From public issues to personal troubles: individualising social inequalities in health within local public health partnerships

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This paper explores public health policy implementation through partnership working at the local level by examining how local actors from public health and the wider workforce, make sense of and work on social inequalities in health. An ethnographic case study was used to examine policy implementation in one local strategic partnership in north-west England during a period of significant resource constraint. Semi-structured interviews were the primary method of data generation. Sensitising concepts from figurational sociology were used to develop a theoretical account of how local policy implementation directed at narrowing social inequalities in health tended to give rise to relatively fragmented and short-term services, projects and practices, which focused on lifestyle factors and behaviour change. Theorising partnership work as figurations goes some way to explaining the apparent paradox among participants who expressed a relatively detached appreciation of wider social influences, alongside emotional involvement in their work. This process of individualisation explains how local professionals tended to conceptualise health inequality and the social determinants of health as personal troubles. Individualisation meant that the social reality of working in partnerships on difficult issues was simplified. Thus, any scope for working on the social determinants of health tended to be overlooked. The extent to which this was intentional or a matter of struggling to see opportunities, or a mixture of the two, was difficult to discern. Although the policy landscape has changed, the findings give some insight into understanding how local collaborative processes reproduce local public health work underpinned by lifestyle choices.

Keywords: Health inequality; social determinants of health; individualisation; partnership; figurational sociology; England

Introduction

Despite concerted policy rhetoric relating to narrowing social inequalities in health, the social gradient has persisted and, in many countries, widened in recent years (Mackenbach et al., 2017). England, however, was the first European country to focus

in a sustained and systematic way on reducing social inequalities in health under successive Labour governments (1997-2010) (Mackenbach, 2011). A variety of policy instruments were developed, which, it was claimed, moved public health policy beyond a focus on individual lifestyle and secondary prevention to include the social determinants of health (Graham, 2009). Local strategic partnerships (LSPs) were established as the non-statutory bodies to co-ordinate and deliver local plans. Comprised as they were of public, private and voluntary sector agencies, LSPs were viewed as the local vehicle for cross-sector horizontal and vertical collaboration to address complex issues, including those relating to the social determinants of health. Although the national and local policy landscape has changed since then – including the formal transfer of public health teams and responsibilities to local government from the National Health Service (NHS) in April 2013 – the emphasis on local-level leadership and collaboration across interrelated networks and institutions has endured (Local Government Association, 2019). There has, however, been little research that has sought to understand the complex environment in which national public health policy intentions are operationalised at a local level (Breton & De Leeuw, 2010) especially through partnership arrangements that involve a very diverse range of actors. This paper goes some way towards addressing this gap by reporting some of the findings from a case study of one LSP in north-west England during April 2010 and September 2011, a time of considerable political and economic flux. We focus on the perspectives of a diverse range of professionals working on the front line of public health in order to understand more adequately the processes through which policies are enacted locally. We start by reviewing relevant research and then move on to explicating our theoretical orientation.

The localisation of public health policy

Research into policy implementation has a long and extensive history but this is less the case with regard to public health policy. This policy field raises particular issues for understanding implementation because it is more ambiguous and less well-understood, as well as more complex given its focus on working through alliances (Sausman, Oborn, & Barrett, 2016) compared to other policy fields. The emphasis given to addressing the social gradient in health augments this complexity given the consensus that long-term, creative and systematic approaches are required if enduring issues are to be tackled effectively (Marmot, 2010), especially during sustained periods of austerity when social inequalities in health tend to widen (Reeves, Basu, McKee, Marmot, & Stuckler, 2013). Individuals within local alliances working across multiple sectors are expected to make sense of and negotiate this terrain, including taking action on the social determinants of health. Although local professionals may have limited influence over the political determinants of health (Schrecker & Bambra, 2015), emerging evidence suggests local action can contribute to reducing health inequities (McCartney et al., 2017).

