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# Does better than expected life expectancy in areas of disadvantage indicate health resilience? Stakeholder perspectives and possible explanations

Rebecca Mead [a,*], Chiara Rinaldi [b], Elizabeth McGill [c], Matt Egan [c], Jennie Popay [d], Greg Hartwell [b], Konstantinos Daras [e], Annabelle Edwards [f], Monique Lhussier [g]

[a] Division of Health Research, Lancaster University, Lancaster, UK
[b] Department Public Health, Environments and Society, London School of Hygiene & Tropical Medicine, London, UK
[c] Department Public Health, Environments and Society, London School of Hygiene & Tropical Medicine, 15-17 Tavistock Place, London, WC1H 9SH, UK
[d] Division of Health Research, Lancaster University, Lancaster, LA1 4YW, UK
[e] Institute of Population Health, Department of Public Health, Policy, and Systems, University of Liverpool, Waterhouse Building, Block B, Brownlow Street, Liverpool, L69 3GL, UK
[f] Lancaster Medical School, Lancaster University, Lancaster, UK
[g] Department: Social Work, Education and Community, Wellbeing, Northumbria University, Coach Lane Campus, Benton, Newcastle Upon Tyne, NE7 7XA, UK

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ABSTRACT

Some places have better than expected health trends despite being disadvantaged in other ways. Thematic analysis of qualitative data from stakeholders ($N = 25$) in two case studies of disadvantaged local authorities the North West and South East of England assessed explanations for the localities' apparent health resilience. Participants identified ways of working that might contribute to improved life expectancy, such as partnering with third sector, targeting and outcome driven action. Stakeholders were reluctant to assume credit for better-than-expected health outcomes. External factors such as population change, national politics and finances were considered crucial. Local public health stakeholders regard their work as important but unlikely to cause place-centred health resilience.

## 1. Background and introduction

Health inequalities are defined as systematic differences in health outcomes by population group, which intersect with place (Bambra, 2022). In the UK, people from the least deprived areas can expect to live 9 years longer and up to 19 years longer in good health compared with people from the most deprived areas (Public Health England, 2021). People living in the north of England have lower life expectancy, higher infant mortality and worse health and wellbeing compared with national averages (Munford et al., 2023).

The causes of health inequalities have long been debated (Bartley, 2016). While explanations focused primarily on statistical artefact and health selection are often rejected, debate continues around the importance on cultural and individual lifestyle verses structural drivers and how they serve the interests of the rich and powerful (McCartney et al., 2013). Geographical variations have been attributed to either compositional explanations emphasising the behaviours of people in particular places, or contextual explanations emphasising the characteristics of the places where people live. However, there have been recent efforts to highlight interrelations between people and place, and macro-level structural influences (Bambra, 2022).

Leading public health scholars argue that action on influences beyond health care, such as education, transport and housing, collectively referred to as the wider social determinants, have the potential to improve health and reduce social inequality in health. Those with better access to supportive conditions are more likely to experience better health and live longer lives compared with those living in disadvantaged circumstances. Differences are observed at any point along the social gradient (Dahlgren and Whitehead, 2021). The wider social determinants are unequally distributed across a range of intersecting social factors, such as gender, ethnicity and social class. The unequal distribution of intersecting axes of inequality is driven by structural

* Corresponding author.
*E-mail addresses:* r.mead2@lancaster.ac.uk (R. Mead), chiara.rinaldi@lshtm.ac.uk (C. Rinaldi), elizabeth.mcgill@lshtm.ac.uk (E. McGill), matt.egan@lshtm.ac.uk (M. Egan), j.popay@lancaster.ac.uk (J. Popay), gregory.hartwell@lshtm.ac.uk (G. Hartwell), Konstantinos.Daras@liverpool.ac.uk (K. Daras), a.edwards1@lancaster.ac.uk (A. Edwards), monique.lhussier@northumbria.ac.uk (M. Lhussier).

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determinants of inequality including power imbalances, stigma, and material disadvantage. These differences do not occur by chance but are influenced by the actions of governments, stakeholders and communities (Bambra, 2022).

Since 2010, English local government has experienced budget cuts, varying by area. These cuts have widened health inequalities by place (Alexiou et al., 2021) with disadvantaged localities tending to be hit the hardest (Evans, 2021; Popay et al., 2021) further entrenching the North-South divide (Munford et al., 2023). Similar patterns have been observed in Wales and Scotland (Hastings et al., 2015; Taylor-Collins and Downe, 2022) and other countries and have been critiqued as politically driven by a preference for the market over the state (Peck, 2014).

