'What Counts is What Works'? New Labour and Partnerships in Public Health

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Abstract

Partnership working has been a central feature of New Labour's approach to the delivery of health and social policy since 1997. A number of partnership based initiatives have centred on reducing health inequalities and improving health. This paper reports on the findings from a systematic review of the impact of partnership working on public health, and considers whether these partnerships have delivered better health outcomes for local/target populations. It finds that there is little evidence that partnerships have produced better health outcomes for local/target populations or reduced health inequalities.

Introduction

Partnership working has a long history in public policy in the UK in respect of the health and social care interface, especially from the 1980s onwards (see Hardy et al 1989; Higgins et al 1994; Hudson 1987; McKeganey and Hunter 1986; Wistow 1982). But interest intensified under New Labour when it was elected in 1997 and was broadened to embrace public health issues, requiring the NHS to work with other agencies in order to achieve the government's wider policy objectives (Secretary of State for Health 1999). Reflecting this increased interest, Glasby and Dickinson (2008) note that the word 'partnership' was recorded 11,319 in 2006 in official parliamentary records, compared to just 38 times in 1989 (this is after removing references to civil partnerships, which were being debated in 2006). As Dowling et

al (2004: 309) state: 'The message is clear…Partnership is no longer simply an option; it is a requirement'.

There is a plethora of literature testifying to the importance of partnership working (see, for example, Clarke et al 2002; Glendinning et al 2005) and partnerships tend to be viewed *a priori* as 'a good thing'. However, it is not the intention of this paper to reflect on, or contribute to, theories of partnerships (for a review of these see, for example, McDonald 2005; Rummery 2002; Hudson 2004), although many of the underpinning values and concepts of partnership theory are cited in this paper, such as the values of trust, co-operation, and whole systems theory approaches and their emphasis on obligational rather than market contracts (Glendinning et al 2005a; Hudson 2004; Hudson et al 1999; Rowe and Devanney 2003). What the paper does aim to show is that little attention has been given to assessing whether public health partnerships actually achieve their stated primary purpose of contributing to better public health outcomes. Wanless (2004), among others, noted the gap between evidence and practice in partnership working and called for evaluation to be undertaken of the emerging ways in which NHS organisations and local authorities were working together in relation to public health. Yet, this gap does not appear to have been addressed. As Glasby et al (2008: 67) note: '…the assumption that partnerships lead to better outcomes is at best unproven and much existing partnership working remains essentially faith-based…'.

This deficit in evidence is ironic given that a parallel New Labour approach to policy-making has been an emphasis on the need for evidence of 'what works' (Labour Party 1997; Cabinet Office 1999). Given the fact that in 2002 alone it was estimated that public sector organisations were involved in approximately 5,500 different partnerships, with annual direct and indirect expenditure totalling between £15-20 billion, it is curious that partnerships have

escaped critical assessment of their (far from negligible) transaction costs (see Audit Commission 2005; Healthcare Commission et al 2008; Sullivan et al 2002).

Public health in England: the national and local context

Under the former Conservative governments (1979-1997), little action was taken to address health inequalities. The prevailing political orthodoxy was that poverty (a major factor influencing health inequality) was largely self-inflicted (Carlisle 2001). But, almost overnight, the arrival of New Labour in 1997 palpably changed the climate. The new government attached considerable importance to public health and tackling health inequalities, appointing the first ever Minister for Public Health. Significant policy energy and resources were expended in the pursuit of innovative policy responses, notably the partnership-centred Health Action Zones and Healthy Living Centres. As discussed above, the government also committed itself to basing policy decisions on 'what works' and, accordingly, many of the early public health interventions it sponsored were evaluated.

By the second and third terms of Labour governments (2001-2005 and 2005-present), it was beginning to seem as if endless successions of policy change and organisational restructuring were New Labour's hallmark. Rather than basing policy decisions on the outcomes of research and evaluation, policies were being discarded 'as though they have no value once they exist' (Sennett 2006: 176). In addition, from 2000 onwards, the government's focus began to shift away from a broad, holistic emphasis on the social determinants of health and towards a growing preoccupation with health care issues, such as the need to reduce waiting times, improve access to beds, and balance the NHS's financial books (Smith et al 2008).