Research suggests that public health policy implementation at the local level tends to be patterned in particular ways. The concept of 'lifestyle drift' has been used to describe the tendency of national policy documents to start with broad rhetorical statements relating to prevention, promotion and the social determinants of health, which give way to a much narrower focus on single-issue lifestyle factors and behaviour change during implementation (Popay, Whitehead, & Hunter, 2010; Williams & Fullagar, 2019). In this way Mills (1959) argued 60 years ago that social problems tend to become conceptualised as personal (health) troubles. Research on this phenomenon has primarily focused on specific professional groups, especially in relation to how they understand social inequalities in health. This emerging body of research indicates that

local health policy-makers and practitioners can hold both behavioural and material explanations for social inequalities in health, although individuals vary in the degree of emphasis they give to each (Babbel, Mackenzie, Hastings, & Watt, 2019; Blackman et al., 2009; Blackman et al., 2012; Brassolotto, Raphael, & Baldeo, 2013; Powell, Thurston, & Bloyce, 2017). Notwithstanding these varied conceptualisations, the over-riding tendency across a variety of professional groups was to see their scope for action in terms of behavioural/lifestyle approaches (Powell et al., 2017), secondary (pharmacological) preventive approaches within primary care, (Cloatre & Pickersgill, 2014; Orton et al., 2011) and/or improving access to NHS services (Blackman, et al., 2009; Blackman, et al., 2012). This pattern has been identified among local policy-makers and practitioners in other countries (Jansson, Fosse, & Tillgren, 2011; Morrison et al., 2014; Tallerek née Grimm, Helgesen, & Fosse, 2013).

One particular aspect of this pattern is the tendency to conceptualise inequality as a problem relating to the poorer health of poor people, with few references to the social gradient in health (Blackman, et al., 2009; Blackman, et al., 2012; Graham & Kelly, 2004; Morrison et al., 2015; Noble, Greenhalgh, & Casalino, 2014; Smith et al., 2009). Blackman et al. (2009, p. 769) concluded that there was a 'surprising lack of scepticism about lifestyle interventions' among local professionals. In a similar vein, Marmot (2010) has argued that focussing on disadvantaged areas or population groups is not sufficient for reducing social inequality in health, as it does not address the wider social factors that influence social position. Rather, social inequality in health becomes a problem defined by disadvantage and unfavourable conditions rather than the unequal distribution of health along the socioeconomic gradient (Graham, 2004). Thus, it 'encourages perspectives which identify the lifestyles of disadvantaged groups as causes of health inequality' (Graham & Kelly, 2004, p. 9). Alternatively, Marmot (2010, p. 16)

promoted the concept of proportionate universalism suggesting that 'to reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage'.

The conceptualisations local professionals hold about social inequality in health are important because people tend to act in ways that correspond with what they believe to be true (Thomas & Thomas, 1928). Recent research suggests that *local* evidence and knowledge is salient for professionals and practitioners (Kelly, Atkins, Littleford, Leng, & Michie, 2017). Local knowledge, however, might serve to displace structural explanations and strategies as well as crowd out a local focus on the social determinants of health inequality (Lynch, 2017). This explains, to some degree, 'the enduring gap between knowledge and implementation' (Salway & Green, 2017, p. 523).

Individualised views of social inequalities in health tend, therefore, to be prominent within and beyond the health sector. This paper focuses on the extent to which working within local partnerships creates the conditions for broader local strategies to be implemented through collaborative processes. Rod (2018) suggests that working with others from different sectors might have a potentially transformative effect on people's understandings of social inequalities in health. The departure point for the research reported here was to explore understandings of social inequalities of health across the diverse LSP.

The analytic value of a sociological approach when examining complex relationships such as that between social structure, human agency and social inequalities in health is increasingly recognised because it provides a lens through which to grapple with the multifaceted, dynamic and interactive character of human action (Øversveen, Rydland, Bambra & Eikemo, 2017; Maller, 2015). We focus on the social processes through which individualised interpretations of health inequality and the social

determinants of health were reproduced and the subsequent actions that emerged within the complex dynamics of local partnerships. In so doing, we aim to make a theoretical (explanatory) contribution to the field by drawing on figurational sociology, to which we now turn.