Local government bodies, called Local Authorities (LAs) in England, have a key role in delivering local services and shaping characteristics of 'places' known to determine population health and health inequalities. Evidence suggests that some place-based interventions can have salutogenic effects, for example improvements to physical environment, housing and transport (McGowan et al., 2021). There is a consistent literature on the benefits of green space for health and wellbeing. While there is a more limited evidence base on whether place-based interventions to improve wider determinants of health are effective in reducing health inequalities, there is growing evidence that improvements in access to greenspace can have equigenic effects whereby those from lower socioeconomic backgrounds benefit the most (Wei et al., 2023).

In the context of increasing financial constraints and growing social and health inequalities, LAs need to make crucial decisions about how to prioritise investment and activities to most effectively and efficiently promote health and wellbeing. Yet research identifying policy options and points of leverage to support LA decision-making processes in the context of financial restrictions is limited.

### 1.1. Health resilience

One area of exploration relates to places that have been labelled as 'health resilient' because they have better-than-expected life expectancy (LE) compared to areas with similar levels of relative disadvantage (Cairns et al., 2012; Cairns-Nagi and Bambra, 2013; Doran et al., 2006; Pearson et al., 2013; Tunstall et al., 2007, 2011; van Hooijdonk et al., 2007). Doran et al. (2006) argue that LA policy and practice may influence health resilience as LAs are responsible for community services and resources (e.g. schools, libraries and recreation), which contribute to the social, cultural, and political context in an area. Some research has sought to identify factors or protective mechanisms associated with so-called health resilience (Cairns et al., 2012; van Hooijdonk et al., 2007).

A small body of quantitative research presents little consensus across studies about which factors are 'protective' in terms of places' health resilience. Studies report conflicting findings that health resilience is associated with high (Pearson et al., 2013) and low (van Hooijdonk et al., 2007) population density. Ethnic diversity was associated with health resilience in a study by Cairns et al. (2012) but not van Hooijdonk et al. (2007). Tunstall et al. (2011) found that areas classified as resilient had lower population loss, whereas Cairns et al. (2012) and Pearson et al. (2013) both associate resilience with high population churn. Qualitative evidence from North East England, identified still more factors with possible associations to resilience: place attachment, the natural environment and social capital (Cairns-Nagi and Bambra, 2013). The literature is currently too under-developed to make sense of these inconsistencies, which could be due to differences in contexts, study methods or conceptualisations of resilience (Castleden et al., 2011; Patel et al., 2017).

### 1.2. Place-centred approaches

The Health and Social Care Act (2012) transferred many responsibilities for public health from NHS organisations to local government in April 2013 – ostensibly to encourage public health roles in wider social policies affecting social determinants of health. Examples of 'place-centred' local government roles include regulating the sale of certain goods (e.g. food, alcohol, tobacco); fiscal measures; economic development and job creation; spatial and environmental planning; housing, community safety; and working conditions. In theory, a local public health policy could attempt to bring greater equity to these social determinants of health. However, Mackenzie et al. (2020) have argued that UK public health policy typically seeks to mitigate the harmful effects of inequity, rather than tackle the inequity itself.

The English government is currently implementing their so-called 'levelling-up' strategy aimed at, among others, reducing place-centred inequalities (Department for Levelling up Housing and Communities, 2022). However, local strategies to improve place that fail to address macro-level drivers of inequality have been criticised for focusing too much on local factors and assets and ignoring the national and macro-level determinants of inequalities (Bambra, 2019). Furthermore, the extent to which targeted versus universal approaches should be adopted to improve health inequalities remains contested (Mead et al., 2022). Hence, there remains uncertainty whether and how LAs can deliver place-centred health resilience.

This paper contributes to addressing the gap in understanding processes contributing to health resilience by undertaking qualitative case studies in two LAs. We identified two LAs for which LE trends were better-than-expected, given the local income deprivation indicators. Using qualitative data from two LAs case studies, the aim of our research was to address the following research question: Do better-than-expected LE trends in areas of disadvantage indicate health resilience and to what extent do local strategic processes contribute to this?

## 2. Methods

### 2.1. Study design

A qualitative comparative case study design was used to examine different place-centred strategies to tackle social determinants of health and health inequalities at the local level. Given the lack of consensus in quantitative studies of factors associated with health resilience, qualitative case study design was selected because it facilitates examining the perspectives of those living and working in areas that might be perceived as health resilient, including possible mechanisms and factors in particular contexts (Green et al., 2022). Two areas were selected for documentary analysis and semi-structured interviews to explore possible explanations for better-than-expected LE.