Another marked difference was that, by 2003, the government in England had begun to embrace market-style thinking and neoliberal principles that stressed individual lifestyle issues and underplayed socio-economic, structural determinants of health and the role of

government in tackling these kinds of determinants (Hunter 2007). Such a shift was particularly noticeable in the second English public health white paper, *Choosing Health* (Secretary of State for Health 2004).

Throughout these various policy shifts, partnership working has remained a central tenet of the government's response to public health priorities. In England, the drive to tackle health inequalities in a local context is currently centred on Local Strategic Partnerships (LSPs) and Local Area Agreements (LAAs). Over the past seven years, LSPs have been established in most English local authorities. These take the form of partnerships between public, private, and third sector organisations, with the aim of creating a framework within which local partners can work together more effectively to secure the economic, environmental and social well-being of their area (ODPM 2005). The purpose of LAAs is to strike a balance between the priorities of central government and local government and their partners in reaching a consensus on how area-based funding will be used. The underlying concept behind LAAs is outcome-based and involves local government choosing up to 35 targets from a longer list of central government priorities. Local partners are then in theory left to decide how best to achieve these targets (DCLG 2006; Local Government Association 2007).

It is against this policy context that the remainder of the paper reports on the findings of a systematic review of the success (or otherwise) of public health partnerships in England. It forms the first stage of a larger study which aims to assess the ways in which partnership working contributes (or not) to reducing health inequalities and improving other public health outcomes. Although a literature review of partnership working had been undertaken by Dowling and colleagues (Dowling et al 2004; Glendinning, Dowling, & Powell 2005; Powell & Dowling 2006), this was a non-systematic review and was limited to peer review papers only. Nor was its focus specifically on partnerships orientated around public health

objectives. Our review is therefore the first of which we are aware to use systematic review methodology to examine public health partnerships.

Methods

The systematic review synthesises empirical studies (both quantitative and qualitative) in regard to two key elements of public health partnership working: process issues (the policy levers, mechanisms and instruments in place to ensure effective delivery of public health outcomes), and outcome issues (whether these policy levers have been effective in delivering the desired outcomes). Public health partnerships were defined as organisational partnerships (of two or more bodies) which aimed to improve public health outcomes (through population health improvement and/or a reduction in health inequalities). To be included, studies had explicitly to describe the public health partnership under evaluation, or assess one of the key known public health partnerships such as Local Strategic Partnerships, Health Action Zones, Neighbourhood Renewal Partnerships, or Health Improvement Programmes, and they had to make some attempt to assess the success (or otherwise) of the partnership in relation to public health outcomes. Only studies that examined partnerships based in England, and which were published in 1997 or later, were included.

Eighteen electronic databases were searched from January 1997 to June 2008. In addition, the bibliographies of all included studies were hand searched and information on unpublished or in-progress research was requested via author contact. The search strategy and quality of papers reviewed is described in more detail in Smith, et al (2009). The searches located 1058 references, 895 of which were excluded at the title and abstract stage; a further 132 were excluded after reading the articles in full as they did not meet the inclusion criteria. 31 references were therefore data extracted, quality appraised, and included in the review.

Results

The majority of these 31 studies focused on the impact of Health Action Zones, as they proved to be a particularly well evaluated initiative, for which a combination of national and local studies have been undertaken. Studies of Health Improvement Programmes and a range of other partnerships were also identified (see box 1). The results of these studies are synthesised below in a discussion which is informed by Dixon-Woods et al's (2006) critical interpretive synthesis (CIS) approach to qualitative systematic reviewing. This involves thematically exploring the theories developed in the various studies, in addition to focusing on the empirical results that are described. Most of the studies examined process, rather than outcome issues and this is reflected in the evidence synthesis in which there are six themes relating to process outcomes (engagement of senior management in partnerships, lack of financial and human resources, sharing information and best practice, contextual challenges, coterminosity of boundaries, the need for 'quick wins') and only two relating to outcomes (health outcomes, monitoring and evaluation problems).

