, ideas which were restated in the Adelaide recommendations (WHO 1998a).

In the UK in the 1980s, there was more focus on disease prevention policies. However, a review of the public health function, chaired by Sir Donald Acheson, included the recommendation that health authorities should have Directors of Public Health (Committee of Inquiry into the Future Development of the Public Health Function 1988). In addition, until there was a national strategy to address inequalities and health improvement, there should be health authority targets around health improvement and inequalities. It was not until several years later that the long-awaited English *Health of the Nation* strategy was produced (Secretary of State for Health 1992). When it did arrive, it was heavily criticised for its strong focus on disease and the medical element of health, particularly by local authorities, which were intended under the strategy to be working closely with the health sector. Such criticisms were reiterated in a Department of Health-commissioned report on the impact of the strategy (Universities of Leeds and Glamorgan and the London School of Hygiene and Tropical Medicine 1998).

During the 1990s, sustainability was becoming another consideration with regard to health improvement. From the 1992 Earth Summit came Agenda 21 (United Nations Environment Programme 1992), concentrating on sustainable development and the environment, as well as on joint working between local authorities and other agencies to address common concerns:

> In health matters, this implied a cross-sectoral approach focusing on the environmental and socio-economic causes of ill-health, in partnership with organisations such as health authorities and the voluntary sector. (Baggott 2000: 83)

Ideas of reducing health inequalities, as well as addressing health improvement in general, were also coming to the fore in the UK, although Evans suggested that

> it was not until the election of the new Labour government in 1997 that a comprehensive policy response to reduction in health inequalities was developed. (Evans 2003:167)

Richards and Smith referred to Labour trying to 're-engage with social problems – seeing them again as the responsibility of state action' (2002: 236). Important actions included the creation of a new post of Minister for Public Health and the acknowledgement that all of public policy could affect health, not only that of the Department of Health, so that the new Minister would work across Departments.

The World Health Organization reaffirmed its commitment of people's entitlement to health in 1998, with its adoption of *Health for All in the 21st Century* (WHO 1998b). In the same year, in the UK, the Acheson report on inequalities arrived (Independent Inquiry into Inequalities in Health 1998). Although criticised for not costing its recommendations and for lacking targets, it received a favourable reception (as mentioned, for example, by Earwicker (2007: 19)), usefully identifying a range of areas for future policy development. It contained thirty-nine recommendations, many of which were aimed at policy-making, including one regarded as crucial:

> All policies likely to have an impact on health should be evaluated in terms of their impact on health inequalities. (Independent Inquiry into Inequalities in Health: 1998: xi)

Importantly, most of the recommendations were not specific to the health sector but addressed the wider determinants of health, such as housing, poverty and unemployment, with responsibilities coming under all sectors of government. Links between policies were recognized as vital, with the need for joint working emphasised in the 1999 Health Act and later in the *NHS Plan* (Secretary of State for Health 2000). However, England's national health strategy, *Saving Lives: Our Healthier Nation* (Secretary of State for Health 1999), still concentrated on disease, although it did acknowledge the importance of the wider determinants of health and emphasised the need for joint working to address the problems. Accepting Acheson's recommendation to assess major policies for health impact, this white paper went on to say that

> this assessment process is important because it acknowledges for the first time the relationship between health and the impact of Government policy generally. (Secretary of State for Health 1999: section 4.46)

One of the three priorities of the Commission of the European Communities' public health strategy for Europe in 2000 was to address health determinants. The Commission pointed out that

> there is a specific requirement that 'a high level of human health protection shall be ensured in the definition and implementation of all Community policies and activities'. (CEC 2000: executive summary: 3)

The UK echoed this in its cross-cutting review of health inequalities, led by the

Treasury, which reinforced the idea of making inequalities central to policy-making:

> The approach is one of mainstreaming work on health inequalities so that it is at the heart of Government policies rather than a marginal 'add-on'. (HM Treasury and DH 2002:3)

The theme was continued in the Wanless report on NHS spending (Wanless 2002), an influential assessment of the long-term resource requirements for the NHS, produced for the Treasury. It emphasised the importance of public health preventive measures and of public engagement. It contributed to the programme for action on inequalities (DH 2003), which had a stated aim of reducing health inequalities by tackling the wider determinants of health inequalities, such as poverty, poor educational outcomes, worklessness, poor housing, homelessness and the problems of disadvantaged neighbourhoods. This was supported by a national Public Service Agreement target – 'by 2010 to reduce inequalities in health outcomes by 10 per cent as measured by infant mortality and life expectancy at birth' (DH 2003, section 1.8).

The *Chief Medical Officer's Report on Strengthening the Public Health Function* (DH 2001a) was another influential report. Of its main recommendations, probably the two of greatest relevance to policy-making were to ensure effective joined-up working and to promote sustained community development and public involvement. The same year, the House of Commons Health Committee reported on the coordination between central government, local government, health authorities and Primary Care

Organizations in promoting public health (House of Commons Health Committee 2001). Their report criticized the emphasis on health care rather than health, a problem addressed by Wanless (Wanless 2004), who stressed, again, the importance of collaboration.

The public health white paper, *Choosing Health: Making Healthy Choices Easier (*DH 2004a), had three underlying main principles (informed choice, personalisation and working together) and was described by the government as

> the beginning of a journey to build health into Government policy and ensure that health is everybody's business. (DH 2004a, p19, section 35)

However, the white paper received a very mixed reception. Hunter criticised it for several reasons: it was a backward step from *Our Healthier Nation* (Secretary of State for Health 1999); it focused too much on individuals instead of on the public; it marginalised local government; and 'the underlying health determinants are virtually ignored' (Hunter 2005:1011). The UKPHA agreed with these criticisms, saying that 'Choice is a spurious, and largely irrelevant, concept in public health' (UKPHA 2005: 5). Nevertheless, the UKPHA also said that it broadly welcomed the paper because

> it puts good health centre stage in regard to the policy agenda and begins to address some of the barriers which hamper individual health and well-being. To that extent it offers real opportunities for a significant change of direction in the management and delivery of health promotion and health, as distinct from health care services. (UKPHA 2005: 3)

The World Health Organization emphasised the importance of the governmental stewardship role. Stewardship had been defined as the 'careful and responsible management of the well-being of the population' (WHO 2000: viii)). Although it related, initially, mainly to health systems and a government's role in looking after health resources, it was made clear that there was a much wider remit:

> It involves influencing policies and actions in all the sectors that may affect population health. The stewardship function therefore implies the ability to formulate strategic policy direction. (WHO Regional Office for Europe 2005: 9)

The Commission of the European Communities also continued to stress the need for all policies to consider health. Its 2007 white paper 'together for health: a strategic approach for the European Union 2008-2013) (CEC 2007, a revision of their 2000 policy) had as one of its principles:

> PRINCIPLE 3: HEALTH IN ALL POLICIES (HIAP)
> The population's health is not an issue for health policy alone. Other Community policies play a key role ... many sectors will be cooperating to fulfil the aims and actions of this Strategy. (CEC 2007: 6)

In 2007, revisions to regulatory impact assessment processes, making health a component (as promised in *Choosing Health: Making Healthy Choices Easier* (DH 2004a)), meant that 'improving population health and wellbeing is built into all national policy' (DH 2010a: 1.1.1). The Department of Health referred to 'health' being synonymous with 'health and wellbeing', which partly widened the scope to cover the factors affecting health but also made it seem like less of a 'health service' problem.

Other cross-departmental UK action included *Health is global* (DH 2007a), which contained proposals for a UK global health strategy and stressed links between health and foreign policy, health and development, and health and the UK economy. In spite of all this apparent cross-departmental activity around health, a joint Audit Commission and Healthcare Commission report found that policies were not fully aligned (citing the example of the inclusion of bars in economic development policies being at odds with obesity or alcohol policies (Audit Commission and Healthcare Commission 2008: 73)). Other problems identified in the report included a lack of capacity of people with public health leadership skills or skills in multi-agency working (*ibid*.: 74).

A major review of heath inequalities, 'the Marmot Review', was commissioned in 2008 by the (then) Prime Minister, Gordon Brown, and chaired by Sir Michael Marmot, with its report published early in 2010 (Marmot 2010). This review was the government's response to a WHO report (WHO Commission on Social Determinants of Health 2008), which stressed the multi-factorial nature of health inequalities. This multi-factorial nature, along with the expressed need for multi-agency, multi-sectoral working, helps to create a very complex context for healthy policy-making, at both national and regional levels. The following section considers the development of the regional role in policy-making, to clarify the regional context in which the research is set.

The regional role in policy-making

Although not national law-making government, the English regional governments had a role in policy-making during my research period. There has been some devolution in the UK in recent years, devolving political decision-making power to Wales, Scotland and Northern Ireland. This section outlines the general development and role of regional government in England (particularly its role around public health) and this is followed by a brief description of the North East region and its regional organizations.

Government Offices for the Regions were created in 1994/1995, with representation from four government departments: Transport; Education and Employment; Environment; and Trade and Industry (HM Treasury and ODPM 2006). The second set of the main regional agencies, Regional Development Agencies, was established during New Labour's first term of office, 'to act as catalysts for economic development' (Pearce, Mawson and Ayres 2008: 443). The third set, Regional Chambers, began operating in 1999, following the Regional Development Agencies Act (1998), to provide scrutiny of Regional Development Agencies, although the RDAs were not to be responsible to the assemblies. 'Providing a counterweight to the Regional Development Agencies (RDAs), regional chambers are intended to provide an inclusive forum for the various local and regional stakeholder interests' (While 2000: 329). The RDAs were to be '*business led,*' in contrast to the Regional

Assemblies, with their mixture of members (Keating, Cairney and Hepburn 2009: 59).

At national government level, the value of the regions (and the need to rely on them more) was recognized in 2000 in ‘Reaching Out: the role of central government at regional and local level’, part of whose Executive Summary appears in Appendix 2**.** Significantly,

> The report recommends a stronger role for Government Offices in the regions in pulling together the different arms of central government; new arrangements in Whitehall; and new mechanisms to streamline the variety of different funding streams, initiatives and arrangements. (Cabinet Office. Performance and Innovation Unit 2000: Prime Minister’s Foreword 1)

By September 2001, Government Offices contained representation from six departments: Transport, Local Government and the Regions; Trade and Industry; Education and Skills; Environment, Food and Rural Affairs; Culture, Media and Sport; and Home Office. The regional public health role was held then by Regional Directors of Public Health based within the Regional Offices of the NHS Executive (part of the Department of Health). The NHS Plan announced the creation of public health groups by 2002 across NHS regional offices and the government offices of the regions, to strengthen the regional role around the health of a region:

> Accountable through the regional director of public health jointly to the director of the government office for the region and the NHS regional director, they will enable regeneration of regions to embrace health as well as environment, transport and inward investment. (Secretary of State for Health 2000, 13.25)

Under *Shifting the Balance of Power* (StBOP) (DH 2001b section 49), the Regional Director of Public Health (RDPH) was to be accountable to the Chief Medical Officer and to a Regional Director of Health and Social Care (one of four in England). When the Regional Director of Public Health was based at the NHS Executive Regional Office, the role was relatively narrow because the organization was primarily concerned with the health service. The designated role of the Regional Director's new public health group was much wider and included, of particular relevance to healthy policy development:

> - the development of an integrated multi-sectoral approach to tackling the wider determinants of health;
> - informing regional work on economic regeneration, education, employment and transport, maintaining an overview to ensure that there is proper health contribution to local strategic partnerships.
>
> (DH 2001b, section 49)

Even in 2002, it was believed that 'at present, regional involvement is viewed as *ad hoc*, reactive, often focusing on known faces in policy circles' (Cabinet Office, ODPM 2002: 16), although StBOP did seem to point the way to improvement. StBOP's implementation document commented that the relationships with local authorities and across government were strengthened by factors including the co-location of the Regional Directors of Public Health alongside Government Offices for the Regions:

> For the first time, the Department of Health's Regional Directors of Public Health and their teams will be uniquely positioned to work with other Government departments in the regions to build a strong health component into regional programmes in areas such as transport, environment and urban regeneration. (DH 2002, Appendix C, section 18)

Scally (a Regional Director of Public Health) suggested that even by 2003, when regional public health groups had only officially been linked to government offices of the regions since early 2002, there was evidence that public health was benefiting from regionalism. In particular, he said there was a change in focus from NHS service provision 'towards the broad determinants of health and the partnership working across sectors that is required' and that

> the growth of regionalism in England has enabled public health to make major steps forward in creating solid working relationships across sectors. (Scally 2003: 54)

The role of public health at the regional level was further considered the same year in the English regions White Paper '*Your Region, your Choice*' (Cabinet Office/DTLR 2002), which set out a policy agenda for regional government, increasing the expectation on the government offices to coordinate policies and to contribute to regional strategies along with the Regional Assemblies. As well as outlining public health roles for proposed elected regional assemblies in England (see Appendix 3), the white paper stated that

> regional assembly responsibilities in the fields of housing, transport, and economic development have significant links with public health. It is important to ensure that all of these functions, including public health, are tackled in a joined-up manner to address problems and help drive improvements in public health outcomes and the narrowing of inequalities – particularly by raising the profile of wider issues of concern to the region which impact on health but are not always obvious at a local level, such as high levels of unemployment or deprivation in the region, and transport related issues. (Cabinet Office/DTLR 2002: section 4.47)

The potential advantages and disadvantages of these proposed elected assemblies were assessed by many commentators. Ayres and Pearce found that regional stakeholders (people with a part to play or an interest) in transport policy in the West Midlands strongly supported the requirements for joint working amongst the major agencies across the region (2004: 247). Stakeholders felt that the joint working would be stronger under the elected assemblies: an elected assembly would be in a stronger position to push for the region's interest at national level (Ayres and Pearce 2003: 1). There were, however, concerns about increased bureaucracy or that the elected regional assemblies would 'crowd' the policy field and could undermine progress made towards partnership working, especially among local authorities (Ayres and Pearce 2003: 1). Stakeholders also felt that assemblies, elected or otherwise, would not lead to major improvement and that 'the real need was for a well-funded regional body with direct authority over statutory bodies and transport operators; the establishment of such a body should not await any move to ERAs' (Ayres and Pearce 2003: 1). When the move to elected assemblies did not take place, the assemblies remained, for a while, in a similar position to when they were formed.

Although there had been some flexibility over how each region's assembly was formed and how it chose to act, their roles remained similar over the

years. As Pearce and Ayres found:

> All Assemblies perform similar tasks, including the following:
> - Advocacy on behalf of the region.
> - Developing coordinated regional priorities.
> - Facilitating regional debate.
> - Performing a lead/partner role in the production of other strategies.
> - Playing the lead role in preparing an RPG/RSS.
> - Providing research and intelligence.
> - Scrutinizing the activities of the RDA.
> - Scrutinizing the activities of other public bodies operating in the region.
>
> (Pearce and Ayres 2007: 701-2)

As well as undertaking similar roles, assemblies adopted similar arrangements for administration and constitution (Pearce and Ayres 2007: 702). One major element of change over their first few years was in resourcing, which had become increasingly dependent on government funding (rather than local authority funding) as their responsibilities grew.

Treasury interest in the regions increased, with a focus on economic regional objectives and central/local government interaction around funding streams (Pearce, Mawson and Ayres 2008: 447). By 2005, the government offices were said to have become ‘Whitehall’s key representatives in the regions’ and to be ‘regarded as a crucial mechanism for policy coordination and delivery’ (Ayres and Pearce 2005: 584). The role of the Regional Assemblies had also expanded, so that by 2005 ‘Regional Assemblies are formally regarded in Whitehall as the legitimate representatives of the region and a key point of focus for the GORs’ (Ayres and Pearce 2005: 588). A favourable government evaluation of the assemblies reported that chambers had ‘fostered strong

regional partnerships with local authorities and with a wide range of other stakeholders' and 'exerted an increasing influence in the field of regional policy-making and co-ordination' (ODPM 2005a: section 4.3).

The delivery plan for the public health white paper *Choosing Health* looked at the role of different levels of public health, including the regional role (DH 2005a - see Appendix 4 for fuller information). Local Area Agreements (LAAs), to be agreed between local authorities, their partners and Government Offices for the regions, were to bring health inequalities and health outcomes to the forefront of local community planning. The white paper recognized that Government Offices (particularly through the Regional Directors of Public Health), Regional Assemblies and Regional Development Agencies 'play an important part in helping to shape the wider economic determinants of health' (DH 2005a: 13).

In 2006, a review of government offices, suggested new strategic objectives for them. These included forming strong working relationships with local and regional partners to set regional priorities, giving feedback to government about regional delivery, and supporting and challenging regional strategies (HM Treasury and ODPM 2006: 16-18).

Other agencies also operated within the regional policy-making sphere. Strategic Health Authorities had a primary role around the provision of good

quality health services, but they were also consulted on wider policy developments. Initially, they were not coterminous with Government Office regions. Other key players included specific regional bodies dealing with sustainability, created following the Government's *Securing the Regions' Futures* (DEFRA 2006) to strengthen 'regional roundtables for sustainable development as champion bodies for the regions' (Sustaine 2010). Local authorities were also important. Although local (elected) councils each covered only a small part of the region, local authorities had positions in the regional assemblies and influenced policy also through regional networks. (The North East network, the Association of North East Councils, is described later.)

Government proposals from its Sub-national Review of Economic Development and Regeneration went out for public consultation in March 2008, with the response published in the November (DCLG and BERR 2008). This included a reformed regional governance structure, the production of a new integrated regional strategy (IRS), with the abolition of Regional Chambers and the delegation of decision-making by RDAs to local authorities and sub-regional partners. Regional Select Committees and Regional Grand Committees were also to be established from 2009 on a temporary basis. It was stated that 'many regions have already gone a long way towards agreeing arrangements for producing and agreeing an IRS' (Lavis 2009: section 1). So, although the commencement of the new arrangements was

after the cut-off date for this research, the actions towards them were probably already under way and their *potential* effects might well have played a part in decision-making in 2008.

This sub-section has looked at English regional governance in general, focusing on the main regional policy-makers. Other vital contributors to policy development will be discussed later. The following sub-section briefly describes the North East region and its regional organizations.

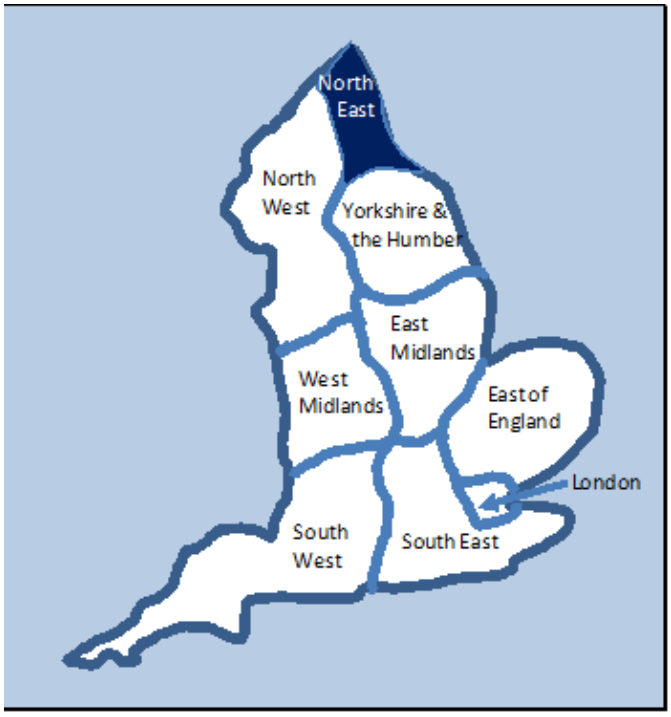
The North East region and its regional organizations

The North East region, highlighted in Figure 1, is the smallest of the nine regions in England in terms of its population (2.6 million in mid-2007) and one of the smallest in terms of its area (8,600 square kilometres)[1].

The population is concentrated in three main urban areas: Newcastle/Tyneside, Sunderland and Middlesbrough/Teesside, with much of the rest of the region still very rural in character. The built-up areas have a long history of industrial growth, with the ship-building and coal-mining sectors previously huge employers. Now the commercial base is much stronger, although there is still car-production with related manufacturing.

[1] Figures from North East Public Health Observatory website, updated June 2009

Figure 1: government office regions of England[2]



Comparative ill-health has been a feature of the region, along with significant deprivation. As an indication of the deprivation, when Health Action Zones were established to target deprived areas, almost the whole of the North East was covered by the Zones. As found by the Commission on Public Service Reform in the North East,

> Whether in terms of life expectancy, entrance to further education, or unemployment, the North East still lags behind other regions. (IPPR 2009, Executive Summary)

Public health consultants and practitioners have been known to talk of the region as a great place for public health work because there is plenty of scope for improvement!

[2] Created from information and maps on GONE and PHO websites.

The main three regional organizations involved in policy-making at the time this thesis was started were Government Office for the North East (including Public Health Group North East and the Regional Director of Public Health). One NorthEast (the Regional Development Agency) and the North East Assembly.

The compositions of Regional Development Agencies and Regional Assemblies varied from region to region. Robinson and Shaw described the North East's RDA (One NorthEast or ONE) as a 'classic quango[3]: its 13 board members are all appointed by the Secretary of State for the Environment' (2001: 474). However, they also pointed out that the criticisms levelled at classic quangos until the 1990s (accusations of sleaze and scandal as well as high levels of secrecy) were now less of a problem, as quangos were becoming far more transparent.

The sizes and membership balance between local authority and non-local authority at the time of the formation of Regional Assemblies were noted by While (2000: 31). Sizes ranged from 35 members (Yorkshire and Humberside) to 105 members (East Midlands), with the North East roughly in the middle (63 members). The proportions of non-local authority members ranged from 28% to 37%, with most having around 33% (including the North East). At its inception, the North East Assembly had representation from the

[3] Quasi-autonomous non-governmental organization: a semi-public administrative body outside the civil service but receiving financial support from the government, which makes senior appointments to it (Concise Oxford English Dictionary 2006)

private/business sector, TUC, voluntary sector, training and education, further and higher education, culture, sport and tourism, health, environment and rural interests (Shaw *et al*. 2003: 5).

Within the North East, the specific body dealing with sustainability became Sustaine (Sustainability North East), a joint creation of the Government Office, the North East Assembly and One NorthEast. It was to be supported by a wider regional mechanism, led by those three agencies. Its role included helping in the achievement of sustainable development through relevant policies.

The Association of North East Councils (ANEC) was formed by all the local authorities in the region. It described itself as the 'political voice for local government in the North East' and represented the region's Local Authorities to ensure that 'their voice and presence is heard at a regional, national and international level' (ANEC 2006a: 8). Prior to the vote on an elected assembly, the North East's Regional Assembly and the Association of North East Councils shared staff and a chairman as well as a building. In the post-referendum fall-out, the organizations split apart again in 2005.

The North East Public Health Observatory, a regional organization, is not itself a decision-making body but works with decision-making bodies and can focus

their attention on specific issues. It is not a formal statutory body so no organizations have an obligation to report to it.

The Health Development Agency (HDA North East) was another organization with a regional role in ensuring that decision-makers had sufficient information on which to base decisions. After my interviews took place, the HDA was integrated into the National Institute for Health and Clinical Excellence (NICE) and its North East-specific regional role disappeared. As well as a national role in lobbying and advocacy, the UK Public Health Association (UKPHA) had a regional role but this was dropped in 2008. Another health organization whose regional remit changed during my research period was the Strategic Health Authority: there were two at the start of this research but, as from 2006, there was only one, covering the same region as GONE.

The academic institutions across the North East (particularly the universities of Durham, Newcastle, Northumbria, Sunderland and Teesside) play their part in the decision-making process, as advisers and providers of information and research capabilities. Several academic departments have roles in supporting regional decision-making, for example CURDS (the Centre for Urban and Regional Development Studies at Newcastle University).

The business sector has a particular role to play in policy development.

Keating, Cairney and Hepburn felt that

> in the absence of significant regional government, groups still operate within UK or English sectoral policy frameworks. Business groups take their lead from London and focus their lobbying on central government as do trade unions. Voluntary organizations are often tied into local government programmes or operate at the local level. (Keating, Cairney and Hepburn, 2009: 59)

Chambers of Commerce are potentially influential voluntary business associations, as the government wishes to work with them (Bennett 1998: 512). Formed in 1995, the North East Chamber of Commerce (NECC) 'champions, connects and develops member businesses, and their people, to win more business, become better businesses and enjoy better conditions for business within North East England and around the world' (NECC 2010: *home* page). It gives to its members 'a voice to influence decision-making at a national, regional and local level – changes that make a difference to the way business works' (*ibid*.). Several other organizations have claimed to represent private industry. The Northern Development Company (NDC) was set up in the 1980s to provide a regional response to the de-industrialisation of the area (Armstrong 2000). It has been described as a 'coalition of private sector interests' and a 'one-stop shop for investors' (Site Selection 96/97: 3). The Northern Business Forum (NBF) is a membership body representing business interests within the region and has members including NECC, CBI, the Engineering Employers' Federation (EEF) Northern, the Institute of Directors and the Federation of Small Businesses. It sets up policy groups and is proactively involved with government agencies, inviting ONE and GONE to

discussions where it can 'bring the attention of the region's governing bodies a wider consensus view of private business' (NBF 2010: *what we do* page). It had particular lobbying interest around the Regional Economic Strategy, where it wished to ensure that private sector priorities were reflected. The CBI describes itself as 'the UK's top business lobbying organisation' and claims to have 'unmatched influence with government policymakers and legislators' (CBI 2010: *home* page). Its North East region geographically matches the government office region and it was said to have strengthened its regional role in response to the establishment of RDAs and Regional Assemblies (Keating, Cairney and Hepburn, 2009: 59). Another business association contributing to the North East regional policy agenda was found by Valler *et al*. to be the House Builders' Federation (2004: 94).

Trade unions were also viewed as contributors to the national decision-making mechanisms, with an increasing role at a regional level.

> From a position of relative isolation, trade unions have become increasingly important agents in local and regional development and governance in the UK since the election of the New Labour government in 1997. (Pike, O'Brien and Tomaney 2004: 102).

The Trades Union Congress (TUC), historically influential only really at national level (*ibid*.: 106), had been slowly developing a multi-layer organizational structure since the 1970s. The national TUC describes itself as 'the voice of Britain at work' (TUC 2010: *home* page). At a regional level, supporting TUC campaigns, it draws on the views of trade unions in the region. The Northern TUC region includes Cumbria as well as the North East.

Reflecting the importance of trade unions to the region, the Regional Development Agencies Act (1998) created a statutory seat for trade unions on RDA boards. Pike, O'Brien and Tomaney suggested there were at least four related parts to the trade union federations' regional roles (2004: 110). One was 'demonstrating credibility and consolidating their participation through delivery of government policy objectives'. Another was 'broadening the issues addressed in mainstream debate (e.g. equalities, diversity)'. A third was 'providing the focus for debate around more localised and welfarist alternatives to the narrow optic of "globalisation-competitiveness"[4].' Finally, there was 'providing a means for other formerly marginalised agents in local and regional civil society (e.g. the voluntary and community sector) to mobilise around a broadly progressive regional agenda'.

Third sector organizations also have a part to play in policy development. Because most were not organized on the same geographical regions as government, Voluntary Sector Networks (VSNs) were formed in each region to help the voluntary sector to contribute to the emerging regional agenda. The Voluntary Organisations' Network North East (VONNE) 'seeks to create the conditions whereby the Voluntary and Community Sector in the North East is fully involved in regional and national developments' (VONNE 2006: 16). VONNE has been involved in policy areas such as communities, environment and planning, equalities, health, infrastructure, regeneration, sector issues and partnership (VONNE 2010: *policy* page).

[4] The authors attribute the phrase to Lovering (2001: 352)

One other political initiative that deserves mention is 'The Northern Way'. This is a broad initiative around planning and development, covering the whole of the North of England (not just the North East region). It was launched in 2004 by a coalition of partners across the North, in response to a challenge from John Prescott and Gordon Brown to

> establish the North of England as an area of exceptional opportunity, combining a world-class economy with a superb quality of life, and to close the prosperity gap between the northern regions and the UK average. (Northern Way 2010: *background* page)

The plan involved joint working with regional institutions (namely RDAs and Assemblies) on issues such as transport, employment, housing, land use and spatial patterns (ODPM 2004; Northern Way Steering Group 2005). Although not a North East regional development as such, its structure and aims could have an influence on regional strategies.

This section has outlined the major organizations involved in policy development in the North East. All could have had significant influence on the way healthy policy emerged and this aspect will be part of my research focus, as described in the following section.

Research aims and research questions

The changes in policy-making responsibilities at the regional level and the growing concern over developing healthy policies appeared likely to have a significant effect in the decision-making arena in the North East. Against this

background, I wanted to explore how policies (particularly those that could have a noticeable impact on health) developed in the region, focusing mainly on the way the policy areas moved up the decision-making agenda and the factors affecting that progress.

The main aim of exploring the factors influencing the position of healthy public policy on the agenda of regional decision-makers gives rise to the main research question:

> **what factors most influence the position of healthy public policy areas on the agenda of regional decision-makers?**

To address this, several sub-questions were formed. The first involved critically evaluating models and frameworks relevant to agenda-building. The intention was to consider not only models that aimed to explain why policy areas reached or climbed the agenda but also models that aimed to explain why policy areas failed to reach or climb up the agenda, as expressed in the research sub-question:

> **what models and frameworks currently exist to explain the progress (or lack thereof) of policy areas on the decision-makers' agenda?**

Identification of existing models allowed their later comparison with the way healthy policy appears to have developed in the region, essentially addressing

the following:

- Can the differences in agenda positions of policy areas be explained by existing models of policy analysis?
- Are there other differences between the agenda positions of policy areas that are not explained by existing models of policy analysis?

I needed also to assess how a policy area got onto the agenda in terms of it actually appearing on an agenda and then climbing it (or, possibly, disappearing). This meant looking at the organizations and people who effectively control the regional agenda and have the power to move policy areas up that agenda. Power plays might be evident, in terms of the power of an individual or a particular organization, including those organizations identified as part of the means of a policy's rise up the agenda. This gave rise to the second research sub-question:

who moves a healthy policy area onto and up the regional decision-making agenda?

Identifying the people and the power involved in getting policy areas onto the agenda would allow me to draw comparisons between policy areas, addressing the questions:

- Are there differences between policy areas in terms of the organizations or individuals involved in their development?
- Are there differences between policy areas in terms of the initial drive for the policy?

A policy area might reach the agenda or be pushed higher on the agenda in different ways. At a regional level, there might be government directives imposed on the region or there might be public pressure from the local population, perhaps in response to specific events. It might also be that there was a combination of factors or a set of different factors. Identification of factors affecting the position on the agenda, additional to those already covered in existing models or frameworks or in consideration of the people involved, can be expressed as the sub-question

what other factors influence the progress of healthy policy areas on the decision-making agenda?

It would be hoped that many, if not most, public policies would improve health. However, the progress of a policy might also be affected if its potential effects on health (either adverse or beneficial) were explicitly considered. So the way in which health was (or was not) addressed in the policy's development was felt to warrant specific consideration, giving rise to the final research sub-question

how and to what extent is health considered during a policy's development?

Drawing together the findings from all the sub-questions should help to explain regional agenda-building for healthy public policy. The potential scope of the study was large, so I needed to impose restrictions. These are described in the following section.

The scope of the study

Geographical restriction to the North East region, rather than considering all the English regions, was one of the ways I chose to limit the scope of the study. I chose the North East as my case study partly because I was familiar with healthy policy development in the region, having worked in public health here for several years. My role, when employed at the NHS Executive Regional Office, included much work at national level, involving liaising with counterparts in the other regions of England in national policy development with particular consideration of regional issues. In that role and in my current role as an independent consultant, I have also built up many personal contacts at strategic level in various organizations across the region, which has provided a good grounding in the health policy issues of the North East. This restriction allowed me to make comparisons to help to build up a better picture of agenda drivers within a region, while keeping constant some factors that might differ according to which region is considered.

As the potential scope of the study was still very large, I also brought in a restriction to the time period. The start of the New Labour era in 1997 formed a recognizable change in administration, treated as distinct by many writers on policy (Alcock 2008: 9; Blakemore and Griggs 2007: 266; Malpass 2005: 137; Richards and Smith 2002: 230). Using 1997 as a starting date allowed some degree of continuity of the governmental approach that formed the background to regional healthy policy development. I decided to consider

policy development from then up until the end of 2008, to allow for as long a period as possible to be covered with the practical consideration of needing to draw a line under it to complete the research.

The range of potential regional policy areas to consider was broad, so I thought it better to restrict the study to four policy areas: tobacco control, housing, worklessness and climate change. (The reasons for these choices are discussed in Chapter 4.)

These restrictions ensured that my research questions could be realistically addressed. The various reasons why the questions are worth addressing are described in the following section.

Rationale for the research

'Surprisingly little guidance is available to public health practitioners who wish to understand how issues make their way onto policy agendas.' So said Buse, Mays and Walt (2005:1), echoing a comment of Walt's, from over a decade earlier (Walt 1994: 1), about the lack of literature on the power, processes and people involved in agenda building. My research could contribute in several ways, including: increased understanding of decision-making processes; increased understanding of the ways in which health and health improvement are incorporated into policy; assessment of explanatory powers of existing models of agenda-building; and contribution to the evidence base for

translation into practical policy-making. An added dimension is my focus on the English regional policy-making setting, which, at the time I started the research, was potentially a very powerful new decision-making environment. Even without the elected assembly, there were roles and relationships emerging in the new regional decision-making environment that would affect policy-making in the North East. During the time of the Labour government, there were major changes in the decision-making structure, with power to develop and implement policy increasingly coming down from the national government level to a regional level. Traditional assessments of agenda-building and development could well have been compromised by the new structures: pressures would be on the decision-makers not only from 'below' but also from 'above', in the form of certain government directives. These competing interests from the people within the region and those at a national policy-making level could have led to a different type of agenda-building and motivation. This project could lead to a greater understanding of the influences of that new structure on the decision-making process at a regional level.

Health and health improvement have been promoted as necessary components of public policy for many years. Without the use of multi-agency, comprehensive policies, the stated aims of health improvement (from WHO, the Ottawa Charter, and Acheson and Healthier Nation policies in the UK) are not expected to be met. The literature review and empirical research should increase the understanding of how policies come to consider (or otherwise)

their likely impact on health. This, in turn, should feed into an understanding of how health improvement can be incorporated into policies. The effects of specific health impact assessments have been the subject of research for many years now and this project could provide additional evidence of their value.

Several models claim to explain how policy areas reach and ascend the decision-making agenda to become policy. Many have been drawn up from or tested against specific policies in specific settings, for example in the USA. Within the new regional setting in England, these models might prove inadequate. The literature search should allow comparison of models against one another, considering the differences between them and between the situations where they might apply. The empirical research, using the views of experienced academics, practitioners and decision-makers, should provide additional material to verify existing models or to show where they are inappropriate and need redesigning.

Within the last decade, there have been calls for the creation of stronger evidence bases on which to form policy (evidence-based policy). The links between practice and research evidence are sometimes believed to be inadequate (Black 2001, Macintyre and Petticrew 2000; Macintyre *et al*. 2001). This specific English regional research could add to the evidence base around successful ways of developing healthy policy.

There appear, therefore, to be several areas where this research should provide a helpful contribution to a range of professionals (both practitioners and academics). The public health oriented policy-making community should benefit, in terms of raising awareness about how healthy policy areas actually arrive on and climb the decision-making agenda. If regional government had continued in the way it was doing until the end of the Labour government, decision-makers might have benefited from an increased knowledge of the issues perceived to affect regional decision-making systems. The research community will have available a comparison of existing theoretical models of agenda-building with what was happening in reality in the North East region. The way in which I carried out the study to obtain all this information is described in the following section.

Outline of study and organization of the thesis

So far, this chapter has outlined the context for the study, in terms of the growth of the importance of healthy policy and the increasing regional role in policy-making, both of which were evident during Labour's time in office. The development of the aims and objectives (the research questions) has also been discussed. To identify existing thought on agenda-building and factors affecting a policy area's position on the agenda, I conducted a literature search, whose findings are described in chapters 2 and 3. Exploring these ideas led to a suggestion of gaps in existing knowledge that could best be filled by fieldwork, comprising interviews and analysis of documentary

evidence. The methods chosen (and the reasons for using them) are described fully in Chapter 4. The following paragraphs summarise the approach taken to address the research questions.

I carried out a first set of interviews as more of a scoping exercise, to help to identify some of the main issues surrounding general healthy policy development as perceived by representatives of the main regional organizations. Interviewees were individuals who held key roles in academic or statutory sector organizations, particularly at regional level. Roles and relationships of the major regional decision-making organizations were explored. There was particular focus on the extent to which the impact on health or health improvement was considered during the development of public policy in the region. Findings from these interviews are described in chapters 5 to 7.

Further fieldwork was carried out in response to both the literature review and the findings from the first set of interviews. It included interviews with an expanded set of interviewees with specific knowledge or expertise in the chosen policy areas. The chosen policy areas (problem areas that could be regarded as potential policy areas) were tobacco, housing, worklessness and climate change. The term ‘problem area’ was perhaps more appropriate for some policy areas, for example, climate change, for which (at the start of the study) no national or regional policy had been developed. These problem

areas were selected with the intention of being able to use them as case studies to identify similarities and differences in the way they reached the regional policy-making agenda. To a certain extent, the areas were deliberately selected to be different, rather than trying to select some kind of representative sample from the whole population of regional policy areas (or potential policy areas). The intention was to assess the way in which specific policy areas could progress up the agenda (or not, as the case might be) towards the formulation of regional policy. Findings are described in chapters 5 to 7.

Alongside the interviews was an analysis of documents relating to regional policy development, particularly in the four areas of policy chosen for investigation. Agendas of the main regional organizations were obtained and assessed for relevance. Then associated reports and minutes were studied to gauge the importance on the agenda of the policy areas and the factors affecting their position on the agenda. Findings are described in chapters 5, 6 and 7. At times, the documentary evidence strengthened findings from the interviews, whilst on other occasions it presented a different viewpoint. The use of both documentary analysis and stakeholder interviews allowed triangulation of results. Documents reflected, to a certain extent, the official view of the process, whilst interviews with key decision-makers across the region provided more detail on what they believed had happened. Interviewees were chosen from a range of organizations. This helped to widen

the set of views. It also enabled me to compare and contrast descriptions and opinions from a range of individuals who had different roles and responsibilities and who came from various organizations (which also had different roles and responsibilities).

Following the chapters on findings, a discussion chapter draws together the various strands, particularly comparing the four specific policy areas. Differences and similarities were considered in the policy areas' positions on the regional decision-making agenda and in the means by which they appeared to have reached the agenda. They were also assessed against existing models of policy agenda-building. This comparison allowed me to identify where those models were sufficiently explanatory and where they did not seem to fit. My analysis allows me to suggest different ways of explaining the reasons for the differences in agenda positions.

This chapter has introduced the context for my research, outlined my aims and objectives and offered a rationale for the study, before summarising the structure of the thesis. Of all the components of the research, the first to be carried out was the literature review, as this was needed to feed into ideas for subsequent fieldwork. This is discussed in the following two chapters.

Chapter 2: Theories of agenda-setting and getting health on the agenda

In the first section of this chapter, I discuss agenda-building theory. I then consider the literature on other factors affecting the position of a policy area on the agenda. Among the most important factors are the people and organizations involved but the huge impact of this aspect means that it warrants a later chapter of its own. In the final section of the current chapter, I look at the literature on methods of getting health to be specifically considered in policy-making.

What models and frameworks currently exist to explain the progress of policy areas on the decision-makers' agenda?

For many years, 'stages'-based models of policy dominated the theories on policy development processes. These outlined a series of steps believed to be followed in the production of a policy, including an agenda-building stage. Although the approach was much criticised for being too linear, unrealistic and ignoring many important factors (Walt 1994: 44-48), it left a legacy on which many influential policy analysts often built. For example, Kingdon (1984), whose focus was on the agenda-setting aspect of policy-making, suggested that his own model showed that policy-making was definitely not based on stages, although for convenience he still split it into separate parts: the setting

of the agenda; the specification of alternatives from which a choice was to be made; an authoritative choice among those specified alternatives; and the implementation of the decision.

I should like, firstly, to comment on one limitation to the agenda-building process that is relevant to my research. The way in which agendas are set varies partly according to whether a particular critical event has prompted a response to a policy issue. Sometimes policy-makers will have to take action in response to some crisis. At other times, they will bring issues onto the agenda without being prompted by any kind of emergency. My focus is on the latter – agenda-setting in times of 'politics-as-usual' (Grindle and Thomas 1991: 83). Although there will be occasions when a crisis-sparked policy will have an impact on population health (such as a war or a pandemic), many of the policies affecting it will be those that affect the underlying determinants of health. These tend to be relatively long term issues, where there is generally more time for consideration and a less urgent need for solution. The question is – when there is no crisis, how does an issue get on to the agenda?

An influential article by Cohen, March and Olsen (1972) described a 'garbage can model of organizational choice'. They applied this both to organizations and to decision situations with three general properties: problematic preferences, where there are no coherent ideas about preferred options;

unclear technology; and fluid participation, meaning that participants in the process vary over time. They suggested that

> one can view a choice opportunity as a garbage can into which various kinds of problems and solutions are dumped by participants as they are generated. (Cohen, March and Olsen 1972: 2)

The aspects of their model that most influenced subsequent writers were their four basic variables, each of which was a function of time: a stream of choices or options; a stream of problems; a rate of flow of solutions; and a stream of energy from participants. These variables influenced the way the contents of the garbage can were processed. This approach was used as a basis for work by Kingdon, in particular, as discussed later in this section.

Cobb and Elder, discussing issue creation and agenda content, suggested that there were four means by which issues were created: manufacture by one or more contending parties; manufacture by people for their own gain; unanticipated event; and public interest (with no gain to those manufacturing it) (Cobb and Elder 1972: 83). As mentioned, my focus is on ‘business-as-usual’, rather than the ‘unanticipated’ event as a trigger. The other three of their four ways are linked to people and power and they will be part of later discussion.

Hofferbert provided a model incorporating a wide range of factors affecting policy formation. These included politically relevant incidents, which could affect the policy development at any time, and a sequence of other factors:

historic-geographic conditions; socioeconomic conditions; mass political behaviour; governmental institutions and elite behaviour (Hofferbert 1974: 228). Hofferbert's diagram of these factors suggested linearity and a fixed sequence of these effects, which he himself recognized was not entirely accurate. The approach therefore suffers from the same criticisms as other approaches based on stages. However, it has value in acknowledging the 'multiple causes of policy-making' (Mazmanian and Sabatier 1980: 440).

Other writers looked at sets of conditions affecting the agenda-building. Two particularly influential approaches were the Hall *et al*. model and the Kingdon model, both of which suggested that the confluence of a set of factors determined the likelihood of an issue rising up the agenda. Hall *et al.* suggested that there were three conditions governing whether an issue would feature high on an agenda: legitimacy, feasibility and support (1975: 475-486). Legitimacy related to whether a government's right to intervene was accepted, particularly with relation to personal choice or freedom and the government's right to stop certain activities. Their description of levels of legitimacy is useful (*ibid*.: 475-479): at one extreme are those issues to which government must traditionally respond and at the other there are those that do not even get into the hypothetical queue competing for its attention. Feasibility referred to the practical aspects of implementing a policy, including availability of resources (human and material), scientific or technical knowledge and capability, and the existence of a suitable administrative infrastructure (*ibid*.: 479-483). Support

referred effectively to the amount of trust the public had in the government but considered political support and pressure group support as well as public support (*ibid*.: 483-486). According to the model, whether a government accepted a problem onto its agenda would depend on the levels of legitimacy, feasibility and support.

A set of conditions was used also by Kingdon (1984 and revised version 2003). He compared his three-stream approach (comprising a problem stream, a policy stream and a political stream) to Cohen *et al*.'s (1972) garbage can model. The problem stream referred to the way in which problems captured the attention of 'important people in and around government' (Kingdon 2003*:* 90). Suggested ways included: through indicators (routinely produced statistics); from focusing events or crises; or from feedback from systematic monitoring or perhaps from more informal complaints processes. Kingdon distinguished between conditions and problems, noting that 'problems are not simply the conditions or external events themselves: there is also a perceptual, interpretative element' (2003: 110). He felt that conditions could become problems because of people's values, such as an acceptance or otherwise that some groups of society were poorer than others. Comparisons could also turn conditions into problems, if it were realised that one area seemed much worse than another. The third way Kingdon believed conditions could become problems had to do with the way they were categorised. He said that 'you may not be able to judge a problem

by its category, but its category structures people's perceptions of the problem.' (2003: 111). By whatever means a problem reached the decision-makers,

> Getting people to see new problems, or to see old problems in one way rather than another, is a major conceptual and political accomplishment. (Kingdon 2003: 115)

Kingdon also commented on problems falling from the agenda, suggesting that sometimes issues dropped from the agenda because it was felt that the problem had been addressed and either solved or recognized as not going to be solved in terms of new policy because of, perhaps, resource shortages (*ibid*.: 103).

The policy stream in Kingdon's model related to ideas floating around in what he called 'the policy primeval soup' (2003: 116). Here, he described a community of specialist individuals and groups with an interest or influence in a policy area, for example the academic community, staff involved in government and interest groups. The generation of alternatives and proposals in this setting of policy communities was compared to 'the process of biological natural selection' (2003: 116). Within the policy community, although Kingdon suggested that 'to some extent, ideas float freely through the policy primeval soup' (2003: 127), there could be 'policy entrepreneurs' who could push forward particular ideas. The criteria for selection of ideas to be considered for policy development varied but included technical feasibility,

value acceptability (public acceptability) and an anticipation of future constraints (similar, in a way, to Hall *et al*.'s 1975 model).

The political stream in Kingdon's model had three main components. The first was political ideologies or, more importantly, their distribution in the governmental decision-making bodies – 'the balance of organized political forces' ('Kingdon 2003: 153). The second comprised public mood and pressure groups and the third was composed of events within government, such as election results or changes in administration.

Kingdon maintained that there were occasions when the three streams (problem, policy and political), although independent, came together to create the right circumstances for policy change to occur. A problem had to be identified but would not be addressed unless there were some feasible alternatives to addressing it. 'The chances for a problem to rise on the decision agenda are dramatically increased if a solution is attached.' (Kingdon 2003: 143). Then, if the important actors in the political stream were supportive and judged that the public mood was also amenable, an issue could jump up the agenda. Kalu criticised the extent to which Kingdon's model relied on chance, suggesting that it 'negates the rather overriding role of individual rational calculations, self-interest, political expediency, as well as the role of public opinion in shaping the policy agenda' (Kalu 2005: 32). However, Kingdon did include policy entrepreneurs and public mood in his

discussions of the streams, so perhaps Kalu's criticism was a little unfair, overstating Kingdon's element of chance.

Zahariadis used the multiple streams approach in non-U.S. situations: agenda-setting in European public policy (Zahariadis 2008) and the selling of British Rail (Zahariadis 1996), suggesting that

> at fortuitous moments in time, skilled actors called policy entrepreneurs attempt to couple the streams together by 'selling' their package of problem and policy to a receptive political audience. The chances that a particular policy will be adopted increase when all three streams are coupled together. (Zahariadis 2008: 517)

Kingdon's approach was used by Exworthy, Berney and Powell (2002) to explain why there were regional differences in implementing the UK government's policies on health inequalities. Their study added in an extra dimension, that of the coupling of streams at national and regional level. They concluded that in this situation the 'policy windows need to be "wedged" open at national and local levels' (Exworthy, Berney and Powell 2002: 93). The appropriate coupling of streams was also raised in Tiernan's study of the failure of Australian housing policy: using a Kingdon-based analysis, Tiernan suggested that the 'wrong problems and wrong policies had been coupled together to become the agenda for reform' (2007: 95).

Zahariadis suggested that the multiple streams framework 'deals with policy making under conditions of ambiguity', where there were perhaps several

different ways of viewing the same situation or problem (2007:65). He differentiated ambiguity from uncertainty, which 'refers to the inability to accurately predict an event'. The concept and influence of ambiguity and uncertainty are discussed later. The streams model, in Zahariadis' view, was a better reflection of reality than the typical rational model in which problems were identified then solutions developed to address them (2008: 519). He suggested that 'often the reverse is true (solutions chase problems)' offering four reasons for this (*ibid.)*. Firstly, scanning for solutions was easier than scanning for problems, because there were vastly more problems, possibly endless numbers of them, that could be identified, as compared to a limited number of potential solutions. Secondly, following electoral victory, 'adopting promised policies is far more rewarding politically than actually solving problems' (*ibid.).* Thirdly, politicians felt that pointing to solutions 'gives them the aura of knowledge and action' (*ibid.:* 520). Finally, the 'success of an instrument or idea in one policy area legitimizes its adoption in another' (*ibid*.).

Baumgartner and Jones' 'punctuated equilibrium' theory argued that, whilst the general tendency was for a fairly stable or incremental policy-making setting, this was sometimes interrupted by 'bursts of activity that modify issue understandings and lead to non-incremental policy change' (Baumgartner and Jones 1993: 54).

Recognizing that agenda-setting theories had been dominated by studies of the United States (a criticism raised, for example by Baumgartner, Green-Pedersen and Jones 2006: 959), Princen widened the applicability, asking 'why certain issues end up as topics for European Union policy-making, while others do not' (2007: 21). He suggested that the European Union was different from other settings as its decision-makers were 'less vulnerable to public mobilization than are decision-makers in democratic domestic polities', had 'limited authority to deal with issues' and its procedures 'require strong majorities to have a proposal passed', so that 'some form of consensus among participants is a precondition for a high agenda status' (*ibid*. 34). The 'limited authority' aspect could also be relevant to UK regional decision-making and the need for consensus is discussed later.

Walgrave and Varone (2008) also addressed the lack of non-USA settings, using Baumgartner and Jones' (1993) punctuated equilibrium ideas in a Belgian case. Agreeing with Baumgartner and Jones' idea of policy punctuations, they commented on the focusing events that can initiate policy punctuations:

> these external shocks, policy analysts agree, highlight policy deficiencies. They may directly challenge the existing policy image and the venue that promotes it. (Walgrave and Varone 2008: 368)

Walgrave and Varone concluded that Baumgartner and Jones' approach had some validity. However, they also suggested that actors must be put centre stage, because 'a new policy image and a new venue do not lead to change

mechanically' (*ibid*.: 387). The importance of actors is discussed in the next chapter. The following section considers other factors that have been recognized as affecting the progress of a policy area.

What other factors influence the progress of healthy policy areas on the decision-making agenda?

In this section, I consider factors not already covered in models of agenda-building (apart from people and organizations). I look first at contextual factors, then consider factors relating to the nature of the problem area.

Models of the context of policy-making

An early identification of contextual factors appears in Alford (1969), suggesting that

> decisions, policies and governmental roles can be explained by a combination of situational, structural, cultural and environmental factors. (Alford 1969: 2)

Situational factors were transient factors, such as wars or incumbent leadership. Structural factors included relatively unchanging factors, like the country's economic base or demographic factors, including the number and type of organizations involved in the decision-making arena, which, Alford suggested, might be quite stable. Cultural factors included traditional social factors and religious beliefs. The final category, environmental factors, included international influences, such as environmental agreements. Alford

described these environmental factors as ‘those which, for convenience, are considered to operate outside the boundaries of the community political system’ (*ibid.).* Although Alford’s factors were developed and tested in his study of political urban culture, they proved helpful also to Leichter (1979), who compared health care policy in four nations. The use of these factors might be feasible in the current study. When looking at regional policies within just one region, it might be supposed that most of these factors will be fairly constant and might be unlikely to affect policy development greatly. However, there could be examples of different policy areas where some of the factors exert a stronger influence. As Kingdon suggested: ‘If there is such a national culture or dominant ideology, it affects different policy arenas differently’ (Kingdon 2003: 134). If national culture is significant in the development of national policy, then it is possible that regional culture is significant in the development of regional policy. Indeed, referring to the development of economic policy, it has been suggested that

> local and regional actors are not passive, nor do they merely respond to the initiatives of the centre. Such actors attempt to develop and pursue strategies shaped by history and their national political economic context. (Pike and Tomaney 2009: 29)

The concept of regional identity or regional culture has been discussed by several writers, with the North East frequently mentioned as being different from other regions. Some writers have found that the concept of Englishness relates far more to the south of the country than to the north: Bond and McCrone found that ‘regional identity weakens as one moves southwards and

eastwards across England' (2004: 7), although they pointed out that London was the exception to this. Although some mention has been made by several writers of the artificiality of many regional boundaries, it has been said that

> the North East, for example, is usually cited as the principal exception to the rule of marginalized English regionalism. At the other extreme, the East and South East regions are almost wholly artificial regional constructions. (Bond and McCrone 2004: 2)

Other writers have also noted the existence of a distinct regional identity for the North East. Fowler, Robinson and Boniface suggested that there was 'a case for considering the North East of England as a distinct cultural region recognizable from the outside, with an identity accentuated by its peripherality in geographical and political terms' (2001: 121). They further suggested that this regional culture had been much influenced by the region's dependency on a small number of key employers and the suddenness of economic change, which they described as a 'catastrophic rather than evolutionary model of economic change' (*ibid.:* 122). Keating, Cairney and Hepburn also referred to the territorial identity of the North East:

> the North-East of England has some territorial identity, including a distinct dialect, a labour-dominated political culture, a certain anti-southern sentiment, and some sense of shared history. (2009: 59)

However, Keating, Cairney and Hepburn went on to suggest that this territorial identity 'has largely been created through public policy since the 1930s and as a standard region since the 1960s' (*ibid*.).

Bond and McCrone found that the North East's regional identity affected the way some policies were developed. They reported that, although Regional Development Agencies in different parts of the country had much in common, there appeared to be very relevant local or regional case studies brought into the North East RDA's Regional Economic Strategy (ONE 1999a) and its Innovation Strategy and Action Plan (ONE 2001), to emphasise regional strengths and history (Bond and McCrone 2004: 15).

Another contextual factor is the historical context of a policy, mentioned earlier as something lacking in the stages-based models.

> Today's policy options are a product of policy choices made previously – 'the path' – sometimes decades previously. Hence the concept of 'path dependency'. Those earlier choices may have both a constraining, or 'lock-in' effect and an opportunity-enhancing effect. (Bardach 2006: 348)

The historical context of a policy is different from general historical context. It relates purely to the history of the development of the policy, although it could be affected by the same general historical context. The need to consider historical influences was emphasised by Rose: 'when a group of politicians enters office, there is no choice: the inherited commitments of past government must be accepted as givens' and 'policymakers are heirs before choosers' (1989: 2). Hence, Rose felt that if a policy area had been acted upon by a previous policy-maker, it would be harder for new policy-makers to alter that policy's progress or the actions initiated by the policy. (This might be

questionable in the light of the new coalition government's NHS white paper (DH 2010b), which significantly contradicted previous policy!)

Historical policy context is related in some ways to the feedback incorporated in some of the models mentioned above: Hudson and Lowe referred to the term 'policy feedback' as being 'designed to encapsulate the view that policies, rather than merely being the outcome of the policy process, can and do become a central part of the policy process itself' (Hudson and Lowe 2004: 153). The historical context of the policy is also very much linked to the idea of an inertia model proposed by Rose and Kerran (1984). This was based on physical inertia, the property of a body to resist changes in its motion. The authors felt that 'governing today is not so much about making fresh choices as it is about living with the long-term inertia consequences of past choices' (1984*:* 2). Their inertia model agreed with incrementalism in rejecting both the 'existence of a central decision-maker' and 'the idea that there is sufficient time and knowledge to make meaningful choices of a comprehensive, synoptic kind' (*ibid*.: 4). To a certain extent, this can also be regarded as an extension of Rose's analysis of 'initial state' (in his earlier stages-based model (1976: 10)): if the initial state is static, there will be resistance to change but if the initial state is a movement in a certain direction, there will be resistance to altering that movement. The related concept of momentum was

raised by Bardach:

> Momentum affects many political processes … On the one hand, it is a movement in the direction of a goal; more indirectly, it creates a stimulus or an opportunity that encourages others to move towards the goal as well. (Bardach 2006: 347)

Other contextual factors have been considered. One model separated decision-making settings according to whether the process was society-centred or state-centred, as described, for example, in Grindle and Thomas (1991: 20). Although not unrelated to Alford's (1969) structural factors, this provided a different breakdown. Society-centred approaches paid little attention to the impact of the government policy-makers, whilst the state-centred approaches did not allow for inputs from the wider public. Policy-making was necessarily dependent on the way the state operated. The state is, by definition, a national entity, so that any policies developed within an English region are subject to the same *overall* state influences. Thus, in terms of regional policy development, it might be that looking at state versus societal influences is not particularly productive, although some policy areas might be subject to a greater degree of public interest and to the effects of the regionalisation agenda described earlier.

Grindle and Thomas described various contexts surrounding policy and affecting decisions: 'societal pressures and interests'; 'historical context'; 'international context'; 'economic conditions'; 'administrative capacity'; and 'other policies' (1991: 38-40). These were not dissimilar to the contexts used

by Alford (1969) and Leichter (1979), as described above. The term ‘societal pressures and interests’ covered the way society is organized and how various interests acted together to affect policy-making. The historical and international contexts referred to the way a country had been shaped by its history and affected by international events, economics and politics. (This is different from the historical context of a policy discussed earlier.) Economic conditions included both international and domestic economic conditions. Administrative capacity would limit the amount of activity that could actually take place with regard to policy-making. The final category (other policies) referred to the way previous or existing policies could have an effect on current policy decisions.

State-/society-centred approaches and situational factor models described circumstances surrounding policy issues. Neither really assessed the effect of combinations of factors and the inter-relationships between factors, although Alford recognized that it was the combination that explained policies (1969:2). The tendency was to assess each factor separately, a similar criticism to that levelled at stages models where analysis tends to concentrate on within-stage analysis. In contrast to this, the agenda-building models discussed earlier often do focus on the ways in which various factors interact with one another to create different overall circumstances under which agendas can be built. As well as being affected by the context of the problem, the decision-making process can be influenced by the nature of the problem or the characteristics

the policy area might have. This aspect of the policy agenda is discussed in the following section.

The nature of the problem

Many of the approaches discussed above focus on the circumstances of a problem issue rather than its nature. However, the problems themselves can very much affect policy development and can be highly complex.

> Agenda-setting processes can generate useful ideas for possible approaches to or solutions for problems. However, agenda-setting often generates problem definitions which are intractable, ill structured and 'wicked'. (Hoppe, van de Graaf and van Dijk 1987: 586-7)

Characteristics and the nature of problems have been described in various ways. Cobb and Elder referred to 'issue characteristics', saying that how an issue is defined will affect how it is addressed. They described five definitional dimensions: the 'degree of specificity'; the 'scope of social significance'; the 'extent of temporal relevance'; the 'degree of complexity'; and the 'degree of categorical precedence' (Cobb and Elder 1972: 96). The position of an issue along each of these dimensions would affect its likelihood of reaching an 'expanded public', thereby expanding the conflict around an issue and helping it to reach a higher place on the agenda. Specificity referred to a continuum of definition whose extremes are concrete and abstract, with the writers suggesting that more ambiguous issues were less likely to reach a wider public. Social significance concerned the extent to which the issue was of

interest to a wider public, rather than just those immediately involved. Temporal relevance referred to whether the issue was long-term or short-term, with longer term issues more likely to reach a wider public. An issue's complexity affected its success, as more complex (possibly highly technical) issues were less likely to climb the agenda. Categorical precedence referred effectively to the history of the issue, suggesting that if clear precedents did not seem to exist, there was more likelihood of the issue reaching the 'expanded public': when a clear precedent was lacking, it was much easier to expand the conflict, because there were no clear guidelines on either side. These dimensions, although much concerned with raising the profile of an issue, also tie in with three other important aspects of the messy nature of a policy problem: conflict (or its converse, consensus); ambiguity; and clarity in causal relationships. The existence of any of these can challenge an assumption of rationality. I shall describe each individually then look at approaches that examine combined effects.

The 'fundamental condition of social conflict', according to Cobb and Elder, was scarcity, which need not be material: it could also relate to positions of power (1972: 39). Where it related to material resources, they defined three important elements to a situation of conflict: the number of people involved, the levels to which people were committed and public awareness of it. These elements related to awareness-raising and the attraction of people to a cause. The awareness-raising issues are much covered by writers looking at the

agenda-setting issues of the media. For example, Soroka concluded that there were three most likely types of issue: issues that affected significant numbers of people; issues that were sensational, although with little effect on most people; and issues that were governmental (such as fiscal matters) (Soroka: 2002a: 20). The first would attract media attention because of affecting many people; the second had the 'greatest potential for public agenda-setting by the media' and the third was not exciting or dramatic enough. Media agendas were only a part of the overall agenda-setting scene but the media's effect on driving policy could be significant (as discussed later), so the attributes that raised an issue's profile on the media agenda could be expected to influence overall policy development.

Hall *et al.* felt there was a general assumption that social policy developed along broadly consensual lines (Hall *et al*. 1975:6), and they suggested that consensus should not be assumed to exist (1975:13). Later writers also assumed non-consensus. For example, consensus-building formed a big part of Kingdon's three streams approach. In his policy stream, he suggested that consensus was built largely through processes of persuasion and diffusion (2003: 159). This contrasted with his political stream, where consensus building was governed by bargaining (*ibid*.).

Three classes of conflict in organizations were identified by March and Simon (1993:132): individual conflict (conflict in individual decision-making);

organizational conflict (individual or group conflict within an organization); and inter-organizational conflict (conflict between organizations or groups). In addition, conflict between the state and local government might be of particular relevance to regional policy-making in England. Alcock referred to the 'inevitable tension at the heart of relations between central and local control over the provision of social policy' (2008: 255). So there would seem to be many areas where conflict can exist and will need some kind of resolution.

The resolution of conflict is strongly connected to the exercise of power, which is discussed in the following chapter. Banfield, talking of transit system plans in Chicago, described several groups with interests opposed to a certain plan (1961: 107), but said that

> When the Governor, the Mayor, and the President of the County Board announced their agreement, most people took it for granted that they would press hard for its adoption. If they did, it would almost certainly be adopted no matter what the opposition, for when the three of them acted in concert they were virtually unbeatable. (Banfield 1961: 116)

Lindblom and Woodhouse described several possible approaches in the search for agreement: looking for ways of getting what one wants without stirring up adverse responses; responding favourably to potential allies; use of counter-proposals; keeping demands reasonable; encouraging moderation (1993: 25-26). All of these are exercising influence or power.

Another potential property of an issue is ambiguity, which relates to vagueness in either the objectives of a policy or the plans for its

implementation. March defined it as referring to ‘a lack of clarity or consistency in reality, causality, or intentionality’, describing this further:

> Ambiguous situations are situations that cannot be coded precisely into mutually exhaustive and exclusive categories. Ambiguous purposes are intentions that cannot be specified clearly. Ambiguous identities are identities whose rules or occasions for application are imprecise or contradictory. Ambiguous outcomes are outcomes whose characters or implications are fuzzy. Ambiguous histories are histories that do not provide unique, comprehensive interpretations. (March 1994: 178)

March distinguished ambiguity from uncertainty, using the latter to refer to lack of certainty in estimates of results following from actions, and suggesting that uncertainty is addressed and reduced by increased knowledge. Ambiguity referred to hazy definitions or multiple possible interpretations. Eaton Baier, March and Saetren suggested, in a similar way to Hall *et al.* (1975) discussing conflict, that in policy-making there is an assumption of clarity of objectives, with policy-makers being sure of what they want (Eaton Baier, March and Saetren 1986: 204). This lack of ambiguity does not always exist and it is possible that one common method for obtaining support for a policy is to make it more ambiguous so that different groups of actors might back the proposals for different reasons (*ibid*.: 206).

Lack of clarity in causal relationships has long been identified as a factor in decision-making. Where the cause and effect relationship is unclear, the decision-making becomes more complicated.

> In many domains of public policy, the world in which the policy maker aims to intervene is beyond complete comprehension. The complexity involved precludes the possibility of being able to predict the consequences of an intervention. (Chapman 2002:19)

Thompson and Tuden used a matrix with ‘beliefs about causation’ (agreement or disagreement) along one axis and ‘preferences about possible outcomes’ (agreement or disagreement) along the other (1959: 198*)*. Appropriate approaches to decision-making were then shown to depend on a problem’s location in the matrix. Where there was agreement about both causation and preference, decision-making was a ‘technical or mechanical matter’; agreement on causation but disagreement on preference meant a compromise strategy was needed; where there was disagreement on causation but disagreement on preferences, ‘judgment’ would be required; and disagreement on both would need ‘inspiration’ (*ibid*.).

Thompson and Tuden’s matrix was further developed by Stacey, who used one axis to represent how far the issue was from agreement (Thompson and Tuden’s ‘preference about possible outcomes’) and the other to represent how far the issue was from certainty (Stacey 1996: 47), equivalent to Thompson and Tuden’s ‘beliefs about causation’. The position of an issue in this matrix helped in the identification of the issue’s nature and the likelihood of finding a solution. An issue could be described as close to certainty when cause and effect linkages could be determined (Zimmerman 2005: *description* page). With issues in this position, it was generally easier to base decisions on past experience and to predict outcomes fairly well. If an issue was described as far from certainty, it was usually because it was a new issue (or at least new to the decision-makers) and it was difficult to identify cause and effect linkages.

Here, there was little past experience on which to draw real conclusions about likely outcomes of decisions. Considering the 'level of agreement' dimension, an issue would be described as close to agreement if there were a high level of agreement about an issue or a decision within the group, team or organization. The outcomes of issues close to agreement and close to certainty could be predicted from past experience and no power plays would be needed to force through decisions. Where an issue was far from agreement and close to certainty, outcomes were reasonably predictable but there was disagreement about which outcomes were desirable, so that coalition building, negotiation and compromise would be needed to create the agenda. Issues close to agreement and far from certainty could not rely on past experience and shared missions might replace plans, with an aim of reaching a certain state even though the paths to it could not be determined. Where there was both low agreement and low certainty, a situation Stacey called anarchy (1996: 47), planning and negotiation would be insufficient: sometimes people dealt with this by avoiding the issue. Stacey's matrix was developed and used more for general management decision-making. However, it is possible to see its application extended to policy-making: its two dimensions, agreement and certainty, occur in other agenda-building discussions.

While Stacey (1996) concentrated on agreement and cause-effect certainty, Matland (1995) considered different combinations of high and low ambiguity

and high and low conflict. Matland's model was developed to apply to policy and, like Stacey's, it can cope with a multitude of factors, not just Alford's (1969) factors but the range of organizations involved and the different levels and sources of power. Policy conflict, he stated, would exist 'when more than one organization sees a policy as directly relevant to its interests and when the organizations have incongruous views' (Matland 1995: 156). He suggested that, although there were times when conflict could be addressed by perhaps offering incentives to some parties, there were many times when this would not be possible, such as when the conflict arose because of differing values (*ibid.* 157). Matland also identified, similarly to Eaton Baier, March and Saetren (1986), two types of policy ambiguity in implementation: ambiguity of goals and ambiguity of means (Matland 1995: 157). He pointed out that goal ambiguity was something which certain organizations or decision-makers would wish to avoid in favour of clarity but that one of the ways to limit conflict was actually through being ambiguous so that participants used their own interpretation (*ibid*.: 158). Ambiguity of means related to uncertainties about the methods that would be used to address a problem: this could include both technical/ technological tools and the specific roles for those involved (*ibid*.).

Matland produced a matrix to illustrate the conflict and ambiguity positions, with ambiguity on one axis and conflict on the other (*ibid*.: 160). He also provided examples of the factors likely to be the most influential in different

circumstances. Problems sitting in the quadrant where both conflict and ambiguity were low, would be relatively straightforward to solve, so long as sufficient resources were provided (*ibid*.: 161). Problems in the quadrant of high conflict and low ambiguity (where actors understood their goals but goals were incompatible) could only be solved by one side having greater power (*ibid*.:163). The way of addressing policies with high levels of ambiguity and low level of conflict would 'depend largely on which actors are active and most involved' (*ibid*. 165), so that it would tend to be the contextual conditions that most affected progress. Matland drew a parallel here with the 'garbage can' model mentioned earlier. The final quadrant was reserved for policies with high levels of both ambiguity and conflict. 'For policy with only a referential goal, differing perspectives will develop as to how to translate the abstract goal into instrumental actions' (*ibid*.: 168). This would then lead to competition, with those involved forming different coalitions.

Cohen, March and Olsen had considered that their 'garbage can' process enabled decision-making 'even when the organization is plagued with goal ambiguity and conflict' (1972: 16). They had recognized that these circumstances occurred and posited that, even then, issues could be resolved. Coalitions *per se* did not come into their model. However, like Matland's model, the garbage can model involved a fluidity of actors and a fluidity of alliances. Hill admitted that although some whole policy areas would not fit neatly into Matland's quadrants, the levels of ambiguity and conflict could be

well recognized elsewhere (2005: 139). He also expressed the idea that the model was perhaps more appropriate for specific policies, rather than for whole policy areas,

The matrix methods of Stacey and Matland were not intended as a solution to the problems raised by the other methods outlined. They merely dealt with a different aspect of policy-making. Usefully, they could be applied irrespective of setting, so did not need to know whether decision-making was society-centred or state-centred. Concepts of legitimacy, feasibility, support, or problem streams, politics streams and policy streams were implicitly covered within the models and did not need separate consideration in applying the model. Plotting selected policy issues on the matrices might well indicate where there is more likely to be success in keeping particular health-related issue on the political agenda. The issues lying in different zones might achieve varying levels of priority.

Factors affecting the way an issue moves up the decision-making agenda can influence many types of policy issue. There are also factors affecting the way that health is considered as a policy area reaches or climbs the agenda: these are discussed in the following section.

How and to what extent is health considered during policy development?

The need to have health and health inequalities included in policy was discussed in my introductory chapter. Many difficulties have been identified in getting health into all policies. Even in the health sector, there has been a tendency to focus on the acute needs and to ignore the massive contributions of health determinants (Sihto, Ollila and Koivusalo 2006: 11). One of the major challenges has been to persuade people of the importance of understanding how health is affected by the policies of other sectors. This can be particularly difficult with people who have not previously considered health as part of their agenda (Sihto, Ollila and Koivusalo 2006: 11). If the inclusion of health will be costly or results not visible for a long time, the problem of persuading others of its importance is greater, exacerbated by the fact that over time organizations and players change so new arrivals also need persuading (Sihto, Ollila and Koivusalo 2006: 14). It has been suggested that

> for health aspects to be introduced in other sectoral policies, the critical health issues must firstly be recognized by health experts or advocates, with lay input where possible, and the determinants of such health challenges defined. (Ritsatakis and Järvisalo 2006: 147)

The presence of health-related targets in a policy could be one indicator of health consideration. Health targets, as considered in WHO's *Health for All by the year 2000* (WHO 1978; WHO Regional Office for Europe 1985), are 'derived from an interplay between epidemiological evidence, moral values and political will' (Marinker 2002: 1). As McCormick and Fulop suggested,

'once common goals are agreed they can be more efficiently achieved when explicitly identified in targets' (McCormick and Fulop 2002: 37). The agreement of common goals, part of the political will, precedes the targets, so that if a health target appears in a policy, health must have been considered during the policy's development. The converse, however – that if health targets are *not* included then health has *not* been considered – is, of course, not true. Nor does the presence of targets necessarily imply that health improvement or inequalities will be appropriately addressed by the policy: as Hunter pointed out, there are many problems with targets, including perverse incentives and the inclusion of something just because it can be measured (2002: 161). On the other hand, the Audit Commission found that 'national targets, set by Government, have clearly driven progress when combined with a good model of delivery' (2008: 71). Nevertheless, whether or not targets are progress drivers, their presence must still mean that some consideration of health did take place.

Whatever the recognized difficulties in getting health into policies (and showing it is there), there has been increasing pressure from Europe and from the UK government to consider health in policies and strategies under development. Incorporating health and wellbeing is not regarded as easy: 'too often, from a policy-maker's perspective, the requirement to take account of health appears to be an additional burden' (Metcalfe and Higgins 2009: 297). When policy-makers do consider health, there appear to be two main

approaches. The first is connected to policy integration and joint working and the second is a more formal, more technical approach, including impact assessment. These approaches are discussed in the rest of this section.

Policy integration and joint working for health

Ritsatakis and Järvisalo felt that, along with knowledge of health determinants, skills in establishing and working with partners were essential (2006: 165). They commented that short courses on working with multiple sectors had been shown to be effective. Where there were already examples of joint action for health, these should be showcased, to 'strengthen the message and indicate opportunities for cooperation', particularly informing about costs and benefits (*ibid*.: 163).

General joint working is discussed in the following chapter on people and organizations involved in policy-making. Involving the health sector in policy-making, as part of this joint working with other sectors, is one approach by which health improvement can be expected to receive consideration on a non-specifically health policy. It has been shown that some policies have successfully incorporated a consideration of health improvement by this means. For example, health became part of Wales' Objective 1 programme[5] without an early health impact assessment (Breeze and Hall 2002: 7). One

[5] Objective 1 Programme: an 'extensive effort to stimulate and support economic development and regeneration' (Breeze and Hall 2002: 7)

reason Breeze and Hall suggested for this was the way the lack of reference to health in the early versions of the programme actually 'triggered discussion between officials' (*ibid*.: 14). This, to a certain extent, is linked with joint working but it must also be borne in mind that the reason it happened might be pure luck and the interests of the officials who happened to see the document. It is also possible that the health sector contribution remains limited to health service related issues, rather than broader public health issues. The personal interest as well as organizational interest of participants will affect viewpoints and contributions. Perkins *et al.* found little evidence that partnerships in public health had actually improved health and suggested that 'the time may have come for a bolder assessment of not merely the alleged benefits of partnership working but also their limits' (Perkins *et al*.: 2010: 13).

Breeze and Hall also offered another explanation for the inclusion of health in Wales' Objective 1 programme: that the Assembly Government had an 'overall commitment to develop a more integrated approach' (2002: 14). This related both to the general joint working ethos and to the specific need to tie policy areas together. Wales' approach to tackling health inequalities also differed from those of Scotland and England, with less focus on 'secondary prevention as a means of tackling inequalities' (Smith *et al*. 2009: 230).

A very different proposed reason for successful inclusion of health was that analysis for the programme had highlighted the links between ill-health and

the economy, so that it was recognized that the economy would suffer if the population was unwell and perhaps off work (Breeze and Hall 2002: 13). The economy as a driver for policy development is an issue that is raised by other writers, too, particularly when economic considerations conflict with health considerations. As an example, an assessment of the European Union Common Agricultural Policy noted some confusing outcomes of tobacco policy: tobacco production subsidies appeared to provide income for farmers (an economic benefit) but this led to over-production of high tar varieties which were exported into neighbouring, poorer countries, worsening health there (Dahlgren, Nordgren and Whitehead 1996: 1). Joossens and Raw made similar points, commenting also that

> the Court of Auditors noted that the smoking part of the 1993 Europe Against Cancer budget was just 1.5m ecu, only 0.1% of total expenditure on tobacco subsidies. This does not suggest a serious commitment to health. . . . The huge disparity between the money spent subsidising tobacco and that spent campaigning against smoking suggests an ambivalence in European Union policy towards health goals. (Joossens and Raw 1996: 834)

Much of the joint working and policy integration mentioned above is carried out on a relatively non-formally structured basis as regards a consideration of health. There are general directives to collaborate across sectors (including health) and general directives to develop integrated policies. The rest of this section will focus on the literature around more formalised techniques used during policy development.

Formalised assessment

Several tools and techniques have been developed to influence or assess programmes, initiatives, projects or policies in terms of the effects they have had or could have. I have concentrated on the literature dealing with their use for policy development, rather than their wider use.

One such tool is the health equity audit. This provides a framework for systematic action for Local Strategic Partnerships and Primary Care Trusts to 'develop a common understanding of the key local health inequalities in their area – and most importantly, to ensure resources are allocated to tackle them' (Hamer *et al*. 2003: 5). It is a cyclical process, involving collecting of information, multi-agency assessment, agreement of priorities and allocation of resources to address the problems, followed by assessment of effect. In 2002, process became mandatory, to be used to inform the community strategy and local neighbourhood renewal strategies. A most important element was the cross-agency agreement on priorities and resource allocation. Health needs assessments are also tools to assess the health of an area and to identify priorities for action. However, although they are designed to inform strategies, they are not specifically linked to the production of particular strategies and my interest is in how health is incorporated into policy rather than what is collected to inform policy.

There exist policy ‘impact assessments’, which can be retrospective (carried out after policy development) or prospective (carried out before or during policy development). Retrospective assessments can provide evidence for subsequent prospective assessments and might sometimes be the only option, for example if an unplanned event (such as a major foot and mouth outbreak) has occurred. Retrospective analysis of such events can lead to suggestions in changes in policy. My focus here is the use of prospective assessments, taking place in the formative stages of a policy.

Specific ‘health impact assessments’ can help in the decision-making process by identifying the likely serious health-adverse effects of a suggested policy, preferably in time to prevent that policy being implemented or continued. They can also help to identify shortcomings in the policy and suggest modifications to strengthen its positive impact on health. For the sake of convenience, although several definitions exist, only the widely-quoted World Health Organization definition is given here:

> health impact assessment is a combination of procedures, methods and tools by which a policy, program or project may be judged as to its potential effects on the health of a population and the distribution of those effects within the population. (European Centre for Health Policy 1999: 4)

It is not solely *health* impact assessment that is of use in improving health (and wellbeing). Similar approaches, such as economic impact assessment, are also relevant to public health. Table 1 summarises the relevance of the different techniques to the development of healthy policy.

Table 1: assessment techniques for healthy policy development

Type of assessment	Relevance to healthy policy[6]
Environmental and strategic environmental IA[7]	Identify potential issues around toxins, pollutants, noise and other factors that can have a direct effect on human health. Can also help to provide an evidence base for more specific health impact assessment.
Sustainability IA	Similar to environmental assessments but with greater emphasis on societal impacts, considering more of the underlying determinants of health.
Social IA	Strong focus on social elements, particularly social exclusion and rural social exclusion, which are part of the health inequalities agenda.
Human rights IA	Include the right to health.
Equality IA	Address inequalities, e.g. those related to race, ethnicity and gender, social inclusion and community cohesion.
Economic evaluations and economic IA	Health status is known to be influenced by economic circumstances (linked with health inequalities agenda). Cost savings identified in one area of health spend should free up funds for investment in other areas of health spend. Rigorous, well established, provide credible evidence.
(Comparative) Risk assessments	Evidence-based, quantitative estimates of risks to populations, mainly from exposure or changes in exposure to hazardous materials (strong links to environmental IA).
Technology assessments	Of particular relevance to health policy and allocation of resources for health care. Also related to direct health improvement.
Health IA	Directly relevant. Identify factors affecting health that might not be picked up in any other assessment.
Integrated IA	Should include most of the above, although sometimes refer to a combination of only two or three. Likely to incorporate qualitative as well as quantitative assessment.

Because my focus is on whether or how these techniques have been used in policy development, rather than on how they are actually supposed to be carried out, I have not described the various methods themselves but have

[6] Adapted from text in Banta and Andreasen, (1990), Davies *et al*. (1994), Hamer *et al*. (2003), Kjellström *et al*. (2003), MacNaughton and Hunt (2009), Mindell, Ison and Joffe (2003) and Mindell and Joffe (2003).
[7] Impact Assessment

concentrated on what has been written about reasons for usefulness and criticisms against them.

The benefits of the techniques come largely from their ability to point out factors that are possibly either detrimental to or beneficial to health. The range of factors is very wide. Different factors will be seen to be of varying success (and of varying direct value to healthy policy) in different types of assessment. Environmental impact assessments, for example, vary in the extent to which they consider human health. A brief outline of problems of impact assessments is helpful because they might affect the success of the assessment. Many are associated with lack of time or resources. A key problem is that of inadequate interdisciplinary participation or lack of understanding of the roles and expectations of the process (Banken 2001; Bond *et al.* 2001; Breeze and Hall 2002; Dora and Racioppi 2003; Gochfeld and Goldstein 1999; Kearney 2004; Künzli 2002; Lebret and Staatsen 2002; Tarkowski 2002). Inadequate representative public participation is also a problem (Francis *et al*. 2001; Gorman and Douglas 2001; Kearney 2004; Parry and Stevens 2001; Parry and Wright 2003).

Timing can be a problem (Scott-Samuel 1998; SNAP; Varela Put *et al.* 2001).