Theorising the localisation of public health policy

In this paper, we use the term 'localisation' to indicate that public health policy implementation is a social process. We draw on figurational sociology, a theoretical approach that has not hitherto been extensively applied within the public health field (Mowles, 2011; Powell, et al., 2017). Elias (1978, p. 127) argues that each and every person is linked to others with invisible ties, in other words in 'figurations' of mutually-oriented people characterised by interdependencies of power. It is, thus, a fundamentally *relational* theory. We conceptualise the LSP as a figuration, with each person being a part of several other figurations. These 'networks of interdependency' stretch beyond those with whom people have direct contact to policy makers, those responsible for implementing policy, and the people it is intended to affect. Theorising partnerships as a figuration in this way implies a dynamic interweaving of processes in which outcomes may be unplanned and unintended. In recent years, the concept of 'complex systems' has been used as a way of theorising public health policy and practice (Grant & Hood, 2017). While this has been a valuable counter to linear models which have a rationalistic bias (Dopson & Waddington, 1996), it can lead to reification and obscure balances of power within networks and the attendant emotional involvement of social relations. Scant attention, however, has been given to the influence of human emotion in decision making and action. Systems theory seems to assume that people are all the same and that the interactions between them are all the

same (Stacey, 2011). This tends to contribute to fantasy-laden thinking about what can be achieved in specific contexts (Elias, 1978). In contrast, we argue that theorising in terms of figurations counters these tendencies and leads to a more adequate way of conceptualising social reality within partnerships.

We focus on the process of individualisation, a term that has been used to reflect the growing tendency of people in western (neoliberal) states to view themselves and others in individualised, rather than collective, ways (Elias, 1991). Thus, individualisation runs counter to an emphasis on the social determinants of health and structurally rooted explanations of inequalities. Elias (1991) argues that an individualised worldview has become part of the predispositions of many people, such that it has become almost second nature. While people remain dependent on others for the conditions in which they live, the majority of these connections are indirect, contributing to an increasing sense of *self*-sufficiency and feelings of separation from others (Elias, 1991), which is augmented in neoliberal contexts (Lynch, 2017). Thus, people become emotionally attached to the idea of self-sufficiency as it reflects positively on them and their personal achievements (Elias, 1991).

A paradox exists in that the figurations to which we belong, with their multitude of direct and indirect connections, obscure the degree to which we are dependent upon one another to function to the extent that people perceive themselves as isolated individuals. At the same time, interactions through direct and indirect connections reproduce an individualised discourse further reinforcing people's perceptions of themselves as isolated individuals. Thus, the problems people face in their daily lives, such as poor health and unemployment, tend to be defined as individual (personal) problems rather than public issues (Mills, 1959). A figurational perspective offers a way of explaining this phenomenon in that individualised explanations of social inequalities

in health reflect the emotionally involved perspectives of those working locally. Furthermore, they are reproduced because their simplicity is attractive, especially in the way in which they seemingly offer up tangible ways of working locally with people. People's tendency towards individual explanations can therefore be viewed as an unintended consequence of their inability to make sense of or control the figurations of which they are a part. This is especially likely to be the case given the dynamic complexities of a figuration such as the LSP, which give rise to interweaving actions of large numbers of people, many of whom are unknown to each other. While a 'measure of intentionality' (Dunning, 1999, p. 16) might characterise these actions, the aggregate consequences and collective outcome is not planned.

Elias (1987) argues that action oriented towards achieving particular goals is always driven by both cognition and emotion. The greater the pressure to achieve such goals – in this case the political pressure to improve life expectancy in disadvantaged areas through action on the social determinants of health – the greater the emotional involvement of those concerned and the more difficult it is to take a relatively detached perspective (Elias, 1987). Dopson (2001, p. 523), commenting on Elias, states that 'individuals involved in social processes offer relatively involved perceptions of the processes of which they are part … such data needs to be complemented with a relatively detached examination of the complex figurations in which they work'.