Box 1: Main types of partnerships reviewed

Health Action Zones (HAZ). 9 studies. Acknowledging the wider determinants of health, HAZs were area based initiatives intended to develop partnership working between the NHS, local government and other sectors with the aim of tackling ill health and persistent inequalities in the most disadvantaged communities across the UK. The first 11 HAZs were launched in April 1998, followed by a further 15 HAZs in April 1999. It was originally intended that they would last between five and seven years, but most had been wound down by 2003. The projects facilitated by HAZs varied extensively but included initiatives that aimed to address social and economic determinants, promote healthy lifestyles, empower individuals and communities, and improve health and social care services.

Health Improvement Programmes (HImP). 4 studies. HImPs are action plans developed by NHS and local government bodies working together. They were introduced in 1999 and, despite being re-named Health Improvement and Modernisation Plans in 2001; they continue to form a key approach to public health in England. The plans set out how these organisations (with, where deemed appropriate, voluntary and private sector input) intend to improve the health of local populations and reduce health inequalities. The programmes offer a three

year plan for identifying local health needs and developing relevant strategies to improve health and health care services at a local level.

Healthy Living Centres (HLC). 1 study. HLCs were introduced in 1998 to tackle the broader determinants of health inequalities and to improve health and wellbeing at a local level. Funding was awarded for 352 community projects which varied in terms of focus, ranging from service- related issues to activities addressing unemployment, poverty and social exclusion. Partnership working was an underpinning concept of HLCs. Interventions included health focussed projects such as a physical activity outreach programme in rural localities, support programmes such as a Community Health Information Project which trained members of the local community to act as ambassadors for HLCs, and services such as 'Bumps to babies' which provided midwifery and health visiting services for young families. Although some HLCs still exist, a lack of clarity with regards to funding means that the future of many HLCs is unclear.

New Deal for Communities (NDC). 2 studies. As part of the Neighbourhood Renewal Strategy, NDC was developed to tackle the health and social inequalities experienced by the 39 most deprived communities in the UK. In partnership with local communities, NDC seeks to address embedded issues of deprivation and long term poverty by improving outcomes in terms of housing, education, employment and health. Interventions have mainly focussed on promoting healthy lifestyles, enhancing service provision, developing the health workforce and working with young people.

National Healthy School Standard (NHSS). 1 study. The National Healthy School Standard is led by a partnership between the Department of Health, the Department for Education and Skills and the Health Development Agency. It has three key objectives: to raise pupil achievement; to promote social inclusion; and to contribute to reducing health inequalities.

(Also partnerships between health and local government not a specific intervention as such).

Process issues

The context against, and parameters within, which partnerships operate may have a profound effect upon the impact partnerships have in addressing health outcomes. This section of the paper draws upon the predominant process issues from the literature review. As discussed, many studies have tended to focus upon process issues without addressing outcomes, but

arguably it is only through being able to contextualise partnerships in relation to the policy environment within which they operate that we are better able to understand the opportunities and barriers to impacting upon health inequalities and health outcomes (Dowling et al, 2004).

Engagement of senior management in partnerships

A major barrier to successful partnership working in many of the studies was the perceived absence of key personnel with authority to act on behalf of relevant organisations within the partnership. The Evaluation of the Impact of the National Healthy School Standard (TCRU & NFER, 2004) found that securing the engagement of senior management in local partnerships to improve the health of schoolchildren was problematic, particularly in respect of managers from PCTs. Similarly, a study of health authorities' efforts to address inequalities in health found that: 'There was seen to be a need to gain a more general commitment to tackling health inequalities and, in particular, to ensure that senior figures were engaged in the agenda' (Benzeval et al 2002: 90). Other studies have also highlighted the need to ensure the engagement of senior management in partnerships for them to succeed (e.g. Arora et al 1999; Geller 2001).