> To be influential, the HIA needs to be carried out early enough to have an effective input into the decision making process, but late enough that the proposals are sufficiently firm to enable an assessment. (Mindell, Ison and Joffe 2003: 648)

Sometimes, the onus is on the project owner to arrange an assessment (particularly for environmental impact assessments), so that its independence is questionable (Mindell, Ison and Joffe 2003: 650). Other potential bias includes the following: the effect of socio-political influences and vested interests (Joffe 2003: 302); the relative value given to clinical judgement compared to social concerns (Crowe and Carlyle 2003: 19); an acceptance of 'scientific' evidence at the expense of ethical or qualitative elements (Kjellström *et al*. 2003: 453); and the over-emphasis on economic effects. The Department of Health's Guide for Policy-makers (DH 1996) has been said to have an exclusive focus on economic appraisal methods of health impact assessment (Scott-Samuel 1996: 183). The evidence used in a health impact assessment might be biased (Birley 2002: 33). Evidence can be interpreted in different ways: even around tobacco control, where there has been a wealth of well-documented evidence accumulating for over half a century, supporters of different viewpoints might choose to call upon different evidence, interpreting it in different ways. There will be extra difficulties in prioritising and weighting different outcomes when more than one type of assessment is being used. Crawley and Ashton (2002) raised this question under the title *'Safety, health or the environment--which comes first?'*

The content of an assessment can be problematic: questions have been raised over the absence of societal criteria (Tugwell *et al.* 1995) or a spiritual health component (Chuengsatiansup 2003; Phoolcharoen, Sukkumnoed and

Kessomboon 2003). Even where health is supposedly part of a strategic assessment, there can be a narrow interpretation of 'health' such that its broader determinants are not always considered (Dora and Racioppi 2002: S130). The inclusion of health in integrated assessments might in some cases reduce the importance of the health element, whereas undertaking health impact assessment separately 'ensures that health remains the prime focus' (Kemm 2000:432).

In spite of potential problems, benefits other than policy improvement have been noted, in particular the way impact assessments can create good interdisciplinary working relationships (Banken 2001: 19). As Sim and Mackie pointed out, local people, as well as organizations, are major stakeholders (2003: 293). The content of an integrated impact assessment has been described by Harrison as a function of the stakeholders involved in its development (2002: 69). Because of the participatory nature of health impact assessments (and of the potentially stronger integrated assessments), they can lead to greater understanding of health and its determinants amongst both professionals and the public and potentially then a greater likelihood of those stakeholders starting to consider health inequalities from the beginning of future projects (Mittelmark 2001; Parry and Wright 2003; Morrison, Petticrew and Thomson 2001; Taylor, Gowman and Quigley 2003).

For a number of years after the early calls came for health impact assessments, several writers bemoaned the lack of assessments actually carried out (Kemm 2001: 83; Scott-Samuel 1996: 183). Even where policy impact assessments have taken place, doubts have been expressed about whether they actually had any effect on policy or on decision-makers (Dannenberg *et al*. 2008; Davies *et al.* 1994; Hoffmann and Graf von der Schulenburg 2000). However, other studies suggest that increasing numbers of studies are finding that impact assessments *did* have a more direct effect on policy-making (Central Liverpool NHS PCT *et al*. 2003; Lock *et al*. 2003; Varela Put *et al*. 2001; Wismar, Blau and Ernst 2007). Analysis of impact assessments in the Yorkshire and Humber region found varying degrees of success in influencing decision-making, from direct influence to no influence, with some cases affecting related activity rather than directly influencing a strategy (Green *et al.* 2004).

Health impact assessments undertaken on several of London's Mayoral strategies between 2001 and 2003 'led to changes and ensured that health and health inequalities were given due consideration as part of the strategy development process' (Bowen 2007: 185). Later analysis of a longer period of mayoral strategies suggested that 'whilst some of the early drafts of strategies encompassed some elements of health, health was not a priority' but that the health impact assessment process evolved over time and 'it is anticipated that

HIA and IIA will continue to be integral to strategy development' (Mindell *et al*. 2010: 107).

Various factors have been identified that might affect the success of impact assessments. One of the most important enablers appears to be effective intersectoral working within an environment that supported such working (Andonova 2006: 157; Wismar, Blau and Ernst 2007:31). Davenport, Mathers and Parry proposed that success was more likely when the issue was not controversial (2006: 196). Mitchell, Clark and Cash suggested, regarding environmental assessments, that there were three 'attributions that determine influence': salience (relevance to potential users); credibility; and legitimacy ('the perception by relevant audiences of an assessment process as "fair", having considered the values, concerns, and perspectives of that audience') (2006: 314, 320). To some extent, these can be linked to issue characteristics that help issues to rise up an agenda (policy or media): relevance to potential users is linked with the public knowledge of a topic and credibility allows people to believe or accept the evidence. Legitimacy relates very much to the public consultation processes that can cause difficulties, when there might be a lack of trust between the community and the policy-makers.

Conclusion to Chapter 2

This chapter has considered the literature around models of agenda-building, factors influencing progress on the agenda (apart from people and organizations) and ways of bringing a focus on health onto the agenda.

There is a wealth of literature around various aspects of healthy policy development. Models exist that claim to describe the policy-setting environment and models exist that claim to identify the reasons why certain policies reach or climb the decision-making agenda. Most of the models have been criticised in various ways, often for lack of applicability to more general situations. However, the very existence of the models and the surrounding literature did provide an answer to my first research sub-question: 'what models and frameworks currently exist to explain the progress (or lack thereof) of policy areas on the decision-makers' agenda?'

There is an increasing range of material on certain aspects of my research question **'**how and to what extent is health considered during a regional policy's development?' Material exists particularly around the more formal techniques, such as health impact assessment. However, even with the impact assessment literature, there was a limited amount on actual examples of its prospective use in developing policy, rather than its use in developing programmes or projects.

Proposed explanations of what influences the progress of policy areas on the agenda have all been criticised: all had flaws and most admitted to limited application, or were said to be theoretical and perhaps just descriptors of an ideal situation. However, they could certainly be of value in a comparison between policies in an attempt to identify the most significant factors.

The literature discussed in this chapter has gone some way to addressing three of my research sub-questions: ‘what models and frameworks currently exist to explain the progress (or lack thereof) of policy areas on the decision-makers’ agenda?’; ‘what other factors influence the progress of healthy policy areas on the regional decision-making agenda?’; and ’how and to what extent is health considered during a regional policy’s development?’ Throughout the chapter, references have been made to another (potentially very significant factor) – the people involved in making or influencing policy decisions. The following chapter concentrates on that aspect of policy-making, considering who is involved (both individuals and organizations) and what power they have in the policy-making process.

Chapter 3: theories about the decision-makers

The previous chapter considered models of policy development, agenda-setting and pushing health into policy, with several references to power and to the people involved in decision-making. This chapter looks at the literature around agenda-building in terms of the people or organizations that own or influence that agenda and the power they have. It addresses the theoretical background to my research sub-question 'Who moves a healthy policy area onto and up the regional decision-making agenda?' There are questions about the role of the region in policy-making: is it in any way autonomous or is it merely an implementer of central government policy, an administrative outpost from the centre? Ayres and Pearce (2005) wrote of the increasing reliance of Whitehall on regional strategy-makers: more exploration of this will take place later.

The major organizations involved in regional policy-making were described in Chapter 1, in terms of their expected roles. However, the ways in which they actually do perform and the ways the organizations or individuals involved work together in practice can be very different. Roles and responsibilities can confer degrees of power but the exercise of that power might vary from organization to organization, from individual to individual and from region to region. Those involved in policy-setting might be individuals or they might be parts of organizations (state or non-state) or other alliances or networks.

Although their actual input seems not to have been much considered in rational (stages-based) models, it has long been recognized that many people can be involved:

> when we describe the decision process of any body politic, then, we expect to find – and we do find – several official and unofficial participants in the arena of politics are implicated at any given cross-section in time. (Lasswell 1956: 94)

Cobb and Elder claimed that 'it is generally agreed that social processes (that is, extra-governmental, though not necessarily non-governmental processes) in large measure provide the primordial stuff of political decision-making' (1972: 17). For many years, discussions of the UK system referred to the Westminster model of government, in which 'power is regarded as sealed within the domain of Westminster' (Richards and Smith 2002: 4). This power includes the power of ministers to dominate civil servants and of national government to dominate local government. However, by the late twentieth century, many writers (for example, Rhodes 2000: 345) were questioning the appropriateness of the Westminster model, suggesting that governance, rather than government, was the reality, with policy networks (discussed later) and intergovernmental working playing a great part. The extent of involvement of a range of people has increasingly been accepted and, in recent years, there has been a shift towards involving more people and having 'governance'

rather than ‘government’.

> Above all the notion of governance refers to governing styles in which the boundaries between and within public and private sectors have become blurred and where new actors – often conceived of as ‘stakeholders’ – are incorporated in the public policy-making process. (Tomaney and Pike 2006: 129)

The following section discusses the literature on the ‘stakeholders’ or ‘actors’ and their roles. In considering the government at a regional level, I have restricted the literature discussed largely to that around the English regions. The European regions are considerably different in size and the regions that exist within other countries tend to have very different structures, purposes, financial arrangements and/or officials (Budd 1997; Cabinet Office, ODPM 2002; Elcock 2008; Herrschel and Newman 2000). Whilst there are some similarities with certain aspects of other countries, these tend to be limited. For example, ‘although the Italian regions have stronger health powers than those proposed for the English regions, the public health strategies in fact rely heavily on the cooperation of many actors in the regions’ (Tomaney 2003: 6).

Who is involved, what do they do and how are they perceived?

As has been mentioned, a whole range of people and organizations can be involved in policy-making. Some might hold more formal ‘official’ allotted roles.

> Questions about the holders or formal offices – as well as their associates in the policy process, such as lobbyists - are relevant to the study of policy only if we can assume or demonstrate that certain of these officeholders are important in making policy. (Hofferbert 1974: 25)

Notwithstanding Hofferbert's comment, there are many official actors generally recognized as playing a part in policy-making. National Government, arguably the most 'official' actor in policy-making, includes Prime Minister and ministers, senior civil servants and parliament. The state includes public servants, local government (elected councillors, local government officials) and quasi-autonomous non-governmental organizations (Quangos)[8] (Blakemore 2003: 115).

Elected and non-elected actors are all part of the official set but there are recognized differences between them (aside from the more obvious power accorded to them). Hill pointed out that newly elected governments might have manifesto pledges to honour (and the mandate to do so) (2005: 161). There are also differences in the way the public regards elected and non-elected actors. Lindblom and Woodhouse queried the public confidence in the elected functionaries (with reference to the UK as well as their main focus of the USA) but suggested that, although there was a certain amount of distrust of this bureaucracy, 'citizens' interactions with government agencies actually work out fairly well much of the time' (1993: 58). Lindblom and Woodhouse also asked whether the bureaucrats actually did set policy, since much of the

[8] a semi-public administrative body outside the civil service but receiving financial support from the government, which makes senior appointments to it (Concise Oxford English Dictionary 2006)

previous literature had assumed that the bureaucrats only implemented it (1993: 59). Their conclusion was that the bureaucrats did formulate policy, because the elected functionaries were not in a position to cover all the possible issues themselves (1993: 60).

Elected functionaries have attracted criticism but so have civil servants, with accusations of subverting political agendas for their own ends or those of their departments (Hill 2005: 164). The power to do so – to take non-decisions – is discussed later in this section.

Governance at the English regional level has been devolved from central government over a number of years. The motives for this have been challenged as being economic rather than out of regard for democracy. Musson, Tickell and John pointed out that the 2003 Budget was 'the first to include a summary document of its implications for each of the English regions' (2005: 1401). They suggested that the government, crucially including the Treasury, accepted the 'argument that the most effective way of approaching uneven development between regions is to encourage economic development-based solutions from within regions' (*ibid*.). Whilst the regional organizations leading on regional policy-making are not elected, Government Offices comprise civil servants representing certain government departments; the memberships of the Regional Chambers do include representation from

statutory bodies and the Regional Development Agencies were established by an Act of Parliament. The given and potential roles of the Regional Assemblies and the Regional Development Agencies have attracted interest from several writers and the following paragraphs consider this.

Robinson and Shaw, aiming to find out who ran the North East, had difficulty obtaining information about board members on unelected bodies. In spite of this, they claimed they had found that it was 'predominantly middle-aged (or older), mainly middle-class men', with little representation from younger men, women, ethnic minorities or disabled people (Robinson and Shaw 2001: 473). Revisiting this question after the elected assembly referendum, they found that, in spite of changes (including the government's emphasis on regions and an increased role in funding allocations for economic development), 'democracy is still at a low ebb in the North East' (Shaw and Robinson 2006: 6). Their study's interviewees generally felt that governance was fragmented with too many organizations, 'unbelievably bureaucratic' and subjected to many structural changes. Criticism was levelled at politicians in the region and the lack of leadership. Shaw and Robinson suggested that there were therefore still many of the same problems they had identified in their previous study (2006: 21).

Considering the Regional Chambers (Assemblies), Pearce and Ayres found that there was 'limited consensus about the role or the relative importance of

their [the Assemblies'] activities, which reflects variations in socio-economic conditions, regional identity and political aspirations.' (2007: 702). They felt that these factors in the North East region (social and economic deprivation and higher proportion of Labour control) had led to greater political cohesiveness. This was said to be in marked contrast to, for example, the South West or Eastern regions, which showed less enthusiasm for new regional institutions.

Enthusiasm for Regional Development Agencies also varied. Ayres, Mawson and Pearce suggested that, although the idea of one had been welcomed initially in the West Midlands region, by the time it arrived in 1999 there was more in the way of concern that the government office would be playing far too great a role (2002: 72). Additionally, the realisation that staff would be moved to the assembly from Government Office gave rise to worries that the ensuing 'civil service' culture would be 'not conducive to partnership working' (*ibid*.). Lee commented that there was frustration in the Yorkshire and the Humber region over the RDA's 'lack of effective powers and their lack of autonomy because of central prescription over policy resources.' (2002: 54). Concerns had also been identified in the South West region:

> there is a genuine enthusiasm among many partners for the new regional networks and institutions, but there also remains some scepticism among those (particularly some in the private sector) of their real added value. (Bridges 2002: 104)

There are variations in the interpretations of the RDA's accountability. Blackman and Ormston found that 'the [North East] Assembly regarded the views and experiences of regional stakeholders as valid issues against which to hold the RDA to account, whilst the RDA believed that the agency should be held to account on the basis of "factual" evidence' (2005: 384).
Not all studies, however, report predominantly negative findings on RDAs. In the North West region, 'in terms of policy areas, it seems that the NWDA has had a positive impact upon the coordination of responsibilities for inward investment' (Giordano 2002: 89). Keating, Cairney and Hepburn found that, in spite of criticisms, in the North East of England, 'The RDA has become an accepted part of the institutional landscape and all groups wanted to keep it.' (2009: 60).

There are many categories of 'unofficial actor' involved in policy-making. They include (from, amongst others, Birkland (2005: 7) and Ham (1999: 129)): institutions; commercial and industrial interests; individual citizens; interest groups, think tanks and research organizations; and the media.

The roles played by institutions, commercial and industrial interests in the policy process have been studied by several analysts. As an indication of what is meant by 'institutions' in this context, Hudson and Lowe provided the following examples: 'election rules, voting systems; party systems and structures; relations between branches of government; structure and

organisation of key economic or interest groups; welfare state agencies and delivery systems' (Hudson and Lowe 2004: 148). The institutionalist approach uses the idea that policies are shaped by the institutional settings in which they are developed. Certain institutions within a country can hold strong positions, for example the medical profession can generally exert pressure around health care policy (as discussed, for instance by Hunter (2003: 114)). Swank and Martin (2001: 915) commented that the 'political economic organization of employers matters in significant ways for the development of contemporary social policy', for example 'employer organizations can directly influence the level of national resources' given for employment-related policies.

John suggested there were several limitations to institutionalism (1998: 49-53). Firstly, 'actors and groups often circumvent institutions in the pursuit of their interests'. Secondly, 'the social context shapes and mediates formal arrangements'. This can be related to contextual factors mentioned earlier. A third limitation was that it was a very static approach, effectively presenting just a snapshot of the process. Thus, the approach did not take account of human action or the fact that institutions changed their roles over time. With the English regionalisation agenda, the main decision-making bodies went through changes with further major changes planned in the event of the referendum coming out in favour of an elected assembly. Hill echoed John's idea: 'what we are concerned with here is a problem that confronts all theories

that emphasise structure: they are better at explaining stability than change' (Hill 2005: 86). John's fourth limitation (*op. cit*.: 54) was that the institutions themselves were not independent but there were links and external influences affecting the way they operated. Commercial and industrial organizations are influenced by legislation: in the field of tobacco control, for example, there are laws about where it is permissible to smoke or to draw attention to places where tobacco can be purchased. Metcalfe and Higgins also used tobacco as an example of an unhealthy product allowing 'significant financial returns', when they proposed that one of the major impediments to healthy public policy was the dominance of commercial power (2009: 297). Some of this commercial power comes from the forming of networks by private businesses. This is discussed later, in the section on groups and networks.

The media occupy a unique position in the way they can influence policy. Although there are arguments about the autonomy of the media and the influence of government on it (outside the scope of this research), it is well recognized that media articles can affect public perception of an issue (for example, Baggott (2007:81)). 'There are examples where the media have forced governments to change policy, or put an issue on the agenda' (Walt 1994: 69). Ader suggested, with regard to environmental pollution, that 'the public needs the media to tell them how important an issue the environment is. Individuals do not learn this from real-world cues' (1995: 310). Tamayo and

Carrillo felt that the media could greatly influence agenda-setting

> no tanto porque 'manipulen' la realidad, sino porque informan sobre las condiciones reales de los problemas. (Tamayo and Carrillo 2005: 679) [not so much because they manipulate reality but because they inform about the real conditions of the problems.]

Tomaney and Pike (2006: 132), considering the shift from government to governance, commented that 'without strong democratic leadership, an additional danger is that the debate about social, economic and environmental priorities are [*sic*] shaped increasingly by the growth of powerful news media.'

Much has also been written about how issues reach the media agenda. This is not a core part of my study but, since the media agenda can influence the decision-makers' agendas, it has some relevance. Key points concerning the media's effect on agenda-setting include the following: not treating people equally (some lobbying groups cannot sustain media attention (Walt 1994: 69)); the media attention-span can be limited but issues that have previously attracted attention can come to the fore again more easily than those that have not (Downs 1972: 41); the media can 'promote public resistance to policies' (Baggott 2007: 91); the media can have more influence when the issue is not one with which people have had much experience (Zucker 1978: 239). Considering attention in the media, Downs suggested that there was an issue-attention cycle (1972: 39). This comprised a 'pre-problem stage' (undesirable social condition not yet attracting much public attention), 'alarmed discovery and euphoric enthusiasm' (where the public had

recognized the problem after some dramatic event and wanted to act on it), ‘realizing the cost of significant progress’, ‘gradual decline of intense public interest’ and the ‘post-problem stage’, similar to the pre-problem stage where little attention was paid to the issue but different in that some activities might have taken place during the period where there was interest, so the underlying situation could have changed. Downs said there were certain characteristics common to issues that went through this cycle (1972: 41). One related to the limited numbers or groups of people affected by a particular social problem: for many people, the issue was not a significant part of their lives much of the time. Another characteristic was the lack of drama attached to the problem most of the time (hence a dramatic event could spark a move in the cycle), rather like Baumgartner and Jones’ (1993) punctuated equilibrium.

The role of the voluntary sector and the role of the public can be very significant. Public acceptability formed part of Hall *et al*.’s (1975) agenda-building model: the support and the legitimacy aspects were crucial. Rates of public participation have been found to differ across England, with the North East having the lowest rate of participation in formal forms of community engagement but not in informal forms (Williams 2003: 536). This might mean that the North East is different from other regions when it comes to the public aspects of agenda-building.

The community and voluntary sectors are amongst the many areas where particular networks have been formed. The following section considers groups, networks and the issues around the ways various organizations work together to address policy areas.

Groups and networks

Voluntary and Community organizations suffer from several disadvantages when it comes to influencing regional policy-making. Aside from the financial issues and lack of resources for contributing, most are not organized in the same way geographically as the English regions (hence the formation of VONNE, as mentioned). Harris, Cairns and Hutchinson identified several problems amongst voluntary sector network (VSN) representatives, including confusion over (or, indeed, ignorance of) the nature of regionalism and a lack of awareness around the regional bodies (2004: 529). Although the VSNs could see opportunities for involvement particularly in regeneration, they reported little actual involvement at that time. Barriers to engagement were reported to be: lack of time; need to balance local with regional needs; lack of resources; being treated unequally by the public sector (which sometimes regarded voluntary organizations solely as providers of services); and the business sector, which also had conflicting, economy-driven aims (*ibid.:* 530).

Voluntary sector organizations are often part of an interest group or pressure group (also known as an advocacy group). Lindblom and Woodhouse

described interest-group activities as ‘interactions through which individuals and private groups not holding government authority seek to influence policy, together with those policy-influencing interactions of government officials that go well beyond the direct use of their authority’ (Lindblom and Woodhouse 1993: 75). Walt suggested that ‘they [pressure groups] use many different tactics to press government into taking their demands or their points of view into account.’ (1994: 97). Hall *et al.* suggested that often a pressure group could use an opportunity to further their cause by linking it with other issues (Hall *et al*. 1975: 486-507). This linkage with other issues also widens the scope – the number of people involved in the conflict. Pralle believed that ‘the amount and type of resources that interest groups possess relative to their opponents at the time of a significant focusing event, venue change, or external shock will also shape subsequent policy developments’ (Pralle 2006: 989). This relates to the power people have to affect policy and it will be further discussed later. John argued that there is no proof that politics is mainly to do with groups or associations (1998: 75). John also expressed the idea that the approach did not address the way in which groups interacted with one another or how some were stronger than others (*ibid*.).

Certain non-governmental organizations are regarded as *insider* groups, ‘accepted as respectable by government policy makers, with whom they have a close consultative relationship’ (Walt 1994: 104). Other non-governmental organizations, the *outsider* groups, are ‘not perceived of as legitimate by

government policy makers, and may therefore have difficulty in penetrating the policy process' (*ibid*.: 105). Pressure groups are not formed solely by voluntary organizations: there are examples of other pressure groups, such as professional groups, including the British Medical Association, with a strong voice in influencing health policy, even though at some points 'the government's relationship with the BMA deteriorated and, at times, degenerated into open hostility' (Baggott 2007:104).

The organization of an advocacy group at the time of key events was considered a vital factor by Pralle (2006: 989), as were the relationships the group had with other groups (helping to address somewhat John's concerns, mentioned above, that group interactions were not considered). The relationships between actors are of importance generally, not only for advocacy groups. Various networks of actors exist, including advocacy coalitions or policy communities and issue networks, which consist of actors with concerns in the same policy area. The effect of momentum on advocacy coalitions was mentioned by Bardach, proposing that when a new recruit joins a coalition, this is a 'bandwagon signal' to others (Bardach 2006: 347).

Networks of businesses have enabled contribution to regional policy from the business sector. Dixon stated that, because of New Labour's regional agenda, the role of the business associations had been very much changed and they were now being given the chance to be much more involved in regional policy-

making (2006: 179). However, Dixon suggested that 'the engagement of business associations in the process of regional governance is dependent upon their "will" and capacity' (*ibid*.). The non-binding voluntary nature of participatory business networks meant that 'businesses were sceptical' (Keating, Cairney and Hepburn, 2009: 60). Nevertheless, Keating, Cairney and Hepburn still felt that the business sector had contributed to the regional agenda in several ways. Valler *et al*., however, found that, although the North East was a 'comparatively coherent English region', there could be

> no automatic assumption of a strong and unified regional voice in the North East, despite the relatively long standing presence such as the NBF. Indeed, business interest representation remains relatively limited in organisational terms in the North East. (Valler *et al.* 2004: 119)

Valler *et al*. commented on the role of the CBI in the region, suggesting that, although it was potentially a significant contributor, it was ' … not seen as the dominant voice in business representation, but rather shares a relatively prominent position in business representation with the North East Chamber of Commerce' (Valler *et al*. 2004: 119). Both of these organizations helped to form the Northern Business Forum, which aimed to provide the business sector view to the Northern Development Company (NDC). However, Valler *et al.* found that the NBF was not particularly significant in the regional business agenda (*ibid.:* 119).

Networks of trade unions within the region have also attracted attention. Fitzgerald and O'Brien suggested there was a 'growing awareness on the part of trade union officers of the current problems of the North East economy, and

possible solutions to those problems' (2003: 28). They proposed that a number of factors would be influential in determining the successful involvement: the extent to which the unions were seen as part of the solution; the level of engagement enjoyed by trade union representatives; the unions' abilities to respond to opportunities; and the level of resources made available. These factors were influenced by the organizational changes in the TUC. For example, the Northern Trades Union Congress (NTUC) obtained funding from the RDA for a Regional Policy Officer post which increased its ability to engage and respond to opportunities (Pike, O'Brien and Tomaney 2004: 110),. Capacity-building was essential to the NTUC: developments included forming links with universities and local policy-makers around academic developments. Contribution to the learning and skills agendas was an important part of trade union activity and The Treasury recognized it as such (Pike, O'Brien and Tomaney 2004: 111). That role has very much broadened. For example, the NTUC's inputs into the Regional Economic Strategy and the development of a regional manufacturing strategy helped to ensure that 'from a relatively marginal position, NTUC is now developing a means of influencing regional economic and social strategies in the North East' (Pike, O'Brien and Tomaney 2004: 111).

This section has considered the groups and networks formed by stakeholders. Allied to coalitions and networks, but with very different initiation, is the concept of joint working, which is discussed in the following section.

Joint working

A very large number of organizations can contribute to what Ayres, Mawson and Pearce referred to as a region's 'governance capacity' (2002: 67). In the West Midlands region, Ayres, Mawson and Pearce found that over fifty organizations were 'involved in setting policies and delivering services in the region' (2002: 67). They suggested that this large number, along with the scale of expenditure, had created the need for suitable arrangements for partnership working. With specific reference to public health, Adshead (Deputy Chief Medical Officer for England) told the 2005 NICE conference that

> at the heart of our public health agenda is a very strong message around working across the whole of society. We need to think about how we move to, not only engaging the public in its own health and health care, but also the broader public sector in terms of local government' (Adshead 2005)

Part of the pressure for joint working appears to have come from the British government's changes from government to governance ('self-organizing, interorganizational networks' (Rhodes 2000: 346)) over the last twenty years of last century. Under this movement towards decentralization, networks bring together a range of sectors (public sector, voluntary sector and private sector). Stoker suggested that this aspect of governance was one where New Labour differed from its predecessor government:

> It looked to build support for reform through the encouragement of egalitarian networks that would facilitate mutual learning and partnership building and create the space for innovation. (2004: 85)

Collaboration or joint working comes in various forms. Peckham uses points on a continuum: isolation, encounter, communication, collaboration, integration (2003:63). The degree of joint working can lie anywhere on the continuum. Barriers to full collaboration (Peckham's 'integration') have been identified by several writers. In connection with joint working for assessing the health impacts of policies and programmes, Banken described several obstacles to intersectoral collaboration. These included: inadequate understanding of health determinants; lack of political will and leadership; competing interests of stakeholders; tensions between different levels of decision-maker; a 'lack of experience and essential expertise' that 'leads organizations to stick to the status quo' (Banken 2001: 4). Asthana, Richardson and Halliday said that barriers to good partnership working included key personalities and organizational ethos, especially if one organization tried to take control (2002: 789). Ranade and Hudson suggested there were five categories of barrier to collaboration: structural (including boundary issues and fragmentation of responsibilities); procedural (including planning and budgeting cycle differences); financial (including funding mechanisms and the flow of resources); professional (ideological and value differences); and status and legitimacy (including self-interest and concerns around loss of autonomy) (2003: 41).

Formal arrangements for joint working, interdepartmental as well as inter-agency, are not the only way collaboration happens. As Turrill pointed out,

> The organization is also clearly more than its formal arrangements ... The informal organization is less tangible but it is the mix of things that give the organization meaning for those who work in it ... it is about allegiances and alliances . . . . (Turrill 1986: 33)

Asthana, Richardson and Halliday found that for partnership working in public policy provision, the important driver was the recognition that there was a real need for it, in order to meet various organizational targets or objectives (2002: 786). The political imperative was another driver, particularly when money was involved. Financial or other resources could also help the partnership to succeed, along with active leadership. Snape and Taylor suggested there were various levers for partnership working (between health and local government): exhortation and rhetoric; structural reorganization; new powers and duties; central funding; integration of strategies and plans; New Partnership programmes; deregulation; incorporation of partnership theme within performance management; and accountability (2003: 6-7).

The different agendas and characteristics of the stakeholders involved in a partnership have attracted attention from some writers. The stakeholders in a partnership ‘may hold different organisational and managerial allegiances, different levels of autonomy within those organisations and different professional perspectives’ (Glendinning 2002: 119). Hill made the point that although organizational or relationship charts could be created, they often failed to show where the power lay: some parts of the system might have had more autonomy than others and some might have had more power but

appeared to be at the same level (2005: 219). (The location of power is further discussed later in this section.) Allison and Zelikov said there was a need to consider the whole policy-making machine, rather than imagining that policy is developed by one unified national government (1999: 5). They suggested that 'government behavior relevant to any important problem reflects the independent output of several organizations, partially coordinated by government leaders' *(ibid.* 143).

The joint working relationships between Government Offices, Regional Assemblies and Regional Development Agencies were not without problems. Government Offices were sometimes bypassed by Regional Development Agencies, which were 'exploiting their well established direct routes into Whitehall' (Pearce, Mawson and Ayres 2008*:* 455). The Regional Development Agencies sometimes treated the GOs with scepticism because of their lack of power and need to obey Whitehall (*ibid*.). This latter Whitehall element was also a cause for tension between the GOs and the Regional Assemblies, as was the way the GOs chaired boards but the assemblies were responsible for coordination of regional strategies (*ibid*.). However, Shaw and Robinson found that, although their North East study's respondents 'detected much more rhetoric than reality' about partnership working (2006: 13), they also felt that the main organizations were working quite well together in 'pragmatic' partnerships (*ibid.:* 21).

Within a few years of Assemblies and RDAs being established, barriers to effective partnership working had been identified. Shaw *et al*. found the elected members were perceived to have greater status, with some elected members showing 'no real desire to work collaboratively with partners' (2003: 9). Bureaucracy and a lack of transparency were also cited as barriers (*ibid*.: 9-10). The Pearce and Ayres study also identified tensions within Assemblies, the first being that local authorities tended towards a local rather than regional perspective in strategic planning (2007: 705). Conflicts also arose because of the urban focus the Assemblies tended to take, to the detriment of the rural areas.

Considering the need for central government departments to work together, Downe and Martin found that the lack of joined-up working caused problems for both local government and central government (2006: 465). Such departmental joint working is relevant not just to central government but to the government offices in the regions, where there is representation of several departments. The general lack of good joint working at a regional level was bemoaned by several writers in the late 1980s and early 1990s. Amongst the 'fundamental weaknesses' of the new regional institutions identified by Lee were that none were 'directly elected or accountable on a regional basis' and that 'the absence of regional accountability and control over resources has meant that policy has remained fragmented rather than "joined-up" and integrated' (2002: 49). Even after several years of being required to engage

in joined-up government, studies in Hull and Dundee reported major difficulties in partnership working:

> Many respondents felt that partnerships were internally fragmented, struggling to develop common cause and compatible organizational cultures. (Davies 2009: 85)

A particular aspect of joint working is that of community or public involvement. Strictly speaking, a community is probably not really an organization but rather a set of individuals linked by circumstance. Community or public involvement will potentially be an important factor in developing healthy policy at a regional level. Indeed, Crowley and Hunter suggested that 'public health will only regain its core purpose [health improvement and the wider agenda in respect of the determinants of health and how these can be addressed] by forging partnerships with local communities' (2005: 265).

The government had its own definition of public involvement, stating that 'Only consultation and participation are forms of public involvement. Information and public opinion research are not' (Cabinet Office Viewfinder 2.1). The Commission for Patient and Public Involvement in Health (CPPIH) was established in 2003 to support patient forums, specifically to obtain public input into NHS matters. Patient forums were replaced in 2008 by Local Involvement Networks, which were established to ensure public involvement in decisions about local health and social care services. Problems in interpretation of community participation have been mentioned by several

writers, including Dargan, who showed that, at least for one regeneration partnership, ‘while partnership members share the same levels of access in decision-making structures, the members of the partnership boards have such different understandings of the purpose of participation and the role of residents in the regeneration process that it has created conflict serious enough to affect delivery of regeneration’ (Dargan 2009: 305).

Previous paragraphs have described people and organizations involved in making policy. The players hold a variety of roles in the system. However, merely having a recognized role does not ensure that those players actually have any power to bring to bear on policy. Analysis of power (and how it is exercised in policy-making) engenders much discussion and controversy, as described in the following section.

Power

It is worth looking firstly at the ideas expressed as to what power actually is in a decision-making context. Dahl conceived of power as the capacity of A to make B do something which B would not otherwise have done (Dahl 1958, 1961; Dahl and Lindblom 1953). Dahl’s work in particular supported the pluralist view that no one group dominated the agenda. Later writers began to question the role of the state as an arbiter. Schattschneider proposed that the state’s role was to manage conflict, suggesting also that there was always bias when a change in the scope of conflict occurred, because perhaps new

players had been attracted to join the conflict and they would be partisan (1960: 13). Bachrach and Baratz extended Schattschneider's ideas of bias operating in favour of some players. They argued that consideration should be given not only to power exercised by A getting B to do something that B would not otherwise do. They suggested that a second dimension of power was also exercised when A got B to be a non-decision-maker in cases where a decision might be against A's wishes (Bachrach and Baratz 1962: 948; Bachrach and Baratz 1963: 641).

Lukes (1974) extended further the Bachrach and Baratz model, taking the example discussed in Crenson's study (Crenson 1971) of the reasons behind the different approaches taken by two American cities to pollution from the steel industry. Crenson had shown that power was exerted where one very large producer was involved, a producer of great economic and political importance to the town, to stop the issue getting properly onto the agenda. In contrast, in another city where several producers were involved, none with that great level of power, the issue reached the agenda and policies were made to combat the problem. Lukes initially defined the first two dimensions of power. The first was that of Dahl (see above), which

> involves a focus on **behaviour** in the making of **decisions** on **issues** over which there is an observable **conflict** of (subjective) **interests**, seen as express policy preferences, revealed by political participation. (Lukes 1974: 15)

The second dimension of power was that of Bachrach and Baratz (see above), involving both decision-making and non-decision-making, which

Lukes concluded 'involves a *qualified critique* of the *behavioural focus* of the first view' (*ibid*: 20). His use of the word 'qualified' reflected his opinion that non-decision-making was actually a form of decision-making. Recognizing the improvement that Bachrach and Baratz made over the one-dimensional view, Lukes went on to suggest that a third dimension of power was exercised when A influenced or determined B's wants. Lukes suggested that conflict was observable (overt) in the one-dimensional view of power and observable (either overt or covert) in the two-dimensional view. In the three-dimensional view, however, conflict could be observable (overt or covert) or latent. Defining the 'latent' conflict, Lukes said that 'it is assumed that there *would* be a conflict of wants or preferences between those exercising power and those subject to it, were the latter to become aware of their interests' (*ibid.* 25). Whilst this assumption is, of course, difficult to verify, its presence increases the scope of the exertion of power. Thirty years later, Lukes revised his earlier ideas, criticising his previous descriptions for 'failing to consider the ways in which everyone's interests are multiple, conflicting and of different kinds' (Lukes 2005: 12). He also admitted that he had mistakenly defined power by saying that A exercised power over B when A affects B in a manner contrary B's interests. Instead, he said that

> power is a capacity not the exercise of that capacity (it may never be, and never need to be, exercised); and you can be powerful by satisfying and advancing others' interests. . . . Those subject to it are led to acquire beliefs and form desires that result in their consenting or adapting to being dominated, in coercive and non-coercive settings. (Lukes 2005: 60)

Power does not reside only with large organizations. Individuals within organizations (or, on occasion, outside of the organizations) have varying degrees of power, which they might be in a position to use to influence the direction a policy takes (or does not take). In Table 2, I have summarised the main sources of power that can be at the disposal of policy-makers.

Table 2: sources of power for leaders and managers[9]

Type of power		Brief definition
Position power		
	Legitimate power	Where power comes from a formal management position and formal authority.
	Reward power (or resource power)	Where leader has control of resources that are desired by potential recipients.
	Coercive power	Where leader has authority to punish or recommend punishment.
Personal power		
	Expert power	Results from leader's special knowledge or skill.
	Referent power	Power from leader's personality characteristics, charisma.
Negative power		
	The capacity to stop things happening, to delay, distort or disrupt them.	

Whatever the type of power, Pfeffer, perhaps echoing ideas of decision-making being about overcoming conflict, suggested that

> it is critical to be able to diagnose the power of other players, including potential allies and possible opponents. We need to know what we are up against. (Pfeffer 1992: 71)

Any or all of the different types of individual power might well be very relevant in identifying some of the differences between approaches taken within a region on different policies. It might be easier to identify the application of position power than to prove that personal power has been applied. For

[9] Adapted from text in Handy (1993: 127-132) and Daft and Marcic (1995: 420-422)

example, the legitimate power of a council leader might be used to push through aspects of a local policy on housing. Reward power or coercive power might be used to persuade local businesses to support an economic policy. Personal power could be harder to identify but might be apparent in, for example, a celebrity chef campaigning for changes in policy in school dinners. Negative power can be concealed but can reside with someone who is not necessarily in a formally powerful position, such as an administrator who is responsible for ensuring timely circulation of consultation documents to relevant stakeholders.

The power (or lack of power) of regional assemblies has been discussed by several writers. Certainly in the early days, it was felt that although the regional assemblies had enhanced partnership working to some extent, the lack of power was still a problem, as their recommendations could actually be ignored by the RDAs (While 2000: 343). The fact that Assembly decisions were not binding led to difficulties, as partners could agree to decisions at the regional level, with seemingly successful joint working and agreement, then divert from the agreed actions at a local level. This ability to ignore regional for local decisions was said to arise mainly because of the lack of executive power of the Assembly. According to Keating, Cairney and Hepburn, this lack of power also frustrated the voluntary sector in the North East, which had supported the Assembly because of being afforded a voice there (2009: 60).

Lee suggested that power was lacking not just in the Assemblies:

> None of them [the regional organizations] possess control over sufficient policy and resources to affect regional economic development at anything other than the margins of a plethora of centrally determined policies and initiatives. (Lee 2002: 49)

The lack of control and accountability was discussed also by Benneworth and Tomaney, who suggested that existing strategies in the North East

> do not demonstrate a strong set of priorities for the region's development. This highlights the absence of an overarching body with the authority and capacity to provide the necessary leadership in the developmental process. In the absence of this body, strategies tend to reflect local concerns, with a tendency to stress broad aspirations, rather than clearly defined priorities. The region remains heavily dependent on decisions taken at the national level, with most regional strategies being principally concerned with adapting national priorities to the regional context. (Benneworth and Tomaney 2002: 140)

As well as the many organizations and alliances involved in policy-making, there are individuals (sometimes known as champions), who might have some power and play a key part in pushing issues up the agenda, particularly around awareness-raising. Stocking (1985: 28) found evidence of the role of champions in NHS decision-making. The influence of specific 'altruistically motivated individuals who initiate a campaign and lobby to draw awareness to an issue' was highlighted by Carpenter, who also referred to these individuals as 'political entrepreneurs' (2007: 104). This political entrepreneurship is similar to that mentioned by Zahariadis as affecting the confluence of multiple streams (2008: 520).

Individuals can also be influential because of expert knowledge. Considine suggested that members of professions can 'cross the borders of different agencies' (2005: 43), which is of relevance in joint working and networking. Considine also pointed out that where there was a profession with a dominant role, this could potentially cause problems for policy-makers with other views (*ibid.*). Experts can sometimes bring in new ideas to the policy-making process, perhaps from academic research into potential solutions to a problem. It has also been claimed that certain professionals working for public services have an influence over policy. These 'street level bureaucrats' (Lipsky 1980) include those who deal very directly with the public (for example teachers or social workers) and who find ways of working with (or against) policy to meet client needs. Their policy-making roles, according to Lipsky, are 'built upon two interrelated facets of their positions: relatively high degrees of discretion and relative autonomy from organizational authority' (1980*:* 13). Lipsky argued that

> the decisions of street-level bureaucrats, the routines they establish, and the devices they invent to cope with uncertainties and work pressures, effectively become the public policies they carry out. (Lipsky 1980: xii)

Lipsky's theory highlighted a particular powerful group that is capable of affecting policy, an idea verified by several studies showing how the actions of the street-level bureaucrats could lead to policy adjustments (Hill 2005: 246).

Another important element of power and the political agenda is non-decision-making (or non-policy-making). As Hogwood and Gunn commented: 'policy

behaviour includes involuntary failures to act and deliberate decisions not to act' (1984: 21). Rose also referred to unintended change: 'change can occur without decisionmakers doing anything; it can occur because a programme is sensitive to alterations in the environment' (1989: 32). Deliberate decisions not to act are rather different. Within tobacco control policy, there were calls for action for many years before national policy was actually developed. Non-policy-making can occur when a decision-maker stops an item getting onto the agenda, for one of a variety of reasons, including when that item does not suit the interests of the decision-maker or perhaps of a political party in power. This does not simply mean that a policy is not made: it means that the policy is not to take action. 'A policy, like a decision, can consist of what is not being done' (Heclo 1972: 85). There are occasions when certain players can act as gatekeepers, who

> reduce the number of demands competing for the time and attention of policy-makers, and non-decision-making operates to rule some issues off the agenda and to prevent others progressing to the point of action within the political system. (Ham 1999: 127)

Cobb and Elder identified different strategies that were used to keep issues off the agenda: attacking or undermining the group promoting the issue or trying to defuse or to blur the issue itself (1972: 125). With so many approaches available to stakeholders, the power to stop issues reaching the agenda needs to be considered along with the power to make them reach it.

Conclusion to Chapter 3

This chapter has considered the people, organizations and power involved in policy-making, as they create the mechanisms by which policy areas can climb the decision-making agenda. It has laid the foundations for the consideration of my research sub-question 'who moves a healthy policy area onto and up the regional decision-making agenda?'

My overall aim is to address my main research question: 'What factors most influence the position of healthy public policy areas on the agenda of regional decision-makers?' To address this question, I needed to be able to answer all of the research sub-questions. To assess how well the theories and models described in Chapter 2 explain policy agendas at a regional level, a closer look at actual policy areas within the region seemed appropriate. This should also help to illuminate theories of ways of getting health onto the decision-making agenda (also in Chapter 2) and theories of the people and organizations involved and the power that pushes items up the agenda (described in this chapter). My next chapter describes the methods I used to gain further insight into regional policy-making from documentary sources and stakeholders.

Chapter 4: Research methods

The research sub-questions described in Chapter 1 were:

- What models and frameworks currently exist to explain the progress (or lack thereof) of policy areas on the decision-makers' agenda?
- Who moves a healthy policy area onto and up the regional decision-making agenda?
- What other factors influence the progress of healthy policy areas on the decision-making agenda?
- How and to what extent is health considered during a policy's development?

Addressing these needed a range of different qualitative research methods. The literature search helped me to identify existing models and frameworks that explain how policy areas climb (or fail to climb) the agenda, as described in the previous two chapters. It also contributed to the questions of the methods by which a policy area ascends the agenda and other factors influencing the progress of healthy policy areas. Many of the models and descriptions were specific to a national rather than a regional agenda-building process. In addition, much of the literature tended towards a prescriptive or normative approach, rather than a description of the reality of healthy policy development, so I felt that other sources of information were needed. This chapter discusses the methods for identifying, accessing and making use of other sources.

The first source was the organizations or individuals with a part to play in North East regional policy-making (the stakeholders), who would be expected to hold views on factors affecting policy development and on the inclusion of health in policy. The second source was the documents produced by the decision-making bodies, describing the origins of policies and the intentions of and actions taken by the various policy-making bodies. The use of both exploration of stakeholder views and documentary analysis allowed triangulation.

Possible methodological problems are mentioned and the means taken to address them are discussed, as are ethical considerations. Validity and reliability are large enough issues to warrant a separate section, so the final section of this chapter discusses these, explaining the issues and how I dealt with them.

Exploration of stakeholder views

The objective for this element of the study was to explore the beliefs of regional stakeholders about certain aspects of healthy public policy. I carried out interviews in two phases. In the first phase, emphasis was on the general movement of healthy public policy areas onto and up the agenda, including facts and views on the roles of the relevant organizations involved and the relationships between those organizations. This phase of the study was

intended also to inform the need for further in-depth examination of views on more specific topics. It was therefore for both data collection and data generation. The second phase focused on four specific policy areas, the choice of which is explained later.

Choosing the approach

I considered several possible approaches: participant observation, observation (non-participatory), a postal or e-mail questionnaire survey, focus group discussions, individual telephone interviews and face-to-face interviews. Face-to-face interviews were deemed the most appropriate for both phases, as discussed in the following paragraphs.

Observation or participant observation over a defined period would have been inappropriate. Firstly, the development of strategy or policy is not a continuous process but tends to take place in a series of meetings over time, not necessarily in the same setting every time, nor even with exactly the same participants. Secondly, confidentiality requirements of the various organizations could have made it difficult for me to be allowed access. Thirdly, this would have allowed consideration only of the few policy areas actually under development at the time, whereas a wider picture was needed, including both policy areas where policy development had already happened and policy areas where there had not yet been any serious attempt at development.

Postal or e-mail questionnaires would have allowed only a limited set of responses to research questions designed to be relatively straightforward to answer. They would not have allowed immediate follow-up for clarification or for exploration of a wider or perhaps unexpected topic area. Additionally, response rates are known to be fairly low for questionnaires (Bloch 2004: 171), so that many important informants might not have actually contributed.

A practical difficulty of focus groups would have been getting the relevant stakeholders together, given that all had busy schedules and could not always even get together to meet for scheduled official meetings! More importantly, seeing the group all together would create difficulties around confidentiality and anonymity, when interviewees were asked to express views on the process or organizational relationships or power. Certain individuals could have dominated the proceedings, allowing less input from other members: if this were a reflection of the decision-making group dynamic, it might be a useful observation but would probably mean that much important comment or insight from other participants failed to emerge.

Qualitative interviews have been described as

> particularly well-suited to research that requires an understanding of deeply rooted or delicate phenomena or responses to complex systems, processes or experiences because of the depth of focus and the opportunity they offer for clarification and detailed understanding. (Ritchie 2003:36)

This would appear to make them very suitable for this project: the development of regional policy is complex in its involvement of a range of different organizations (with varied agendas), a range of different individuals from those organizations (with varied agendas potentially at both organizational and individual levels) and the pressures arising from both above (government) and below (local residents). The individual interview has also been described as a particularly useful method 'for accessing individuals' attitudes and values – things that cannot necessarily be observed or accommodated in a formal questionnaire' (Byrne 2004: 182). I felt that attitudes and values of the stakeholders in the decision-making arena would provide an important contribution to knowledge about the factors influencing the process. Sensitive issues can also be addressed more readily than in other approaches (Byrne 2004: 182), which might be of relevance where individual interviewees have concerns about the decision-making process, for example with regard to equity or transparency and the ability of certain groups or individuals to manipulate a group or a decision. The flexibility of the approach was also important: if participants seemed unwilling to discuss what might be seen as failings in the system or their organization, I could use a more sensitive way of broaching the subject or encouraging the interviewee into a more frank discussion.

Individual interviews can be done either by telephone or face-to-face. In telephone interviews there are 'fewer interviewer effects – that is the personal

characteristics of the researcher will be less obvious than in face-to-face situations and are therefore less obtrusive' (Bloch 2004: 167). (Such bias is discussed later, along with my approaches to minimising it.) It is much more difficult for a researcher to strike up any kind of rapport with a telephone interviewee. In face-to-face interviews, non-verbal reactions of interviewees can be observed and followed up, if appropriate. In addition, questions in telephone interviews must be kept simple and short enough for interviewees to understand, as there are no non-verbal clues and it is more difficult to ask for clarification. In face-to-face interviews, it is easier for the researcher to clarify any questions, not just those that the interviewee says are difficult or confusing but also those that the interviewee simply shows signs of finding confusing or difficult.

Interviewees are more likely to grant more time for face-to-face interviews than they might for a self-completed questionnaire, with participants less likely to give up part way through if they are being interviewed face-to-face (Bloch 2004: 165). In a telephone interview, also, an interviewee could simply get bored with the process and claim a reason for halting the call.

A major disadvantage of face-to-face interviews is the amount of time taken. Sometimes, this limits both the size of the project (the numbers interviewed) and the geographical area covered (Bloch 1994: 166). My research is set in the North East of England, so the geographical area is already limited partly

for reasons of organizational and political boundaries. Regarding the numbers of people interviewed, I shall discuss later how there were actually limited numbers of potential interviewees with knowledge and experience of the decision-making agenda. Therefore, the practical consideration of available time was not a major barrier to individual face-to-face interviews.

A potentially more damaging disadvantage of face-to-face interviews is distortion caused by the researcher's input. 'Such bias might emerge from the way in which questions were asked, or in the personal characteristics of the interviewer, or in interviewees' wish to give socially desirable responses' (Bloch 1994: 166). To a certain extent, the wish to give socially desirable responses appears unlikely in the context of this research. A parallel might be 'organizationally desirable responses' but the interviewees were led to understand that their views on the policy process included their comments and opinions on organizational roles and relationships, so that a degree of adverse comment would not be unexpected. The assurance of confidentiality and anonymity should also help with this. (I also had to make it clear that I was not actually inviting adverse criticism, to avoid bias in the direction of over-criticism). The effects of the 'personal characteristics of the interviewer' are more difficult for me to estimate. However, from past experience, and because I am not unknown to many of the interviewees, I was aware that often people felt able to comment fairly frankly to me on a range of issues. Avoiding bias from the way I actually asked questions is discussed later. Processes and

development of the discussion topics and questions themselves are discussed further in the following section.

Developing the discussion topics

As a guide to discussion in my first phase interviews, I developed outline interview schedules. Whilst an unstructured approach (with a list of prompts or topics to focus the interview) might have allowed a more wide-ranging discussion, I felt that a semi-structured approach would enable the collection of views on specific topics, on which the ideas of all participants were needed. Closed questions were generally inappropriate because of the limits they place on interviewees' answers, whereas open questions allow clarification of any ambiguity as well as the chance to follow the interviewees' thoughts in other directions, perhaps towards new avenues of exploration.

Appendix 5 contains the interview schedule for the first phase interviews. As only a few interviews were planned for this phase, and they were intended to be formative as well as fact-gathering (almost a type of pilot in themselves), I decided not to carry out a pilot for them. My first questions required relatively factual, straightforward answers (to ease the interviewee into the interview), including asking interviewees to describe the roles they and their organizations held. In general, less demanding questions were raised first, with a gradual exploration of views on 'relationship' and the reasons behind healthy policy development. I tried to minimise ambiguity or confusion,

avoiding lengthy, awkward questions and being prepared to state any questions in a different way if needed. I also avoided leading questions, which would indicate to the interviewee that a certain response might be expected.

Even with care taken over the order of the questions, and efforts made not to influence the interviewees, I recognized that there might have been bias imposed by referring directly to ‘health impact’, putting in people’s minds the phrase ‘health impact assessment’ (possibly a bit of a buzz-word at the time of the interviews) as a first thought of ways in which issues of health impact are addressed. However, asking a very broad question about addressing health impact without using the term could have confused or resulted in an indeterminate answer.

The first phase interviews (between March and August 2004) informed my choice of discussion topics for the second phase interviews. Given the importance of people, power and joint working in the literature, it was not surprising that these elements had engendered much discussion in the interviews. I therefore considered that this aspect was well worth pursuing, looking for differences between policy areas. The question of how to ensure that health was considered in policy development elicited different views, suggesting that this too was an area warranting investigation. Other discussion topics for the second phase were more relevant to the specific policy areas, for example: the opinions of the interviewees on the main drivers

for a policy area; the context of the issue; the nature of the issue; and factors connected with feasibility or implementation. The intention with these questions was to allow comparison against existing models of agenda analysis and between different policy areas.

For the second phase interviews, I developed an initial interview schedule for a semi-structured interview. I piloted this with three interviewees and, in the light of their responses and recognition of any awkward questions (confusing or apparently repetitious), the schedule was amended to become the final schedule, as shown in Appendix 6. The choice of interviewees is explained in the following section.

Identifying and accessing participants

In identifying the appropriate people to interview, my main consideration was the extent of knowledge of potential participants about general policy development in the first phase and specific policy development in the second.

> Researchers should ensure, as far as possible, that interviewees have the necessary knowledge about the subject of questions in order to answer them It cannot be assumed that interviewees will voluntarily admit a lack of knowledge. (Bloch 2004: 172)

For the first phase interviews, I considered the relevant organizations before identifying individual interviewees. There are relatively few organizations recognized as key to the public policy-making and decision-making process at a regional level. This obviated the need to choose a representative sample of

organizations: instead, views from all of the main organizations were sought. I hoped that representatives from each agency could be interviewed and, in fact, all of the agencies were happy to be involved.

Potential interviewees were generally identified as being those individuals who held the health brief for their organizations and usually attended as representatives when some kind of health input was requested from the organization. I had some concerns about the use of these 'usual suspects' as interviewees. It was to be expected that these people already had an interest in health, so might be both much more aware of health-related issues and much more involved in pushing the health message in policy-making than other representatives from the non-health organizations might be. So there might be some elements of bias from them. I recognized, however, that these individuals would probably be the ones most able to inform about the influence of health concerns in policy-making. They all held senior positions and would be expected to attend meetings *on behalf of* their organizations. I hoped also that the interviewees would raise any issues they had about their actual influence. Additionally, the first set of interviews was a scoping exercise, intended to lead to other avenues of exploration around the healthy policy area, so these interviewees could very well be a suitable route into that.

In total for the first phase, I interviewed ten individuals, some of whom held more than one role. The range of responsibilities of GONE led me to interview

three of its directors and one deputy, rather than just one representative. Two interviewees represented Public Health Group North East, two the Public Health Observatory, two the Health Development Agency, one the academic sector, one the Regional Housing Group (part of a dual role, as my decision to focus on housing amongst other policy areas had not yet been taken), one the Regional Assembly, one the UKPHA and one the Regional Development Agency. (The number of representatives mentioned exceeds the actual number of interviewees because of the dual roles held by several.)

For the second phase interviews, I wanted to consider specific policy areas, so the number of organizations that I wanted to involve was larger than for the first phase. Again, the three major regional decision-making bodies (GONE, ONE and the Regional Assembly) would be essential, along with ANEC, the academic sector, the Health Development Agency and the UKPHA. For tobacco control, the relevant regional organization was the Regional Tobacco Office. The Regional Housing Board, for which an interviewee had been interviewed for the first phase by dint of holding another role, now became an essential organization for discussion of housing policy, as it held the primary responsibility for regional housing policy and strategy. Climate change, at the time without a regional policy or specific lead, was to be considered in interviews with the Regional Assembly, which had a major role in the Sustaine collaboration and was planning to host a specific leading officer for climate change at this stage of my research. (This officer came into post and able to

be an interviewee during the time I was carrying out my interviews.) To assess worklessness policy development, organizations I wished to consult included the Trades Union Congress, the Department for Work and Pensions and the Chamber of Commerce. There were other organizations with a broad remit, whose work could well encompass one or more of my chosen policy areas, including, particularly, the voluntary sector. The list of useful organizations grew as I started interviewing (see later comment on 'snowballing'). The final list of organizations represented by interviewees appears in Appendix 7, which also notes the policy areas with which the interviewees had been involved and on which they offered comment. In the second phase, there were 18 interviews on tobacco control, 21 on housing, 21 on worklessness and 22 on climate change. Most of the interviewees from phase 1 also participated in phase 2.

Boundary differences were rather problematic. Government Office for the North East, the North East Assembly, One NorthEast and the Association of North East Councils covered the same geographical areas but the voluntary sector, local authorities, housing authorities and trade unions had different areas of coverage. Northumberland and County Durham, at the time of the research, also had both county councils and district councils, with separate responsibilities at the different levels, unlike the other counties in the region, which had single tier local authorities.

There has been much change in the past few years, with new and altered organizations having to come to terms with new roles and develop different sets of relationships. Most of those interviewed (in both phases of interviews) had been 'on the scene' for a long time, in various roles in different organizations, and had long been involved in health issues at a regional political decision-making or decision-influencing level. Long-standing relationships between those who have been involved for a long time might influence both how things were viewed and how things got done (or did not get done). This aspect did emerge to a certain extent in the first phase interviews and it would certainly affect the generalizability of any conclusions. The relatively small number of individuals forming this group might be a unique factor in the development of policy in the North East of England, which again might affect the generalizability of findings. At the time of the first phase interviews, there was also uncertainty over the future of the organizations involved, particularly as it was not known whether there was going be an elected regional assembly. If there was, very new ways of working together might have been needed and a lot of effort and resources would be devoted by all of the existing organizations to identifying the best way forward. Prior to the referendum, organizations and potential interviewees certainly had these issues in mind. If interviewees' personal influences were affecting the decision-making process, there would be the possibility of great change with new key personnel arriving. This could have affected the continuity and choice of interviewees for the second phase interviews. As the interviewees had

generally been involved in health policy for a long time, it was likely that many would still be in post to be interviewed in the second phase of this project but it was also possible that some would become redundant.

Many potential interviewees in both phases of interviews were already known to my supervisory team or to me, both from my time as a senior policy manager at the Regional Health Authority/NHS Executive Northern and Yorkshire and from my involvement as an independent consultant in several region-wide policy analyses. I had to consider whether this would bias the results in any way, perhaps with interviewees being reluctant to be too open with a colleague. I was not exactly an 'outsider'. However, as an independent consultant, neither was I an 'insider'. Biggam asks the question: 'how can the researcher maintain objectivity when he interviews colleagues in an environment wherein he works?' (2008: 123). My position is rather different from this, in that I occasionally work with some of the interviewees now but generally on specific projects rather than in an everyday work situation. However, I did aim for objectivity and tried to ensure that discussion topics were introduced in similar, non-biased ways to each interviewee. I also guaranteed confidentiality and anonymity (as described in the later section on ethical considerations).

Although the 'upper echelons' of corporations and large government agencies are 'notoriously difficult to infiltrate' (Taylor and Bogdan 1998: 29), all of those

invited to be interviewees in the first phase accepted. In the second phase many of the highest level invitees accepted and those that felt they were not the most appropriate people suggested other informants, supporting me to access those people. This might have been partly because of the subject matter: unlike research into services, where directors might be wary of criticisms being raised, the topic of policy-making might have appeared less controversial. Interviewees appeared to appreciate the opportunity to express their views. Willingness to be interviewed might also have been promoted in part because of the prestige or professional recognition of my supervisory team.

The recommending of other informants happened not just with people who felt inappropriate for interview themselves but also with people who were interviewed and who felt there were others whose views would be valuable. A potential drawback of this snowballing approach is that it can 'limit the diversity of your informants' (Taylor and Bogdan 1998: 93). I aimed to overcome this possibility by using a wide range of contacts to identify other potential informants, including contacts known to my supervisory team and myself and contacts suggested in organizational websites.

My supervisory team discussed potential informants with me and agreed my choice of interviewees. Whenever people are interviewed in a research project, there are ethical issues to consider. In the following section, I describe

how I took account of these issues and approached the research in an ethical fashion.

Ethical considerations

Even though my interviewees were not patients of the health service or members of vulnerable groups, but professionals dealing with healthy policy, it was necessary to consider the ethical questions around interviewing them. The chair of the university ethics committee suggested that undergoing the full ethics approval process was not necessary for this work but I still wanted to ensure that I carried out the research in an ethical manner.

Informed consent should be obtained for any research involving interviews. Interviewees had been informed about the general aim of the research prior to arranging interview but at the beginning of the interviews, I again outlined my role and the focus of the research and explained about confidentiality being assured. Interviewees confirmed that they understood what it was all about and that they were happy for notes to be taken (on paper in the first phase but tape recordings and written notes in the second phase, as discussed later in the ‘data recording’ section). I made it clear that the interviewee could stop the interview at any time. Only when it was clear that the interviewee was informed and in agreement with proceeding, did I begin to ask the questions and guide the discussion. As my group of interviewees comprised senior professionals in leading major organizations, I had fewer concerns about their

understanding than I would have had if I were interviewing members of the public, particularly vulnerable groups. However, I still made sure that they were aware of the purposes of the research and how it was to be used.

Privacy, confidentiality and data protection are linked concerns that need careful management so that no harm is done to participants. For the first set of interviews, I only took notes on paper rather than on tape. This was because I was aware from previous work that several professionals are reluctant to have what they actually say recorded on tape if they are offering personal views and insights into their jobs, their organizations and the processes and systems within which they work. I did ask some of the potential interviewees and it was confirmed that they would be reluctant to be taped. One participant had mentioned a previous uncomfortable experience – walking past a room in a different office building and hearing a recorded (and supposedly confidential) interview in which they had taken part being played back loudly enough for people in the corridor and neighbouring rooms to hear clearly and recognize the interviewee's voice. It has been recognized that tape recording can increase refusal rates or lead to 'sanitization of expressed views of participants for fear of reprisals arising from disclosure of the interview to others' (Polgar and Thomas1995: 140). I did record the second set of interviews on tape, having asked for and obtained permission first in every case (see later section on data recording).

For both sets of interviews, I assured interviewees that I would be the only person to see my written notes or hear the tapes and that in my writing up of the research I would ensure that no contribution would be attributed to a particular individual. This assurance of confidentiality was necessary to allow people to present honest opinions about the policy process. I took steps also to keep interviewees' names separately from my records of their interviews, using reference numbers instead. All interview notes and tapes are stored (with numbers rather than names) in a locked cabinet in my house, accessible only to me. (An added protective element is that my handwriting is barely legible to anyone else, anyway!) I wrote up all notes and transcribed tapes myself. My computerised records are also accessible only to me.

To avoid identifiable attribution, I also divided my interviewees into categories and, where quoting from an interview, attributed the quote only to the category. I used five categories, as shown in Table 3, taking the most relevant role of the interviewee when the individual held more than one role.

Table 3: categories of interviewee

Category	Components	Number of interviewees
Health sector	GONE Public Health Group and Health Development Agency	9
Academic sector	University and Public Health Observatory	5
Non-health-group-1	Regional Assembly, Association of North East Councils, CSIP, Chamber of Commerce and One North East (Regional Development Agency)	8
Non-health-group-2	Job Centre Plus and GONE, apart from GONE Public Health Group	5
Non-statutory sector	Voluntary organizations and business/commercial sector, TUC	5

There are also ethical issues involved in data analysis, in particular when a researcher chooses to follow certain lines of analysis: 'choosing not to go down a particular route may have ethical implications: decisions made at this stage may "silence" certain voices and give undue prominence to others' (Ali and Kelly 2004: 124). My intention was always to avoid this type of bias and, indeed, because my aims included looking for similarities and differences between policies and views, I wanted to include all contributions and not to give prominence to any particular contributor.

I aimed to make clear to all interviewees the way I had considered these ethical issues. The explanations formed an important part of the way I arranged and carried out the interviews, as discussed in the following section.

Arranging and carrying out the interviews

The fact that most of the potential interviewees for the first phase interviews were known to me lent a degree of informality to the process of inviting people to be interviewed, so I sent invitations by e-mail rather than in more formal letters. Appendix 8 contains a sample e-mail invitation, which outlined briefly my position and reasons for contact and asked for suitable possible interview times. If contacts asked for more information about the amount of time needed, I suggested that an hour and a half to two hours would be preferred,

although if the contact could only afford an hour, perhaps follow-up discussions could later be arranged.

I confirmed suggested times and locations promptly. Anticipating that the schedules of the interviewees might lead to changes in the time and place, I kept available much more time than was needed for these interviews. Contacts had been asked for locations that would be convenient and comfortable for them. Many chose their own offices or meeting rooms within their own buildings (including coffee rooms in their own buildings when private offices were unavailable). One opted to visit me at my home and two (one of whom had recently retired from post and no longer had access to an office) invited me to their homes. Some interviews also took place in coffee bars, mainly for interviewees whose role involved travelling around the country without a specific office base. The privacy and confidentiality aspect of the interviews was discussed, particularly when more public locations were suggested, so that interviewees could offer alternatives if they felt they could in some way be compromised. Although none felt concerned about this, I made sure that the issue was discussed. The practical problems of recording the second phase interviews in a public place were considered but the interviewees' comfort and willingness to participate were of greater importance and I took my usual copious notes to back up recordings. Sound effects such as coffee machines, serving staff taking orders, other people talking and doors opening and closing were expected and interviewees could be asked to repeat

their answers or comments if necessary. The recordings of some of the interviews that took place in private houses were punctuated by noises from family pets, intent on not being ignored: the informality of the situation might even have lent a degree of shared experience that encouraged the interviewee to open up even further!

My preparation for the interviews involved collecting background information about the organizations and participant roles.

> If you do not know why the organization was set up or what they do, they in turn may not take your project seriously. (Bhatt 2004:422)

Yin also refers to the need to have a firm grasp of the issues being studied: reasons for this include the idea that if the interviewer does not understand the issues they might 'miss important clues' (2009: 71). To a certain extent, my involvement in the policy-making arena eased this task, as I had already some awareness of the basic roles and responsibilities of the organizations from my regional senior policy manager role. However, I collected information from relevant websites to ensure that my knowledge was current and accurate.

At the beginning of the interviews, I again outlined my role and the focus of the research and assured confidentiality. This was to ensure I had the informed consent of the interviewees, as discussed under 'ethical considerations'. I then asked questions about roles and responsibilities to clarify or expand the 'official' information, to put the interviewee at ease with relatively

straightforward questions and to lead to discussion about relationships between organizations in the decision-making process.

During interviews, I aimed to listen well. As Yin argues, there is more than just the spoken word: the good listener ‘captures the mood and affective components and understands the context from which the interviewer is perceiving the world’ (2009: 70). Remembering what the interviewee has previously said is valuable, enabling cross-referencing and showing that one has been listening. To some extent, my ongoing notes helped this, as I could occasionally glance down to refresh my memory about a particular phrase or comment. Listening also involves allowing the interviewee to talk. Even though my interviewees were all professionals used to focusing on a particular topic, there were some instances of straying from the topic, where I generally allowed free rein rather than trying to force the interviewee back onto my desired track. Paying attention was rather more difficult when interviewees had moved into irrelevant areas! In general, however, even moving away from the main intended focus could still provide interesting information and asides, even if not directly relevant to this study, so I did not find it too challenging to pay attention. Sometimes this could also give a real insight into which issues interviewees thought were important, so there was also the possibility that some material might suggest relevant factors not previously addressed.

Interviewing without bias is a skill mentioned by several writers. Yin warns against using a case study to 'substantiate a preconceived position' (2009: 72). I do not believe I had a preconceived position but still aimed to minimise the risk of this, taking care to note responses in the interviewee's words and not to ask leading questions (even when some very obvious non-verbal responses were showing). Bias from the way I actually asked the questions is not simple to address, although I made every effort to ensure that the phrasing and delivery of the questions did not show bias but allowed free and open discussion. This was tied in also with my being non-judgmental, part of which involves letting the interviewee know it is all right to reveal information. Some of the information revealed in interviews might be detrimental to the decision-making organizations, even quasi-heretical, so I had to be ready to reassure informants about acceptance of varied views, as well as reassuring them about confidentiality and anonymity.

Taylor and Bogdan feel that the researcher has sometimes to 'play dumb. . . . without being insulting' and to be 'sympathetic, but not patronizing' (1998: 101). These aspects were in my mind when carrying out the interviews. Playing dumb was hardly an issue, since the informants were being interviewed because of their levels of knowledge (considerably greater than my own). I wanted to test for common understanding of the key terms 'public health' and 'health impact' and to avoid making interviewees feel under pressure when I asked them about this, I explained that I was not trying to

question their knowledge but looking for shared understanding. Sympathy with interviewees was not necessarily a major need, although at times interviewees did express concerns about their own roles and futures with an organization. I hoped that I was sensitive to the interviewees' body language or tone of voice (recommended by Legard, Keegan and Ward (2003: 156)), as these do not always match the words being delivered. For example, an interviewee made an apparently matter of fact comment to the effect that joint working on policy development was going well, but there was a wry smile or slightly sarcastic tone accompanying the words, which led me to further questions. As I already knew many of the interviewees, there was probably already an element of rapport in some cases that could have helped interviewees to relax more.

Using open questions allowed whole discussion areas to be opened up on the basis of a response. At times, this led to further probing to clarify or expand interviewee responses. In some instances, I found that it was body language, rather than the words used, that suggested an area could be probed, where perhaps there was a degree of hesitation on the part of the interviewee in answering a particular question and it seemed the hesitation was because of slight nervousness about committing to a particular view, rather than the hesitation of memory-dredging. Memory-dredging was another reason for probing: when interviewees seemed vague about events or processes, probing sometimes helped to retrieve the memories.

At times, I noted that two or more of an interviewee's comments or answers did not immediately tie in with one another, so I used cross-checking questions to clarify what the interviewee intended. Such cross-checking can be needed to deal with exaggerations and distortions on the part of the informant (Taylor and Bogdan 1998:108), for example exaggeration of the importance of their role or their part in a particular success. Individuals might exaggerate the importance of their role in policy-making. Although it was sometimes possible to cross-check with the individual about this, I could also compare the stories told by others who had roles in the same policy-making arena, as well as any related documentation describing the policy development.

My taking of notes, already briefly mentioned in this section, was an important element of the recording of the interview data. The following section discusses in more detail the data recording and the data analysis processes.

Data recording and analysis

With the wealth of information likely to be obtained from the interviews, I was aware that I would need reliable ways of collecting the information and storing it in such a way that analysis would be facilitated.

Data recording

For the first set of interviews, I took notes only on paper rather than on tape, as discussed under ethical issues. Recording on tape is important for discourse analysis or for conversation analysis (Byrne 2004:191), but for this phase of the study, my intention was to collect some data (for example, on individual and organizational roles) and to generate further ideas for more specific research, so recording was not essential. Keeping interviewees comfortable at this stage might also make them happy about being involved in further interviews at a later stage.

An obvious disadvantage of not recording interviews was the need to rely on my ability to write quickly enough to cover the answers given (and legibly enough to read it back later!). There is also no possibility of listening again to the interview to check for correct recording. I intended to record in writing as much as possible the actual words used by the interviewee. Where particular phrases were used by the interviewee, I sometimes asked for repetition or clarification before transcribing, so that I could include direct quotations in my findings. Immediately after each interview, I reviewed my handwritten notes to ensure that they were both legible and as complete as possible, reflecting the interview content. Then I typed them up as soon as possible.

For the second set of interviews, it was more important to consider the language used by individuals (and any significant pauses that might, for

example, indicate a reluctance to criticise part of the decision-making process). Therefore, I recorded them on tape, having first obtained permission from interviewees. (The ethical aspects of this were discussed above.) Advantages of tape-recording over unstructured notes include the reduction of possible bias from the interviewer 'adjusting the information provided by the interviewee' (Polgar and Thomas1995:141). I made handwritten notes as well, reviewing them for legibility immediately after interviews, then transcribing them as soon as possible with the aid of the tapes.

Once the interviews had been transcribed, analysis could begin. An early part of this analysis is coding, ideally carried out soon after the fieldwork has been done. The coding and subsequent further analysis are described in the following section.

Coding, data management and analysis

Codes can be described as 'tags or labels for assigning units of meaning to the descriptive or inferential information compiled during a study' (Miles and Huberman 1994: 56). The coding process

> involves bringing together and analyzing all the data bearing on major themes, ideas, concepts, interpretations and propositions. What were initially general insights, vague ideas, and hunches are refined, expanded, or fully developed during this process. (Taylor and Bogdan 1998:150)

Soon after completion of the first phase interviews, I re-read my transcripts to refresh my memory and to allow the beginning of an assessment of the important themes emerging from the whole set of interviews. During the reading, I jotted down notes of the themes that appeared to be emerging then categorised these and created a more formal structure, against which codes were allocated to different sections of the texts on the next read through. These annotations on the texts allowed easy recognition of the responses related to the emerging themes, as well as identifying areas that appeared to be inadequately coded on the first run-through. It was an iterative process to allow me to build a themed discussion of topics.

The coding of the second set of interviews used a similar approach. On completion of the interviews and their transcription, I read through all of the notes to identify a preliminary set of themes (thematic analysis), then went through annotating the notes with appropriate coding, adjusting the main theme lists as necessary when more appropriate themes seemed to emerge. The list of thematic codes is shown in Appendix 9 and a sample annotated page is shown in Appendix 10. The coding process for the second phase interviews was necessarily longer and involved a larger number of iterations because of the number of interviews. I decided to adopt an approach for effectively managing or storing the themed data in such a way that each piece of data was still easily located within its context but it could also be very easily compared with related data from the same or different interviews. I used a

spreadsheet approach, to allow easy visual access to every piece of data, taking the basic idea for this data management approach from ‘Framework’, which is a

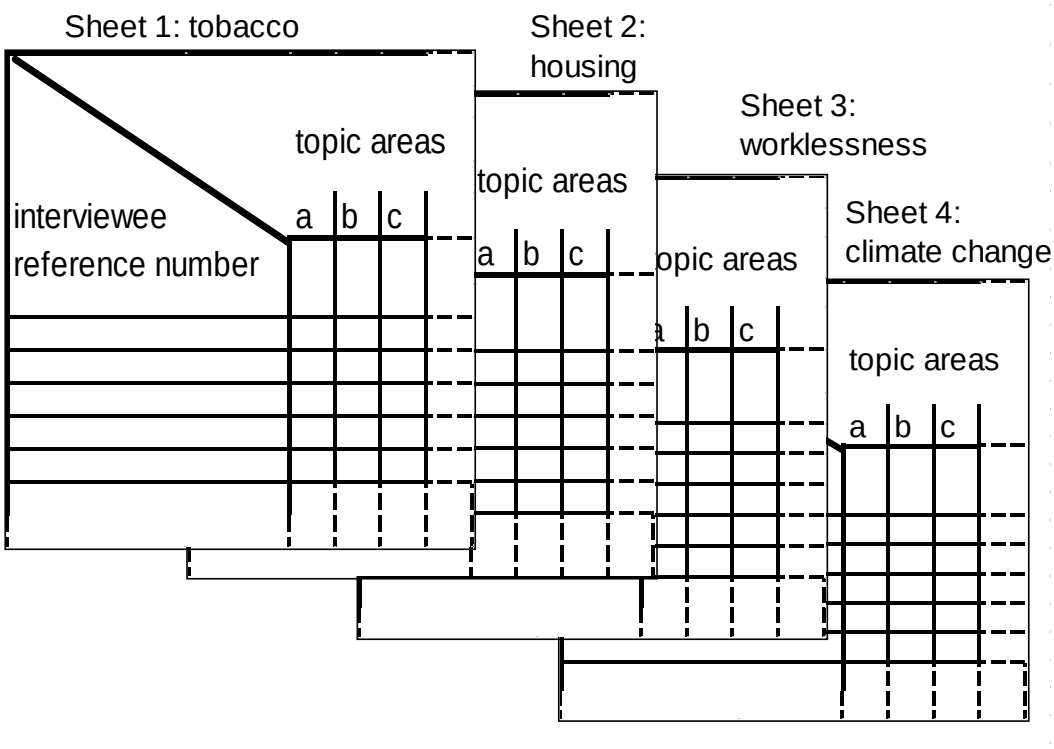
> matrix-based analytic method which facilitates rigorous and transparent data management such that all the stages involved in the ‘analytical hierarchy’ can be systematically conducted. (Ritchie, Spencer and O’Connor 2003: 220)

A key element of Framework (a term deriving from ‘thematic framework’, (*ibid.*: 220) is that each interviewee is allocated a row in the spreadsheet and each column represents a theme or concept. Use of a spreadsheet allows easy access to all the data, with the facility for searching for key words or phrases but still maintaining a view of how the data in any cell relate to the data in other cells. Although my approach was based very much on the Framework approach, I extended it to a multi-dimensional spreadsheet, which contained four sheets, each with an identical layout but each relating to the interviews for only one policy area, as illustrated in Figure 2.

Each line of the spreadsheet related to one interview by one interviewee on one policy area. Lines were allocated to every interviewee in each of the four sheets, even where that interviewee had not discussed that policy area. This was done in this way because several interviewees had taken part in interviews for more than one of the policy areas and this layout meant that their responses, thematically coded for each policy area, would sit in the same reference cell in each sheet. Likewise, column headings in each sheet were

identical, even if for any particular policy area there were no responses coded in a particular theme or category.

Figure 2: layout of overall spreadsheet



Because the coding often allocated more than one code to the same piece of data in an interview, some pieces of data appeared in more than one cell. The intention here was not to allow any data to be 'lost' by being categorised in only one way. If later perusal suggested some data would be usefully included in a different place, copying and moving cells was easily accomplished. To maintain awareness of where interviewees mentioned certain factors in association with other factors, annotations included references across to other cells.

As well as relying on interviews for information, I was collecting documents relating to interviewee organizations and to my chosen policy areas. The following section describes my approach to documentary analysis.

Documentary analysis

Stakeholder interviews were expected to provide much information, possibly in a highly subjective way. Although discussions with a wide range of informants would be likely to create a more balanced picture (part of the triangulation process mentioned above), the incorporation of documentary analysis into the study should provide an even greater understanding of the context and the policy developmental processes. The use of the formal documents, such as agendas and minutes of meetings, should also help in identifying how high on the agenda a particular policy area is. (For example, a policy area for which the imminent production of a regional strategy is on the agenda is likely to occupy a higher agenda position than a policy area for which a new regional group has just been established.) Appendix 11 contains a list of all the regional documents considered. Although most of the documentation was for regional policy, I also collected data on national legislation from government sites and information from certain pressure groups (for instance Greenpeace and Friends of the Earth for commentary on climate change policy).

There were effectively six phases to the collection of relevant regional organizational documents. The first phase, part of the pre-interview process

for both the first and second phase interviews, involved looking at information on organizational websites to give an understanding of the roles of the organizations and their stated responsibilities. This was partly to aid the interview process, as discussed in the section on administration of the interviews, suggesting to the interviewees that I was armed with relevant background information against which to carry out the interview in an informed manner. The second phase was part of the interview process: interviewees were asked to provide or recommend any relevant documentation that would shed light on the decision-making process.

The third, fourth and fifth phases were related to the four chosen specific policy areas (the choice of which is described in the following section). Phase 3 was an exploration of the publicly accessible websites of the organizations named above, searching for agendas and minutes of their Executive bodies' meetings. In general, only relatively recent agendas and minutes appeared on these websites so, in the fourth phase, requests were sent under the Freedom of Information Act (2000) for agendas for the same groups for preceding years. These were then trawled for agenda items of relevance to my four specific policy areas and further Freedom of Information requests were sent (the fifth phase of documentary evidence collection), asking for relevant related information. Along with the agendas, certain organizations (notably the Regional Assembly) had been producing regular newsletters outlining progress and activities of the organization. There were newsletters for public

dissemination and newsletters for informing the members of the Assembly about proceedings. I expected the two sets of newsletters to have different focuses and to provide information about the context of policies. Some issues focused on specific policy areas, adding to my information on the importance of the topic on the agenda at particular times. Accessing documents relating to the North East Assembly proved interesting. Some documents, referenced in minutes or reports, were found to be missing from the Assembly's archives, not a totally unexpected situation. However, the most awkward aspect was that just after I began requesting items, the abolition of the regional assemblies was announced. Not all archived material in the Assembly was transferred to a new home, although the major documents were moved in spring 2009 to the care of One NorthEast.

The remaining phase of document collection, running in parallel throughout the project, was the collection of completed policies and strategies particularly related to the chosen policy areas. This was to confirm the methods of development (as policy documents usually contain at least a brief history of their development), to ensure that relevant partners had been consulted (documents contain lists of stakeholders involved in the development) and to assess whether there was evidence that health improvement had been specifically considered.

In analysing the documents, my approach was very much related to the way I had analysed the interviews. I searched the documents for content relevant to the headings already identified in my spreadsheet. I intended to add further headings if the documents contained material not reflected in the interviews, but this proved unnecessary.

Collection and analysis of documents allowed a more comprehensive picture to be built up of the historical context and of the decisions actually taken and the stated rationale for them. I expected to find gaps in the information provided by interviewees (either through occasional absence or through variation in memories, especially when referring to events some time ago). The documents should show the 'official' version of events, which might differ from the version provided by interviewees (again possibly because of memory). This should help to illuminate the decision-making process and identify areas where there had been conflict or an overriding organization or individual. I recognized that the documents themselves might not be free from bias, as they were written from certain perspectives and with the aim of informing or being used by specific organizations. Indeed, Taylor and Bogdan recommend examining documents 'not as objective data, but rather to lend insight into organizational processes as well as to alert the researcher to fruitful lines of inquiry' (1998: 81). They also suggest that 'materials that are thought to be useless by those looking for objective facts are valuable to the qualitative researcher precisely because of their subjective nature' (Taylor and

Bogdan 1998:130). It is not certain to what extent the subjectivity distorts any reality, since (from my own experience) government and other statutory groups and many multi-agency groups circulate minutes of meetings to those who attended to allow them to comment or amend before they become the 'official' minutes. However (again from my personal experience), frequently few responses are obtained to the request for amendment of draft minutes, so subjectivity must be considered in analysing such documents.

Documentary analysis contributed to the assessment of policy area progress and to the identification of factors enhancing or impeding policy development in my selected policy areas. The choice of those policy areas is described next.

Choosing specific policy areas and assessing progress on the agenda

To identify the factors most influencing the progress of a healthy policy area on the regional agenda, comparison between different policy areas was needed. With a large number of policy areas being addressed or potentially addressed at the regional decision-making level, the scope of this research could be very large, if all were to be investigated. To restrict the scope and to allow a comparison between a realistically manageable set of policy areas, I decided to carry out a series of case studies or detailed investigations of specific examples. Although case studies by their nature will give a limited

view of the overall picture, they can still enable the researcher to glean much helpful information.