### 2.2. Case study areas

To select our two cases, we focused on the trends in LE after the introduction of austerity policies in 2010, when gains in LE generally stalled. We looked at Upper Tier[1] LAs within the upper centile of Income Deprivation, based on the 2015 Index of Multiple Deprivation (IMD) (Gov.Uk, 2015). Changes in LE at birth and at 65 years, between 2010–12 and 2015–17, were identified based on analysis of data supplied by Public Health England (PHE, 2023)[2] and the Office for National Statistics (ONS, 2021). Within this group of most disadvantaged areas, approximately two thirds experienced an increase in LE at birth and at 65 (69% and 61% for females and 77% and 77% for males respectively).

[1] Responsibility for services is split between two tiers of local government: county councils (upper tier) and borough councils (lower tier).

[2] Now the Office for Health Improvement and Disparities (OHID).

We then broadly identified the top 10 LAs in terms of positive changes in LE at birth and at 65. Within this 6-year period, these areas experienced greater gains in male LE (between 1 and 2 years at birth and 0.6 to 1.4 at 65) compared with females (0.6–1.6 and 0.4 to 1 respectively). From the 10 areas identified, we used a pragmatic approach based on researcher contacts and diversity (e.g. region, rurality, local authority structure) to select two areas for detailed case study analysis. Table 1 provides an overview the areas key characteristics.

(PHE, 2023).

Like all LAs after the introduction of austerity measures, our case study areas were affected by central government funding cuts: a reduction of £176 and £200 per capita between 2013–18, compared with the English average of £117.[3] It is worth noting however that these cuts were less severe than many other similarly disadvantaged LAs during that period, as the most deprived areas generally experienced the deepest cuts (Alexiou et al., 2021).

### 2.3. Data collection

Data were collected through documentary analysis and interviews. The aim of the documentary analysis was to identify area-specific strategic intentions that might contribute to better-than-expected outcomes. The aim of the interviews was to examine the perceptions of those working and living in the areas regarding possible explanations. In comparing the two we sought to reveal where perceptions about strategic intent and working practices aligned and diverged.

Documents were retrieved from LA websites and other relevant local organisations between March and May 2021 following a search for documents relating to corporate aims, health and wellbeing or addressing poverty and deprivation. Contextual descriptive information was also collected. A list of anonymised analysed documents is provided in appendix A. These were uploaded to NVIVO12 software to facilitate analysis.

Interviews were undertaken with 17 stakeholders working at either LAs, local third sector organisations or health care organisations. Eight members of the public living in the LAs of interest were also interviewed. Table 2 below provides further detail. Interviews took place between December 2020 and September 2021. Participants were recruited through contacts at the case study LAs to facilitate the identification of participants with relevant experience and knowledge on the changes, priorities and activities. Snowball sampling was used to identify further stakeholders through the networks of interview participants, particularly those working in local third sector ~~VCFSE~~ organisations. Members of the public living in the case study areas were recruited through existing networks and contacted via email or telephone. Most interviews took place remotely using video conferencing software Zoom or Microsoft Teams due to practical constraints including Covid-19 restrictions. Interviews with members of the public were conducted and recorded via phone or Zoom. The duration of the interviews ranged from between 20 and 90 min. Informed consent was obtained prior to the start of the interviews through digitally signed consent forms. Ethical approval was granted by Northumbria University (Ref: 17134) followed by local approval from the London School of Hygiene & Tropical Medicine Ethics Committee (Ref: 17954) and Lancaster University Ethics Committee (FHMREC20053). Table 2 lists participants by their employing organisation/area of residence.

**Table 1**
Information about case study areas.

| | Area North West (NW) | Area South East (SE) | England Average |
|---|---|---|---|
| Region | North West England | South East of England | |
| Local Authority Structure | Two tier | Unitary[a] | |
| Geography | Rural | Urban | |
| Level of deprivation | 33% most deprived | 33% most deprived | |
| Male LE at birth (2019) | Below English average | Below English average | 79.6 |
| Female LE at birth (2019) | Below English average | Below English average | 83.2 |

[a] Responsibility for services contained within a single organisation.

**Table 2**
Information about interview participants.

| Interviewee type | Area North West (NW) | Area South East (SE) | Total |
|---|---|---|---|
| Local authority (borough council, county council or unitary) | 6 | 4 | 10 |
| Health care organisation | 1 | 2 | 3 |
| Third sector organisation | 1 | 3 | 4 |
| Member of the public | 6 | 2 | 8 |
| **Grand Total** | **14** | **11** | **25** |

### 2.4. Participants

Interviews were semi-structured using a topic guide based on the research question, documentary analysis and existing literature (see appendix B and C). Participants from LAs and other local organisations were asked about general trends and changes to the area in the last decade; the impacts of austerity measures on the LA's strategy and actions; the extent to which health inequalities and wider social determinants were strategically prioritised in the LA's work; and the involvement of residents in local decision-making processes. Members of the public were asked about changes in the local area; their expectations of the LA and other local organisations; the impacts of austerity measures on the lives of residents; and the extent to which they felt involved in local decision-making processes. Interviews were audio-recorded and transcribed verbatim. Anonymised transcripts were uploaded to NVIVO12 software to facilitate analysis.