With or without the engagement of senior management, 'local champions' were regarded as crucial in some of the partnerships; in order to drive the policy agenda forward (Arora et al 1999; Benzeval et al 2002; Speller 1999).

Lack of Financial and Human Resources

A common feature of most of the studies was that partnerships were frequently found to lack the resources (both financial and human) adequately to respond to the policy demands made of them. A recurring issue in several studies was the lack of joint funding. Several studies reported complaints that some partners had not contributed enough (or even at all) to funding

due to competing priorities on their resources (Hills et al 2007; Arora et al 1999; Powell et al 2001; Arora et al 2000; Sullivan et al 2002; Benzeval 2003; Bauld et al 2001; Mackenzie et al 2003; Matka et al 2002). In addition, commitments to contributing resources to a partnership were usually only made for a finite period of time caused planning difficulties for several of the partnerships (Hills et al 2007; Bauld et al 2001; Mackenzie et al 2003; Matka et al 2002).

The difficulties with financial resources (particularly their short-term nature) often had knock- on effects on human resources, sometimes making it difficult to retain staff, who were wary of the finite nature of their contract, or to persuade potential new recruits to take up short-term contracts (Hills et al 2007; Cole 2003). Uncertainty around funding also had a number of other implications; including some programmes and activities having to be curtailed or abandoned (Hills et al 2007; TCRU & NFER 2004). All this created considerable uncertainty around planning for future service provision (Speller 1999; Arora et al 1999; Arora et al 2000; Hills et al 2007).

In respect of HAZs, the pressure to demonstrate 'success' in tackling long-term and complex health issues within a relatively short period of time meant that many struggled to set realistic objectives, given the resources and time available to them, and placed themselves in a position where they were unlikely to be able to meet their own objectives (Bauld et al 2005b; Mackenzie et al 2003; Matka et al 2002; Bauld et al 2001; Jacobs et al 2002). Each of the strands of the national evaluation of HAZs concluded that a key barrier to success included the short-term (and often uncertain) nature of available funding (Bauld et al 2005a; Mackenzie et al 2003; Matka et al 2002).

Sharing information and best practice

Many of the studies cited the importance of sharing information between partner agencies as a key requisite of partnership working. This involved both information concerning

operational issues and the sharing of data sets (Speller 1999; Freeman and Peck 2006; Benzeval and Meth 2002; Durham University 2008). However, the studies also highlighted the difficulties and unease felt by some partners with regard to sharing information (CRESR 2005; Speller 1999; TCRU & NFER 2004; Freeman et al 2006). In their study of HImPs, Benzeval et al (2002: 131) recount the case of one local authority encountering precisely these difficulties:

'One LA had tried to develop a database of partner agencies' activities in order to map strategies, initiatives and good practice, and had found it very difficult to gather information from organisations. This was thought to be partly because of time constraints, but also because of a protective approach to what they were doing, where they had achieved success and where they had failed.'

A study of the New Deal for Communities (NDC) echoed this finding, maintaining that 'silo' mentalities of partner organisations hindered the sharing of information (CRESR 2005). Conversely, sharing best practice was seen as one of the major benefits of partnership working within some of the studies (TCRU & NFER 2004; Speller 1999; Freeman and Peck 2006). One of the studies included in the HAZ national evaluation which specifically set out to explore 'collaborative capacity', claimed that HAZs achieved at least some success on this front (Sullivan et al 2005; Sullivan et al 2002). Sullivan et al (2005), note that a key aspect of a willingness to work in partnership and share information involves the building of trust and goodwill between partners, an issue which is also highlighted in many of the other studies (Powell et al 2001; Speller 1999; Hills et al 2007; CRESR 2005).