The case study approach is sometimes criticised for lack of generalizability. My use of several case studies for comparison, along with the multiple sources of evidence for each, should help to reduce this problem. Bias can also be an issue for case studies. Yin comments that 'too many times, the case study investigator … has allowed equivocal evidence or biased views to influence the direction of the findings and the conclusions' (2009: 14). I aimed to reduce the likelihood of bias in my case studies by my use of multiple sources of information (a range of interviewees and a range of documentation) to reduce the likelihood of any one source of information dominating the findings and conclusions.

With multiple-case studies, 'the evidence is often considered more compelling, and the overall study is therefore regarded as being more robust' (Yin 2009*:* 53). The need for the separate case studies to be comparable is brought out by Yin (2009: 53). Both the way the interviews were carried out and the types of documents obtained and studied were comparable in several ways. Firstly, the same semi-structured interview schedules were used for each topic. Although the discussion was allowed to roam freely, I aimed in all cases to gain information on specific areas and topics. There was the additional factor that some of the interviewees were questioned about two or more of the policy

areas, perhaps because of their positions as overseers of their organization's general policy development or perhaps because of organizational or personal involvement in more than one of the policy areas. Because of the specialised nature of the policy areas, there were also some individuals who were interviewed only on one specific policy area. In those cases, I relied on the degree of consistency provided by use of the same semi-structured interview schedule. Similarly, with documentary evidence, there were some pieces of documentation that would be expected to deal only with a single policy area from a specific single source but many documents (for instance North East Assembly agendas, minutes and newsletters) would be expected to refer to more than one policy area. Even single policy issues tended to be addressed by multi-agency groups, thus lessening the variation between types and content of documents.

The choice of policy areas was made following the first set of stakeholder interviews and was informed by those interviews, as well as by my own knowledge and that of my supervisory team. Careful consideration was given to the selection. I accepted that, because of the sheer range and number of possible policy areas, there was no likelihood of choosing a representative sample. Instead, it seemed that a useful approach might be to consider policy areas that were in some way already known (or suspected) to be very different from one another. Several possibilities presented themselves, some related to policy areas in general, others to policies themselves.

With regard to policy areas, some might be very much in the public eye, so that any policy moves attract attention. Some might be of greater importance than others at a regional (as opposed to a national) level. There might also be specific issues affecting healthy policy development at that level of government, which is heavily influenced from two directions: from above in the form of national government and from below, in the form of much more public accountability at a local level. Some policy areas might appear to be extremely complex, in terms of either problem identification or solution identification. Others might be highly controversial, in terms of evidence available or not available or open to interpretation.

With regard to policies themselves, those for some policy areas might or might not include health or health improvement as an objective. Some might be broadly acceptable (achieved through consensus) or very controversial. Some regional policies might have already been developed and acted upon or the policy area might appear fairly low on the decision-making agenda.

The possibilities for selection of diverse policy settings therefore seemed promising. There are many factors recognized as the wider determinants of health, including education, economic status, housing, employment situation and environmental factors. I considered a wide range of these policy areas with regard to the differences outlined above, to try to determine which might

provide useful contrasts for the study. I considered firstly policies that already existed at a regional level within the North East. Appendix 12 lists the regional policies that existed or were under consultation at the time I was making my choice of policy area. It also includes comments on whether health improvement or inequalities is an objective of the policy and whether the policy appears controversial.

The Regional Economic Strategy and the Regional Spatial Strategy (along with the unifying Integrated Regional Framework) were very wide-reaching, encompassing many of the aspects of other policies (for example housing was incorporated into them). They also addressed, at least in part, many wider determinants of health and other issues with a less directly measurable effect on health. Their aims were thus very broad and, if the nature or characteristics of the issue addressed were to prove a driving factor in a policy's development, then analysis of these overarching policies would be unlikely to yield any differentiating information.

I decided against using some of the policies as case studies because their focuses were much less on areas generally recognized as being major wider determinants of health. These included the Regional Information Technology and Communications Strategy and the Regional Image Strategy. Most of the other policies listed were designed without health improvement as their major specific objective, although some (for example, the regional tobacco control

strategy and the teenage pregnancy strategy) were developed with the health sector as the lead and health improvement as the main aim. Several of the others were led by multi-agency collaborations and some had leads such as the Regional Assembly, ONE or GONE. It seemed sensible to use as one case study a specifically health-sector led policy. From my previous role as regional tobacco control lead, I was aware that tobacco control, whilst health-driven, was very much in need of a multi-agency approach, so it seemed to present good opportunities for assessment of the relationships between the organizations involved.

The tobacco strategy is also an example of a policy developed largely by consensus. Most surveys, at the time this research began, were finding that the majority of people were in favour of a smoking ban in public places and that most smokers wanted to stop smoking. The strategy would also benefit many organizations, including the Department of Health (in terms of the health of both smokers and non-smokers), HM Revenue and Customs (in terms of smuggled tobacco and lost revenue), Trading Standards departments (sales to under-age clients), and employers (in connection with both days lost to sickness and hours lost in smoking breaks). The main opposition was the tobacco trade. In contrast, there were major conflicts around housing policies, with a demolish-and-rebuild approach potentially benefiting the house-building trades but causing difficulties with rehousing for councils, and concerns over community development in the health and social sectors. Housing policy,

therefore, offered a contrast with tobacco policy that might help in the identification of important driving factors. One important similarity between housing and tobacco was that the regional policies were well established.

Certain policy areas attract a lot of public attention. Tobacco was (and is) a policy area very much in the public eye, with publicity surrounding many aspects, for example lung cancer, smuggling or the effects of second-hand smoke. Housing policy, although housing itself concerns everyone very directly, appeared to attract less media attention, except for some instances of locally specific housing developments or problems. Economic policy, certainly at a national level, tends to receive publicity and criticism and it might be that many policy areas, such as housing, are well covered because they are an integral part of economic policy. Worklessness received relatively little publicity, apart from around factory closures or unemployment figures, but I chose it less for that reason than for its perceived position on the policy development ladder. Having chosen housing and tobacco from the list of existing policies, I wanted to find policy areas not yet translated into regional policy that might also offer useful insight into the policy development process. Within the region, there were many local initiatives around worklessness and health. Employment and skills were mentioned or addressed in the Regional Economic Strategy and the North East Framework for Employment and Skills Action, where the focus was largely economic but there was not yet a regional strategy on worklessness. I was aware from work I had done with local health

and worklessness groups that this was another area where there was great need for multi-agency working and that larger-scale strategies were to be developed.

Given my intention to consider the regional policy-making level, I wanted to select some policy areas where the regional dimension seemed particularly important and some where the regional dimension was perhaps not significantly different from a national focus. For example, climate change policy would tend to be similar across most regions, partly because of the way effects are limited by surrounding regions, countries or continents. Tobacco could be regarded as a fairly non-regional specific area: although the North East regional smoking rates were higher than much of England, the issues arising were very much the same as in the rest of the country. Actions required might differ to some extent (for instance, tackling smuggling might be more important than in an area with few ports) but the overall tenor of a policy would be similar to that of most regional or national policies. Housing could be seen as needing quite a region-specific policy, as the region's housing problems are not the same as other regions: the main issue for the South East, for example, is a shortage of housing, whereas in the North East, there are problems with quality and suitability of housing rather than quantity. Worklessness is potentially much more of a regional issue, as patterns of employment within the region differ from other regions, with a strong history of skilled and unskilled labour in a few large industries (and recently in call

centres), a heavy reliance on public sector employment and high levels of unemployment, with associated unemployment benefits and sickness benefits.

As a final case study policy area, I wanted to consider a problem area where the problem itself or solutions to it would be very difficult to define. For tobacco, housing and worklessness, problems and potential solutions can be relatively straightforward to define or identify (although, of course, this is not to say that solutions can be easily implemented). I considered the problems that were frequently in the media at the time. One area, increasingly in the public eye, was that of climate change, with environmental issues frequently mentioned on news items. Therefore, at the time of choosing my policy areas, climate change was becoming a very important public issue. Although there were moves towards considering some of its repercussions in, for example, the sustainability agenda, a regional climate change strategy was not yet under development. There was much argument, mainly nationally or internationally, about the extent to which human activity was altering the climate and damaging the world, so even the problem definition was not straightforward and many did not accept that there was a problem. There were major disagreements over the extent to which people could or should change this activity and in what ways. There were also many references to this being a global rather than a local issue, so it would need addressing on a global rather than a local scale. Climate change, as a policy area, certainly showed promise as a major challenge, with the possibility of very different factors

affecting policy development compared to tobacco, housing and worklessness.

Some description of progress on the agenda must be made to allow comparison between areas, to allow an assessment of the relative strengths of the factors affecting policy development. Kingdon (1984) used his interviews with relevant stakeholders, asking which policy areas currently occupied them the most, then assessing prominence on the agenda from this. Whilst I also planned to obtain stakeholder views, my intention was to compare specific, pre-identified policy areas, so Kingdon's approach was not appropriate for this element.

Baumgartner and Jones made use of media indicators 'to note the degree to which an issue is on the broad public agenda' (1993: 49). They focused on publicly available records, in particular media coverage of policy debates. However, as they pointed out, 'Kingdon noted that media coverage and congressional hearings often did not correspond to those issues that his informants within the Washington community described as high on the governmental agenda' (*ibid*.). I was concerned more with the actual policy agenda, not just the public agenda, although I intended to note the opinion or role of the public and the media to a certain extent. Soroka tried to assess issue prominence by using a mixture of newspapers, public opinion polls, Question Period, committees, Throne speeches and legislation in Canada

(Soroka 2002b: 272). The disadvantage of the methods used by those writers is the very specific nature of policy-making in different countries. Baumgartner, Green-Pedersen and Jones recognized that the very USA-specific congressional hearings analysis was inappropriate for other countries when trying to assess which indicators of government activity are important (2006: 970). Expanding their work on 'policy dynamics', the tracing of attention to and government action on particular policies over long periods of time, they suggested that media coverage was certainly important but that legislation could be an indicator in most countries, and there might be potential to use budgetary information too (*ibid.:* 970*).* They felt that policy dynamics could be used for comparison of several issues, commenting that much agenda literature concentrated only on single issues (*ibid.:* 963).

There appeared to be potential for me to use the idea of legislation as an indicator. A very simplistic policy dynamics approach would be to assume that a policy area had reached the highest point at a regional level if a defined regional policy or strategy for it existed. This could be the English regional equivalent of legislation. Using this idea, a simplified pathway might be used to track progress to that point, perhaps from the widespread recognition of the policy area's importance, via the formation of a regional group tasked with addressing it and the initiation of a consultation. All of these might be aspects that helped to define a position on the agenda, its prominence in the eyes of the agenda controllers.

I discussed my ideas on appropriate policy areas with my supervisory team and agreed with them the four areas. Whatever the policy areas chosen, and however their position on the agenda is assessed, there are methodological issues to consider in their use as case studies. Some of these have been mentioned previously. Others of importance are validity and reliability, discussed in the following section.

Validity and reliability

The goal of reliability is to 'minimize the errors and biases in a study' in such a way that if the same case study were to be repeated, the 'later investigator should arrive at the same findings and conclusions' (Yin 2009:45). Some aspects of minimizing errors and biases have already been discussed above. Inevitably, interview timing can cause a problem when personal opinions are sought: both the stage of the professionals' careers and the state of the policy area will affect the way the interviewees answer. Memories can be flawed and opinions can change over the course of time. My use of triangulation, with documentary evidence and many interviewees, should have helped to minimise this problem. I believe that the way I have set out the spreadsheet of data also adds to the reliability, in that it leaves the data readily accessible in its raw format, without the loss or over-emphasis of any part of it. Representativeness is also a part of reliability. I have discussed previously my approach to choosing interviewees, where I wanted to be on my 'guard against producing a restricted sample' (as recommended by Devine (2002:

205)). I therefore identified interviewees through a variety of sources, including my personal knowledge and that of my supervisory team, a study of the organizational information on organizations' websites and a snowballing approach, using recommendations of other interviewees.

Both internal and external validity need to be considered. My approaches to providing internal validity, the 'validity of causal inference' (Rudestam and Newton 2001: 98), included the use of multiple sources of data (documentary evidence and multiple interviewees) and ensuring that during interviews I clarified what the interviewees meant, sometimes cross-checking with further questions. I also drew comparisons with existing explanatory models of policy-building.

External validity, relating to the generalizability of the study's findings, is more problematic to assess. There are different dimensions of external validity that can be considered, including both the geographic context of the study and the restricted set of policy areas considered (thinking of my chosen policy areas as a sample from the population of all policy areas). Firstly, considering the geographic limitations, the North East region might have characteristics that make it different from other regions in England. Where such characteristics are believed to exist, mention is made of them in the chapters on findings. It is arguable whether these characteristics actually affect the extent to which findings on policy development can be generalized to other regions: for

example, if the North East is felt to be more insular, with a smaller range of decision-makers than other regions, does this necessarily mean that findings around the need for joint working on policies cannot apply elsewhere? I have tried to address such issues in the discussion section. The use of four different case studies (policy areas) should also help to increase external validity: the regional setting, in which all four policies are made, remains relatively stable across all four, so that the similarities and differences between the policy areas should not be dependent on the setting. This use of four different policy areas also helps to address the problem of the external validity relating to other policy areas: because I used four very different policy areas, there should be less concern that my findings are applicable only to policy areas that are very similar to one another.

It is not only with interviews that issues of validity and reliability arise. Documents are also subject to bias. (Who wrote them and who approved them? How long after an event or meeting were they written? Who was the audience for them? What political pressures surrounded their emergence?) Again, one way in which I hoped to minimise this problem was by the use of multiple data sources, both other documents and interviews. Regarding comparison with other documents, for example, I used both minutes of meetings and reports produced for specific audiences by (sometimes) different organizations. The minutes would perhaps reflect the decision-

making processes and the reports, particularly those produced for the public, might reflect the political needs of the time as well as the decisions taken.

Conclusion to Chapter 4

This chapter has identified the approaches I took to ensure that I was using appropriate methods for each element of my study, in order to address each of my research questions. I have also described the ways I dealt with the possible methodological problems that I could expect to encounter along the way. As I carried out the fieldwork, I aimed always to anticipate and address such problems so that my findings would be reliable and valid. My findings, using my chosen approaches, are described in the following three chapters.

Chapter 5: findings 1 – Who moves a healthy policy area up the regional decision-making agenda?

This chapter describes my findings related to the people and organizations responsible for moving policy areas onto and up the regional decision-making agenda. I should like first to comment on the interpretation of the term 'policy'. There are complications at a regional level: sometimes policy is initially designed at national level and then devolved for either further development or adaptation and implementation at the regional level. To a certain extent, the terms 'policy' and 'strategy' appear interchangeable at a regional level, as the regional level often includes more in the way of practical issues of implementation than the national level. The definition of 'policy' used by Ritsatakis *et al*. is 'an agreement or consensus on the issues, goals and objectives to be addressed, the priorities among those objectives and the main directions for achieving them', whilst the definition they use of 'strategy' is 'broad lines of action to achieve the goals and targets' (2000: 3). Regional policies or strategies appear to encompass both of these. During my interviews, I noted particular issues around interpretation of the term 'policy' with regard to the four specific policy areas and these are mentioned in appropriate sections. With regard to general policy development, the term appeared less open to different interpretation, with focus being more on development of policy areas.

The findings come from both my documentary analysis and the interviews I carried out with key stakeholders. Interview findings on general policy are mainly from the initial (first phase) set of interviews with a limited number of interviewees. Those interviews explored North East general policy development and helped to indicate potential areas for further exploration (as described in the methods chapter). Interview findings on the four specific topic areas (tobacco control, housing, worklessness and climate change) are mainly from the topic-specific interviews carried out with larger numbers of interviewees (key players across the three main organizations and other relevant organizations contributing directly to the specific policy areas). In those interviews, I delved more deeply into specific policy development. Inevitably, there was some crossover: first phase interviewees made reference to specific policies and interviewees in the second phase referred to general policy as well as their specific topic. The second phase pilot interviews took place in the summer of 2006 and the bulk of the main second phase interviews happened between November 2006 and April 2007, with the final one in July 2007. The numbers of interviews are shown in Table 4.

To remove the possibility of interviewee identification amongst the interviewees in the first phase (general policy) interviews, I have not attributed quotes from those interviews to interviewee groups. When using quotes from the interviews on *specific* policy topics, I have generally attributed them to the relevant interviewee group, with one exception: to avoid identification of the

one non-health-group-2 interviewee on tobacco control policy, the non-health groups were merged when attributing quotes on tobacco control policy.

Table 4: policy development interviewees

Interviewee category descriptor	Category definition	Number of interviews				
		General policy	Tobacco control	Housing	Worklessness	Climate change
Health sector	Health sector (statutory health bodies, including Public Health Group based in Government Office)	2	6	6	6	4
Academic sector	Academic sector	2	2	3	4	4
Non-health-group1	Regional Assembly and One North East (statutory regional agencies) plus Association of North East Councils	2	4	6	4	8
Non-health-group-2	National government representatives: Government Office for the North East (national government at regional level), excluding Public Health Group; JobCentre Plus	4	1	3	3	3
Non-statutory sector	Voluntary sector or business sector	0	5	4	4	3
Total		***10***	***18***	***22***	***21***	***22***

The main organizations involved in regional policy-making were described briefly in my introductory chapter. Findings reported in this section concern the involvement of the organizations and relationships between them, as discussed in documents or as perceived by interviewees. I asked interviewees about organizations working in the region, rather than about the government bodies overseeing those organizations. In discussing organizational roles, most interviewees commented not just on their own organizations but also on the other organizations involved.

This chapter combines findings from interviews and documents, looking firstly at those relating to general policy then considering the four specific policy areas. My focus is on the people and organizations and their power to affect policy progress.

Who generally moves a policy area onto and up the regional decision-making agenda?

In this section, I look firstly at views and documentary evidence on the people and organizations working together, then at leadership and power.

Working together on policy in general

Government Office (including Public Health Group North East), the Regional Assembly and the Regional Development Agency were seen by interviewees

as the three main bodies involved in healthy policy-making. Their roles were described in Chapter 1. The intention to work in partnerships was expressed in many organizational documents. A Concordat was developed, stating that

> One NorthEast, the North East Regional Assembly and GO-NE will work together to help improve the economic performance of the North East Region to enhance the Region's environment and to improve the social well-being of all citizens within the Region. (ONE, NEA and GONE 2000: 1)

In 2002, GONE's vision and values statement included the following:

> We want the North East to be a modern, prosperous, safe and confident region. In moving towards this vision, we will demonstrate leadership and work in partnership to:
> - Use local knowledge and understanding to influence and manage government policy and programmes
> - Ensure that delivery is co-ordinated, effective and efficient.
>
> (GONE 2002a: 1)

In 2003, GONE announced the creation of an inter-agency working group (IAWG):

> The IAWG is perhaps the first group of its kind to be established in the English regions. Work is progressing on a number of areas including the integration of strategies, developing partnership working and leadership. (GONE 2003: 9)

A review of the joint Directorate of ANEC and the North East Assembly began in autumn 2004 to consider arrangements to ensure that both organizations would be able to 'maximise their contribution and effectiveness' (NEA 2005a: 1). In 2006, part of the prescribed role of a new Assistant Chief Executive in the NEA was to strengthen partnerships 'between the Assembly, its stakeholders and other institutions' (NEA 2006a: 8). These examples of

organizational intentions around joint working had appeared by the time of my first phase interviews. After that, there was a continued, possibly increased, commitment expressed by those same regional organizations.

Preceding statements on joint working related very much to the main decision-making organizations. Other important influences were said to be the voluntary sector and the general public. Private sector involvement in general policy-making was not mentioned by any interviewees but was shown to be important in interviews around my chosen policy areas.

Voluntary sector engagement was not a specific topic in my first phase interviews. However, VONNE (the North East's voluntary sector network), was involved in the development of Regional Spatial Strategies and health and well-being strategies (VONNE 2010: *policy* page). The voluntary sector was said to have been 'fully involved in the regional Economic Strategy review process via BECON (Black Minority Ethnic Communities Organisations Network) and VONNE' (ONE 2005a). In 2006, a Compact was signed between the public sector and the voluntary sector. Supporting the Government's 1998 national Compact, its signatories included One NorthEast, VONNE, National Offender Management Service, North East Assembly, BECON, NHS North East, Association of North East Councils, Learning and Skills Council, JobCentre Plus, Funding Information North East, Business Link North East and the North East Social Enterprise Partnership. The Compact

set out a ‘general framework for enhancing the relationship between the Government and the third sector’ (GONE: 2006a: 8) and it was hoped that it would lead to

> improved partnership working and relationships between regional organisations within the third sector and the public sector in the North East. (GONE 2006a: 2)

The role of the public in policy-making was not a specific topic in my first phase interviews, although it formed an important element of my interviews about particular policy areas. However, statements about public involvement in general policy-making do appear in organizational documentation. Governance training for economic and social partners included representatives from communities, voluntary sector, black and ethnic minorities (NEA 2003a: 1). Possibly the most significant declaration of public involvement came in the RSS Statement of Public Participation:

> the main aim of the consultation and communication strategy was to enable community groups, stakeholders and members of the public to gain a clear understanding of what VIEW: Shaping the North East is and how it relates to them. (NEA 2005b: 6)

Joint working amongst all stakeholders was thus very much a part of policy-making intention. The effectiveness of it, however, was a rather different matter. Some interviewees felt it was reasonably successful, and several first phase interviewees said this was because there was quite a lot of movement between the three main regional organizations, with people seconded or permanently moving from one to another. As the North East was a small

region, with only a small number of people involved in regional policy-making, informality was said to have been possible and most contacts were generally felt to have been well established. One first phase interviewee described the North East as a ‘big village’, where many of the key players knew each other. That interviewee suggested that other regions were more complex because they were bigger.

A few interviewees said it had been unclear, at first, how the Regional Assembly, Regional Development Agency and Government Office could work together but this was much clearer by 2003. Although first phase interviewees generally felt that the three main regional agencies now had a ‘reasonable’ working partnership, some felt that it could be difficult to maintain continuity of relationships when there were changes in policy forums and major reorganizations (such as in the NHS). Many relationships that were believed successful were said to owe their success to individuals and their particular interests in the health agenda (mentioned by four first phase interviewees). Relationships developed specifically around health issues are discussed in Chapter 7.

Relationships existed not just amongst the three main regional organizations but also between those organizations and other agencies. The Regional Development Agency had formed relationships with environmental agencies and various health agencies, participating in forums with each of these

groups. Some relationships pre-dated the RDA but some had developed since it came into being. Recognizing the importance of strong relationships, the RDA had six ‘relationship managers’, who focused on the development and maintenance of relationships with groups of organizations under key focus areas.

The Regional Public Health Group (PHG) had links with Government Office departments and with the Association of North East Councils (ANEC). The relationship of the PHG with the Health Protection Agency was unclear at the time of the interviews. Both were involved in emergency planning, where there was an overlap with the two Strategic Health Authorities, whose relationship with the PHG was felt by a few interviewees at that time to be problematic. Interviewees reported that there was little contact with one of the SHAs, although the informal network of the other appeared more successful. Several commented that, in the event of a merger of the two Strategic Health Authorities (which did eventually happen), relationships might be expected to improve. The PHG had a direct line of influence on Primary Care Organizations and a line of influence with Local Authorities, although interviewees were generally uncertain how this latter worked. Two interviewees felt that, although it was beneficial for public health to be represented at all three levels of the NHS, the levels were not well connected and relationships needed strengthening. Good relationships were felt to exist between the PHG and most of the universities in the region.

The North East Public Health Observatory (NEPHO) was said to be dependent on cultivating individual relationships because no organizations were under obligation to report to it. It dealt with public health networks, rather than with individual Primary Care Trusts. Some interviewees felt that the physical location of the NEPHO office affected its relationships. Based at the Durham University Stockton campus, rather than being close to Primary Care Trusts or public health networks, it was near the Health Protection Agency and, at the time of interview, the Health Development Agency. Links with the HDA and HPA were therefore easier to build, as were links with some of the co-located university departments, such as health: staff in the various organizations got to know one another and understand other organizational functions through informal as well as formal contact. More than one interviewee suggested that the PHO had been personality-driven in the past, strongly influenced by leading personalities. It was viewed as a provider of advice as well as information, with representation in policy development groups.

At the time of the first phase interviews, the Health Development Agency was a separate agency, looking to formalise its relationships. Core bodies to which it related were Government Office (mainly the PHG but the intention was to link more with the other departments, such as housing and transport), the Regional Assembly, the RDA and both of the Strategic Health Authorities. The HDA was hoping to build more relationships with Primary Care Trusts and

Local Authorities via Local Strategic Partnerships. (Because of the number of Primary Care Organizations and Local Authorities, it was not considered practical to expect to work with every one individually.) It had some formal relationships, reporting to the Health Forum and Health Interest Group. Relationships with other arms-length bodies, such as English Nature, Sport England and the Countryside Agency, were also being strengthened. Links with the academic and voluntary sectors were seen as valuable, the former in terms of influencing research priorities and influencing syllabuses around public health leadership. Informal relationship-building, mentioned by several interviewees, had played an important part, being deliberately cultivated and evolving through specific pieces of work (such as health impact assessments, integrated impact assessments and health summits). These more informal relationships featured in several of the interviewees' discussions.

Of the main academic departments, the Centre for Urban and Regional Development Studies (CURDS) was said to have good working relationships with the RDA and Government Office. This was felt to reflect the longevity and experience of CURDS in producing good quality work to schedule. Its role was perceived by some interviewees as one of giving advice as well as information.

Interviewees generally felt that good working relationships and joined-up working were essential to allow healthy policies to develop. Several felt that

the most successful relationships and networks appeared to be those that existed before *Shifting the Balance of Powe*r (DH 2001, 2002), which were often interpersonal relationships (person-led). *Shifting the Balance of Powe*r was felt to have had a very disruptive effect, although after some of the chaos it initially generated had died down, relationships were said to have developed more satisfactorily.

Both formal and informal relationships were deemed important, the informal allowing the raising of awareness of issues. The co-location of the Public Health Group with Government Office was said by one first phase interviewee (in a leadership role) to enhance informal contact. At a formal level, regular meetings were believed essential between the three main regional organizations, to ensure detailed contribution to strategies.

There was no evidence that interviewee perceptions of their own or other organizational roles depended on their organization or role or level of seniority.

As well as joint working of individuals and organizations, there can be integration of strategies. An early example of an initiative to ensure a degree of strategy integration was the Integrated Regional Framework (IRF) for the North East, launched in July 2004 to ensure a certain level of cohesion over strategies in terms of adhering to sustainability principles. Later examples

included GONE's Business Plan for 2007/08, which expressed an aim of integrating regional strategies (GONE 2007a: 5). This aspect is further discussed in Chapter 7.

Leadership and power within relationships are also relevant to policy-making and these are discussed in the following sub-section.

Policy in general: leadership and power

A range of opinions emerged about power in the healthy policy arena, mainly around the power specifically to increase the 'health' element of policy, which is described in Chapter 7. The current chapter considers power more generally. One first phase interviewee (in a leadership role) felt that the important thing was persuasion rather than power, a view shared by another (also in a leadership role), who referred to the importance of personal relationships and said that affiliation was better than control and command. However, the question of leadership arose in many organizational documents. One NorthEast's corporate plan for 2003-06, in a section entitled 'building regional leadership capacity', stated that

> strong and inclusive organisational leadership will be crucial if we are to realise our potential. With local partners, the Agency will develop an initiative to create a self-sustaining, inclusive, leadership culture across the public, private and voluntary sectors. (ONE 2003: 3)

ANEC also talked of leadership, although it linked this with co-operation. Core values in its Corporate Plan for 2004/05 included seeking to 'play a leading

role in shaping and influencing future outcomes for the benefit of the North East' and operating 'in a spirit of partnership and co-operation'. (ANEC 2004a: 2)

The North East Assembly expressed great interest in regional leadership, with regular sections on this in its bulletins and reports. The issue of leadership was much more prominent in the second stage interviews, as described later in this chapter.

The power of the media to influence policy was mentioned by one first phase interviewee, describing the media as 'phenomenally important'. Capitalising on the media was said to allow effective communication of health messages about what the government and public health are doing in their strategies. A good evidence base was believed to be essential to underpin the messages, with useful assimilation of the evidence of effective interventions already being compiled, for example by the Health Development Agency. The media were also recognized as important in the RSS Statement of Public Participation:

> The aim of the media strategy for VIEW: Shaping the North East was to stimulate, generate and sustain media interest and coverage throughout the consultation period. (NEA 2005b: 10)

Direction, rather than developing ownership, of policy, was described by one first phase interviewee as harmful. Another (first phase) interviewee suggested that when people at the operational level took some kind of lead in

policy development, this was a good thing in terms of getting community support but there was a risk of isolation or being at too low a level to get things into practice, so it was important that the top levels gave firm commitment and the right kind of support to those at the operational end.

Preceding paragraphs have described the relationships perceived between the actors involved in general policy-making across the region and the power that some have (or have not). The following sections look at the same issues in my specific policy areas.

Who moves the healthy policy area 'tobacco control' onto and up the regional decision-making agenda?

The term 'regional tobacco policy' was interpreted in different ways. Some interviewees saw it as the regional tobacco control policy/strategy, some as the formation of the regional tobacco control office and others as the regional implementation of national legislation on smoke-free public places. Where appropriate, I shall draw attention to this if it appears to affect people's comments on any aspects of the tobacco policy area. One policy that was not much mentioned was the first regional tobacco control strategy (Regional Task Force on Tobacco Control 1998), produced for the former Northern and Yorkshire region (which existed before the North East region was created). This had been published just before the tobacco white paper, Smoking Kills

(Secretary of State for Health *et al.* 1998), and indeed had been submitted to the Department of Health for consideration during the white paper's development. I found it slightly galling that it did not rate an unprompted mention, as I had been heavily involved in its development in my role as regional office tobacco control coordinator! (Although its title was 'action plan' rather than strategy, it was widely circulated around the region as a regional strategy and its text referred to itself as 'strategy'.) I could not resist the temptation to prompt a few interviewees about it during the interviews. It seems that the main reason it did not achieve long-lasting prominence, in spite of being very widely circulated, was that the White Paper itself overtook it, with its statutory requirements. It had also been eight years since it was produced, so interviewees felt that it just might have been forgotten!

Working together on tobacco control policy

The development of the first regional tobacco control strategy (Regional Task Force on Tobacco Control 1998) was funded by the Northern and Yorkshire Regional Office and the main thrust was a wide consultative process. It built very much on the work of the tobacco alliances that existed across the region and was written by a multi-disciplinary writing group, following consultation with a wide group of people in the region with experience in tobacco control. (The process is described in Edwards *et al.* 1999.) Consultation took the form of two workshops and invitations to health and local authorities and voluntary sector organizations to comment in writing.

Multi-agency involvement remained an important aspect of tobacco control policy design. The newly formed regional coalition Fresh Smoke Free North East (Fresh) aimed to ensure contribution from a wide range of organizations to the 2005/06 regional tobacco strategy (PHGNE 2005). Consultation on a draft involved presentations and meetings with GONE teams, SHA, healthy schools coordinators, VONNE, ANEC, Chief Executives' Group, Regional Health Forum, Sustaine, Regional Environmental Health Officers Group, Regional Trading Standards Officers Group, Customs and Excise, stop smoking coordinators, the Commission for Patient and Public Involvement in Health (CPPIH) and patient forums. Responses to the consultation were received also from health and local authorities, regional organizations, voluntary organizations and the Tobacco Manufacturers' Association. Interviewees mentioned being aware of a range of different agencies directly involved in policy development, including: RA, ONE, ANEC, PCTs, SHA, Fresh, LAs (including Trading Standards, Social Services and Environmental Health departments), Public Health Group North East, the Chamber of Commerce, EEF, TUC, voluntary sector, Action for Smoking and Health (ASH), the regional alliance formerly known as North East Against Tobacco (NEAT), MPs, a PR company, the freedom organisation for the right to enjoy smoking tobacco (FOREST) and the tobacco industry. Interviewees mentioned that there were many networks across the region so that far more people were represented or informed than might be immediately obvious. Informal networks, as much as formal ones, were said by one health sector

interviewee to have a great effect, with personal networking allowing more access to politicians than formal arrangements did.

Interviewees from different sectors said there was not a fixed group of people or organizations involved: different organizations were allowed to come and go, according to the particular policy issues being addressed.

> It is hard to know where strategy sits. High level partnerships cover all major regional agencies. Also, the strategy was consulted on at local levels – SHAs and health networks did a lot of work on it and made a lot of changes. (Non-health-group interviewee)

Most interviewees felt that the partnerships developing tobacco policy were fairly comprehensive and probably no major groups were missing that should have been included:

> We were pretty scrupulous about trying to get as many people involved as we could. (Health sector interviewee, reinforcing the idea that the health sector took the lead)

There were, nevertheless, some concerns raised about representativeness. One interviewee (non-health-group) felt there was token representation, suggesting that ‘most key players were round the table, some possibly notionally’. Several interviewees did feel some groups had possibly been omitted. A health sector interviewee had been disappointed that mental health services had not been involved until late in the day. There were problems obtaining the views of mental health in-patients, who have high rates of smoking, and, similarly, the views of homeless people (another group with

high smoking rates) were not sought (academic informant). A few commented on limited private or commercial sector involvement. Connections with business were said to be improving, particularly as the Chamber of Commerce was engaged. However, one health sector interviewee felt that clubs and pubs should have been more involved early on in considering second-hand smoking policy, so that they could 'understand the issues'. Another health sector interviewee questioned why environmental groups were not now on board, though the same interviewee felt that at the time (leading up to the smoke-free legislation) all the right people had been involved. A health sector interviewee felt that one of the major trade unions had been reluctant to be involved, because at the time there was still a local tobacco product manufacturer (later closed). A non-health-group interviewee commented on the difficulty of bringing Customs and Excise on board, suggesting that although attempts were made, they were not seriously engaged. This was also a concern of a health sector interviewee, who felt that perhaps even though Customs and Excise were in favour of the policy, they might be worried about potential loss of income if the budget for tackling smuggling was divided across several organizations.

The role of the public (and, particularly, public pressure) was felt by some to have been important, certainly at a national level.

> Policy in this country is developed at a national level – based on what the government thinks will win elections. Tobacco is interesting – the Government was dragged reluctantly into creating policy that it might not otherwise have created out of choice. Often government policy is ahead of popular thinking/public attitudes – but with tobacco, the government was in danger of being behind public attitudes, especially around the smoke-free agenda. The government was in danger of being criticised for not taking action to protect the public health. (Academic sector interviewee)

Although one academic sector interviewee said that the regional agenda seemed to have been very much driven by national policy, rather than the public, some interviewees were aware of public involvement. Generally, interviewees cited examples of consultation on specific aspects, rather than on regional policy as a whole. Several believed that there had been surveys about public attitudes towards smoking in public places and that public support was already known to exist for action on this. (This is borne out by results of surveys cited by ASH (2008: 35)). A health sector interviewee felt that public attitude was itself influential in forming the smoke-free policy, because MPs used it as evidence to be bolder with legislation. One non-statutory sector interviewee felt that the policy actually preceded the evidence of public acceptability, a view not held by other interviewees.

When considering whether attempts had been made to engage the public in actually shaping tobacco control policy, most interviewees said that there had not really been any attempts, although local tobacco alliances, advocacy groups (and opponents to legislation) and the media were mentioned as having done useful work. A local public relations company gained a contract to work with Fresh and became involved in all aspects of its work. One health

sector interviewee suggested that there was very little work with the public but a lot with service users and carers in the development of the stop-smoking services. Interviewees also mentioned work done by various organizations (including the regional tobacco office, VONNE and the TUC) to get the public to lobby for smoke-free legislation (a highly successful campaign, producing the biggest response from any region in the country (Fresh 2006: 6)). Additionally, the Fresh website was seen as one approach the public could use. Public representation on Fresh's steering group was mentioned, although one health sector interviewee felt that there was 'no evidence that this translated into public engagement'.

A health sector interviewee suggested that joint working in the early stages of trying to form a regional tobacco office was helped by the fact that they were not asking for money but for support for securing external money so that 'people could get into the thinking without worrying about having to pay for it.' A bid for European funding failed but it was believed that support for the office was galvanised by the application process. I was aware from my own work that there was subsequent disagreement over the funding arrangements for Fresh: some people objected to the top-slicing by the SHA from PCT budgets. A health sector interviewee commented that all but one PCT was cooperating but interviewees generally did not mention this issue. This was possibly because, at the time of interviews, the arrangements were in place and were effectively history. It was also seen perhaps as an implementation issue rather

than a policy disagreement. However, if this was the case, it was perhaps surprising that it got little mention in the interviews when policy leadership was discussed. There were perceived difficulties over the way Fresh was seen to take over from existing alliances.

> There is a kind of cottage industry aspect to tobacco action in the past – where people had the money locally and were quite happy being champions in exile, fighting the corner against tobacco and with a machine that failed to support them. Now the machine supports them, they are not that happy about it taking over. (Health sector interviewee)

Nevertheless, joint working appears to have been regarded as successful. A health sector interviewee said it had created commitment to tobacco control policy, reducing duplication of effort by different local organizations. Other interviewees suggested that it allowed a comprehensive approach to the issue, with greater access to a range of both help and influence from other organizations.

> All brought something different and something strong to the table. Everybody felt very much that this was a team effort. (Non-statutory sector interviewee)

One interviewee said that, had there not been the amount of joint working that there was around regional tobacco control strategy,

> the approach would be just NHS, therefore cessation and no concern with smoke free public space. (Health sector interviewee)

The following section considers the leadership and power of those involved in tobacco control policy development.

Tobacco control policy: leadership and power

From the time of its formation in 2005, Fresh took the lead in regional policy development, in accordance with its stated role. At the time of the interviews, it was a fairly new organization. Interviewees varied in their thinking about who took the lead in tobacco policy but generally did not mention Fresh. One health sector interviewee felt that tobacco policy was driven by the NHS; a non-statutory sector interviewee said the local authorities were key and employers crucial; and one non-health-group interviewee suggested that perhaps ANEC was the most powerful lobby because it was backed by 25 local authorities. The last-mentioned interviewee also felt that they were 'lucky to have Fresh keeping an eye on the ball' because the biggest factor was coordinating the work. There was a general feeling that the joint working was really joint, rather than with one dominant partner.

The power to increase consideration for health improvement or inequalities in regional tobacco control policy is discussed in Chapter 7. Interviewees generally felt that the power to push the issue of tobacco control up the agenda existed in three or four different places. There was said to be power at both national (government) level and regional level (including GONE, ANEC and Fresh), as well as at the local level (mainly PCTs, local authorities and strategic health authorities). Although ANEC's influence was mentioned by a few, a different perspective on ANEC's position was provided by one health sector interviewee, saying that ANEC was a good lobbying body but had no

power. One health sector interviewee felt that the new health commissioning arrangements would create more opportunities for the Regional Director of Public Health to have a powerful influence, although this might be seen to be more on the implementation side than the policy development side. A health sector interviewee said that Fresh's power was increasing, attributing this to the resources attached to the office. Interviewees tended to refer to power being vested in an organization (public sector), rather than in an individual or in an individual's role within an organization, for example a non-statutory sector interviewee simply stated that 'public services carry the responsibility'.

The need to bring on board the right influential people was stressed by a health sector interviewee, who felt that whilst the political leaders matter, there were also some individuals with influence who needed to be involved. The interviewee felt that 'there are always some people who have more influence than status suggests they should have'. (No ideas were presented as to how to identify or engage these individuals and I was uncertain whether the interviewee had some historical grievance against someone in this position!)

Local passionate leaders, in the right places at the time, were mentioned by only two interviewees (one health sector and one academic sector) as playing a major part in driving tobacco up the agenda in terms of establishing the Regional Tobacco Office. Other interviewees did not mention such champions having played a part in pushing tobacco control up the agenda. With regard to

legislation on smoke-free places, several interviewees said that advocacy groups in favour of it had played an important part, whilst advocacy groups against it were thought *not* to have been very influential, because the legislation had actually been passed and it had both government and public support.

Several interviewees felt that the power was linked to strong public feeling nationally about smoking, suggesting that the government was influenced particularly by public support for smoke-free legislation, which also existed at a regional level. Linked with public power and public awareness were the media, acknowledged as an important force in Fresh's annual report 2005/06 (Fresh 2006: 14).

The best locus for power to drive tobacco up the agenda or to keep it high on the agenda was thought by many interviewees to be the health sector, principally the Department of Health. A non-statutory sector interviewee felt that the Department of Health should continue to raise awareness of the health issues of tobacco and keep this constantly in the media. Some interviewees just said power already lay where it should be or suggested it needed to be a broad effort, with strong national government input. It was

> not down to a single individual. . . . a collective effort with champions, individuals and organizations. (Health sector interviewee)

Linked to the best location for power, the need for leadership was mentioned by a few interviewees. One health sector interviewee commented, frustratedly, that it was ‘hard to get local authorities to do anything without leadership’.

Most interviewees believed that there were very few people or organizations that would wish to keep tobacco off the agenda, although many felt that the tobacco manufacturers (with very strong financial motivation) and the pro-tobacco lobby (for example, FOREST) would so wish. A non-statutory sector interviewee said that some of the large advertising companies would hope for no further tobacco policy because advertising revenue was hugely important to them. There was, however, more of a feeling that it was specific actions rather than policy that had met (or would meet) with opposition, for example working men’s clubs not wishing to go smoke-free. One health sector interviewee felt that the hospitality and leisure industry was wary of forthcoming regulation, rather than strongly opposed to it in the way the tobacco industry was. Another suggested that, although they had expected the hospitality industry to be an ’enemy’, involving them in discussions had ensured their cooperation.

Views varied about whether those opposed to having tobacco on the agenda actually had the power to keep it off the agenda. One interviewee (non-health-group) said categorically that they would *not* have the power. A health sector interviewee, whose views were echoed by others, said that there was no

power to keep the smoking in public places aspect off the agenda because the government had public backing. Others suggested that there was power amongst GPs and local councils to affect the implementation. One non-health-group interviewee felt that the tobacco industry still had huge power. The power and nature of the tobacco industry, although having long been recognized as having tremendous economic and political clout, came into the public eye when internal industry documents were released in the U.S., providing 'fascinating insights into industry behaviour and activities' (Gilmore, McKee and Pomerleau 2005: 187). In the U.K., the power of the motor racing industry was revealed in 1997 when the government allowed the tobacco-sponsored industry certain exemptions from the advertising ban (Spencer 2007: 163). One interviewee commented that

> the tobacco industry are the best advertisers in the world. We need to be seen to be a power to attack this. (Health sector interviewee)

One health sector interviewee felt that, although the EU was not against tobacco policy, it restricted the ability of countries to act, effectively watering down measures.

This section has described my findings on the people and power involved in the development of tobacco control policy. In the following section, I move to my findings related to people and power and the housing agenda.

Who moves the healthy policy area 'housing' onto and up the regional decision-making agenda?

As with regional tobacco policy, there were different interpretations of the term 'regional housing policy'. Some interviewees (all sectors) considered it to be the Regional Housing Strategy. (At the time of the interviews, the 2007 Regional Housing Strategy was under development.) Others talked more of the Regional Spatial Strategy or the Regional Economic Strategy, where these related to housing. Others thought of it more in terms of the sub-regional decision-making around housing, where four sub-regional strategies were produced (Northumberland Housing Board 2007, Northern Housing Consortium 2007, Tees Valley Living 2008 and arc[4] [*sic*] 2007). Where appropriate, I shall draw attention to this if it appears to affect people's comments on any aspects of the housing policy area.

Working together on housing policy

Many organizations were believed to be involved in housing policy-making, notably the larger regional agencies. Most interviewees mentioned the Regional Housing Board.

> The Regional Housing Board involved a variety of different partners, including Local Authorities, private house owners, community associations, Federation of Builders. And there are sub-groups feeding in. (Non-health-group-1 interviewee)

Several people referred to private sector involvement; one interviewee (non-health-group-1) commented that 'elsewhere it is often not involved' and made

the same comment about the involvement of residents' and tenants' representatives. One academic sector interviewee said that the Regional Assembly tried hard to engage the independent sector. In the updating of the strategy for 2005, the Regional Assembly had expressed its intention to create a private sector advisory forum (NEHB 2005:106). This was established before the preparation of the 2007 strategy and it was agreed at their first meeting that it would contribute to the revised housing strategy (NEHB PSAF 2006). A specific event was arranged for private sector consultation (NEHB PSAF 2007).

A non-statutory sector interviewee suggested that 'the public sector had a small part', although most other people stressed the role of the Local Authorities. Interviewees also mentioned the TUC, voluntary sector, the House Builders' Federation (suggested by one health sector interviewee as being the most significant partner), English Partnerships and the Northern Housing Consortium (the latter covering three regions).

With different levels of decision-making, partners were involved in various ways. Some agencies worked at more local levels (for example, sub-regional housing associations, mentioned by several interviewees). A health sector interviewee suggested that at the local level, all of the *Supporting People*[10] partnerships were focused on health and social care but at the regional level,

[10] DCLG programme, started 2003, providing housing related support to vulnerable people to enable them to live more independently.

although there were possibly some regional network processes, people were probably only just kept informed.

When considering whether there were any people or organizations not involved in housing strategy that should have been, one academic sector interviewee described the Regional Housing Strategy development process as ‘very inclusive’ and several felt that probably none were missing.

> I’m not aware of any that have been screaming out ‘why weren’t we?’ (Non-statutory sector interviewee)

> I have not been aware of anyone coming late to the party. And from seeing it pan out, I am not aware that there is anyone missing who would have brought something different. (Non-health-group-2 interviewee)

However, many interviewees felt that there were serious omissions in the consultations and involvement in policy development. Greater national involvement would have been preferred by one non-health-group-1, interviewee, for example from CABE, bringing in the national agenda to give it more strength. One interviewee (non-health-group-2) suggested that people involved in transport policy should have been more involved. Several contributors mentioned limited private sector involvement, contradicting others mentioned earlier.

> The private sector is a big facility – they have the power to deliver but we are not asking them what they can do. (Health sector interviewee)

There was a lack of consensus over the extent of health sector involvement, with many interviewees suggesting that the health sector was not well engaged. I shall discuss this further in Chapter 7. Lack of involvement of the academic sector was raised by some interviewees.

> There is a need for better quality research and analysis of the local/regional economy. No organization exists that tries to offer a research-based view of the issues. (Academic sector interviewee)

There were discrepant views on the extent of voluntary sector engagement. According to housing board documentation,

> In 2004, the North East Housing Board sought to ensure the voluntary sector was able to inform the development of this [2005 Regional housing] strategy. The Board's Voluntary Sector Advisory Group played a significant and very positive role in informing the strategy, particularly with regard to the housing issues of vulnerable groups identified in section 6. The Board is committed to developing the role of that group further as part of the delivery of this strategy. (NEHB 2005: 107)

Certainly, the up-dating of the Regional Housing Strategy for 2007 was regularly on the agenda of the Voluntary Sector Advisory Group (for example, NEHB VSAG 2007). Perceptions of voluntary sector involvement, however, did not match the implications of the documentation: many interviewees felt the sector was not involved. According to an academic sector interviewee, the Regional Assembly 'tried hard [but unsuccessfully] to engage the voluntary sector'. Concern over the lack of voluntary and community participation was expressed by several interviewees.

> The third sector feels less involved. Over the past two to three years, it has become common to find housing organizations, social services and health sector working together on a continuous basis [but not the third sector]. (Health sector interviewee)

When asked whether there had been any assessment of public support for housing policy, some interviewees were not aware of any. One interviewee (non-health-group-1) felt that there was representation from community groups on the Regional Housing Board and that the building up of the evidence base had the involvement of local people. A few felt that there was good consultation via the *Examination in Public* for the Regional Spatial Strategy, including meetings and a website approach. However, there were suggestions that not many members of the public would understand the ramifications of the RSS. An academic sector interviewee suggested that there was less controversy over housing in the North East than in other regions, so that there was less publicity over RSS consultation meetings: 'there was possibly more publicity in other regions, where it was more controversial'. Several interviewees (from all sectors) suspected that the public did not actually get much involved in public consultation.

> The examination in public was only very marginally for the public. There was more potential for civil servants to come to meetings. Although open to the public, I am not sure how widely known they were. (Academic sector interviewee)

> They were probably not overwhelmed by the general public response! (Non-health-group-2 interviewee)

> Probably the public are not expected to respond to consultation on a strategy. It is really about getting the views of the Local Authorities and getting regional bodies to agree. (Non-health-group-1 interviewee)

Some interviewees felt that the public actually had a chance to shape housing policy, through the RSS consultation process or otherwise. However, one

health sector interviewee stated that 'the [RSS] consultation was on *existing* policy, not formative'. Another suggested that

> there were attempts to engage – possibly in just accepting it rather than shaping. There was no grand debate about principles or alternatives. (Academic sector interviewee)

A non-statutory sector contributor stated that 'the Assembly is not in listening mode' and another interviewee suggested that there was very deliberately *no* direct way for people to influence it:

> This is related to the depoliticisation of the housing agenda. Ambitious people in power do not want to be linked with failure They do not want to initiate debate about it, so the public do not hear about it and do not comment. (Health sector interviewee)

Consultation on the 2007 Regional Housing Strategy itself was described as 'fairly closed' (non-health-group-1 interviewee). However, one interviewee (non-health-group-2) felt it was a wide consultation, with many people getting the chance to have their say. Several interviewees expressed doubt that public consultation would have happened at all:

> I very much doubt it. There has been no big public debate about whether housing market renewal is a good thing or a bad thing, partly because the people most affected by it are the least organized and least able to give their points of view in these debates. In the South, some of the 'sustainable communities' proposals were fiercely resisted by people (notably Stansted). Even in Gateshead[11], there is probably not widespread opposition. (Academic sector interviewee)

One interviewee (non-health-group-2) pointed out that Local Authorities had opportunities to comment and that Local Authorities were 'guardians of the public'. The voluntary sector was considered in a similar way: one non-

[11] Drastic plans for large-scale demolition in Gateshead were in the news at the time.

statutory sector interviewee said that the voluntary sector had been consulted, had publicised the consultation and were representative, although one step removed from the public. Tenants' associations and registered social landlords were also said to have responded to consultation and fed back views where there was controversy (according to a non-health-group-1 interviewee). Other interviewees believed that it tended to be the 'usual suspects' who got invited to consultations, 'probably those involved with LSP community empowerment networks', according to a health sector interviewee.

The housing board had stressed the importance of consultation while updating the strategy in 2005 (NEHB 2005: 1, 106). The process involved a public consultation on documents developed with stakeholder involvement. Regarding the 2007 update, the North East Assembly reported on extensive consultation on the strategy's priorities, with all those who had a stake in the future of North East England's housing, 'to ensure that the regional objectives for housing address the varied needs and complex housing challenges we face' (NEA 2008a: 3).

More than one interviewee suggested that consultation would be less appropriate at regional level than at local level, where implementation was happening. A few referred to there being many studies based very much in local communities, with local survey information helpful in media stories. Commenting that the government did not want to support demolition in areas

where it was unpopular, one interviewee (non-health-group-2) mentioned local examples of consultation with resident groups, and councils employing Mori for attitude surveys.

The North East Assembly had been increasing its commitment to joint working on housing. In 2004, a housing specialist from GONE was seconded to the Assembly: ‘the post will facilitate improved joint working between housing and planning at the regional and strategic level’ (NEA 2004a: housing section). After the North East Housing Board became part of the Assembly, emphasis was laid on the ability of other sectors to influence policy

> Public, private, community and voluntary sector organisations have the chance to influence the development of the next edition of the North East Housing Strategy. (NEA 2006b: housing section)

In spite of this, interviewees expressed many doubts about the success of any joint working arrangements. A non-health-group-1 interviewee felt that, although health, education, transport and other professionals were involved in regeneration, there was not always enough integration because of multiple agencies, multiple initiatives and competing priorities. One non-statutory sector interviewee said that several regional organizations just did not want to talk to one another and that a more joined-up approach was essential. A health sector interviewee thought there was no strategy about how the health sector could work more closely with housing colleagues. Others suggested that the joint working was of limited success with regard to taking on board the views of various sectors, particularly the voluntary sector.

> I do not know whether any voluntary sector representations that they made are in there [the Regional Housing Strategy] yet. (Non-statutory sector interviewee)
>
> The local authorities do not listen to the private or voluntary sector. (Non-statutory sector interviewee)
>
> Stakeholder groups, environmental groups *et cetera* in principle can be engaged – *in principle* – but systems are dominated by vested interests – the rich get consultants to produce arguments (however ill and poorly argued). There is a mismatch with what small-scale organizations and large-scale organizations can do. (Academic sector interviewee)

Others felt that the joint working was only partially effective in terms of adding value to housing policy. One believed this was

> a reflection of the point that housing is still very much economy-led – it tends to be about the cheapest route to providing it. …. The cultural concept of housing cost means that we are not as influential as we want. The problem is to get big house builders to consider this and agree to build properties that are "homes for life" rather than just go for quick returns. (Non-health-group-1 interviewee)

Only one interviewee seemed to think that joint working was really successful:

> all brought different expertise. Government Office was seen as having the inside track to Civil Service policy but the Consortium (representing the political interests of local authorities) is a very good lobbying body. (Non-health-group-2 interviewee)

Integration of strategies, as well as of organizational inputs, was felt to be important. Strategy alignment was, according to housing board documentation, an important element of the 2005 strategy:

> The Housing Board is ... strengthening the relationship between housing, economic and demographic change. This will integrate the Regional Housing Strategy (RHS) with the emerging Regional Spatial Strategy (RSS) and the Northern Way Growth Strategy and align the RHS with the Regional Economic Strategy (RES). (NEHB 2005:1)

At the time of my interviews, responsibility for the North East Housing Board had just moved to the North East Assembly, thus 'enabling regional policies on housing to be much more closely aligned with those on planning and transport' (NEA 2008b: 10).

An academic sector interviewee drew attention to contradictions between the drivers of the Regional Economic Strategy (economic) and the Regional Spatial Strategy (determining spatial allocation and how the housing infrastructure is developed). Some interviewees, however, felt that joint working had led to an element of cross-strategy agreement around housing:

> I believe that the big agencies worked quite well together, with the Regional Spatial Strategy and the Regional Economic Strategy having agreement on the economic growth rate and the same vision [around housing]. It was more joined up than things used to be. (Non-health-group-1 interviewee)

> It [the RSS] would be even more straightforward economic regeneration if done in isolation – not enough attention to social, cultural and health aspects. (Health sector interviewee)

Other interviewees (from various sectors) suggested that the joint working made the RSS and the Regional Housing Strategy more sensitive to regional needs and that far more realistic policies and better working arrangements emerged as a result of joint working, from which there was potentially huge added value.

> Efforts for joint working [on the Regional Housing Strategy] were very interesting – people were talking to people they hadn't talked to before. It was exciting – and the reality is difficult. (Health sector interviewee)

Interviewees presented various ideas as to which organization took the lead in housing policy development. These are discussed in the following section.

Housing policy: leadership and power

Many interviewees (in different categories) stated that the Assembly was the lead agency and some felt the Regional Housing Board was the lead. A few thought Government Office took the lead, with heavy involvement from the RDA and Local Authorities. One non-health-group-2 interviewee believed that the RDA was involved but did not have as much influence as it might. Many felt that the Local Authorities (and specific departments, such as planning) had great influence; this influence was sometimes independent (involving both political members and officers) and sometimes via the Association of North East Councils.

In contrast to the desire for more government involvement mentioned earlier, some people expressed concern about too much government involvement.

> There is an uneasy relationship between central government and regional initiatives. Government policy sometimes limits resources and there is often not control of it in the region. (Non-health-group-1 interviewee)

> The Government want to plan regionally. The local authorities want to plan locally without restriction. (Non-health-group-1 interviewee)

One health sector interviewee felt that the issue of ownership of housing policy was never really tackled. Another believed that one particular Assembly individual took on a leadership role without involving others; however, this was

not thought to be a power issue, just a belief that the post-holder thought it was their job and knew the process better than others, so that there was no need to involve them! No clear picture on leadership emerged from the interviews, as reflected in one comment:

> It is hard to know where strategy sits. High level partnerships cover all major regional agencies. Also, the strategy was consulted on at local levels. (Non-health-group-1 interviewee)

Interviewee thoughts on the power to increase consideration of health in housing policy appear in Chapter 7. Different opinions were given as to where the power lay to push housing up the agenda. Several felt it was with the Housing Board ('really quite a powerful body', according to a non-health-group-1 interviewee), although one health sector interviewee questioned whether the board had any power to act if the local authorities were against an action. Another health sector interviewee pointed out that, although the housing board could lobby effectively, it only represented one area of housing.

A few informants felt that the Regional Assembly was the key powerful agency. However, one non-health-group-1 interviewee pointed out that it was only as strong as the local authorities; another suggested that the process was flawed and that, although the Assembly had the power at present, over 80% of people had voted against an (elected) assembly.

> The general population does not understand the power vested there or where the authority comes from or why. (Non-statutory sector interviewee)

> It would be different if the Assembly vote had been different – people do not see power vested in any one of the regional organizations. (Health sector interviewee)

The Regional Development Agency was also cited as a power able to get housing on the agenda, specifically by its inclusion of housing in the Regional Spatial Strategy and the Regional Economic Strategy in an aligned cohesive way. Others felt that although the local authorities had implementation power, rather than strategic power, they were still very influential.

> Housing at regional and local level always will be high [on the agenda]: councillors have people in surgeries every day with problems. At a local level, it is very important - it is the key to regeneration. (Non-health sector group 1 interviewee)

> Housing is one of the most controversial areas. The local authorities are taking power from the region. (Academic sector interviewee)

An academic sector interviewee said that ONE must be slightly lower down in the hierarchy than the Assembly or GONE, because it lost out when it had proposed a different growth rate for the economy and the figures were altered to make the RES and RSS comparable.

Many others felt that it was government that had the power:

> Ministers, ministers, ministers! (Non-health-group-1 interviewee)

> Local MPs regard it as important. (Non-health-group-2 interviewee)

> Nationally, John Prescott[12]. The National Sustainable Communities Plan [ODPM 2003] brought it up the agenda, partly because of the South East (affordability). Then void rates in the North East took it up the agenda… the market had power (people left the council properties, voting with their feet). (Non-health-group-1 interviewee)

[12] Deputy Prime Minister - housing was then a departmental responsibility of the Office of the Deputy Prime Minister.

Amongst government departments, the Treasury and its power were specifically mentioned:

> If it is not funded, it loses a tremendous amount of momentum. It will still happen – well, the local authorities will still want to deliver these physical plans but what it would mean is that it would be difficult to commit resources beyond current phases. (Non-health-group-2 interviewee)

There was no suggestion of any individuals with particular power to move housing up the agenda.

> There was engagement and ownership – credit to the Regional Assembly for being inclusive – possibly too inclusive – there was some criticism that it lacked assertiveness/leadership instead of being non-committal and trying to please everyone, leading to unfocused provision: but in terms of policy development process, it was very open, inclusive and transparent. (Non-health-group-1 interviewee)

The power of the media was acknowledged. In connection with media coverage of local action, one interviewee (Non-health-group-2) commented that whilst the national media would pick up one-sided stories, local media were 'much more balanced and recognized the many occasions when the local community supported a demolition programme'. This was helped by good relationships with local editors and by keeping journalists informed of plans and statistics from local surveys.

There was also variation in where people thought the power *should* lie to get

or to keep housing on the agenda. Many agreed that

> Local Authorities should have more power. Local communities should have more power – it is all about community and social interactions. (Health sector interviewee)

Only one interviewee (non-health-group-1) felt this power should lie in the housing market, one (non-statutory sector) suggested it should be with the private and voluntary sectors and one (academic sector) said it should be at the heart of a number of organizations. A few said it should be a national (government) responsibility, although most of these were thinking in terms of government financing rather than governments actually forcing the agenda.

> National finances have to rest with the Treasury. It would be very helpful for the next Comparative Spending Review to set out not just three years commitment but an indication of whether this will continue beyond that. (Non-health-group-2 interviewee)

> Regional planning but with central government involvement – there should be more latitude at regions to find more innovative solutions. (Academic sector interviewee)

One health sector interviewee felt that ideally power should be with some form of elected regional Assembly, because there needed to be a regional overview of policy and 'the regional body should be more accountable than at present – through stakeholder partnership arrangements.'

The majority of informants said that there were no organizations or individuals

who wanted to keep housing off the agenda.

> A comfortable place to sleep is one of the basic animal requirements all humans have – housing policy can never be off the agenda. (Non-health-group-2 interviewee)

> No one is disinterested in the question of housing. The issue is regarded as central to people's sense of well-being. (Academic sector interviewee)

However, one interviewee (academic sector) felt that some local authorities would be happier without a strategy like the Regional Spatial Strategy, because of the stringency of some of the constraints. Because implementation tended to be at local authority level, where there was not a strategic health agenda, there was potentially power on their part to concentrate on numbers of houses demolished or built, rather than on *which* houses were demolished.

> The problem with housing is that it is largely geared by planning – and planners like to feel they are independent and won't be told by anyone else what to do. The ability to get housing policy to work without having planners on board? – it is impossible. (Non-statutory sector interviewee)

In similar vein, one interviewee (health sector) stated that the private sector, with its huge expertise and knowledge, had the power *not* to follow policy.

> There can be rearguard action from certain motivated individuals pursuing causes for their own political ends – ostensibly trying to defend a community – in fact, generating an enormous amount of press interest on not well-founded facts – just telling one side of the story. (Non-health-group-2 interviewee)

Considering housing as part of the RSS, a non-statutory sector interviewee felt that, since the RSS was flawed and would, if it was accepted, hinder economic growth, 'the natural reaction of everybody will be to make sure it just

dies a death'. This was very much a minority view. Generally, rather than keeping housing off the agenda, there were believed to be groups who really just wanted a focus on different parts of the agenda or a different approach to tackling the issues. One interviewee suggested that the complexity or scale of housing problems, although not leading to people wanting to keep housing altogether off the agenda, might prevent it from being a fully addressed agenda item:

> some organizations believe housing has become such an expensive issue because of the value in housing so they feel it is beyond their capabilities to tackle. (Non-statutory sector interviewee)

Cynicism was expressed over the reasons why some people wanted to ensure housing was kept on the agenda. Reasons included people being able to make money for themselves from the regeneration money flowing in (suggested by a health sector interviewee) and people wishing to maintain their own powerful position in an organization (suggested by another health sector interviewee).

This section has considered the people and power playing a part in driving the regional housing policy agenda. The following section describes findings on these aspects with regard to the worklessness agenda.

Who moves the healthy policy area 'worklessness' onto and up the regional decision-making agenda?

There was not a common understanding of the term 'regional worklessness policy'. A specific 'regional worklessness policy' did not exist. Some (from different sectors) felt that policy related to developments around health and worklessness and others believed that it meant simply the national policies around benefits or the elements of the Regional Spatial Strategy or Regional Economic Strategy that dealt with employment issues. Where appropriate, I shall draw attention to this if it appears to affect people's comments on any aspects of the worklessness policy area.

Working together on worklessness policy

Interviewees gave different lists of partner organizations when asked which agencies were involved in developing worklessness policy. There were several reasons for this: the different ideas interviewees had about which policy development was under discussion; the different times individuals became involved or for how long they were involved; and the possibility (not unrealistic) that people simply forgot!

It was generally recognized that a wide range of agencies was involved. The most-mentioned agency was One NorthEast, variously described as being the key, the lead agency with the ability to bring in employers and 'the one with the money'. Government Office for the North East, the Strategic Health

Authority and the Regional Public Health Group were also mentioned by many, although one health sector and one academic interviewee thought that the health sector had not been much involved or contributed enough. National government departments were mentioned, including the Department of Health, the Department for Education and Skills, the Department for Work and Pensions (including JobCentre Plus), the Health and Safety Executive (mentioned by only one interviewee) and the Treasury. Although the Treasury was mentioned specifically by only one interviewee (non-statutory sector), its role was implicit when interviewees discussed key policy drivers. One non-health-group-2 interviewee said that MPs and the Citizens Advice Bureau had also been involved.

Early examples of joint working and consultation included the production of the 2002/03 Framework for Regional Employment and Skills Action (FRESA) in the North East (ONE 2002a). Led by the Regional Development Agency, its priorities emerged from ‘a wide-ranging consultation and analysis of the North East labour market’ (ONE 2002c). The consultation was with many organizations, including statutory agencies and voluntary and community sector groups.

The North East Assembly expressed its aim of shaping and influencing

regionalisation of the skills agenda through the Regional Skills Partnership, which

> brings together the region's Learning and Skills Council, One NorthEast and JobCentre Plus, amongst others. The creation of the Regional Skills Partnership is viewed by the Assembly as an opportunity for all partners to work together to increase skills levels, maximise economic performance and promote social inclusion. (NEA 2004b: 7)

The Assembly's 2005 scrutiny report (NEA 2005c: 15) also stressed the value of joint working and, according to GONE, there were certainly, during 2004/05, efforts to engage a wide range of people in consideration of worklessness issues:

> We engaged regularly with a wide range of business organisations in the region to support enterprise, entrepreneurship and business creation. These include the Confederation of British Industry (CBI), North East Chamber of Commerce, Federation of Small Businesses, Northern Offshore Federation, Engineering Employers' Federation and the Northern Business Forum. (GONE 2005: 4)

GONE had also organized a regional worklessness summit, with regional and national decision-makers, including ONE, DWP, local authorities and other key agencies within the public, private, voluntary and community sectors. Its aims were to examine how to overcome barriers stopping people from moving into employment and to develop a 'shared understanding of the regional issues' (GONE 2005: 11). At national government level, the jointly produced 'Health, work and well-being' strategy (DWP, DH and HSE 2005) emphasised the importance of engaging stakeholders because national strategy would not be successful without them.

The Regional Assembly was mentioned rarely by interviewees: when it was mentioned, it was said to be much less involved than, for example, ONE or GONE. Other regional agencies, mentioned by several interviewees, were ANEC, the Care Services Improvement Partnership (CSIP), the Learning and Skills Council (LSC) and the Public Health Observatory. One academic sector interviewee also mentioned the Health Protection Agency and the Health Development Agency. Others referred to the academic sector in general.

At a sub-regional level, several interviewees mentioned Local Authorities, although some felt they had contributed little and that the main representation was from regeneration departments. Primary Care Trusts received some mention, although again their contribution was not felt to be great: National Health Service representation was thought to be mainly through Public Health

Group North East. ‘Connexions’ was mentioned by one interviewee. Other organizations said to be involved included the Chamber of Commerce (mentioned by several interviewees), the Trades Union Congress, the Employers’ Organization, some private sector employers (as job providers and contributing to the Employability Framework), training providers, the Engineering Employers’ Federation and the Federation of Small Businesses. The Northern Business Forum was not mentioned, although its website referred to being involved in policy development generally and in the Regional Economic Strategy particularly (NBF 2010). While one health sector

interviewee talked of increasing employer involvement, particularly in 'health at work' events, others questioned the motivation or likelihood of some employers being involved, with one referring to a recent influx of Eastern European workers:

> If you ask the average employer what motivation they have to employ workless people, they say it is much easier to employ Poles. (Non-statutory sector interviewee)

Various interviewees mentioned that, at a local level, Local Strategic Partnerships had worklessness as a key priority. Other partnerships were mentioned, including local regeneration partnerships and local learning partnerships, which aimed to boost learning rates and equip people to go to work. Informal networks were said to be extremely important, as well as more formally established networks:

> In a sense, you can't do the informal bit without the formal bit. The formal bit can get you so far … but most business is about the informal networks: a huge amount of business gets done there (or the foundation is laid for much business that might or might not get done). (Academic sector interviewee)

Agreeing with this, a first phase informant (in a leadership role) commented that a degree of informal contact was necessary to keep in touch with other organizations, such as JobCentre Plus, to ensure that different groups were not all trying to do the same thing.

Several interviewees mentioned voluntary sector representation, thought to be very much through VONNE, whose role was believed to be increasing. The Assembly's 2002 business-related scrutiny report (NEA 2002a: 24) noted that

ONE had acknowledged the valuable contribution and was attempting to ensure third sector engagement.

One interviewee said that individuals make a huge difference and that there were several champions, not all seeing the same views but all determined to get the issue on the agenda.

> You can't implement or deliver with champions alone but they are a very good starting point. (Health sector interviewee)

User representation was hardly mentioned, unprompted, in the interviews. One interviewee, talking of discussion on the DWP policy around assessment processes for benefit eligibility, commented wryly that

> the user representative was from the unemployment centre: rather than an unemployed person, this person was employed to work with unemployed people – this was the answer to 'how do we get representation?' (Non-health-group-1 interviewee)

Several interviewees did not know whether there had been any formal assessment of public acceptability (talking mainly of the DWP policy on assessment processes for benefit eligibility), either at national or regional level. One non-health-group-2 interviewee believed there would probably have been some local consultations or research with small numbers of Incapacity Benefit claimants, and a non-statutory sector interviewee said there had been consultations with disabled user groups. Another (academic sector) stated that things would have been different under an elected assembly, when more

debate could have been expected because planners had to justify spending. Voluntary sector representatives mentioned helping to publicise the process and trying to make it user-friendly, hoping to get, if not the views of directly affected people themselves, then those of the people closest to those people. However, the majority felt that there had not really been any assessment of public views, one responding to the question with a brief laugh and a categorical denial.

> *Question*: 'Has there been any assessment of the likely level of public support for the [DWP] policy?'
> *Answer:* 'No, **absolutely** not!' (Health sector interviewee)

Some interviewees felt that it had been assumed that people would think the policy was a good thing. One Local Authority had reportedly produced, for public consideration, a strategic plan with worklessness as a top agenda item: however, the authority's procurement department and planning department had not adhered to this, so any public response would have been ignored anyway:

> One lot write the strategy, another lot take action and never the twain shall meet! (Non-statutory sector interviewee)

A non-health-group-2 interviewee said that research on support for worklessness policy had been part of several studies around social inclusion and stigma, and this had been used to inform policy. The studies reportedly showed that people felt that getting vulnerable people back to work was a good thing, particularly if related to depression or stress. However, they also found that there was less likely to be support when it was suggested that in a limited job market, these people should have priority.

Press coverage has been used as a way of assessing public response, usually when a policy has been drawn up, rather than beforehand. An example was given of press coverage of local people from welfare rights groups saying they felt the national policy was bad for disabled people. (This was after the policy statements had been made and the health sector interviewee felt these people had 'missed the point' anyway.) One academic sector interviewee felt that the debate tended to be more of a national concern and one described the issues as "Daily Mail issues".

> On the one hand, getting work-shy people back to work and, on the other hand, the DWP did not want to be seen as coercing people. (Academic sector interviewee)

Opinions diverged as to whether the public had actually been engaged in shaping policy. Some interviewees did not know; some referred to the public consultation on the Regional Economic Strategy or to focus groups during its development, with representatives from unemployment (mainly recipients of Incapacity Benefit, sometimes involved in testing the process). One interviewee suggested that many Local Authorities involve local people in their design of worklessness solutions and one felt that engagement in many initiatives came through service user input via the voluntary sector. The voluntary sector was mentioned several times as providing representation, for example around disabled groups. However, some interviewees felt that the (sub-regional) planning did not even involve the particular group the schemes were intended to support, and they described the development process as

very bureaucratic. Several interviewees stated that there was minimal engagement or none at all:

> The DWP is not great on engaging the public! (Academic sector interviewee)

Although two or three interviewees felt that probably all the relevant bodies were included in worklessness policy development, others said that certain groups of people were missing. Several (from different sectors) believed that the voluntary sector had been under-represented. In its 2002 business-related scrutiny report, the Assembly had expressed concern that the third sector was 'neither getting a place at the table in partnerships nor having its important contribution recognized' (NEA 2002a: 24). The Assembly recommended greater working with third sector regional or sub-regional networks such as BECON.

One health sector interviewee felt that the LSC had been omitted and another said that JobCentre Plus had been 'a bit hit and miss about turning up'. Several felt that the private sector had not been much involved.

> The business sector will say 'What's in it for us? We want to make our business work; we want to make profits out of it, why should I help wider social causes if it might put the business at risk? (Health sector interviewee)

A non-health-group-1 interviewee suggested that it was difficult to engage PCTs and Local Authorities at a regional level. Several interviewees described NHS involvement as poor; an academic sector interviewee felt that it was

assumed that SHA involvement was sufficient to cover NHS viewpoints. The difficulty of representing any wide community by just one person was raised also in connection with geography (less involvement from rural communities) and with the contribution of the academic community. An academic sector interviewee suggested that there was only nominal academic involvement, even though the universities were described in the Regional Economic Strategy as a 'key to change the North East to a more knowledge-based economy'. One interviewee (non-health-group-1) said that it was mainly because of the sheer scale of it that not everyone was involved who ideally would have been.

The perceived lack of any regional-level worklessness policy development at the time of my interviews prompted one interviewee to say they were uncertain whether there was a policy around which joint working could happen:

> I see small is beautiful, rather than large scale. I don't see a serious strategy but I see a lot of people doing a lot of good work on the ground. (Non-statutory sector interviewee)

A non-statutory sector interviewee claimed that 'there was a complete lack of joined-up thinking' but others seemed to feel that there had been joint working on worklessness policy. The Regional Employability Framework, whose main purpose was 'to contribute to the Regional Economic Strategy (RES) through improving participation in economic activity', also aimed to

> create an explicit strategic commitment to joint action to drive up performance through joint procurement and commissioning approaches and development support on the ground – this will provide a clear context for local partnership action. (Rocket Science 2006: 2)

A non-health-group-1 interviewee referred to a recent process to address worklessness, which had involved three large conferences, attended by employers, providers, policy people and funders. Other interviewees also saw an increase in commitment to working together, and a greater openness about expenditures, following greater pressure to be cost-effective and avoid duplication.

> The mantra has not been about money but has been about working more effectively together. (Health sector interviewee)

> The Regional Employability Framework – its main thrust is people pooling funding - it needs a lot of commitment to get them to do that because at the same time they need to hit their own targets that are identified driven nationally. (Health sector interviewee)

A non-statutory sector interviewee stated that it definitely needed all three sectors – public, private and voluntary – to work together. That informant felt that the private sector had recognized that it needed to be involved but the public sector had not yet woken up to that. Joint discussions between the sectors were thought necessary:

> I see too much policy made behind closed doors then imposed. If it is discussed properly before, we could have workable solutions. (Non-statutory sector interviewee)

One interviewee felt that the voluntary sector was unable to contribute particularly well, not because of its own limitations or because of any lack of a desire to be involved, but because

> the DWP has little understanding of the voluntary sector and how it operates - it is imposing its stamp on the responsive voluntary sector. (Academic sector interviewee)

Integration of worklessness-related strategies with other strategies had been a theme at least since the 2002/03 Framework for Regional Employment Skills Action for the North East (FRESA), which was 'aligned to the objectives of the Regional Economic Strategy' and whose 'priorities will also benefit from aims identified in the Regional Image Strategy' (ONE 2002a: 3). Joint working was recognized as essential in the formation, in 2004, of Skills North East, the Regional Skills Partnership, which produced the Regional Skills Action Plan 2005/06 (Skills North East 2005) as part of its role in

> transforming attitudes towards learning and developing a highly skilled workforce to underpin a high performing economy. (Skills North East 2005: 2)

The perception of many interviewees, however, was that there was no integration of policies across sectors or departments. Referring to the potential use of housing policy to contribute to the worklessness agenda at a particular sub-regional level, one non-statutory sector interviewee commented that, whilst the local authority economic development people said 'yes, fantastic',

the local Authority planners turned it down as they did not want to be told what to do.

> Even though the corporate local authority goal was to tackle worklessness, the planners were not aware of the corporate goal. Even though we said 'if we could keep a certain number of people in work, it would improve health, reduce health costs (we could work out how much it would save the NHS) and reduce crime', the Local Authority said ratepayers would not benefit (NHS budget or Home Office budget would benefit). (Non-statutory sector interviewee)

This comment highlighted the difficulties of departmental responsibilities and conflicts, which are linked with the leadership and power issues discussed in the following sub-section.

Worklessness policy: leadership and power

Most felt that the lead was with One NorthEast, although a health sector interviewee suggested that *'one part of it was heavily driven, others were not'.* A non-health-group-1 interviewee thought there might have been some 'jockeying for position'. A health sector interviewee felt that ONE might have taken the lead only because of JobCentre Plus reorganization at the time, although another interviewee (non-health-group-1) said that JobCentre Plus was 'absolutely on board'. Several interviewees stressed the need for joint working rather than leadership in this area, with one (non-health-group-1) suggesting that great care was taken in the way related meetings and events were 'badged' to stress joint responsibility.

Views on the power to get health issues considered in worklessness policy are described in Chapter 7. The power to keep worklessness on the agenda was believed by some to lie with JobCentre Plus. 'It is one of their reasons for being', said an interviewee in non-health-group-2. However, another felt that it was ONE that held all the power, largely because of resource control:

> The health service and local authorities can try to influence but ONE chooses where to put resources. (Academic sector interviewee)

Reservations were also voiced about the power that actually exists at a regional level:

> There is still a lot of national power: setting rates of benefits, putting in Pathfinders, other actions that affect where businesses locate, for example: whether they choose the UK or elsewhere; or port policy that says that moves should favour the North East; or transport policy. Lots of issues that are national government-determined (about infrastructure) affect employment across the country. (Health sector interviewee)

> People in regional organizations feel they are developing their own policies but, on close inspection, these policies have been designed for them - most of the big decisions are made centrally. (Academic sector interviewee)

Interviewees were asked whether they believed that there were any organizations or individuals with an interest in keeping worklessness off the agenda. Several said there were none and that it was a very big issue for everyone.

> Obviously, there are different political views about changing the laws…There are different perceptions of why we are doing it but solutions tie together and there is political consensus that worklessness needs tackling. (Academic sector interviewee)

Several other interviewees (from different sectors) felt that there was some reluctance to embrace a new policy because the status quo is easier than

change: inertia might be the problem rather than self-interest. Corporate social responsibility, with employers wanting to engage in good practice, was mentioned by one academic sector interviewee. However, some informants (different sectors) felt there were organizations opposed to worklessness being on the agenda. One (non-health-group-1) felt that there might be many employers who were not really bothered about worklessness being on the policy agenda, in particular not minding where their cheap flow of labour came from as long as it came. Similarly, another suggested that the CBI and the business community were opposed to it, especially around minimum wage issues and the importing of cheap labour:

> the business community's default position is to get the lowest paid worker we can to do the job. (Academic sector interviewee)

According to a health sector interviewee, many employers felt that helping people with health problems back to work was an economic drain. Several interviewees also mentioned particular individual opposition to worklessness being on the agenda. One cited the example of local councillors who were on benefits and did not want to lose them under new policy. Another felt that

> it would be foolish not to recognize that some individuals are comfortable with a diagnosis of being unable to work – they do not want change. (Non-statutory sector interviewee)

Although many interviewees felt there were organizations or individuals with an interest in keeping worklessness off the agenda, most of them believed that those people did not have any real power to influence the agenda. One (non-health-group-2) felt that local communities had a certain amount of

power (more in terms of influencing implementation) and another (academic sector) pointed out that economic muscle is important, so employers could have an influence.

There were sometimes felt to be people who objected not to worklessness being on the agenda but to some aspects of worklessness policy. A health sector interviewee said that there were tensions between primary care practices and certain elements of the worklessness policy agenda, particularly around the idea that GPs should not always sign sick notes without considering the case further.

This section has described findings on the people and power involved in the development of worklessness policy. The next section describes findings related to my final policy area, climate change.

Who moves the healthy policy area 'climate change' onto and up the regional decision-making agenda?

At the time of the interviews, there was not an actual 'regional climate change policy', nor were there any national or sub-regional climate change policies. So the term was open to interpretation. Many comments from interviewees did relate to climate change policy in general but many related to the sustainability agenda. The sustainability theme was part of the Regional Economic Strategy and the Regional Spatial Strategy and these were the most frequently cited

relevant policies. There were also some sub-regional plans mentioning sustainability issues. Other related plans and strategies included a plan produced, following a commitment from four local authorities, to address the causes and effects of climate change (Sustaine 2002a); a renewable energy action plan; and the Assembly's Rural Action Plan. Some interviewees also referred to national or international policy related to climate change. I shall draw attention to different policy references if it appears to affect people's comments on any aspects of the climate change policy area.

Working together on climate change policy

There was considerable variation in the partners mentioned by different interviewees. Sustaine (itself a partnership) was mentioned by several. There was more emphasis on national agencies (Environment Agency, DEFRA, DTI, CLG and Natural England) than there had been in discussion around the other policy areas. The Regional Development Agency, North East Assembly, Regional Housing Board and GONE were mentioned but there was more focus on local authorities and their associations such as ANEC and the Local Government Association. The NHS, the police, the CBI, the TUC and the voluntary sector received mention, along with several energy-specific agencies, such as Energy North East, the Energy Saving Trust and the Northumberland Renewable Energy Group (involving district councils, county council and a number of renewable energy advisory bodies and providers).

Several interviewees believed that the partnerships were more like loose federations than clear partnerships. Most commented that climate change was a very cross-sectoral topic. A new ‘climate change officer’ post had been created, a partnership post funded by key partners, aimed at working with as many people as possible across the region. However, one non-statutory sector interviewee described the post as window-dressing and very dependent on the individual and the level of support.