### 2.5. Analysis

Documents were analysed using content analysis. An initial set of codes was developed based on the research questions and existing literature. Each document was read for content which was captured in the relevant code (Bryman et al., 2022). Interview data was analysed using thematic analysis (Braun and Clarke, 2021). An iterative approach was used whereby the initial set of codes developed for documentary analysis provided our first framework and additional codes were developed from the interview data. This involved data familiarisation and repeatedly reading data to generate themes and sub-themes. Transcripts were analysed separately for the two case study sites by two authors (RM and CR) and reviewed by another two authors (JP and EM). Results from the documentary analysis and interviews were summarised based on the most salient findings and possible explanations for better-than-expected LE in each of the local contexts. These findings were subsequently discussed among authors to identify common themes and differences between case study areas.

## 3. Findings

The findings from our two case studies are summarised below. We begin with an exploration of possible explanations for better-than-expected outcomes: 1) partnership working, 2) strategic intent and 3) population change. We then discuss the impact of austerity. The themes

[3] The available data does not tell us how they compare in the post 2018 period.

across the two sites were broadly similar. The key difference was strategic intent. Area NW illustrated a bottom-up approach to policy making and implementation while Area SW illustrated more top-down approach. Illustrative quotations are provided with a standard set of information that includes case study area, participant's reference number and whether they were a stakeholder - in which case their employing organisation is listed - or a member of the public [e.g. (NW01_LA) or (NW16_Public)]. Employing organisations are distinguished using the following key: Local Authority (LA), Health care organisation (HC), Third Sector Organisation (TS) or member of the public (Public).

### 3.1. Possible explanations

In general, participants were not aware that the areas had better-than-expected LE compared with similar areas and were unclear about what actions and interventions could have led to these positive health outcomes, or whether they were better explained by external factors. Summarising this, one participant stated:

> It didn't feel like we were having better than expected life expectancy. […] Um, it's difficult to really put your finger on a particular approach that we took (SE04_LA).

When questioned about factors that might contribute to better-than-expected outcomes, participants reflected on current working practices including partnership working and strategic direction. While participants were positive about the improvements in working practices, they were cautious about describing a straightforward causality between working practices and better-than-expected LE given the complexity inherent in public health work and the fact that similar approaches were evident in most areas. As the following participant summaries:

> To be fair I'm sure other areas are doing it, so I don't think that's a unique thing. If we've done something right then I'll say it. But I just don't think we've done anything so extraordinary in [area NW] that's so different (NW08_HC).

#### 3.1.1. Partnership working

In both case studies, improvements in partnership working and joint interventions were repeatedly discussed with the suggestion that effective partnerships are more efficient and 'better for communities' when engaging with statutory organisations. The following participant described how a recent meeting was about:

> Bringing key people together and understanding more about where the gaps are that aren't being achieved …. Engaging with mental health services, … CCGs [Clinical Commissioning Groups] and the connection with the GPs and the primary care networks. I think that's where we've seen a lot of change, and that's really improved for communities (NW01_LA).

There was limited discussion about the possible pathways that would link improved partnership working with improved health outcomes beyond partnership working being considered a more efficient way of providing services. Limited funding was described as an influencing factor in perceived improvements to partnership working and joint initiatives, as described in the following statement:

> We need to be working in really close partnerships … [and] by doing so, will we be able to maximise the spend that we've got, and the resources that we've got (SE03_LA).

Partnerships with third sector organisations were specifically highlighted. In Area NW there was a perception that voluntary organisations had responded to the emerging needs in the community because of austerity measures and cuts to services with some suggestion that support provided by third sector could be buffering the worst effects of austerity for the most disadvantaged populations.

> As austerity has kicked in and the voluntary sector stepped in to pick up the pieces really. They provided an amazing support system that certainly wasn't there on the ground more than 10 years ago (NW03_LA).

While the benefits of effective partnership working were frequently discussed, statements were often accompanied with caveats about the extent to which effective partnership working actually translated into or explained improved health outcomes. Indeed, many partnerships referred to were statutory arrangements required by law and therefore existed in most LA areas. This participant suggested that the people involved, rather than the formal structures in place, may have the greatest influence on successful partnership working.

> I don't think it's unique to [the town], I think a lot of places will have like a Drug and Alcohol Board or a Community Safety Partnership or a partnership and discussions with the police. But I think there's a lot of very dedicated people in [the town] that really care about [the town's] population and really want to make a difference (SE06_LA).