Crawford (1980) has argued that an individualised model has come to dominate common sense understandings of health and illness through a process of medicalisation. Thus, the causes and treatment of ill-health are located at the individual level through exposure to 'risk factors', which draw attention away from structural processes. Because individual behaviour is viewed as a causal factor, 'solutions are seen to lie within the realm of individual choice' (Crawford, 1980, p. 368).

We also draw on Elias's concept of 'established and outsiders' and 'blame gossip' to understand community relations in the study of partnerships (Elias & Scotson, 1965). Elias applied the principles to various kinds of social conflict (van Krieken, 1998). Characterised by an uneven balance of power, established groups are able to construct an image of themselves based on the actions of a 'minority of the best', which is contrasted with an image of outsiders based on the actions of 'a minority of the worst'. 'Praise gossip' is used to reinforce good behaviour and 'blame gossip' to stigmatise deviant behaviour, invariably based on the images of the minorities of the best and worst in the established and outsider groups, respectively. There is also a tendency for outsider groups to internalise the negative characteristics attributed to them by more established groups.

We use this framework of sensitising concepts to explore and understand thinking and actions within the LSP in order to explain the pattern of local services and the form of public health practice that emerged.

Study design and methods

Figurational sociology as a process-oriented methodology provides researchers with a framework for exploring dynamic processes and the outcomes they tend to give rise to (Baur & Ernst, 2011), especially in relation to how actions are constrained and enabled by human interactions. The aim was to develop a synthesis of theory and empirical data in order to explain the specific situation but also theoretically generalise beyond it. As Dopson and Waddington (1996, p. 546) argue, although the process of theorising starts from participants' ways of seeing the world, 'views such as those expressed … should be treated not as an explanation, but as data to be explained'.

An ethnographic case study approach was used to examine the views and actions of professionals working in one LSP in north-west England. The case study site was composed of some of the most and least deprived areas in England and these communities were situated very close to one another, which is reflective of many areas across the country. Health inequality had also been highlighted as 'at risk' in the Comprehensive Area Assessment; a government assessment of how effectively local organisations were working together to achieve their priorities. The fieldwork period (April 2010 to September 2011) took place immediately after a change in political leadership allowing observation of how participants responded to changes in government policy, including unprecedented budget cuts across government departments.

A qualitative approach was adopted, which included 31 participants, 27 of whom participated in a semi-structured interview and four in one focus group. These data are supplemented by qualitative data from 35 observations of partnership meetings. A purposive approach to recruitment was used in order to capture diversity across the LSP in terms of those from differing organisations, professions and positions of power. Observations revealed the complexity of networks within and beyond the formal LSP and were used to select participants based on which organisations were most frequently represented, which people attended and the contributions they made.

Anonymised quotations are used to illustrate the analysis. Participants from public health are referred to as Public Health Professionals (PHPs). All other participants were recorded as Officer. Table 1 lists participants by their employing organisation. Where participants refer to specific places, pseudonyms are used.

[Table 1 near here]

Interviews focused on exploring participants' perceptions of health inequality

locally and the social determinants of health alongside how these issues were being

addressed. Transcripts were uploaded to QSR NVivo 9, which was used to support the

analysis. Grounded theory provided a systematic approach to moving back and forth

between "two layers of knowledge," empirical observations and existing frameworks or

concepts (Elias, 1978, p.89). The data were coded in three main phases; initially line by

line, followed by analytic and then theoretical coding (Charmaz, 2014). Sensitivity to

the figurational concepts outlined above was maintained throughout the study. The

concepts developed during the final phase of analysis were extended into a substantive

theory of public health policy implementation through partnership working.

Findings

Across the partnership, there was a dominant discourse that social inequalities in health

was a problem associated with poor people living in poor places and driven by their

personal lifestyle choices. Individualised interpretations were shared through interaction

with others in the partnership network, including at partnership meetings. Even when

there were divergent voices – for example, from those within public health, who

discussed the social gradient in health – these tended to be unheard or under-

appreciated, especially with regard to any broader scope for action locally. These

discourses are explored below.