It was not until after my main interview period that a new North East Climate Change Partnership (NECCP) met for the first time in July 2007. Attended by 64 people from across the region, this led to the formation of nine groups within the partnership, which would inform the region’s climate change action plan. Strategic level multi-agency support for work on climate change was later highlighted by the Assembly:

> Regional partners in the public, private and voluntary sector have gathered together to sign a special declaration pledging to tackle climate change. The North East Declaration of Climate Change was signed at a special ceremony at the Government Office for the North East... (NEA 2008c)

Several interviewees had felt that there were attempts to ensure genuine inclusivity within the Sustaine Partnership.

> Sustaine is well developed to represent all sectors, including commercial and voluntary. (Health sector interviewee)

One non-health-group-1 interviewee felt that networks could ensure inclusion, saying that there were many representatives in the various partnerships involved and that various sub-groups tended to work on plans, consulting with other networks as appropriate. It was also pointed out that with climate change being such a broad agenda, it was difficult to say whether there were any organizations not included that should have been:

> The problem is that because climate change will impact on everyone, potentially all need to be involved – but you cannot generate policy by having everybody involved. (Non-health-group-1 interviewee)

> I am not able to think of any civic institutions that can't be involved – LA, ONE, EA – a mélange of all activities. (Non-health-group-1 interviewee)

Nevertheless, some possible omissions were mentioned. These included (from one non-health-group-1 interviewee): CPRE, Transport 2000 and Friends of the Earth (although the latter were said to have had some input in the formative stages). Another interviewee (non-health-group-2) felt that the private sector generally was not sufficiently represented, although said that it was difficult in this region to engage them (compared with other regions, where the private sector was more heavily involved in sustainable development). Other private sector omissions were said to be the construction and transport sectors and the commercial sector.

> The commercial world has been slow at coming to an understanding – and people who have potentially the most leverage: investors and commercial banks. (Non-health-group-2 interviewee)

Two interviewees were uncertain about the RDA's level of engagement:

> ONE was initially slow to come on board, not seeing this as an area of work of legitimate interest for them – but this is now turning around … DTI have told them to be more involved. (Non-health-group-1 interviewee)

> Regionally, getting the likes of RDA to be more engaged is quite an influential process. (Non-health-group-1 interviewee)

A few interviewees felt that the NHS was not much involved, a big omission in view of the fact it was such a major user of energy, the biggest employer in Europe and had such a huge procurement role.

> Government (regional and local) is involved. Plus the NHS – though this is a long way behind and it is often personal rather than organizational interest. (Non-statutory sector interviewee)

Several interviewees (from different sectors) said they were not aware of any assessment of the likely level of support from the public for a policy and some said they doubted there would have been. Two said that it was too early to assess it:

> There is still a long way to go before bringing the public in on the issue – or even elected members [of the Regional Assembly]. There is not yet great awareness around the connections between economic development and sustainability. (Academic sector interviewee)

Others believed that, although they had not seen it, there would have been some assessment of public support. Several said there had been a lot of research showing that people recognize the importance of the climate change issue. This included some local research, related to carbon-neutral North East, which raised awareness and helped people to understand what actions

could be taken. Several interviewees felt that there was increasing public awareness about climate change issues, not necessarily assessed locally but apparent nationally. It was suggested that, although there had been no specific regional assessment,

> The regional media are quite keen on it – concerned about it – so it does get coverage. You can perhaps interpolate that as public interest. (Health sector interviewee)

On the question of whether there had been attempts to engage the public in shaping climate change policy, some felt there had been none but others said there were at least elements, with the new climate change control officer talking to groups across the region. One interviewee (non-health-group-1) suggested that, although the partnerships were 'not public facing', the various partners' networks could to be used as links with the public. Sustaine, with involvement of Local Authorities and groups such as VONNE, was mentioned as a possible conduit for public involvement. One non-health-group-2 interviewee referred to a current consultation on the North East Environment strategy, although felt it might be less for the public and more for organizations. The *Examination in Public* (for the RSS) was only mentioned by one in this context, but was described as

> only marginally for the public. Civil servants came to meetings – I am not sure how widely known the meetings were. People could lobby but there was no wide public consultation. A lot of people know the process is going on but it is difficult to engage them until you have a concrete plan. (Academic sector interviewee)

There had certainly been consultations on various other policies associated with climate change, such as renewable energy (NEA 2004b: 15).

Consultation and public engagement were described as essential by several interviewees.

> If you asked 100 people, probably a high proportion would say climate change was important but if you asked them if they would be prepared to pay to drive a car in the centre of Newcastle they might say no. We need to be mindful there is a lobby out there and engage with lobbyists to understand people's objections. (Non-health-group-1 interviewee)
>
> The public opinion issue is complex - combating fatalism… defeatism … 1) that it is already too late and 2) 'what difference will it make if I change, compared with China and its power station emissions'. (Health sector interviewee)

Some interviewees commented on the way the public puts pressure on the politicians, so that involvement of the public would act as a lever:

> Politicians often need to act for increasing votes or decreasing costs (this is not a criticism, as it is the nature of their job). They will deliver on climate change because public pressure makes them do it rather than because they naturally lean to it. (Non-statutory sector interviewee)
>
> To tackle it means a radical rethink of lifestyles and fuel usage. The power to change it is therefore difficult. People are going to have to push politicians – we need public groundswell. (Health sector interviewee)

Several informants said that joint working was both important and effective. A non-health-group-1 interviewee thought that links both regionally and

nationally speeded up access to good practice. It was also said that without the joint working

> it would have been easy for it to be like Agenda 21 – marginalised. (Health sector interviewee)

Some concerns were expressed about the difficulties of joint working at regional level:

> We work well as a partnership but it is hard for a regional partnership to keep its presence felt at local level. (Health sector interviewee)
>
> There are problems around fragmentation – English Nature, Environment Agency, Sustainable Development Commission – they overlap, there is shared interest but fragmentation. You don't get a regional focus (you occasionally get a national focus). No one takes the lead or overview. (Academic sector interviewee)

Several interviewees felt that the process was hampered by a lack of clarity over relationships, roles and priorities.

> There is a lack of clarity about what is the best thing to do and a feeling of impotence on the part of most people. (Health sector interviewee)
>
> We need to articulate where people fit in an organization – what we need to do to achieve real benefit. (Non-health-group-1 interviewee)
>
> Emerging policy priority will need clarity about how it is managed. (Non-health-group-2 interviewee)

Joint working could take place on general climate change issues in many ways. One specific way was the work towards integration of climate change strategy with other strategies. By late 2008, with the knowledge that Sustaine was to be involved in the development of the new single regional (economic) strategy, the Sustaine board began to look at how the Integrated Regional

Framework could be used to influence climate change (NEA 2008d). Such influence is related to power, which is discussed in the following section.

Climate change policy: leadership and power

The issue of leadership on climate change policy caused some confusion amongst interviewees. Some felt that there had been a partnership of equals, with different organizations adopting different roles and no particular leading single agency.

> The regional bodies jockeyed for who was going to take a lead on climate change …they decided to work together for the benefit of the people of the North East. The Regional Assembly could have the lead role, from what was said by government. All have a central role: the Regional Assembly is good at convening and has a broad membership, bringing people together from a broad base; ANEC is good and has intimate relationships with Local Authorities; Government Office is key; the Environment Agency is crucial. All of these can be central if they need to be – let's work together…Sustaine is independent and will have put the partnership together on behalf of the region. (Non-health-group-1 interviewee)

> I am not aware of anyone in charge. (Health sector interviewee)

However, many saw the Regional Assembly having a sort of lead role, or at least a nominal lead role in climate change policy. The influence of the Sustaine partnership was also mentioned:

> Sustaine can be a bit of an invisible organization to some organizations but their strategies do inform other strategies. (Non-health-group-2 interviewee)

Leadership on sustainability issues in general was claimed by the North East Assembly, a claim legitimized by government guidance (DCLG and DEFRA 2007). Sustainability had been a theme of its agenda updates and newsletters for some time. From December 2007, the section heading in NEA newsletters changed, to reflect very clearly the leadership aspect, to '*Sustainability: leading and facilitating partnerships that deliver sustainable development'*:

A non-health-group-1 interviewee suggested that there might actually not be any specific organizational or individual power to push climate change control up the agenda: instead, 'it is absolutely and utterly dependent on persuasion and partnership'. However, most felt that there was power somewhere.

The power of the government to keep climate change on the agenda was mentioned by many interviewees (from all sectors). They believed that the push was definitely from national government rather than from within the region, as 'all the major parties have climate change at or near the top of the agenda' (said a non-health-group-1 interviewee) and the push is from 'the government through DEFRA', according to a non-health-group-2 interviewee. Some interviewees (various sectors) mentioned the power of specific government departments, including DEFRA and DTI, through their control of funding streams, which enabled them to influence how things are delivered. Many just referred to government or political power in general, recognizing

that no one department was responsible (at that time) and that climate change policy would have an influence on many other policy areas.

More detailed references to the government lead were also made.

> Since June 2005 – political will. Prior to that, worthy individuals tried to get it taken seriously. Political leadership (international and national) plus business leadership have led to a rapid result in taking climate change up the agenda. (Non-health-group-1 interviewee)

> The National Planning Policy is coming out. Policy Planning Statement (PPS 26) – currently in draft – will give planners a more focused need to respond to climate change in their policies – it will be quite influential. The Climate Change Bill later this year ... will be pretty far-reaching. Things like this will help drive delivery of climate change action. (Non-health-group-1 interviewee)

> We were fortunate to have DEFRA: though often maligned, they did see it was an issue. They funded the UK climate change impacts programme – fabulous stuff that can be used to integrate in business – risk assessment, uncertainty, *et cetera*. (Non-health-group-1 interviewee)

Several interviewees felt that, once the government had started the push, the power lay with regional or local organizations to maintain momentum.

> The government can do something to stimulate debate. The region must show its relevance to individuals and what they can contribute. (Non-health-group-1 interviewee)

> Local Authorities – even more so after the ministerial statements about expecting Local Authorities to play a huge role, including taking the lead to do things individually. (Non-health-group-1 interviewee)

Some interviewees pointed out that the government was influenced by the public, where there was a lot of power in terms of consumers being able to

modify their behaviour. Public demand and the public interest were mentioned by several interviewees:

> Politicians following public concern (rather than leading). (Health sector interviewee)

> The power to get something done is political will. Globally the issue is increasing, including a lot of people power. (Non-health-group-1 interviewee)

Linked with growing public awareness was the importance and power of the media. A non-health-group-2 interviewee felt that the media now took the issue far more seriously. It was felt that public concern affected the response of both local and national government:

> More and more a concern of residents, too, so councils respond to that. There is recognition that Local Authorities have a role to play… We need to get our house in order. (Non-health-group-1 interviewee)

> The growing awareness among the ordinary population makes it easier for elected political representatives to be able to take potentially difficult decisions. (Non-health-group-2 interviewee)

A few interviewees suggested that the power lay elsewhere:

> President Bush! (Non-health-group-2 interviewee)

> Totally with the scientists and the environmental lobby. (Non-statutory sector interviewee)

Several interviewees felt that the power rested with a whole range of individuals or organizations:

> The government, intergovernmental activity, elected members, scientists, everybody! (Non-health-group-2 interviewee)

> Central, regional and local government, including ANEC and the RDA. The media are also important. (Health sector interviewee)

When asked where the power *should* lie to push climate change issues up the agenda, answers ranged from 'individuals' through 'local level' through 'government' through 'international government' to 'everyone'. The majority favoured it lying widely. Those who favoured power lying at an individual or local level tended to suggest this because the necessary actions would take place there.

> Local Area Agreements need to have climate change as a priority in them… These are good mechanisms, with partnerships coming together with a lot of different interests but a lot of common themes and concerns. Climate change is one that is cross-cutting. (Non-health-group-1 interviewee)

> It ought to lie with planning authorities and organizations that can exercise public procurement. (Non-statutory sector interviewee)

Some interviewees wanted power at a regional level.

> In theory, a partnership like Sustaine … the economic backing, *et cetera*, should be very powerful but, in practice, it does not seem to be that simple. (Health sector interviewee)

Interviewees who felt power should lie with government (or at an international level) often felt that government push was necessary to persuade individuals or communities to take action.

> Individuals need to be persuaded to take responsibility, e.g. with the breathalyser, the legal requirement changed cultural perceptions - and with seatbelts. You need both the carrot and the stick. (Non-health-group-1 interviewee)

> It is a big issue. We still need government to push the agenda. You can't rely on change in public knowledge – need is more urgent than want. (Non-health-group-2 interviewee)

> Individuals have the power to change things but only government has the power to do it for a lot of people. (Non-health-group-1 interviewee)

Only one interviewee (non-health-group-2) stated that there was no one who wished to keep climate change off the agenda. A non-statutory sector interviewee believed that the U.S. government wished to do so. Several believed there were organizations or industrial sectors that so wished:

> The road lobby is scared about it – they feel picked on as they make only 20% of the carbon impact of the country. …The aviation lobby is worried about the impact on air travel – but it is their business. (Non-health-group-1 interviewee)

> People whose income from activities which are ultimately destructive of long-term natural resources. (Non-health-group-2 interviewee)

> Those who have a vested interest in the status quo –they don't want to move from high energy use *et cetera* – producers/ companies that sell those commodities. (Non-health-group-1 interviewee)

On a more individual level, other potential opponents to a climate change

agenda were mentioned.

> Some people who can see a huge cost but no benefit. (Non-health-group-1 interviewee)

> Human nature is the problem when it comes to climate change. ... People are concerned about environmental change but equally concerned about their everyday lives. (Non-health-group-1 interviewee)

Of those said to be opposed to having climate change on the agenda, several were said to be powerful and able to influence the agenda.

> The road lobbies are very powerful indeed – far more powerful than we give credit for. Governments do bow down to them… it needs the bold step change that the Mayor of London has brought. We don't have that political assurance elsewhere. (Non-health-group-1 interviewee)

> The airport is in the [Regional Economic] strategy as a positive thing so they have kept out climate change ... if climate change were bigger, they would have wanted a reduction in air travel! (Academic sector interviewee)

> The car lobby is a tough nut to crack – the public, in general, like their cars! (Non-health-group-1 interviewee)

> How much power does the petrochemical industry have? How much power do car manufacturers have? Quite a lot. Not power to keep it off the agenda at a local level but they have the power to influence it at international or even national level. (Non-health-group-1 interviewee)

> They've got the power and they've got the numbers, e.g. countries like the U.S. - or China, where it is not good news if they cannot achieve the standards of living of the west. (Non-health-group-2 interviewee)

One interviewee suggested that the issue was not necessarily opposed but was put on the back shelf because it was difficult:

> For the NHS this is in the "too hard" category – i.e. there is benign neglect, not deliberate. Similarly with Local Authorities. Some organizations wish to avoid addressing the issue as long as they can. (Health sector interviewee)

Several others felt that it was not so much a case of keeping it off the agenda but keeping some of the possible actions off the agenda.

> Some organizations lobby against road charges... and possibly some politicians who are against using taxation to make change. (Non-health-group-1 interviewee)

> Not climate change itself but some of the actions that are necessary. There are quite strong vested interests. (Academic sector interviewee)

> At national and regional level, most people realise some policy is needed. The question is just about how deep it should bite. (Non-health-group-1 interviewee)

Conclusion to Chapter 5

This chapter has described my findings, from documents and from interviews, on the people and power involved in driving the regional policy agenda. General policy-making has been considered along with policy-making for tobacco control, housing, worklessness and climate change. This should help me to draw comparisons (in my discussion chapter) to help in the identification of the factors most affecting regional policy development. People and power are extremely important in agenda-building but there are also many other factors that might affect the way a policy area rises up the regional decision-making agenda. Findings related to these other factors are described in the next chapter.

Chapter 6: What other factors influence the progress of healthy policy areas on the regional decision-making agenda?

The previous chapter described my findings around the people and power involved in policy agenda-building. This chapter looks at findings around other factors influencing the progress of a policy area on the decision-makers' agenda. I shall describe firstly my findings relating to general policy development. (Again, to avoid identification, quotations are not attributed to specific interviewee groups when they are from the small number of scoping phase interviews). Subsequent sections will contain my findings on the specific policy areas, in broadly the same order as they were discussed in the literature review chapter, namely: factors in agenda-building theories: other contextual factors: and the nature of the issue. To avoid repetition, when factors appear in various models, I have addressed them in the most appropriate section only. (For example, Hofferbert's (1974) factors are considered within the contextual factors section, rather than within agenda-building models, because his overall model is probably most valuable for its recognition of the multivariate nature of policy-making.) Factors are therefore generally discussed only in one section in this chapter, leaving fuller consideration until the final discussion chapter.

Agenda-building models are more relevant to particular policy than to general policy development. Similarly, the concepts of complexity, uncertainty and consensus are less useful in general policy development. Factors that are most relevant to general policy are contextual factors, resources and an evidence base.

Contextual factors, as described by Alford (1969) or Leichter (1979), arose in several interviews on general policy. One (first phase) interviewee felt strongly that it was possible to shift the cultural or social environment as it was being created and that it was easier to affect or influence policy at a regional level where there is a coherent region like the North East. Organizational changes in regional governance also affected policy development. Particularly significant were the formation of the Regional Development Agency and the North East Assembly (1999) and the increases, at various times, in the number of government departments represented in Government Office for the North East.

Restructuring affected organizational boundaries: several interviewees commented that it was much easier to work with other agencies when boundaries were common. Restructuring could damage strong multi-agency partnerships, where networks had built up over time and trust had been established.

There were several changes in responsibilities for the production of Regional Planning Guidances. From 1999, the process became more transparent, had to include wide stakeholder consultation and formal examination in public, and became subject to sustainability appraisals (Counsell and Bruff 2001: 486). The Assembly became the regional planning body in 2002. In 2004 came the introduction of statutory Regional Spatial Strategies, to be prepared by Regional Assemblies. Changes specific to particular policy areas are mentioned in discussion on those areas.

Resources were mentioned by several first phase interviewees. As well as the resource of good leaders and advocates, adequate financial resources were said to be essential. However, several interviewees stressed that it was important not just to have these resources but to have direct control over them so that adequate staffing at all levels could be ensured.

Referring to lack of a research-based view during the development of housing policies, an academic sector interviewee suggested that

> this is a problem common to virtually all policy – we have no idea what is going on and no idea what we should do about it most of the time.

Agenda-building models and explanatory factor models are much more pertinent to specific policy areas, such as tobacco control, which is the subject of the following section.

What other factors influence the progress of the policy area 'tobacco control' on the regional decision-making agenda?

Previously mentioned differences in interpretation of 'tobacco control policy' are highlighted if appropriate in this section, in which I describe my findings on factors in agenda-building models, policy context and the nature of tobacco control policy issues.

Factors in agenda-building models: tobacco control policy

In terms of Cobb and Elder's (1972) issue creation, no interviewees (unsurprisingly) felt that the issue was created by an unanticipated event. Nor was it suggested that the issue was manufactured by someone for their own gain. Several saw the health sector in general as the driver, two (different sectors) pointed to the influence of international pressure but most said the main driver was national government, particularly the Department of Health, via both the Tobacco White paper and the *Choosing Health* white paper, acting in the public interest.

Several of the issues discussed by interviewees can be viewed in terms of the legitimacy, feasibility and support used in Hall *et al*.'s (1975) model of agenda-building. Tobacco, apart from the taxation element, is not strictly an issue to which government must traditionally respond: it is not an urgent problem such as civil disruption or a national economic emergency. However, many interviewees spoke of the growing awareness of tobacco's economic impact

and many believed that the economy was the main driver, particularly with the rising costs to the National Health Service. So, whilst not an economic emergency, tobacco consumption creates an economic problem, which is a 'normal' government responsibility. Within the region, the economic problem was also recognized and tobacco could be seen as being strongly linked with poor economic performance: it was therefore part of the problem to be addressed when looking at regional economic improvement policy. The legitimacy of tobacco control policy was not questioned by any interviewees, at either a national or a regional level. National legislation is from an elected national government but no one suggested there was any reason to object to the regional statutory organizations creating tobacco control strategies. Legitimacy therefore appeared therefore strong at both regional and national level.

I assessed the perceived feasibility of tobacco policy mainly through the discussions on implementation (see interview schedule in Appendix 6), considering both known and anticipated problems. I also gleaned much from comments made about agreement and certainty of success. Addressing the tobacco problems appeared to be technically feasible: interviewees did not suggest that there were any major technical difficulties. However, various resource issues were raised, including a general lack of funding (for many aspects of tobacco control, including stop smoking services, smuggling control and enforcement of the law on smoking in public places) and a shortage of

some suitably qualified staff for some actions, such as the public places enforcement. Although interviewees did not question the feasibility of tobacco control at a regional rather than national level, this concern had been expressed elsewhere, for instance:

> There is one compelling reason why the government should – for once – forego devolution. Direct action by government on passive smoking will allow restrictions to be put in place much faster than if the decision is left to individual local authorities. (HSJ 2004: 6-7)

Perhaps unexpectedly, several interviewees felt that there was no shortage of money for the implementation of tobacco policy, although some said that anything started with pump priming money would lead to financial problems when it came to continuing activity. A non-statutory sector interviewee mentioned the location of government investment, saying that policy success was made more likely by the government's 'rooting of anti-smoking more firmly in the primary care setting.' Another non-statutory sector interviewee suggested that it would be essential to maintain continued commitment, which needed funding. With regard to the smoke-free public places legislation, there was thought to be a shortage of enforcement officers for dealing with non-compliance and contraband. General administrative capacity for tobacco policy-making had increased with the creation of Fresh. A few interviewees (from various sectors) suggested that the feasibility of policy was undermined when organizations had to concentrate on targets, forcing all efforts into meeting particular targets, to the potential detriment of other activity. (The focus on quit-rates, historically a controversial target, was believed to detract

from work on preventing children smoking.) Overall, there are some doubts about feasibility, which is perhaps best described as strong rather than very strong.

The huge change in public attitude (not sudden but growing over the years) was mentioned by several interviewees, particularly with regard to smoke-free public places. One non-statutory sector interviewee also felt there had been a corresponding change in political attitudes to support policy. A report from ASH commented that

> public support for tobacco control remains strong ... Experience of the benefits of smokefree enclosed public places appears to have increased public enthusiasm for new initiatives in tobacco control. (ASH 2008: 4)

Some of the potential opposition to tobacco policy was discussed in Chapter 5. Much of it related to very specific elements of policy. With regard to implementing the smoke-free legislation, some interviewees expected to see problems in persuading certain pubs and clubs to comply. Difficulties in accessing vulnerable groups were also mentioned, and a health sector interviewee suggested that there could be lack of effort made in this regard because of a belief it would fail. However, none of these issues was thought to be a serious threat to policy development. International examples of public support were also cited by interviewees, exemplified by the success of the California approach to tobacco control and with the suggestion that if it works

in America, it can work in Britain. Since there were some reservations about the level of public support, I have classed this is as strong rather than very strong.

Political support for tobacco policy appeared strong, as evidenced nationally by the legislation around smoking in public places and the tobacco white paper, and within the region by the development of regional tobacco control strategies and the formation of the regional tobacco control office. There was a long history of supporting pressure group activity, including the more recent activity around smoking in public places. I have therefore classed both of these as very strong.

More serious barriers were those that could pervade the policy-making arena. Several interviewees (from different sectors) referred to the impact of reorganizations on working relationships, potentially very damaging to policy development and the likelihood of success. However, relationships at the time of the interviews were generally good, as described in Chapter 5.

I have summarised overall views on legitimacy, feasibility and support, as discussed in preceding paragraphs, in Table 5, to help in later comparison with other policy areas.

Table 5: Hall *et al.*'s model with relation to tobacco control policy

Legitimacy		Feasibility	Support		
National	**Regional**		**Public**	**Political**	**Pressure group**
Strong	Strong	Strong	Strong	Very strong	Very strong

Many of the findings contributing to assessment for Hall *et al*.'s (1975) model are relevant to Kingdon's (1984) model, particularly those relating to the policy stream. In terms of Kingdon's problem stream factors, the detrimental effects of tobacco on health have been long recognized, particularly amongst health professionals: a range of systematic indicators shows that the North East exhibits a very poor record of tobacco-related disease and death rates in comparison with the rest of England. Interviewees frequently referred to the wealth of evidence and public awareness of tobacco-related problems, both as a national problem and a particular issue for the region. Outside of the health indicator field, other agencies make use of indicators showing the problem to be more severe within the region than elsewhere: smuggling hotspots exist within the region, leading to reductions in revenue and customs income; counterfeit tobacco products create problems for trading standards departments; illegal sales to minors create higher workloads for the region's local authorities. Many of the agencies involved in tobacco control thus have routine indicators showing that the problem within the region is either worse than the rest of the country or is growing in severity. Feedback on current programmes related to tobacco control also contributed to a growing evidence base. For example, smoking cessation services, an integral part of the

tobacco white paper, have been shown to be instrumental in helping smokers to quit smoking. There was also a high and increasing demand for such services, an indication of general recognition of smoking as a problem. No interviewees suggested that there were any particular focusing events around tobacco. Indeed, several said that it was merely a continuing growth in the awareness of the problem, rather than any specific event, that forced the issue onto the policy agenda.

In terms of Kingdon's political stream, there appears to have been not a specific sudden swing in public mood, but rather a gradual move towards an acceptance of the need for control, particularly in the area of second hand smoking. (There have been pressure group campaigns for decades.) Nor has there been particular ideological disturbance in government: rather, there has been an increasingly supportive environment for tobacco control. A swing might well be unnecessary if the mood is already there. It might be that when the factors in the policy stream are positioned in a certain way, there is no need for the more marked changes to occur in the political stream.

I have summarised, in Table 6, my assessment of the factors in Kingdon's (1984) agenda-building model, based on the preceding paragraphs.

Table 6: Kingdon's model with relation to tobacco control policy

Problem stream				
Indicators		**Focusing events**		**Feedback**
Yes		No		Yes
Policy stream				
Technical feasibility	**Budgetary feasibility**	**Human resource feasibility**	**Fit with dominant values & current national mood**	**Political support or opposition**
Very strong	Quite strong	Quite strong	Strong	Strong support
Political Stream				
Swings in public mood	**Pressure group campaigns**	**Election results**	**Partisan or ideological changes in government**	**Changes in administration**
No (not sudden)	Yes	No	No	No

The other main agenda-building process model discussed in the literature review, punctuated equilibrium, is not a model borne out by interviewee views. Certainly, no one suggested that particular events sparked off action in an otherwise fairly stable setting. Additionally, looking at documentary evidence of the history of the region's policy development, one can see that there was nearly always at least one aspect of tobacco control policy under development. This is further discussed in the following section on contextual factors.

Policy context: tobacco control policy

Interviewees identified various contextual factors. Of relevance to Alford's model, structural factors include the economic base and demography of the region and the number and type of organizations involved. Changes that affect general policy development (which can also affect particular policies) were mentioned in the introductory section of this chapter. The establishment of the Regional Task Force on Tobacco Control in 1997 was key to the development of the first regional tobacco strategy but the task force was a short-term initiative – funded by a one-off pot of money from the Department of Health Regional Office – with the one specific objective of producing a strategy. The main directly relevant significant change in organizational structure during the time period was the formation of the regional tobacco control office (Fresh), as discussed in my previous chapter. The closure of a tobacco industry factory in the region reduced the need for union opposition to policy. Over the whole period, though, there was a context of networked agencies working together on tobacco-related policy and action across the region.

The economic status of the region was felt to be relevant to tobacco control. There are proven links between poverty and smoking (referenced, for example, in the 1998 policy (Regional Task Force on Tobacco Control 1998)) and the North East is a highly disadvantaged area. About a third of all premature deaths under 65 in the region are caused by smoking-attributable diseases, compared to only a quarter in England (Walrond, Natarajan and

Chappel 2004: 1). The region has a history not just of ill health but also of high rates of smoking and smoking-related disease, with associated high costs to the health service and to employers and benefits agencies (which will be discussed under worklessness). Several interviewees stressed the general economic aspects of tobacco control. One (non-statutory sector) suggested that the key driver to tobacco policy was the cost to the National Health Service. Another also alluded to the use of economic drivers:

> Morally we should address it [inequalities] anyway but from an economic perspective we brought in a range of new partners, particularly ONE *et cetera*, who said 'hang on, we have these high level strategies which are seeking to move the region forward in a very progressive manner – if you don't address health, the economy will be undermined'. (non-health-group interviewee)

A self-described cynic commented that, while smoking is increasingly a habit more for the economically disadvantaged (of whom there are greater proportions in this region),

> The current government is trying to appeal more to the economically well-off… the Treasury does not have a social conscience – the corporate system is not made to have a social conscience even if the individuals do. (Non-statutory sector interviewee)

There was said to be a possible political motive for North East regional action on smoke-free policy, perhaps a sign of regional organizational self-interest, mentioned because of the proposed elected regional assembly:

> The Assembly was looking for flagship ideas to make its mark in the run-up to the referendum. The action [smoke-free legislation] was high impact with low risk from their point of view. (Health sector interviewee)

One interviewee (non-statutory sector) suggested that there was no real regional perspective to tobacco policy; another (academic sector) suggested that the region had little opportunity to have an effect on national policy. However, others (from different sectors) felt there was a strong regional imperative for tobacco control, tied into the employment and employability agenda.

> The Chamber of Commerce wants high productivity from an effective workforce … good productivity comes from having a healthy workforce. (Health sector interviewee)

Several interviewees perceived a general cultural shift towards banning smoking in public places. This related to the national level but there was also evidence at a regional level, with high levels of support for the smoke-free legislation. This public support forms part of the societal pressures and interests of Grindle and Thomas's (1991)'s model and is linked to the public pressure and power of the public discussed in the previous chapter.

Historical policy context can include a range of international and national policy developments (extra-regional developments), as well as developments within the region. There was much tobacco policy action at both international and national levels. International activity (for example the WHO Framework Convention on Tobacco Control (WHO 2003)) can put pressure on national governments to act. It can also influence regional policy, for example in providing evidence for action for the 1998 strategy (Regional Task Force on

Tobacco Control 1998) and for the formation of the Regional Tobacco Office, which was based on the 'California model'. National policy events can be expected to have a direct effect on regional activity, in providing evidence (for example, the SCOTH reports (SCOTH 1998 and SCOTH 2004), in setting required standards (for example, National Service Frameworks) or in requiring implementation (for example, *Smoking Kills* (Secretary of State for Health *et al.* 1998)).

Turning to the history of the policy itself, the main tobacco policy events within the region have already been described, including the development of the 1998 and 2005 regional policies and the formation of the Regional Tobacco Control Office. I also alluded earlier to the fact that the 1998 strategy appeared to have sunk into oblivion, rather than providing a recognized basis for subsequent strategies. However, both strategies used the readily available wealth of evidence and knowledge around tobacco control, so the second was in no way in conflict with the first. During the years between the two strategies, there had also been major changes in regional boundaries (with the North East region moving out of the Northern and Yorkshire region). Coupled with the organizational changes (including the establishment of Fresh), this created a rather different environment for policy development, so the history of the policy was fragmented. The nature of the tobacco control issue is not subject to those same influences and is described in the following section.

Nature of the issue: tobacco control policy

Interviewees mentioned several factors matching Cobb and Elder's (1972) five issue characteristics. One health sector interviewee suggested that the timing for tobacco policy generally was partly anticipated and partly luck, with policy-makers catching the crest of the wave. With reference particularly to the smoke-free legislation, interviewees noted several points: smoking had been on the agenda for a very long time; the public was becoming more aware of the evidence; and many were affected by it, thus it had a high degree of social significance. Tobacco control had a high degree of temporal relevance because it was a long-term issue rather than something very short term. Categorical precedence can be assessed from the description of policies, international, national and regional. Clearly, tobacco is an issue that has a long history of policy precedence. In terms of specificity, tobacco control is very much at the concrete rather than the abstract end of the scale and in terms of complexity it is very much at the non-complex end.

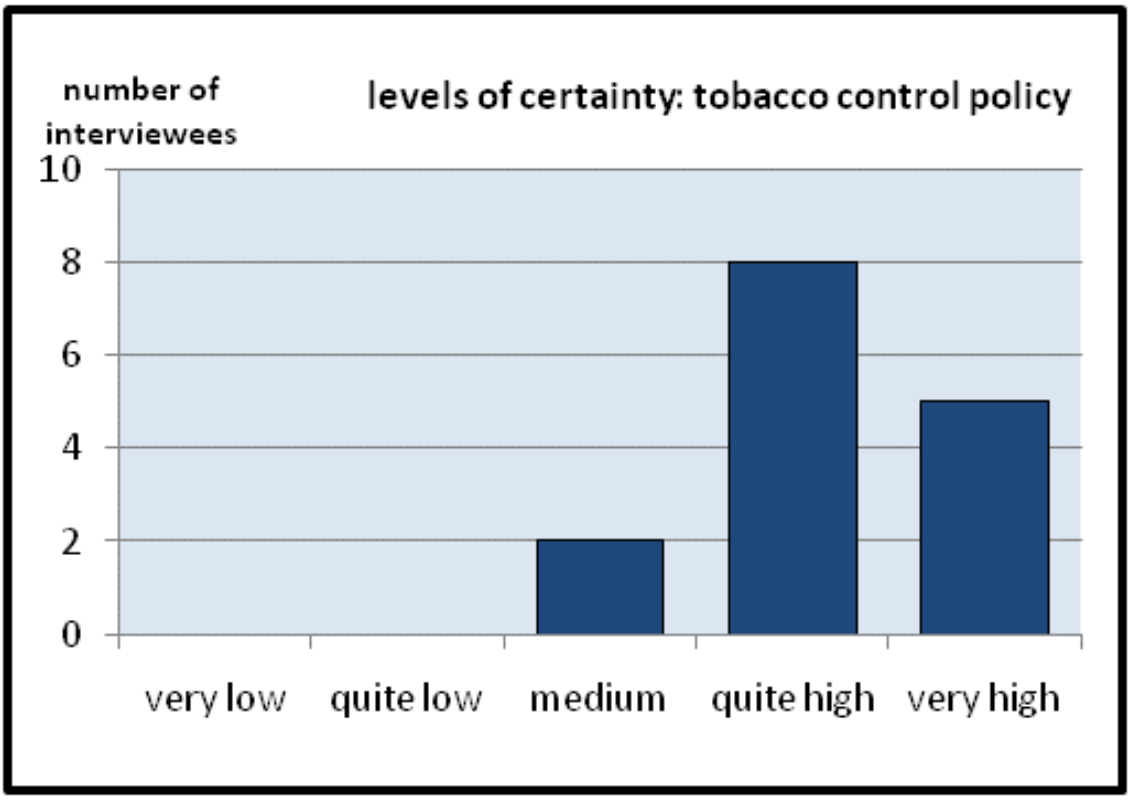
One of the factors in Stacey's (1996) model is that of certainty: something is close to certainty when cause and effect linkages can be determined. Interviewees raised several issues when asked about the certainty of success of tobacco policy. Most felt fairly certain of success, some because of financial investment but many because of the strong evidence base and

> very straight cause and effect – unequivocal – tobacco kills. Also, it is one of the most researched topics in medical history. (Health sector interviewee)

Evidence of successful approaches, as well as of health damage, was felt to be important. Although a few interviewees were unaware of examples of other places where similar policy had been developed, several referred to tobacco control policy or action elsewhere, most notably California, as evidence on which their certainty of success was based. Some talked of the certainty of success of particular aspects of tobacco policy. For example, a few mentioned that Scotland and Ireland, with their high levels of compliance, provided evidence of the success of smoke-free legislation. The legislation itself would contribute to the success of overall tobacco policy in the region, according to one non-statutory sector interviewee.

In allocating numerical scores to certainty, most interviewees felt that tobacco policy had a very good chance of success. Several described it as very high or gave high scores on a 0 to 5 scale of certainty. This applied to all aspects of policy that interviewees were considering: general tobacco policy; legislation on smoking in public places; and the setting up of a regional tobacco office to aid a cultural change in the public view of smoking. Levels of certainty ascribed to tobacco control policy are shown in Figure 3.

Figure 3: levels of certainty: tobacco control policy



The level of agreement is the other dimension of Stacey's (1996) model. Broadly, interviewees felt that there was a good level of agreement around the policy-making. This was suggested during discussion on joint working as well as when I asked interviewees specifically about agreement.

> People understand the extent of the problem and broadly how to tackle it and the opportunities. (Non-health-group interviewee)
>
> The Chamber was aware that it was a policy position that they couldn't NOT back! (Non-health-group interviewee)

One interviewee (non-health-group) felt that the main sensitivity was public reaction, rather than anything between the partners. Another suggested that

relatively trivial issues caused more argument:

> I can't think of an area where there was particularly strong disagreement. We argued about the colour of the logo [for the regional tobacco office]! It was pretty cohesive, which is unusual! (Non-statutory sector interviewee)

A few reservations were expressed about the amount of agreement.

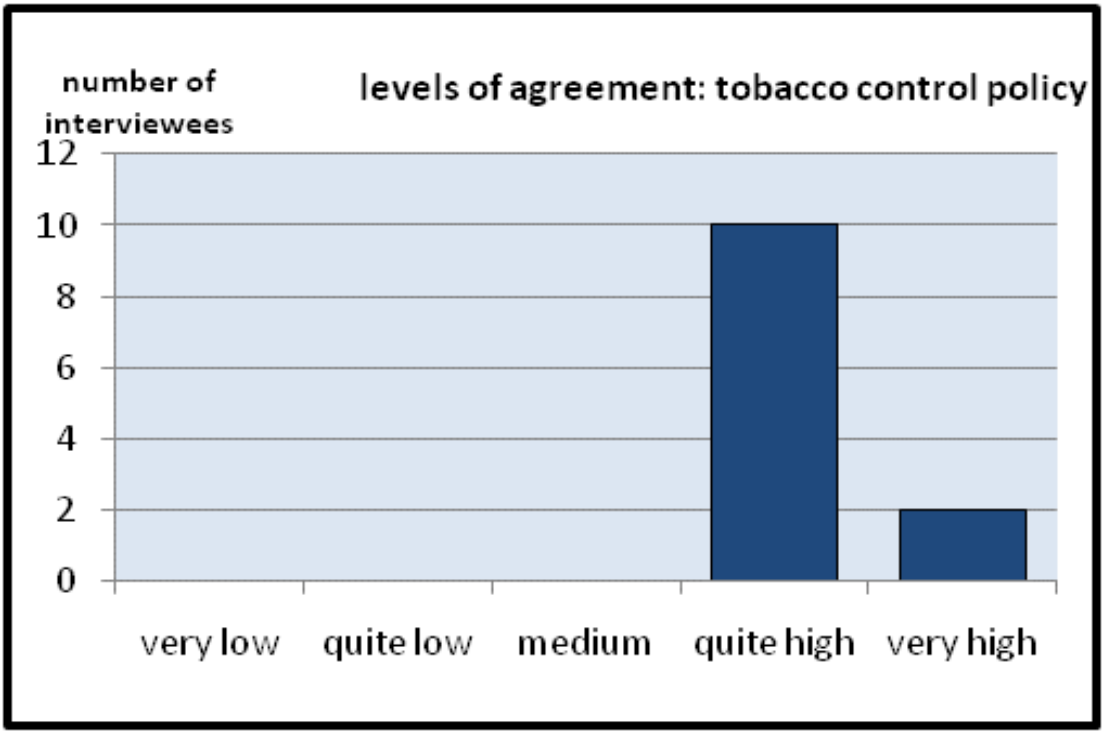
> There was agreement that the approach is better than what was there before – it was a piecemeal approach before. There was not the political clout for the PCT to get Local Authorities on board. Now it is more cost effective, especially media campaigns. (Health sector interviewee)

Government departments have also been known to be at odds with one another over tobacco policy development. Some of the early arguments against reducing tobacco sales were said to be that this would reduce the amount of money going into the Treasury (mentioned, for example, by Kemm 2001: 81).

There were a few differences in opinion amongst interviewees about the correct approach taken to address the issue. For example, local protectionism of existing methods and services was mentioned by some interviewees, although they still felt that there was a good level of overall agreement. An academic sector interviewee believed that the approach might widen inequalities, because the actions in the strategy would more easily reach those who were not in the more deprived 'hard-to-reach' groups.

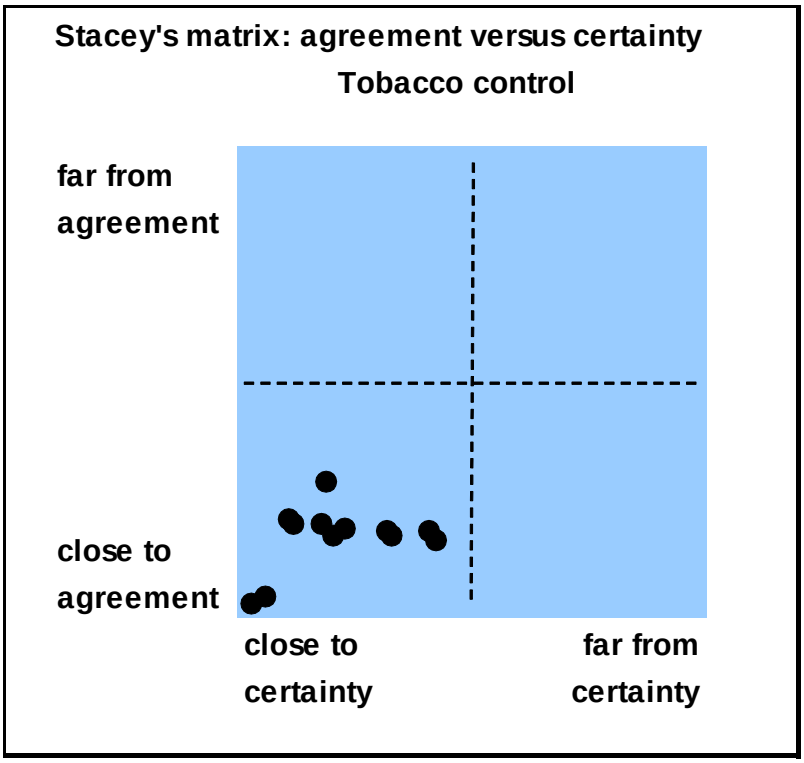
Interviewees offering assessment of the levels of agreement suggested it was high or very high, as shown in Figure 4.

Figure 4: levels of agreement: tobacco control policy



Not all interviewees felt able to allocate a score of 0 to 5 to both the level of agreement and to the level of certainty over tobacco control policy. Figure 5 shows responses from those that did (66%), using Stacey's matrix. Tobacco control is definitely in the quadrant representing close to agreement and close to certainty. This is in line with the agreement and certainty assessments considered separately above, which included views from more interviewees.

Figure 5: Stacey's matrix: tobacco control policy



For Matland's (1995) model, I used these levels of consensus or agreement along with my assessment of levels of ambiguity. There was, inevitably, a degree of subjectivity in this assessment. I based it partly on wording of tobacco policies but more on the ways interviewees had talked of policy development, key drivers, joint working and aims of policies. (Aims of policies regarding health and inequalities are further discussed in the next chapter.) There appeared to be no evidence of vagueness either in the objectives of the policies or in implementation plans. My feeling was that tobacco control policy would therefore lie in Matland's quadrant representing low conflict and low ambiguity. This will be used in later comparison between policy areas. The suggestion from Matland's model is that tobacco control policy could be

implemented quite successfully so long as there were sufficient resources (Matland 1995: 160).

This section has described findings related to tobacco control policy. In the following section, I look at housing policy.

What other factors influence the progress of the policy area 'housing' on the regional decision-making agenda?

Previously-mentioned differences in interpretation of 'housing policy' are highlighted if appropriate in this section, in which I describe my findings on factors in agenda-building models, policy context and the nature of housing policy issues.

Factors in agenda-building models: housing policy

In terms of issue creation (Cobb and Elder 1972), no one felt that housing policy resulted from an unanticipated event. One health sector interviewee suggested that 'commercial interest was top'. An academic sector interviewee believed that 'the notion that big decisions are taken at regional level is a bit misguided', but many interviewees said the government drove regional housing policy.

> Strategy is governed by government policy – on brownfield sites *et cetera*. (Non-health-group-1 interviewee)

> Central government has a lot of influence in terms of the 'sustainable communities' agenda[13]….but translated at regional level to reflect the particular requirements and focus and the housing markets. (Non-health-group-1 interviewee)
>
> There is a diktat from central government that policy has to be refreshed periodically and signed off. (Non-statutory sector interviewee)

A few interviewees believed the drive was from the local authorities or the Regional Development Agency. Ensuring that housing was 'fit for purpose' (a local authority duty) was given as the main driver by several informants. One interviewee (non-health-group-1) said that the drive was from the bottom to stimulate support from the government.

Some of the issues discussed by interviewees can be viewed in terms of the legitimacy, feasibility and support of Hall *et al*.'s (1975) model of agenda-building. The legitimacy of housing policy was not questioned by any interviewees, at either a national or a regional level. National legislation is from an elected national government, which imposes some requirements on regional and local organizations: national legitimacy would therefore be described as strong. Housing was traditionally part of the remit of the local authorities and was therefore an accepted area for local politicians to address. The regional agencies accepted it as part of their remit in producing the regional housing strategies. There is perhaps a lower level of legitimacy on a regional basis because of the historical role of individual local authorities. Disagreement over regional housing policy appears to be very much discord

[13] For example, ODPM (2003)

between local areas and the regional agenda, with many interviewees suggesting this is a problem best addressed at the local authority level rather than the regional level. Legitimacy at a regional level could probably best be described as ‘quite strong’, rather than ‘strong’.

Technical feasibility around housing policy did not appear to be an issue. Several interviewees had no particular knowledge of resourcing difficulties that would affect housing policy implementation. Indeed, one non-health-group-1 interviewee suggested that the large amount of money awarded to the Regional Housing Board was a factor likely to make the policy successful, assuming there was continued commitment from the Regional Assembly. A non-statutory sector interviewee suggested that there were no financial issues and that ‘all local authorities have been able to find cash to do what they need’. This was a minority view: many others felt that lack of financial resources was either a real problem or a highly likely problem, both for general housing improvement and for specifically attempting to address the difference between the worst and best housing. Concern was expressed that the government might not continue to support initiatives. Money was said to be lacking for two specific aspects: building a good evidence base locally (non-health-group-1 interviewee) and funding the process structure to create a healthy built environment:

> Things are not available for the money available – exercise, green space. Things like that are generally funded through other policies. (Health sector interviewee)

Many interviewees expressed concern about financing mechanisms Several recognized a ‘growing, unhelpful public sector culture of grants’ (non-health-group-1 interviewee), which led to a real need to get the private sector to invest, so the public sector could borrow more (through matched funding initiatives). It also led to difficulties in assessing how much money there actually was:

> The Treasury does not really appreciate how much money is being put in, because it has all gone in through different routes. (Non-statutory sector interviewee)

A few interviewees mentioned skills shortages. One (non-health-group-1) suggested that there were too few people with the right knowledge and skills necessary for project management and for community involvement. Another shortage was in skilled labour, needed for rapid implementation of housing improvement policies. Generally, though, there was not thought to be a problem with human resources.

Other factors affecting policy feasibility were poor consultation; developers buying land and doing different things with it; the finding of contaminated land necessitating treatment; and the sheer length of time taken by processes such as compulsory purchase. A few interviewees pointed out that it was far easier to implement housing strategies in much smaller areas. Overall, only technical feasibility seems good and other aspects suggest that feasibility is best described as ‘quite weak’.

Public support for housing policy generally was not deemed an issue. Several interviewees said that housing was always an important issue for all, so that attempts to improve it were in line with national feeling. Political support for addressing housing problems was said to have been present for many years. Support also refers to interest group support but interviewees made no reference to any pressure group activity around housing.

In Table 7, I have summarised, from the previous paragraphs, my assessment of legitimacy, feasibility and support.

Table 7: Hall *et al*.'s model with relation to housing policy

Legitimacy		**Feasibility**	**Support**		
National	**Regional**		**Public**	**Political**	**Pressure group**
Strong	Quite strong	Quite weak	Strong	Strong	Weak

Kingdon's (1984) policy and political stream factors reflect factors already discussed for Hall *et a*l.'s model. For Kingdon's problem stream, the state of housing within the region shows in indicators for targets around decent homes' standards. With responsibility for council housing historically resting with local authorities, the monitoring of these indicators has tended to be at local authority level. However, with the development of regional agencies and the Regional Housing Board, there appears to be growing recognition of a widespread regional problem of poor quality housing. Although the links between poor housing and poor health are well recognized in public health

communities, no interviewees mentioned any specific health outcome indicators linked with housing quality. Interviewees did not feel that there were any particular focusing events affecting the area's position on the agenda.

I have summarised my assessment of Kingdon's factors for housing policy in Table 8, based on preceding paragraphs.

Table 8: Kingdon's model with relation to housing policy

Problem stream				
Indicators		**Focusing events**		**Feedback**
Yes		No		Yes
Policy stream				
Technical feasibility	**Budgetary feasibility**	**Human resource feasibility**	**Fit with dominant values & current national mood**	**Political support or opposition**
Strong	Weak	Quite weak	Strong	Strong support
Political Stream				
Swings in public mood	**Pressure group campaigns**	**Election results**	**Partisan or ideological changes in government**	**Changes in administration**
No	No	No	No	No

There is no evidence to support the use of Baumgartner and Jones' (1993) punctuated equilibrium model. There has been continuous activity on the housing agenda at all levels (for example, regionally with routine strategy production, sub-regionally with routine plan production and nationally with related green papers).

Policy context: housing policy

Most interviewees (all sectors) felt that the biggest driver of housing policy was the economy. One (non-health-group-1) said that the huge amounts of money and large amounts of land tied up with various housing programmes were driving factors.

The number and type of organizations involved in housing policy changed over the research period. Changes relating to general policy development were discussed in this chapter's introduction. In the years prior to my interviews, there had been a huge change in responsibility for housing: instead of local authority control, there were now arms-length arrangements with new social landlords. A few interviewees mentioned the influence of this change on decision-making, freeing up financial support and allowing fresh players into the market place. These changes in responsibility, along with the involvement of more organizations, were said to have increased flexibility and extended the awareness that there was joint responsibility:

> We need flexible solutions – we lacked flexibility and sensibility until recently. (Non-health-group-1 interviewee)
>
> Initiatives were legion in the last ten to fifteen years. It is not until two to three years ago that it has been seen as the business of a broader group of partners (previously it was for local authority housing associations). (Health sector interviewee)

Housing policy was significantly affected by the change in organizational structure in 2002, when the North East Assembly became the regional

planning body and ANEC transferred to the Assembly the responsibility for the Regional Planning Guidance. The Assembly then started to host the North East housing forum's link officer (to enhance links between regional strategies). In 2004, the Assembly and housing partners submitted to government its plans for the merger of the regional planning body and the housing board, in response to ODPM requirements following the Barker Review (Barker 2004). The merger took place in 2006 and the North East Housing Board became part of the North East Assembly, ‘enabling better integration of housing policies with other plans and strategies across the region’ (NEA 2006b: housing section).

Several interviewees mentioned differences between the North East and other regions. An academic sector interviewee claimed there were inequalities between regions, with large amounts of central (national) investment going into sustainable communities in the South rather than into the North East. The 2007 Housing Green Paper stated that its first challenge was to provide more homes (DCLG 2007: 6): but several interviewees (different sectors) referred to the fact that the region’s housing problem was not a shortage of houses.

> There are different situations in different regions – a north-south split. The south has increasing population, problems with lack of housing and natural resources, e.g. water. The north has problems with the quality of housing stock and where to build new housing. (Non-health-group-1 interviewee)

The housing quality problem was also mentioned in the 2005 Regional Housing Strategy:

> There is a clear mismatch between the current stock profile and the need and aspirations of the various socio-economic groups within our region. (NEHB 2005:11)

Regional changes in demand for housing were recognized by several writers. Whereas, in some English regions, new (mainly white collar) jobs led to dual incomes and increasing demand for suburban housing, in the northern industrial cities the economic heart was lost with industrial decline so demand and property prices fell (Hudson and Lowe 2004: 67).

Another recognized regional difference was the extent of fuel poverty (which occurs when a household spends more than 10% of its disposable income on fuel). The North East had a higher proportion of households experiencing it than any other English region, with significant variation also across the region (NEHB 2005: 27-28).

There is not the same level of international policy around housing as there is around tobacco control. There have been, however, significant national developments, for instance the Housing Green Paper (DCLG 2007, mainly affecting local authority planning or control of housing provision or management) and the Barker review of housing supply (Barker 2004).

Housing policy at a regional level had a later start than tobacco control, with the earlier years in my research period dominated by local authority and other sub-regional control. One feature of the 2005 strategy was that it maintained very much a sub-regional approach: each of the four sub-regional partnerships had to produce its own sub-regional strategies (Northumberland Housing Board 2007, Northern Housing Consortium 2007, Tees Valley Living 2008 and arc[4] [*sic*] 2007). Nevertheless, some regional actions and responsibilities were included, such as those around involving other sectors and integrating with other policies (NEHB: 2005: 111-115).

Much of the history of housing policy in the region has already been covered, including the changes in responsibility for housing and the development of housing policy and its revision every two years. Each revised Regional Housing Strategy is developed very much from the base of the previous strategy so, in this instance, the policy history plays a vital part. The following section looks at the nature, rather than the context, of housing policy.

Nature of the issue: housing policy

With regard to Cobb and Elder's (1972) issue characteristics, it can be seen that housing policy has a long history (extensive categorical precedence). It has a high degree of social significance (of interest to lots of people), a relatively low degree of complexity, a high degree of temporal relevance (a

long-term issue) and a fairy high degree of specificity (towards the concrete rather than the abstract end of the spectrum).

Interviewees varied as to how certain they felt the policy would work. One very sceptical interviewee (academic sector) felt that there were major problems in housing policy and that claims about house price gaps closing were untrue. Others agreed there was little certainty:

> There are too many uncontrolled variables – especially with the increase in involvement of the private sector and voluntary sector. (Health sector interviewee)

Some of the reasons for doubt were mentioned in Chapter 5. Other reasons for doubting success included uncertainty around the necessary local drive and commitment (non-health-group-1 interviewee) and the possible lack of plans in place to deliver housing policy (non-statutory sector interviewee).

Other interviewees felt that some specific parts of the Regional Housing Strategy would work: for example, better heating and insulation would be effective, would improve how people felt and would reduce their spending on heating. The use of grants made it fairly certain that the decent home standards work would succeed, according to a non-health-group1 interviewee. (I realise here that it is difficult to separate out implementation success from the success of the policy that advocates those measures.) One interviewee felt uncertain about most elements but certain that the social housing aspects

of the policy would succeed because of the

> long-standing commitment in the region to social housing, the high performing local government (divesting responsibilities in a responsible way) and the strong cadre of professionals in the region with that ethic and commitment. (Health sector interviewee)

Some interviewees challenged the ability of the decision-making system to cope with the complex issues. One felt that there were many concerns over the quality of buildings, over environmental amenity, over the infrastructure and the unsustainable way car-borne transport is fuelled, and that

> there is a whole set of problems which the existing systems of decision-making are ill equipped to deal with. (Academic sector interviewee)

Although some interviewees expressed a lack of certainty around the policy, others (from all sectors) felt rather more certain (and, indeed some felt *very* certain) that the Regional Housing Strategy would work, giving various reasons for this. One significant factor was felt to be the relatively recent shift of housing responsibility to social landlords.

> Housing associations are able to drive things in a more focused way but we have still got the full range of involvement from government down to regional level. Local support for day-to-day decision-making is much better. (Non-statutory sector interviewee)

Several (from all sectors) referred to the growing evidence base, although one academic sector interviewee commented that it was not a good evidence base because the housing market, particularly public ownership, had changed considerably since the 60s and 70s, the source of much of the evidence.

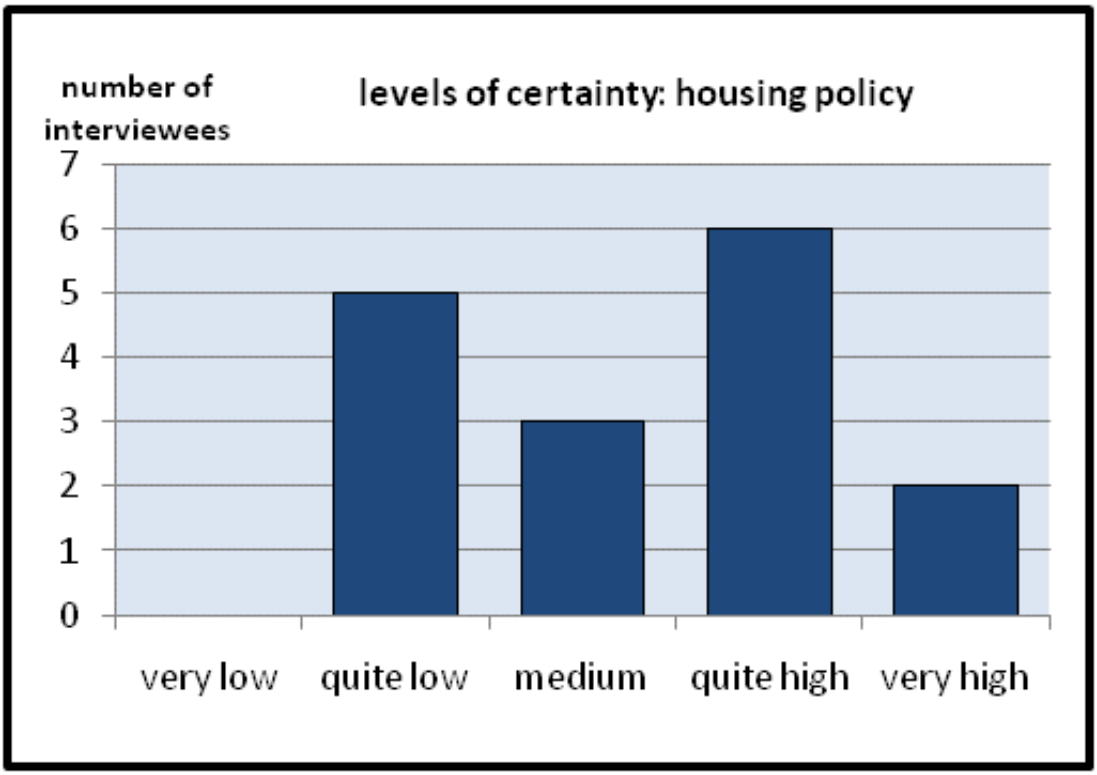
Several interviewees mentioned evidence for certain aspects of housing policy, generally related to small-scale initiatives. Although housing policy had to be renewed every few years, there seemed to be little suggestion that previous policy provided any evidence for current policy. One non-health-group-1 interviewee believed that there had never been any similar policy in the past.

Government influence and statutory requirements were also given as reasons for certainty of success of the Regional Housing Strategy:

> It is a statutory policy; therefore it is about moulding something that has to happen. It will be binding on Local Authorities. (Academic sector interviewee)
>
> Ruth Kelly's Department [DCLG] is likely to make it likely that broad successful policy will be delivered… All housing authorities submit housing proposals... This helps make sure what has been set out in regional housing policy has teeth and will be followed through to delivery end. (Non-health-group-1 interviewee)
>
> The Government has devolved responses to the regions so they have a stake in where things happen – people know their own environment better than central government. (Non-health-group-1 interviewee)

The levels of certainty suggested by interviewees are shown in Figure 6..

Figure 6: levels of certainty: housing policy



A range of views also emerged when interviewees were asked about the level of agreement between the partners involved. A health sector interviewee commented that they could not easily assess the level of agreement but they themselves were not happy with the product. The most cynical responses were:

> There was equal tension about the outcome – no one was happy! (Non-statutory sector interviewee)
>
> High level of agreement over a low common denominator, agreement achieved by: avoiding controversial issues; not asking difficult questions; accepting top-down analysis of what the issues are … No great conflict is apparent – you don't see it in the newspapers often because there is no debate over principles. (Academic sector interviewee)

Several informants mentioned political infighting between local authorities and groups of local authorities over housing allocations in housing policy. One non- statutory sector interviewee commented that this would continue to be a problem for the Regional Assembly (70% of whose members were Local Authority members). Conflict between agendas was also mentioned:

> So many different agendas running – technical housing agenda, housing and planning, housing and health. The political imperative was very focused – sort out social housing. It is difficult for politicians to grasp and engage with this. (Health sector interviewee)

> There is a big tension between pushing the wider benefits for health compared with other aspects of the benefits of housing, especially new housing as a commercial venture. (Health sector interviewee)

> Social housing dominates the agenda and the private and voluntary sector do not share the same ideas on addressing this. (Health sector interviewee)

'Personal rivalries stop progress,' stated one non-statutory sector interviewee (evincing a personal knowledge but not wishing to expand on the case). There was said to be a degree of tension and lack of agreement between representatives of rural settlements and representatives of urban settlements over where to build new housing. Some criticised the motivations of the private sector:

> Private sector profits are in the margins – a tree is a hole in profit. (Health sector interviewee)

Others suggested that there was conflict between national and regional or local views.

> It is difficult for London to understand when the market is different – there was a lack of comprehension among those we were trying to persuade – it did help when we brought people up from London to show them. (Non-health-group-2 interviewee)

> Central government has essentially a one-size-fits-all notion – in the south, there are not enough houses – build more. In the north, there is not enough demand – knock them down. This is too simplistic. We need a closer relationship between housing policy and economic policy to stop these two scenarios getting worse. (Academic sector interviewee)

Some interviewees saw quite a lot of agreement within certain sectors (for example, amongst key private sector players about what needs to happen (academic sector interviewee)) or between certain sectors (for example, the commercial interests and some elements of planning (health sector interviewee). Similarly, some felt there was agreement over certain aspects of policy:

> There was strong consensus about the priorities and objectives – centred around regeneration of older housing stock. The knock down/rebuild issue was only different at a very local level, not from the regional perspective. (Non-health-group-2 interviewee)

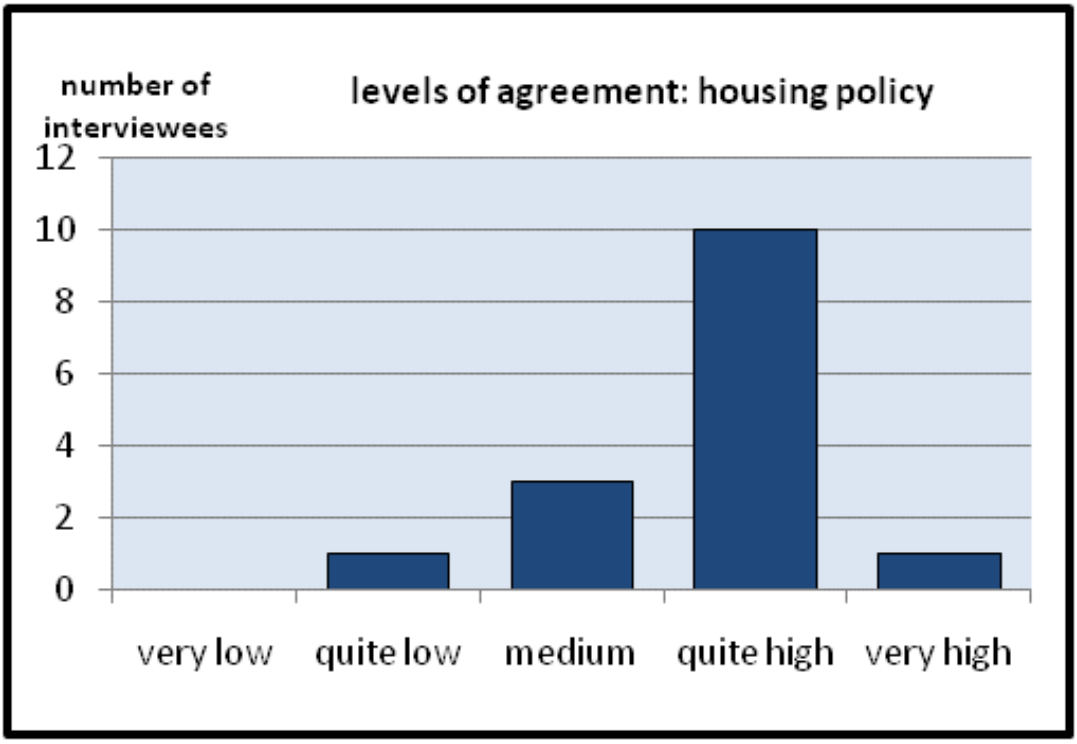
Other interviewees felt that the only lack of agreement was in the house-building numbers but that people became happier with the numbers as time went on. There were more interviewees who felt agreement was fairly or very

high than there were those who felt it low.

> Good consensus - I did not detect a lot of people walking away from the table in disgust. (Non-health-group-1 interviewee)
>
> Broad agreement - I am not aware of any conflict over the direction of travel. (Non-health-group-2 interviewee)
>
> There seems to be quite a lot of agreement. I am not aware of major rifts (though I might not be aware of some of the problems). (Health sector interviewee)
>
> Basically, all agreed with the policy and strategy. There are tensions around the distribution of funding and following through to what they can invest in. (Non-health-group-1 interviewee)

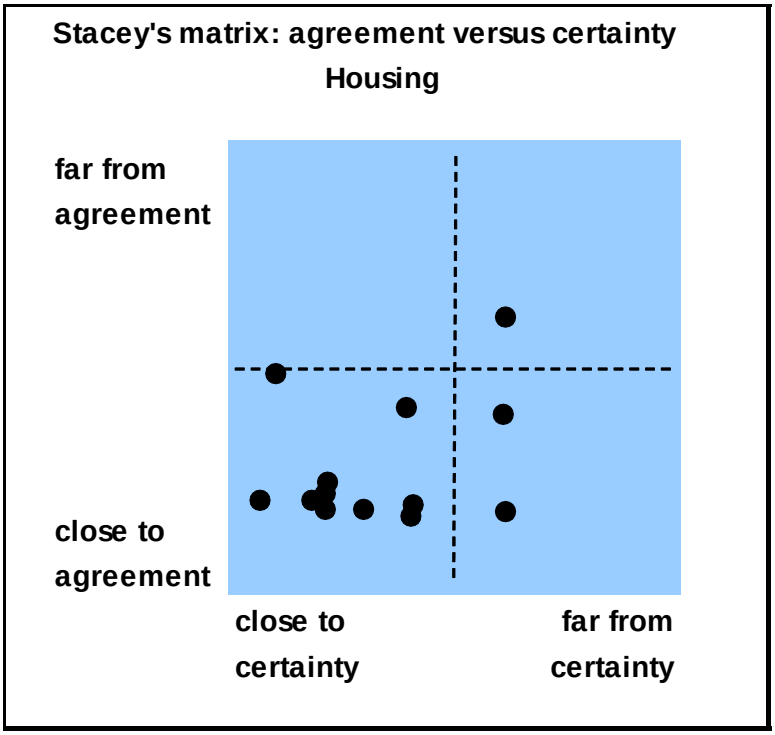
The levels of expressed agreement over housing policy are illustrated in Figure 7, showing a range of opinions though not indicating major levels of disagreement. The apparently quite high level of agreement is somewhat surprising, given all the comments just described about lack of consensus. Many of those who talked of disagreements did not allocate a score indicating high levels. Perhaps it suggests that interviewees wanted to have a grumble but really did not think there were huge disagreements!

Figure 7: levels of agreement: housing policy



Not all interviewees felt able to allocate a score of 0 to 5 to both the level of agreement and to the level of certainty in housing policy. Figure 8 shows responses from those that did (60%), using Stacey's (1996) matrix. There is a spread of values but there is concentration in the quadrant representing close to agreement and close to certainty, although there are some also outside of this quadrant, mainly in the 'further from certainty' quadrant. This is not inconsistent with the picture formed by considering the views expressed on agreement and certainty separately (when the views of more interviewees can be incorporated).

Figure 8: Stacey's matrix: housing policy



One health sector interviewee felt that there was lack of clear policy but another interviewee felt that

> things have changed a lot in the last five years…There is greater clarity on what the problems are and how they might be addressed and the strategy is founded on evidence and is more robust than ever before. (Non-health-group-1 interviewee)

Ambiguity of aims was mentioned, such as aims of altering the prevalence of asthma by housing alterations or changing physical behaviour through housing developments: a health sector interviewee felt it would not be possible to assess these aims. Ambiguity due to conflicting policy was mentioned: regional policy around conservation conflicted with housing policy,

as did policy in the Northern Way, which was said to be more economically driven and to have

> queered the pitch in terms of where housing needs are greatest and what was the plan of attack to deal with it. This led to uncertainty about where that would lead the policy agenda. (Non-health-group-1 interviewee)

This ambiguity, along with the mention of differing agendas and the relatively high agreement levels, suggested that housing policy in the region belonged, in Matland's model, in the low conflict half (further from 'no conflict' than tobacco control) and perhaps mid-way between the low ambiguity and the high ambiguity areas. As with tobacco control, adequate resourcing should therefore help to ease the problem (as Matland (1995: 160) suggests it does for low conflict/low ambiguity issues). However, there might also be a need for improvement in the contextual factors, such as the actors involved and their level of involvement, as Matland says would be appropriate for low conflict/high ambiguity issues (*ibid*.: 165).

This section has considered factors influencing the housing agenda. In the following section, I consider the worklessness agenda.

What other factors influence the progress of the policy area 'worklessness' on the regional decision-making agenda?

Previously mentioned differences in interpretation of 'worklessness policy' are highlighted if appropriate in this section, in which I describe my findings on factors in agenda-building models, policy context and the nature of worklessness policy issues.

Factors in agenda-building models: worklessness policy

Most interviewees believed that the main drive for worklessness policy was from central government, for economic reasons: when government became increasingly aware that unemployment, along with Incapacity Benefit, was a big drain on resources, political will emerged to do something about it.

Government policy to reduce the number of people registered unemployed was linked to the aim of improving economic performance, known to be particularly poor in this region. Many interviewees stated that there was also a genuine desire in the region to tackle the problem (not only in the North East region but also in the wider Northern Way). Therefore, they felt that even without government push, the regional agencies (particularly ONE) would still have pushed for action. Other interviewees also mentioned the influence of Europe on policy, suggesting it will increase over time and has already definitely influenced worklessness.

Considering the factors in Hall *et al.*'s model, legitimacy appears strong, with the government, an elected body, taking the lead. Worklessness has been an accepted part of national government concern for many years. At a regional level, there are some of the same difficulties as with housing, with some call for local rather than regional level decision-making. However, the national drive for cost-cutting around disability benefits has given legitimacy to regional policy-makers, particularly since the North East has such a high proportion of its potential workforce on benefits.

No concerns were raised over technical feasibility. One threat to feasibility was thought to be the problems of joint working but most threats related to resource issues. Several interviewees mentioned shortages in the system of people with skills in policy development. Reorganizations were said to have reduced the number of qualified people in the right places, particularly in JobCentre Plus. There was also a recognized shortage of people with skills in effecting change, particularly when the change spanned more than one area. Such shortages also affected the ability to construct policy.

> By and large, people are managing either health or employment and they do not know the other areas. (Health sector interviewee)
>
> We need people with a broad knowledge of mental health/employment/JobCentre Plus/ Department of Work and Pensions, *et cetera.* (Non-health-group-1 interviewee)

National skills shortages (of occupational therapists and people with certain mental health therapy skills) were said to be key practical barriers to

implementation. These shortages were becoming even more serious because, increasingly, national and regional policies required those professional groups for projects. One informant felt that no consideration was given to the timescales involved in building up capacity.

Regarding finance, several informants agreed that the region was ‘awash with money for worklessness’ (non-health-group-2 interviewee).

> Financing? - Not a major problem to date. We have tended to cut the cloth according to the resources available ... One thing that has driven the regional employability framework is an expectation that money will decline in the next few years. We anticipate a tough financial settlement across all of the partners, so we are positioning ourselves to get the same out for less money in. (Health sector interviewee)

However, many felt that there might be enough money but it was often short-term and frequently ‘all in the wrong pots’ and not thought out in a cohesive partnership way. The funding streams were all from different places and it was proving difficult to bring them together.

> The aspiration might be there to combine funds but practically it is difficult. (Non-statutory sector interviewee)

Resourcing mechanisms were criticised: different organizations received resources through different agencies with different priorities and sometimes several organizations provided a similar service, for example, computer training, but none provided training for self-confidence. One informant questioned the financial commitment of some organizations, suggesting that the health sector did not want to spend on specific worklessness initiatives.

Other factors also cast doubt on feasibility. A health sector interviewee felt it was difficult to get people to want to take up training opportunities, rather than see it as 'they are coming to get me'. Another anticipated problem was that of convincing GPs of the value of the policy. (Some interviewees believed that this was not a problem but just required a different approach.) A minority believed that things just went ahead because people wanted to ensure they got the resources they were bidding for and were working to a tight timescale. Many more thought that there had been insufficient anticipation of problems and that there was a 'gung-ho' culture of

> let's not think about what we're going to do, let's do something. (Health sector interviewee)

Regarding lack of anticipation in a more positive light, one interviewee (non-health-group-2) suggested that it was a characteristic of policy that those involved were so passionate about it. However, the same interviewee felt that there was really no clear formula for making things work, which was unsettling to the Treasury.

Public support for worklessness policy proved difficult for interviewees to assess, although there was a suggestion (unevidenced) that research had shown it existed. However, some interviewees commented that some people wanted to continue as before. Political support for action around worklessness appeared to be growing, as the economic effects of high disability payments and high unemployment were well recognized. Support also refers to interest

group support but interviewees made no reference to any pressure group activity around worklessness.

I have summarised the previous paragraphs, assessing the factors for Hall *et al.*'s (1975) model in Table 9.

Table 9: Hall *et al*.'s model with relation to worklessness policy

Legitimacy		**Feasibility**	**Support**		
National	**Regional**		**Public**	**Political**	**Pressure group**
Strong	Quite strong	Weak	Neither weak nor strong	Quite strong	Weak

Kingdon's (1984) policy stream factors have already been discussed with relation to Hall *et al*.'s model. Indicators for the problem stream include monitoring of benefits. Government (DWP) monitoring showed the escalating costs of Incapacity Benefit, whilst local or regional monitoring showed the comparatively high proportions of residents within the region who are in receipt of these benefits. Although the public health community has long understood the links between worklessness and ill health, no interviewees mentioned any specific indicators of health outcomes linked to worklessness. Interviewees did not suggest that the position of worklessness on the agenda was linked to any focusing events.

In terms of the political stream, although there appears to be no feeling of sudden swings in public mood or of pressure group campaigns, the political

awareness of the economic effect of worklessness appears relatively recent, with a pronounced effect in the North East.

I have summarised, in Table 10, my assessment of Kingdon's factors with regard to worklessness policy, based on the preceding paragraphs.

Table 10: Kingdon's model with relation to worklessness policy

Problem stream				
Indicators		**Focusing events**		**Feedback**
Some		No		Some
Policy stream				
Technical feasibility	**Budgetary feasibility**	**Human resource feasibility**	**Fit with dominant values and current national mood**	**Political support or opposition**
Strong	Very weak	Very weak	Quite strong	Quite strong support
Political Stream				
Swings in public mood	**Pressure group campaigns**	**Election results**	**Partisan or ideological changes in government**	**Changes in administration**
No	No	No	No	No

There was no evidence of the punctuated equilibrium suggested by Baumgartner and Jones (1993). Although the recognition by central government of the scale of economic impact of worklessness might have appeared as a major catalyst, it resulted from monitoring rather than a specific event (and it had already been recognized at a regional level). Large factory closures might also be considered as catalysts but the effects of these tended

to be localised rather than region wide. In addition, as will be discussed later, there was a flow of policy activity throughout the whole time.

Policy context: worklessness policy

Most interviewees felt that national government, for economic reasons, was the key driver. Several interviewees (different sectors) referred to the region being singled out by government to address its significant problems of high unemployment and low productivity. An academic interviewee commented that the problem was seen 'very much in economic terms, rather than human terms'. The aims of policies addressing the Incapacity Benefit element of worklessness were generally described as economic, increasing the capacity of the economy and cutting the benefits bill (described, for example, by Beatty and Fothergill (2005: 852)). The regional imperative, driven by national requirement, was also economic, with the Regional Economic Strategy aiming to increase the skills base to improve the economy (according to a non-statutory sector interviewee).

Had my interviews taken place some years later, views on the economy being the national driver might have been slightly different. Dame Carol Black's review of the health of Britain's working age population (Black 2008) aimed to identify factors affecting health and work and to find ways of addressing them, so that people with health problems could stay in work and people who were workless would be able to enter or return to work. Importantly, although the

effect on the economy of high levels of worklessness was a major part of the review, there was also stress on the health effects of worklessness on the individual and family. The measures proposed in the review were favourably received by the Government, which responded by establishing a number of key initiatives to address the challenges of improving the health and well-being of Britain's working-age population (DWP 2010). Although some of these related just to the NHS and other public sector employers, there was also an intention to create the 'first-ever cross-governmental national mental health and employment strategy' (*ibid*.). Some of the national policies are mentioned in Chapter 7, in connection with their inclusion of health improvement or health inequalities.

Changes affecting general policy development in the region (and potentially affecting worklessness policy) were mentioned in this chapter's introduction. Organizational changes specific to regional worklessness policy include the creation, in 2002, of a new Employment and Skills Board (involving the Assembly) and the establishment, in 2004, of Skills North East (the Regional Employment and Skills Partnership).

A few informants noted that there were important links with the Northern Way, so policy was going to be directly affected by the policies of the other regions involved. However, two interviewees (different sectors) said that the links were

not clear and there appeared to be different initiatives (Northern Way and *Pathways to Work*[14]) addressing the same problem.

The particular characteristics of the region affected the development of worklessness-related policy. The region experienced the lowest rate of economic activity or participation (Skills North East 2007: 28). It had an industrial heritage but the major growth in GDP across England between 1997 and 2007 was in knowledge-based, creative and cultural services. Major industries such as coal-mining had already declined seriously in the North East but during 1998 a series of very high profile factory closures also occurred, including two microelectronic concerns, which were 'flagship' inward investments (Pike 1999: 567). Small and medium enterprises also closed as this customer base collapsed. The Department of Trade and Industry provided funds (controversially diverted from Single Regeneration budgets) to the Regional Development Agency, and task forces were established to address the crisis (Pike 1999: 567). (The task force approach was deemed successful and later rolled out throughout England.)

Although there was regional growth in GDP per capita across the country, London and the South East experienced far more growth, so the North-South divide in general was widened (Martin 2009: 248). Figures for both unemployment benefits and Incapacity Benefits (mentioned by many

[14] Government Scheme, piloted in several areas, including some in the North East.

interviewees) were high across the North East. Patterns of unemployment were different from other regions:

> In the North East of England, the proportion of working age males without a job is twice as large as in the relatively prosperous South East. Even more striking in the north-south gradient is the composition of non-employment. . . . The share of the non-employed no working "for reasons of sickness of disability" is strongly and positively correlated with the non-employment rate. . . . Almost half of all 60-64 year old males in North East England are not working by reason of sickness or disability – three times the proportion in the South East. (Anyadike-Danes 2004: 85)

One reason for the high proportion of Incapacity Benefits could have been changes in the workplace: areas with a former heavy industry base were able to redeploy unhealthy workers to less strenuous jobs but that option has disappeared with the industrial base (Beatty and Fothergill 2005: 847). Patterns in Incapacity Benefit were beginning to change at that time: the DWP's 'New Deal for Welfare: empowering people to work' stated that there were more people in the South East than the North East claiming it (DWP 2006: 3).

There was an apparent mismatch between some national policy and regional needs. In the same way as the housing problem for the North East was different from that elsewhere, the worklessness problem differed:

> [Government] initiatives implicitly assume that this is a *labour supply* problem. The marked concentration in Britain's older industrial areas, on the other hand, suggests that in fact it is a *labour demand* issue. Very large numbers have been diverted from unemployment to sickness benefits because there have not been enough suitable jobs in these places. (Beatty and Fothergill 2005: 852)

Interviewees said that the scale of the worklessness problem had been recognized within the region, so that the Regional Economic Strategy included worklessness because the regional agencies, not just the Government, wished it.

> One of the motivating factors behind this is the sense that we are worse off than anyone else – this helps people get behind an intervention. And then, as soon as we go faster than the others, you get a sort of regional pride kicking in – 'we're worse off than every other region but we are going to be better at tackling it'. (Non-health-group-1 interviewee)

A non-statutory sector interviewee commented that not only did the region have high levels of unemployment but it also had a low skill base. The worklessness agenda was therefore different from other regions.

Like housing, but unlike tobacco control, worklessness tends not to be a policy area at an international level. (European legislation over the research period focused mainly on employment rights, equality and discrimination, health sector employment and cross-border arrangements.) Much of the national legislation deals with welfare rights and benefits, although the *Health, work and well-being* strategy (DWP/DH/HSE 2005) was wider than this and Dame Carol Black's Review of the health of Britain's working population was a milestone mentioned earlier (Black 2008).

As with housing, developments at regional, (instead of a sub-regional) level began part way through the period covered. The Regional Economic Strategy and the Regional Spatial Strategy have implications for employment and

worklessness and, because of strong efforts to ensure cohesion of policy, affect the way worklessness policy can develop. Some of the major policy events in more specific worklessness policy history have already been described, including the production of the Framework for Regional Skills Action (ONE 2002a) and the formation of the Skills North East partnership in 2004. An earlier development was the production of *Building bridges to employment in the North East* (CRC and NEEF 2000), a report that aimed to provide recommendations for action related to unemployment and social exclusion (*ibid*.: 3). It was not itself a policy but helped to provide evidence that action was needed. This is further discussed in the next chapter. The following section considers the nature of the worklessness policy area.