#### 3.1.2. Strategic intent

From a strategic perspective, the case studies demonstrated contrasting approaches to health and wellbeing policy making and implementation. Area NW illustrated a more bottom-up approach while Area SE demonstrated a more top-down approach.

*3.1.2.1. A bottom-up approach.* Participants from Area NW described a lack of strategic engagement in health and wellbeing in the borough with much of the work undertaken by middle managers integrating an emphasis on health and wellbeing into their existing roles and responsibilities. As one third sector representative states:

> I've Chaired our health and wellbeing partnership for a while. Actually for a long time, up until recently, they [The LA] have sent a junior, middle manager to represent the Council in those type of forums […] So in some ways that you know some will be critical of that; they've not really prioritized it (NW06_TS).

Rather than viewing this lack of strategic engagement negatively, there was a perception that this had created space for middle management and frontline staff to work flexibly in their approach. The statutory HWB operated at the county level, however key individuals from the borough council, NHS and third sector had developed a local board specifically for the borough, as the above participant goes on to state:

> In other ways, what they've done is, they've taken a facilitation role, rather than a command and control [ …] to lead and to drive change and to build connections between different organisations (NW06_TS).

There was a sense that partnership working was successful because of the particular individuals involved holding personal views about the benefits of such an approach.

At a more senior level, the borough council's main strategic focus in Area NW had been economic development, in particular town centre renewal as illustrated in their corporate strategy and planning documents. Significant investment had been made in two of the four town centres, which was well received by residents from across the borough.

> There's been a particular focus on town centres and we've been bidding for some Heritage Lottery funding, that sort of thing. So we had a couple of million …. It's been used to basically do up the buildings in the town centre to transform some of the shop fronts (NW06_LA).

The town centres had been neglected and were run-down in appearance. The changes had improved the general look and there was a sense that local people and tourists were more likely to visit areas that had been rejuvenated.

*3.1.2.2. A top-down approach.* Participants in Area SE described the

council's efforts to strategically prioritise population health and health inequalities during the last decade, and with renewed emphasis during the COVID-19 pandemic. This was demonstrated in key strategies including the Council's corporate strategy, health and wellbeing strategy and in the work of the HWB which represent different parts of the public local system.

> The Strategy is all about that fundamental understanding of the wider determinants of health. The fact that the economy is important. The fact that the skills are important. The way that the system works together is important. That's happened not by chance, that has been something that we've been working towards for a good period of time now. […] It is a really clear and close alignment of the strategic intent of two of the major parts of the system (SE03_LA).

When talking about the LA's approach to tackling health inequalities, one participant said that *"it's embedded in everything we do (…) most programmes and projects have an element of inequalities in them"* (SE03_LA) later adding *"I'm sure [strategic emphasis] had an impact on inequalities." (*SE03_LA).

Participants also talked about changes in the council's approach to commissioning public health services throughout the last decade, including a focus on achieving broader outcomes rather than a narrow focus on performance indicators determined by central government, as well as using the best available evidence and knowledge of the population.

> Rather than some of the specific things that we did, it is the approach to having those outcomes at the centre of your thinking, and as a local authority being focused on outcomes and taking a Public Health approach to your thinking. So outcomes, population, evidence base, getting to know and understanding your population, I think is important (SE04_LA).

Participants from the LA argued that this outcome-oriented approach led to the delivery of more efficient services on a smaller budget. Focusing on improving LE, the council also took a targeted approach by prioritising services in more disadvantaged areas of the town and towards vulnerable population groups. This was in line with the council's corporate strategy focused on eradicating poverty.

However, due to budget cuts the prioritisation of objectives was also at times pragmatic, based on the target savings for a particular budget and prioritising statutory services.

> It's very difficult to be entirely objective and scientific about prioritisation, so some of that was probably quite subjective. Looking at whether we had to statutorily provide something or not, which is obviously pragmatic. (SE04_LA).

#### 3.1.3. Population change

Beyond the working practices and strategic intent, participants in both case studies described population change factors. In Area NW there was a perception that people were moving into the area and commuting to the local urban centre. Such individuals were perceived as having good jobs and more money, which was associated with higher LE.

> I'd heard about the in-migration of people, probably from [large city]. And the rental costs for housing in [the town] have gone up according to Rightmove. I think it was in the very recent past, so I do wonder when we look at this question as to whether there might have been an influx of middle class folks who are escaping the city (NW06_LA).

There were new housing developments and also a suggestion that town centre improvements discussed above may have contributed to the area becoming a more attractive place to live for people moving out of the city. While house prices and rental costs were lower compared with surrounding areas, they were rising significantly, which may have implications for the existing population. As the following participant indicates, higher rent might impact on local people who are already financially challenged as they will have even less money to manage the challenging circumstances they already occupy, such as poor access to key services without owning a vehicle.