Poor people living in poor places

Participants consistently raised health inequality as the priority issue. Reflecting their

relatively involved position in the partnership, health inequality tended to be expressed

in terms of lower life expectancy in areas of deprivation compared with more affluent

localities. The borough was described by a senior local authority (LA) officer as having

predominantly 'affluent areas' alongside 'small pockets of deprivation'. As such, local actors tended to conceptualise health inequality not in terms of a gradient but as a dichotomy, predominantly focusing on poorer people living in poor places. One LA officer said:

> Well for me it's the fact that there's still this great divide between the more affluent areas of [the borough] and the less affluent, and … there's still this seven-year gap in life expectancy and that, to my mind, is the biggest issue.

The emphasis on poorer people and places was influenced, in part, by the way in which statistics about the area were used. By highlighting the gap between areas with the highest and lowest life expectancy, attention was drawn away from the social gradient towards specific areas where poorer people tended to reside. For example, a senior police officer said: 'the key measure that really started to bring Oaktown into sharp focus was the … seven-year life expectancy difference between Park City and Oaktown'.

The Indices of Multiple Deprivation (IMD) were used to first focus attention on the places in the borough with high concentrations of deprivation and then onto the people living in those places. Reflecting on health inequality, a senior PHP said, 'you probably have many more health problems if you fall into the IMD one and two groups'. These statistics were used by local professionals to justify a focus on specific areas – and the people living in those areas – rather than taking a borough-wide approach.

The connection local professionals made between lower life expectancy in areas of deprivation and lifestyle choices contributed to a view that people should take greater responsibility for their own health. Their poverty and poorer living conditions tended to be viewed as irrelevant to their lifestyle choices and therefore, more or less, within their

control. This was exemplified by one LA officer who, when trying to make sense of health inequality, asked, 'why do people make certain lifestyle choices in that community compared to a different community?' When contemplating these 'choices', this participant placed greater emphasis on where they lived than the social conditions they experienced. Emphasising people's decision-making, she went on to list aspiration, attitude and behaviour as differences between people in different communities. This conceptualisation gave rise to the explanation that in order to reduce health inequality, the people living in deprived areas needed to change their poor lifestyle choices.

There was, however, a divergent and relatively more detached but somewhat marginalised discourse regarding how one senior PHP discussed health inequality. This participant was invited to partnership meetings on an *ad hoc* basis to share expertise on specific topics and was, therefore, on the periphery of the partnership network (or figuration) compared to her public health colleagues who routinely attended partnership meetings. Therefore, she had relatively less power and influence on discourses permeating the wider partnership network. She expressed concern about placing emphasis solely on areas of deprivation where life expectancy was the lowest: 'everybody thinks of the inequalities agenda as just the two extremes. I have to highlight [the gradient] time and time again because everybody thinks about just the most deprived area'. This participant made several attempts during partnership meetings to emphasise the importance of universal services across the borough rather than focussing solely on areas of deprivation. On these occasions, the discussion invariably drifted back to areas of deprivation.

Alternative conceptualisations of health inequality that reflected the social gradient went against the grain of the dominant involved view within the partnership. This meant that it was difficult for divergent views to be sustained and thus influence

the perceptions of others especially because of the lesser relative power and position of those expressing such views. In the same vein, it meant that forming strategic alliances to work on borough-wide initiatives rather than those focussed on specific areas of deprivation was difficult given the predominant perspective of those in the partnership figuration. Furthermore, closing the gap in life expectancy by targeting specific areas was perceived to be a more straightforward and practical way for local strategy to be formulated and implemented. Moreover, LAs were responsible for addressing issues in areas of deprivation and health inequality was viewed as an integral aspect of that work. As such, health inequality tended to become conflated with deprivation: working on one was a way of addressing the other, albeit somewhat simplified.