Nature of the issue: worklessness policy

Looking firstly at Cobb and Elder's (1972) issue characteristics, interviewee comments suggested that worklessness had quite low specificity (further from the concrete end of the concrete-abstract spectrum than tobacco or housing); high social significance (but not as high as tobacco or housing, which affect even more people); a lesser degree of temporal relevance than tobacco or housing, because it is not always a long term issue; a greater degree of complexity than housing or tobacco control; and, probably, less categorical precedence as a policy area than the other two.

A variety of responses was generated by the question of how much certainty there was of policy success. Some suggested that, because the policy did not yet exist (or it was not a single policy), it was too early or too difficult to tell. Others commented that it would depend very much on the various agencies working together and being committed to adopting the policy.

A health sector interviewee suggested that many organizations felt that worklessness fell into the “too hard” category and many communities preferred not to face it. Complexity, particularly around mental health, was mentioned by one interviewee, who drew a distinction between the conscious level and the unconscious level of thought around worklessness being on the agenda. Consciously, people wanted to help those currently unfit to get back to work. At the unconscious level, there was still stigma and people worried about the high costs of getting people with serious mental health problems back to work:

> Creating jobs for communities is complex but creating jobs for people with a long history of worklessness and with mental health problems is more complex. (Non-health-group-1 interviewee)

Some interviewees were uncertain that the policy would work because of a poor record of working together. The extent of sign-up from many organizations was of some concern and tension between different agencies was a potential barrier to success. The related lack of engagement from employers (including the public sector) also threatened success. Other

reasons for doubt included general unpredictability and the variation between communities. The large scale of the problem, although thought by one non-health-group-1 interviewee to be overestimated and an excuse for inaction, was thought by some to be a factor:

> I have a fundamental belief that nothing has worked that well so far on a grand scale. There are lots of examples of really effective work on a small scale but I am not sure whether we can do anything on a grand scale – not at regional level and possibly not even at local authority level – you can't do it with a broad brush. (Non-statutory sector interviewee)

Most of those who thought there was certainty referred to evidence. For some, this was evidence of the relationship between health and work (providing evidence of the need for policy) or research-based evidence that economic inactivity leads to poor health, which in turn leads to economic inactivity. However, most evidence mentioned was related to interventions and came either from pilots or from work elsewhere, usually in small areas.

Several interviewees said that another reason for certainty of success was inevitability: the Regional Economic Strategy was a statutory policy requirement – therefore it must happen! An academic sector interviewee said that whether it was fully implemented was a different matter. One interviewee said, rather cynically, that

> the government just made the decision to roll nationally – therefore I am quite convinced that by the end of 2008, all of the UK will have 'Pathways[14]'. (Non-health-group-2 interviewee)

As a slightly tongue-in-cheek alternative to this, one said that

> a lot of people point out that many workless are over 55 and are going to retire soon, so there is the lovely concept that the problem is going to go away through ageism! (Non-statutory sector interviewee)

Financial input to the policy was one factor that at least one interviewee felt would help it to succeed.

> In terms of the Regional Economic Strategy – the great advantage of something like ONE is they have money to spend and look to spend it, so - as a result of the strategy - there WILL be action. (Academic sector interviewee)

A non-statutory sector interviewee pointed out that there were degrees of success. For example, the aim of a policy might be to get 80,000 people back to work but even getting 20,000 back to work would be a massive achievement.

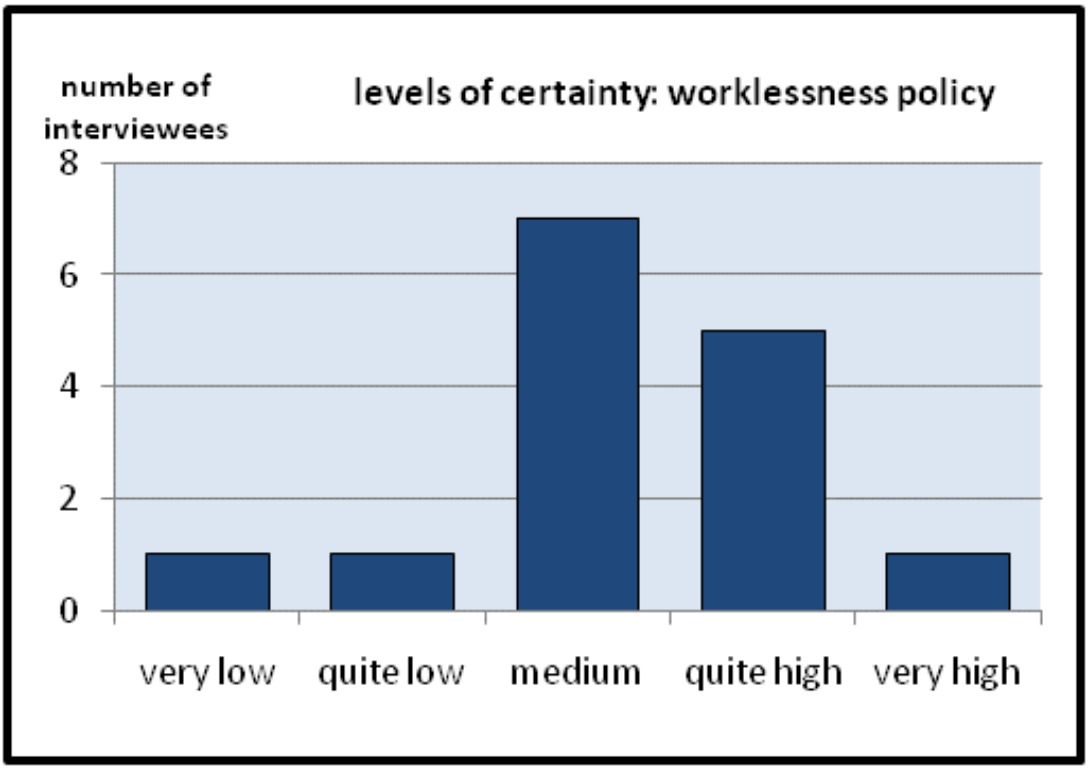
Interviewees thought there was not yet much evidence around worklessness policies (as opposed to initiatives). Two interviewees raised the problem of not being able to compare like with like.

> There are issues around definition. There are things like New Deal for Disabled People, which had similar outcomes but very different policy philosophy. It started from the assumption that people with disabilities are not ill and identified employment opportunities. (Non-health-group-1 interviewee)

> The shift in policy in 1999 was stark. If we go back to the 1980s, the policy was that unemployment was a cost of prosperity so the policy was to support them. . . . Now the policy is that entitlement to work (and support to get into work) is the best welfare for people. (Non-statutory sector interviewee)

The levels of certainty ascribed to worklessness policy are shown in Figure 9.

Figure 9: levels of certainty: worklessness policy



Opinions varied as to the level of agreement on worklessness policy. Several interviewees referred to the complexity of the problem and the resultant need for lots of agencies to come together. With such a multi-faceted policy area, interviewees often were not surprised that the process occasionally stalled through lack of agreement.

> Getting agreement as to what to do is technically quite hard so there has been quite a lot of slippage. (Health sector interviewee)

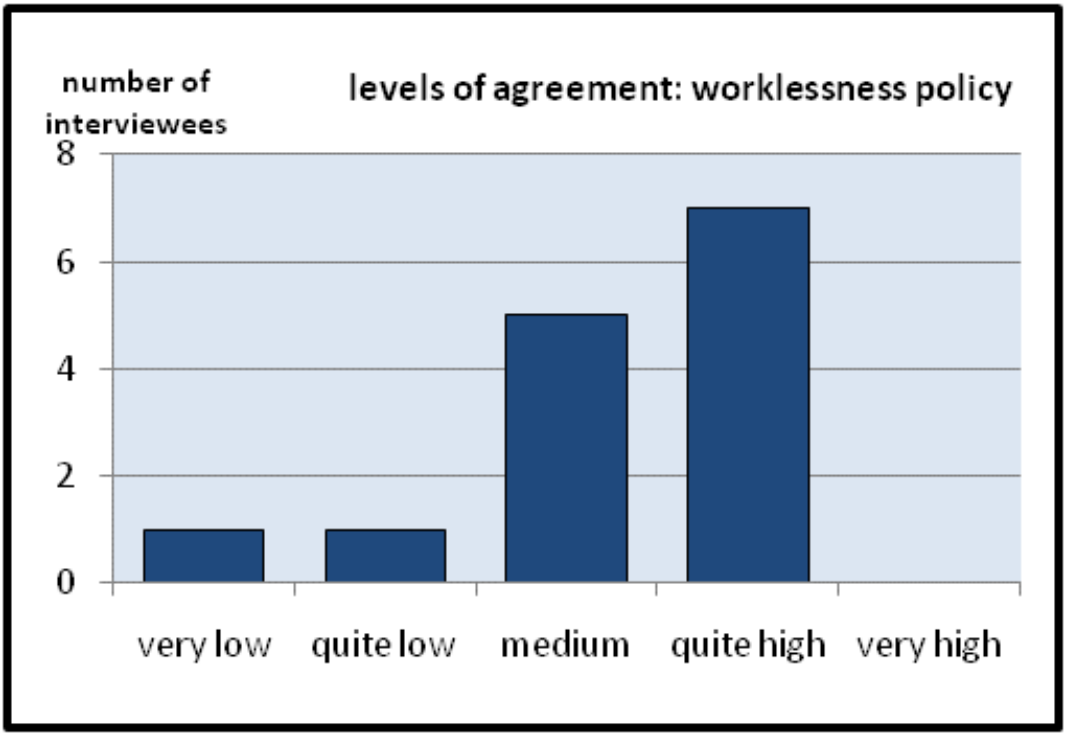
The focus of different agencies led to some disagreement. For example, addressing worklessness for those with severe mental health problems could be costly but because the numbers were so small it would not much affect

economic returns, so it would not meet the needs of those aiming for economic improvement. A non-health-group-1 interviewee mentioned permanent tension between regional and national priorities, also in connection with economic imperatives. A non-health-group-2 interviewee felt that there was quite a high level of agreement between individuals but that some clashes arose because of the organizational approaches, such as the JobCentre Plus emphasis on implementing national policy without any flexibility.

Nevertheless, many (from all sectors) felt there was a good deal of consensus, especially in recognizing the need for joint working. Consensus existed particularly at the strategic level (and high level aims), if not at the operational level, according to a non-health-group-1 interviewee. A health sector interviewee felt that there was good agreement on the level of priority of the policy and on the need to improve regional skills.

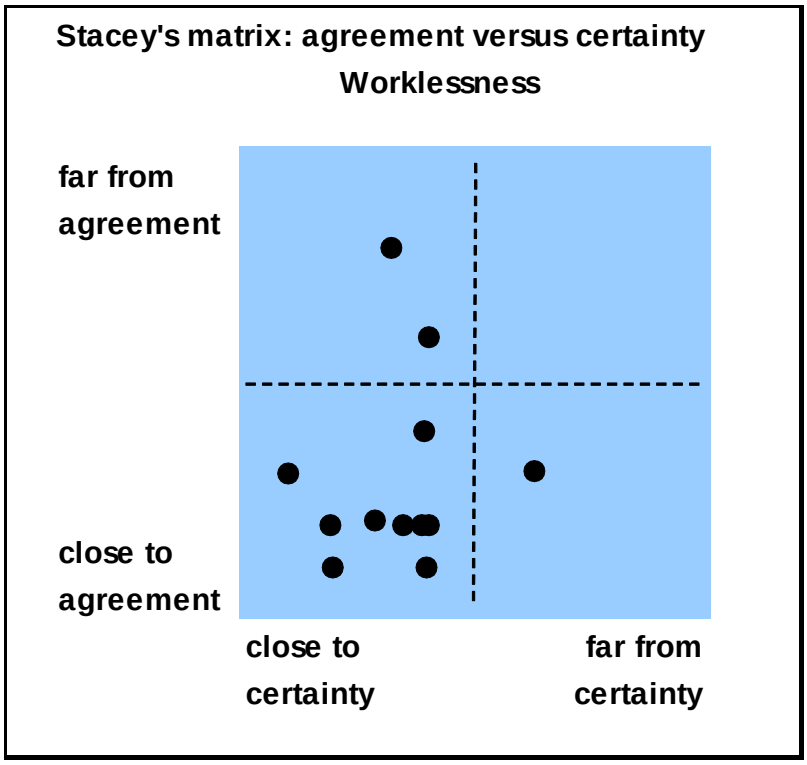
The levels of agreement expressed on worklessness policy are shown in Figure 10.

Figure 10: levels of agreement, worklessness policy



Not all interviewees felt able to allocate a score of 0 to 5 to both the level of agreement and to the level of certainty over worklessness policy. Figure 11 shows responses from those that did (57%), using Stacey's (1996) matrix approach.

Figure 11: Stacey's matrix: worklessness policy



Although several people had suggested that there was agreement over aims, two interviewees (one non-statutory sector and one health sector) said that policy aims were ambiguous or fuzzy: was the aim to get people into work in existing jobs or was it to create jobs? Considering these views and the findings about conflicting approaches, I concluded that some ambiguity existed in worklessness policy. Linking this with the findings on agreement suggests that worklessness would sit in Matland's (1995) model in a location indicating more conflict than either tobacco or housing and a similar level of ambiguity to housing. According to Matland, this position would indicate that there are problems with political implementation (1995: 164) and coalition strength (*ibid.:* 168). This will be used later for comparative purposes.

What other factors influence the progress of the policy area 'climate change' on the regional decision-making agenda?

Previously mentioned differences in interpretation of 'climate change policy' are highlighted if appropriate in this section, in which I describe my findings on factors in agenda-building models, policy context and the nature of climate change policy issues.

Factors in agenda-building models: climate change policy

The main driver of climate change policy was largely felt to be economic, from the government, with environmental and health benefits seen almost as a side effect (further considered in my chapter on getting health into policy).

> One of the key elements in strengthening decisions on this was the Stern report on the economics of climate change [HM Treasury 2006]… this concentrated people's focus on the economic dimension to it – if we don't do something now, our lives will change –we need to invest now. And the fact that we can improve the economy by investing in the environment… we must take advantage of the opportunities... it is a fantastic opportunity for the UK manufacturing regions. (Non-health-group-1 interviewee)

> In terms of economic regeneration, the key aim is to tackle worklessness, particularly in deprived areas. But more jobs lead to more cars, more electronic goods, *et cetera* - therefore increased carbon dioxide. The key driver is to improve the economy but how do we regenerate without compromise? (Non-health-group-1 interviewee)

One interviewee suggested that the economic drive came from local rather than national pressure, though still with economic motives.

> It is more bottom-up than top-down. The government is pushing the protection of the environment and reduction of carbon. For employers, it is a bottom-up approach – very much economics. . . . We see a lot of retail organizations picking up the agenda – it is a marketing decision rather than landfill protection. (Non-statutory sector interviewee)

Several points made by interviewees can be linked to the factors used in Hall *et al.*'s model. Legitimacy for policy-making around climate change is difficult to judge. Interviewees sometimes commented that people thought something should be done but action needed to be universal, probably international rather than even national, let alone regional. Nationally, though, the government has accepted a responsibility (for example, in the Stern Review (HM Treasury 2006)) and national legitimacy is probably reasonably high, coming from departments of an elected government. However, it is probably not as high as for the other policy areas, as there is some conflict between international pressure and national desires (mentioned later under contextual factors). At a regional level, there is much less legitimacy, as there is a feeling that the climate change agenda is so large and in need of national and probably international leadership, rather than regional. Nevertheless, the regional agencies have accepted some responsibility in creating the post of climate change officer.

Technical feasibility was a problem raised by many interviewees. The perceived scale of action and the amount of expenditure needed for possibly small visible returns were also mentioned. Most interviewees raised resource

issues, including the expenses recognized in the Stern Review (HM Treasury 2006) – a percentage of GDP as a necessary investment. An academic interviewee said there were cost elements at different levels – individual, employer and producer.

> Most organizations who want to put something in have short/medium term targets. The cost of investing long-term feels great. There is no incentive to put into something that might or might not have big benefits in 40 years' time. (Health sector interviewee)

Lack of government funding was a common complaint, with interviewees expecting DEFRA to impose more requirements without providing resources:

> The great minister David Miliband[15] makes a lot of noise about the need to deal with threats and adapt to it, *et cetera*, but provides no extra resource to deal with it, to implement change or to help service providers to encourage health service users to change patterns of behaviour. The Environment Agency knows it is important but DEFRA is paring back what the Environment Agency or Government Office can do. They only give money for statutory functions, such as waste management…so if you're looking for a villain in the piece, I wish DEFRA would be a bit more supportive, as well as saying the right things. (Non-health-group-1 interviewee)

One interviewee regarded the public as a resource, not just a political support mechanism, suggesting that the most important resource for climate change policy was

> the interest and switching of the man in the street – if you can capture their ownership and involvement then you can do a great deal. The resource is commitment from the citizen. (Non-health-group-2 interviewee)

[15] Local MP and Secretary of State for the Environment at the time of the interview.

Other challenges to feasibility included the complexities and practicalities of carbon-trading, and a perceived lack of appropriate technology. A non-health-group-2 interviewee commented: 'it's been a drag. People say it is too difficult.' Negative thinking was implied by one interviewee, who thought that although it was still too early to identify problems,

> We are operating in a political environment which is mindful of potential barriers to progress. (Non-health-group-1 interviewee)

A concern of several interviewees was the dependence on the actions of other areas, regions and countries. Lack of action there could damage the effects of any regional policies.

> The challenge is on such a global scale that whatever we do in the North East is inadequate. (Health sector interviewee)
>
> We might reduce our emissions but, for example, China is trebling emissions. (Non-statutory sector interviewee)

Several interviewees mentioned the increasing public recognition of the issues (with related rising public concern, media interest and lobbying):

> We had seen the international pictures – France, the Mediterranean, then the south of England (Boscastle), then the Tyne Valley. This was a wake-up call. (Non-health-group-1 interviewee)

Interviewees suggested that climate change policy was not fully in line with dominant values and current national mood but that climate change was also the only area where there seemed to be large or rapid swings in public mood. These rapid swings make it difficult to assess the strength of public support.

Given the comments about the public not wishing to take some of the individual actions and the lack of fit of policy with national mood, along with the way public recognition rather than support tended to be mentioned, I have rated public support as quite weak. Political support for climate change action was evidenced regionally by the appointment of the climate change coordinator, as well as by the inclusion of sustainability in the RES and RSS. Support also refers to interest group support. Several interviewees mentioned the pressure from environmental groups.

I have summarised from the paragraphs above my assessment of the climate change factors for Hall *et al.*'s (1975) model in Table 11**.**

Table 11: Hall *et al*.'s model with relation to climate change policy

Legitimacy		**Feasibility**	**Support**		
National	**Regional**		**Public**	**Political**	**Pressure group**
Quite strong	Weak	Very weak	Quite weak	Quite strong	Very strong

The factors in Kingdon's (1984) policy stream are strongly related to those described for Hall *et al*.'s model. For the problem stream, the use of systematic indicators is less obvious and more problematic than in the other policy areas: there is some national monitoring of consumption of energy and certain emissions to atmosphere, but little local routine monitoring. No interviewees referred to any local indicators raising the profile of the issue. On the other hand, several interviewees referred to an awareness of the problems

being caused or enhanced by certain events, ranging from international disasters (for example, Hurricane Katrina in the U.S.A.) to more local events, such as major flooding problems in Northumberland or general feelings that the weather was wetter or hotter than it used to be. The fact that particular events raise awareness makes climate change significantly different from my other three policy areas.

The political stream is also noticeably different from those of the other three policy areas, because both public mood and government ideology have experienced changes. Swings in public mood have been occurring over the past few years. It might be better to consider the public mood as swinging towards favouring climate change policy, rather than considering it as a general public mood, and therefore more appropriate to consider under Kingdon's (1984) political stream instead of his policy stream. There have also been pressure group campaigns, including those from environmental organizations such as Greenpeace and Friends of the Earth. Interviewees mentioned an increasing concern at government level, influenced by international conferences and evidenced by the commissioning and acceptance of the Stern Review (HM Treasury 2006).

From the preceding paragraphs, I have summarised, in Table 12, my assessment of Kingdon's factors.

Table 12: Kingdon's model with relation to climate change policy

Problem stream				
Indicators		**Focusing events**		**Feedback**
No		Yes		No
Policy stream				
Technical feasibility	**Budgetary feasibility**	**Human resource feasibility**	**Fit with dominant values and current national mood**	**Political support or opposition**
Very weak	Very weak	Very weak	Quite weak	Quite strong support
Political Stream				
Swings in public mood	**Pressure group campaigns**	**Election results**	**Partisan or ideological changes in government**	**Changes in administration**
Yes	Yes	No	Yes	No

Events, such as the floods mentioned above, could be regarded as events punctuating the equilibrium (for Baumgartner and Jones' 1993 model). At regional level, action has sometimes been galvanised by government action: for example, in the follow-up to the Stern Review (HM Treasury 2006), there was increased activity. However, it is questionable whether this can be defined as punctuated equilibrium: as discussed in the previous chapter, sustainability is regarded as an important part of the climate change agenda and there has been considerable activity to address sustainability over quite a number of years, both nationally and regionally. However, it is difficult to judge to what extent the climate change element has been consistently addressed.

Policy context: climate change policy

I outlined changes affecting the development of general regional policy (and potentially climate change policy) in this chapter's introduction. There were also organizational changes specifically affecting climate change: the launch, in 2004, of the North East Energy Forum (involving the Assembly); the reformation of Sustaine – the 'independent regional champion body for sustainable development in the North East' (Sustaine 2010); and the appointment of a climate change officer in 2006. Local government gained increased opportunities to drive local climate change action from the Local Government White Paper, *Strong and Prosperous Communities* (DCLG 2006).

Some interviewees commented on the difference between English regions, suggesting that the impacts were perhaps less obvious in the North East so that recognition of the problem was later here.

> As climate change moved up the national agenda (after Kyoto), regions responded with their own structures to put in place a strategic answer to deal with the climate change issue. The North East was late on board (not surprisingly as the climate change agenda is much more prolific to the South East, with high growth demand plus very marked climate change towards a semi-arid climate and water supply stresses). . . . It did not really hit the political agenda as strongly here at first. Now it has changed and the effects on human health, on economic viability, on flood defences for communities on the coast and on rivers are more marked. . . . The drive was national, coupled with local events and recognition. (Non-health-group-1 interviewee)

There are significantly more international influences than for the other three policy areas, including worldwide policies such as the Kyoto protocol, which was agreed in 1997 (United Nations 1998) and European policies like the European Climate Change Programme (established by the European Commission in 2000). National significant productions include the Stern Review on the economics of climate change (HM Treasury 2006) and the Climate Change Act 2008. Within the region, the Regional Economic Strategy and the Regional Spatial Strategy contain elements at least of sustainability, if not of climate change specifically. Because there is a requirement to create cohesive policies, these affect climate change policy. One early significant policy event specific to climate change was the production of *And the weather today is...* (Sustaine 2002a), which provided an assessment of the impact of climate change on the region and the need for action. The creation of the post of 'climate change officer', in 2006, was also a major event, as the post holder's remit was to update *And the weather today is...* and to develop a regional climate change strategy. The regional climate change action plan arrived in 2008 (Sustaine 2008a), a year that also saw the North East signing a declaration on climate change (NEA 2008c). There appears to have been a fairly clear pathway of climate change policy development in the region, with early policy events providing a foundation for later events, although the time gaps in between these events were long.

Nature of the issue: climate change policy

Cobb and Elder's (1972) issue characteristics for climate change are rather different from those of the other policy areas. The lack of existence of climate change policies in the past is complicated by the definitional issues discussed above, so the topic cannot be said to have a high degree of categorical precedence. Several interviewees mentioned such complications and the high level of complexity of climate change issues. Complexity arises partly because it is not just a matter of regional action.

> [People say] 'it's too big to do. Why should we do it if China doesn't' (Non-health-group-1 interviewee)

The temporal relevance of climate change is very high, with its very long-term implications. Its degree of social significance is also very high, as it affects everyone. The degree of specificity, on the other hand, is very low, as the area tends very much towards the abstract rather than the concrete end of the spectrum.

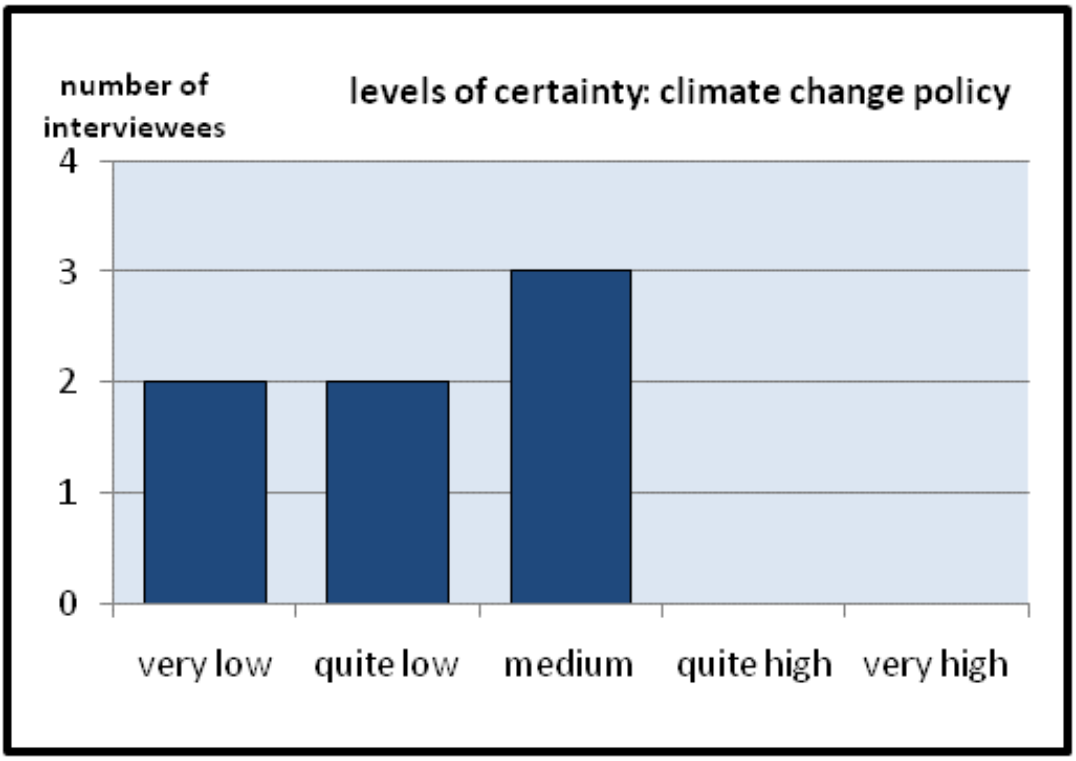
Several interviewees felt that it was far too early to comment on the certainty of success of climate change policy. As one health sector interviewee expressed it: 'People haven't the foggiest idea what will work. There is little available evidence.' However, some interviewees expressed a degree of

optimism or confidence around certain aspects of policy:

> It is a statutory policy – therefore, it is about moulding something that has to happen. It will be binding on local authorities… it has the potential to be very effectively implemented. (Academic sector interviewee)

A few interviewees mentioned policies or actions developed elsewhere. Some regions were working with the Environment Agency, which was felt to be a good approach. A health sector interviewee thought the national approach to carbon footprints was useful. A non-health-group-1 interviewee thought that areas signing up to the Nottingham agreement and the advent of the national proposed climate change bill were likely to increase success. A health sector interviewee praised Sweden's carrying out of health impact assessments on every government policy decision, although the extent of subsequent changes following assessment was unknown. A few interviewees mentioned specific successful aspects, such as recycling initiatives in Denmark and Germany, waste management in France and general environmental health in Canada. Figure 12 shows the levels of certainty expressed by those who felt able to specify.

Figure 12: levels of certainty: climate change policy



Although some interviewees felt it was too early to assess the level of agreement between the agencies, several (from different sectors) felt there was widespread consensus on principles and that something needed to be done, although a lot less on developing the policy's means and actions.

> We can't NOT agree about using less resources to protect the planet - massive degree of consensus. The question is about the how, when and where. (Non-health-group-1 interviewee)
>
> Agreement is high regarding the principles. The next activity is to identify what the priorities are and who is responsible for delivering those actions and by when. (Non-health-group-1 interviewee)
>
> There is consensus that something needs to be done. David Miliband[15] is in our area. The question is: how powerful is DEFRA in government? (Non-health-group-1 interviewee)

A non-health-group-1 interviewee suggested there was high agreement on principles because it made sound business sense as well as environmental sense. Others also mentioned business or economic reasons:

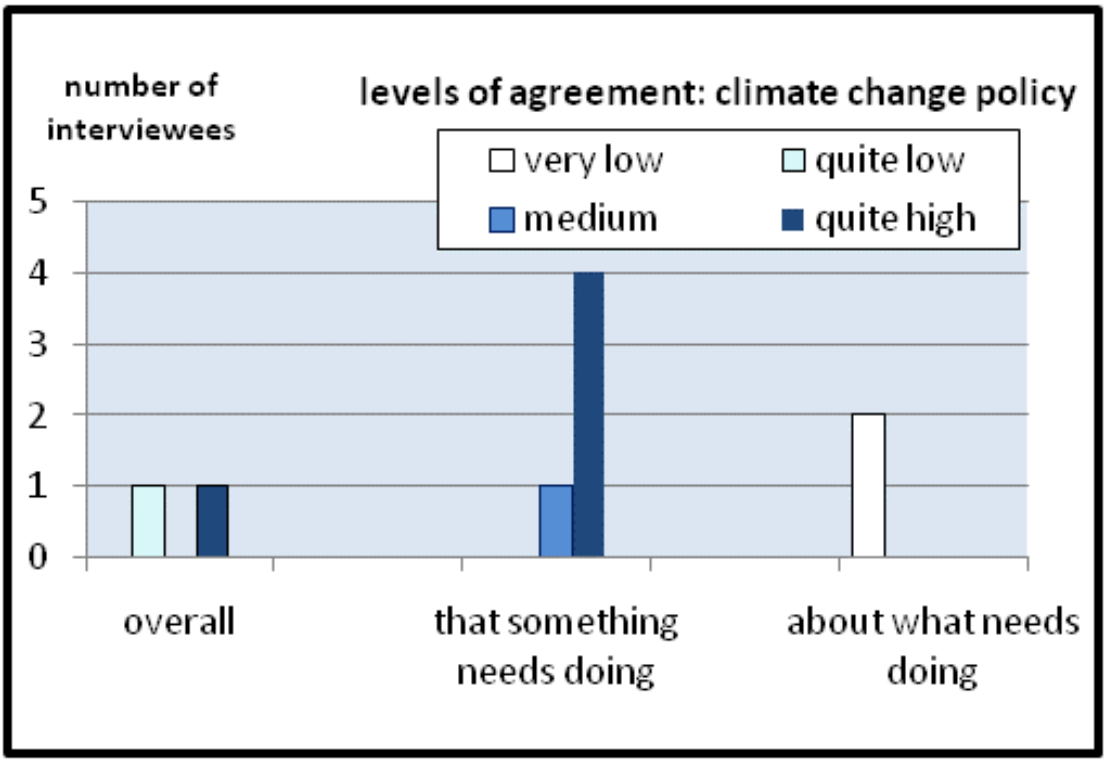
> The mindset still is ‘let’s develop the region’s economy – improve quality of life in terms of economic development.’ (Academic sector interviewee)

Disagreement can exist between strategies as well as between individuals or organizations. As mentioned, many interviewees felt that sustainability and climate change agendas were strongly linked. However, this does not mean that a sustainability-related strategy is necessarily addressing the climate change agenda: one interviewee pointed out potential conflict between strategies, suggesting that, although the Regional Economic Strategy mentioned sustainability,

> In many ways, the RES tends to be about economic growth, which is not always entirely congruent with climate change and sustainability agendas. (Academic sector interviewee)

Figure 13 shows the level of agreement over the policy, as expressed by those interviewees who felt able to specify.

Figure 13: levels of agreement: climate change policy



Because only three interviewees gave an assessment for general agreement and several interviewees gave very different answers for agreement on the need for doing something and agreement on actions in policy, the graph shows these separately. (Agreement that something needs to be done was not a specific question in the interviews but was mentioned by sufficient people to warrant consideration here.)

To use Stacey's (1996) matrix for assessing the relative positions of certainty and agreement, as I have done for the other policy areas, only those interviewees who provided assessments for both elements should really be considered. As there were only two such interviewees, charting individual

points would not be an informative exercise. However, looking at certainty and agreement findings individually suggests that the appropriate quadrant for climate change would be low certainty and low agreement (the latter taking into account both overall agreement and agreement about what needs doing).

The fact that only a small number of interviewees felt able to comment on certainty or on agreement is a finding in itself. It contributes to the assessment of the ambiguity of the climate change policy area. There is ambiguity about aims and a 'lack of clarity about what is the best thing to do' (health sector interviewee). There is ambiguity about whether the policy is to prevent greenhouse gas emissions or to mitigate their effects (non-health-group-1 interviewee). Several interviewees mentioned problems around understanding the issues and changing behaviour (of both individuals and organizations):

> There is a real difficulty getting people to change their behaviour. Nationally and internationally we need fundamental changes as to how we organize energy generation, mitigation, transport use. (Non-statutory sector interviewee)

This suggested level of ambiguity and my findings on conflict (lack of agreement) would indicate that climate change policy belongs in the high ambiguity/high conflict quadrant of Matland's matrix, where the strength of coalition is a very important factor (Matland 1995: 168). The position of the climate change agenda in this model will be used for comparative purposes in my discussion.

Conclusion to Chapter 6

In this chapter, I have described my findings on factors (other than people and power) that affect the policy agenda. These have included factors appearing in the agenda-building theories of, for example, Cobb and Elder (1972), Hall *et al*. (1975) and Kingdon (1984). I have considered contextual factors, such as the history, geography and socio-economic background to policy, particularly with regard to the North East region. Other reported findings related to the nature of the policy areas, with particular attention given to consensus, certainty and ambiguity. These findings should allow me to compare my four policy areas and help in the identification of the most significant factors affecting regional policy development. That discussion will take place in my final chapter. My next chapter outlines findings on how and to what extent health is considered in regional policy.

Chapter 7: Findings 3 - How and to what extent is health considered during a regional policy's development?

In my first phase interviews, I checked whether there was a common understanding of terms such as 'public health', 'health impact' and 'healthy policy'. As Humpty Dumpty said:

> When I use a word ... it means just what I choose it to mean – neither more nor less. (Humpty-Dumpty in Through the Looking Glass (Lewis Carroll))

I felt that if participants understood these terms differently, it could affect how they considered healthy policy. Therefore, before looking at how health is considered in regional policy development, I shall outline my findings on the interpretation of those terms.

There was general agreement about the term 'public health'. All interviewees referred to considering the health of a whole population, rather than individuals, and some referred to taking action to improve people's health and well-being by doing things at a population level. Most referred to the best-known definition of public health at that time, that adopted by the Committee of Inquiry chaired by Sir Donald Acheson ('Acheson's definition'):

> The science and art of preventing disease, prolonging life and promoting health through organised efforts of society. (Committee of Inquiry into the Future Development of the Public Health Function 1988: 1)

None of the interviewees quoted the full definition. The most common way of referring to it went something like this:

> The science and art of . . . blah blah [*sic*] . . . organized efforts of society, *et cetera.*

One first phase interviewee felt that this definition was used by people who knew about public health but that other people tended to regard public health as more narrow and more medical. Another felt that there was now a growing movement away from a narrow focus on illness and treatment towards a more general consideration of social and economic conditions. Another preferred to add Wanless's coda '[through organized efforts] and informed choice [of society]' (Wanless 2004: 23). However, another stated disagreement with the Wanless coda.

Several first phase interviewees also mentioned the need to define 'health', with one interviewee referring to the WHO definition ('*Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'* (WHO 1946: preamble)). This questioning of definitions made me realise that topic-specific questions on the health element would be better split into questions on health improvement and questions on addressing health inequalities: these aspects of health could be addressed very differently and I wanted to ascertain views on both.

A first phase interviewee suggested that, at a regional level, the Regional Director of Public Health now had the opportunity to ensure that the language

was understood across the region – not just literal language but an interpretation of policy and organizational language. Some planners use 'well-being', the health sector uses 'health'. The interviewee suggested that

> if people understood the health agenda, there would be no opposition. (First phase interviewee)

The suggestion that people (at least policy-making professionals) did *not* understand the health agenda was not really borne out by what other interviewees said. There appeared to be understanding amongst all groups of the terms used. However, I realised I would still need to be careful in later interviews to watch for any signs of different interpretation.

A common understanding amongst the first phase interviewees also seemed to exist over the term 'health impact'. Typical comments were:

> Things that make a difference to well-being – wide-ranging, including the economy, poverty, policy on transport, housing, food.
>
> Whether particular activities have positive or negative influences on health status at a population level.

Although those with a more specific public health background tended to produce more formal definitions, all the interviewees (from all sectors) seemed to have a good understanding. So I felt reasonably confident that my 'health' specific questions would be sufficiently understood.

Not only did there appear to be a shared understanding of what healthy policy was but, without exception, the first phase interviewees stated that they

thought healthy public policy-making was important. Several had this as part of their role but others felt their roles were more to do with interpretation, influencing or integrating policy or providing an informed evidence-base for the development of health policy. Distinctions were drawn between different levels of policy: some policy issues were felt to be regional rather than national issues. One first phase interviewee suggested that

> national [policy] addresses 80% of health issues in the North East but not economic policy development (which is not devised to address health policy but is very important).

The way and the extent to which health is considered in policy vary according to the policy area. Before considering my specific policy areas, I shall describe my findings related to health in general policy development.

How and to what extent is health generally considered during regional policy development?

My findings in this section come from both first and second phase interviews, as well as documentary evidence. First phase interviews included discussion on the ways in which health could generally come under consideration during policy development. Several ways (or 'tools') were mentioned, including joint working arrangements, networks and influence, awareness-raising and integration of policies, as well as the more formal techniques such as health impact assessment. In the second phase interviews, several interviewees commented on general policy development, as well as on the specific policy areas. In this section, I look firstly at people and organizations working

together for health, then at cross-cutting policies, then at more formal ways of pushing health into policy.

Joint working for health: general policy

General joint working was discussed in Chapter 5. This chapter includes findings on joint working specifically to increase consideration of health issues. One interviewee felt that opportunities for health-related joint working were already being fostered. This suggestion is verified by documentation from the regional agencies. In 2000, a compact was signed between One NorthEast and the Northern and Yorkshire Regional Office of the NHS, recognizing that there is 'an integrated relationship between health and the sustainable development of the regional economy' (NHS and ONE 2000: 1). An arrangement was also made for an NHS senior manager to be based within the Regional Assembly, whose board membership had always included health representation. By 2003, a Regional Health Forum had been established, accountable to the Assembly, with a focus mainly on public health issues and there were meetings of regional partners specifically around health (NEA 2003b), mentioned by several first phase interviewees. Sometimes the same group of people met to discuss different topics, a point made by interviewees. Such networks were felt to be very valuable, particularly when supported by some power or authority. Interviewees felt that the building and maintenance of relationships contributed greatly to ensuring consideration of health during public policy development.

The (Department of Health) Public Health Group was integrated into GONE, with aims including: 'to lead the improvement of public health in the region by tackling its wider determinants with the help of regional organisations' (GONE 2003: 32). The North East Assembly said in its 2004 report that

> health partnerships became more embedded into the working arrangements of the North East Assembly. A review of the Health Forum, which focuses on public health, has resulted in closer dialogue with the Regional Director of Public Health, with clearer accountability to the Assembly. ..... Closer working relations between the health and voluntary sectors have been forged. (NEA 2004b: 3)

Joint working for health appeared to be happening but interviewees expressed concerns about conflicting agendas and organizational arrangements. According to one first phase interviewee, the structure 'currently tends to keep health in a box, rather than embedding it in other areas'. The general role of the health service did not appear to help: one first phase interviewee suggested that the country has a 'health service that doesn't think health is part of its agenda'. This concern was echoed in a North East Assembly report, which concluded that partnership-working approaches were 'not yet mainstreamed or consistent', even though there was 'considerable enthusiasm for partnership working between NHS/DH organizations and regional agencies and broad agreement on which issues should be taken forward' (Rodger 2005: 8-9).

Several first phase interviewees said that the power (or lack of power) of the public health advocates was a major issue. One expressed the view that personalities could drive the move to ensure health was considered, so that it

might depend on what the Regional Director of Public Health wanted. Another commented that

> public health [the department or professionals therein] can often influence but has not the power to direct.

In the absence of power in the public health function itself, another first phase interviewee (in a management role) suggested that ‘powerful friends are a great asset.’ Whether or not public health power existed, there were certainly questions raised about public health capability and capacity, in terms of the availability of people who could intensify the focus on health during policy development. A first phase interviewee (in a leadership role) said that the region had sufficient public health capacity, particularly as there seemed to be plenty of funding around. The siting of the Public Health Group in Government Office was said to have enhanced its position. All of the other first phase interviewees talked of shortfalls in both capacity and capability, across all areas of public health. One said that lip-service was being paid to training and development – a culture of ’saying the words and not doing the actions’.

Organizational structure was criticised by interviewees. The different boundaries of Primary Care Organizations and Local Authorities were classed as a problem by some interviewees, who felt that fully shared boundaries would give opportunities to identify single public health representatives. Interviewees said that the two-tier local government (which existed in two North East counties at the time) also limited potential effectiveness. The

organization of the public health function itself came under fire, too. In particular, several interviewees mentioned the ‘very unhelpful’ fragmentation of the specialist public health workforce, with the structure leading to what one called a

> thin resource being spread very thinly across a myriad of PCTs and other organizations.

The organizational structure of public health was said to rely on the region’s two public health networks. These were felt by some interviewees to be improving, thereby helping to address the capacity and capability issues. However, they had very different styles and objectives, with one half of the region putting more resources into its network. The lack of formality of the networks was criticised by two interviewees, suggesting that it was too easy for a Primary Care Organization to opt out so that the network could not operate properly.

First phase interviewees said that new roles affected capacity and capability. One referred to the regional role: previously, the Regional Health Authorities had some of the functions of the Regional Public Health Group but focused on directing and regulating the NHS and services, not influencing other regional policy, so the influencing role was a new function. This interviewee felt that building capacity and capability for this would take time, particularly when people were slotted into substantially different posts in reorganizations: people did not yet really understand what skills would be required for their roles. The

same interviewee said that new organizations had inherited strong technical (statistical and analytical) skills at a regional level but not the skills necessary for real collaborative working or influencing political leadership.

First phase interviewees commented on members of other disciplines with roles that affected public health. One felt that these people were often not enabled to incorporate health in their roles. Another said there was a need to develop capacity in other sectors (especially Local Authorities) and to 'develop roles (but not change jobs)' in, for example, Trading Standards and Environmental Health. One interviewee felt that local authorities had problems around capability and capacity because there were new public health responsibilities being thrust on them.

Several first phase interviewees said there was a lack of strong advocacy for public health: what was needed was leaders with visibility and authority, who should be persistently 'omnipresent and banging on about it' and 'refusing to go away'. The advocacy could be opportunistic, as well as planned, and opportunities to spread the public health message should be constantly sought. Several interviewees, saying that written communication was a very poor way of getting the message across, stressed the advantage of verbal (and to-the-point) communication.

One first phase interviewee saw a need to ensure that regional decision-makers (in Government Office and the Regional Development Agency particularly) understood the public health agenda. It was also felt essential to educate and influence all those people who could influence health (for example councillors or directors and senior managers in Local Authorities, Primary Care Organizations and voluntary sector organizations). Health (clearly distinguished from health care) needed to become part of the thinking, not a separate agenda item, and be firmly embedded in all regional policy.

Awareness-raising was felt to be linked to networks and influence but spread more widely, trying to engage the 'hearts and minds' of all relevant players. First phase interviewees felt that health had to be recognized as a regional issue and that a joined-up agenda would be enhanced by awareness. Essential to the awareness-raising was a robust evidence base, which several interviewees said helped people to understand the nature of public health and health inequalities and the actions that could be taken. The most important contributions to awareness-raising, however, were generally taken to be the people involved and the organizational structures allowing (if not actually promoting) public health. One interviewee (in a leadership role) felt that awareness of public health issues had been increasing, particularly through the Government Office, and that public health professionals were now more involved in policy areas. Another interviewee supported this, saying public health now appeared routinely in other places, such as social services. A first

phase interviewee felt that, because there were support and encouragement for links between organizations, we could now see knowledge of health increasing and health infiltrating other areas, such as in the regional transport strategy.

Health in cross-cutting policy

Sometimes, said first phase interviewees, public health professionals had input from the start of a strategy's development (for example, the sustainability strategy). Sometimes the Health Forum and workshops were involved, as happened with the Regional Economic Strategy. At other times, strategies were felt to have slipped past, including the regional waste strategy, which did not tackle the health-related issues of contaminated waste.

There was some suggestion that health improvement had been taken into account in the Regional Spatial Strategy and in the Regional Economic Strategy but either not very strongly or perhaps just as an implicit rather than explicit concern. One interviewee said that, although both of those strategies considered inequalities, neither had moved towards this as much as had been hoped, although the word 'exclusion' had crept in:

> We achieved greater recognition [of the inequalities agenda] but made little impact in terms of the policy agenda. (Academic sector interviewee)

Along with enhanced joint working (both in intention and with actual established mechanisms), the decision-making organizations increasingly referred to more joint consideration of policies and their health elements. The first Regional Economic Strategy*, Unlocking Our Potential* (ONE 1999a), acknowledged that economic growth was hindered by poor health, although there was little other mention of health in this economic growth document. It contributed significantly to the push for joint working, laying great stress on the need for organizations to work together. The Regional Economic Strategy in itself anyway was more a set of policies than one single policy.

The Compact between One NorthEast and the Northern and Yorkshire Regional Office of the NHS Executive was developed mainly

> to address the issues relevant to health contained in the Regional Economic Strategy *Unlocking Our Potential* and commits both parties to, among other things,
>
> - develop the economic and health prospects of the Region's citizens;
> - reduce health inequalities and promoting social inclusion;
> - develop complementary and mutually consistent strategies, investment plans and, as far as possible, integrated implementation plans. (ONE 2000)

The second Regional Economic Strategy, *Realising our Potential*, showed even more enthusiasm to promote cross-cutting action. Amongst its five underpinning, cross-cutting themes was that of a 'healthier and safer North East' (ONE 2002b: 2).

The Health Development Agency (North East region) held a ‘policy, practice and evaluation’ day in 2002 to ‘increase synergy across policy sectors working to address social inclusion and reduce inequalities in health across the North East’ (Learmonth and Ford 2002). Participants included representatives of ONE, GONE, the Regional Assembly, the voluntary sector, local authorities and the PHO, as well as academics and consultants. Joint working towards policies was recognized as essential and several participants commented on the need for organizational stability to allow consolidation and mainstreaming of work (Learmonth and Ford 2002).

The Health Interest Group, including partners from the Regional Assembly, GONE, One NorthEast and the Strategic Health Authorities, was the group that suggested the use of health impact assessment on the Regional Planning Guidance in 2002 (HIG 2002: note 7). The group also sought input into the forthcoming housing and waste strategies (HIG 2003: notes 10b and 10c). Relevant impact assessments are further discussed later.

ANEC, in its 2002-04 Corporate Plan, expressed its intention to ‘maintain a key role in the development of other regional strategies [i.e. as well as the RES] and action plans (including culture, housing, sustainability, rural issues, the environment, health, *et cetera*)’ by ‘... close working with other partners at a regional level, such as the Strategic Health Authorities’ (ANEC 2002: 6).

ANEC's 2005/06 manifesto stated an intention to 'continue to champion issues affecting the health of people in the North East' (ANEC 2005: section 3).

In a section actually headed 'improving integration of policy', GONE's annual report for 2004/05, talking of its reviews of Local Strategic Partnerships, said that

> we advised LSPs of their role in improving public health, as well as helping the health service improve their engagement with deprived communities. (GONE 2005: 31)

GONE's cross-cutting work for health continued to be emphasised in business plans and corporate plans.

> We will develop a better shared understanding of how pivotal policy areas – education, economic, transport, spatial and others – impact upon health, and how improving health can assist in delivering goals in these areas. (GONE 2007a: 17)

The Regional Assembly had established a cross-cutting themes group, which, as early as 2002, was working with all of its Scrutiny and Policy Development Panels to ensure they explored the extent to which One NorthEast's actions were promoting a healthier region (NEA 2002b: 1). The Assembly had policy integration built into its role and recognized the importance of considering health, at least in connection with some strategies:

> In the [Regional Spatial] Strategy we recognise how important Green Belt is to people's health, wealth and well-being. (NEA 2006d)

A particular type of cross-cutting policy was mentioned by several interviewees, namely a regional public health policy. At the time of the interviews, the North East region, unlike some other regions, did not have an explicit regional health strategy. The strategy *Better Health, Fairer Health* (Public Health North East 2008), unplanned at the time of my interviews, arrived in 2008, was in the very early stages of implementation at the end of my research period and was expected to take some time before its effects would be felt. First phase interviewees generally saw both advantages and disadvantages in having a regional public health policy. ‘People are sick to death of regional strategies’, said one. Others felt a strategy could provide a much-needed focus for debate and action that moved public health and health improvement further up the agenda. Several thought it better to have health in all other policies rather than as a separate policy. However, they felt that the ideal, with the strongest effect, would be to have both an explicit strategy and the inclusion of health in all other policies, so that the two strands were ‘mutually reinforcing’.

Irrespective of whether a regional public health strategy existed, most first phase interviewees put people and personalities at the top of their lists of things that worked in keeping a consideration of health on the agenda. One referred to ‘knowledgeable people to explain the state of the region’s population’s health and identify the big issues’. Another commented that ‘personality, not formal structures, gets things done’.

This sub-section has looked at the way cross-cutting policy includes (or fails to include) health. In the following sub-section, I describe the views on and use of more formalised techniques for pushing health into policies.

Formal consultation and policy assessment pushing health into general policy

Several first phase interviewees said that consultation was the traditional way of doing things, as opposed to using a specific tool for health impact assessment. One said that this approach, not ideal, involved sending drafts of strategies to health (and other) organizations for comment, but that this often happened late in the day and success depended on who actually responded. Sometimes this approach was a statutory requirement (for example, the consultation and sustainability appraisal on the Regional Planning Guidance) but often it depended on the originator or developer of the strategy. Consultations tended to take place earlier if some technical expertise was needed, for example on illegal drugs or drugs in prisons – things that people already recognized as having a health impact.

The first Regional Economic Strategy (ONE1999a) resulted from extensive consultation. One NorthEast had published *Towards a Vision* (ONE 1999b) to spark off a debate on what was needed for the region. This was deemed successful: a ‘large number of individuals and public, private and voluntary

organizations throughout the region offered many constructive comments' (ONE 1999a: 6). A similar widespread consultation took place for the second Regional Economic Strategy (ONE 2002b) and there was major consultation over the following Regional Economic Strategy: the Regional Development Agency led the *Shaping Horizons in the North East* (SHINE) scenario development process. This was a substantial consultative exercise, involving over 1,500 people from the private, voluntary and public sectors, following which eight regional themes were put forward as the priorities for the revised Regional Economic Strategy (ONE 2005b).

The Integrated Regional Framework tool was developed within the region in 2004 'to place sustainable development principles firmly at the heart of the region's policies, plans and programmes' (Sustaine 2004: 3). It comprised a framework, against which policy-makers in the region were to assess their developing policies. Regional partners had agreed its seventeen sustainability objectives, which included one specific health objective: 'to improve health and reduce inequalities in health'. Other objectives addressed some of the wider determinants of health, such as crime and fear of crime, access to facilities and services, employment, environment and educational achievement. The Regional Assembly carried out training to ensure that regional lead agencies and stakeholders became familiar with the tool (NEA 2005a, item 13). In 2007, a consultative event, with a range of organizations represented, contributed to a revision of the Integrated Regional Framework,

so that the 2008 version contained only ten objectives. This was a rationalisation and regrouping of elements, rather than a real reduction. The specific health objective remained, slightly altered: ‘improving health and well-being *whilst* [not ‘and’] reducing inequalities in health’. In using the tool, sub-objectives had to be graded according to the strength and direction of the proposed policy’s effect). The Regional Assembly produced annual reports assessing progress against each of the objectives in the Regional Strategy Framework.

Some first phase interviewees mentioned specific health impact assessment tools. One referred to ‘health impact assessment’ being jargon for looking at the likely or actual way in which policy or plans affect populations and individual health. Another referred to the recognition that all kinds of social interventions impact on health and that it was necessary to build public health concerns into the design and implementation of public services. Most of the first phase interviewees did *not* feel that impact assessment methods were the most important tools in the development of healthy public policy. Three suggested that health impact assessment tools could be useful for reflecting and influencing major policy areas.

Interestingly, when asked about the main ways health impact was addressed in the region, most first phase interviewees focused on specific assessment techniques, even though most had concentrated on other tools when talking of

tools for delivering healthy public policy. This might be simply because the technique's name includes the words 'health impact'! One first phase interviewee felt that health impacts were 'pretty under-addressed' and that there was a struggle to get a lot of major decisions on to the agendas of the Regional Development Agency and Government Office, although they expect to see this change over time. However, most of the first phase interviewees had actually been involved in at least one impact assessment and over a third of the Regional Development Agency's staff had received some training in it.

Questions were raised over who made the decision to carry out an assessment and what exactly determined which policies should be subject to one. Some interviewees said that there were few resources available for assessing impact. Several felt that the scrutiny function was very important, particularly the new Local Authority power of scrutiny over health issues. Although several first phase interviewees felt that the NHS was not yet fully engaged with health impact assessment, others felt that the Regional Public Health Group (though too small) and Primary Care Organizations (through Local Strategic Partnerships) were starting to have an effect. One felt that integrated impact assessment, in particular, would eventually be a good approach.

More than one interviewee spoke of limitations of integrated impact assessment, including the lack of widespread awareness of its application in

practice and the difficulty of engaging the private sector. One interviewee questioned the lack of evidence on its outcomes, asking ‘does it do any good?’ and ‘does it change things for the better?’. Another described the difficulty of getting people to concentrate on the health issues in an assessment, using the example of the housing strategy, where there appeared to be far more interest in the number of houses to be knocked down than in any health effects.

All of the first phase interviewees felt that impact assessment was a more powerful tool when used proactively. Since it was able to alter people’s perceptions or mindsets, one interviewee said that it was better to do this early in the policy process. Some stated that there was some value in reactive assessments, saying they were better than nothing, particularly if it was too late for proactive ones, or that they could be useful in terms of mitigating features of related policy under development.

The different levels at which assessment should be brought in were mentioned by a few first phase interviewees. One felt there was room to address health impact in terms of national, regional and local needs. Another felt that the higher the level, the better, as small changes nationally or regionally can have huge effect, thereby increasing the chances of it working at local level. One first phase interviewee said assessments were difficult at a regional level because the region had no power to do regulatory things (a

central government activity) and it did not do things on the ground (where local authorities carried out the actions).

One first phase interviewee suggested that people should be dealing with broader health improvement, not just health impact, and that the legislative framework (for example for smoking in public places), statutory frameworks (planning industrial development or road improvements), societal influences and individual choice needed consideration. Another felt that impact assessment should be built in to the development of all societal policy.

In spite of the various objections and difficulties of health impact assessments, several were carried out in the region. An early regional rapid health impact assessment took place on the Regional Planning Guidance (GONE 2002b) in 2003. Participants were from a range of backgrounds and organizations: North East Assembly, GONE, SHA, NHS Trusts, ONE, PHO and universities. It was a 'rapid' assessment because of timescale but it involved three separate scheduled meetings, with participants attending every one. Participants received briefing material and preparatory work in advance. Working in groups, each group focusing on specific chapters of the Regional Planning Guidance, they assessed impacts in the first session, enhanced priority areas in the second and consolidated the report in the final session. The major criticisms of the Guidance were a lack of focus on disadvantaged communities; lack of explicit statement of health implications; and lack of

integration of transport strategy. The strategy was also said to need to acknowledge trade-offs and consider mitigation for adversely affected populations. (The assessment report was sent as a response from the RDPH (RDPH 2003)).

Many of the same issues for the Regional Planning Guidance were raised again in the formal assessment of the Regional Spatial Strategy. The Regional Planning Guidance had become the draft Regional Spatial Strategy in 2004 and a ‘pre-consultation draft’ was made available to health partners that year. Because of time pressure, it was decided to carry out a ’screening health impact assessment’, which included a meeting for a range of people from different health organizations and backgrounds. In that half-day meeting, nine of the 54 policies included were assessed according to a scoring system, policies were identified with the greatest potential health impact for further discussion and a general discussion took place to consider additions or omissions. The ensuing report was discussed in meetings of both the North East Health Forum and the North East Health Interest Group, with the latter finalising the document. The main effects considered were those relating to public health but, recognizing the confusion between ‘health’ and ‘health services’, the report did also highlight issues of relevance to health services. Although several participants decried the absence of a regional health strategy (as did my interviewees), the Regional Spatial Strategy was broadly welcomed, with several of its strategies recognized as having a positive

impact on health (Chappel and Bailey 2004: 13), although it was thought to be lacking in considering inequalities (*ibid*.: 14). One of my interviewees later commented on probable limitations to the success of the assessment:

> Different bits of the Regional Spatial Strategy brought out different things important for health or the health service … what they did around it was called screening – topics were identified to be picked up … but it is a 'spatial strategy' so this limits what is included. (Academic sector interviewee)

The next version appeared to acknowledge, at least to a small extent, some of the concerns expressed. For example, it made several references to improvement of health and providing a sense of well-being. However, at least one health sector professional felt that the screening had not altered anything and another interviewee suggested that

> we tried hard but were not really successful, though there is more mention of social exclusion or disparities in later documents….The Regional Assembly will acknowledge deprivation and inclusion *et cetera* but these did not seem to figure in the Regional Spatial Strategy. (Academic sector interviewee)

After the RSS consultation, a draft was submitted to government in 2005, following which there was an Examination in Public in 2006 and further consultation until the final strategy was accepted by Government in 2008.

Several months after the Regional Spatial Strategy assessment, there was a 'rapid health impact assessment' of the latest Regional Economic Strategy, again organized by the North East Public Health Observatory and again involving an event with public health professionals from a range of backgrounds and organizations. Different groups discussed different draft

Regional Economic Strategy themes, for which the participants had been sent preparatory information. Once again, the lack of a regional health strategy was noted as an issue, since a regional statement of health priorities could 'facilitate the process of HIA' (Bailey, Chappel and Sher-Arami 2005: 1). Other key messages were that the Regional Economic Strategy needed to acknowledge the potential contribution of health improvement to economic and quality-of-life improvement. It was also felt that the role and potential of the public sector, particularly the NHS, should be better acknowledged. Consideration of health inequalities and of joined-up thinking were also said to be lacking. However, the document was broadly welcomed. When the final version was produced (ONE 2006), there did appear to be greater emphasis on the potential of the public sector, and health inequalities were certainly considered with relation to some aspects, such as worklessness.

Comparing the Regional Economic Strategy and Regional Spatial Strategy assessments, one interviewee suggested that it had been hard to influence the Regional Spatial Strategy in the same way as the Regional Economic Strategy,

> Possibly because our arguments are more powerful around the Regional Economic Strategy, or we didn't have the commitment to change the RSS compared with the RES – or perhaps the Regional Assembly is much more difficult to influence than One NorthEast. (Health sector interviewee)

There were two very big differences between the assessment on the Regional Planning Guidance and the assessments on the Regional Spatial Strategy

and Regional Economic Strategy. One was the time allowed for the professional groups to work on the assessment: half a day for the Regional Spatial Strategy and the Regional Economic Strategy, compared to three separate sessions spread over three weeks for the Regional Planning Guidance. The other difference was in the professional and organizational backgrounds of the participants. Whilst the Regional Economic Strategy and Regional Spatial Strategy assessments were done by health (mainly public health) professionals, the participants in the Regional Planning Guidance assessment were from a variety of professions, disciplines and organizations. I shall return to this theme later when describing the assessment of the regional housing strategy, after the following section on tobacco control policy.

How and to what extent is health considered during tobacco control policy development

I have drawn attention to previously mentioned different interpretations of the term ‘regional tobacco control policy’ where they appeared to affect interviewee comments on how health is considered during tobacco policy development.

Tobacco control differs from the other three policy areas in terms of directly considering health. It has generally been a policy area under the control of the Department of Health and is therefore often seen as being driven by health, although certain aspects (such as smuggling and under-age sales of tobacco)

fall under different remits. Tobacco strategies have a strong focus on the health-detrimental effects of smoking.

> The publication of *Smoking Kills* (Secretary of State for Health *et al.* 1998) was the first time that the scale of the harm caused by tobacco received a proportionate response from government. (ASH 2008: 2)

Smoking-related health inequalities were considered in several Department of Health policies, such as the National Service Frameworks for Mental Health (DH 1999), Coronary Heart Disease (DH 2000) and Children, Young People and Maternity Services (DH 2004b), as well as plans such as the *Cancer Reform Strategy* (DH 2007b). However, the levels of importance attached to health improvement and to addressing health inequalities can vary and have varied at both national and regional levels. *Smoking Kills* clearly stated a government aim of reducing inequalities in smoking but there was some concern about whether banning public place smoking would increase exposure of disadvantaged children to smoke in the home (Amos 2007: 198-201).

At a regional level, ANEC recognized the harmful effects not just of smoking but of second-hand smoke, and pledged in its 2005/06 manifesto to reduce the harm caused by second-hand smoke, including supporting a public places ban (ANEC 2005: section 3). In its 2006/07 manifesto, it reiterated support for the ban and said it would work in partnership towards reducing the number of smokers in the region (ANEC 2006b: 9).

All interviewees felt that the improvement of population health was a fundamental consideration of policy-makers in the development of tobacco policy. However, one said, slightly more cynically, that the policy on smoking in public places might have been driven firstly by a desire to cut down on health costs and secondly by the potential for litigation around second-hand smoke in the public sector.

> To get the government interested, there needs to be a financial incentive. (Non-statutory sector interviewee)

There was a lesser degree of consensus about whether the need to address health inequalities was a major tobacco policy driver. It was pointed out that there were two levels of inequality to consider: that between the North East and other regions of England and that between different areas of the North East.

> At a regional level, we are addressing more the level of inequalities between the North East and the rest of England. (Non-health-group interviewee)

Some interviewees felt that inequalities within the region were almost automatically addressed because smoking is associated more with people who are economically disadvantaged and/or suffering from mental health problems. Others felt that disparities between different parts of the region had been less well addressed, although some thought that the differences between social classes within the region had been a consideration. One health sector interviewee felt that, although it had not been as great as would

have been liked, there was in the region ‘a very clear commitment to tackle inequalities’.

The improvement of population health was generally considered a much stronger driver than the reduction of health inequalities. One interviewee suggested that economic inequalities were considered but not other inequalities,

> Not in the sense that there were the typical equality streams – not particularly strong issues around race, gender or disabilities but we understand poorer people smoke – the economic inequality argument – we approached it that way. (Non-statutory sector interviewee)

Both inequalities and health improvement were stressed in the regional 1998 strategy (Regional Task Force on Tobacco Control 1998), which cited death rates from cancer-related diseases and the proven links between poverty and smoking, with related higher levels of smoking-related disease in disadvantaged communities. The 2005-08 strategy also not only outlined the general health improvement aspect but also said that

> smoking is the greatest single factor in the difference in life expectancy between the social classes.’ (PHGNE 2005: 3)

A policy can contain specific health-related (rather than process-related or service-related) targets that can indicate the strength of its focus on population health improvement or on addressing health inequalities. Many interviewees were not aware of any particular performance management of health

outcomes of tobacco policy, although they were sure there would be some. A few referred to targets for smoking rate reduction or service provision. Mortality rates from certain tobacco-related conditions were mentioned as targets for Local Strategic Partnerships. There were varying opinions on the use of targets. One interviewee felt that there might be problems in attaching responsibility for some targets:

> Whilst individual directors cannot be held accountable for death rates in areas, they can be made to account for taking measures to help to address the problem (directors of crime or regeneration or whatever). (Non-health-group interviewee)

A health sector interviewee felt that tobacco control policy should not stand on its own but should be an integral part of other policies, because where an activity or a policy is seen to be the responsibility of one particular agency, other people could assume everything was being done by that agency. This view was echoed by two interviewees (from different sectors), when asked where the power lay to drive through changes to bring in a greater health dimension to tobacco control policy: they said that the power should not be restricted to the health sector but should be embedded elsewhere. Answering that same question, most other interviewees felt that this policy area was almost inevitably going to be health-driven.

Because of its usual origins within the health sector, health impact assessment has generally not been considered essential for this policy area: it

is assumed that public health policy is specifically designed with health improvement or reducing health inequalities in mind.

In this section, I have described my findings on how and to what extent health improvement and health inequalities were considered during the development of tobacco control policy. In the following section, I shall relate my findings on housing policy with regard to these issues.

How and to what extent is health considered during housing policy development?

I have drawn attention to previously mentioned differences in interpretation of the term ‘regional housing policy’ where the interpretations appeared to affect interviewee views on how health is considered during housing policy development.

The extent to which health is considered in housing policy

Only one interviewee (non-health-group-2) believed that health was the reason we had a public housing strategy. An academic sector interviewee felt that health was certainly not considered at national level, where focus was on the economic impacts. There were examples of the health aspect of housing policy being considered (at least in writing) at a national level, including the Labour Party manifestos of 1997 and 2001. The 2007 housing green paper

(DCLG 2007), which post-dated many of my interviews, also recognized that factors such as overcrowding adversely affect health and it included health in its vision. However, much of the green paper's health-related content referred to health and social services, such as access to services and the cost to services of adaptations for warmth and safety reasons.

The 2005 Regional Housing Strategy did not refer to health improvement *per se*. It certainly addressed inequalities: one of its four objectives was concerned with decent homes' standards and one was

> to promote good management and targeted housing investment to address specific community and social needs, including an ageing population and the needs of minority communities. (NEHB 2005: 3)

Rural affordability, fuel poverty and the housing needs of vulnerable people received significant attention in the strategy. The effects of restrictive planning regulations on poorer rural communities have been much criticised across the country (for example, Gallent (2009: 154)). The inequalities in the regional strategy were implicitly, rather than explicitly, connected with health inequalities.

A similar criticism could be levelled at the 2007 Regional Housing Strategy, which talked of addressing the market exclusion that is 'most significantly felt by the most vulnerable and least affluent' (NEA/NEHB 2007:13). This relates strongly to health inequalities but the health aspect was not really mentioned.

Consideration of health improvement was also almost a by-product of the improvement of access to public transport and to facilities including recreational spaces and of increased community cohesion. There was, however, one small paragraph stating that

> these are important aims that illustrate the important relationships between housing and health, which the NEHB is keen to promote. (NEA/NEHB 2007: 65)

Later sections in the strategy did address the needs of vulnerable people. A health impact assessment on the strategy (discussed later) referred to inequalities being 'potentially' well addressed. However, several interviewees (from all sectors) expressed the opinion that health was not well considered at the regional level.

> Health was not mentioned much at all. (Academic sector interviewee)

> I am not convinced health came into it. Generally, people perceive that public health and housing is something that was achieved rather longer ago – clean water *et cetera*. . . . When they are going through housing policy, people just adhere to best practice rather than with a view to imposing a health agenda. (Non-statutory sector interviewee)

> It could have and should have been more informed by health improvement and health. . . . There is a disconnection between health and housing. (Non-health-group-1 interviewee)

One interviewee commented that the lack of health consideration was partly because of the roles and skills of those in the field:

> there is still only a limited number of people with an understanding of health in regional policies – many senior staff are just in NHS health care. (Non-health-group-1 interviewee)

Another suggested there was little involvement from health professionals who might be expected to ensure that health was taken into account. However, it was proposed that this was partly because of awareness in non-health professionals:

> There is a strong understanding and recognition amongst housing professionals of the importance of housing to physical security and the effect on mental health. (Non-health-group-2 interviewee)
>
> People might be health aware even if they are not working within health. (Non-health-group-1 interviewee)

The differing agendas of the organizations involved in housing policy (discussed also in Chapter 5) were felt to contribute to health not always being well considered.

> The motivations of the private sector lead to a different agenda. Social landlords/property developers are interested in life cycle housing and putting marginal investment in the environment – greenness, e.g. trees – and the beneficial effect of mental health, *et cetera.* (Health sector interviewee)

Some interviewees commented that a range of factors had an influence on the aims of housing policy, so that it was difficult to attribute health improvement to specific interventions or policy. A health sector interviewee said that, unlike the situation with tobacco policy, there were many diverse views about the way housing policy worked, with regard either to regenerating communities or to influencing health.

In comparison with population health improvement acting as a driver, more interviewees thought that addressing health inequalities had been an important consideration. One interviewee (non-health-group-2) suggested that *'*a significant part of the agenda relates to vulnerable sectors of the community'. However, others were dubious.

> I'm not sure it was driven by health – it was driven by either a social agenda or the desire to find funding to deliver social housing. (Non-statutory sector interviewee)
>
> From where I see it, I think the main driver was to improve the quality of housing stock to attract people with higher level skills and higher earners. (Non-statutory sector interviewee)

One interviewee opined that housing policy actually tended to widen inequalities:

> The operation of housing markets contributes to widening inequalities in the UK and in the regions. There is socio-economic polarisation in the housing market. (Academic sector interviewee)

Others suggested that health inequalities were addressed not as a main focus but almost as a by-product.

> [Addressing health inequalities] is implicit in the housing agenda. In social housing, you see inequalities writ large when you are talking about overcrowding. (Non-health-group-1 interviewee)
>
> There are big implications for health inequalities. One issue is that if we attract the higher income householders that in the Regional Economic Strategy could contribute to economic growth, what would be the implications in patterns of inequality? ... economic development can fuel a growth in health inequalities. (Academic sector interviewee)
>
> I don't think they think specifically in terms of health inequality – they've got this kind of economic approach – a trickledown assumption – if you deal with the economic problem then people get richer and it can improve health. (Health sector interviewee)

A few interviewees felt that inequalities were properly considered but, generally, even those who thought that health was a driver of housing policy felt that it was not the key driver.

> Housing is a driver in improving health. . . . How strong a driver was health as compared to economics? – they were both strong. The economic driver was there. (Non-health-group-1 interviewee)

> Sorting out social housing was the greatest priority – there was a drive from national to local government. The second priority was to have a cogent wider planning policy. . . . Third was the health and well-being of people. (Health sector interviewee)

Targets in housing strategies tend not to be specifically health-related. At the national level, one major Government target was to increase the proportion of vulnerable households living in decent homes, indirectly addressing health inequalities. This indirect consideration of health was reflected in interviewee comments. There was little recognized attempt to use health-related targets in regional housing policy. Many interviewees were not aware of any performance management of the health component of housing policy. Several said there definitely was none, although attempts had been made to bring some into the 2005 strategy. Others suggested that there were indirect rather than direct measures, including energy efficiency targets (since energy efficient homes would be beneficial to health). Other indirect measures that appeared in the 2005 Regional Housing Strategy were the targets around fuel poverty, homelessness, housing adaptations and decent homes for vulnerable people (NEHB 2005: 124-131). Similarly, in the 2007 Regional Housing Strategy (NEA/NEHB 2007: 113-119), targets were only

indirectly related to health (for example, affordability, homelessness, decent homes, adaptations and fuel poverty).

This sub-section has described findings on the extent to which health is considered in housing policy. The following sub-section contains findings on the power of people or organizations to get it considered, along with mechanisms for them to do so.

Power and mechanisms for considering health in housing policy

A few people mentioned the use of organizational arrangements to integrate health with housing, suggesting that the existing post shared between the North East Assembly and the health sector helped to create a good infrastructure. There was a lack of consensus over the extent of health sector involvement, with at least one interviewee admitting to ignorance on this:

> If the question was around 'was there a health consideration/organization involved in developing the housing strategy?', I'm not sure that there was – but I'm not sure that there wasn't! (Non-statutory sector interviewee)

One health sector interviewee felt that the issue of engagement in the housing strategy was never really tackled. Another doubted whether the most recent strategy had even been sent to health organizations for comment. One reason offered for this was that the health sector was still seen mainly as just a health care provider. One interviewee referred to previous research (Rodger 2005),

saying it had shown that ‘housing was an area where health did not extend itself’ and there was no great engagement.

There were also doubts about health organizations being able to influence policy.

> I don’t know how much influence health [i.e. the health sector] has, though. My hope is that if we finally manage to get a regional health strategy, the health community might have more influence – it will integrate strategies. (Non-statutory sector interviewee)

> We wanted more public health representation. The ideal with this sort of policy is to look through and say you should adopt salutogenic principles - policies should be about improving quality of life *et cetera*. (Health sector interviewee)

Only one interviewee (health sector) felt that the health sector had much influence, saying that it was now a major player, along with local authorities and the third sector. Another (academic sector) felt that, since local authorities deal with the issues locally, it would be at the local level where engagement with health would take place. One interviewee (non-health-group-1) said that although health interests were not explicitly involved on the Regional Housing Board, the health sector was consulted. A few said that the absence of a health representative on the housing board had been flagged up. An academic sector interviewee just commented that ‘people in health kept out of the debate’. Many more (from all sectors) said health agencies were not very much involved. One believed that this was because

> no health providers (PCTs etc) are deeply involved in delivery or governance. (Non-health-group-2 interviewee)

It was also suggested (by a non-health-group-1 interviewee) that health professionals had such a heavy workload anyway that there were practical issues around their involvement but that they were represented through the joint health/Regional Assembly post.

Various ideas were expressed about where the power lay to drive through changes in housing policy to help it to improve health. One health sector interviewee felt it was with central government; several (from various sectors) felt it was largely within the health sector (specifically the Strategic Health Authority) through its engagement with the Regional Assembly. Organizations rather than individuals tended to be mentioned.

Several referred to the power of the market and several believed the power to ensure consideration of health lay with local authorities but many others suggested it was diffuse, with opportunities at regional government and local government levels.

> The Local Authorities and partners have a lot of scope to develop their own policies and seek government support. (Non-health-group-2 interviewee)

To improve the likelihood of influencing the policy to make it health-beneficial, a few people commented that there was a need for more evidence, ‘so that we are much more alive to the connections between health and housing’ (non-health-group-1 interviewee). Others felt that the power should lie more with

the Strategic Health Authority. One non-statutory sector interviewee said ‘it would be nice to see the SHA exercising its expertise there.’ Several people, however, wanted greater shared responsibility, with all partners playing a part, including the community, but more specifically joint approaches between the statutory sectors.

> It is a shared responsibility. Those responsible for policy in all aspects are not likely to exercise it unless people bang their heads together. Therefore, we need responsible health people to bang heads. (Health sector interviewee)

The need for joined-up policy was stressed in the 2007 Regional Housing Strategy, which claimed that it complemented other regional strategies and that

> it particularly works alongside the Regional Spatial Strategy (RSS) and shares common information and evidence. (NEA/NEHB 2007: 5)

Formal assessments were carried out on both the 2005 Regional Housing Strategy and, as mentioned earlier, the Regional Spatial Strategy. In 2003, an Integrated Policy Appraisal (IPA) Pilot took place on the draft Regional Housing Strategy. This approach was taken opportunistically, because the Department of Health was running a pilot of IPA, asking regions to try out the approach. The appraisal involved participants from a range of backgrounds: Government Office, North East Assembly (housing experts), ONE, Public Health Group North East, English Nature, Local Authorities, Health Authorities and Trusts, Health Development Agency and public health consultants.

Participants were sent preparatory work to familiarise them with both the process and the draft housing strategy and action plan. A half-day workshop was held, where different groups assessed the policy in terms of three different aspects: economic, social and environmental. Of greatest relevance to health improvement was the social section: questions to address included:

> Will the policy or project enhance or harm health or safety?
> Will it affect the use of the work environment to maintain or improve health, or the ability of people to return to work from illness?

The output of the discussions was supposed to include a completed table, with qualitative assessment indicated for each question by a number on a scale running from strongly negative to strongly positive via no effect. (Such numerical assessment proved interesting for the question 'will the policy or project enhance or harm . . . ?') Identification of inequalities was also part of the assessment, with consideration of the differential impacts on a range of groups, such as low income groups (text responses rather than numerical scales for this aspect). The focus on the impact of the housing strategy itself was necessarily diluted because the exercise had been designed to assess the viability of the assessment method. However, several points about the housing strategy were made in both the assessment tables and, invaluably, in the discussions taking place among participants, including in the plenary session (Brown 2003). A major concern was that the focus was definitely on the economy, with little thought given to health improvement. The commercial interest of house-builders was thought to have had too much influence in the 'destroy-and-rebuild' recommendations. By the time the final strategy emerged

(NEHB 2005), some changes had been incorporated. The ‘community housing needs’ section evolved into ‘meeting community and social needs’. There was also more emphasis on various vulnerable groups. However, much of the ‘health improvement’ or ‘addressing health inequalities’ element was still felt by a health sector interviewee to lack a necessary explicit focus.

Concerns have been raised about the use of health impact assessment for housing strategy. One is that a broad evidence base is needed to inform the assessment, particularly with local data but these are not always available (Thomson, Petticrew and Douglas 2003: 11). In the region’s 2003 assessment, there was no formal mechanism for submitting evidence. A second concern is that local stakeholder involvement (not professional) is needed but there are issues about such a group understanding both the issues and the assessment technique (SNAP (Scottish Needs Assessment Programme)). The assessment processes took time to understand for the experienced professionals in the North East’s 2003 assessment, which did not include the public.

One very positive outcome of the 2003 Integrated Policy Assessment event was the awareness-raising amongst participants whose background was not related to health or public health. Several said that they had been very surprised to learn some of the health effects of housing and were keen to

learn more, intending to make use of their new awareness when designing policy (Brown 2003).

With reference to the housing and planning elements of the Regional Spatial Strategy, one interviewee remembered that

> clear messages came out [of the health impact assessment screening for Regional Spatial Strategy policies] about high Index of Multiple Deprivation areas. For example, don't put highways through communities….You could question how effective it was but I feel, being pragmatic, that it did start to get policy-makers to come together and listen to health practitioners together – turning the big ship around – it did make people start to see health as a driver. (Non-health-group-1 interviewee)

This comment about the value of the impact assessment in bringing people together echoes some of the points raised about the integrated impact assessment on the Regional Housing Strategy. It also reflects the thoughts of some interviewees about policy development in general – people, not processes get things done. Possibly the greatest benefits of impact assessments lie in their bringing people together to share views and enhance one another's awareness of public health issues. For housing, it looks as though this might be the case.

Consultation with key housing stakeholders took place for the 2007 North East Housing Strategy. The voluntary and community sector advisory forum and the private sector advisory forum were an important part of the process, feeding in views from a wide range of non-statutory organizations. (The advisory forums were described earlier.) The Regional Housing Board was

multi-agency, from both statutory and non-statutory agencies. The strategy was also assessed under the Integrated Regional Framework and the consultation draft underwent a Health Impact Assessment, led by the Public Health Observatory.

> The feedback from this assessment was that inequalities... were potentially well addressed... Moreover, the assessment reported that housing should be considered to be a key factor in the care and support of vulnerable people. The NEHB will look to ensure that health and housing become more aligned. (NEA/NEHB 2007: 3.6)

This section has focused on findings on getting health considered in housing policy. In the next section, I move to look at the issues around the worklessness agenda.

How and to what extent is health considered during worklessness policy development?

I have drawn attention to previously mentioned differences in interpretation of the term 'regional worklessness policy' where they appeared to affect interviewee views on how health is considered during worklessness policy development.

The extent to which health is considered in worklessness policy

Nationally, the link between unemployment and health improvement had certainly been recognized, for example in the Labour Party's 1997 manifesto and in several of its ensuing policies and reports, including the *Health, Work*

and Well-being strategy (DWP, DH and HSE 2005) and *New Deal for Welfare: empowering people to work* (DWP 2006), which pre-dated my interviews. Later policies also stressed the link, including for example, the Green Paper *No-one written off: reforming welfare to reward responsibility* (DWP 2008a) and the subsequent White Paper *Raising expectations and increasing support: reforming welfare for the future* (DWP 2008b).

None of the interviewees specifically mentioned the *Health, Work and Well-being* initiative (DWP, DH and HSE 2005). One believed that the health and worklessness joint agenda had only moved up the government's agenda since the Layard report (LSE 2006), whose

> interesting analysis encouraged DWP and DH to think they had something in common in terms of GPs accessing benefits or services. (Health sector interviewee)

At the regional level, in the earlier years considered, worklessness and health were sometimes linked more in terms of the effects of health on worklessness, rather than the effects of worklessness on health – more of an economic consideration. The 2000 report, *Building bridges to employment in the North East* (CRC and NEEF 2000) had used a consultation process with focus groups, looking at issues such as social exclusion and minority ethnic and faith groups (*ibid*.:4). However, the finished report did not appear to address either health improvement or health inequalities.