Contextual challenges

Agencies engaged in partnerships do not operate in a policy vacuum and many of the studies found that shifting policy priorities and processes of organisational restructuring tended to

have a detrimental effect on partnership working as partners had to either re-negotiate relationships with new or reconfigured agencies, or re-orientate themselves towards a new policy framework. In the case of many HAZs, both these issues had to be tackled at the same time. Many of the HAZ studies reported that those involved in implementing HAZs believed each new Secretary of State for Health brought a new focus for national health policy and that this resulted in constantly changing priorities for the HAZs. It appears to have been partly as a consequence of these changing priorities that the future of HAZs became increasingly unclear (Benzeval 2003; Sullivan et al 2004; Bauld et al 2005b). By 2000, the future funding available to HAZs was already less certain and the policy focus had shifted away from the original public health goals towards health-service related issues (Sullivan et al 2004). By 2003, researchers involved in the national evaluation of HAZs found that the HAZ programme was being effectively wound down (Bauld et al 2005a). Most of the studies of HAZs concluded that their success was constrained by this shifting policy context (Benzeval, 2003; Sullivan et al, 2004; Bauld et al, 2005).

Similarly, in the various studies of HImPs (Arora et al 1999; Arora et al 2000; Benzeval et al 2002; Geller 2001; Powell et al 2001; Speller 1999), a major concern among those involved was found to lie with the restructuring of health authorities and with the consequent shift in responsibility for leading on health inequalities to Primary Care Groups (which were subsequently replaced by Primary Care Trusts). As well as causing uncertainty for the actors involved, constant restructuring required partnerships to be reconfigured and new policy networks to be formed, all of which required further effort and resources to be put into developing new relationships.

In addition to the unpredictable policy context, the researchers evaluating the partnerships included in this review often had to contend with the fact that a number of other area-based initiatives were rolled out during the lifetime of the partnership being studied. Consequently,

many of the studies of partnerships included in this review have been undertaken in a context in which a number of overlapping programmes emerged, some of which appeared directly to duplicate the aims of the partnership being studied (CRESR 2005; Hills et al 2007; Sullivan et al 2002; Bonner 2003, Halliday et al 2005). This made it extremely difficult for researchers to attribute identifiable outcomes to specific partnerships.

Coterminosity of boundaries

Many of the studies found that the requirement of some partnerships to operate with partners that had different geographical and political boundaries caused problems. For instance, the difference between local authority and local NHS boundaries posed particular problems for delivering some joint services to users. As Glendinning et al (2001: 31) note in their study of Primary Care Groups and developing partnerships:

'…differences in the boundaries of primary care groups and trusts and local authority departments continue to present problems in aligning both the planning and delivery of services…Only a sixth of groups and trusts were planning to merge or become trusts because they wanted to align their boundaries more closely with those of their local authority partners'.

Likewise, the case studies of three HAZs in Sheffield, East London and North Staffordshire (Benzeval 2003) and the CRESR (2005) study of the NDC also suggest an absence of co-terminous organisational boundaries was problematic for partnership working.

The need for 'quick wins'

Improving health and tackling health inequalities requires a long-term policy commitment. However, many of the HImP and HAZ studies noted policy pressure to demonstrate 'quick wins', which often worked to undermine long term strategic planning (Speller 1999; Arora et

al 1999; Arora et al 2000; Benzeval et al 2002; Powell et al 2001; Bauld et al 2005a; Mackenzie et al 2003; Matka et al 2002). As Benzeval et al (2002: xi) note:

'…there was a concern that performance management pushed agencies towards focusing on short-term targets, which did not sit easily with the long-term nature of a strategy to achieve reductions in health inequalities.'

Outcome issues

One of the aims of the partnerships included in the systematic review was to improve public health outcomes. Yet, as noted, much of the existing literature on partnerships is concerned with process issues and does not address whether partnerships are improving services or outcomes for local communities (Dowling et al 2004). Health-related outcomes are examined here in the context of, first, whether the partnership affected health-related outcomes, and, second, if not, whether monitoring and evaluation mechanisms have been put in place to be able to capture such effects in the future.