> It makes it more difficult for people locally, doesn't it? Because you know, if they're already struggling too. If they don't have a car, … if they don't have access to things, that makes it so much more difficult (NW07_LA).

In Area SE, two participants suggested that a recent influx of (high skilled) young professionals and young families attracted by new and higher paid jobs, which were replacing jobs in the manufacturing industry, could have impacted the overall health indicators of the town. As one health professional described:

> The industry has changed; it used to be a car town where [large car manufacturer] was based and there was lots of middle-aged men working in factories. There's now much less of that and there's a lot more sort of tech industry that's come in …. so they've brought in a younger population. In terms of linking to health issues I think it's much more the population migration sort of background that has an impact (SE07_HC).

The town has one of the youngest populations in England, with just under 40% of the population below 25 years. Participants also highlighted the transient nature of the town's population and associated difficulties in gathering and analysing data on health outcomes.

### 3.2. Austerity impacts

The impact of austerity was considered the main barrier to LA work throughout the last decade with budget cuts featuring heavily throughout interviews in both case studies.

> It's been challenging because every department had a savings' target. We had to make some really difficult decisions about where those savings could come from.[ …] Obviously we have statutory services that we have to deliver. […]So we're always looking at things that would have a limited impact [on the population], but it has been challenging (SE06_LA).

Grappling with reduced budgets by reducing services and staffing numbers had influenced all aspects of LA work including setting priorities, joint commissioning and partnership working. Despite improvements in health outcomes, there was a perception that some of the council's decisions had a disproportionate negative effect on vulnerable people, particularly children and young people and those living in more socio-economically disadvantaged areas.

> There is an increasing awareness that there are, sort of, vulnerable people out there for whom there doesn't seem to be any readily available services (NW02_LA).

One way the LAs in both areas sought to manage budget cuts was by reducing the workforce through voluntary redundancy, recruitment restrictions and organisational restructures. This had implications for remaining staff who had to take on additional work and reduce the breadth of support provided.

> There were many situations where the cuts have been felt and just recently this Flying Start Programme and the provisions for nought to fives has undergone a restructure because it's just so underfunded, you know, and that is a tragic loss to us because it was actually an excellent service and was making a difference (SE01_LA).

Access to local amenities such as banks and post offices was also an issue for those reliant on public transport. Those who could afford a car were less affected, as described by one participant with a young child:

My older kids had the swimming baths and now the swimming baths are closed down so it means having to travel to a different town just to get a swimming lesson again. Those centres are not within reach of buses, so I can't access that unless I booked taxis to do that. So we're like at a loss really, with lots of stuff like that (NW12_Public).

## 4. Discussion

The aim of this study was to assess how local strategic processes may contribute to better-than-expected health outcomes. We identified two areas (one in the NW and one in the SE) where life expectancy had increased at a faster rate compared to areas with similar social and economic conditions according to the IMD 2019. We undertook in-depth case studies in these areas to explore how local professionals working in public and third sector services and local people might account for such outcomes.

Existing studies have labelled areas with better-than-expected health outcomes as health resilient and used quantitative methods to examine relationships between health outcomes and a range of possible 'protective factors', such as population density and rates of home ownership. This small body of work reveals a complicated picture as findings across the studies are inconsistent. The only factor in which there was a degree of consensus was population change defined as either population loss (Tunstall et al., 2011) or population churn (Cairns et al., 2012; Cairns 2017; Pearson et al., 2013). Cairns et al. (2012) suggest inward migration may be related to perceived advantages in the area, while high population churn might negatively affect social stability and cohesion. More recent evidence suggests that an influx of new residents into an area can increase social divides (Cairns, 2017). It is reasonable to assume such findings depend on who migrates into or out of the areas of interest.

Our qualitative study is consistent with existing literature in that population change was highlighted as a possible influencing factor. However, being qualitative, our study gave stakeholders more scope to expand on their views about local resilience. In both case studies there was a perception that people moving into the area could be affecting LE figures. In Area NW, some stakeholders thought young families moving into the area were taking advantage of lower house prices and rental costs compared with more expensive areas near the urban centre, whereas in Area SE it there was a perception that young professionals with highly paid jobs were re-locating, against the backdrop of an existing transient and diverse population. These perceived population changes may have been influenced by policy decisions affecting wider determinants of health'; town centre renewal programmes attracting young families in NW, and improved rail links with the major city attracting young professionals in SW. Inward migration positively affecting health outcomes and LE does not suggest these areas are health resilient. Indeed, local professionals suggested there could be negative outcomes for the existing population if more affluent people are moving in, such as local residents being forced out of the area due to increasing rent and house prices.