The first *Framework for Regional Employment and Skills Action* (FRESA), was launched with a news release: 'The Framework will provide a mechanism through which employment and skills information, strategies and initiatives can be better aligned, co-ordinated and levered to the needs of employers' (ONE 2002c). The emphasis was on employer needs, not the health needs of the workless. However, the 2006 Regional Economic Strategy, in its section on improving access to employment, acknowledged that widespread health problems and a dependence on Incapacity Benefit were particular barriers in the North East (ONE 2006: 99). This had also featured in a GONE review of Local Strategic Partnerships:

> The performance against worklessness was limited by a combination of factors including skills development, economic development and job seeker advisory services, together with the poor health of the population with high levels of incapacity benefit. (GONE 2005: 31)

Both the Regional Partnership group (multi-agency, including all three main regional decision-making organizations) and the Public Health Research and Action Collaborative (PHRAC, a joint NHS and academic sector concern) held seminars in 2005/06 considering the health and worklessness agenda. The focus of the former (Regional Partnership Group 2005) was recruitment to the health and social sectors, recognizing the role that the sectors could play in bringing people back into work from Incapacity Benefit. The PHRAC seminar concluded that the impact of health on worklessness needed emphasis at a regional strategic level (PHRAC 2006).

Later documents showed more progress. ANEC's 2006/07 manifesto, reporting its concerns on the high levels of people unemployed by reason of ill-health or disability, stated that

> we will seek to influence the debate on employability to ensure that future strategies and policies reflect a strong social agenda, which recognizes the linkages between employability and health, transport, skills and employer engagement. (ANEC 2006b: 5)

The region's *Skills Action Plan 2006-07* aimed to 'enable those excluded from the labour market to access learning and sustainable employment' (Skills North East 2006a: 7), noting that the high proportion of working age people in the region with 'work-limiting disabilities' was a significant factor (*ibid*.: 39). It referred specifically to the effect of mental health on employment but most of its other references to health related to skills for employment within the health sector. The 2007 *Employability Action North East* report also referred to a need to focus on priority groups (Skills North East 2007: 14), one of which was 'IB stock' (those on Incapacity Benefit). Planned actions, although including a personal assessment of non-employed client needs, did not relate specifically to health improvement.

ANEC's Employability Task and Finish Group report referred to the relationship between health and employability as 'symbiotic' and outlined common health problems associated with long-term unemployment (ANEC 2007a: 6). In its description of the regional picture, references to the cost of

Incapacity Benefit were listed first but the scale of mental health problems affecting this also received a mention (*ibid*.).

There was considerable variation between interviewees' views on whether improving population health had been an important driver in developing worklessness policy. At one end of the spectrum were those who felt that it was not important at all

> [It was] not considered! The important thing was the government view that those slacking should bloody well work. (Health sector interviewee)

Several other interviewees also stated that the key driver was economic:

> ONE's reason for setting up the framework – the *raison d'êtr*e for ONE – is to increase the economic efficiency of the region – so their key driver is economic. (Non-statutory sector interviewee)

There was perhaps just a broad acknowledgement, according to one interviewee (non-health-group-1) that getting people into work improves mental health. Another informant (non-statutory sector) felt that although health was considered, the main focuses were connecting individuals to job opportunities and developing skills. One interviewee (non-statutory sector) thought that local authorities only paid lip-service to health improvement, with any health benefits only being an indirect effect of their actions. This idea of indirect effect was the tenor of several responses.

Some interviewees (from various sectors) felt that health improvement was certainly one driver, although probably not at the top of the list. Many of those

who said that the key driver was economic suggested that the health benefits were not lost on anyone:

> Everyone is aware that being out of work is bad for health. Translating to action is difficult. (Academic sector interviewee)

One academic sector interviewee said that health was known to be an issue in worklessness but was seen as an issue peripheral to overall economic strategy. A non-health-group-1 interviewee believed that health sector colleagues came to the table over worklessness policy because they saw employment as a good route to health improvement, even though the main focus was overcoming barriers to participation. One interviewee said that the third sector was on board with worklessness policy because of its links with health:

> [Health was] not the primary consideration but it is a powerful argument that it improves health as well as improving the economy. (Non-statutory sector interviewee)

At the other end of the spectrum, only one interviewee (non-health-group-2) believed that health was the number one driver, although others said it was vital or near the top of the list. One interviewee recognized the likelihood of different responses to the question of health being a driver:

> It depends who you speak to. In public health, it is our mantra – you are not going to be a very productive region, you are not going to achieve economic growth unless you have a healthy workforce. I guess for other partners around the table, for example JobCentre Plus, it is just a bit of a conveyor belt, getting the right numbers through doors. (Health sector interviewee)

The fragmentation of targets and different settings for different elements of policy were mentioned by one interviewee:

> Health element is a recognition – taking broader definitions of health – that government targets require strategies to deal with Incapacity Benefit, which is related to health. Other elements are a part of it. One challenge of public policy is that if you fragment it you are less likely to achieve it. (Non-statutory sector interviewee)

There was variation, though perhaps not so broad as for population health improvement, in views as to whether policy developers were concerned about addressing health inequalities. Several interviewees felt this had been very much a concern, whilst others felt that the inequalities agenda was implicitly rather than explicitly there, as people on benefits tend to be amongst the most disadvantaged.

> If people move from worklessness to working this increases income, improves health and social status - BUT this is not considered part of the policy – that is someone else's agenda. (Health sector interviewee)

> It has always been seen as a fortunate by-product that, by getting this bunch of people back to work, we are likely to improve their health directly (managing their condition) or indirectly (happier, feeling better re self, self esteem). (Non-health-group-1 interviewee)

One interviewee (non-statutory sector) felt that there was too much concentration on a blanket attempt to get people back to work, rather than considering how to help those in the worst conditions (on Incapacity Benefit). However, another (also non-statutory sector) said that those with mental health problems were the most discriminated against but that the building blocks were in place to help them, so inequalities were being addressed.

Several interviewees suggested that social exclusion, part of the inequalities agenda, was a driver of worklessness policy. One felt that worklessness was

> rising up the agenda as part and parcel of the acknowledgement that the social exclusion of the hard-to-reach – those not working or not skilled to work – is a core component. (Non-statutory sector interviewee)

When asked whether there was any performance management of the health outcomes related to worklessness policy, a few interviewees said they just did not know and the majority said that there was not, although one believed that *Pathways to Work*[14], was going to have a national evaluation incorporating some health outcomes. Many pointed out that health organizations would not be performance managed for the number of people going back to work and that the number of people coming off Incapacity Benefit would not really be seen as a health outcome. Global targets in Local Area Agreements would be around decreasing mortality rates but nothing relating to mortality or morbidity would be specifically related to worklessness. Even targets in schemes funded by Neighbourhood Renewal Funding (agreed and arranged by partnerships involving the health sector) related just to Department of Work and Pensions outcomes. One interviewee commented on trying unsuccessfully to obtain figures showing the impact on the NHS of taking people out of worklessness:

> The only performance management is the cost to the public purse of worklessness. When I tried to get figures showing the impact on the NHS of taking people out of worklessness, no one could provide them. (Non-statutory sector interviewee)

Several interviewees felt that there were related measurements for specific areas of worklessness policy that were implicitly connected to health, because health improvement would be part of the process of getting people back to work. One interviewee commented that public health representatives would probably say that one of the best things you could do for people's health would be to get those sick people back into work and, although that was being done,

> We don't have a mechanism in place for measuring the change to their health outcome because the people paying for it only care about the employment outcome. (Non-health-group-1 interviewee)

Most interviewees felt that health outcomes were not performance managed but some felt they could comment on the difficulties of performance management of the health outcome. One concern was that changes in inequalities (particularly around people with mental health problems) would not be captured with simple measurement of those returning to work. Interviewees also said it was difficult to attribute results to one particular policy when other policies were simultaneously tackling related issues.

Targets and indicators in the *Skills North East Action Plan 2006-07* (Skills North East 2006a: 35-46), around people excluded from work, were largely non-health-specific. The levels of people on Incapacity Benefit were included, which can be an indicator of health. Benefit dependency reduction remained a target in *Employability Action North East* (Skills North East 2007:4).

At the time of the interviews, impressions of the interviewees that health was not a major driver of worklessness policy in the region appear to be borne out by the documentary evidence, although changes were beginning to happen. The mechanisms and power to improve the way worklessness policy includes health are described in the following sub-section.

Power and mechanisms for considering health in worklessness policy

Sub-regional health-and-worklessness groups were active in the region in the early 2000s (for example, in 2004, two Durham PCTs laid on events for GPs and employers about finding ways to address the problems (Employment and health group, Easington and Sedgefield 2004). At a regional level, things were rather slower to develop. However, by 2006, the Public Health Group had been involved in developing a pilot scheme to get people on Incapacity Benefit back to work and was testing new ways of involving employers and the voluntary sector (GONE 2006b: 30). There was a regional worklessness task group in Skills North East and one health sector interviewee said there had been a meeting between regional health sector leads and regional DWP leads, to initiate discussion on ways of working together.

The power to ensure health was considered in worklessness policy was felt by most interviewees to lie with the health sector, particularly the Public Health Group and the Strategic Health Authorities. One health sector interviewee

believed there were now opportunities to work with the strategic health authorities, which were very powerful and could influence not just the NHS but also other agencies. However, two interviewees expressed some doubts about this.

> As an organization, they [SHAs] have been disconnected from (or not included in) economic/social policy discussions 'til recently. The RDA should pull them in! (Non-statutory sector interviewee)

> Public health inputs are informative/advisory, only recently brought in. Other agencies do not have a culture of using evidence. Evidence-based approaches are almost anathema to them. (Health sector interviewee)

The Department for Work and Pensions was also felt to be in a powerful position to bring in health. A health sector interviewee said DWP was developing more of an interest in health aspects because JobCentre Plus had 'put a lot of money in to support people with health problems through their Disability Employment Advisers'. GONE and Local Authorities were also believed to be in a position to influence the worklessness policy agenda in favour of health. An academic sector interviewee suggested that the Regional Assembly Overview and Scrutiny Committees could 'take a stronger line', as their scrutiny officers were very powerful and were becoming more skilled in their scrutiny role.

Worklessness policy in general has perhaps not been well assessed for its impact on health. Skivington *et al.* pointed out that, although tax and welfare policies are 'an obvious possible means of improving the health of the worst

off and reducing health inequalities', this 'appears to be a particularly neglected policy area with respect to knowledge of health impacts' (2010: 4).

Since no specific regional worklessness policy existed at the time of my interviews, the closest thing to health impact assessment on worklessness policy was the HIA on the Regional Economic Strategy, previously described. It was recognized in that assessment that what makes economic sense may not necessarily benefit health. The main criticism of the worklessness strand that emerged was that

> there is no recognition within the RES of the importance of improving the health of the population. Nowhere is the relationship between work, health and economic productivity seen more clearly than in the North East - where we have the worst health in the country and the highest percentage of the working age population unable to work through incapacity. (Bailey, Chappel and Sher-Arami 2005: 4)

This section has outlined findings on the way and the extent to which health is considered in regional worklessness policy. In the following section, I shall report on the findings on these issues for climate change policy.

How and to what extent is health considered during climate change policy development?

I have drawn attention to previously mentioned differences in interpretation of the term 'regional climate change policy' where they appeared to affect interviewee views on how health is considered during climate change policy development.

Most interviewees described climate change as crucial to health, although several believed that the improvement of population health was not an important driver in the development of policy or that it was not a stated objective in climate change policy, at best perhaps being only implicit rather than explicit.

> I suppose *ultimately* it is the key driver, since if change leads to natural disasters, more people will be killed by storms, floods, *et cetera*. (Non-health-group-1 interviewee)

> It is more of a high strategic issue – ultimately we will all be dead if we don't do something about it. (Non-statutory sector interviewee)

The main driver of the climate change agenda was felt to be the economy, with subsequent benefits to the environment seen as almost a side-effect. Health benefits were then seen as a side-effect of the environmental benefits!

> It impacts [on population health] because of its impact on the environment … The major things are about the economy but the environmental parts of it will benefit. (Non-health-group-1 interviewee)

When considering whether addressing health inequalities was a major consideration of policy-makers, most interviewees said it was not, although it was a concern:

> I'm not sure that it is a consideration at all at the moment. (Non-statutory sector interviewee)

Only one interviewee (non-health-group-1) felt that both population health improvement and addressing health inequalities were quite important drivers,

although they felt that the consideration of health inequalities was not particularly successful, only leading to slightly more mention of social exclusion or disparities in later versions of the Regional Spatial Strategy.

One interviewee considered ways of showing whether health improvement and climate change policy were linked by policy-makers:

> Taking a pragmatic and short-term horizon – as politicians have to do – which PSA[16] targets would be affected by climate change policy? NONE! (Health sector interviewee)

This was one indication that health targets were not yet integrated with climate change policies. Most interviewees said it was too early to say whether there would be performance management (with targets) of the health outcomes of climate change policy. Others generally felt there would be no such direct performance management, although there might be some indirect measurement around environmental management.

Interviewees thought that the power to drive through salutogenic changes in climate change policy lay with a range of organizations. Interviewees mentioned the Regional Assembly (through its engagement with the health sector), the Strategic Health Authority, the Environment Agency, Local Authorities and PCTs. The Local Authority role with regard to climate change had certainly been strengthened by the 2006 Local Government white paper (DCLG 2006). A health sector interviewee felt that the power for pressing for health improvement in policies lay really with government and voluntary

[16] Public Sector Agreement

organizations but their focus was not really human health. A non-health-group-2 interviewee stressed that to strengthen the health aspects of the policy, the health sector and health professionals needed to be active and engaged and to draw attention to linkages with their objectives and with other policies. The health sector was criticised for lack of involvement:

> there is a little bit of a tendency for health [that is, the health sector] to be isolationist in its approach to things – it is huge and keeps to itself, sorting its own problems out. It needs to engage with environment, social, economic sectors – to engage properly. (Non-health-group-2 interviewee)

Prior to 2006, the Regional Spatial Strategy had been the main potential location for climate change policy within the North East. However, work towards a North East Climate Change Action Plan had started when my interviews took place, although the plan did not emerge until 2008. Meanwhile, ANEC produced its 'Green Manifesto', in which it stated, as well as a commitment to implement the Climate Change Plan, that

> as 'place shapers' we have a crucial role to play in promoting well-being, health and the environment, which are inextricably linked. (ANEC 2006c: 2)

The Stern Review (HM Treasury 2006), which had an economic focus but did include effects on health, was cited by ANEC (2007b: 21), when it announced the setting up of a Climate Change Task and Finish Group (ANEC 2007b:34). In 2008, this group presented its report, in which it recognized the need to contribute to policy development at all levels (ANEC 2008a: 3). The most

significant policy development in the region in 2008 was the production of the Climate Change Action Plan for North East England (Sustaine 2008a). Produced as an evolving plan on a website, rather than a printed document, it offered readers the chance of involvement – a sort of ongoing consultative process. Health effects receive little mention directly, as the focus is more on the actions needed to deal with climate change.

Whilst the Climate Change Action Plan was available for comment and participation, previous strategies with potential climate change content were more conventional in their approach to consultation and assessment. The Regional Spatial Strategy underwent not just an impact assessment (previously described) but also a sustainability appraisal, though an academic sector interviewee pointed out that the sustainability appraisal had only a minimal health aspect. The same interviewee felt that the health sector had not pushed for health improvement in the Regional Spatial Strategy's consideration of climate change, 'other than saying it looked good'!

Conclusion to Chapter 7

This chapter has described the findings from my interviews and documentary searches around the consideration of health in regional policy development. I looked at the techniques used to ensure that health effects were considered. I also explored the extent to which health improvement and health inequalities

were considered during the development of the specific policy areas of tobacco control, housing, worklessness and climate change. This is the final of three chapters on findings. In the next chapter, I bring together all the findings and compare the factors involved in the development of general policy and specific policy areas.

Chapter 8: Discussion

Chapters 2 and 3 considered theories of agenda-building processes, addressing my first research sub-question

- **What models and frameworks currently exist to explain the progress (or lack thereof) of policy areas on the decision-makers' agenda?**

and providing the theoretical background to my other research sub-questions:

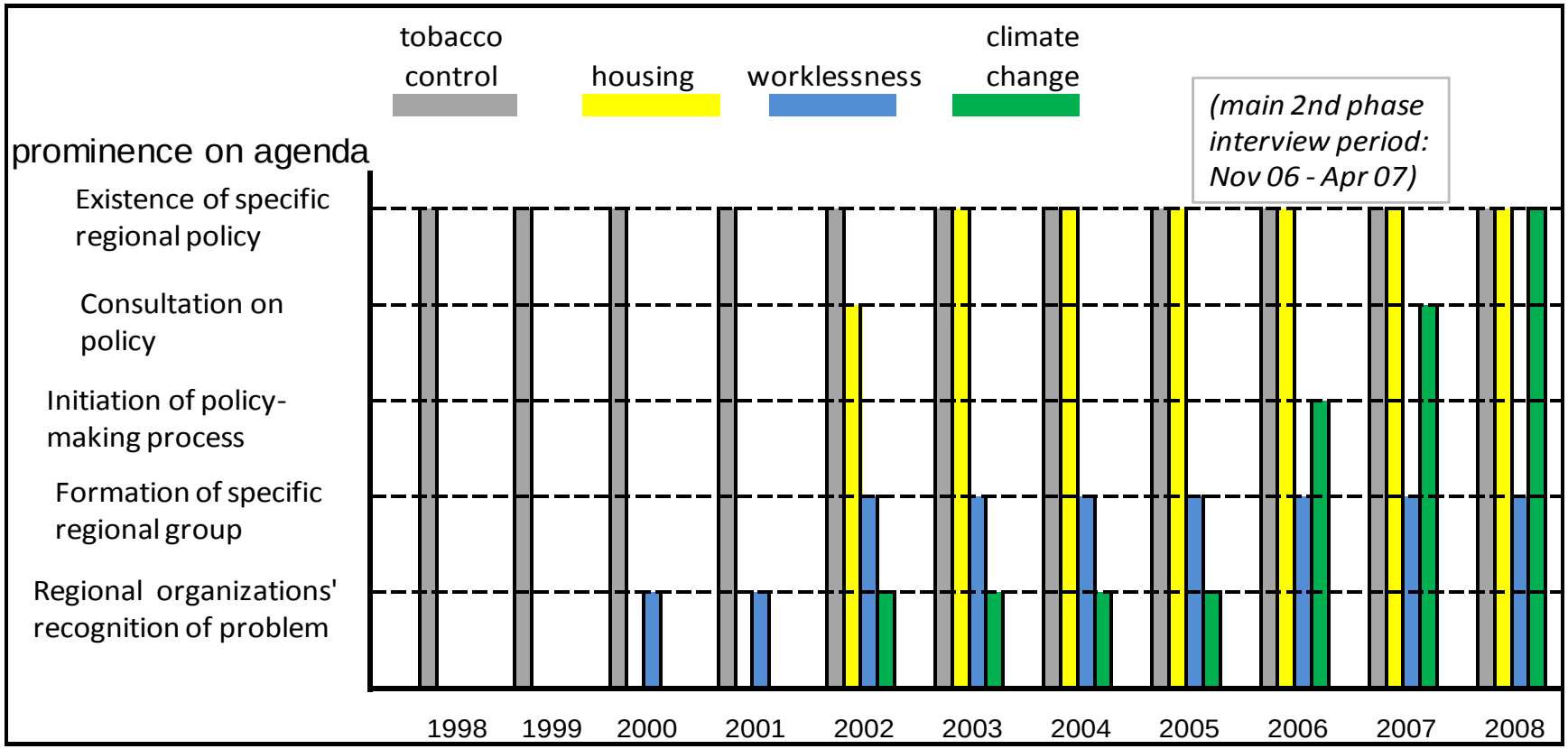
- **Who moves a healthy policy area onto and up the regional decision-making agenda?**
- **What other factors influence the progress of healthy policy areas on the regional decision-making agenda?**
- **How and to what extent is health considered during a regional policy's development?**

These latter three sub-questions were also the focus of chapters 5 to 7, which described my findings for the North East region with regard to both general policy and my four chosen topics. Chapter 5 concentrated on the 'people and power' aspects of policy agendas, Chapter 6 described other factors influencing the agenda and Chapter 7 focused on the way health was considered during policy development.

In this chapter, I bring together the findings, in particular comparing the four policy areas to assess where differences and similarities lie as well as to consider whether existing models provide sufficient explanatory power. Firstly, I needed to compare the progress of the policy areas along the policy-making

path. In Chapter 6, I outlined the main activities that had taken place around each of the areas. As discussed in Chapter 4, my intention was to use as the pinnacle the existence of a topic-specific regional policy. There are, however, several difficulties with this. Firstly, there are different interpretations of 'policy', as mentioned in the chapters on findings. Secondly, the breadth and scope of possible policy varies considerably amongst the different policy areas. For example, the climate change agenda is much broader than the tobacco control agenda, as the latter contains well-established actions, areas for action, and evidence for effect and action: climate change, on the other hand, has limited or controversial evidence and a great many unknowns, in terms of what will work and who should be involved. This is linked with a third difficulty: how can we assess whether a policy that exists under a different name or apparent different policy area, actually constitutes a policy for our specific policy area? In climate change, there are policies around sustainability, which can be related to environmental or climate change control as well as to economic sustainability. Additionally, there are wide-reaching strategies that encompass many aspects of several policy areas: the Regional Economic Strategy and the Regional Spatial Strategy are amongst these. Notwithstanding these complications, I have constructed Figure 14 to show the progress of my four specific policy areas in terms of five significant stages in their development.

Figure 14: prominence on the agenda: significant stages in specific policy areas



Tobacco control policy appears the most well established, with a regional policy having existed for many years. Housing policy is the next well-developed at a regional level, with regional housing policies now up-and-running and regularly revised. At the time of my second phase interviews, the worklessness agenda was perhaps the next most well-developed, although it is worth noting that much of the strategy development was initially at a sub-regional level. It is also slightly questionable whether Skills North East can actually be regarded as the specific regional group for worklessness, as its focus is skills development for employers' benefit rather than for the workless population's benefit. However, it is not unreasonable to suppose that any worklessness policy would be likely to arise within that group. Climate change was the least advanced policy area, although it was beginning to take off rapidly and the appointment of the officer with responsibility for policy development was followed quickly by the emergence of the policy.

Inevitably, because my fieldwork took place while policy development was continuing in all of the areas, there have been developments since the interviews, and so some of the comments made by participants might have been rendered out-of-date. For example, a regional public health policy, which could affect all of the policy areas, did not emerge until well after the interview period and its desirability and the problems of its absence were mentioned by several interviewees. However, those comments were believed valid when they were made and they still offer useful insight into the policy-making

process. Interviewee responses contribute greatly to the following section, which looks at the people involved in policy-driving and the power they have (or are believed to have).

Who moves a healthy policy area onto and up the regional decision-making agenda?

For policy in general and for each policy area, a range of actors was identified (described in the chapters on findings), through consideration of organizational literature, policy documentation and discussions with interviewees. The success (or otherwise) of joint working arrangements was also assessed. In this section, I compare the findings on actors and joint working for all policy areas and consider the links between these factors and policy development.

The prescribed roles of various organizations involved in making decisions at a regional level, and their relationships with one another, are laid out in their constitutions. However, at a practical level, roles and relationships might differ from those expected and the decision-making process might operate in various ways according to the interpretation and personalities of the players involved. Additionally, some of the organizations might have been allowed to evolve according to the political environment or in response to changes in the political agenda. Such evolution and changes could affect the whole process

of decision-making. Several interviewees, from a range of roles, commented that reorganizations adversely affected inter-agency working.

There was noticeable disparity between ‘official’ relationships and reality: in the real world, the informal contacts and networks were felt to be extremely important. In general, the three main regional organizations were believed to be well established and the informality of the region was felt to contribute significantly to this. In tobacco control, the informality was also said to be valuable. There was less mention of informal relationships in housing than in the other policy areas (and joint working, generally, was not thought to be particularly good, as discussed later). The informal relationships around worklessness were said to be very important. For climate change, a specific policy area very much in its infancy in the region at interview time, neither formal nor informal relationships were very clear. In contrast to other policy areas, most who spoke about climate change did not have ‘climate change’ as part of their role (although this changed with the appointment of the climate change officer).

The perceived success of joint working varied amongst the policy areas. With tobacco control, although there were said to be some tensions between certain organizations, the joint working on policy was generally felt to be ‘joint’, rather than led by any particular agency, and was thought successful. Part of the recognized success of Fresh appears to come from its partnerships.

> The success of Fresh Smoke Free North East reflects the strength of its partnerships: as well as harnessing the energy and expertise of local NHS organisations and practitioners, Fresh has developed close relations with local authorities, NGOs, local business organizations and the trades unions. (ASH 2008: 22)

The involvement of other agencies in tobacco control was also said to have allowed even better connections or cross-connections to arise. For instance, the TUC were said to have opened many doors at government level to push home the message of smoke free public places.

Serious doubts about the success of joint working were expressed over housing, with its multiple agencies, multiple initiatives and competing priorities. In contrast to tobacco control, the housing agenda was felt to be very much led. The worklessness area was said to be poor with regard to joint working, although some aspects were felt to be satisfactory. Climate change, at the time, was not a well developed policy area: although there were thought to be some effective partnerships, there were also thought to be many difficulties at the regional level, some because of the lack of clarity over the problems.

Joint working appears to be most effective in tobacco control, the most developed policy area, and least effective in climate change, the least well developed policy area (at interview time). Housing appeared to have slightly better joint working than worklessness and the housing policy area appeared to be better developed than worklessness or climate change. It would seem

that the effectiveness of joint working arrangements is linked to the position of the policy area on the agenda.

Along with central government directives on collaborative working, there were many regional organizational statements about the need for joint working, and repeatedly expressed intentions to work together. It is perhaps rather surprising, and perhaps disheartening, that interviewees have raised so many doubts about the success of joint working. Did the reliance on the informal relationships arise to counteract failures in the formal system? – or was it already a feature of regional decision-making that actually contributed to the lack of success of formal arrangements? This also raises the question of whether the success factors of informal relationships can somehow be built into formal relationships – if they were, would they then be lost?

As the lead sector on tobacco control policy, the health sector was heavily involved in tobacco control policy development. However, there were serious concerns about the lack of health involvement in the development of the other policy areas. Several interviewees queried its contribution to climate change policy, many criticised its lack of involvement in worklessness policy and there was considerable criticism of its absence in housing policy. This links in very much with the ways in which health becomes a real consideration in the development of policies of non-health origin. It might be a reflection of the role

of the Department of Health at the time, particularly with the extent of control over local and regional health organizations.

I found no evidence of major differences in opinion between different groups on joint working or the importance of informal relationships. This perhaps suggests that the views I obtained from my interviewees were more personal than corporate: a corporate view would surely be the view expressed in the organizational documentation, praising the joint working!

Leadership and power

When interviewees referred to power, they tended to talk of it residing with an organization, such as the Regional Development Agency, or even a whole sector, such as the health sector, rather than with an individual in a particular role. This applied with interviewees in all sectors and roles. The power to get health considered in a policy is dealt with separately later.

There was much confusion over who took the lead in any of the policy areas. In tobacco control, joint working was seen to be really joint, with no one dominant partner, although some interviewees felt that there was a need for strong leadership. For housing, more interviewees thought the Regional Housing Board or the Assembly took the lead than other organizations, although not all interviewees were clear on this and one said the Assembly had been heavily criticised for lacking leadership. The lead role for

worklessness was thought by some to be with the Regional Development Agency, although others said it was really JobCentre Plus, which had possibly allowed the RDA to lead while JobCentre Plus was being reorganized. Several interviewees said the worklessness lead was national and that there had been regional jockeying for position. Climate change was also an area where there was said to be jockeying for position. The question of leadership in climate change caused much confusion. Some suggested the Assembly was the lead but many others said it was a partnership of equals. Sustaine (a partnership) was suggested by some.

The lack of consensus on lead roles might indicate that leadership itself was not regarded as particularly important by the interviewees. Only a few called for stronger leadership in any area - tobacco control, perhaps unexpectedly as that area has apparently been the best performing. This also presents a contrast to many organizational statements, as described in Chapter 5, which pointed to an intention to provide leadership!

Effective joint working appears to be far more important to interviewees. Power, rather than leadership, also seemed to be of more concern, although some interviewees stated there should be persuasion, rather than power, and affiliation, rather than control and command. Using Lukes' (1974) definitions, persuasion can actually be regarded as a dimension of power so perhaps this is just a reflection on overt leadership. Ownership of policy was felt to be

important but this related to ownership by all parties. The power of the local authorities was mentioned by several interviewees: in housing, the Regional Housing Board was thought not to have enough power to act if opposed by the local authorities. The Regional Assembly was also said to be only as strong as the local authorities. The Regional Development Agency was said to be perhaps less powerful than GONE and the Assembly because it had to yield to them over proposed growth rates. With regard to housing, the government was said to have the power, rather than the region.

The power to push policy areas up the agenda was said to lie with different agencies for each policy area. For tobacco, national government was the most mentioned, with regional power said to be with all of the regional agencies and the local authorities. Fresh was said to have this power only because it had the resources. For housing, the Regional Development Agency was said to have the power to get housing into the Regional Spatial Strategy and the Regional Economic Strategy. It was believed that worklessness was pushed up the agenda at a national level or by the regional representation in JobCentre Plus. For climate change, persuasion and partnership were believed to be the way the issues were moved higher on the agenda, along with much national government pressure, influenced heavily by public opinion. Climate change was regarded rather differently from the other policy areas: the government push was said to need follow-up at all levels, regional, local

and individual. Interviewees generally felt that the power to push it higher up the agenda should lie with everyone.

If Fresh was supposedly in a position to push tobacco control up the agenda just because it has resources, this suggests that the links between power and financial control might be worth investigating. Certainly the regional tobacco control policies of 1998 (Regional Task Force on Tobacco Control 1998) and 2005-08 (PHGNE 2005) were developed specifically following allocation of funding. Similarly, the first regional climate change policy emerged following the creation of a post designed to develop policy. Perhaps not unrelated is the way worklessness-related policy has developed because of economic considerations. The housing policy agenda is also very much tied to economic growth. The importance of resources to policy is discussed later when I consider other factors related to agenda-building.

Individual power, for example from champions, received very little mention. Only two interviewees mentioned it with regard to the drive for a regional tobacco office. On the other hand, the power of the media and the power of public feeling were mentioned several times, particularly around tobacco and, to a lesser extent, housing.

When considering where the power should lie to push policy areas up the agenda, answers varied. For tobacco control, the general feeling was that the

health sector was the best place. This is perhaps a disappointing finding, since one of the problems with treating it as a health issue is that it can be difficult to persuade other organizations that it is their business too. For housing, the preferred locus was the local authorities, rather than a regional organization.

Several categories of people were said to want to keep some issues off the agenda: the tobacco industry and the motor-racing industry (with huge tobacco advertising revenue); and the energy industry and major transport producers with regard to climate change. Whether these opponents had the power to keep the issues off the agenda was arguable, although the tobacco industry was known to be powerful and the energy and transport industries were tremendously significant to the economy (and therefore had power). More commonly though, interviewees said that certain groups would just want to keep certain solutions or policy options off the agenda: for example, the construction industry would not want restriction on new building.

Tobacco control has interesting parallels with Crenson's (1971) example of the power of large concerns to affect control of pollution from the steel industry. Historically, tobacco producers held powerful positions in some communities, and the government departments of trade and industry and the Inland Revenue (now part of HM Revenue and Customs) were said to have interests in maintaining tobacco production. The closure of the region's last

tobacco product manufacturer was said to have allowed policy to develop without the opposition of the unions.

Also similar to Crenson's example, regional housing strategies are affected by large building concerns, and climate change policy is affected by the large energy producers and those involved in transport. Worklessness policy can be dominated by large commercial or industrial concerns and, indeed, the focus of the employment-related policy in the region has tended to be on the employers' wants and needs, rather than those of workless individuals.

There was no suggestion that any interviewees felt that they themselves lacked the power or influence to affect policy development. The joint working ethos appeared strong throughout, with a willingness to work together. This might be particular to the North East, in light of the insularity and close-knit policy community aspect mentioned earlier. The new localism could seriously harm these relationships and the joint working ethos.

Having considered the people and power aspect of policy-making within the region, I move in my next section to a consideration of other factors affecting policy development.

What other factors influence the progress of healthy policy areas on the decision-making agenda?

Factors described in agenda-building theories

Some of the factors described in Chapter 2 are common to two or more models and, to avoid repetition, I have tried to consider them only in one place. This includes factors such as conflict or consensus, which are discussed by many writers. I have incorporated these into my discussions of the Stacey (1996) and Matland (1995) models. In addition, because Cohen and March's garbage can model (1972) formed the basis for Kingdon's more advanced explanatory model (1984), I shall leave discussion on the garbage can elements until my discussion of Kingdon's model.

In terms of Cobb and Elder's (1972) issue creation model, concerning the source of the issue and the motives of those sources, none of the areas was thought to have become an issue because of an unanticipated event, although the importance of climate change was felt to have increased with certain local flooding. No area issue was thought to have been created by one or more contending parties for their own gain, although the disagreement between the construction industry (demolish-and-rebuild) and other parties was felt to be based very much on self-interest and affected the content of housing policy. Tobacco control policy was believed to have been created in the public

interest and this was the impression for all areas, which suggests that the model is not of particular help in this case.

In Chapter 6, I assessed the levels of legitimacy, feasibility and support used in Hall *et al*.'s model. These are summarised in Table 13.

Table 13: Hall *et al*.'s model with relation to the four policy areas

		Tobacco Control	Housing	Workless-ness	Climate change
Legitimacy					
	National	Strong	Strong	Strong	Quite strong
	Regional	Strong	Quite strong	Quite strong	Weak
Feasibility		Strong	Quite weak	Weak	Very weak
Support					
	Public	Strong	Strong	Neither weak nor strong	Quite weak
	Political	Very strong	Strong	Quite strong	Quite strong
	Pressure group	Very strong	Weak	Weak	Very strong

Tobacco control, which appears the most well developed policy area, is at least as strong as any of the other three with regard to most of the factors. Climate change is weakest (or at least no stronger than others) in all areas, apart from pressure group activity, and was the least well-developed policy area at the time of interviews. Housing, though stronger than worklessness for feasibility and support, is similar in terms of legitimacy at both national and regional level. Hall *et al*.'s model, therefore, does not differentiate between housing and worklessness in terms of legitimacy. Only if legitimacy is ignored,

can we say that it fully reflects the way the policy area's position on the agenda is related to the strengths of the factors. Whether it is valid to ignore legitimacy is difficult to say. National legitimacy might possibly be put to one side but if regional legitimacy is also ignored, what does this say about the region as a decision-making level? Regional legitimacy might in any case be different following the 'no-vote' over an elected assembly!

A related question arose with relation to the politics stream when I compared the factors for Kingdon's (1984) model, although there were no difficulties with the problem stream and the policy stream. A summary of the elements of Kingdon's streams for each of the four policy areas is given in Table 14.

Table 14: elements of Kingdon's streams in four policy areas

Problem stream					
	Indicators		**Focusing events**		**Feedback**
Tobacco Control	Yes		No		Yes
Housing	Yes		No		Yes
Worklessness	Some (mainly economic)		No		Some
Climate change	No		Yes		No
Policy stream					
	Technical feasibility	**Budgetary feasibility**	**Human resource feasibility**	**Fit with dominant values and current national mood**	**Political support or opposition**
Tobacco Control	Very strong	Quite strong	Quite strong	Strong	Strong support
Housing	Strong	Weak	Quite weak	Strong	Strong support
Worklessness	Strong	Very weak	Very weak	Quite strong	Quite strong support
Climate change	Very weak	Very weak	Very weak	Quite weak	Quite strong support
Politics stream					
	Swings in public mood	**Pressure group campaigns**	**Election results**	**Partisan or ideological changes in government**	**Changes in administration**
Tobacco Control	No (not sudden)	Yes	No	No	No
Housing	No	No	No	No	No
Worklessness	No	No	No	No	No
Climate change	Yes	Yes	No	Yes	No

In the problem stream, there are noticeable differences among the four policy areas. Tobacco control and housing occupy similar positions but worklessness has less in the way of either monitoring or feedback and climate change lacks both. Climate change is different from the others because focusing events have played some part. There are issues around indicators that might need considering. There are differences in both the geographical levels of monitoring and the numbers and types of agencies collecting or using indicators. Another difficulty with indicators is that they tend to come to the attention of a limited group of professionals. Raising awareness of their significance might not be straightforward and is probably linked to general awareness-raising issues.

Examination of the factors involved in the policy stream shows that there are definite differences amongst the four policy areas. These differences have been discussed above with reference to Hall *et al.'s* model.

The strengths of the political stream differ among the chosen policy areas, although many of its components are not relevant at regional level, namely election results, partisan or ideological disturbances in government and changes in administration. Other elements, such as swings in public mood and pressure group campaigns, can be assessed at least partly at regional level. Pressure group campaigns are strongly present for both tobacco control and climate change. So are public mood changes, far more rapid in climate

change but noticeable for some elements of tobacco control, such as smoking in public places.

For ease of comparison, I have attempted to summarise the previous table into simply the three main streams, indicating the strength of each stream, as shown in Table 15.

Table 15: strength of Kingdon's streams for the four policy areas

	Problem	Policy	Politics
Tobacco Control	Strong	Strong	Quite weak
Housing	Strong	Quite strong	Weak
Worklessness	Quite strong	Weak	Weak
Climate change	Weak	Very weak	Quite strong

Bearing in mind the timing of the interviews, when these assessments were made, this would suggest that tobacco control had reached the highest or most firm position on the agenda when its problem stream and policy stream were both strong and the politics stream was quite weak. Housing, the next highest at the time, had a strong problem stream and quite a strong policy stream, though the politics stream was weak. Worklessness came third on the agenda and, at the time had only a quite strong problem stream and a weak policy stream. Like housing, its politics stream was weak. The policy area that had progressed least at the time – climate change – had a weak problem stream and a very weak policy stream but, uniquely, a strong politics stream. I surmise that at a regional level, the politics stream might not be of particular importance but confluence of the problem stream and policy stream is highly

significant. If this is the case, then Kingdon's model seems a useful one to adopt. So the question arises: is it likely that the political stream is of less relevance at a regional level? The political stream in Kingdon's model has three main components. One, political ideologies, would certainly be more appropriate at a national level (although might have differed with a regional elected assembly). Another is composed of events within government, such as election results or changes in administration. Again, this would be a national issue, rather than regional. The final component comprises public mood and pressure groups. It is possible that relevant aspects of this are contained in the policy stream, under the dominant mood. In addition, given that there is not an elected assembly, might the power of the public be of much less importance to regional policy-makers and of much greater import only at the implementation stages?

My feeling is, therefore, that it might well be appropriate to use a modification of Kingdon's approach as a model for regional policy. This ties in with, although is not the same as, the way Exworthy, Berney and Powell (2002) used Kingdon's approach to look at regional policy on healthy inequalities. They posited the need for a coupling of national with regional windows (*ibid*.: 84). My adaptation involves attributing the political stream to national policy analysis and focusing on the other two streams for regional policy analysis. The national pressure on regions to act could actually be reflected in both the

problem and the policy stream, as the problem must be recognized and the actors must take note of national pressure.

If Kingdon's model is an appropriate one to use, there could be scope to influence the problem or policy stream to push a policy higher up the agenda. The strength of joint working was discussed earlier. This forms a substantial element of the policy stream, with actors and their ideas for potential solutions to problems floating round in Kingdon's 'primeval soup'.

In the following sections I consider other factors that have been identified as important in policy-making: the policy context and the nature of the issue.

The context of policy-making

Analysis in terms of whether processes are society-centred or state-centred is perhaps not particularly helpful, as policies in one region are going to be subject to the same conditions with regard to being state-centred, so comparisons at this level are not meaningful. Even if one were to consider regional government instead of national government, these arguments still apply. Another limitation is that the approach ignores many of the other factors that are recognized as affecting policy development.

The Alford (1969) or Leichter (1979) approach does aim to involve the other influences omitted by the society/state-centred approach, in that it looks at the

effects of situational, structural, cultural and environmental factors. At a regional level, many of these factors would tend to be fairly stable across any policy development so it would be difficult to use them to explain any differences between policies. The greatest use for the whole set of Alford's factors as a means of comparison would probably be in a study between regions in the development of same-issue policies. Nevertheless, there are some factors worth considering. One potential factor was the status of the Regional Assembly: this was a situational factor in that it concerned leadership and a structural one in that it related to organizational types. The anticipated organizational change from an unelected to an elected regional assembly did not materialise: had it done so, it could have been a significant factor, changing policy-making processes in the middle of my research period.

There are other structural factors that could provide material for comparison, including the economic base and the number and type of organizations involved. With regard to tobacco control policy, at one time the economy of certain parts of the North East was dependent on cigarette-related manufacturing, which provided much-needed employment, so there was opposition to any moves to reduce the demand for cigarettes. Once all these factories had closed, the related trade unions had no specific opposition. Worklessness was also very much affected by the economic history of the region, where the heavy industrial base was fairly rapidly declining. Amongst other structural factors more specific to certain policies were the types of

organizations involved: tobacco control gained its own strategy-making regional office; housing had a regional housing board; climate change developed an officer role specifically for strategy development; and there was a skills board that might be expected to deal with worklessness. The formation of the relevant organizations featured in my descriptions of policy progress.

There are also cultural factors affecting policy areas in the region, where there might be different factions with different cultural ethics or mores fighting for opposing sides in a policy. Relating to tobacco control, smoking was culturally the norm in large areas within the region. Regarding worklessness, comparatively high proportions of jobs were in the public sector, particularly as heavy industry closed and there were low levels of educational attainment. There was also a culture in which unemployed people, who had been made redundant from the heavy industrial sector, turned to sickness benefits rather than unemployment benefits.

The history of a policy area, as opposed to the historical context of the region, is trickier to assess at a regional level than at a national level. This is partly because of the way the regional organizations and regional boundaries have evolved. Regional tobacco control policy existed from 1998 but was for a larger region (Northern and Yorkshire) and early policy appeared not to have directly influenced subsequent policy. Regional housing policy existed from 2002 but was still very much framed around a sub-regional level. However, a

new housing policy was produced every two years, based very much on its predecessor (although many interviewees did not know of the link). Worklessness at a regional level was addressed mainly just around the skills agenda. Much of the policy work around climate change had happened at international levels, with the regional development only really taking off in 2007 and some scepticism about the validity of regional climate change policy.

Connected with the history of a policy are the concepts of inertia and momentum. Inertia and momentum models provide some explanatory power. For instance, the late twentieth and early twenty-first centuries saw many movements nationally and internationally towards controlling the consumption and distribution of tobacco: informed opinion suggested that the bandwagon had really started rolling – in other words, the inertia or momentum factor might be making it more difficult to resist tobacco control legislation. Housing has not had the same pressures and has been more of a sub-regional activity (Northumberland Housing Board 2007, Northern Housing Consortium 2007, Tees Valley Living 2008 and arc[4] [*sic*] 2007). Indeed, the national pressures, which are difficult for local areas to resist, have been towards provision of more housing, whilst the region generally needs quality rather than quantity. In the area of worklessness, pressure and momentum appear again to be from government, with a strong push towards reducing expenditure on unemployment (particularly sickness-related unemployment) benefits. Momentum for climate change policy appears to be increasing: international

pressures, national pressures and recognition of economic issues meant that from having no responsible body or officer in 2006, a fully-fledged policy emerged in 2008. This was a far more rapid rise than tobacco control or housing. Inertia and momentum could be reflected in Kingdon's (1984) model, in both the fit with dominant values and the level of political support.

The nature of the problem

Cobb and Elder's (1972) issue characteristics and their positions on each of five dimensions were considered for the four policy areas in my findings sections. For ease of reference, I summarise them in Table 16. I have adjusted some definitions so that the term 'high' always refers to a greater likelihood of an issue hitting the agenda.

Table 16: Cobb and Elder's issue characteristics

	Tobacco control	Housing	Workless-ness	Climate change
Specificity (concrete (high) to abstract)	High	Quite high	Quite low	Low
Social significance (numbers affected)	High	High	Quite high	High
Temporal relevance (long term (high) to short term (low))	High	High	Medium	High
Lack of complexity (less complex = high)	High	Quite high	Medium	Low
Categorical precedence (history of policy) (long history = high)	High	High	Medium	Low

There appears to be some useful discrimination using this approach. Tobacco control, which had the highest or most long-standing place on the policy

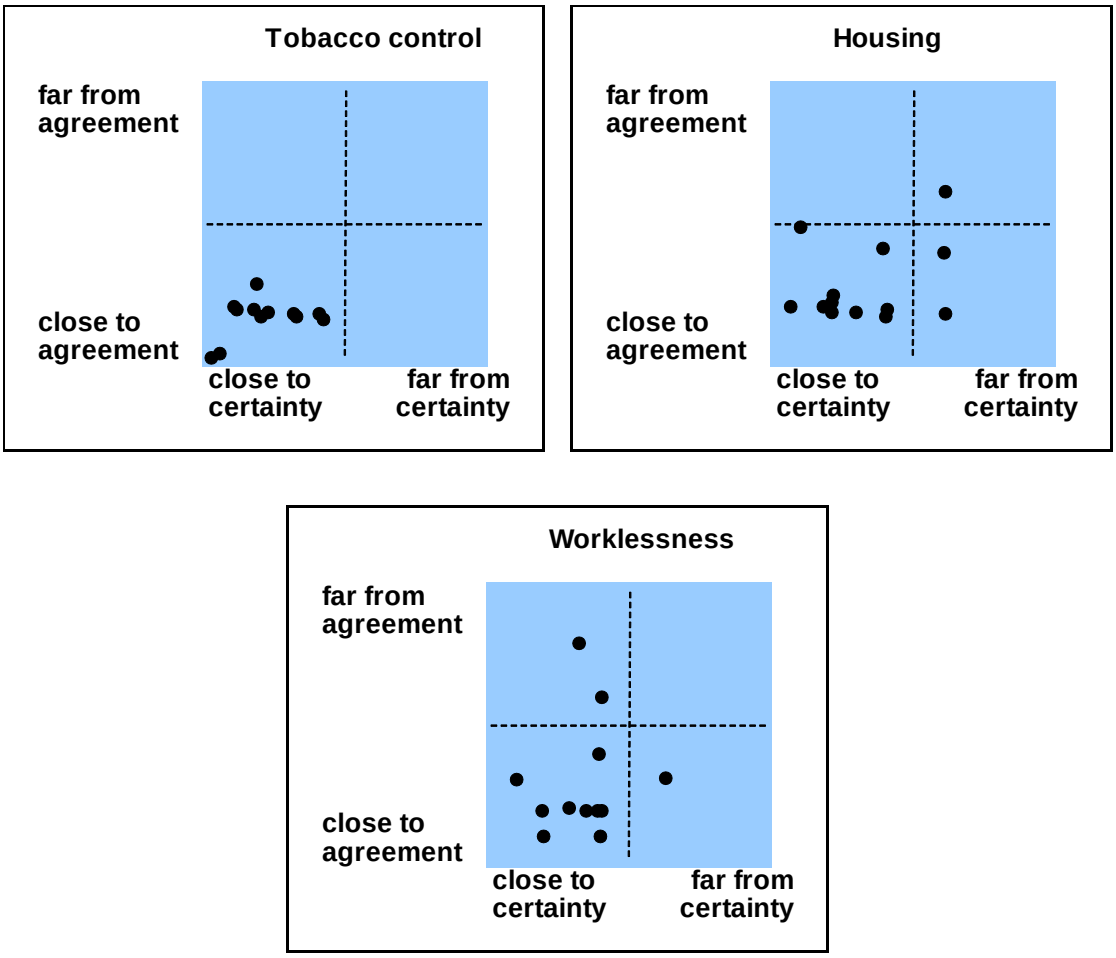
agenda, exhibits high degrees of all the characteristics that tend to make a policy area hit the agenda. Housing has a lower degree of two of the characteristics and worklessness shows even lower degrees of all characteristics. Climate change is harder to judge, with the lowest degrees of three characteristics but as high as tobacco for social significance and temporal relevance. There is a question over its social significance: although climate change does affect everyone, whether this is yet the public perception is doubtful: if the fairly recent floods were the start of an awakening, it is possible that not all have yet been awoken. Perception of numbers affected could be a contributory factor. One further complication of the model is that it does not suggest whether the position in any category is more significant than position on any other. Although the model shows some promise, apart from for climate change, it is probably not ideal for comparing regional policies.

Of Soroka's (2002a: 20) three significant types of issue (those that affected a significant number of people; those that were sensational but had little effect on many people; and those that were related to government), the third is not of relevance at a regional level. Tobacco control, housing and climate change all fit into the same category, since all are recognized as affecting significant numbers of people. Worklessness affects possibly lower numbers of people but does not fit into the category of being sensational without affecting many. This approach would therefore not discriminate well between my policy areas so would not be a helpful choice of model in this case.

One of the much analysed aspects of the nature of a problem is the degree of conflict (or, conversely, agreement) associated with it. Cobb and Elder's (1972: 39) suggestion that the 'fundamental condition of social conflict is scarcity' is of relevance to resources, as discussed above in connection with Hall *et al*.'s (1975) model. March and Simon (1993: 132) provided categories of conflict: individual, organizational and inter-organizational conflict. There was little reference by any interviewees to individual conflict and relatively little to organizational conflict, although there was a suggestion that one housing professional believed it was their job to control housing policy and, again with relation to housing, there was reportedly conflict between some local authority departments and the planning department. However, in general, the biggest conflict seemed to be between organizations: the tobacco industry versus tobacco control, the energy and transport companies versus Sustaine over climate change activity, the Regional Development Agency with its economic focus versus health professionals. Interestingly, for tobacco, there was no mention of the vast amount of work that had been carried out to create the environment to support the legislation on smoke-free public places in the region. I was aware from colleagues that, in the early stages, many councillors did not want this, so a lot of persuasion or negotiation had been needed to produce the levels of agreement that were then generally recognized. Whether interviewees had forgotten about this, had chosen to ignore it or did not know about it was not part of my discussions: my snapshot approach in the interviews was more focused on perceptions at the time.

In my findings for three of the policy areas, I presented charts indicating levels of agreement versus levels of certainty over policy, using Stacey's matrix. For ease of reference, these are repeated in Figure 15.

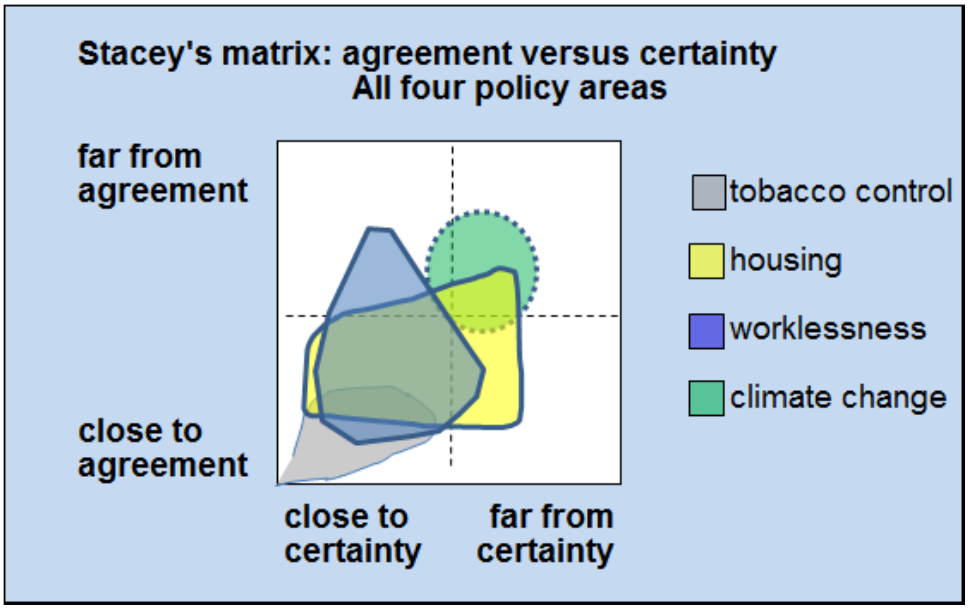
Figure 15: Stacey's matrix: individual policy areas



There were too few assessments in climate change interviews to warrant a climate change chart with individual data points. However, considering the responses obtained for the two variables, I estimated that climate change would lie in the quadrant representing low levels of certainty and fairly low levels of agreement. To aid comparison here, I have combined the charts, in

Figure 16, using different colours to indicate the areas in which the interviewee assessments fall, rather than the individual points.

Figure 16: Stacey's matrix: all four policy areas



Tobacco control sits at the 'close to agreement' end of the agreement spectrum, whilst there is disagreement around housing, for example between those who support a demolish-and-rebuild approach and those who prefer retention and refurbishment of existing stock. There is less agreement around worklessness policy, which is often aimed at meeting employer needs rather than unemployed peoples' needs and is also economically focused rather than, say, environmentally focused. Climate change is the area exhibiting the lowest levels of agreement.

Tobacco control also sits at the 'close to certainty' end of the certainty spectrum. Worklessness also appears more in the 'close to certainty' half of

the matrix, while housing encroaches noticeably into the ‘far from certainty’ half. Climate change sits more in the ‘far from certainty’ half. Tobacco control belongs definitely in the ‘close to agreement’ and ‘close to certainty’ quadrant and there was far less divergence of views over it, hence the smaller shape representing its spread. Housing, although much of it is within the same quadrant, has a much wider spread of views and exhibits much less certainty than tobacco control. Worklessness also has quite a spread of views and, although again centred within the same quadrant, exhibits much less agreement than either tobacco control or housing. Climate change is centred in the ‘far from agreement’ and ‘far from certainty’ quadrant.

According to Stacey (1996: 47), these positions would indicate that tobacco control has cause-and-effect linkages that can be determined and decisions could be based on past experience with predicted outcomes. The position of housing, slightly further from agreement than tobacco and further from certainty, would suggest that there was less likelihood of anticipating outcomes from past experience and that goals might have to be agreed to move towards an agreed future state without being able to determine the pathways to reach it. Goal agreement here might need a degree of negotiation and compromise not essential in tobacco control. Worklessness, further from agreement than tobacco or housing, would need much more negotiation, compromise and coalition-building. Climate change falls into the position

supposedly occupied by issues that are new or at least new to the decision-makers, where it is difficult to identify cause-and-effect linkages.

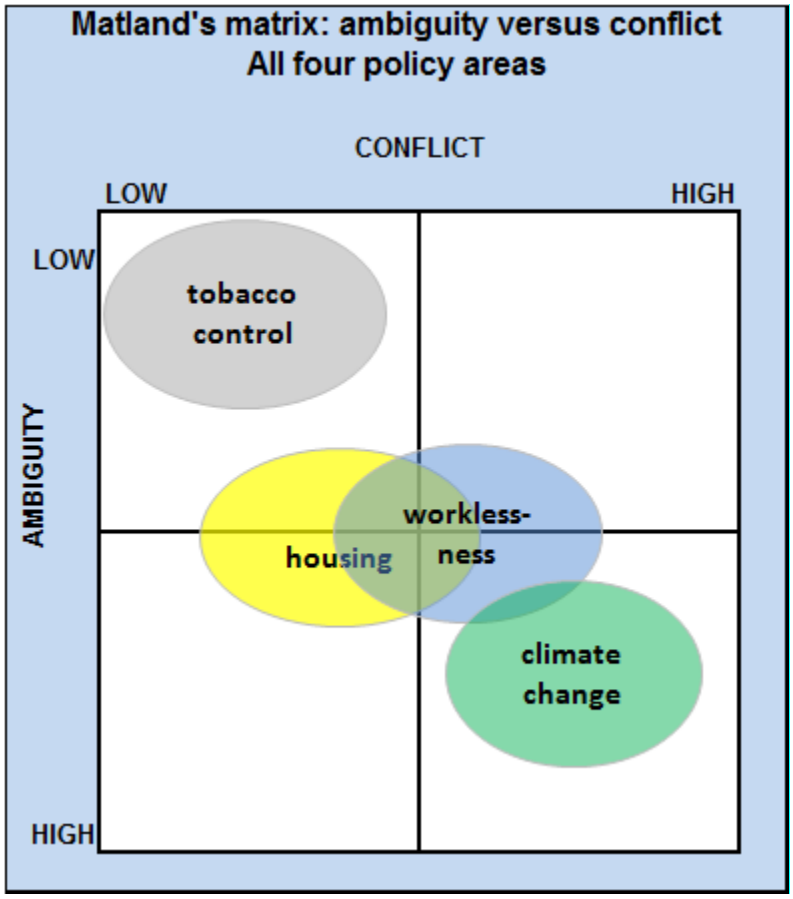
There are certainly aspects of Stacey's (1996) analysis that can be seen to apply to my four policy areas. The model's conclusions on tobacco control tally with interviewees' impressions of the amount and importance of evidence available. Climate change also is an area where Stacey's description fits: it is an area where there are many doubts about cause-and-effect linkages and has possibly been avoided, as one interviewee suggested, because it fits into the 'too hard' category. Worklessness policy development has suffered from perceived poor joint working and Stacey suggests (1996: 47) that issues with reasonable certainty but poor agreement need negotiation and compromise.

However, the model does not particularly fit the case of housing. Housing strategy has developed without any suggestion of ideological control or creation of agreed goals without pathways. Interviewees suggested joint working on housing was poor, yet agreement was not said to be low. Perhaps in housing is there not such a strong relationship between joint working and perceived agreement as there is in the other areas? The model is perhaps also not as discriminating as would have been hoped: three of the areas do sit mainly in the same quadrant and two overlap two other quadrants, possibly suggesting that they all need a mixture of all approaches to deal with them, which is not helpful. Stacey's model (1996: 47) does actually incorporate an

area between the extreme high uncertainty, high disagreement quadrant in the top right) and the other three quadrants, which he calls the 'zone of complexity'. Perhaps housing and worklessness fit here, in an area needing high creativity and innovation, particularly innovation in ways of working.

The other matrix model I described in Chapter 2 was Matland's (1995) model. In my chapters on findings, I assessed the positions of each of the four policy areas in terms of ambiguity and conflict. Figure 17 illustrates the positions of all four together for ease of comparison, using Matland's approach.

Figure 17: Matland's matrix: all four policy areas



Matland's approach does seem to bear some relationship to interviewee perceptions. Tobacco control, in what one can describe as the easiest position, in the low conflict, low ambiguity quadrant, requires the most straightforward element – resources – for success. Specific funding for tobacco control policy has been found to be successful. Resources were mentioned by interviewees as an important factor for continuing success. Housing, with slightly greater conflict and higher ambiguity, would need adequate resourcing but also would need an improvement in contextual factors, such as the actors involved and their levels of involvement. Both joint working and resources were regarded by interviewees as having some problems. Worklessness, with greater conflict than housing and a similar degree of ambiguity, would need resources, contextual improvement and greater coalition strength. Interviewees did feel that the joint working for worklessness was poor or limited. The related skills policies, although not specific to worklessness, derived from the specifically established (and funded) Skills North East. For climate change, the high ambiguity and high conflict would suggest that it needed all aspects of support but that the strength of coalition was the most important factor. Interviewees saw some difficulties in joint working on climate change at a regional level but several saw very effective partnerships developing, and the policy area took off very rapidly part way through my interview period. The rapid arrival of a regional climate change policy was linked to the injection of funding for policy development and to the joint working and consultation that ensued.

Matland's matrix shows greater variation among my policy areas and appears to reflect interviewee thinking and the policy situation rather better than Stacey's. An issue's position on either of the matrices will be influenced by a range of other factors, and the matrices themselves do not help to identify which of those other factors is important. Both indicate where there are high levels of disagreement and where power might be needed. Because both Stacey and Matland use consensus or agreement, there are parallels in their implications for the four policy areas. Housing shows up effectively in both as needing negotiation and compromise (tied in with the actors involved and their levels of involvement). Power relationships would be expected to be a factor here, as negotiation and compromise are not independent of control and strength. Negotiation can involve any of Luke's three dimensions of power. Persuasion by one party might be essential to allow things to move forward. Worklessness shows in both models as needing improvement in the involvement of actors but the strength of coalition becomes more important, again linked with power. Climate change in both models needs a strong coalition to progress, so again any of the three dimensions of power could be needed.

The Stacey and Matland models, therefore, return similar results in some ways. However, Stacey's model is less able to differentiate between my policy areas, so is less helpful. Also, Matland adds the dimension of resources as a solution to the problem, which is an issue raised by interviewees in connection

with all policy areas to varying degrees and has been shown to play an important part in relation to power (resource control) as well as featuring in Hall *et al.*' s and Kingdon's models. Matland's model would appear to be the more useful of the two in regional policy analysis. However, it is debatable whether it provides more useful information than Kingdon's (1984) model. The ambiguity of Matland's model would be expected to contribute to Kingdon's problem stream: if the problem is not clear then the aims or means of addressing it will not be clear, so ambiguity is reflected there. It is also reflected in the policy stream: if there is low feasibility, there is likely to be ambiguity of means. In terms of the agreement aspect of Matland's model, this will be reflected in both the national mood and the political or public support. It seems better, then, to make use of Kingdon's model, which appears to cover Matland's factors but differentiates better among my chosen policy areas. There is also less subjectivity involved in assessing the factors for Kingdon's model. (I was fully aware of the subjectivity involved when I assessed the levels of ambiguity for the Matland model.)

Having looked at the factors affecting agenda-climbing for my policy areas, I now explore the extent to which health is considered during their development.

How and to what extent is health considered during a regional policy's development?

Many interviewees felt that there were numerous opportunities for joint working for health. Organizational arrangements that support this idea were the compact between ONE and the NHS Executive Office (Northern and Yorkshire) (NHS and ONE 2000) and, later, the joint post shared between the Regional Assembly and the health sector and the increasing number of Directors of Public Health appointed jointly between the health service and local authorities. Health equity audits, a requirement on Local Strategic Partnerships in drawing up community strategies and local neighbourhood renewal strategies, were not mentioned by any interviewees, possibly because this was a local rather than a regional requirement. The Regional Health Forum was mentioned by some interviewees, as was the siting of the Public Health Group within Government Office for the North East. All of these arrangements should have enabled integration of health issues into other policy areas. However, many interviewees expressed concerns about the conflicting agendas of the organizations involved, including the strong economic focus of the Regional Development Agency. The different boundaries of organizations were also felt to be problematic.

Problems of health and health determinants are well known to all public health professionals but the need to address the issues does not always make it into policy. The lack of power of health advocates was mentioned by several interviewees from various sectors, along with a lack of public health capacity

(exacerbated by the organizational arrangements that split the public health function). Interviewees felt that health awareness should be fostered and developed much more in non-health agencies. The awareness-raising was felt to be very important and the informal approach to this was said to be very valuable, with professionals taking advantage of all opportunities to stress the health message.

The general feeling was that health should be embedded in all regional policies, rather than being a stand-alone policy, and in fact this was an intention expressed in several of the regional organizational documents. The Integrated Regional Framework was said to help this in respect of sustainability rather than health directly. Impact assessments were felt useful for raising awareness of the issues but to have had limited success in influencing the Regional Planning Guidance, Regional Spatial Strategy and Regional Economic Strategy.

Comparing the four specific policy areas, tobacco differs from the others because it is an area where policy tends to come from the health sector (nationally from the Department of Health, regionally from the NHS Executive Regional Office then later from the Regional Tobacco Office, a health sector funded organization). All interviewees believed that the improvement of population health was a fundamental concern in developing tobacco control policy but there were doubts about whether health inequalities had been

considered. In fact, both the 1998 (Regional Task Force on Tobacco Control 1998) and the 2005-08 (PHGNE 2005) regional tobacco strategies did stress the need to address inequalities. The need for multi-agency action, responsibility and involvement in tobacco strategy was expressed by many interviewees, recognizing that it was not just the responsibility of health professionals.

Organizational arrangements for integrating health and housing were mentioned by several interviewees, referring to the joint post between the health sector and the Regional Assembly. Interviewees believed that housing policy did not explicitly address health improvement but many felt that inequalities were considered, although there was a suggestion from some that this happened almost as a by-product of the economic focus. It seems to have been generally felt that the health sector did not have much influence over housing issues and the absence of a health representative on the Regional Housing Board was raised. The power to ensure a consideration of health in housing was felt by several interviewees to lie with the local authorities, although others suggested it was with the health sector, especially the Strategic Health Authorities. Comment was made that more evidence was needed linking housing with health – in fact, there is a wealth of such evidence that has been accumulating over many years, which suggests that the message has just not been getting through. Formal assessments, including the Integrated Policy Appraisal, were felt to have been of limited value in

influencing the housing strategy but of great value in awareness-raising in a multi-agency, multi-disciplinary setting.

Although there were some inter-organizational arrangements for health and work issues, consideration of health during the development of worklessness policy was not felt to be good. The key driver was very definitely felt to be economic. There was more emphasis on the effects of health on work than the effects of work or worklessness on health. Some interviewees suggested that lip-service was paid to health improvement and others, who said inequalities were addressed, suggested this was again only a by-product of the economic focus. The power to increase the focus on health was felt to lie with the health sector, especially Public Health Group North East and the Strategic Health Authorities, but also with the Department for Work and Pensions.

Climate change was recognized as being crucial to health but the driver for climate change policy was definitely felt by interviewees to be economic, with neither health improvement nor inequalities addressed in the development of climate change-related policy. The power to bring in health was felt to lie with a range of organizations, including the Regional Assembly, the Strategic Health Authorities, the Environment Agency, local authorities and Primary Care Trusts.

The economy, then, comes over as a far stronger and more frequent driver of

regional policy than health. Even where there are mechanisms in place that should allow health to be fully considered (such as organizational arrangements and impact assessments), their effectiveness is questionable. I have already mentioned the effect of the strong steer from the Department of Health possibly affecting the health organizations' contributions. With regard to formal assessments, there is certainly no real belief that they have led to significant alteration in the North East's policies. The biggest advantage of the assessments appears to have been that they raise awareness in non-health professionals of the health issues existing in different policy areas. Opportunistically 'spreading the word' seems to be thought a good way, as much as any formal arrangement. There are questions to ask about why the power of the health advocates appears limited and whether this is partly because of a lack of capacity so that there is not always appropriate representation in policy groups. Any lack of capacity is likely to be exacerbated with the forthcoming localism: once again, instead of a regional focus for public health advocacy, the resources (largely human resources) could be split into smaller groups, all with limited capacity.

What factors most influence the position of healthy public policy areas on the agenda of regional decision-makers?

My research sub-questions considered the people and power involved in regional policy-making, other factors affecting the policy agenda and the way and the extent to which health was considered in regional policy. These are all

elements of the main research question: what factors most influence the position of healthy public policy areas on the agenda of regional decision-makers?

There is no simple answer to the question! It needs to be considered in separate parts. There is firstly the issue of the policy area climbing the agenda, and then there is the question of ensuring that health is properly incorporated into the policy. These aspects are affected by different factors.

With regard to the policy area climbing the agenda, my conclusions were that the most appropriate model to use to compare policy areas was that of Kingdon's (1984) multiple streams, but modified to exclude factors less appropriate at a regional level. According to this, a policy area that has reached a high place on the regional decision-making agenda will be strong in both the problem stream and the policy stream. The problem stream encompasses indicators, focusing events and feedback, suggesting that a policy area strong here will be one where there is information or evidence available to show the extent of the problem. This will allow it to be fully recognized and understood that there is a significant problem to be addressed. Tobacco control was strong in this regard: several routine indicators showed the severity of both the health problem (death and sickness rates, adversely comparable with the rest of the country) and the economic problem (sickness leading to worklessness and benefit claims). Feedback was

also available on the positive effect of the stop smoking services. At the other extreme, at the time of my interviews, climate change had no routine indicators or feedback and most of the focusing events had happened in other parts of the world or in other parts of the country – though they were getting closer! The local flooding was said to have had quite an effect on people's perceptions of the effects, so it was a focusing event.

Kingdon's policy stream encompasses feasibility (including technical and budgetary feasibility), fit with dominant values and national mood, and political support. (Issues around funding for policy development were discussed earlier.) Again, tobacco was strong in this area, with a wealth of evidence showing technical feasibility, the ability to allocate resources with awareness of cost of initiatives, and a high level of public support. On the other hand, climate change had little incontrovertible evidence, great uncertainty over outcomes and mixed support at the time of my interviews. After that time, the evidence base and political pressure were growing quite rapidly and the political support created a major opportunity for policy development.

Kingdon's model certainly helped in the identification of some of the important factors, those of his problem stream and his policy stream. My consideration of other factors (excluding people and joint working) led me to believe that Kingdon's model was the best for showing differences between policy areas

and for providing a good degree of explanation for the different levels of success in climbing the agenda.

Although Kingdon's model reflects the importance of factors in a very helpful way, it perhaps does not show enough of the importance of the people involved and the way they work together. Even with all streams in full flow, Kingdon's windows have to be opened. The players, of course, will influence every aspect of Kingdon's model, including the collection and dissemination of indicator evidence, assessment and enhancement of feasibility issues, provision and management of resources, and influencing of public or political support. Considering the people and ways of working therefore involves looking at the 'how' – the way in which Kingdon's factors are influenced. (People will also be of importance when I look at the ways health is incorporated in policy.) Effective joint working was found particularly in tobacco control, to a lesser degree in housing, even less in worklessness and, at the time of the interviews, it was not prominent in climate change. Effective joint working was also stressed as a vital component for success by most interviewees. Only with effective joint working can the factors that are shown to be important actually be improved so that policy can progress. Informal as well as formal joint working mechanisms are essential. In particular, where people have been given funding and resources to develop policies, the development has been rapid.

The joint working element is also essential when it comes to getting health considered in policies. In this case, however, it is more of an awareness-raising kind of joint working. Impact assessments are one formal way of helping to raise awareness (apparently more successful on this front than in enhancing policy directly) but opportunistic, informal awareness-raising was also felt to be vital. Opportunities can be deliberately provided by, for example, the co-location of public health advocates in non-health settings such as Government Office or, in the past, in the Regional Assembly. Provision of opportunity for awareness-raising is also linked to funding issues. If an event such as an impact assessment is funded, it might attract more cross-agency participants so that the public health connections can be strengthened and opportunities for advocacy present themselves. Without strong health advocacy, the general main driver for policy is likely to remain the economy: likely economic effects led to the rapid climb of the climate change policy; the economy dominates the Regional Economic and Spatial strategies; economic considerations significantly affect the housing agenda; the economic effect of worklessness (Incapacity Benefit) is pushing the employment agenda: and even tobacco control is not immune from being considered in an economic light.

Limitations of the study

The use of a case study inevitably means that the findings will be limited in generalizability. I used a set of case studies (the four policy areas) within a case study (the North East region) so the problems are compounded. To what extent can findings related to the North East be generalized to other regions? There are regional characteristics described in the literature (for example, the declining industrial base and the small size of the region), as well as findings from my fieldwork (including the presence of a relatively small number of people involved in regional policy making, people who have been well known to one another over a long time period). These characteristics might well mean that within the North East, policy has developed in a different way from other regions. However, the use of one region provided a stable background against which my four chosen areas developed.

Regional characteristics are only one problematic aspect of policy at a regional level. There is also the concept of a regional policy itself. A definitional issue mentioned earlier is the blurring between policy and strategy. Using definitions from Ritsatakis *et al*. (2000: 3), I showed that regional strategy could encompass the elements of a policy. A more serious problem is the nature of the region as a policy-maker or even as an entity. To what extent is the region actually in a position to develop its own policy? To what extent is it merely an implementer of nationally imposed policy? My research was not intended to address these questions but, inevitably, the questions have to be

posed. I took a pragmatic approach to this: there *do* exist strategies at a regional level that fit the definition of policy and are owned by agencies within the region. However, it must be recognized that the low degree of public visibility of the regional agencies and the possible lack of a strong political presence possibly affect policy development. Nevertheless, such problems will apply to any English regional policy assessment, so it should still be possible to draw conclusions appropriate to this setting.

The four specific policy areas, although within the same region, were chosen deliberately for their known or suspected differences. None was intended to be a typical policy area, if such a thing actually exists. Their differences were to enable a picture to be built of the way and the strength with which various factors affect policy development.

The timing of the interviews will have affected the way my interviewees viewed the general policy-making world. There was not to be an elected Regional Assembly, which had been expected, and the future of the existing assembly had been put in doubt. Organizational changes at all the major agencies had affected, and were continuing to affect, relationships and arrangements for joint working. Interviews two years earlier might have been very different with the possibility of an elected assembly looming. On the other hand, interviews two years later would have been affected by the abolition of the (non-elected) assembly. However, as it tended to be the same people involved, even with

organizational changes, it is possibly less likely that very different views would be expressed at other times.

The state of each of the individual policy areas was also affected by timing. Fresh was a new organization for tobacco control; the responsibility for housing had changed; a climate change officer came into post during the interview period; a regional public health strategy did not exist at the time of the interviews, although one was much talked about. My intention had been to take a snapshot of policy area development, so the interviews were intended to take place in a short time space, against a fairly constant background (one region and a fixed set of regional organizations with defined relationships).

The time over which interviews took place was longer than I had hoped, so the consistency in background was not quite as high as desired. The picture obtained was less of a snapshot and more of a short film, perhaps rather blurred and with its actors changing roles mid-shoot! The prominence of particular issues on the agenda would have been expected to change over time, as Kingdon (1984) found in his studies. In tobacco control, the national legislation on smoke free public places was the main policy hitting the headlines, and this was in many interviewees' minds at the time. My use of documentation alongside the interviews meant that I had another source for identifying prominence of issues. I was able to look at all the policy areas as

they developed both before and after the interviews, to try to provide additional context for their development.

As mentioned in my methods chapter, I intended to restrict my study to agenda setting in times of 'politics-as-usual' (Grindle and Thomas 1991: 83). Imposing this restriction meant that I was not looking at any policy developed in a time of crisis, such as war or pandemic. Anyway, most such policies would have been national rather than regional. There was, however, reference in some interviews to reactions to particular events. For instance, the climate change policy area was thought to have been influenced by serious local flooding, which was said to have affected public mood, relevant to Kingdon's (1984) model or, perhaps, Baumgartner and Jones' (1993) 'punctuated equilibrium'. Whether this flooding constitutes a major crisis at a regional level, is questionable. Even if it does, it has been incorporated as a factor in some of the agenda-building models and has not been ignored.

I did experience some practical difficulties during my research. I have already mentioned the longer time needed for interviews, largely because of having to fit into very busy schedules of interviewees. In terms of the documentary research, there were the unsurprising instances of documents having simply disappeared, being misfiled or wrongly labelled or just not retained because of storage difficulties. The closure of the Regional Assembly also affected

availability, as not all records were archived with their new host and I lost the help of a particularly valuable information provider there.

Perhaps one of the greatest methodological difficulties was that of assessing the position of the policy areas on the agenda. The existence of a regional policy or strategy as the pinnacle was not ideal, as discussed earlier. Just because a policy exists does not mean it is a successful policy: its implementation should be the measure of its success. There is also some circularity in policy development so that implementation can affect the next iteration and some policies are continually being redeveloped. Nevertheless, I needed some measure to suggest that, for example, tobacco policy was higher on the agenda than climate change policy. My consideration of implementation issues was more to see whether the difficulties (or anticipated difficulties) had affected the policy development.

Defining policy positions on the agenda was not the only definitional issue I encountered. Whilst my first phase interviews showed that terms such as healthy policy, health improvement and inequalities were fairly consistently understood, I was surprised to find the different interpretations of ‘policy’ with respect to each of my four areas. Having been personally involved in regional tobacco control policy and regional housing policy, I think I had naïvely assumed that these documents would be the ones that people knew and referred to as the relevant regional policies. I commented on the different

interpretations in my findings sections. Regional tobacco control policy to some people was just the implementation at regional level of the national legislation on smoking in public places. Regional housing policy, to some, was just the elements of housing that appeared in the regional spatial strategy or the regional economic strategy. Worklessness, not unexpectedly since there was not a regional worklessness policy, was regarded by many as part of the regional economic strategy. Climate change, which was developing most rapidly during my interview period, was very much linked with sustainability and the environmental aspects of the regional spatial strategy and the regional economic strategy.

Definitional issues arose again when I compared my findings with existing models that aimed to explain factors affecting agenda-building. Appropriately enough, the concept of ambiguity (for use in Matland's model) was not straightforward: there could be ambiguity of aims or ambiguity of problem definition. I had deliberately not attempted to ask interviewees whether they believed a policy area was ambiguous. Whereas I directly sought views on certainty and on agreement or consensus, I felt that ambiguity would be best assessed by considering interviewee responses and comments generally. I believe this approach did work and enabled me to form an assessment of ambiguity levels. The concept of agreement proved slightly awkward, particularly around climate change: interviewees referred sometimes to

agreement that something should be done, rather than agreement over a policy. I made use of these interpretations in my assessment of ambiguity.

In assessing ambiguity and, to some extent, certainty and levels of agreement, there was an element of subjectivity. I acknowledge that there was also subjectivity in my attributing levels of significance to the feasibility, legitimacy and support of Hall *et al*.'s (1975) model and the problem, policy and politics streams of Kingdon's (1984) model. It might be that, in future, secondary analysis of my (suitably anonymised) interview transcripts could be used to reduce subjectivity. However, because I used interviews from a range of individuals and documents from a range of sources, I hope to have reflected these issues as accurately as possible. The fact that the interviews were semi-structured, rather than structured, also helped, allowing me to clarify what interviewees meant and to use follow-up questions for further detail if appropriate.

My interviewees were chosen for their knowledge and/or input into regional policy-making. It is possible that regional policy would be very differently perceived from a sub-regional level. Interviews with local authorities, for example, might have given a very different impression of certain factors, such as power. Similarly, discussions with national government representatives might have led to different conclusions about the locus of power at a regional level. My choice of interviewees was made to enable me to collect views of

those actually involved in the regional decision-making but outside perceptions might have been informative too.

In spite of the limitations and difficulties encountered, I believe my study has enabled me to contribute usefully to the question of factors affecting regional policy development. I discuss this in the following section.

Contribution to knowledge

My research has contributed to regional agenda-building theory in more than one way. Considering four different policy areas within the same regional context, where the major decision-making bodies are the same, has provided an opportunity for comparison and identification of the most significant factors.

Although joint working has long been recognized as an important factor in policy-making, its value as a factor in policy-making at an English regional level has received little attention, particularly in terms of considering specific policy areas. I have shown that it is extremely important in at least four specific policy areas and in more general policies, such as the regional spatial strategy and regional economic strategy. Informal as well as formal joint working arrangements seem very significant. The region might be unlike others in this: informality was said to be possible because all the stakeholders knew one another.

Impact assessments have received much attention and they are requirements in much policy development. My study, in common with a few other studies, suggests that the greatest value of assessments is in raising awareness amongst stakeholders. Their value in directly influencing the health content of policy is small in comparison and there are concerns that they become tick-box exercises. However, merely taking part in them can enhance the public health knowledge of participants from a range of backgrounds. They are not the only way and they might not be the best way of raising awareness but they contribute towards it.

With regard to methodological innovations, my study has used a variety of models and approaches, assessing their value as descriptors of the regional policy-making arena. Previous studies have considered the use of one of these models, for example Zahariadis (1996, 2008) and Exworthy, Berney and Powell (2002) both used Kingdon (1984). My study has applied a set of models to the same regional policy areas. Some of the similarities noted between models might not otherwise have been recognized. Some of the factors identified for use in both Hall *et al,* and Kingdon were the same, although the titles and apparent categorisation were different at first sight. (For example, the elements of Kingdon's policy stream mostly appear in Hall *et al*.'s model.) My study has pointed out parts of both of these models where they are not appropriate at a regional level but might be at a national level. Kingdon's model has still been predominantly applied at a national level and

mainly in the USA. Here, I have shown that it has validity at an English regional level to a wider set of policies than that used by Exworthy, Berney and Powell (2002).

My use of both Stacey and Matland's matrices has allowed comparison between two different approaches, not commonly used in the same context. Indeed, Stacey has been far more used in organizational decision-making than in policy-making. Although both use agreement or consensus as one of their axes, the amount of differentiation they show between the policy areas is not the same. With Stacey, there was great overlap, almost to the extent of making the model rather unhelpful. On the other hand, the differentiation shown using Matland's model is quite significant: the four policy areas overlap far less. To allow comparison, we need a reliable way of distinguishing between policy areas. This would suggest that Matland's model could be a far more useful way of comparing policies. However, I also showed that Matland's factors were present in Kingdon's model, which had advantages over Matland's in being more discriminating between policy areas and being less subjective to assess.

Practical implications for policy-making

I believe that, as well as contributing to agenda-building theory, my study has practical implications for policy-making. There are several aspects to this:

helping policy areas to climb the decision-making agenda: ensuring that policy is salutogenic; and understanding organizational and regional approaches.

My research suggests that effective joint working is the most significant factor in getting policy areas to climb the agenda. The formal and mechanisms for this need to be enhanced, so that those involved are easily able to work with other agencies and are less likely to be excluded from deliberations.

I found that the best way of ensuring that health was considered in policy was to encourage and support health advocacy. The public health messages need to be disseminated, using informal as well as formal approaches. Formal approaches, such as impact assessments, have their main value in facilitating the raising of awareness of health issues. If these mechanisms are the only way available, then they should be used, and resourced, although a more general infiltration of health into all areas would be preferable. Policy developers might be made more aware of their potential impact, so that considering health becomes automatic in and across all agencies. The fact that the economy, rather than health, drives most policy agendas, suggests that if public health advocates can find more ways of showing that good health improves the economy, this might be a more persuasive argument for including health.