Partnerships and outcomes

In respect of HAZs, perhaps due to the complexities involved in these kind of partnerships, as well as the changing policy context, six of the publications included in the review do not state whether any clear aims are being addressed and instead focus on providing descriptive accounts of aspects of HAZs or on contributing to relevant theoretical/methodological debates (Sullivan et al 2002; Kane 2002; Bonner 2003; Evans et al 2000; Halliday et al 2005; Bhatti 2002). Nevertheless, all of the studies do at least briefly consider the extent to which HAZs, or specific interventions that were facilitated by HAZs, might be considered 'successful' (or otherwise) and, given the simultaneous emphasis on partnership working within HAZs, they therefore meet the inclusion criteria for this review. However, the way in

which 'success' is constructed varies between studies, not least because the HAZs themselves appear to have varied greatly in their aims, as well as in their chosen means of achieving these aims.

In order to try to assess the possible impact of HAZs on health outcomes more clearly, two studies drew upon an analysis of data from the 'Compendium of Clinical and Health Indicators' (which is commissioned by the Department of Health and produced by the National Centre for Health Outcomes and Development). This data set 'brings together 150 indicators from several datasets including the Public Health Common Data Set indicators, population health outcome indicators, *Our Healthier Nation* indicators, clinical indicators, cancer survival indicators and others' (Bauld et al 2005a: 160). The HAZ national evaluation team drew on a range of indicators from this data set, with the objective of identifying whether there was a demonstrable difference between HAZ and non-HAZ areas in relation to changes in health outcomes through time. Baseline data were taken from 1997/98, the year before the first wave HAZs, and compared with the latest available data, which was for the year 2001/02. Local authority level data were chosen to facilitate comparisons between HAZ and non-HAZ areas. Local authorities located within HAZ areas were then compared with those in non-HAZ areas which appeared to have similar levels of disadvantage (Bauld et al 2005a; Bauld et al 2005b).

This analysis produced some evidence to suggest that HAZs outperformed other areas in relation to a number of indicators related to HAZ programmes and national policy priorities (Bauld et al 2005a). For example, positive changes in relation to all cause mortality and CHD mortality were visible in the earlier, first-wave HAZ areas (which had had an extra year to make an impact). However, the findings were not consistent and mortality from suicide, for example, had increased in all areas, with the largest increase being in first wave HAZ areas,

even though some of these areas had prioritised suicide reduction programmes. Overall, the data employed in this strand of the national evaluation:

'…do not support the view that HAZs made greater improvements to population health than non-HAZ areas between 1997 and 2001.' (Bauld et al 2005b: 436).

In contrast, three studies of particular interventions that had been facilitated by HAZs made greater claims to the impact of the respective interventions on local public health outcomes (Burton & Diaz de Leon 2002; Bhatti, Cuthburt & Lunt 2002; Kane 2002). All three of these interventions involved some level of partnership working. One of these (Burton & Diaz de Leon 2002) involved studying the impact of partnerships between the primary care services in which advice about benefits was offered by voluntary and public sector workers in primary health care settings (such as GP surgeries). The second (Bhatti, Cuthburt & Lunt 2002) involved an intervention designed to provide a space in which mothers who were largely not accessing health visitor services could come together, share information and relax. The third (Kane 2002) was a study of a project designed to engage disabled people in mainstream leisure and sports activities. All three reported positive health outcomes for participants. Unfortunately, the methodological approach taken by these three studies was unclear so it is difficult to assess the reliability of these findings.

In summary, the HAZ studies identified very little reliable evidence that partnership working had impacted positively on public health outcomes, although there was some evidence that partnership working had helped broaden organisational understandings of the wider determinants of health and/or push the issue of health inequalities up local policy agendas (Mackenzie et al 2003; Sullivan et al 2002; Benzeval 2003).

With regard to HImP partnerships, Directors of Public Health were pessimistic that their local HImP would improve public health in their districts (Geller 2001). As Benzeval et al (2002: 26) state in their study of Health Authorities' policies for reducing health inequalities:

'…respondents who answered this question said that their HA did have health inequalities targets. However, many of the targets cited as examples actually focused on processes or activities rather than health outcomes… A small proportion said that they had 'tried and failed' to identify appropriate targets. Just over ten per cent said that they had no plans to develop targets in the foreseeable future'.