Only one previous study used qualitative methods to examine possible explanations for better-than-expected health outcomes. This study found place attachment, the natural environment and social capital were considered possible mediating factors by local residents (Cairns-Nagi and Bambra, 2013). Our study included some public participants but focused more on stakeholders from public and third-sector organisations. Our study participants at times identified possible mediators consistent with the contextual factors identified Cairns-Nagi and Bambra (2013) - however responses in our study focused more on strategic decision-making processes (such as partnership working) or on critically examining the premise that their local area was resilient.

Our study extends the existing body of knowledge by examining the perspectives of stakeholders about possible explanations for the better-than-expected health outcomes and in particular whether strategic processes might contribute. Participants from both case studies were surprised to hear their area had better-than-expected LE compared to areas with similar levels of disadvantage. Many could not recall seeing data of this kind before: that is, data comparing outcomes for similarly disadvantaged LAs. Some told us they were more used to seeing data that compared more disadvantaged LAs with less disadvantaged LAs (as measured by area-level indices like the Index of Multiple Deprivation). Moreover, participants' perceptions of outcomes were influenced by their experience of living or working in the areas, where material disadvantage was evident in, for example, the reduction of services and closure of amenities. While outcomes might be better-than-expected compared with other similar areas, the consequences of material disadvantage for heath inequality remain stark when compared with UK averages. Existing studies compare health resilience based on relative disadvantage (Doran et al., 2006; Tunstall et al., 2007). Labelling these areas as 'resilient' may draw attention away from the harm they are experiencing in health outcomes, particularly the harmful influence of socio-economic disadvantage. Furthermore, LA populations with 'better-than-expected' health trends still experience within area inequalities. Cairns et al. (2012) ask whether "pockets of increasing affluence" could be raising average indicators within such areas.

Previous studies suggest that some crucial decisions influencing local health outcomes are taken at a national level: notably financial policies including cuts in central government funding of LAs. The cuts in our case study areas were less severe than many LAs during that period (Alexiou et al., 2021) suggesting that rather than being health resilient, the LAs simply escaped the worse effects of austerity. The impact of funding cuts does not appear to have been measured in the existing literature on health resilience.

When contemplating possible factors that might explain better-than-expected health outcomes, stakeholders from both case studies reflected on working practices in their areas. Participants highlighted that partnership working and joint initiatives had improved in recent years. However, they also cautioned against placing too much emphasis on the explanatory power of improvements in partnership working because similar approaches were being used in most areas across the UK. Collaborative efforts across sectors are notoriously difficult (Perkins et al., 2019). There is an unquestioning belief among policy makers in the positive impact of effective partnership working yet little evidence demonstrating that collaborative efforts actually improve health outcomes (Alderwick et al., 2021). In 2022 (after our fieldwork), the Integrated Care System established new arrangements to formalise links between councils, health service, voluntary sector and others facilitating a whole system approach to improving population health - the impact of which has only begun to be assessed (Hewitt, 2023).

Participants from both case studies also emphasised that informal networks and the commitment of particular people involved was equally or more important than the formal structures in place. Previous research has found a blend of formal (e.g. governance and strategy) and informal ways of working in most partnership arrangements (Mead et al., 2020) suggesting that local context and relational work may provide future avenues for deeper exploration.

The increasing involvement of third sector organisations in partnership arrangements and service delivery was noted. The term 'community' tended to be used as a catch-all term with a blurring of the boundary between voluntary and community organisations and people in the community. The LAs themselves did not necessarily have established communication channels with their local populations, rather this was mediated through third sector organisations. There was a recognition in both areas that 'the community' is not a homogenous group but rather a collection of various groupings of people with different social identities, and interweaving connections, alliances and divisions (Cairns, 2017). The impact of connection with the community on health and other outcomes is difficult to demonstrate (Baxter et al., 2022).

There were differences in the emphasis given to strategic intent and operational decision making in our case studies. In Area NW, strategic

emphasis had been given to economic development and town centre renewal programmes. In Area SE, a unitary authority, there was an explicit focus on prioritising population health through action on the wider social determinants and targeting particular groups. However, translating strategic objectives into tangible differences on the ground can often be challenging, widely referred to as the policy implementation gap. Compared with Area NW, there was more discussion of targeting services and using the best available evidence as mechanisms to manage funding restrictions in Area SE. Targeting services towards those in most need is an increasingly popular approach to delivering services in the context of constrained resources. There is some evidence that targeting services can be effective in the right situation, for example, when members of affected communities are fully involved in design and delivery processes (Fisher et al., 2021). However, commentators argue that targeting can also be paternalistic, cause stigma for the 'targeted' population and is often less efficient (Mead et al., 2022).