As the writing up of my work was reaching its conclusion, a change of government occurred and the role of the regions – as empowered policy-makers – appears to be diminishing. Within my chosen policy areas, the regional tobacco office, with its apparent high levels of success, would not have come into existence at a small local level. Climate change also became very much a regional policy area, albeit late in my research period. Both tobacco control and climate change are issues where it was recognized that a larger (regional) scale of activity was needed. Housing, although there are regular routine housing policies, is still much organized on a sub-regional level, although region-wide problems have been recognized (particularly the difference from the rest of England in needing quality not quantity of housing). With worklessness, the scale of the regional worklessness problem did prompt regional-level work on skills development and reduction of Incapacity Benefits. Both the Regional Spatial Strategy and the Regional Economic Strategy (which were later to be combined) contained region-wide recommendations and actions. Any funding for development of all the policy areas has been on a regional basis, in recognition of economies of scale. If power is devolved (or returned) to local levels, it might be beneficial to consider joint policy developments (networks?) to retain the advantages of scale and to access the expertise of those who have been policy-makers at a regional level and who have built up networks facilitating joint working.

Suggestions for further study

The limitations caused by choosing one region as a case study have been mentioned. A potentially fruitful avenue to explore further would be whether other regions show the same characteristics in their policy-making and whether the same factors have similar influence elsewhere. This would address the problem of the North East being unique in its policy development. To carry out this research, the best approach would be to look at the same four policy areas in one or more regions. Hall *et al.'s* model might be of particular use, if regional as well as national legitimacy were considered. If not all other regions are to be examined, then as a first step, it might be preferable to choose a region with some characteristics in common with the North East. The North West region is sometimes classed as similar because of its industrial heritage and high levels of poor health. However, more frequently now, Wales is taken as a comparator, although obviously not an English region, because of its similar population size as well as a similar health profile and many similar cultural and historical factors, including the decline of its former heavy industrial base. Such a study could add not only to knowledge of policy agenda-building but also to knowledge of the effect of regional identities. This regional identity aspect could be further explored to see whether perceptions of the region within the region differ from perceptions of it in other regions. (Practical difficulties with this, in the light of the new government moves away from regionalism, would include identifying and contacting former regional agency decision-makers!)

The other case-study-imposed limitation, the limited number of policies examined, would nicely be overcome by a study of other regional policies within the North East region. Ideally, all policy areas would be investigated and comparisons made across similar factors as used in this study. If only a few could be considered, then alcohol might be worth investigating, given that it now has a regional office similar to that of tobacco control. Transport policy would also be a good comparator, as the literature already contains several analyses of transport policy in different parts of the country.

The limited time period considered was chosen to start at the beginning of the labour government's long spell in office, but to finish in 2008 for practical considerations for the research. This would ideally be extended to cover the whole of the labour government's period in office, up to spring, 2010. There would be additional complications, such as the closure of the Regional Assembly and the increasing focus on sub-regional activity, which began after my cut-off point. However, it would be a period where the national influence would be fairly constant, allowing regional development to be a focus. The major changes announced by the new Conservative/Liberal Democrat government include changes to all regional health structures, measures which would be expected significantly to influence regional decision-making, adding weight to the argument that the end of the labour government would be a good end point to the time period. However a prospective longitudinal study of my four policy areas could shed further light on the role of the region as policy-

maker. Other policy areas could also be studied (both retrospectively and prospectively) to assess the effect of any move towards greater localism.

Expansion of the study, by looking at other regions, more policy areas or future developments, might also help to identify the best way of measuring progress of a policy area on the agenda, which did prove awkward. Additional questions could be asked about what stakeholders felt was a good way of assessing policy area prominence. A similar approach to Kingdon's (1984), with interviews in batches over several years, could inform this aspect.

A different expansion would be to include sub-regional (particularly local authority) and national government representatives as interviewees, so that their perceptions, particularly of regional power in decision-making, could be assessed. This might be of increasing relevance, with the pending shift towards localism.

Several factors came to light that might bear further investigation. For example, tobacco control policy appears to have been influenced by the injection of money and resources specifically to develop policy. Funding was provided to develop the first (Northern and Yorkshire) tobacco control policy (Regional Task Force on Tobacco Control 1998) and, later, the regional tobacco control office was funded with policy development as an aim. The same is true of climate change policy, with a climate change officer appointed specifically to develop regional policy. The new regional alcohol office has a

similar format and parallel aims to the regional tobacco control office. Future analysis of this might shed even more light on policy development and confirm whether an injection of funds does aid policy development.

With the importance of joint working being very much stressed in my findings, there would be value in examining further the joint working structures, ways of enhancing them and the effects of reorganizations on the decision-making processes. A cross-regional study would probably prove the most helpful option for this, particularly if the North East is as insular and full of the 'usual suspects' as suggested. This leads into research specifically related to the study's implications for professional practice. Similarly, since awareness-raising appears vital for getting health into policy, further research into the most effective ways of doing this could prove useful, since it is believed that health advocates do not have the power to ensure that health is considered in policy-making. Cross-regional and further policy area research could show whether some policy areas are more difficult to get health into and could identify ways of easing the process.

Still with regard to joint working, it could be interesting to examine further the discrepancy between official and interviewee perceptions of collaborative working. The regional agencies frequently expressed intentions to work together and described the formation of various inter-agency groups, with occasional comments about success. However, there were many doubts expressed by interviewees about this success. Informal arrangements were,

on the other hand, highly valued and felt to contribute to policy-making success. Various explanations might apply. The formal arrangements might be pure rhetoric, or totally overstated. Perhaps they have been impossible to put into practice due to lack of resources or lack of agreement on procedures. The informal arrangements might have arisen to overcome the difficulties of the formal arrangements or they might have pre-existed in such a way that they effectively scuppered any chance of the formal system working. I suspect that the best way to examine this aspect would be with a series of interviews over time, asking interviewees their views whenever particular regional organizational statements or reports are produced that praise collaborative working. This could be done for general policy-making or for specific policy areas.

Conclusions

To address the question of which factors influence the healthy public policy agenda at a regional level, I have made use of a range of sources: the literature, interviews with key professionals involved in regional decision-making processes, and documents from the main organizations developing or contributing to regional policy-making. I considered general policy development and then the specific policy areas of tobacco control, housing, worklessness and climate change.

I found that there were three distinct aspects to healthy public policy on the regional agenda: the people and organizations that influence the progress of policy areas on the regional agenda; other factors that influence policy area progress; and the ways that health is brought into policy. The following paragraphs address each of these aspects.

Many agenda-building models, although generally developed for national (and often non-UK) settings, contained elements highly relevant to English regional policy-making. Particularly significant were the models of Hall *et al.* (1975) and Kingdon (1984). The legitimacy of Hall *et al*.'s model was not a good explanatory factor but its other two components – feasibility and support – appeared helpful. Tobacco control, the most well established policy area on the North East regional agenda, had the fewest feasibility problems and the highest levels of support (public, political and pressure group). At the other extreme, at the time of interviews, climate change was the least well developed and was the least feasible and the least well-supported (strong pressure group activity but weak public support). Similarly, Kingdon's problem stream and policy stream were flowing most strongly for tobacco control policy and most weakly for climate change. Streams for housing were stronger than those for worklessness, reflecting the slightly stronger position of housing on the regional agenda at the time. Kingdon's politics stream seemed of less relevance to regional policy. It is likely that both legitimacy and the politics stream are both more important at national policy-making levels, as they

include changes in administration and election results. Although Kingdon's politics stream also includes pressure group activity, this is to a certain extent subsumed in 'fit with dominant values and current national mood', which is part of the policy stream.

As well as models of agenda-building, the literature described other potential influences on policy-making. Some proved less helpful, such as several of Alford's situational, structural, cultural and environmental factors. I suggest that these could, however, be very useful in comparisons between regions. On the other hand, characteristics of the policy areas, such as the degree of conflict (or agreement) and the certainty of success had some value in discriminating between policy areas. Tobacco control encountered the least conflict and had the most certainty, whereas there was felt to be huge disagreement over the content of climate change policy and very little certainty of success. Levels of ambiguity, another part of the nature of a problem area, also varied amongst the policy areas, with tobacco control being the least ambiguous and climate change suffering from lack of clarity of both aims and approaches.

Whatever the importance of the factors described above, the most important factor was the people involved. Without the people, the windows of opportunity in Kingdon's model, for example, would not be opened. The relationships between organizations and the arrangements for joint working

proved highly significant. It was vital not just to create the formal structural arrangements for cross-sectoral, cross-organizational working, but also to create an environment supportive of informal networking and contact.

Formal and informal joint working arrangements emerged as vital also in getting regional policy-makers to consider effects on health and inequalities. Formal impact assessment tools appeared to have most value not in themselves but as significant methods of raising awareness of health so that all parties involved in policy-making understood the implications and acted on them. Consideration for health was not good in the policy areas I considered: three were felt to be very much driven by the economy, rather than by health, and even the exception (tobacco control) was said to have some economic basis. Lack of capacity in public health affected the extent of health advocacy. The demise of the region as a policy-making level is likely to have a significant effect on the way policy develops, splitting resources and reducing opportunities for widespread public health advocacy.

Regional structures at the time of my research underpinned all the regional policy-making. The regional role in policy-making is not straightforward. There were issues around the level of power there is at regional level to make policy, given that much policy is imposed by central government However, regions have produced policies, influenced by local partners. The most successful of my chosen areas, tobacco control, has a regional office with power and

influence that would not have come into existence at a local level. The climate change agenda took off rapidly following the funded establishment of regional arrangements. Regional economic and spatial policies are based on a whole region, not on small localities, and make use of the expertise of a wide range of policy-makers in a wide range of organizations.

Within the North East region, there appears to have been a strong culture of commitment to working together to produce meaningful policies. The importance of the health element of policy is very well understood and appreciated. The North East has perhaps a smaller, more close-knit cadre of decision-makers than other English regions, which might have worked to its advantage in allowing the growth of both formal and informal relationships. With such relationships, fostered by supportive regional structures, healthy policy-making capacity has been increasing. There is still a long way to go but, without this environment, it is doubtful that there will be sufficient people in the right places with the right connections to continue to make all policy healthy policy.

==========

Appendix 1: Ottawa Charter public health policy statement

Build Healthy Public Policy

Health promotion goes beyond health care. It puts health on the agenda of policy-makers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health.

Health promotion policy combines diverse but complementary approaches including legislation, fiscal measures, taxation and organizational change. It is coordinated action that leads to health, income and social policies that foster greater equity. Joint action contributes to ensuring safer and healthier goods and services, healthier public services, and cleaner, more enjoyable environments.

Health promotion policy requires the identification of obstacles to the adoption of healthy public policies in non-health sectors, and ways of removing them. The aim must be to make the healthier choice the easier choice for policy-makers as well.

(World Health Organization 1986)

Appendix 2: Executive Summary – 'reaching out: the role of central government at regional and local level'.

THE CHALLENGE

How does Government achieve better integration at regional and local level?

To improve delivery of Government objectives – especially on education, health, crime, competitiveness, sustainable development and social exclusion – better mechanisms are needed to link different policies at regional and local level.

THE PROBLEM

Central Government initiatives which affect the same people in local areas are run separately and not linked together. This reduces their effectiveness, not least in the poorest neighbourhoods, and imposes unnecessary management burdens on local organisations. Regional networks of Government Departments are fragmented, with no part of central Government responsible for bringing its contribution together to assist local areas.

Problems are becoming more acute, and greater importance is attached to integrated solutions to local problems.

THE SOLUTION

Strengthened and higher profile Government Offices are needed in the regions covering all Government policies affecting local areas, with more discretion on how to achieve results – but more clearly accountable for delivery of cross-cutting outcomes.

GOs will continue to work closely with Regional Development Agencies.

Strengthened Ministerial and Whitehall co-ordination of policy initiatives and of Government Offices.

Greater focus is needed on strategic outcomes of central Government initiatives affecting local areas, with success judged against these.

Spending Review in 2000 making greater linking of area initiatives a priority.

Cabinet Office. Performance and Innovation Unit (2000)

Appendix 3: roles for public health in proposed elected regional assemblies

Have a duty to promote the health of the population of the region. This will include scrutinising the assembly's own policies and strategies to ensure they have a positive impact on public health and the tackling of inequalities, in order to produce more joined-up and better health outcomes for the region

Support the development and implementation of a health improvement strategy for the region, working with the relevant Regional Director of Public Health (who will be based in the Government Offices) and partner organisations

Appoint the Regional Director of Public Health as the assembly's health advisor in order to form a co-ordinated regional public health group and strengthen the public health function in the region.

'*Your Region Your Choice*' (Cabinet Office/DTLR 2002)

Appendix 4: Regional delivery (Delivering your choice: making healthy choices easier)

REGIONAL DELIVERY

The GORs, Regional Assemblies and Regional Development Agencies (RDAs) also play an important part in helping to shape the wider economic determinants of health and strategy on transport, employment, the environment and regeneration. GORs bring together the activities of 10 Whitehall departments within a single organisation in the region. These activities include, for example, ODPM's interests in sustainable communities and in deprived neighbourhoods, DfES's interests in children and learners, and Home Office's interests in crime, community safety and community involvement. GORs are ideally placed to make the connections necessary between these activities to improve health and wellbeing. GORs are already leading the negotiation of LAAs on behalf of central government which wants to strengthen their role and delegate more activities currently carried out in Whitehall.

Regional Directors of Public Health and their Public Health Groups (PHGs) are based within GORs and will support local delivery of health improvement by:

- working with other key regional stakeholders such as RDAs and Regional Assemblies to deliver health improvements;
- integrating health improvement and activity in supporting local planning and delivery mechanisms within GORs;
- encouraging closer working with GORs and SHAs;
- coordinating regional task forces and other action to support the delivery of health improvement PSAs;
- work [*sic*] closely with regional PHOs to track and report performance;
- identifying regional issues and concerns that may need a national policy response;
- brokering support for local action and facilitating cross-regional learning and development opportunities.

(DH 2005a)

Appendix 5: interview schedule for first phase interviews

PREAMBLE

Outline of position of researcher (carrying out the work as part of PhD rather than as a project carried out as an independent paid management consultant).

Outline of research area and format of interview, emphasising confidentiality and anonymity aspects.

Confirmation that the interview is not to be taped and agreement to researcher making written notes during the interview.

DISCUSSION AREAS FOR SCOPING INTERVIEWS

1. Role of interviewees and their organizations in decision-making process
    a. Past 2-3 years
    b. Next 2-3 years (with and without elected regional assembly)
2. Relationships with other regional decision-making bodies
    a. Current relationships - both formal and informal
    b. How these have changed or are changing (e.g. with Shifting the Balance of Power or with regional public health joining the GOs)
3. Healthy public policy and health impact
    a. What does interviewee understand by the terms ‘public health’ and ‘health impact’
    b. Does interviewee see healthy public policy-making as important
    c. Is healthy public policy-making a part of interviewee’s role and, if so
        - Which tools do they think help to deliver it?

- Views on capability and capacity in progressing the public health agenda

d. Main ways in which issues of health impact are addressed in region's policy-making
e. proactive and reactive approaches (including different levels at which health impact could be addressed)
f. Pros and cons of an explicit regional health strategy

4. What works and what doesn't work in keeping health consideration on the agenda?

Also, as appropriate

- *request use of minutes of various relevant meetings*
- *ask re researcher's potential involvement in regional policy development projects (either as an observer or as a professional public health management consultant)*
- *refer to possible follow-up interviews in 18 months time.*

Appendix 6: interview schedule for phase 2 interviews

Introductory blurb to introduce self and topics to interviewees

Also include statement re confidentiality and anonymity.
Request re tape-recording interview

NB – questions are to be asked about each policy about which the interviewee is being questioned.
(Tobacco; housing; worklessness; climate change)

1. Interviewee role

Question 1 – Please can you describe your role(s) with regard to the policy being considered.

IF not apparent, probe for:

- *formal/informal role*
- *personal interest*
- *historical reasons*
- *power - relationship with others?*

2. Health aspects of policy

Question 2.1

a) How important do you feel the improvement of population health was in developing the policy?
(depending on interviewee, might need to amplify idea of improving health – well-being etc)

b) Were policy developers concerned with addressing inequalities in health? *(depending on interviewee, might need to explain possibility of health improving whilst inequalities widen)*

c) If both were important – which of these (population health improvement or addressing inequalities in health) was more of a focus?

Question 2.2

What were the key drivers affecting the position of the issue on the agenda?
(prompts might be needed – e.g. government directives, arrival of funding to address specific issues, local public concerns, ideology – personal values etc)

3. The nature of the issue

a) Certainty

Question 3.1

a) How much certainty is there that this policy will work?

b) if you were to give a score out of 5 for the degree of certainty (0 being lowest, 5 being highest) what would it be?
(if interviewee says this is difficult, this is in itself a finding)

c) what do you think creates this certainty?
Possible prompt – e.g. government or evidence base etc

Question 3.2

a) Are you aware of any similar policy/action in the past – either in this region or elsewhere?

b) If so, do you know whether that policy was felt to have been successful? (*possibly take questions further – recognized factors in success/failure*)

b) Agreement

Question 3.3

a) Please can you describe the partnerships/shared priorities/shared decision-making in this policy

If joint working was not thought to have been done:
b) What were the reasons for lack of joint working?

(Assuming joint working) –

c) What were the reasons for inclusion or exclusion of various bodies?

d) How effective do you feel the joint working has been in terms of adding value to the policy and its outcomes?

e) What might have been different if there had not been that amount of joint working?

f) Was this a partnership of equals or could you rank the partners in order of significance?

Question 3.4

a) can you assess the level of agreement between the partners over the way the policy was developed?
(might have to prompt – agreement re priority, re approach)

b) if you were to give a score out of 5 for the degree of agreement (0 being lowest, 5 being highest) what would it be
(might have to split between agreement re whether doing right thing and agreement whether agree doing the right thing right)

4. Power

Question 4.1

a) Where do you think the power lies to get this area of concern on the agenda?
e.g. with an organization? Or with an individual (position power or personal power)

b) where do you think the power should lie?

c) Do you believe that there are organizations/individuals with an interest in keeping this area of concern off the agenda?

d) If so, why – and do they have the power to do so?

Question 4.2

a) Where does the power lie to drive through changes in the policy to help it improve health (to bring in the health dimension)?

e.g. with an organization? Or with an individual (position power or personal power)

b) where do you think the power should lie?

5. Performance management of health component

Question 5

a) Is there any performance management of the health outcome element?
(point out that the performance management might not be specific to the policy – there might be elements in several places)

If so
b) Where/how is the health outcome element to be performance managed?

c) what are the particular targets and performance indicators used? (*ask for copies of documents or references)*

d) Are there any targets or indicators you feel should have been included that weren't? If so, why were they not included?

e) Do you see any particular difficulties arising over this health-related performance management?

6. Other factors

Question 6.1 (feasibility/implementation problems)

If policy has been implemented
a) What implementation problems have there been with this policy?

Whether policy has been implemented or not
b) Did the prospect of implementation problems slow or change the policy's development? *(or "has the prospect of.. slowed the policy's development")*

Question 6.2 (Resource allocation – if not already mentioned)

Are there any particular difficulties around resourcing that might influence the policy's implementation? (resourcing in terms of either financial or human resources *(skills shortages etc*))

Question 6.3 (Public acceptability – if not already mentioned)

a) has there been any assessment of the likely level of support from the public for the policy?

b) has there been any attempt to engage the public in shaping or influencing the policy?
might have to stress the difference between collecting people's views (e.g. in survey prior to development) and actually involving them in policy development

Question 6.4(other)

Are there any other factors you think have played an important part in the development of this policy?

Thank interviewee for their time. Ask if can approach again with follow-up questions if necessary.

Appendix 7: interviewee organizations and areas of contribution

Organizations represented		General policy (phase 1)	Specific policy areas (phase 2)			
			Tobacco control	housing	Workless-ness	Climate change
1	ONE				✔	
2	Sustaine/NEA			✔		✔
3	GONE/RHB	✔	✔	✔	✔	✔
4	NEA		✔	✔	✔	✔
5	NEA		✔	✔		✔
6	NEPHO			✔	✔	✔
7	VONNE		✔	✔	✔	
8	GONE	✔		✔		✔
9	Vol sector/Univ				✔	
10	Sustaine					✔
11	UKPHA/univ		✔			✔
12	PHG	✔				
13	HDA	✔	✔	✔	✔	✔
14	GONE		✔	✔		✔
15	ANEC		✔		✔	✔
16	NEA		✔	✔		✔
17	GONE/RHB			✔		✔
18	DWP				✔	
19	NEA	✔	✔	✔	✔	✔
20	TUC		✔	✔	✔	✔
21	NECC		✔	✔	✔	✔
22	Fresh		✔			
23	HDA/UKPHA	✔				
24	PHG			✔	✔	
25	CSIP		✔	✔	✔	
26	PHG		✔		✔	✔
27	IPPR		✔		✔	✔
28	CURDS	✔		✔	✔	✔
29	ONE/RHB	✔		✔	✔	✔
30	NEPHO	✔	✔	✔	✔	✔
31	CSIP			✔	✔	
32	GONE/NEPHO	✔	✔	✔	✔	✔
Totals		**10**	**18**	**21**	**21**	**22**

Appendix 8: sample e-mail request for interview with potential phase 1 interviewees

Dear

As part of my PhD research into healthy public policy at a regional level, I am hoping to interview key players in the region about the ways in which healthy public policy is developed and considered in this region. I wondered whether you'd be able to give me an hour or so of your time for such an interview. If so, please could you suggest some possible times for me to come and see you (maybe in the first two or three weeks of March?). I'd really appreciate it.

Hope to see you soon.

Best wishes

Jean

Appendix *9*: outline of thematic codes

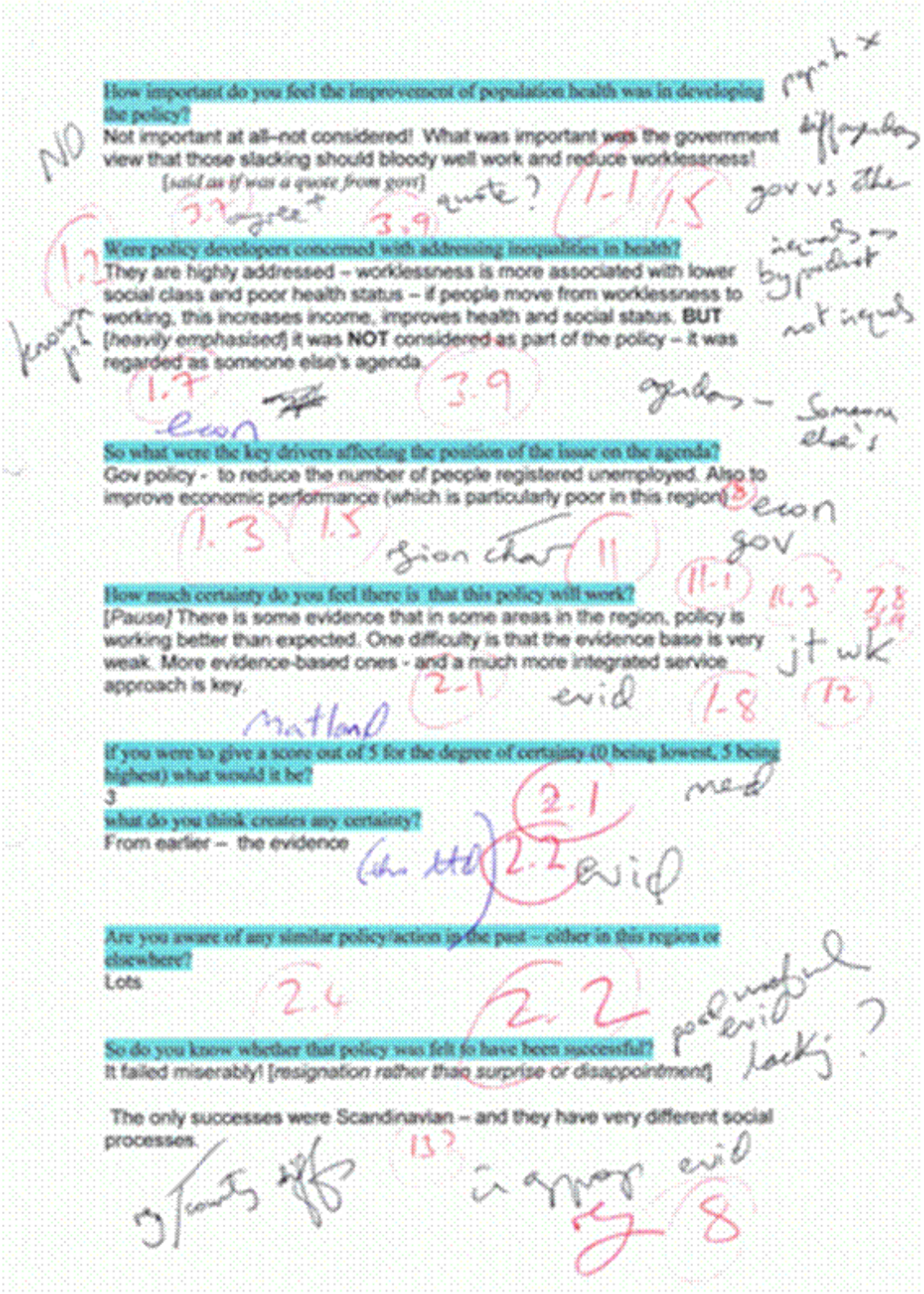
1	**Policy drivers**	1.1	Population health improvement		
		1.2	Addressing health inequalities		
		1.3	Political level (international, national, regional, local, individual, other)		
		1.4	Public pressure		
		1.5	Economic		
		1.6	Tipping point		
		1.7	Health implicitly considered		
		1.8	Build-up of evidence or awareness		
2	**Certainty**	2.1	Degree of certainty, incl scale measurement		
		2.2	Reasons for high certainty		
		2.3	Reasons for low certainty		
		2.4	Awareness other policies and success		
3	**Joint working**	3.1	Participants	3.1.1	who
				3.1.2	Why
				3.1.3	Lead role/ ownership
				3.1.4	Need for leadership
				3.1.5	Not know
		3.2	Omissions	3.2.1	Who
				3.2.2	Why
		3.3	Formal and informal networks		
		3.4	Added value provided by partnership		
		3.5	Level of engagement		
		3.6	Level of openness/transparency		
		3.7	Agreement	3.7.1	Degree, incl scale value
				3.7.2	Reasons
				3.7.3	Headline agreement/ in principle vs detail, need to act vs how
		3.8	Work well or badly together		
		3.9	Different agendas		
		3.10	Professional awareness-raising		
4	**Power**	4.1	Power to intro or keep on agenda	4.1.1	Where it lies
				4.1.2	Type of power
				4.1.3	Where should lie
				4.1.4	why
		4.2	Orgs/ individs want keep off agenda	4.2.1	Who
				4.2.2	Why
				4.2.3	Have they power
				4.2.4	Not off agenda but against some actions
		4.3	Power to	4.3.1	Where this power lies

			keep health aspect on agenda	4.3.2	Hia etc
				4.3.3	Where should be
		4.4	other		
5	**Implementation problems**	5.1	Actual known problems	5.1.1	Financial resources, incl sources and pooling
				5.1.2	Human resources
				5.1.3	Speed of progress
				5.1.4	Obstructive orgs/ individs
				5.1.5	Focus on wrong problem
				5.1.6	Reorganization
				5.1.7	other
		5.2	Anticipated problems	5.2.1	Perceived scale of problem
				5.2.2	Financial resources, incl sources and pooling
				5.2.3	Human resources
				5.2.4	Obstructive orgs/ individs
				5.2.5	Reorganization
				5.2.6	Need social change – long term
				5.2.7	Speed of progress
				5.2.8	External (e.g. international) effects/ pressures
				5.2.9	Other
				5.2.10	Anticipation probs delay pol dev?
6	**Public involvement**	6.1	Assessment of public opinion	6.1.1	Did it take place
				6.1.2	At which political level
				6.1.3	Formal vs informal (eg assess from media coverage etc)
				6.1.4	media
		6.2	Engagement of public in policy development	6.2.1	Did it take place
				6.2.2	Service users as opposed to public
				6.2.3	Role of vol sector as representatives
				6.2.4	Role of media
				6.2.5	Social mkting/ engage public more
		6.3	Raising public awareness		

7	**Other perceived factors**	7.1	Political environment
		7.2	Constraints/advantages of existing systems incl elected assembly
8	**Specific to region**		
9	**Performance management**		
10	**Links with other policies**		
COMPARISON WITH OTHER MODELS			
11	**Hall**	11.1	legitimacy
		11.2	Feasibility
		11.3	Support
12	**Kingdon**	12.1	Politics stream
		12.2	Problem stream
		12.3	Policy stream
13	**Leichter**	13.1	Situational
		13.2	Structural
		13.3	Cultural
		13.4	environmental

NB Numbering system has been tidied up for easy reference – in practice, numbering scheme evolved over time with successive runs through

Appendix 10: sample page of transcript with coding annotations



How important do you feel the improvement of population health was in developing the policy?
Not important at all–not considered! What was important was the government view that those slacking should bloody well work and reduce worklessness!
[said as if was a quote from govt]

Were policy developers concerned with addressing inequalities in health?
They are highly addressed – worklessness is more associated with lower social class and poor health status – if people move from worklessness to working, this increases income, improves health and social status. **BUT** [heavily emphasised] it was **NOT** considered as part of the policy – it was regarded as someone else's agenda.

So what were the key drivers affecting the position of the issue on the agenda?
Gov policy - to reduce the number of people registered unemployed. Also to improve economic performance (which is particularly poor in this region)

How much certainty do you feel there is that this policy will work?
[Pause] There is some evidence that in some areas in the region, policy is working better than expected. One difficulty is that the evidence base is very weak. More evidence-based ones - and a much more integrated service approach is key.

If you were to give a score out of 5 for the degree of certainty (0 being lowest, 5 being highest) what would it be?
3
what do you think creates any certainty?
From earlier – the evidence

Are you aware of any similar policy/action in the past – either in this region or elsewhere?
Lots

So do you know whether that policy was felt to have been successful?
It failed miserably! [resignation rather than surprise or disappointment]

The only successes were Scandinavian – and they have very different social processes.

Appendix 11: regional documents examined

Documents are listed by topic of relevance: general policy, tobacco control, housing, worklessness, climate change and other (RPG, RES, RSS, Public Health, Northern Way). Excludes general organization websites and press releases.

GENERAL POLICY

Corporate plans, business plans and manifestos

ANEC Corporate Plan 2002-04 (ANEC 2002)
ANEC Corporate Plan 2004/05 (ANEC 2004a)
Association of North East Councils 2005/06 Manifesto (ANEC 2005)
Association of North East Councils 2006/07 Manifesto. ANEC 2006b)
ANEC Corporate plan 2008-11 (ANEC 2008b)
ANEC Green Manifesto: well-being, health and the environment. (ANEC 2006c)
ANEC Revised Business Plan 09-11 (ANEC 2009)

GONE Business Plan 2006/07 (GONE 2006c)
GONE Business Plan 2007-2008. (GONE 2007a)
GONE Corporate Plan 2008-11. (GONE 2008b)
GONE. Vision and Values Statement: (GONE 2002a)

NEA Business Plan 2006-09 (NEA 2006e)
NEA Business Plan 2007-10 (NEA 2007a)
Responding to change : NEA Business plan 2008-2011 (NEA 2008e)
NEA Revised Business Plan 2008/2011 (NEA 2008f)

ONE Corporate Plan Summary 2003-2006. (ONE 2003)
ONE Corporate plan 2008-13 (ONE 2008)

Annual Organizational Reports

ANEC Association Review 03/04 Building on progress (ANEC 2004b)
*ANEC. The year in highlights - 2006/07. (*ANEC 2007b)
ANEC A picture of the year's highlights - annual report 2007/08 (ANEC 2008c)

GONE Annual Report 2002/03. (GONE 2003)
GONE Annual report 2003/04 (GONE 2004)
GONE Annual Report 2004/05. (GONE 2005)
GONE Annual Report 2005/06. (GONE 2006b)

NEA Review 04. (NEA 2004b)

NEA Shaping the future of the North East – annual report for 2005/06 (NEA 2006f)
NEA Working for the region: Annual report 2006/07 (NEA 2007b)
NEA Delivering through change. Annual report 2007-08. (NEA 2008b)
NEA Annual report 2008/09 (NEA 2009a)

One Vision: One NorthEast Review of the Year 2004. (ONE 2005d)

Annual scrutiny reports

NEA The First Report of the Scrutiny and Policy Development Committee. (NEA 2005c)
NEA Scrutiny Annual Report 2006
NEA Fitting the pieces together: final scrutiny review (NEA 2009b)

Agendas, minutes and meeting notes

HIG Notes of meetings Aug 2002, Jan 2003, Mar 2003. Apr 2003, Jun 2003, Nov 2003, Jan 2004. (Newcastle upon Tyne, Health Interest Group)
North East Assembly agendas and meeting notes (excluding panels more relevant to specific policy areas)
NEA Agenda updates: issues 1 (Jul 2002), 2 (Aug 2002), 3 (Sep 2002), 4 (Oct 2002), 5 (Nov 2002), 6 (Dec 2002), 7 (Jan 2003), 8 (Feb 2003), 9 (Mar 2003), 10 (Apr 2003), 11 (May 2003), 12 (Jun 2003), 13 (Jul/Aug 2003), 14 (Sep 2003), 15 (Oct 2003), 16 (Nov/Dec 2003), 17 (Jan 2004), 18 (Feb 2004), 19 (Mar 2004), 20 (May 2004); (21 not available); 22 (Aug 2004), 23 (27/09/2004-01/10/2004), 24 (mis-numbered 23) (Feb-Mar 2005), 25 (Apr-Jun 2005), 26 (Sep 2005); editions 27 (Nov 2005), 28 (Jan 2006)
(publication then becomes *NEA news)*)
NEA news (continuation of *NEA Agenda updates*): editions 29 (Mar 2006, 30 (Jun 2006), 31 (Aug 2006), 32 (Nov 2006), 33 (May 2007), 34 (Jul 2007), 35 (Dec 2007), 36 (Mar 2008), 37 (May 2008), 38 (Jul 2008), 39 (Oct 2008),
NEA members bulletins. 01/02/2007, 09/03/2007, 01/11/2007, 05/12/2007. Changed to *NEA e-bulletin,* 31/01/2008, 07/04/2008, Oct 2008.
Development board: Jun 2006 – Sep 2008.
Economic and social partners: Oct 07.
NEA Annual meetings: 30/06/2005, 28/06/2006, 14/07/2008.
NEA executive board meetings: 10/09/2007, 12/11/2007, 14/01/2008.
NEA Special executive, 12/05/2008.
Meetings of Assembly chairs, panel chairs and chief executives: 19/02/2002, 25/04/2002, 19/06/2002, 08/07/2002.

Plenary meetings: 20/01/2005, 15/09/2005, 15/12/2005, 13/02/2006, 22/01/2007, 16/07/2007, 03/03/2008.
Special plenary meetings: 11/03/2005, 03/06/2005, 31/07/2007, 27/03/2008, 23/10/2008.
Scrutiny Management Group: 11/03/2003, 08/05/2003.
Scrutiny and Policy Board : 25/9/2007, 23/10/2007, 20/11/2007, 22/01/2008, 19/02/2008. 18/03/2008, 20/05/2008, 17/06/2008, 23/09/2008, 21/10/2008,18/11/2008, 16/12/2008.
Sites and premises scrutiny panel 6/12/02, 09/01/2003, 13/02/2003, March/April unavailable,14/05/2003, 20/06/2003, 08/07/2003.
Scrutiny and policy development panel – inward investment and marketing: 04/02/2002, 06/03/2002, 08/04/2002, 13/05/2002, 06/06/2002 (including draft questions for Select Committee), 28/6/2002.
Scrutiny and development panel: information and communications technology (ICT) and e-commerce: Jan 2002 unavailable, 21/02/2002, 20/03/2002, 10/4/2002, 20/06/2002.
Cross-cutting themes group – 25/11/2002, 17/12/2002.

Corporate magazines and newsletters

ANEC *Dialogue:* issue1 (summer 2006), issue 2 (autumn 2006), issue 3 (spring 2007), issue 4 (winter 2007), **5** (spring 2008), **6** (autumn 2008).
GONE *Government Office Focus* (5 December 2008). (GONE 2008a)
GONE *Citygate Courier*: Issues 1 (Dec 04), 2 (Mar 05), 3 (May 05), 4 (Nov 05), 5 (Dec 05), 6 (Apr 06), 7 (Aug 06).
GONE *Focus* : 11/02/2008 (issue 1), 09/04/2008, /06/2008,22/08/2008, 20/10/2008, 05/12/2008
GONE *Public Health Group Bulletins*: issues 17 (Jul 04), 21 (Nov 04), 22 (Dec 04), 24 (Feb 05)
NEA Snapshot 01/02/04
VONNE *The Vine.* Issues 22 (Aug 2006), 28 (spring 2008), 29 (summer 2008), 30 (autumn 2008), 31 (winter 2008).

Interorganizational agreements

Compact between the National health Service and One NorthEast (NHS and ONE 2000)
Concordat between One NorthEast, the North East Regional Assembly and the Government Office for the North East. (ONE, NEA, GONE 2000).
Agreement on scrutiny and policy development between the North East Assembly and One NorthEast (ONE and NEA 2005).
*Regional Compact: a framework for strong and effective relationships between the Public Sector and the Third Sector in the North East. (*GONE 2006a).

Other

Sustainable Communities in the North East: building for the future. (ODPM 2003)

TOBACCO CONTROL

Strategies

An Action Plan for Tobacco Control in the Northern and Yorkshire Region. (Regional Task Force on Tobacco Control 1998).

A Smoke Free North East: Regional Tobacco Strategy 2005-2008. (PHGNE 2005)

Business plans and memoranda

Fresh Smoke free North East Business plan 2007-08 (Fresh 2007)

Fresh Smoke free North East Business plan 2008-09 (Fresh 2008a)

Fresh Smoke free North East Regional delivery plan 2009 (Fresh 2009)

Draft Memorandum of Understanding between Smoke free North East Office and Primary Care Trusts 2005.

Annual reports

Fresh Smoke Free North East. Annual report 2005/06. Fresh (2006)

Fresh Smoke Free North East. Smokefree Journey: a diary of events April 2006 – March 2008 (Fresh 2008b)

HOUSING

Strategies

NEHB A new housing strategy for the North East. (NEHB 2005).

NEA/NEHB Quality places for a dynamic region: the North East England Regional Housing Strategy. (NEA/NEHB 2007).

Technical paper 4: housing (explains policy approach to housing in draft RSS) (NEA 2005e)

A sub-regional housing strategy for Northumberland 2007-11. (Northumberland Housing Board 2007).

Making your home in Durham a great place to live: a housing strategy for Durham 2008-11 (Northern Housing Consortium 2007).

Tees Valley Sub-Regional Housing Strategy 2007 (Tees Valley Living 2008)

Tyne and Wear Sub Regional Housing Strategy 2007-2012 (arc^4 2007).

Agendas, minutes and meeting notes

NEA Notes of Special Plenary Meeting. (NEA 2005d)
NEHB Executive Board: 27/9/06,25/10/06, 22/11/06, 31/1/06, 7/3/07,, 26/4/07, 23/5/07, 27/6/07, 19/9/07, 16/11/07,30/1/08, 12/3/08, 29/5/08, 23/7/08, 18/9/08, 7/11/08, 20/11/08,
NEHB: 25/4/07, 14/6/07, 25/10/07, 10/1/08, 17/4/08, 26/6/08, 9/10/08.
NEHB PSAF (North East Housing Board Private Sector Advisory Forum): 6/12/2006, 28/02/2006, 30/10/2007, 28/01/2008, 22/07/2008.
NEHB VSAG/VSAF (Voluntary Sector Advisory Group (VSAG) , later renamed *Forum (VSAF),* later renamed *Voluntary and Community Sector Advisory Forum*, retaining initials *VSAF*): 01/02/2005, 29/07/2005, 26/10/2005, 25/04/2006, 04/0702006, 03/10/2006, 23/03/2007, 27/07/2007, 09/11/2007, 25/01/2008, 23/05/2008, 18/07/2008

Consultations and assessments

Integrated Policy Appraisal on North East Regional Housing Strategy, 26/3/2003. Briefing documents, including unpublished *Facilitator notes taken during the IPA* (Brown 2003).
Launch of the NE regional housing strategy Aug 2005 – outline programme. (NEHB).
Updating the North East Housing Strategy. Sub-regional "pre-consultation" events, Nov 2006. Programme of events (NEHB).

Other

North East regional study on methods for maximising the delivery of affordable housing. A study for the North East Assembly/North East Housing Board. (Storeys:ssp 2007).
North East Assembly response to Housing Green Paper (2007). (NEA 2007c).

WORKLESSNESS

Strategies and plans

Framework for Regional Employment Skills Action (FRESA). (ONE 2002a).
Skills Action Plan 2005-2006. (Skills North East 2005).
Skills Action Plan 2006-2007. (Skills North East 2006a).
One North East Regional Employability Framework Stage 1 Executive Summary. Rocket Science (2006).

Reports

Strengthening accountability in the North East. First report November 2002. (The business-related scrutiny report) (NEA 2002a).
Strengthening accountability in the North East. Scrutiny and

development 2nd report, September 2003 (The tourism, skills and business scrutiny report). (NEA 2003c).

Report on key findings and recommendations of the Employability Task and Finish Group. (ANEC 2007a).

Employability Action North East final report 2007 (Skills North East 2007)

Worklessness - final paper (Health at Work Group 2005a)

Agendas, minutes and meeting notes

North East Assembly

Scrutiny and policy development panel – tourism:23/01/2003 23/02,2003, 20/03/2003, 24/04/2003, 22/05/2003, 09/07/2003.

Scrutiny and policy development panel 4: SME creation and survival (SAPD4): 11/01/2002, 13/02/2002, 15/03/2002, 15/04/2002, 17/05/2002, 05/06/2002, 01/07/2002. Gap and change of name to Scrutiny and Development Panel: survival of small and medium-sized enterprises: 19/12/2002, 07/02/2003, 20/02/2003, 20/03/2003, 17/04/2003, 23/05/2003 (Pre-meeting for Select Committee, Select Committee hearing), 23/06/2003.

Scrutiny and policy development panel: skills and training : 19/11/2002, 22/01/2003, 03/03/2003, 27/03/2003, 29/04/2003, 23/05/2003, 26/6/2003 (Pre-meeting for Select Committee, Select Committee hearing).

Scrutiny and policy development: Job creation in deprived communities: 14/01/2002, 30/01/2002, 26/02,2002, 19/03/2002, (Apr 2002 unavailable),24/05/2002, 14/6/2002 (including questions for Select Committee).

Health at work group minutes December 2005 (Health at Work Group 2005b)

Consultations and workshops

A business approach to workforce ill health. A breakfast event for GPs and employers in Easington and Sedgefield. (Briefing notes) *(*Employment and health group Easington and Sedgefield 2004)

Notes on reducing worklessness seminar, December 2005. (Regional Partnership Group 2005)

Draft action plan 2008 (Skills North East 2008)

Conference notes: regional employability framework 2006 (Skills North East 2006b).

Worklessness and Health seminar report. (PHRAC 2006)

CLIMATE CHANGE (includes sustainability)

Strategies and plans

The Integrated Regional Framework for the North East. (Sustaine 2004)

The Integrated Regional Framework for the North East of England (Sustaine 2008b)

*Climate Change Action Plan for the North East of England. (*Sustaine 2008a)

*Association of North East Council's Climate change: our commitment to a greener future. (*ANEC 2007c)

Reports

And the weather today is... (Sustaine 2002)

Climate change: key findings and recommendations of the Climate Change Task and Finish Group. (ANEC 2008a)

Consultations and seminars

Towards a Renewable Energy Strategy for the North East. Consultation Summary Oct 2003. (TNEI Services and NEA 2003).

Towards a waste strategy for the North East. Consultation summary. (ERM and NEA 2003)

Review of the North East Integrated Framework, workshop 18th June 2007, agenda and papers (organized by ARUP for Sustaine).

Other

North East Assembly response to the draft climate change bill. (NEA 2007d)

OTHER POLICY AREAS

Strategies and plans

1999

Unlocking Our Potential: the Regional Economic Strategy for the North East. (ONE 1999a).

2001

Innovation Strategy and Action Plan. One NorthEast. (ONE 2001a)

Everybody's Business. The North East of England Enterprise Strategy 2001 (ONE 2001b).

Culture North East: regional cultural strategy for the North East of England 2001-10. (Culture North East 2001).

Rural Action Plan. (ONE *et al*. 2001).

2002

Realising Our Potential: the Regional Economic Strategy for the North East of England. (ONE 2002b).

Regional Planning Guidance or the North East to 2016 (RPG1). (GONE

2002b).

Reducing reoffending in the North East: the regional resettlement strategy. (GONE 2002c).

2004

Making it happen: the Northern Way. (ODPM 2004).

Turning ambitions into reality: the North East regional plan for sport and physical activity 2004-08). (Sport England North East 2004).

*Regional Spatial Strategy (RPG1 becomes draft statutory RSS, s*ee GONE 2002b).

2005

Moving Forward: the Northern Way. Business Plan 2005-08 (Northern Way Steering Group 2005).

Better Health Fairer Health: a strategy for 21st Century Health and Well-being in the North East of England. (Public Health North East 2008).

North East England Tourism Strategy 2005-2010. (ONE 2005e).

Regional Information Communications and Technology Strategy (ONE 2005g), incorporated into *Regional Economic Strategy*.

Passionate people passionate places. The Regional Image Strategy (ONE 2005h)

Trees, woodlands, forests... and people. The regional forest strategy for the North East of England. (North East Forestry Action Group 2005)

2006

Leading the Way: Regional Economic Strategy 2006-2016. (ONE 2006).

Sustainable farming and food: facing the future (SFFS 2006).

2008

The North East of England Plan: Regional Spatial Strategy to 2021. (GONE 2008c).

Reports

Shaping Horizons in the North East: evaluation report. (ONE 2005f).

Regional Health Engagement Research (Rodger 2005).

Moving forward : the Northern Way. Action plan progress report summary. (Northern way steering group 2005).

Regional Spatial Strategy for the North East. Annual monitoring report 2005/06 (NEA 2006g).

Regional Spatial Strategy for the North East. Annual monitoring report 2006/07 (NEA 2007e).

Regional Spatial Strategy for the North East. Annual monitoring report 2007/08 (NEA 2008g).

Regional Spatial Strategy for North East England. Annual monitoring report 2008/09 (NEA 2009c).

Consultations, assessments and seminars

Quality of Life in the North East: towards a regional framework. (Sustaine 2002b).

Health consultation on the Regional Planning Guidance for the North East. Briefing papers and *A response on behalf of the Regional Director of Public Health, based on a rapid health impact assessment, March 2003.* (RDPH 2003).

A framework for health? A screening Health Impact Assessment of the pre-consultation draft of the Regional Spatial Strategy. (Chappel and Bailey 2004).

North East England Tourism Strategy 2004-2007, draft for consultation. (ONE 2004a).

Shaping Horizons in the North East: the strategic futures project for the North East of England. (Draft) (ONE 2004b).

Rural white paper- regional case studies: North East. (DEFRA 2004)

North East Regional Spatial Strategy: health sector presentation and Discussion. September 2004, Newcastle upon Tyne. Briefing materials.

View: shaping the North East. Regional Spatial Strategy for the North East. Submission draft June 2005. (NEA 2005f).

Regional Transport Strategy. Consultation. Incorporated into Regional Spatial Strategy.

A Rapid Health Impact Assessment of the Draft Regional Economic Strategy. (Bailey, Chappel and Sher-Arami 2005). (and related briefing papers).

Regional Spatial Strategy for the North East: Statement of Public Participation. (NEA 2005b).

Regional Spatial Strategy for the North East. Final report of the sustainability appraisal. (ERM 2005).

North East of England Regional Spatial Strategy. Secretary of State Proposed changes to draft revision submitted by the North East Assembly, May 2007. (GONE 2007b)

Appendix 12: regional policies existing or under consultation at time of choice of case study policies

Policy/strategy	**Lead organization or sector *(reference)***	**Suspected* consensus / controversy**	**Health as a specified main aim?** [#]
Regional Economic Strategy 2002 and consultation for 2006 RES	ONE *(ONE 2002b, ONE 2006)*	Controversy	No
Regional Spatial Strategy (formerly RPG1) and consultation towards final RSS	ONE *(GONE 2002b GONE 2008c)*	Controversy	No
Sustainable Development Framework (Integrated Regional Framework) 2004	Sustaine *(Sustaine 2004)*	Consensus	Yes
Regional Tobacco Strategy 2005	Health *(PHGNE 2005)*	Consensus	Yes
Regional Transport Strategy (consultation)	North East Assembly *(later incorporated into RSS)*	Controversy	n/a
Regional Housing Strategy 2005	NE Housing Forum/ Regional Housing Board *(NEHB 2005).*	Controversy	No
Regional Information Communications and Technology Strategy 2005	ONE *(ONE 2005g), (later incorporated into RES)*	Consensus	No
Reducing Reoffending.(Regional Resettlement Strategy) 2002	GONE *(GONE 2002c)*	Consensus	No
Regional Energy Strategy (consultation draft)	NE Energy Group (GONE, ONE, NEA) *(TNEI Services and NEA 2003).*	Controversy	n/a
North East Regional Plan for Sport and Physical Activity	Sport England North East *(Sport England North East 2004).*	Consensus	Yes
Regional Waste Strategy (consultation)	NEA *(ERM and NEA 2003)*	Controversy	n/a

Policy/strategy	Lead organization or sector *(reference)*	Suspected* consensus / controversy	Health as a specified main aim? #
North East Framework for Regional Employment and Skills Action/Skills North East Skills Action Plan 05-06	ONE *(ONE 2002a, Skills North East 2005).*	Consensus	No
Sustainable Farming and Food Strategy (consideration)	GONE (SFFS 2006)	Consensus	n/a
Rural Action Plan 2001	ONE, the Countryside Agency, GONE and NEA *(ONE et al. 2001)*	Mixed	No
Regional Image Strategy 2005	ONE *(ONE 2005h)*	Consensus	No
Regional Forest Strategy 2005	GONE *(North East Forestry Action Group 2005)*	Controversy	Yes
Regional Tourism Strategy 2005	ONE. *(ONE 2005e)*	Mixed	No
Teenage Pregnancy Strategy	Health	Consensus	Yes
Regional Culture Strategy 2001	ONE (*Culture North East 2001)*	Consensus	No
North East of England Enterprise Strategy	ONE *(ONE 2001b)*	Consensus	No

**'Suspected' because of discussions in first phase interviews, personal knowledge or awareness of media issues covered.*

 # Only properly applicable to completed strategies.

Annex: analysis of tobacco control policy

This annex describes how tobacco control policy was analysed separately, without the comparison of policy areas that was carried out in the main thesis.

Introduction

A study of regional policy-making in the North East region of England investigated the driving factors and progress of four policy areas during the period of the Labour government from 1997 to 2010. Its focus was *healthy* public policy – policy that did not necessarily develop within the health sector but should benefit the health of the population. Healthy public policy is 'multi-sectoral' and 'participative' (Coombes 1998, 3: 10.2). Over the time period in question, there was a continually increasing emphasis on healthy public policy, both internationally and nationally (for example in *Health in All Policies* (CEC 2007) and *Our Healthier Nation* (Secretary of State for Health 1999)).

Running parallel to this was the gradual transference of decision-making power from central Government to the English regions, following the creation of the Scottish Parliament and Welsh Assembly. 'Reaching Out: the role of central government at regional and local level' (Cabinet Office. Performance and Innovation Unit 2000: Prime Minister's Foreword 1) recommended a stronger role for Government Offices in the regions in pulling together the different arms of central government.

Three main bodies were to become the locus of regional power: Government Offices for the Regions, created in 1994/1995, representing certain government departments (HM Treasury and ODPM 2006); Regional Development Agencies, established during New Labour's first term of office, 'to act as catalysts for economic development' (Pearce, Mawson and Ayres 2008: 443);

and Regional Chambers, which began operating in 1999, following the Regional Development Agencies Act (1998), to provide scrutiny of Regional Development Agencies.

Responsibilities for public health were also reconfigured. The regional public health role had been held by Regional Directors of Public Health based within NHS Executive Regional Offices. The NHS Plan announced the creation of public health groups across NHS regional offices and regional government offices, to 'enable regeneration of regions to embrace health as well as environment, transport and inward investment' (Secretary of State for Health 2000:13.25). Their role included, of particular relevance to healthy policy development,

> 'the development of an integrated multi-sectoral approach to tackling the wider determinants of health; informing regional work on economic regeneration, education, employment and transport, maintaining an overview to ensure that there is proper health contribution to local strategic partnerships' (DH 2001b section 49).

The English regions White Paper (Cabinet Office/DTLR 2002) gave further consideration to the regional public health role:

> 'regional assembly responsibilities in the fields of housing, transport, and economic development have significant links with public health. It is important to ensure that all of these functions ... are tackled in a joined-up manner to address problems and help drive improvements in public health outcomes ... ' (Cabinet Office/DTLR 2002: section 4.47).

The Treasury, which had recognized the detrimental effect of ill-health on national government expenditure on the NHS, as highlighted by Wanless (2002), also increased its interest in the regions, with a focus on economic regional objectives and central/local government interaction around funding streams (Pearce, Mawson and Ayres 2008: 447). By 2005, the government offices had become 'Whitehall's key representatives in the regions' and were

‘regarded as a crucial mechanism for policy coordination and delivery’ (Ayres and Pearce 2005: 584). The role of the Regional Assemblies had also expanded, so that by 2005 they were ‘formally regarded in Whitehall as the legitimate representatives of the region and a key point of focus for the GORs’ (*ibid*.: 588).

It had been expected, at least in some quarters, that the North East would become the first English region to have an elected regional assembly, with considerable political power and influence over many organizations. However, in a North East referendum in 2004, there was a resounding vote against this and plans for elected regional government were shelved. Nevertheless, policy-making power was increasingly devolved to the regional level, with each region expected to develop a range of regional strategies. The terms ‘policy’ and ‘strategy’ appear almost interchangeable at a regional level. (Ritsatakis *et al*. (2000: 3) define ‘policy’ as ‘an agreement or consensus on the issues, goals and objectives to be addressed, the priorities among those objectives and the main directions for achieving them’, whilst they define ‘strategy’ as ‘broad lines of action to achieve the goals and targets’: regional policies or strategies appear to encompass both of these meanings.)

The North East, geographically very distant from Westminster, had the smallest population of England’s nine regions (2.6 million in mid-2007) and one of the smallest areas (8,600 square kilometres). The population is concentrated in three main urban areas, with much of the rest of the region still very rural. The built-up areas have a long history of industrial growth, with ship-building and coal-mining sectors previously huge employers. Now the commercial base is much stronger, although there is still car-production with related manufacturing.

Comparative ill-health has been a feature of the region, along with significant deprivation. As found by the Commission on Public Service Reform in the North East,

> 'Whether in terms of life expectancy, entrance to further education, or unemployment, the North East still lags behind other regions' (IPPR north 2009, Executive Summary).

Public health consultants and practitioners have been known to talk of the region as a great place for public health work because there is plenty of scope for improvement!

The labour government's period of office therefore encompassed an increase in regional policy-making power, a growing focus on healthy policy and a heightened awareness of the links between health and economy. This paper concentrates on developments in the North East region in one particular policy area, tobacco control, considering how policy developed under these new conditions. Tobacco consumption was well known to be a key contributor to ill-health. Compared to other regions, the North East had high rates of smoking and of smoking-related illness and mortality. Smuggling and counterfeit tobacco products were also rife in the area, partly because of the number of ports in the region. So tobacco control was a policy area with particular resonance in the region because of its link with poor health and because it needed very much an integrated approach to address all its issues, for example: the health sector (which provided services to help smokers to stop and services to deal with smoking-related illness); HM Revenue and Customs (concerned with smuggled tobacco and lost revenue); Trading Standards departments (concerning sales to under-age clients and counterfeit cigarettes); those involved in the manufacture, distribution and sales of tobacco products; and employers (concerned with both days lost to sickness and hours lost in smoking breaks).

Hudson (1987) had called for greater focus on inter-organizational (as opposed to intra-organizational) behaviour because collaborative activity in social welfare had become a '*sine qua non* of effective practice' at both practitioner and policy-making levels. He found that an important aspect of collaboration was consensus, which included agreement on specific organizational goals and compatibility of organizational philosophies.

As the extent of collaborative policy-making grew, so did the theories of network analysis, which could 'demonstrate structural effects on policy formation' (Dowding 2001). Government pressure on regional agencies to collaborate in strategic partnerships led to what Rhodes described as government changing from 'government' to 'governance' in the late 20th century, with governance defined as 'self-organizing, interorganizational networks'. (Rhodes 2000: 346). Hudson and Lowe (2004: 128) suggest that the notion of policy being shaped by 'policy networks' is central to this shift from government to governance.

Policy networks involve independent actors (usually from a range of organizations) working together around particular policy areas. Although the characteristics of networks might vary amongst writers, the notions of conflict and of compatible values are core to most. The advocacy coalitions of Sabatier's network-based framework (Sabatier 1988 and revisions1993 and 2007) consist of 'people from various governmental and private organizations who share a set of normative and causal beliefs and often act in concert' (Sabatier 1993:18). Within the policy subsystem, various advocacy coalitions reach decisions and influence policy changes. This approach is designed specifically for a time period in excess of ten years, which fits with the period under consideration here.

Policy networks approaches tend to focus on organizations (statutory or otherwise), so can fail to account for important informal relationships. Greater allowance for this is made by some writers. Adam and Kriesi (2007) suggest a typology of network structure in a policy subsystem comprising two dimensions – actors' attributes or capabilities and the mode of interaction. Capabilities are related to where power resides within the policy subsystem, either with a dominant actor/coalition or shared between actors/coalitions. The model recognizes the existence of interest groups and nongovernmental /social movement organizations as well as state actors, thus taking into account more informal groupings. The interaction dimension relates to the degree of cooperation between actors. Three aspects to this are considered: conflict/competition, bargaining/negotiation and cooperation. Using the two possible capabilities and the three possible interaction states gives rise to six possible types of network structure, each of which can determine the potential for, and the type of, policy change. For example, where there is conflict, if power is concentrated, a coalition with a policy monopoly could dominate smaller, minority coalitions and there is potential for rapid shift in policy. On the other hand, where there is cooperation, there would be much lower potential for change and a tendency to maintain the status quo.

Healthy policies, including tobacco control policies, need inter-organizational networks to achieve the requirement of the White Paper (Cabinet Office/DTLR 2002) for the 'joined up' approach to ensure that public health problems are addressed in regional policies. A network approach to analysis, particularly one taking more account of informal relationships, should shed light on the multi-agency, multi-disciplinary approach to tobacco control.

Methods

The study comprised semi-structured interviews (two phases) and documentary analysis. There were 92 interviews with Chief Executives, directors or senior staff with a key role in North East regional policy development, from a range of organizations: the three main regional policy-making organizations (GONE, ONE and the NEA); the Association of North East Councils (ANEC); academic, business and voluntary sector organizations with a broad remit potentially including the chosen policy areas; and bodies specifically relevant to each policy area (including the Regional Tobacco Office).

First phase interviews focused on the development of healthy public policy in general. Most interviewees described tobacco control as a key policy area for the region and this, along with factors mentioned in the introduction, influenced the choice of tobacco as one of the four specific policy areas that were the focus of the second (policy-specific) phase. Frequently recurring themes also suggested key policy-specific discussion topics: perceived key policy drivers; the nature of the policy area; involvement and joint working; the power or ability to affect policy development; and the regional aspects of policy-making.

Data from transcribed interviews were managed using a spreadsheet system based on ‘Framework’ (Ritchie, Spencer and O’Connor 2003: 220), which provided flexibility, allowing easy access to the raw data, any annotations, and its original context, as well as comprehensive cross-referencing during the iterative process of categorisation. A set of initial categories was created, which was continuously refined, and extra categories created, with subsequent interviews. Cross-referencing was essential, as many elements were very interlinked; early interviews had suggested that the interdependence of factors

was significant and this was idea was not dispelled as the interviews progressed. Whilst overarching themes could be determined, there were also cross-cutting themes that linked or pervaded other themes.

To maintain interviewee anonymity in presenting quotes, four descriptor categories were used, based on interviewees' employer organizations: 'health sector' (statutory health bodies); 'academic sector' (universities and the Public Health Observatory (because of its role with information and data)); 'non-health group' (the three statutory regional agencies and the Association of North East Councils); and 'non-statutory sector' (voluntary and business sectors, including Trade Unions).

Analysis was also carried out on documents, including: agendas and minutes, mainly from the three regional policy-making bodies; completed regional policies and strategies; national legislation, government reports and reports from pressure groups (such as ASH); and organizational newsletters produced for public dissemination or for staff or councillors, outlining organizational progress and activities. Two particular elements were sought in the documents: references to the processes or background of the development of policy (and specifically tobacco control policy); and references to joint working in policy development. Themes arising in these aspects mirrored the themes and categories developed for the interview analysis, so no new categories needed to be created. The joint working references within regional tobacco control policy documents were also useful in verifying that relevant policy-making organizations had been involved in interviews.

Findings

National and North East tobacco control policies

The first regional strategy (Regional Task Force on Tobacco Control 1998) was for the larger region (Northern and Yorkshire) that existed at the start of the Labour Government's time in office. It slightly predated the first national tobacco white paper (Secretary of State for Health *et al*. 1998). With increasing regional involvement in creating national (Department of Health) policy, representatives from the Regional Offices had become part of policy-making groups, meeting regional and national colleagues on a regular basis. Findings from any regional developments, including the Northern and Yorkshire regional tobacco strategy, could thus inform the work of national policymakers. The development of the regional strategy was begun by the Public Health department of the Northern and Yorkshire Regional Office, which had been given funds to support regionally relevant public health initiatives. Smoking-related death and disease had long been recognized as a problem both nationally and within the region, whose related death and disease rates far exceeded national rates. Urgent action was deemed necessary, action specific to the needs and organizational arrangements of the region, so some of the funding was used to pay for a series of regional events, involving a range of agencies, with an aim of creating a strategy to address this.

When the national white paper arrived later the same year (Secretary of State for Health *et al*. 1998), it allocated funds to health authorities within Health Action Zones (almost all of the region's health authorities), ahead of other health authorities, to set up smoking cessation services. Although smoking cessation became a prime focus, the region continued to recognize the need for other aspects of tobacco control. Financing remained an issue and a bid was submitted in 2003 for European funding to establish a regional tobacco

control office, based on a well-publicised model used in California. Although the bid failed, interviewees said that the preparatory work of the agencies involved helped to raise the profile of tobacco control and created a feeling within organizations across the region that they should support a regional tobacco office, so amended plans were carried forward without European funding. The Regional Tobacco Office (Fresh) thus came into being in 2004, notable for its innovative and pioneering approach: no other region had such an office. As with the regional strategy predating the national strategy, recognition of the region's poor situation had created a sense of urgency and led to the region acting ahead of the rest of the country, doing something 'novel and different to meet the challenge which was especially acute in the North East', according to an academic sector interviewee.

Fresh's brief included finalising an updated regional tobacco control strategy (PHGNE 2005), work on which had been under way since 2003/04 (Following reorganization, this applied to a smaller geographical region than the first, namely the North East of England, rather than the Northern and Yorkshire region.) Fresh was to be the 'vehicle for delivering the strategy' (GONE 2004).

Although previous regional strategies had developed ahead of national policy, production of an expected continuation regional strategy was delayed to ensure full consistency (policy alignment) with the national tobacco strategy, *A Smokefree Future* (DH 2010c). (The delays put the strategy development outside the research period.)

Interviewee perceptions and documentary evidence of key policy drivers

All interviewees thought that general health improvement was a fundamental consideration of North East tobacco policy-makers, knowing that the region

experienced worse health and more smoking-related ill-health than other regions. However, hardly any thought this was the key driver. Many believed that the key driver was the economy: reference to the economic imperative to address tobacco occurred frequently very early on in interviews, leading the interviewer to realize that this was a highly significant driver, an impression which was strengthened as further interviews took place. 'I personally think [the key driver] was the cost of the NHS', said one non-statutory sector interviewee.

Many interviewees mentioned the relationship between health and the economy.

> We have these high level strategies which are seeking to move the region forward in a very progressive manner – if you don't address health, the economy will be undermined. (Non-health-group interviewee)

References to the 'enormous cost of tobacco use to our region' (PHGNE 2005: 8) also pervaded tobacco strategy documentation – smoking-attributable costs to the NHS and costs to employers from sickness absence. Regional economic improvement policy increasingly alluded to the strong link between tobacco and poor economic performance. Employability in the region was felt to be one of the main tobacco-related economic drivers.

> The Chamber of Commerce wants high productivity ... – good productivity comes from having a healthy workforce. (Health sector interviewee.)

Several interviewees commented that the policy development process had been shown to work elsewhere when dedicated resources were attached. Many drew attention to the fact that funding was provided for policy development in the region (as distinct from funding for policy implementation). Specific funding was given to support multi-agency events and consultation to develop the Northern and Yorkshire Regional Tobacco Control Strategy (Regional Task Force on Tobacco Control 1998). The second regional policy

(PHGNE 2005) was finalised by the specially-funded Fresh, whose remit included strategy development. This ring-fenced money in the region was felt to contribute to successful development.

Although funding was available for policy development, interviewees raised doubts about other resources, particularly human resources and whether there were enough people with expertise in cross-agency working who could intensify the focus on health during policy development. The role of the previous Regional Health Authority had been around health services regulation, whilst the newer regional office and public health group were to influence regional policy – developing the capacity and collaborative working skills around this would take time, although the siting of the Public Health Group in Government Office was said by several interviewees to have enhanced its position, providing opportunities for formal and informal contact. All interviewees recognized collaborative working as essential to the success of policy development where so many agencies were involved. The policy 'couldn't have happened without partnership', said a non-health group interviewee.

Organizational arrangements were believed to have reduced the capacity and ability of public health professionals to affect policy regionally. The 'very unhelpful' fragmentation of the specialist public health workforce led to what one interviewee called a 'thin resource being spread very thinly across a myriad of PCTs and other organizations'. Primary Care Organizations and Local Authorities covered different geographical areas and there was a two-tier system of local government in two North East counties at the time: it was said to be much easier to work with other agencies when boundaries were common. Interviewees said that the restructuring of organizational boundaries could 'damage strong multi-agency partnerships', where networks have built up over

time and trust has been established. Organizational change could threaten policy development 'if relationships get destroyed', said one academic sector interviewee, while another suggested that reorganization caused 'interpersonal rather than structural problems – temporary problems but causing a lull in momentum'. The way that interviewees spoke of these organizational issues as a serious barrier to successful working, with reorganization adversely affecting relationships between partners and agencies, reinforced the idea that the joint working itself was a major feature of policy-making in the region.

Several interviewees felt that the public view was important in affecting the development of tobacco control policy, with public pressure and a general shift in public attitudes affecting the government's actions in creating tobacco control policy, which in turn influenced regional policy. In particular, the public favoured the smoke-free legislation about to come into effect at the time of the interviews. Regionally, evidence of public support was found in the high numbers of people sending signed postcards to the Government in support of legislation (Fresh 2006: 6).

The effect of the nature of the policy area on policy development

The nature of a policy area encompasses several aspects, including the availability of related evidence, the certainty of the policy's success and the degree of controversy surrounding it.

Many interviewees felt that a strong evidence base was an important reason for progress in tobacco policy, including evidence of the success of policies such as California's policies, on which the setting up of Fresh was based. The long history of evidence of the harm tobacco does to health was mentioned by many, suggesting that although the sheer volume of evidence was influencing policy development, a greater prominence was being given to it because of its

links with the economy and because it was being brought more to people's attention.

> '[The evidence] may have been there before but it was really proactively brought to my attention and to the attention of other influencers'. (Non-statutory sector interviewee)

Interviewees felt certain of policy success because of the evidence and because of the level of support from politicians (national and local), from the health community and from the public. There was felt to be very little opposition to tobacco control policy (with some exceptions, as mentioned later) and this lack of controversy was said to improve the chance of policy success.

The effect on policy development of the way policy-makers worked together

All interviewees referred to the need for multi-agency participation in policy development. Some had roles specifically involving creating or enhancing networks, so that all relevant agencies were involved in policy development.

Interviews and documentation showed that a wide range of organizations – from statutory, voluntary, academic and private sectors – was involved in making tobacco control policy. Several interviewees said that different organizations were able to come and go: one health sector interviewee described it as, 'a very organic process ... the coalition [the group of people involved] was not fixed.' Other respondents said that more people were represented than might be immediately obvious because there were many networks (both formal and informal) across the region that could lead to input from others.

Intentions to build and maintain partnerships in developing policy were stressed in documents, including compacts and concordats between the major

organizations (for example: NHS and GONE 2000; ONE, NEA and GONE 2000; GONE 2006a) and many references in annual organizational reports to strengthening joint working. Interviewees' perceptions that collaboration was happening were supported by a government evaluation, stating that regional chambers had 'fostered strong regional partnerships with local authorities and with a wide range of other stakeholders' and 'exerted an increasing influence in the field of regional policy-making and co-ordination' (ODPM 2005a section 4.3).

Joint working was certainly a part of the region's tobacco strategy development. The main thrust of its first regional tobacco control strategy (Regional Task Force on Tobacco Control 1998) was a wide consultative process (described in Edwards *et al*. 1999), involving a range of people in the region with experience in tobacco control. Consultation took the form of workshops and invitations to statutory, academic and voluntary organizations to comment in writing.

Multi-agency involvement remained important in the 2005/06 regional tobacco strategy (PHGNE 2005). Its consultation, which involved presentations and meetings, received responses from health and local authorities, academic and voluntary agencies, the Tobacco Manufacturers' Association, the Commission for Patient and Public Involvement in Health (CPPIH) and patient forums. Few interviewees felt that there were people omitted from the decision-making processes who should have been involved.

> We were pretty scrupulous about trying to get as many people involved as we could. (Health sector interviewee)

Generally, although some commented on the possible absence of businesses, interviewees felt that private sector involvement was improving but there was

some doubt about the extent of involvement from the voluntary sector, Public involvement (as opposed to the public support mentioned earlier) was not much mentioned by interviewees. An academic sector interviewee suggested that it had been 'very much a professionally driven agenda'.

Almost all interviewees felt that tobacco policy was not really led by the NHS. Although Fresh had acquired the policy lead role, interviewees generally did not suggest it as the lead, probably because it was such a new organization at the time. The local authorities were deemed very important, both individually and through ANEC. There was a general feeling that the joint working was joint, rather than with one dominant partner. One non-statutory sector interviewee said

> All brought something different and something strong to the table. Everybody felt very much that this was a team effort. (Non-statutory sector interviewee)

There was very little mention of particular individuals being significant in North East tobacco policy. Indeed, one health sector interviewee categorically stated that 'it was not down to a single individual'.

How policy development was affected by the ability of stakeholders to help or hinder the process

Most interviewees believed that very few would want to keep tobacco off the agenda, apart from possibly tobacco manufacturers and some retailers (with very strong financial motivation) and the pro-tobacco lobby (for example, FOREST). The recent closure of the region's last large tobacco product manufacturer was felt to have been an advantage to tobacco control. There was more of a feeling that specific actions (rather than policy) met with opposition, for example working men's clubs not wishing to go smoke-free. One health sector interviewee suggested that, although they had expected the

hospitality industry to be an ‘enemy’, involving it in discussions had ensured cooperation.

Many interviewees felt that there was no power to keep tobacco control off the agenda: in particular, the movement towards smoke-free public places had received such political and public support that the related legislation must go ahead.

Several interviewees felt that persuasion rather than power was important and that effort had to be invested in awareness-raising amongst professionals, ensuring that regional decision-makers recognized health as a regional issue: a few felt that their own efforts to raise awareness of tobacco control issues had improved policy development. Tobacco control policy was making progress because

> There has been a real effort to educate, previously not seen as worthwhile. (Non-health group interviewee)

The most important contributions to awareness-raising were generally taken to be the people involved and organizational structures supporting promotion of public health. Getting the attention of the ‘higher reaches of finance and Chief Executives’ was felt to have enhanced support for tobacco control policy.

Interviewees felt that joint working in the region on policy in general was successful also because there was a lot of movement between the main regional organizations, with people seconded or permanently moving from one to another. As the North East was a small region, with only a small number of people involved in regional policy-making, informality was said to have been possible and most contacts were generally felt to have been well established.

One interviewee described the North East as a ‘big village’, where many of the key players knew each other.

Many interviewees commented on the value of joint working to tobacco control policy: it had ‘created commitment to tobacco control policy’; it had ‘reduced duplication of effort by different local organizations’; and it allowed a ‘comprehensive approach to the issue’, with greater access to a range of both help and influence from other organizations. Strongly linked with this was the growing awareness and shared understanding of both health and economic issues. This helped to create the level of consensus already mentioned as a facet of the nature of a policy area. Interviewees said that there was an unusually high level of agreement around the policy-making, so that it developed by a consensus approach, rather than by the imposition of the ideas of one (more powerful) party in an environment of conflict. Only relatively minor disagreements were mentioned: one interviewee mentioned arguments being only over the colour of the logo for the regional tobacco office!

Even varying organizational perspectives (such as a focus on economic growth rather than on general health improvement) do not appear to have adversely affected the high level of agreement between partners. This reflects the importance of the shared understanding of the issues.

Tobacco control policy, and indeed all public health-related policy, was felt to be something that should not stand on its own – joined-up policy, as well as joined-up working, was felt essential. Nationally, tobacco control appeared in many policies, for example the National Service Framework for Mental Health (DH 1999) and the Cancer Reform Strategy (DH 2007b). At a regional level, the development of an Integrated Regional Strategy went some way towards integration of policies in general. Specific to tobacco control, ANEC promised in

its manifesto to work in partnership towards reducing the number of smokers in the region (ANEC 2006b: 9).

Why the North East developed tobacco control policy ahead of national policy

The North East developed its first regional tobacco strategy before the national policy emerged and was also the first region to set up a Regional Tobacco Office. Many of the factors outlined above played a significant part in this advance action. There was growing recognition of the importance of health to the region's economy, and increasing awareness that the North East ranked very low in terms of both health (due in no small way to smoking) and economic performance.

> 'There is a gradual realization in the higher reaches of finance and Chief Executives that the region consistently failed ... this leads to smoking being a top priority.' (Health sector interviewee)

The awareness of the issues provided a spur to action, aided by the injection of funds to help in tobacco strategy development (the first strategy) and the setting up of the Regional Tobacco Office with a strategy-making brief. The awareness-raising, in a relatively small and self-contained region with key players of long-standing known to one another, fostered an environment in which policy development could take place with low levels of disagreement.

Regional strategies were felt to be able to address those issues particularly relevant to the North East, including smoking rates, high rates of mortality and illness and poor economic performance.

> National [policy] addresses 80% of health issues in the North East but not economic policy development - which is not devised to address health policy but is very important for it. (Non-health group interviewee)

Discussion

Several interlinking factors affect the development of tobacco control policy in the North East region. Although health improvement was part of it, the economy was felt to be much more of a spur to action, because of growing recognition of the links between a healthy community and the economy. Tobacco was increasingly recognized as the cause of much of the region's ill-health.

Dedicating resources to the policy-making process was said to have positively influenced development. Several writers (for example Kingdon 1984) stress that policy needs resourcing but this tends to be within the context of implementation rather than development. However, Snape and Taylor (2003) identified targeted funding as a key lever for partnership working in general.

The lack of controversy over tobacco issues was believed to be of great importance in allowing the policy to develop, reflecting Hudson's (1987) finding on the significance of consensus. There was not the conflict (individual, organizational or interorganizational, to use March and Simon's (1993: 132) classes) for whose resolution an exertion of power might be needed. This was very helpful to the policy area, since both Lee (2002: 49) and Benneworth and Tomaney (2002: 140) had suggested that none of the regional organizations possessed the kind of power and control needed for the region's development! The wealth of evidence of the links between tobacco, ill-health and the economy had become known widely enough to reduce potential disagreement.

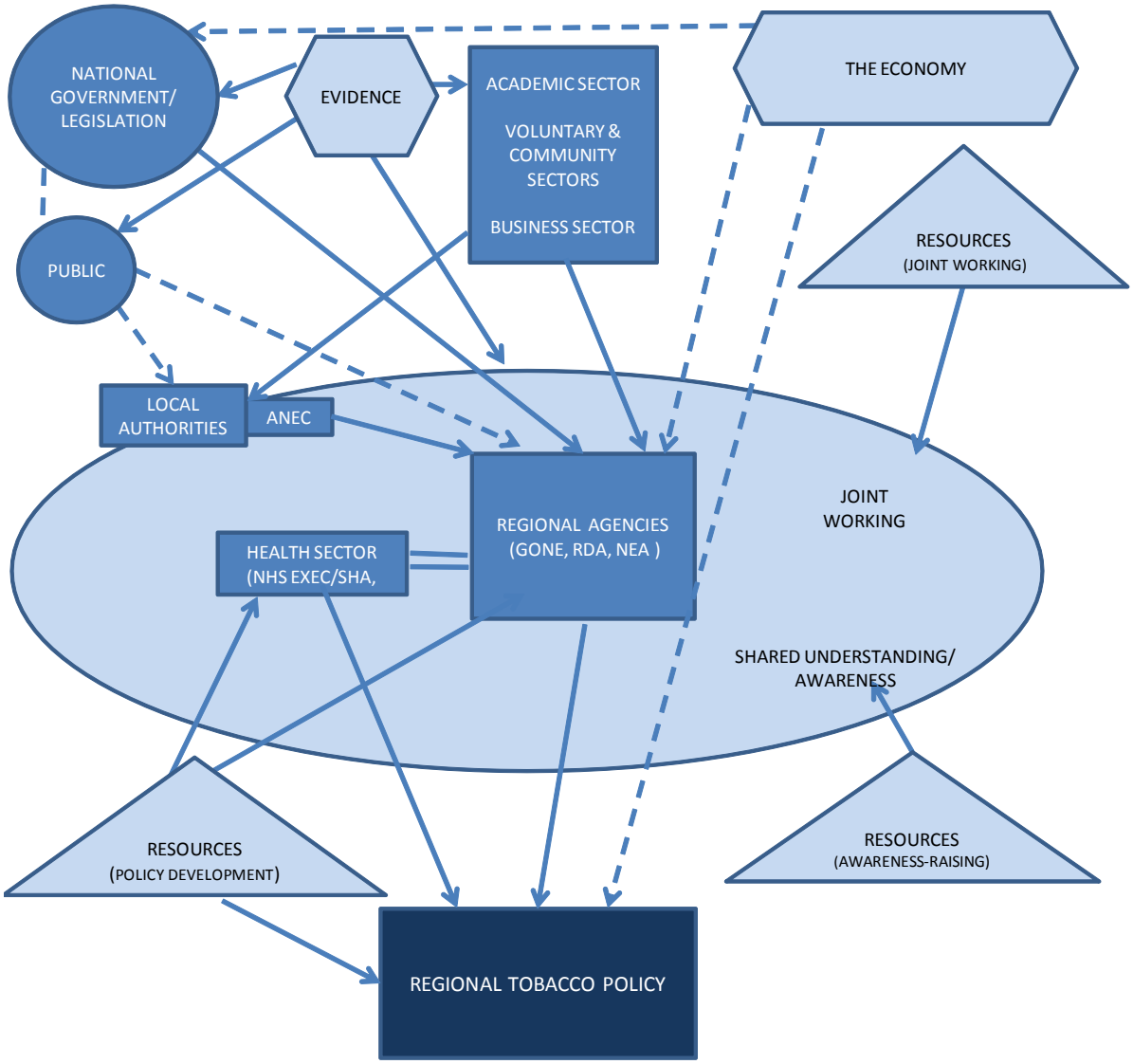
Interviewees pointed to differences between the North East and other regions, including its small size and the interrelatedness of the policy-makers. The North East has frequently been cited as a region that differs from others in terms of

regional identity. Fowler, Robinson and Boniface (2001: 121) suggested that there was ‘a case for considering the North East of England as a distinct cultural region recognizable from the outside, with an identity accentuated by its peripherality in geographical and political terms’. Bond and McCrone (2004: 15) found that the North East’s regional identity affected the way some policies were developed, with its Regional Development Agency’s strategies containing much more in the way of local case studies than other regions.

By far the most important contributor to the success of the policy development was the effective joint working amongst all those agencies and individuals with a role to play in tobacco control. The importance of joint working was stressed by interviewees and in documents, an importance reflected in the literature: Downe and Martin (2006: 465) found that the lack of joined-up policy working caused problems for both local government and central government; Ritsatakis and Järvisalo (2006: 165) stressed the need for skills in working with partners in making healthy policy.

This collaboration involved formal and informal networks and allowed the raising of awareness of the issues amongst all key players. Figure 1 depicts the influences on North East tobacco control policy development.

Annex figure 1: influences on regional tobacco control policy



Organizations are shown as blue rectangles and those responsible for producing the regional policy appear within the large blue oval, where joint working (networking) and awareness-raising (and advocacy) are paramount. The influences of the public and government are indicated by arrows from the blue circles.. Resources for policy development (shown as blue triangles) are enablers for the organizations, for the policy itself and for joint working. The pervasive influence of evidence and of the economy is indicated by arrows from the blue hexagons.