Other studies of HImPs have also found this to be the case (Arora et al 1999; Arora et al 2000). In respect of the NDC, research by Stafford et al (2008: 301), focusing upon the health inequalities impact of the programme, found that:

'There were no consistent differences between NDC and comparator areas in the pattern of health-related outcomes for different demographic groups. In other words… robust evidence of an NDC effect was not found, either overall or in terms of differential impacts, over and above the developments in the comparator areas'.

A comprehensive longitudinal study by CRESR (2005: xix) also found relatively little data to support claims that NDC areas had been able to improve their relative position with regard to indicators of health outcomes.

Monitoring and Evaluation

Part of the difficulty that many of the studies experienced in evaluating the impact of public health partnerships appears to relate to a lack of monitoring and evaluation within the partnership. For example, a study on the Evaluation of the Impact of the National Healthy School Standard (TCRU & NFER 2004: 50) found that:

'Although the NHSS national team were said to have spent time developing targets and indicators for evaluation, a usable set of indicators had not yet been agreed'.

In the case of HAZs, even though many of the local actors involved in them were keen to produce 'hard evidence' to 'prove' the health benefits of HAZ interventions, they faced the key problem that:

'...relevant [comparable] data simply were not available in a usable form, as data were collected on different scales, over different time periods and with different degrees of population coverage.' (Sullivan et al 2004: 1609).

Reviewing the studies overall, the lack of indicators of improved outcomes appears to have been due to a combination of factors including: a lack of agreed priorities; a lack of good quality baseline data; and an absence of clear policy goals or targets (Arora et al 1999; Arora et al 2000; Benzeval et al 2002; Geller 2001; Powell et al 2001; Speller 1999; CRESR 2005; Health Development Agency 2005). It is clear that more robust monitoring and evaluation frameworks need to be implemented in future to appraise progress in partnerships. In addition, there are also difficulties in producing effective frameworks for evaluating partnerships and whether the impact of short-term programmes to address the long-term nature of health inequalities can be satisfactorily ascertained (see Dickinson 2008).

Discussion

Recent evidence shows that the government is failing to tackle health inequalities and meet its own targets to reduce inequalities in health outcomes by 10% by 2010, as measured by infant mortality and life expectancy at birth (Department of Health 2008a; Department of Health 2008b). This may in turn suggest that the government's approach to tackling health inequalities, with its heavy reliance on local partnerships, has not hitherto been a success.

The failure of partnership based projects effectively to achieve their aims is likely to relate to many, if not all, of the reasons set out in this paper. Despite this rather pessimistic conclusion, the government's faith in partnerships remains undimmed, with recent statements suggesting it continues to regard LSPs and LAAs as the way forward (Department of Health 2008b).

Continuing belief in partnerships may seem odd given the findings from the systematic review of public health partnerships reported in this paper, and those from a non-systematic review of partnership working by Dowling et al (2004). Both reviews conclude that there is a lack of sound evidence to show that working in partnership will improve outcomes. Furthermore, a systematic review of the factors promoting, and obstacles hindering, joint working between the NHS and social services (Cameron and Lart 2003: 15) reached much the same conclusion, noting that, 'very few of the studies looked at either the prior question of why joint work should be seen as a 'good thing' and therefore why it should be done, or at the subsequent question of what difference joint working made'.

Indeed, it could be argued, in the light of the available evidence, that partnerships established to tackle health inequalities and improve public health have clearly failed. However, the matter is not that simple. As Dowling et al (2004: 311) note, it is important to acknowledge that '…an emphasis on the process of partnerships may be seen as a pragmatic, albeit second best, solution…this avoids the challenge of identifying outcomes that may take a long time to materialise and also be difficult to attribute to the partnership'. Given these problems, Glasby et al (2008: 43) pessimistically surmise that '…we do not yet know what impact partnership working has, for whom or under what circumstances. However, the reality is that we are probably unlikely to know this with any certainty for some time (if ever)'.