Individualising social influences on health

Interwoven with perceptions of *health* inequality being a consequence of individual lifestyle choices, participants viewed people living in areas of deprivation as experiencing challenging social conditions. For example, one senior PHP described how there were 'concentrations of individuals with poor life expectations really from all aspects, educationally, employment, health, housing etc.' There was a shared understanding of the connections between poor health and other social issues prevalent in deprived communities, such as poor educational attainment and high unemployment. From the relatively involved position of practitioners in the figuration, these social and economic conditions, however, tended to be viewed as individual risk factors for health rather than as patterns relating to the social distribution of influences according to social position. The intersection of the national context with local conditions and the complex networks of interdependency of which participants were a part was, therefore, obscured. Thus, there was no discussion in interviews or observed meetings about the

15

consequences of national-level policy influences on local conditions. This meant that the 'local' tended to be dislocated from the 'national' in the minds of participants.

Poor living conditions and a lack of opportunity were seen as pressures which could lead to making 'unhealthy choices'. However, this was often linked to an expectation that, nonetheless, people should still try to overcome their difficulties and make rational choices. For example, one senior police officer described how being healthy takes 'conscious' effort and that this might not be considered worthwhile by someone for whom the future does not look secure. He said:

> If you're not looking forward to a long, pleasant, well-catered for retirement, then actually you might as well enjoy, you know, the fast food, the smoking, the drinking, now, because why not? If there is no aspiration for something better then why would you work hard? And to be healthy actually takes some effort … it takes conscious decisions for people.

This highlights how local actors tended to understand the influence of social factors on health illustrating a degree of empathic understanding. He went on to say 'all of that aspiration opportunity stuff all comes together around health', demonstrating how empathy was interwoven with the idea that poor health still came down to conscious choices and effort and the need to overcome the constraints of living in difficult circumstances. Promoting an 'aspiration for something better' was a theme that was frequently raised by members of the partnership network in observed meetings and interviews. This reflected an interpretation of personal responsibility for health imbued with ideas of moral obligation and social responsibility, even in relation to factors over which people had little or no control. In this regard, the formulation of 'aspiration for something better' was also individualised in that it was not related to the social conditions in which people lived nor the way in which those conditions could erode a sense of self and aspiration. Therefore, many felt that solutions were to be found in

16

providing opportunities and raising the aspirations of people living in deprived areas. For example, programmes designed to improve individuals' interview skills were prioritised rather than generating employment opportunities locally, which were perceived to be beyond the control of those working at the operational level of local organisations. From this perspective, the following senior LA officer described a need to change 'the behaviours and the aspirations of people and that's about them taking personal responsibility'. In the same way that health inequality was individualised, as described above, social problems, such as high unemployment, also tended to be interpreted as personal troubles relating to particular people in particular places with little consideration to the wider social and economic context in which individuals' lives were embedded.

Other participants described a set of overlapping social issues, such as teenage pregnancy or domestic violence, that tended to cluster in deprived neighbourhoods. These issues were considered the outcome of broader problems, such as unemployment and low educational attainment. For example, one LA officer described 'complex issues' such as domestic abuse, substance abuse and illegal money lending as 'inter-related'. The way in which they made sense of these interconnections, however, was to focus on the individuals' experiencing these issues and the implications for their overall health. For example, in relation to domestic violence, a different LA officer described the difficulties faced by a person experiencing domestic abuse by saying 'you don't look after yourself, you're drinking, you're smoking because you're stressed out', though she recognised that 'there are other pressures in your life that are affecting you'. In a similar vein, anti-social behaviour was described as causing stress and anxiety for people living in those areas because they felt unsafe and the difficulties this created for leading a healthy lifestyle. However, the general view was that, difficult as it was,

people should show resolve and had a moral obligation to cope with such a stressful

life. As one LA officer reflecting on the aims of a local intervention said:

> It's addressing those factors whether it be educational attainment levels, whether it
> be the lifestyle issues, employment aspirations… They're the first steps, if you like,
> to pulling people out of those areas or helping people to support themselves.

In this way, little if any connection with the national political context was made.