The term ‘policy network’ could describe the arrangement for tobacco control policy development in the North East - independent actors (usually from a range of organizations) working together around particular policy areas (Adam

and Kriesi 2007: 132). The focus with policy networks, however, tends to be on the institutions from which the actors come, rather than the actors as individuals (Schlager 2007: 298). Certainly the interrelationships between organizations in the North East region are important: interviewees criticised organizational structures and reorganizations for adversely affecting working relationships. That this focus loses sight of individual contributions is perhaps not the most important issue, given that findings indicated that the drive towards policy-making was generally not from single individuals. More importantly, it is difficult to identify where to situate in the framework the effects of factors such as the economy, resources for policy development, existence of evidence and the character of the region, all of which were found to be significant. The approach also underplays the impact of the awareness-raising aspect, found to play a major role.

The tobacco control policy situation could be described as an advocacy coalition: ‘people from various governmental and private organizations who share a set of normative and causal beliefs and often act in concert’ (Sabatier 1993:18). (Nothing in the findings indicated that it would be inappropriate to replace ‘governmental’ by ‘regional governmental’.) This sharing of normative and causal beliefs implies a heightened awareness of the values and beliefs of others, possibly allowing greater consideration of the awareness-raising aspect than general network approaches, Many aspects of the framework do ring true for the region’s tobacco control policy, particularly the multitude of external as well as subsystem-specific factors. There is a minor difficulty with the idea of aggregating the actors within the subsystem into separate advocacy coalitions for the advocacy coalition framework: fewer actors are involved than for national policy-making so that the grouping might be very unbalanced or even pointless. Yet would regarding the policy system as just one advocacy coalition be appropriate? More significantly, it shares with general network

frameworks the problem of identifying where to situate the impact of those other factors that were found to be very important influences. Nor does it take much account of the informal networking deemed important within the North East.

Adam and Kriesi (2007)'s typology of network structure has some applicability. For tobacco control policy within the North East, there was not one dominant actor – power was fragmented. Cooperation was the general mode of working, rather than conflict or bargaining. Accordingly, the model would refer to the situation as 'horizontal cooperation' and suggests that this gives low to moderate potential for policy change, with a tendency to maintain the status quo. Although the category might be appropriate, this is clearly not what happened within the region: policy development was proactive and ahead of the rest of the nation, both in developing strategy and establishing a dedicated tobacco office with a remit for strategy development. Nor does the model sufficiently account for the other influential factors,

Findings, therefore, present challenges for these existing frameworks: none allows emphasis on the influential factors such as the economy, resources and the regional character; general networks and advocacy networks focus too much on institutions or organizations and do not sufficiently account for the informal networks that play a significant part in the North East, aided by the small size of the region and the movement of a limited number of key players across and between roles and organizations. Adam and Kriesi (2007)'s typology falls short not so much in its ability to deal with informal networks but in suggesting that maintenance of the status quo would be the outcome for a network in the category to which North East tobacco control policymaking would be allocated.

There are questions around the suitability for regional policy of models generally developed for national governmental policy analysis. Although joint working has long been recognized as an important factor in policy-making, its value as a factor in policy-making at an English regional level has received little attention, particularly in terms of considering specific policy areas. Informal as well as formal joint working arrangements are very significant, although the character of the region, especially with the relatively small policy communities and related scope for informality, might be unlike others in this respect: informality was said to be possible because all the stakeholders knew one another and had often moved between organizations in the region. The context of the relationships affects the relationships themselves.

Particularly highlighted in this research is the awareness-raising, both formal and informal, allowing all players to grasp the importance of tobacco control not just to health but to the economy. The need for capacity and skills to enable awareness-raising across the range of decision-makers has also been found to be significant: Banken (2001:4) identified inadequate understanding of health determinants as a major barrier to intersectoral collaboration. The provision of resources specifically for policy development (rather than implementation) had a sizeable effect on the development of awareness-raising skills and capacity. The influence of the economic argument on what might seem to be a predominantly health-related problem suggests that there are more important connections between policy areas than previously recognized.

These contributions to theory might well translate to practice – for example in the provision of resources for policy development, for joint working and for awareness-raising and a greater focus on linking the economic driver with health improvement. Whether this is at all possible at any kind of regional level, given recent or proposed changes in regional government arrangements

(for example, the demise of regional assemblies, regional development agencies and strategic health authorities, and the relocation of much of the public health function to a local authority level), remains to be seen.

This paper has shown how the development of tobacco control policy in the North East of England has been influenced by many factors, including: ring-fenced resources for policy development; a substantial evidence base; and the character of the region itself – a small region, comparing badly to other regions in terms of health and economy, and a relatively small pool of policy-makers generally known to one another. These factors have fostered highly successful joint working, leading to (and enhanced by) a level of awareness amongst key players about the links between health and the economy, with regional economic improvement thus very much a driver of tobacco policy development. Tobacco control policy has developed in advance of the rest of the country because of the combined effects of all of the factors on the region's policy-makers and their ability to work collaboratively.

References

Adam, S. and Kriesi, H. (2007) The Network Approach. In: Sabatier, P.A. (ed.) (2007) *Theories of the Policy Process*. 2nd edition. Boulder: Westview Press. pp. 129-154.

Ader, C. (1995)' A longitudinal study of agenda-setting for the issue of environmental pollution.' *Journalism and mass communication quarterly* **72**(2): 300-311

Adshead, F. (2005), cited in 'conference news'*. Public Health News*, 12 Dec 2005

Alcock, P. (2008) *Social Policy in Britain*. 3rd edition. Basingstoke and New York: Palgrave Macmillan.

Alford, R. (1969) 'Bureaucracy and Participation: political cultures in 4 Wisconsin cities.' *American Politics Research Series*. Chicago: Rand McNally and Company.

Ali, S. and Kelly, M. (2004) 'Ethics and social research.' in Seale, C. (ed.) (2004) *Researching Society and Culture*. 2nd edition. London, Thousand Oaks, New Delhi: Sage. pp 115-127.

Allison, G. and Zelikov, P. (1999) *Essence of Decision. Explaining the Cuban Missile Crisis*. 2nd edition. New York, Reading, Menlo Park, Harlow, Don Mills, Sydney, Mexico City, Madrid, Amsterdam: Addison Wesley Longman

Amos, A. (2007) 'From self-regulation to legislation: the social impact of public health action on smoking.' in Scriven, A. and Garman, S. (eds*.) Public Health: social context and action.* Maidenhead and New York: McGraw Hill Open University Press. pp 193-205.

Andonova, L.B. (2006) 'Structure and influence of international assessments: lessons from Eastern Europe.' in Mitchell, R.B., Clark, W.C., Cash, D.W. and Dickson, N.M. (eds.) (2006) *Global Environmental Assessments. Information and influence*. Cambridge (Massachusetts) and London: The MIT Press. pp. 151-173.

ANEC (Association of North East Councils) (2002) *Corporate Plan 2002-04.* Newcastle upon Tyne: Association of North East Councils.

ANEC (Association of North East Councils) (2004a) *Corporate Plan 2004/05.* Newcastle upon Tyne: Association of North East Councils.

ANEC (Association of North East Councils) (2004b) *Association Review 03/04: Building on progress*. Newcastle upon Tyne: Association of North East Councils.

ANEC (Association of North East Councils) (2005) *Association of North East Councils 2005/06 Manifesto.* Newcastle upon Tyne: Association of North East Councils.

ANEC (Association of North East Councils) (2006a) *Dialogue* issue1. Newcastle upon Tyne: Association of North East Councils.

ANEC (Association of North East Councils) (2006b) *Association of North East Councils 2006/07 Manifesto.* Newcastle upon Tyne: Association of North East Councils.

ANEC (Association of North East Councils) (2006c) *Green Manifesto: well-being, health and the environment*. Newcastle upon Tyne: Association of North East Councils.
ANEC (Association of North East Councils) (2007a) *Report on key findings and recommendations of the Employability Task and Finish Group.* Newcastle upon Tyne: Association of North East Councils.
ANEC (Association of North East Councils) (2007b) *The year in highlights. 2006/07.* Newcastle upon Tyne: Association of North East Councils.
ANEC (Association of North East Councils) (2007c) *Climate change: our commitment to a greener future.* Newcastle upon Tyne: Association of North East Councils.
ANEC (Association of North East Councils) (2008a) *Climate change: key findings and recommendations of the Climate Change Task and Finish Group*. Newcastle upon Tyne: Association of North East Councils.
ANEC (Association of North East Councils) (2008b) *Corporate plan 2008-11* Newcastle upon Tyne: Association of North East Councils.
ANEC (Association of North East Councils) (2008c) *A picture of the year's Highlights - annual report 2007/08.* Newcastle upon Tyne: Association of North East Councils
ANEC (Association of North East Councils) (2009) *Revised Business Plan 09-11* Newcastle upon Tyne: Association of North East Councils.
Anyadike-Danes (2004) 'The real North-South divide? Regional gradients in UK male non-employment.' *Regional Studies* **38**(1):85-95
arc^4 (2007) (for Tyne and Wear Housing Partnership) Tyne *and Wear Sub Regional Housing Strategy 2007-2012.* Manchester: arc^4.
Armstrong, H. (2000) Regional Assemblies in House of Commons Debate, 21st February 1996. Hansard Volume **272,** column 320.
ASH (Action for Smoking and Health) (2008) *Beyond Smoking Kills: protecting children, reducing inequalities*. London: ASH
Asthana, S., Richardson, S and Halliday, J. (2002) 'Partnership working in public policy provision: a framework for evaluation.' *Social Policy and Administration* **36**(7): 780-795.
Audit Commission and Healthcare Commission (2008) *Are we choosing health? The impact on the delivery of health improvement programmes and Services*. London: Commission for Healthcare Audit and inspection.
Ayres, S., Mawson, J. and Pearce, G. (2002) 'Institutional collaboration in the West Midlands region' in Tomaney, J. and Mawson, J. (eds.) (2002) *England – the State of the Regions*. Bristol: The Policy Press.
Ayres, S. and Pearce, G. (2003) *The English Regions White Paper: assessing its implications for transport.* Birmingham: Devolution and Constitutional Change Programme. (Devolution Policy Paper No. 8).
Ayres, S. and Pearce, G. (2004) 'Devolution to the English regions: assessing its implications for transport.' *The Town Planning Review* **75**(2): 231-255.
Ayres, S. and Pearce, G. (2005) 'Building regional governance in England: the view from Whitehall.' *Policy and Politics* **33**(4): 581-600.
Bachrach, P. and Baratz (M.S. (1962) 'Two faces of power.' *The American*

Political Science Review **56**(4): 947-952.
Bachrach, P. and Baratz, M.S. (1963) 'Decisions and Nondecisions: an analytical framework.' *The American Political Science Review* **57**(3): 632-642.
Baggott, R. (2000) *Public health: Policy and Politics*. Basingstoke and New York: Palgrave Macmillan.
Baggott, R. (2007) *Understanding Health Policy.* Bristol: The Policy Press.
Bailey, K., Chappel, D. and Sher-Arami, D. (2005) *A Rapid Health Impact Assessment of the Draft Regional Economic Strategy (June 2005).* North East Public Health Observatory.
Banfield, E.C. (1961) *Political Influence*. New York: The Free Press.
Banken, R. (2001). 'Strategies for institutionalizing HIA. ECHP HIA Discussion paper 1.' *ECHP Health Impact Assessment Discussion Papers*. Brussels: European Centre for Health Policy, WHO Regional Office for Europe.
Banta, H.D. and Andreasen, P.B. (1990) 'The political dimension in health care technology assessment programs.*' International Journal of Technology Assessments in Health Care* **6**(1): 115-123.
Bardach, E. (2006) 'Policy Dynamics.' in Moran, M., Rein, M. and Goodin, R.E. (eds.) *The Oxford Handbook of Public Policy*. Oxford: Oxford University Press. pp 336-366.
Barker, K. (2004) *Review of housing supply: delivering stability: securing our future housing needs: final report - recommendations*. London: The Stationery Office.
Baumgartner, F. and Jones, B. (1993) *Agendas and instability in American Politics*. Chicago and London: University of Chicago Press.
Baumgartner, F., Green-Pedersen, C. and Jones, B. (2006) 'Comparative studies of policy agendas.' *Journal of European Public Policy* **13**(7): 959-974'
Beaglehole, R. and Bonita, R. (2004) *Public Health at the Crossroads. Achievements and prospects*. 2nd edition. Cambridge: Cambridge University Press.
Beatty, C. and Fothergill, S. (2005) 'The diversion from "unemployment" to "sickness" across British regions and districts.' *Regional Studies* **39**(7): 837- 854.
Bennett, R.J. (1998) 'Explaining the membership of voluntary local business associations: the example of British Chambers of Commerce.' *Regional Studies* **32**(6): 503-514.
Benneworth, P. and Tomaney, J. (2002) 'Regionalism in North East England.' in Tomaney, J. and Mawson, J. (eds.) (2002*) England – the State of the Regions.* Bristol: The Policy Press.
Bhatt, C. (2004) 'Doing a dissertation.' in Seale, C. (ed.) (2004) *Researching Society and Culture*. 2nd edition. London, Thousand Oaks, New Delhi: Sage pp 409-430.
Biggam, J. (2008) *Succeeding with Your Master's Dissertation.* Maidenhead and New York: Open University Press, McGraw Hill.
Birkland, T.A. (2005) *Introduction to the policy process: theories, concepts and*

models of public policy-making. 2nd edition. New York: M.E. Sharpe Inc.
Birley, M. (2002) 'A review of trends in health-impact assessment and the nature of the evidence used.' *Environmental Management and Health* **13**(1): 21-39
Black, C. (2008) *Working for a healthier tomorrow: Dame Carol Black's review of the health of Britain's working age population*. London: The Stationery Office.
Black, N. (2001) 'Evidence based policy: proceed with care.' *British Medical Journal* **323**(7307): 275-278.
Blackman, T. and Ormston, C. (2005) 'Discourses of accountability: policy scrutiny of an English regional development agency.' *Regional Studies* **39**(3): 375-386.
Blakemore, K. (2003) *Social Policy: an introduction*. 2nd edition. Buckingham and Philadelphia: Open University Press.
Blakemore, K. and Griggs, E. (2007) *Social Policy: an introduction*. 3rd edition. Maidenhead and New York: Open University Press, McGraw Hill.
Bloch, A. (2004) 'Doing social surveys.' in Seale, C. (ed.) (2004) *Researching Society and Culture*. 2nd edition. London, Thousand Oaks, New Delhi: Sage. pp. 163-178.
Bond, R., Curran, J., Kirkpatrick, C., Lee, N. and Francis, P. (2001) 'Integrated impact assessment for sustainable development: A case study approach.' *World Development* **29**(6): 1011-1024.
Bond, R. and McCrone, D. (2004) 'The growth of English regionalism? Institutions and identity.' *Regional and Federal Studies* **14**(1): 1-25.
Bowen, C. (2007) 'Health impact assessments in London: assessing the London Mayoral strategies.' *NSW Public Health Bulletin* 18(9-10): 185-7.
Breeze, C. and Hall, R. (2002). 'Health impact assessment in government policy-making: developments in Wales.' *Policy Learning Curve Series No. 6*. Copenhagen: WHO (World Health Organization) Regional Office for Europe.
Bridges, T. (2002) 'The South West.' in Tomaney, J. and Mawson, J. (eds.) (2002) *England – the State of the Regions*. Bristol: The Policy Press.
Brown, J.S. (2003) unpublished facilitator notes taken during Integrated Policy Appraisal on North East Regional Housing Strategy, 26/3/2003.
Budd, L. (1997) 'Regional government and performance in France.' *Regional Studies* **3**1(2): 187-192.
Buse, K., Mays, N. and Walt, G. (2005) '*Making Health Policy'*. Maidenhead: Open University Press. 'Understanding public health' series (editors: Black, N. and Raine, R.)
Byrne, B. (2004) 'Qualitative interviewing.' in Seale, C. (ed.) (2004) *Researching Society and Culture*. 2nd edition. London, Thousand Oaks, New Delhi: Sage. pp 179-192.
Byrne, D. (2004). *Enabling good health for all. A reflection process for a new Health Strategy.* European Commission. http://europa.eu.int/comm/health/ph_overview/strategy/health_strategy_en.htm, 27/9/04
Cabinet Office/ DTLR (Department for Transport, Local Government and the

Regions) (2002) *Your region, your choice: revitalising the English regions*. [White paper]. London: The Stationery Office.
Cabinet Office, ODPM (Office of the Deputy Prime Minister (2002) *Incorporating regional perspectives into policy-making Toolkit: Transforming Public Services - A Civil Service that delivers*. London: Cabinet Office.
Cabinet Office. Performance and Innovation Unit (2000). *Reaching Out: the role of central government at regional and local level*. London: The Stationery Office.
Cabinet Office Viewfinder: *Viewfinder: a policy maker's guide to public involvement.* Policy Hub website, last accessed 7/7/2010 www.nationalschool.gov.uk/policyhub/docs/Viewfinder.pdf
Carpenter, R.C. (2007) 'Setting the advocacy agenda.' *International Studies Quarterly* **51**(1): 99-120.
CBI (Confederation of British Industry) (2010) website (accessed 5/2/10) http://www.cbi.org.uk/ndbs/staticpages.nsf/StaticPages/home.html/?OpenDocument
CEC (Commission of the European Communities) (2000) *Communication from the Commission to the Council, the European Parliament, the Economic and Social Committee and the Committee of the Regions on the health strategy of European Community*. Brussels: CEC.
CEC (Commission of the European Communities) (2007) [White paper] *Together for health: a strategic approach for the European Union 2008-2013* (COM (2007) 630 final.) Brussels: CEC.
Central Liverpool NHS PCT, North Liverpool NHS PCT, South Liverpool NHS PCT, The City of Liverpool Council, Strategic Housing Partnership in Liverpool and Liverpool partnership group (2003) *Health impact assessment of Liverpool City Council's Housing Strategy Statement. Final report.* Liverpool: Liverpool City Council.
Chapman, J. (2002) *System failure*. *Why governments must learn to think differently*. London: Demos.
Chappel, D. and K. Bailey (2004). *A framework for health? A screening Health Impact Assessment of the pre-consultation draft of the Regional Spatial Strategy*. Thornaby: North East Public Health Observatory.
Chuengsatiansup, K. (2003). 'Spirituality and health: an initial proposal to incorporate spiritual health in health impact assessment.' *Environmental Impact Assessment Review* **23**(1): 3-15
Cobb, R.W. and Elder, C.D. (1972) *Participation in American politics and the dynamics of agenda-building.* Baltimore: The Johns Hopkins University Press.
Cohen, M.D., March, J.G. and Olsen, J.P. (1972) 'A garbage can model of organizational choice.' *Administrative Science Quarterly* **17**(1): 1-25.
Committee of Inquiry into the Future Development of the Public Health Function (1988). *Public Health in England. Report of the Committee of Inquiry into the Future Development of the Public Health Function* [Cm289]. London: HMSO.
Considine, M. (2005*) Making Public Policy*. Cambridge: Polity Press.

Coombes, Y. (1998) *Foundations of health promotion*. Module 3 of Health Systems and Health Policy unit for MSc in Health Systems Management. London School of Hygiene and Tropical Medicine. London: University of London.
Counsell, D. and Bruff, G. (2001) 'Treatment of the environment in regional planning: a stronger line for sustainable development?' *Regional Studies* **35**(5): 486-492.
Crawley, F. K. and Ashton, D. (2002). 'Safety, health or the environment—which comes first?' *Journal of Hazardous Materials* **93**(1): 17-32.
CRC (Churches Regional Commission) and NEEF (North East Employment Forum) (2000) *Building bridges to employment in the North East*. Durham: Churches Regional Commission in the North East
Crenson, M. (1971) *The Un-politics of Air Pollution*. Baltimore: The John Hopkins Press.
Crowe, M. and D. Carlyle, D. (2003) 'Deconstructing risk assessment and management in mental health nursing.' *Journal of Advanced Nursing* **43**(1): 19-27.
Crowley, P. and Hunter, D.J. (2005) 'Putting the public back into public health.' *Journal of Epidemiology and Community Health* **59**: 265-267.
Culture North East (2001) *Culture North East: regional cultural strategy for the North East of England 2001-10.* Newcastle upon Tyne: Culture North East secretariat.
Daft, R.L. and Marcic, D. (1995) *Understanding Management*. 2nd edition. Fort Worth, Philadelphia, San Diego, New York, Orlando, Austin, San Antonio, Toronto, Montreal, London, Sydney, Tokyo: The Dryden Press (Harcourt Brace and Company.)
Dahl, R. (1958) 'A critique of the ruling elite model.*' American Political Science Review* **52**: 463-469.
Dahl, R.A. (1961) *Who Governs? Democracy and Power in an American City*. New Haven and London: Yale University Press.
Dahl, R. and Lindblom, C. (1953) *Politics, economics and welfare*. New York: Harpers.
Dahlgren, G., Nordgren, P. and Whitehead, M. (1996) *Health Impact Assessment of the EU Common Agricultural Policy (Summary).* Swedish National Institute of Public Health.
Dannenberg, A.L., Bhatia, R., Cole, B.L., Heaton, S.K., Feldman, J.D., Rutt, C.D. (2008) 'Use of health impact assessment in the U.S.: 27 case studies, 1999-2007.' *American Journal of Preventive Medicine* **34**(3):241-56.
Dargan, L. (2009) 'Participation and local urban regeneration: the case of the New Deal for Communities (NDC) in the UK.' *Regional Studies* **43**(2): 305-317.
Davenport, C., Mathers, J., Parry, J. (2006) 'Use of health impact assessment in incorporating health considerations in decision making.*' Journal of Epidemiology and Community Health* **60**(3): 196-201.
Davies, L., Coyle, D., Drummond, M. and the EC Network on the methodology of Economic Appraisal of Health Technology (1994). 'Current status of

economic appraisal of health technology in the European Community: report of the network.' *Social Science and Medicine* **38**(12): 1601-7.
Davies, J.S. (2009) 'The limits of joined up government: towards a political analysis.' *Public Administration* **87**(1): 80-96.
DCLG (Department for Communities and Local Government) (2006) *Strong and Prosperous Communities: the Local Government white paper.* [Cm 6939] Norwich: The Stationery Office.
DCLG (Department for Communities and Local Government) (2007) *Homes for the future: more affordable, more sustainable.* [Housing green paper Cm 7191] London: The Stationery Office.
DCLG (Communities and Local Government) and BERR (Department for Business Enterprise and Regulatory Reform) (2008) *Prosperous places: taking forward the review of sub-national economic development and regeneration. The government response to public consultation.* London: The Stationery Office.
DCLG (Communities and Local Government) and DEFRA (Department for Environment, Food and Rural Affairs) (2007) *Climate change and sustainability: the crucial role of the new local performance framework.* Wetherby: Department for Communities and Local Government.
DEFRA (Department for Environment, Food and Rural Affairs) (2004) *Rural white paper – regional case studies – North East.* London: Department for Environment, Food and Rural Affairs.
DEFRA (Department for Environment, Food and Rural Affairs) (2006) *Securing the Regions' Futures: strengthening delivery of sustainable development in the English regions*. London: Department for Environment, Food and Rural Affairs.
Devine, F. (2002) 'Qualitative methods' in Marsh, D. and Stoker, G. (eds.) (2002) *Theory and Methods in Political Science*. 2nd edition. Basingstoke and New York: Palgrave Macmillan. pp 197-215. (Political Analysis series edited by Peters, B.G., Pierre, J. and Stoker, G.)
DH (Department of Health) (1996). *Policy appraisal and health: a guide for policy makers.* London: HMSO.
DH (Department of Health) (1999) *A National Service Framework for Mental Health: modern standards and service models.* London: Department of Health.
DH (Department of Health) (2000) *National Service Framework for Coronary Heart Disease: modern standards and service models.* London: Department of Health.
DH (Department of Health) (2001a) *The Report of the Chief Medical Officer's Project to Strengthen the Public Health Function*. London: Department of Health.
DH (Department of Health) (2001b) *Shifting the Balance of Power within the NHS: securing delivery.* London: Department of Health.
DH (Department of Health) (2002) *Shifting the Balance of Power: the Next Steps.* London: Department of Health.
DH (Department of Health) (2003). *Tackling Health Inequalities: a Programme*

for Action. [Cm 6374] London: Department of Health.
DH (Department of Health) (2004a) *Choosing Health: Making Healthy Choices Easier.* London: Department of Health.
DH (Department of Health) (2004b) *National Service Framework for Children, Young People and Maternity Services.* London: Department of Health.
DH (Department of Health) (2005a) *Delivering Choosing Health: Making Healthy Choices Easier.* London: Department of Health.
DH (Department of Health) (2005b) *Independence, well-being and choice: our vision for the future of social care for adults in England.* [Social care green paper Cm 6499] Norwich: The Stationery Office.
DH (Department of Health) (2006) *Our health, our care, our say: a new direction for community services.* [White paper Cm 6737] Norwich: The Stationery Office.
DH (Department of Health) (2007a) *Health is global: proposals for a UK government-wide strategy.* London: Department of Health.
DH (Department of Health) (2007b) *Cancer Reform Strategy*. London: Department of Health.
DH (Department of Health) (2008) *Consultation on the future of tobacco control. Consultation Report: December 2008.* London: Department of Health.
DH (Department of Health) (2009) *Tackling health inequalities: 10 years on. A review of developments in tackling health inequalities in England over the last 10 years.* London: Department of Health.
DH (Department of Health) (2010a) *Putting health into the policy picture: review of how health impact assessment is carried out by Government departments*. London: Department of Health.
DH (Department of Health) (2010b) *Equity and excellence: liberating the NHS.* [NHS white paper Cm 7881] Norwich: The Stationery Office.
DH (Department of Health) (2010c) *A Smokefree Future: a Comprehensive Tobacco Control Strategy for England.* Gateway reference 12863.
DHSS (Department of Health and Social Security) (1976*) Prevention and Health: Everybody's Business*. London: HMSO.
DHSS (Department of Health and Social Security) (1977*) Prevention and Health* [Cmnd 6233] London: HMSO.
Dixon, L. (2006) 'The representative role of regional business associations: the Engineering Employers' Federation Northern Association in North East England.' *Regional and Federal Studies* **16**(2): 179-196.
Dora, C. and Racioppi, F (2002) 'Health impact assessment as part of strategic environmental assessment: Moving the European policy framework towards a greater integration of health consideration in the development of policies, plans and programs.' *Epidemiology* **13**(4): Supplement S130 (item 280).
Dora, C. and Racioppi, F. (2003) 'Including health in transport policy agendas: the role of health impact assessment analyses and procedures in the European experience.' *Bulletin of the World Health Organization* **81**(6): 399- 403.

Dowding, K. (2001) There must be end to confusion: policy networks, intellectual fatigue, and the need for political science methods courses in British universities*. Political Studies* 49: 89-105.
Downe, J. and Martin, S. (2006) 'Joined up policy in practice? The coherence and impacts of the local government modernisation agenda.' *Local government studies* **32**(4): 465-488.
Downs, A. (1972) 'Up and down with ecology – the "issue-attention cycle". *Public Interest* **28**: 38-50.
DWP (Department for Work and Pensions) (2006), *New Deal for Welfare: empowering people to work*. London: The Stationery Office.
DWP (Department for Work and Pensions) (2008a) *No-one written off: reforming welfare to reward responsibility: public consultation* [Green Paper Cm 7363] Norwich: The Stationery Office.
DWP (Department for Work and Pensions) (2008b) *Raising expectations and increasing support: reforming welfare for the future.* [White paper Cm 7506] London: The Stationery Office.
DWP (Department for Work and Pensions) (2010) website (accessed 25/2/2010) http://www.dwp.gov.uk/policy/welfare-reform/health-work-and-well-being/
DWP (Department for Work and Pensions), DH (Department of Health) and HSE (Health and Safety Executive) (2005) *Health, work and well-being: caring for our future: a strategy for the health and well-being of working age people.* London: DWP, DH and HSE.
Earwicker, R. (2007) 'Progress in tackling health inequalities: a policy maker's reflections.' in Dowler, E. and Spencer, N. (eds.) *Challenging health inequalities. From Acheson to "Choosing health"*. Bristol: the Policy Press. pp 17-30.
Eaton Baier, V., March, J.G. and Saetren, H. (1986) 'Implementation and ambiguity.' *Scandinavian Journal of Management Studies* **2**(3-4): 197-212.
Edwards, R., Brown, J.S., Hodgson, P., Kyle, D., Reed, D. and Wallace, B. (1999). 'An action plan for tobacco control at regional level.' *Public Health* **113**: 165-170.
Elcock, H. (2008) 'Regional futures and strategic planning.' *Regional and Federal Studies* **18**(1): 77-92.
Employment and health group Easington and Sedgefield (2004). *A business approach to workforce ill health. A breakfast event for GPs and employers in Easington and Sedgefield.* Events held 27/4/2004 and 6/5/2004 Easington NHS PCT and Sedgefield NHS PCT.
ERM (Environmental Resources Management) and NEA (North East Assembly) (2003) *Towards a waste strategy for the North East. Consultation summary.* Newcastle upon Tyne: North East Assembly.
ERM (Environmental Resources Management) (2005) *Regional Spatial Strategy for the North East. Final report of the sustainability appraisal. .* Newcastle upon Tyne: *North East Assembly*
European Centre for Health Policy (1999). *Health impact assessment: main concepts and suggested approaches.* Gothenburg: World Health

Organization.
Evans, R.G. and Stoddart, G.L. (1990) 'Producing health, consuming health care.' *Social Science and Medicine* **31** (12): 1347-1363.
Evans, D. (2003) 'New directions in tackling inequalities in public health.' in Orme, J., Powell, J., Taylor, P., Harrison, T. and Grey, M. (eds.) (2003*) Public Health for the 21st Century. New perspectives on policy, participation and practice*. Maidenhead: Open University Press. pp 163-176.
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.
Fitzgerald, I. and O'Brien, P. (2003) 'Trade Unions and regional development.' *Northern Economic Review* **33/34**: 19-31.
Fowler, P., Robinson, M. and Boniface, P. (2001) 'Pride and prejudice: two cultures and the North East's transition.' in Tomaney, J. and Ward, N. (eds.) (2001) *A region in transition: North East England at the Millennium*. Aldershot: Ashgate.
Francis, N., Dyer, S., Egbeare, D. and Kilduff, C. (2001) 'Health impact assessment.' *Journal of Public Health Medicine* **23**(2): 164-5.
Fresh (2006) *Annual report 2005/06*. Chester-le-Street: Fresh – Smoke Free North East.
Fresh (2007) *Fresh Smoke Free North East Business plan 2007-08.* Chester-le-Street: Fresh – Smoke Free North East.
Fresh (2008a) *Fresh Smoke Free North East Business plan 2008-09.* Chester-le-Street: Fresh – Smoke Free North East.
Fresh (2008b) *Smokefree Journey: a diary of events April 2006 – March 2008.* Chester-le-Street: Fresh – Smoke Free North East.
Fresh (2009) *Fresh Smoke Free North East Regional delivery plan 2009.* Chester-le-Street: Fresh – Smoke Free North East.
Freud, D. *Reducing dependency, increasing opportunity: options for the future of welfare to work. An independent report to the Department for Work and Pensions.* Leeds: HMSO.
Gallent, N. (2009) 'New agendas in planning and rural housing.' *Planning practice and research* **24**(2): 153-159.
Gilmore, A., McKee, M. and Pomerleau, J. (2005) in Pomerleau, J. and McKee, M. (eds.) (2005) *Issues in Public Health*. Maidenhead and New York: Open University Press. pp 173-190.
Giordano (2002) 'England's North West' in Tomaney, J. and Mawson, J. (eds.) (2002) *England – the State of the Regions*. Bristol: The Policy Press.
Glendinning, C. (2002) 'Partnerships between health and social services: developing a framework for evaluation.*' Policy and Politics* **30**(1): 115-127.
Gochfeld, M. and Goldstein, B.D. (1999) 'Lessons in environmental health in the twentieth century.' *Annual Review of Public Health* **20**: 35-53.
GONE (Government Office for the North East) (2002a).*Vision and Values Statement: September 2002*. Newcastle upon Tyne: Government Office for the North East.
GONE (Government Office for the North East) (2002b*) Regional Planning*

Guidance for the North East to 2016 (RPG1). (Became draft *statutory Regional Spatial Strategy* in 2004) London: The Stationery Office.
GONE (Government Office for the North East) (2002c) *Reducing reoffending in the North East: the regional resettlement strategy.* Newcastle upon Tyne: Government Office for the North East.
GONE (Government Office for the North East) (2003) *Annual Report 2002/03.* Newcastle upon Tyne: Government Office for the North East.
GONE (Government Office for the North East) ((2004) *Annual report 2003/04.* Newcastle upon Tyne: Government Office for the North East.
GONE (Government Office for the North East) (2005) *Annual Report 2004/05.* Newcastle upon Tyne: Government Office for the North East.
GONE (Government Office for the North East) (2006a) *Regional Compact: a framework for strong and effective relationships between the Public Sector and the Third Sector in the North East.* Newcastle upon Tyne: Government Office for the North East.
GONE (Government Office for the North East) (2006b) *Annual Report 2005/06*. Newcastle upon Tyne: Government Office for the North East.
GONE (Government Office for the North East) (2006c) *Business Plan 2006-2007*. Newcastle upon Tyne: Government Office for the North East.
GONE (Government Office for the North East) (2007a) *Business Plan 2007-2008*. Newcastle upon Tyne: Government Office for the North East.
GONE (Government Office for the North East (2007b) *North East of England Regional Spatial Strategy. Secretary of State Proposed changes to draft revision submitted by the North East Assembly, May 2007.* Newcastle upon Tyne: Government Office for the North East.
GONE (Government Office for the North East) (2008a) *Government Office Focus* (5 December 2008). Newcastle upon Tyne: Government Office for the North East.
GONE (Government Office for the North East) (2008b) *Corporate Plan 2008-11.* Newcastle upon Tyne: Government Office for the North East.
GONE (Government Office for the North East) (2008c) *The North East of England Plan: Regional Spatial Strategy to 2021.* Norwich: The Stationery Office
GONE (Government Office for the North East) (2010) http://www.gos.gov.uk/gone/aboutus/ (website accessed 4/2/10).
Gorman, D. and Douglas, M. (2001). 'Health impact assessment of Merseyside Integrated Transport Strategy.' *Journal of Public Health Medicine* **23**(2): 164.
Green, G., Cromar, P., Whittle, S., Greig, S. and Butler, D. (2004) *Health impact assessment in Yorkshire and the Humber region.* Sheffield: Sheffield Hallam University.
Grindle, M.S. and Thomas J.W. (1991) *Public Choices and Policy Change. The political economy of reform in developing countries.* Baltimore and London: The Johns Hopkins University Press.
Hall, P., Land, H., Parker, R. and Webb, A. (1975) *Change, Choice and Conflict in Social Policy*. London: Heinemann.

Ham, C. (1999) *Health Policy in Britain*. 4th edition. Basingstoke and New York: Palgrave.
Hamer, L., Jacobson, B., Flowers, J. and Johnstone, F. (2003) *Health Equity Audit Made Simple: a briefing for Primary Care Trusts and Local Strategic Partnerships. Working document*. Public Health Observatories and Health Development Agency.
Handy, C. (1993) *Understanding Organizations*. 4th edition. London: Penguin Books.
Harris, M., Cairns, B. and Hutchinson, R. (2004) '"So many tiers, so many agendas, so many pots of money": the challenge of English regionalization for voluntary and community organizations.' *Social Policy and Administration* **38**(5): 525-540.
Harrison, D. (2002) *Integrated Impact Assessment and Public Health Governance.* Dissertation submitted in partial fulfilment of the requirements for the degree of Master of Public Health, University of Liverpool.
Health at Work Group (2005a) *Worklessness - final paper.* Newcastle upon Tyne: North East Assembly.
Health at Work Group (2005b) *Health at work group minutes, December 2005*. Newcastle upon Tyne: North East Assembly.
Heclo, H.H. (1972) 'Policy Analysis.' *British Journal of Political Science* **2**(1): 83-108.
Herrschel, T. and Newman, P. (2000) 'New regions in England and Germany: an examination of the interaction of constitutional structures, formal regions and informal institutions.' *Urban studies* **37**(7): 1185-1202.
HIG (Health Interest Group) (2002) notes of meeting held 22 August 2002 at Government Office, Newcastle upon Tyne. Newcastle upon Tyne: Health Interest Group.
HIG (Health Interest Group) (2003) notes of meeting held 21 January 2003 at North East Assembly, Newcastle upon Tyne. Newcastle upon Tyne: Health Interest Group.
Hill, M. (2005) *The Public Policy Process*. 4th edition. Harlow: Pearson Education Ltd.
HM Treasury (2006) *Stern Review on the economics of climate change*. London: HM Treasury (later published as Stern, N.H. (2007) *The economics of climate change: the Stern review*. Cambridge: Cambridge University Press).
HM Treasury and DH (Department of Health) (2002) *Tackling Health Inequalities: summary of the 2002 Cross-Cutting Review*. London: HM Treasury and Department of Health.
HM Treasury and ODPM (Office of the Deputy Prime Minister) (2006) *Review of Government Offices*. Norwich: HMSO.
Hofferbert, R.I., (1974) *The study of public policy.* Indianapolis and New York: Bobbs-Merrill Co., Inc.
Hoffmann, C. and Graf von der Schulenburg, J.M. on behalf of the EUROMET group (2000). 'The influence of economic evaluation studies on decision making. A European survey.' *Health Policy* **52**(3): 179-92.

Hogwood, B.W. and Gunn, L.A. (1984) *Policy Analysis for the Real World*. Oxford: Oxford University Press.
Hoppe, R., van de Graaf, H. and van Dijk, A. (1987) 'Implementation research and policy design: problem tractability, policy theory, and feasibility testing.' *International Review of Administrative Sciences* **53**(4): 581-604.
House of Commons Health Committee (2001) *Public Health. Second Report. Volume I: Report and Proceedings of the Committee. Session 2000-01. HC30-I.* London: The Stationery Office.
House of Commons Health Committee (2009) *Health Inequalities. Third report of session 2008-09 Volume 1: report, together with formal minutes. HC286-I.* London: The Stationery Office.
HSJ (Health Service Journal) (2004) comment: 'Devolved power is too low on smoking bans.' *Health Service Journal* 28/10/2004 (vol. 114).
Hudson, B. (1987) Collaboration in social welfare: a framework for analysis. *Policy and Politics* **15**(3): 175-182
Hudson, J. and Lowe, S. (2004) *Understanding the Policy Process. Analysing welfare policy and practice*. Bristol: The Policy Press.
Hunter, D.J. (2002) 'England' in Marinker, M. (ed.) (2002) *Health Targets in Europe. Polity, progress and promise.* London: BMJ Books. pp 148-164.
Hunter, D J. (2003). *Public Health Policy*. Cambridge: Polity Press.
Hunter, D.J. (2005) 'Choosing or losing health.' *Journal of Epidemiology and Community Health* **59**(12): 1010-1012.
Independent Inquiry into Inequalities in Health (1998). *Independent Inquiry into Inequalities in Health: Report* (Acheson report). London: The Stationery Office.
IPPR north (Institute for Public Policy Research north) (2009) *Public Service Paradox: the final report of the commission on public sector reform in the North East*. Newcastle upon Tyne: IPPR.
Joffe, M. (2003). 'How do we make health impact assessment fit for purpose?' *Public Health* **117**(5): 301-304.
John, P. (1998) *Analysing Public Policy*. London: Continuum.
Joossens, L. and Raw, M. (1996) 'Are tobacco subsidies a misuse of public funds?' *British Medical Journal* **312**: 832-835.
Kalu, K.N. (2005) 'Competing ideals and the public agenda in Medicare reform: the "garbage can" model revisited.' *Administration and Society* **37**(1): 23-56.
Kearney, M. (2004) 'Walking the walk? Community participation in HIA: a qualitative interview study.' *Environmental Impact Assessment Review* **24**(2): 217-229.
Keating, M., Cairney, P. and Hepburn, E. (2009) 'Territorial policy communities and devolution in the UK.' *Cambridge Journal of Regions, Economy and Society* **2**: 51-66.
Kemm, J. R. (2000). 'Can health impact assessment fulfil the expectations it raises?' *Public Health* **114**(6): 431-433.
Kemm, J. (2001) Health impact assessment: a tool for healthy public policy.' *Health Promotion International* **16**(1): 79-85.

Kingdon, J.W. (1984) *Agendas, Alternatives and Public Policies.* New York: Longman
Kingdon, J.W. (2003*) Agendas, Alternatives and Public Policies* 2nd edition. New York: Longman.
Kjellström, T., van Kerkhoff, L., Bammer, G. and McMichael T. (2003) 'Comparative assessment of transport risks--how it can contribute to health impact assessment of transport policies.' *Bulletin of the World Health Organization* **81**(6): 451- 457.
Künzli, N. (2002). 'The public health relevance of air pollution abatement.' *European Respiratory Journal* **20**(1): 198-209
Lalonde, M. (1974) *A new perspective on the health of Canadians: a working document*. Ottawa: Minister of Supply and Services
Lasswell, H.D. (1956) 'The Decision Process: Seven Categories of Functional Analysis' reprinted in Polsby, N.W., Dentler, R.A. and Smith, P.A. (eds.) *Politics and Social Life: an introduction to political behaviour*. Boston: Houghton Mifflin Company: 93-105.
Lavis, A. (2009) *Sub-National Review – Key Policy Outcomes.* London: CRC (Commission for Rural Communities)
Learmonth, A. and Ford, C. (2002) *Towards a framework for learning from doing in the North East of England. Policy, practice and evaluation: addressing social inclusion and reducing inequalities in health.* (Draft report.) Health Development Agency.
Lebret, E. and Staatsen, B. (2002). 'Health Impact Assessment, current practice in the Netherlands.' *Epidemiology* **13**(4) Supplement: abstract number 287.
Lee, S. (2002)'Yorkshire (and the Humber)' in Tomaney, J. and Mawson, J. (eds.) (2002) *England – the State of the Regions*. Bristol: The Policy Press.
Legard, R., Keegan, J. and Ward, K. 'In-depth interviews.' in Ritchie, J. and Lewis, J. (eds.) (2003) *Qualitative Research Practice. A guide for social science students and researchers*. London, Thousand Oaks, New Delhi: Sage Publications. pp 138-169.
Leichter, H.M. (1979) *A Comparative Approach to Policy Analysis. Health care policy in four nations.* Cambridge, London, New York, New Rochelle, Melbourne, Sydney: Cambridge University Press.
Lindblom, C.E. and Woodhouse, E.J. (1993) *The Policy-making Process.* 3rd edition. New Jersey: Prentice Hall. (Prentice Hall Foundations of Modern Political Science Series, ed. Dahl, R.A.)
Lipsky, M. (1980) *Street-level Bureaucracy. Dilemmas of the individual in public services.* New York: Russell Sage Foundation.
Lock, K., M. Gabrijelcic-Blenkus, M., Martuzzi, M., Otorepec, P., Wallace, P. and Dora, C. (2003). 'Health impact assessment of agriculture and food policies: lessons learnt from the Republic of Slovenia.' *Bulletin of the World Health Organization* **81**(6): 391-8.
Lovering, J. (2001) 'The coming regional crisis (and how to avoid it).' *Regional Studies* **35**(4): 349-354.
LSE (London School of Economics and Political Science) (2006) *The*

depression report: a new deal for depression and anxiety disorders [The Layard report]. London: London School of Economics and Political Science.
Lukes, S. (1974) *Power: a radical view*. Basingstoke and New York: Palgrave. (Studies in Sociology Series, edited by Giddens, A.)
Lukes, S. (2005) *Power: a radical view*. 2nd edition. Basingstoke and New York. Palgrave MacMillan.
Macintyre, S., Chalmers, I., Horton, R. and Smith, R. (2001). 'Using evidence to inform health policy: case study'" *British Medical Journal* **322**: 222-5
Macintyre, S. and Petticrew, M. (2000) 'Good intentions and received wisdom are not enough.' *Journal of Epidemiology and Community Health* **54**: 802-803.
MacNaughton, G. and Hunt, P. (2009) 'Health impact assessment: the contribution of the right to the highest attainable standard of health.' *Public Health* **123**(4):302-305
Malpass, P. (2005) Housing and the Welfare State*. The development of housing policy in Britain*. Basingstoke and New York: Palgrave Macmillan.
March, J.G. (1994) A *Primer on Decision Making. How decisions happen*. New York, London, Toronto, Sydney: The Free Press.
March, J.G. and Simon, H.A. (1993) *Organizations*. 2nd edition. Cambridge, Massachusetts: Blackwell.
Marinker, M. (2002) 'Evidence and imagination.' In Marinker, M. (ed.) (2002) *Health Targets in Europe. Polity, progress and promise*. London: BMJ Books. pp. 1-17.
Marmot, M. (2010) *Fair Society, Healthy Lives: the Marmot Review. Strategic review of health inequalities in England post-2010*. London: The Marmot Review.
Martin, R. (2009) 'The recent evolution of regional disparities – a tale of boom and bust.' In Tomaney, J. (ed.) *The future of regional policy.* London: The Smith Institute.
Matland, R.E. (1995) Synthesising the implementation literature. *Journal of Public Administration Research and Theory* **5**(2): 145-174.
McCormick, J. and Fulop, N.J. (2002) 'For and against health targets.' in Marinker, M. (ed.) (2002) *Health Targets in Europe. Polity, progress and promise.* London: BMJ Books. pp 34-48.
Mazmanian, D.A. and Sabatier, P.A. (1980) 'A multivariate model of public policy-making.' *American Journal of Political Science* **24**(3): 439-468.
Metcalfe, O. and Higgins, C. (2009) 'Healthy public policy – is health impact assessment the cornerstone?' *Public Health* **123**(4): 296-301.
Miles, M.B., and Huberman, M. (1994) *Qualitative Data Analysis*. 2nd edition. Thousand Oaks, London, New Delhi: Sage Publications.
Mindell, J., Bowen, C., Herriot, G., Findlay, G. and Atkinson, S. (2010) 'Institutionalizing health impact assessment in London as a public health tool for increasing synergy between policies in other areas.' *Public Health* **124**(2):107-114).
Mindell, J., Ison, E. And Joffe, M. (2003) 'A glossary for health impact assessment.' *Journal of Epidemiology and Community Health* **57**(9):

647-651.
Mindell, J. and Joffe, M. (2003) 'Health impact assessment in relation to other forms of impact assessment.' *Journal of Public Health Medicine* **25**(2): 107-112.
Mitchell, R.B., Clark, W.C. and Cash, D.W. (2006) 'Information and influence.' in Mitchell, R.B., Clark, W.C., Cash, D.W. and Dickson, N.M. (eds.) (2006) *Global Environmental Assessments. Information and influence*. Cambridge, (Massachusetts) and London: The MIT Press. pp 307-338.
Mittelmark, M. B. (2001). 'Promoting social responsibility for health: health impact assessment and healthy public policy at the community level.' *Health Promotion International* **16**(3): 269-74
Morrison, D. S., Petticrew, M. and Thomson, H. (2001). 'Health Impact Assessment -- and beyond.' *Journal of Epidemiology and Community Health*
55(4): 219-20
Musson, S., Tickell, A. and John, P. (2005) 'A decade of decentralisation? Assessing the role of the Government Offices for the English regions.' *Environment and Planning A* **37**: 1395-1412.
NBF (Northern Business Forum) (2010), http://www.nbf.co.uk/ (website accessed 5/2/10).
NEA (North East Assembly) (2002a) *Strengthening accountability in the North East. First report November 2002*. Newcastle upon Tyne: North East Assembly.
NEA (North East Assembly) (2002b) 'Cross-cutting themes' list in notes of cross-cutting themes group meeting, 25th November 2002. Newcastle upon Tyne: North East Assembly.
NEA (North East Assembly) (2003a) *Agenda Update* **16** (November/ December 2003) Newcastle upon Tyne: North East Assembly.
NEA (North East Assembly) (2003b) *Agenda Update* **15** (October 2003) Newcastle upon Tyne: North East Assembly.
NEA (North East Assembly) (2003c) *Strengthening accountability in the North East. Scrutiny and development 2nd report, September 2003* (The tourism, skills and business scrutiny report). Newcastle upon Tyne: North East Assembly.
NEA (North East Assembly) (2004a) *Agenda Update* **22** (August 2004) Newcastle upon Tyne: North East Assembly.
NEA (North East Assembly) (2004b) *Review 04*. Newcastle upon Tyne: North East Assembly.
NEA (North East Assembly) (2005a) *Agenda Update* **24** (February/March 2005 (wrongly printed as issue **23**)) Newcastle upon Tyne: North East Assembly.
NEA (North East Assembly) (2005b) *Regional Spatial Strategy for the North East: Statement of Public Participation.* Newcastle upon Tyne: North East Assembly.
NEA (North East Assembly (2005c) *The First Report of the Scrutiny and Policy Development Committee*. Newcastle upon Tyne: North East

Assembly.
NEA (North East Assembly) (2005d) 'Transfer of North East Housing Board activity to the Assembly'. *Notes of Special Plenary Meeting*. 11th March 2005. Newcastle upon Tyne: North East Assembly.
NEA (North East Assembly) (2005e) *Technical paper 4: housing.* Newcastle upon Tyne: North East Assembly.
NEA (North East Assembly) (2005f) *View: shaping the North East. Regional Spatial Strategy for the North East. Submission draft June 2005.* Newcastle upon Tyne: North East Assembly.
NEA (North East Assembly) (2006a) *NEA News* **31** (August 2006) Newcastle upon Tyne: North East Assembly.
NEA (North East Assembly) (2006b) *NEA News* **32** (November 2006) Newcastle upon Tyne: North East Assembly.
NEA (North East Assembly) (2006c) *Agenda Update* **28** (January 2006) Newcastle upon Tyne: North East Assembly.
NEA (North East Assembly) (2006d) news release, 6/12/2006. Newcastle upon Tyne: North East Assembly. .
NEA (North East Assembly) (2006e) *Business Plan 2006-09*. Newcastle upon Tyne: North East Assembly.
NEA (North East Assembly) (2006f) *Shaping the future of the North East – annual report for 2005/06.* Newcastle upon Tyne: North East Assembly.
NEA (North East Assembly) (2006g) *Regional Spatial Strategy for the North East. Annual monitoring report 05/06* Newcastle: North East Assembly.
NEA (North East Assembly) (2007a) *Business Plan 2007-10*. Gateshead: North East Assembly.
NEA (North East Assembly) (2007b) *Working for the region: annual report 2006/07.* Gateshead: North East Assembly.
NEA (North East Assembly ((2007c) *North East Assembly response to Housing Green Paper (2007).* Gateshead: North East Assembly.
NEA (North East Assembly) (2007d) *North East Assembly Response to the draft climate change bill.* Gateshead: North East Assembly.
NEA (North East Assembly) (2007e) *Regional Spatial Strategy for the North East. Annual monitoring report 2006/07.* Gateshead: North East Assembly.
NEA (North East Assembly) (2008a) 'Building foundations for success.' *NEA News* **39**: 03.Gateshead: North East Assembly.
NEA (North East Assembly) (2008b) *Delivering through change. Annual report 2007-08*. Gateshead: North East Assembly.
NEA (North East Assembly) (2008c) 'NEA News' in *NEA e-bulletin,* 31st January 08. Gateshead: North East Assembly.
NEA (North East Assembly (2008d) 'Sustaine Board' in *NEA e-bulletin,* October 2008. Gateshead: North East Assembly.
NEA (North East Assembly) (2008e) *Responding to change: Business plan 2008-2011.* Gateshead: North East Assembly.
NEA (North East Assembly) (2008f) *Revised Business Plan 2008/2011*. Gateshead: North East Assembly.
NEA (North East Assembly) (2008g) *Regional Spatial Strategy for the North*

East. Annual monitoring report 2007/08. Gateshead: North East Assembly.
NEA (North East Assembly) (2009a) *Annual report 2008/09.* Gateshead: North East Assembly.
NEA (North East Assembly) (2009b) *Fitting the pieces together: final scrutiny review.* Gateshead: North East Assembly.
NEA (North East Assembly) (2009c) *Regional Spatial Strategy for North East England. Annual monitoring report 2008/09.* Gateshead: North East Assembly.
NEA (North East Assembly)/NEHB (North East Housing Board (2007) *Quality places for a dynamic region: the North East England Regional Housing Strategy.* Gateshead: North East Assembly.
NECC (North East Chamber of Commerce) website (last accessed 5/2/10) http://www.necc.co.uk/subindex.aspx?id=72
NEHB (2005) *A new housing strategy for the North East.* Newcastle: North East Housing Board.
NEHB PSAF (North East Housing Board Private Sector Advisory Forum) (2006) *Notes of meeting held 6th December 2006*. Newcastle upon Tyne: North East Housing Board.
NEHB PSAF (North East Housing Board Private Sector Advisory Forum) (2007) *Notes of meeting held 28th February 2007*. Newcastle upon Tyne: North East Housing Board.
NEHB VSAG (North East Housing Board Voluntary Sector Advisory Group (2007) Agenda 27th July 2007. Newcastle upon Tyne: North East Housing Board.
NHS (National Health Service) and ONE (One NorthEast) (2000) *Compact between the National Health Service and One NorthEast.* Newcastle upon Tyne: One NorthEast.
North East Forestry Action Group (2005). *Trees, woodlands, forests... and people. The regional forest strategy for the North East of England.* Newcastle upon Tyne: Government Office for the North East and the Forestry Commission.
Northern Housing Consortium (2007) *Making your home in Durham a great place to live: a housing strategy for Durham 2008-11.* northern-housing.org.uk
Northern Way (2010). Moving forward: the Northern Way. Background. Website http://www.thenorthernway.co.uk/ (accessed 10/7/2010).
Northern Way Steering Group (2005) *Moving forward: the Northern way. Business plan 2005-2006.* Newcastle: The Northern Way Secretariat (or ONE, Yorkshire Forward or Northwest Development Agency).
Northumberland Housing Board (2007) *A sub-regional housing strategy for Northumberland 2007-11.* Morpeth: Northumberland Housing Board.
ODPM (Office of the Deputy Prime Minister (2003) *Sustainable communities in the North East: building for the future. (*Regional element of national Sustainable Communities Plan) London: ODPM.
ODPM (Office of the Deputy Prime Minister (2004) *Making it happen: the Northern Way*. London: ODPM.

ODPM (Office of the Deputy Prime Minister) (2005a) *Evaluation of the role and impact of Regional Chambers: feasibility study – final report*. London: ODPM.
ODPM (Office of the Deputy Prime Minister) (2005b) *Sustainable Communities: homes for all.* Norwich: The Stationery Office.
Oliver, A. and Nutbeam, D. (2003) 'Addressing health inequalities in the United Kingdom: a case study.*' Journal of Public Health Medicine* 25(4): 281-287.
ONE (One NorthEast) (1999a) *Unlocking Our Potential: the Regional Economic Strategy for the North East*. Gateshead: One NorthEast.
ONE (One NorthEast) (1999b) *Towards a Vision* (consultation document for the 1999 Regional Economic Strategy for the North East*)*. Gateshead: One NorthEast.
ONE (One NorthEast) (2000) 'Healthy communities for sustainability'. *News article,* 11 apr 2000. One NorthEast website (last accessed 9/7/2010) http://www/onenortheast.co.uk/news/article
ONE (One NorthEast) (2001a) *Innovation Strategy and Action Plan*. Gateshead: One NorthEast.
ONE (One NorthEast) (2001b) *North East of England Enterprise Strategy*
ONE (One NorthEast) (2002a) Framework for Regional Employment Skills Action (FRESA). Newcastle upon Tyne: One North East.
ONE (One NorthEast) (2002b) *Realising Our Potential: the Regional Economic Strategy for the North East of England*. Newcastle upon Tyne: One NorthEast.
ONE (One NorthEast) (2002c) 'Minister to Launch Framework for Regional Employment Skills Action (FRESA)' *News article* 15th November 2002. Gateshead: One NorthEast.
ONE (One NorthEast (2003) *Corporate Plan Summary 2003-2006*. Newcastle upon Tyne: One NorthEast.
ONE (One NorthEast) (2004a) *North East England Tourism Strategy 2004-2007, draft for consultation.* Newcastle upon Tyne: One NorthEast
ONE (One NorthEast) (2004b) *Shaping Horizons in the North East: the strategic futures project for the North East of England.* (Draft) Newcastle upon Tyne: One NorthEast.
ONE (One NorthEast) (2005a) website (accessed 25/3/05): http://www.onenortheast.co.uk/page/regionalinit/crosscut/volunsec.cfm
ONE (One NorthEast) (2005b) 'Shaping the future of our region.' *News article* 6th June 2005 Gateshead: One NorthEast.
ONE (One NorthEast) (2005c) website (accessed 25/3/2005) (http://www.onenortheast.com/page/regionalinit/thenorthernway.cfm
ONE (One NorthEast) (2005d) *One Vision: One NorthEast Review of the Year 2004*. Newcastle upon Tyne: One NorthEast.
ONE (One NorthEast) (2005e) *North East England Tourism Strategy 2005-2010.* Newcastle upon Tyne: One NorthEast
ONE (One NorthEast) (2005f) *Shaping Horizons in the North East: evaluation report*. Newcastle upon Tyne: One NorthEast.

ONE (One NorthEast) (2005g) *Regional Information Communications and Technology*, incorporated into *Regional Economic Strategy*. Newcastle upon Tyne: One NorthEast.
ONE (One NorthEast) (2005h) *Passionate people, passionate places. The regional image strategy*. Newcastle upon Tyne: One NorthEast.
ONE (One North East) (2006) *Leading the Way: Regional Economic Strategy 2006-2016.* Gateshead: One NorthEast.
ONE (One North East) (2008) *Corporate plan 2008-13* Gateshead: One NorthEast.
ONE (One NorthEast) and NEA (North East Assembly) (2005) *Agreement on scrutiny and policy development between the North East Assembly and One NorthEast.* Newcastle upon Tyne: North East Assembly/One NorthEast.
ONE (One NorthEast), NEA (North East Assembly), GONE (Government Office for the North East) (2000) *Concordat between One NorthEast, the North East Regional Assembly and the Government Office for the North East.* Newcastle upon Tyne: One NorthEast.
ONE (One NorthEast), the Countryside Agency, Government Office for the North East and the North East Assembly (2001) Rural Action Plan. Newcastle upon Tyne: One NorthEast.
Orme, J., Powell, J., Taylor, P., Harrison, T. and Grey, M. 'Introduction' in Orme, J., Powell, J., Taylor, P., Harrison, T. and Grey, M (eds.) (2003) *Public Health for the 21st Century. New perspectives on policy, participation and practice.* Maidenhead: Open University Press. pp 1-14.
Parry, J. and Stevens, A. (2001). 'Prospective health impact assessment: pitfalls, problems, and possible ways forward.' *British Medical Journal* **323**(7322): 1177-82.
Parry, J. and Wright, J. (2003). 'Community participation in health impact assessments: intuitively appealing but practically difficult.' *Bulletin of the World Health Organization* **81**(6): 388.
Pearce, G. and Ayres, S. (2007) 'Emerging patterns of governance in the English regions: the role of Regional Assemblies.' *Regional Studies* **41**(5): 699-712.
Pearce, G., Mawson, J. and Ayres, S. (2008) 'Regional governance in England: a changing role for the government's regional offices?' *Public Administration* **86**(2): 443-463.
Peckham, S. (2003) 'Who are the partners in public health?' in Orme, J., Powell, J., Taylor, P., Harrison, T. and Grey, M. (eds.) (2003) *Public Health for the 21st Century. New perspectives on policy, participation and practice.* Maidenhead: Open University Press. pp 59-78.
Perkins, N., Smith, K., Hunter, D.J., Bambra, C. and Joyce, K. (2010) '"What counts is what works"? New Labour and partnerships in public health.' *Policy and Politics* **38**(1): 101-117.
Pfeffer, J. (1992) *Managing with Power. Politics and influences in organizations.* Boston, Massachusetts: Harvard Business School Press.
PHGNE (Public Health Group North East) (2005). *A Smoke Free North East: Regional Tobacco draft Strategy 2005 – 2008*. Newcastle upon Tyne, Public

Health Group North East.
Phoolcharoen, W., Sukkumnoed, D. and Kessomboon, P. (2003) 'Development of health impact assessment in Thailand: recent experiences and challenges.' *Bulletin of the World Health Organization* **81**(6): 465-7.
PHRAC (Public Health Research and Action Collaborative) (2006) *Worklessness and Health seminar* report. Durham University and NHS.
Pike, A. (1999) 'The politics of factory closures and task forces in the North East region of England.' *Regional Studies* **33**(6): 567-586.
Pike, A. and Tomaney, J. (2009) 'The state and uneven development: the governance of economic development in England in the post-devolution UK.' *Cambridge Journal of Regions, Economy and Society* **2**: 13-34.
Pike, A., O'Brien, P. and Tomaney, J. (2004) 'Trade Unions in local and regional development and governance: the Northern Trades Union Congress in North East England.' *Local Economy* **19**(2): 102-116.
Polgar, S. and Thomas, S.A. (1995) *Introduction to Research in the Health Sciences*. 3rd edition. Melbourne, Edinburgh, London, Madrid, New York, Tokyo: Churchill Livingstone.
Pralle, S. (2006) 'Timing and sequence in agenda-setting and policy change: a comparative study of lawn care pesticide politics in Canada and the US.' *Journal of European Public Policy* **13**(7): 987-1005
Princen, S. (2007) 'Agenda-setting in the European Union: a theoretical exploration and agenda for research.' *Journal of European Public Policy* **14**(1): 21-38
Public Health North East (2008) Better Health Fairer Health: a strategy for 21st Century Health and Well-being in the North East of England. Newcastle upon Tyne: GONE.
Ranade, W. and Hudson, B. (2003) 'Conceptual issues in inter-agency collaboration.' *Local Government Studies* **29**(3): 32-50.
RDPH (Regional Director of Public Health) (2003) *Health consultation on the Regional Planning Guidance for the North East. A response on behalf of the Regional Director of Public Health, based on a rapid health impact assessment, March 2003.* Newcastle: GONE - Regional Director of Public Health.
Regional Partnership Group (2005) *Notes on reducing worklessness seminar*, December 2005.
Regional Task Force on Tobacco Control (1998). *An Action Plan for Tobacco Control in the Northern and Yorkshire Region*. Durham: NHS Executive, Northern and Yorkshire Region.
Rhodes, R.A.W. (2000) 'The governance narrative: key findings and lessons from the ESRC's Whitehall programme.' *Public administration* **78(**2): 345-363.
Richards, D. and Smith, M.J. (2002) *Governance and Public Policy in the UK.* Oxford: Oxford University Press.
Ritchie, J. (2003) 'The applications of qualitative methods to social research.' In Ritchie, J. and Lewis, J. (eds.) (2003) *Qualitative Research Practice. A guide for social science students and researchers*. London, Thousand Oaks,

New Delhi: Sage Publications. pp 24-46.
Ritchie, J., Spencer, L. and O'Connor, W. 'Carrying out qualitative analysis.' in Ritchie, J. and Lewis, J. (eds.) (2003) *Qualitative Research Practice. A guide for social science students and researchers*. London, Thousand Oaks, New Delhi: Sage Publications. pp 219-262.
Ritsatakis, A., Barnes, R., Dekker, E., Harrington, P., Kokko, S. and Makara, P. (eds.) (2000) Introduction to 'Exploring health policy development in Europe.' *WHO regional publications, European Series no. 86*. Copenhagen: WHO Regional Office for Europe.
Ritsatakis, A. and Järvisalo J. (2006) 'Opportunities and challenges for including health components in the policy-making process' in Ståhl, T., Wismar, M., Ollila, E., Lahtinen, E. and Leppo, K. (eds.) *Health in all policies: prospects and potentials. (2006)* Finland: Finnish Ministry of Social Affairs and Health (under the auspices of The European Observatory on Health Systems and Policies), pp. 145-168.
Robinson, F. and Shaw, K. (2001) 'Governing a region: structures and processes of Governance in North East England.' *Regional Studies* **35**(5): 473-492.
Rocket Science (2006) *One North East Regional Employability Framework Stage 1 Executive Summary.* Newcastle upon Tyne: One North East.
Rodger, E. (2005) *Regional Health Engagement Research 2005*. Report to Regional Partnership Group, December 2005. Newcastle upon Tyne: North East Assembly.
Rose, R. (1976)' Models of change' in Rose, R (ed.) (1976) *The dynamics of public policy: a comparative analysis.* London and Beverly Hills: Sage publications inc.
Rose, R. (1989) 'Inheritance before choice in public policy.' *Studies in Public Policy* **180**. Glasgow: Centre for the Study of Public Policy, University of Strathclyde.
Rose, R. and Kerran, T. (1984) 'Inertia or incrementalism? A long-term view of the growth of government.' *Studies in Public Policy* **126**. Glasgow: Centre for the Study of Public Policy, University of Strathclyde.
Rudestam, K.E. and Newton, R.R. (2001) *Surviving Your Dissertation. A comprehensive guide to content and process*. 2nd edition. Thousand Oaks, London, New Delhi: Sage Publications, Inc.
Sabatier, P. (1988) 'An advocacy coalition framework of policy change and the role of policy-oriented learning therein.' Policy Sciences 21: 129-168.
Sabatier, P.A. (1993) Policy change over a decade or more. In: Sabatier, P.A. and Jenkins-Smith, H.C. (eds.) *Policy Change and Learning: an Advocacy Coalition Approach*. Boulder: Westview Press. pp. 13-39. (Theoretical Lenses on Public Policy series (ed. Sabatier, P.A.)).
Sabatier, P.A. (ed.) (2007) *Theories of the Policy Process.* 2nd edition. Boulder: Westview Press.
Scally, G. 'Public health: a vision for the future.' in Orme, J., Powell, J., Taylor, P., Harrison, T. and Grey, M (eds.) (2003) *Public Health for the 21st Century. New perspectives on policy, participation and practice.* Maidenhead: Open

University Press. pp. 48-56.
Scargill, D.I. (1998) 'The French Region: a flawed institution?' *Regional Studies* **32**(9): 879-885.
Schattschneider, E.E. (1960*) The semisovereign people: a realistic view of democracy in America*. New York: Holt, Rinehart and Winston.
Schlager, E. (2007) A comparison of frameworks, theories, and models of policy processes. In: Sabatier, P.A. (ed.) (2007) *Theories of the Policy Process.* 2nd edition. Boulder: Westview Press.
SCOTH (Scientific Committee on Tobacco and Health) (1998) *Report of the Scientific Committee on Tobacco and Health*. London: The Stationery Office.
SCOTH (Scientific Committee on Tobacco and Health) (2004) *Secondhand Smoke: review of evidence since 1998*. London: Department of Health.
Scott-Samuel, A. (1996). 'Health impact assessment - An idea whose time has come.' *British Medical Journal* **313**: 183-184.
Scott-Samuel, A. (1998) 'Health impact assessment - theory into practice.' *Journal of Epidemiology and Community Health* **52**(11): 704-5.
Secretary of State for Health (1992). *The Health of the Nation. A Strategy for Health in England* [Cm 1986]. London, HMSO.
Secretary of State for Health (1998) *Our Healthier Nation: a contract for health.* [Green paper Cm 3852]. London: Department of Health.
Secretary of State for Health (1999) *Saving Lives: Our Healthier Nation* [White paper Cm 4386] London: The Stationery Office.
Secretary of State for Health (2000) *The NHS Plan: a plan for investment, a plan for reform*. [Cm 4818] London: Department of Health.
Secretary of State for Health (2009) *The Government's Response to the Health Select Committee Report on Health Inequalities.* [Cm 7621] Norwich and London: The Stationery Office.
Secretary of State for Health and Secretaries of State for Scotland, Wales & Northern Ireland (1998). *Smoking Kills: a White Paper on Tobacco*. [Cm 4177] London: Department of Health.
SFFS (Sustainable Farming and Food Strategy) in the North East (2006) *Sustainable farming and food: facing the future* (SFFS 2006).
Shaw, K., Humphrey, L., O'Brien, P. and Tomaney, J. (2003) 'Stakeholder involvement in the new regional governance: a case study of the North East Assembly.' *Northern Economic Review* **33/34**: 1-18.
Shaw, K. and Robinson, F. (2006) 'Governance in the post-referendum North East. *Northern Economic Review* **37**: 5-24.
Sihto, M., Ollila, E. and Koivusalo, M. (2006) 'Principles and challenges of health in all policies.' in Ståhl, T., Wismar, M., Ollila, E., Lahtinen, E. and Leppo, K. (eds.) *Health in all policies: prospects and potentials.* (2006) Finland: Finnish Ministry of Social Affairs and Health (under the auspices of The European Observatory on Health Systems and Policies) pp. 3-20.
Sim, F. and Mackie, P. (2003). 'Health impact assessment--a science and art for public health.' *Public Health* **117**(5): 293-4.
Site Selection magazine 1996/97. 'The North of England: from ships to chips.' *Site Selection magazine*, website http://www.conway.com/northuk/9612/

accessed 4/2/2010.
Skills North East (2005) *Skills Action Plan 2005-2006*. Newcastle upon Tyne: Skills North East.
Skills North East (2006a) *Skills Action Plan 2006-2007*.Newcastle upon Tyne: Skills North East.
Skills North East. (2006b) *Conference notes: regional employability framework 2006*. Newcastle upon Tyne: Skills North East.
Skills North East (2007) *Employability Action North East. Final report.* Newcastle upon Tyne: Skills North East.
Skills North East (2008) *Draft Action Plan 2008.* Newcastle upon Tyne: Skills North East
Skivington, K., McCartney, G., Thomson, H. and Bond, L. (2010) 'Challenges in evaluating Welfare to Work policy interventions: would an RCT design have been the answer to all our problems?' *BMC Public Health* **10**:254
Smith, K.E., Hunter, D.J., Blackman, T., Elliott, E., Greene, A., Harrington, B.E., Marks, L., McKee, L. and Williams, G.H. (2009) 'Divergence or convergence? Health inequalities and policy in a devolved Britain.' *Critical Social Policy* **29**: 216-242.
SNAP (Scottish Needs Assessment Programme) (undated) Health impact Assessment of the City of Edinburgh Council's Urban Transport Strategy. Scottish Needs Assessment Programme.
Snape, S. and Taylor, P. (2003) 'Partnership between health and local government: an introduction.*' Local Government Studies* **29**(3): 1-16.
Soroka, S.N. (2002a) *Agenda-setting dynamics in Canada*. Vancouver: UBC Press, University of British Columbia.
Soroka, S.N. (2002b) 'Issue attributes and agenda-setting by media, the public, and policy makers in Canada.' *International Journal of Public Opinion Research* **14**(3): 264-285.
Spencer, N. (2007) 'Behaving badly? Smoking and the role of behaviour change in tackling health inequalities.' in Dowler, E. and Spencer, N. (eds.) (2007) *Challenging health inequalities. From Acheson to "Choosing health"* '. Bristol: the Policy Press. pp 157-174.
Sport England North East (2004) *Turning ambitions into reality: the North East regional plan for sport and physical activity 2004-08)*. Durham: Sport England North East.
Stacey, R.D. (1996*) Strategic Management and Organisational Dynamics.* 2nd edition. London: Pitman Publishing.
Stocking, B. (1985) *Initiative and Inertia: Case Studies in the NHS.* London: Nuffield Provincial Hospitals Trust.
Stoker, G. (2004) *Transforming local governance: from Thatcherism to New Labour*. Basingstoke: Palgrave Macmillan.
Storeys: ssp (2007) *North East regional study on methods for maximising the delivery of affordable housing. A study for the North East Assembly/North East Housing Board.* Newcastle upon Tyne: Storeys: ssp.
Sustaine (2002a) *And the weather today is...* Newcastle upon Tyne: North East Assembly.

Sustaine (2002b) *Quality of Life in the North East: towards a regional framework.* Newcastle upon Tyne: North East Assembly.
Sustaine (2004) *The Integrated Regional Framework for the North East*. Newcastle upon Tyne: North East Assembly.
Sustaine (2008a) *Climate Change Action Plan for the North East of England.* Newcastle upon Tyne: Association of North East Councils. Web-based. http://www.climatene.org.uk/ (accessed 9/7/2101)
Sustaine (2008b) *The Integrated Regional Framework for the North East of England.* Newcastle upon Tyne: Association of North East Councils.
Sustaine (2010) http://212.67.202.56/~itadmin/ (website accessed 7/2/10)
Swank, D. and Martin, C.J. (2001) 'Employers and the welfare state: the political economic organization of firms and social policy in contemporary capitalist democracies'. *Comparative Political Studies* **34**(8): 889-923.
Tamayo, M. and Carrillo, E. (2005) 'La formación de la agenda pública' ['setting the public agenda']. *Foro Internacional* **45**(4): 658-681.
Tarkowski, S. (2002). 'Risk assessment of chemicals -- the role of epidemiological methods.' *International Archives of Occupational and Environmental Health* **75** Suppl: S17-20.
Taylor, S. and Bogdan, R. (1998) *Introduction to Qualitative Research Methods.* 3rd edition. New York, Chichester, Weinheim, Brisbane, Singapore, Toronto: John Wiley and Sons, Inc.
Taylor, L., Gowman, N. and Quigley, R. (2003). 'Addressing inequalities through health impact assessment'. *Learning from Practice bulletin*. London: Health Development Agency.
Tees Valley Living (2008) *Tees Valley Sub-Regional Housing Strategy 2007* Middlesbrough: Tees Valley Living.
Thompson, J.D. and Tuden, A. (1959) 'Strategies, structures and processes of organizational decision.' in Thompson, J.D., Hammond, P.B., Hawkes, R.W., Junker, B.H. and Tuden, A. (eds.) (1959) *Comparative Studies in Administration*. Pittsburgh: University of Pittsburgh Press.
Thomson, H., Petticrew, M. and Douglas, M. (2003). 'Health impact assessment of housing improvements: incorporating research evidence.' *Journal of Epidemiology and Community Health* **57**(1): 11-6.
Tiernan, A. and Burke, T. (2002) 'A load of old garbage: applying garbage-can theory to contemporary housing policy.' *Australian Journal of Public Administration* **61**(2): 86-97.
TNEI Services and NEA (North East Assembly) (2003) *Towards a Renewable Energy Strategy for the North East. Consultation Summary Oct 2003.* Newcastle upon Tyne: TNEI and North East Assembly.
Tomaney, J. (2003). *Public Policy and the Challenge of Regional Governance: Evidence from North East England - a discussion paper.* Seaford, Regional Studies Association.
Tomaney, J. and Pike, A. (2006) 'Deepening democracy and engaging civil society? "Economic and social partners" and devolved governance in the UK.' *Regional and Federal Studies* **16**(2): 129-135.
Townsend, P., Whitehead, M. and Davidson, N. (1992) in Townsend, P. and

Davidson, N. (eds.) *Inequalities in Health: the Black Report; the Health Divide.* London: The Penguin Group.
TUC (2010) http://www.tuc.org.uk/the_tuc/index.cfm (website, accessed 5/2/10)
Tugwell, P., Sitthi-Amorn, C., O'Connor, A., Hatcher-Roberts, J., Bergevin, Y. and Wolfson, M. (1995). 'Technology assessment. Old, new, and needs-based.' *International Journal of Technology Assessments in Health Care* **11**(4): 650-62.
Turrill, T. (1986) 'Change and innovation: a challenge for the NHS.' IHSM *management series 10*. London, Institute of Health Services Management.
UKPHA (2005). *Choosing health or losing health? UK Public Health Association response to the White Paper "Choosing health -making healthy choices easier."* London: UKPHA.
United Nations (1998) *Kyoto Protocol to the United Nations Framework Convention on Climate Change*. United Nations.
United Nations Environment Programme (1992) *Agenda 21*. Document resulting from the United Nations Conference on Environment and Development. Rio de Janeiro, 3-14 June 1992 ('The Earth Summit.') United Nations Environment Programme.
Universities of Leeds and Glamorgan and the London School of Hygiene and Tropical Medicine (1998) *The health of the nation - a policy assessed.* London: The Stationery Office.
Valler, D., Wood, A., Atkinson, I., Betteley, D., Phelps, N., Raco, M. and Shirlow, P. (2004) 'Business representation and the UK regions: mapping institutional change.' *Progress in Planning* **61**: 75-135.
Varela Put, G., den Broeder, L., Penris, M. and Roscam Abbing, E.W. (2001) *Experience with HIA at national policy level in the Netherlands: a case study.* (Policy learning curve series no. 4.) Copenhagen: World Health Organization Regional Office for Europe.
VONNE (Voluntary Organisations' Network North East) (2006) *The Vine. VONNE information News Etc.* Issue 22 August 2006.
VONNE (Voluntary Organisations' Network North East) (2010) website http://www.vonne.org.uk/aboutus/ (accessed 702/2010)
Walgrave, S. and Varone, F. (2008) 'Punctuated equilibrium and agenda-setting: bringing parties back in: policy change after the Dutroux crisis in Belgium.' *Governance: an International Journal of Policy, Administration, and Institutions* **21**(3): 365-395.
Walrond, S., Natarajan, M., Chappel, D. (2004) *Premature Mortality from Smoking in the North East of England.* (NEPHO Occasional Paper no. 8) Stockton on Tees: North East Public Health Observatory.
Walt, G. (1994) *Health Policy: an introduction to process and power.* Johannesburg: Witwatersrand University Press; London and New Jersey: Zed Books Ltd.
Wanless, D. (2001) *Securing Our Future Health: Taking a Long Term View. Interim Report*. London, HM Treasury.
Wanless, D. (2002) *Securing Our Future Health: Taking a Long Term View.*

Final Report. London, HM Treasury.
Wanless, D. (2004)*Securing good health for the whole population. Final report.* London: HMSO.
While, A. (2000) 'Accountability and regional governance. The emerging role of regional chambers in England.' *Local Economy* **14**(4): 329-345.
WHO (World Health Organization) (1946) *Constitution.* Official Records of the World Health Organization **2**, 100). Geneva: World Health Organization.
WHO (World Health Organization) (1978) Alma-Ata conference. *Declaration of Alma-Ata*. (Including item X: Health for All by the Year 2000) Declaration from International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978. Geneva: World Health Organization.
WHO (World Health Organization) (1986) *Ottawa Charter for Health Promotion*. Ontario: World Health Organization.
WHO (World Health Organization) (1998a) *Adelaide recommendations on Healthy Public Policy.* (Second International Conference on Health Promotion, Adelaide, South Australia, 5-9 April 1998) (WHO/HPR/HEP/95.2). Geneva: World Health Organization.
WHO (World Health Organization (1998b) *Health for All in the 21st Century*. (51st World Health Assembly, agenda item 19) (A51/5.) Geneva: World Health Organization.
WHO (World Health Organization) (2000) *World Health Report 2000*: *health systems: improving performance*. Geneva: World Health Organization.
WHO (World Health Organization) (2003) *WHO Framework Convention on Tobacco Control.* Geneva: World Health Organization. (Adopted by World Health Assembly 2003, entered into force 2005.)
WHO (World Health Organization) Commission on Social Determinants of Health (2008) *Closing the gap in a generation. Health equity through action on the social determinants of health.* Geneva: World Health Organization.
WHO (World Health Organization) Regional Office for Europe (1985) *Targets for health for all: targets in support of the European regional strategy for health for all.* Copenhagen: World Health Organization Regional Office for Europe.
WHO (World Health Organization) Regional Office for Europe (2002) *Warsaw Declaration for a tobacco-free Europe.* Warsaw: World Health Organization Regional Office for Europe.
WHO (World Health Organization) Regional Office for Europe (2005) *Strengthened health systems save more lives: an insight into WHO's European Health Systems' Strategy*. Copenhagen: World Health Organization Regional Office for Europe.
Williams, C. (2003) 'Developing community involvement: contrasting local and regional participatory cultures in Britain and their implications for policy.' *Regional Studies* **37**(5): 531-541.
Wismar, M., Blau, J. and Ernst, K. (2007) 'Is HIA effective? A synthesis of concepts, methodologies and results.' In Wismar, M., Blau, J., Ernst, K. And Figueras, J. (2007) *The effectiveness of Health Impact Assessment. Scope and limitations of supporting decision-making in Europe.* Copenhagen:

European Observatory on health systems and policies. WHO Regional Office for Europe, pp. 15-33.
Yin, R.K. (2009) Case Study Research. Design and methods. Los Angeles, London, New Delhi, Singapore, Washington DC: Sage. (*Applied Social Research Methods Series* Volume 5. Series editors Bickman, L., Rog, D.J.))
Zahariadis, N. (1996) 'Selling British Rail: an idea whose time has come?' *Comparative Political Studies* **29**: 400-422.
Zahariadis, N. (2007) 'The multiple streams framework: structure, limitations, prospects.' in Sabatier, P.A. (ed.) *Theories of the Policy Process*. 2nd edition. Boulder, Colorado: Westview Press. pp 65-92.
Zahariadis, N. (2008) 'Ambiguity and choice in European public policy.' *Journal of European Public Policy* **15**(4): 514-530.
Zimmerman, B. (2001) Ralph Stacey's agreement and certainty matrix. http://www.plexusinstitute.com/edgeware/archive/think/main_aides3.html (website accessed 9/8/2005).
Zucker, H.G. (1978) 'The variable nature of news media influence.' In Ruben, B.D. *Communication Year Book 2*. New Brunswick: Transaction Books.