Problems of establishing attribution were evidenced in several of the studies included in this review (Sullivan et al 2002; Bonner 2003; Halliday et al 2005; TCRU & NFER 2004). It also

appears to have been a particular concern for the national evaluation of LSPs (ODPM 2005). In addition, partnerships have had to contend with an ever changing policy framework, continuous organisational change, a lack of resources, and, increasingly, pressure to produce evidence of 'quick wins'. It could be argued that to achieve measurable outcomes in this context is at best difficult and at worst impossible.

In such circumstances, perhaps the government's simple faith in partnerships is not so incomprehensible after all. However, the evidence, such as it is, does offer some helpful pointers to improve policy and practice in this area. The systematic review we conducted suggests that partnerships have not always helped their cause. Problematic issues highlighted in this review, which partnership working perhaps ought to have been able to overcome, include a 'silo' mentality, that is, an unwillingness by some partners to share information or resources, and a failure to accord partnership working sufficient priority or support. Glasby et al (2008) argue that structural changes or re-configurations of partnerships will not necessarily lead to improved outcomes. Re-structuring is time consuming, diverts human and financial resources, and can be counter-productive. This is a conclusion supported by the Healthcare Commission and Audit Commission in their stock-take of the NHS reforms (2008) and by the Department of Health's assessments of the impact of public health policies since 1997 (Department of Health 2008a and 2008b). The same conclusions were also reached by Wanless and colleagues in their assessment of progress in achieving the 'fully engaged scenario', namely, constant structural changes were hampering delivery of services (Wanless et al 2007). Despite the clear message, restructuring remains in fashion and shows little sign of abating.

Ways of trying to make partnership working more effective include the introduction of joint posts such as joint director of public health appointments between the NHS and local government. They are designed to give public health more clout in local government. But

there remains limited evidence as to whether such posts are effective or not and some concerns that in the rush to establish them insufficient attention has been given to their purpose, function, role and the skills required to make them work effectively (Hunter 2008). An alternative and more radical approach to trying to make partnerships work better across agencies may be to reconfigure the functions and responsibilities of particular organisations so that, for example, local authorities take over some or all of the commissioning responsibilities of PCTs, thereby possibly removing some of the complexities and accountability problems arising from LSPs and LAAs (Glasby, Smith and Dickinson 2006; Local Government Association 2008). The transfer of public health to local authority control was explored by the Local Government Association's Health Commission. Many witnesses argued strongly in favour of local government as the 'prime mover' in public health with one claiming that public health was not the business of the NHS which 'picks up the tab' (Local Government Association 2008: 92). The Commission decided against recommending a wholesale transfer of functions favouring instead an approach that built on initiatives already underway in which 'local authorities take more of a leading role in relation to public health' (ibid: 106). These might include transferring some PCT public health responsibilities to local authorities where local agreement to do so exists.

A full consideration of potential alternatives to public health partnerships goes far beyond the scope of this review but the findings presented here do suggest that further reflection on these issues is merited.

Conclusion

Partnerships have been held up by New Labour as their preferred approach across all sectors of public policy (Dickinson 2007). Indeed, it could be said that partnerships have been promoted as a panacea to cure all ills. However, in the case of tackling health inequalities and

improving public health, partnerships hitherto have had only a marginal impact and, on the basis of the admittedly poor evidence available, the cure could be said to have failed, or at least to have fallen short of expectations. As Dowling et al note (2004: 310): 'If 'what counts is what works'…it is uncertain whether partnerships work, and therefore, whether they should count'. The further evidence reported here from the systematic review, conducted as the first stage of a larger study of partnership working across the NHS and local government, only serves to reaffirm and reinforce that conclusion. Given the continuing appeal of partnerships, and their pervasiveness in all sectors of public policy, two questions arise: (1) how long is it necessary or acceptable to wait in order to be able to establish if partnerships are having any tangible effects? And (2): would it not make more sense, and be in the spirit of 'evidence based policy', to begin to look elsewhere for solutions? On the basis of the evidence and issues presented and commented upon here, the time may have come for a bolder assessment of not merely the alleged benefits of partnership working but also their limits.

Acknowledgements

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