The specific areas identified as deprived in the 1980s and 90s were still the same

areas, despite high levels of investment by previous governments, which was noted by

participants. For example, a senior LA officer said: 'the previous Government put

stacks of money into estates and things … but we've still got those sink estates, we've

still got the problems'. In this respect, there was an awareness that focussing on areas of

deprivation had not produced the desired results. However, these same areas remained

the focus of attention, with increasing emphasis being given towards individual lifestyle

approaches reflected in specific (often time-limited) projects. He went on to say 'we're

not dealing with the people issues…. you can build a fantastic estate of houses but

within 10 years they'll be pig sties unless you've dealt with the people issues'. This

highlights how people in particular places were perceived by some powerful individuals

as 'outsiders' and blamed for the social conditions affecting their lives. Another senior

LA officer described a 'new' local project as different because it sought to 'get people

to a position where they can take responsibility for their own lives'.

Social circumstances also tended to be individualised when discussing the so-

called 'dependency culture' in deprived areas, which a high-profile local project had

been set up to address. Such a culture was expressed as an over-reliance on welfare

benefits and local public services. A local document described the project as focused on

'reaching and engaging individuals' and providing 'bespoke personal support' to enable people to overcome barriers to employment, identified as one of the key drivers of the dependency culture. As one senior Police Officer summarised, this approach focussed on providing intense support 'tailor[ed] around the individual'. He went on to describe this individualised support as 'understanding the link with your personal wellbeing, your sense of belonging, your aspiration and your opportunity'. In this way, unemployment was interpreted as an individual responsibility (and, to some degree, a personal failing) rather than a structural issue relating to the labour market. Some felt that a history of paternalism had created a culture in the deprived communities where people expected things to be done for them rather than doing things for themselves. As one LA officer summarised:

> That community might have had a history of paternalism and that's often the case in a lot of our deprived communities, they've always been done to, they've never been encouraged to do for themselves.

The professionals involved in the high-level project were emotionally invested in its success and firmly believed that 'encouraging people to do things for themselves' was the answer to addressing issues in so-called problem areas, overlooking the structural inequalities constraining individual capacity that they also seemingly expressed awareness of at other times.

Discussion

The findings from this study reveal the predominance of individualised explanations for inequalities in health within the local partnership. In this regard they support previous work (Blackman, et al., 2009; Blackman, et al., 2012; Morrison, et al., 2015; Noble, et

al., 2014) and add to the accumulating evidence that these perspectives are deeply entrenched within local professional networks regardless of the policy rhetoric. The findings also reveal a generalised awareness across the partnership of the ways in which social conditions affect health, as others have shown in various settings (Babbel et al., 2019; Brassolato et al., 2013; Powell et al., 2017). This paper, however, contributes further detail to understanding the particularity of the process of individualisation by revealing how social inequalities in health, as a complex phenomenon, tend to be simplified. Local evidence (IMD statistics, for example) and experience (including a degree of empathic understanding) were interpreted through the lens of individualism contributing to a focus on geographical areas and those living there.

Figurational sociology helps explain the predominance of individualism within partnership networks with diverse actors whose work is focused on addressing social inequalities in health, and, inter-relatedly, their perpetuation. First, although referred to as an apparent paradox – that is to say, the expression of an awareness of the social determinants of health alongside views relating to personal responsibility for health are viewed as opposites – they are better viewed as two sides of the same coin and thus closely related and inseparable. Working within the partnership figuration, interdependent relations generate degrees of emotional involvement, which makes taking a more detached view unlikely. While expressing their awareness of the social determinants of health their (re)interpretation of these as individual risk factors can be understood as a rational response to their perceived positions within the local partnership that gives them little control over the structural determinants whilst having responsibility for taking action on social inequalities. The tendency to simplify their social reality is thus perhaps an inevitable consequence of working in a complex figuration of interdependent relations in which resources are constrained and

expectations to meet local targets quickly are ever-present. That is to say, processes of individualization gave rise to professionals having some sense of control in the face of an otherwise seemingly overwhelming context. In this regard, local knowledge about historical investment in deprived areas and the limitations of lifestyle focused work was also part of the individualising processes by which professionals simplified their day-to-day reality. We might also add that processes of simplification may emerge as important in partnerships, which tend to increase complexity for those working within them. In this way, living in deprived areas was translated into being poor, inadequately educated and/or unemployed, each of which was then interpreted as an *individual* risk factor for health. This meant that the social gradient was simplified through a process of dichotomisation: areas as deprived or not deprived and highest and lowest life expectancy. The upshot was that the scope for action was similarly construed at the individual level (improving skills and signposting to services, for example), which in turn gave rise to expressions of personal and moral responsibility for improving one's situation.

Figurational sociology can also provide a more adequate theoretical understanding of why individualism, as the dominant discourse, is sustained in partnerships composed of diverse actors. Drawing on Elias (Elias & Scotson, 1965), the focus on poor people living in poor places is perpetuated through blame gossip and perceptions of behaviours based on a minority of the worst in areas of deprivation, which is contrasted with the behaviours of a minority of the best in more affluent communities. In this context, divergent voices tended to have little impact, largely because of the relative lack of power of those who articulated such views because of their position on the periphery of the network and their perceived status as outsiders within the partnership figuration. The presence of divergent voices within the

partnership seemed not to disrupt these interweaving processes. We conclude, therefore, that rather than partnerships being transformative (Rod, 2018), they tend to sustain and reproduce the hegemonic individualistic perspective in a way that explains lifestyle drift. It is likely that the interdependency between people in the figuration – for example through the discourses generated through formal and informal meetings – further reinforced their collective conceptualisations of health inequality and how local services and projects could address local issues.

Crawford (1980, p. 377) has argued that the (over) emphasis on personal responsibility is problematic because 'it risks fostering the illusion that individual responsibility is sufficient' to improve or maintain health. Elias offers a way of explaining why the ideology of individualism is pervasive in the face of mounting evidence within public health of its limitations. As the predominant worldview, individualism has become part of the predispositions of many people in the west (Elias, 1991). This means there is an increasing propensity among members of complex state societies towards viewing themselves – that is, their thoughts and actions – as isolated from others in the same way that our bodies are separate physical entities. Thus, there is a tendency to view the choices people make as isolated from their social context and without constraint. Moreover, people are emotionally attached to individualised perspectives as they reflect 'positive valuations' of themselves and their personal achievements gained through their own 'energy and merit' (Elias, 1991, p. 85). Less emphasis was given to social conditions that supported these personal achievements, because it is easier to think in individualised ways than grapple with the complexity of the figurations of which they are a part, which are impossible for any one individual to fully comprehend. Such perspectives contribute to more fantasy-laden thinking in trying to resolve problems, such as the continued focus on individual behaviour in areas of

deprivation. Furthermore, because thinking is always intertwined with emotional attachment to deeply held and rarely examined values and beliefs (Elias, 1978) the rational interpretation of evidence is rarely straightforward. It is therefore unsurprising that the participants in this study expressed – to a greater or lesser extent – an individualised world view to make sense of their social reality. Influencing social conditions is much more difficult, which may also have contributed to the continued focus on areas of deprivation where local professionals needed to be seen to be doing something. Failure of the population to engage with the opportunities provided might reinforce the view that the people themselves are the problem. The unintended outcome is that this way of thinking exacerbates the very problem they are trying to 'resolve' in what Elias (2007) referred to as a double-bind.

Conceptualising local professionals as involved in a complex web of interdependency helps to explain the social processes that contributed to relatively restricted interpretations of public health policy priorities and practice. Elias (1991) suggests the complex webs of interdependency that connect people, both directly and indirectly, constrain and enable their intended actions. These findings highlight professional dilemmas inherent in public health work in relation to a tension between the actions relating to the social determinants of health, and the constraints placed upon their actions by the complex networks of interdependency to which they belonged. The enduring emphasis on local collaborative networks during a period of widening social inequalities in health and continued resource constraints highlight the relevance of these findings. They shed light on why local networks might struggle to be transformative and tend to reproduce local public health work underpinned by a focus on poor people and their lifestyle choices.

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