### 4.1. Strengths, limitations and recommendations

Life expectancy overlooks other important measures of health. Future studies might include morbidity measures as indicators of quality of life.

The study took place during the COVID19 pandemic, which restricted availability and willingness of local authorities, stakeholders and members of the public to take part in research such as this. Once we identified our 10 potentially relevant areas, we adopted a pragmatic approach to site selection and participant recruitment. Nonetheless, the selection did achieve our intention of sampling one from the North and one from the South. We also sampled one of each of the two main types of local government authority structure in England (unitary and two-tier authority). Our stakeholder recruitment strategy was pragmatic and faced challenges during the COVID lockdown period. A theoretically driven qualitative sampling procedure would have been preferable - for example, by ensuring greater diversity of participants and perspectives.

Sampling for interviews was also influenced by the different organisational structures in our case studies. Stakeholder participants in Area NW were employed at more middle management and operational level. They may not have been as involved with strategic decision making, particularly targeted service provision, which was undertaken at a county level. They were more concerned with operational delivery, hence partnership working on the ground and VCS relations were highlighted. This might also be considered a strength in our analysis because it reveals something about top-down and bottom-up policy making processes.

When reflecting on possible explanations for better-than-expected health outcomes, stakeholders are likely to describe factors in which they have experience, in this case their daily working practices either strategic or operational. They are less likely to comment on factors beyond their daily experience – external factors, such as migration patterns. Future research might engage in a more fine-grained analysis of migration patterns in such areas as well as qualitative research exploring the experience of people moving into the area and that of the existing population.

Access to members of the public in the NW was facilitated by existing contacts. There were particular challenges recruiting members of the public in the SE where time constraints prevented establishing new relationships for this purpose. A possible area for future research would be to explore public understandings and experiences of (apparent) resilience in greater depth then we were able to achieve in this study.

## 5. Conclusion

We interviewed stakeholders from two local authorities in England to assess explanations for the localities' apparent health resilience. Participants expressed surprise about, and were reluctant to assume credit for, their better-than-expected health outcomes. Nonetheless, they identified ways of working that might contribute to improved life expectancy, such as partnering with third sector, targeting and outcome driven action. External factors such as population change, national politics and finances were considered crucial. Local public health stakeholders regard their work as important but unlikely to cause place-centred health resilience. As others have argued (Alexiou et al., 2021), slowing or reversing funding cuts could be a clear way to reduce health burdens on the most vulnerable.

## CRediT authorship contribution statement

**Rebecca Mead:** Writing – original draft, Project administration, Methodology, Investigation, Formal analysis, Data curation. **Chiara Rinaldi:** Writing – original draft, Investigation, Formal analysis, Data curation. **Elizabeth McGill:** Writing – review & editing, Project administration, Investigation, Funding acquisition, Formal analysis. **Matt Egan:** Writing – original draft, Supervision, Resources, Project administration, Funding acquisition, Data curation, Conceptualization, Investigation. **Jennie Popay:** Writing – review & editing, Supervision, Project administration, Funding acquisition, Conceptualization. **Greg Hartwell:** Writing – review & editing, Formal analysis, Data curation. **Konstantinos Daras:** Data curation, Formal analysis, Writing – review & editing. **Annabelle Edwards:** Formal analysis, Writing – review & editing. **Monique Lhussier:** Writing – review & editing, Supervision, Project administration, Conceptualization, Data curation.

## Declaration of competing interest

The authors declare no competing interests.

## Data availability

Data will be made available on request.

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## Appendix A. summary of documents analysed

| Area | Anonymised author | Date | Anonymised Title |
|---|---|---|---|
| NW | LG Inform | 2020 | Data and reports. Housing, Health and Wellbeing in NW Area |
| NW | NHS East County Hospital Trust | n.d. | Discovery report |
| NW | NW Area Borough Council | 2011 | Core Strategy Plan |
| NW | NW Area Borough Council | 2016 | Integrated performance report |

(*continued on next page*)

(*continued*)

| Area | Anonymised author | Date | Anonymised Title |
|---|---|---|---|
| NW | NW Area Borough Council | 2017 | Corporate Strategy 2017–2021 |
| NW | NW Area Borough Council | 2018 | Statement of accounts |
| NW | NW Area Borough Council | 2019 | Area NW Local Plan |
| NW | NW Area Borough Council | 2020 | About NW Area |
| NW | NW Area Borough Council | 2020 | Corporate Strategy refresh 2020–2021 |
| NW | NW Area Borough Council | n.d. | Tackling social isolation and loneliness |
| NW | NW Area County Council | 2014 | Health inequalities in Area NW County: A joint strategic needs assessment |
| NW | NW Area County Council | 2019 | Report of the Director of Public Health |
| NW | NW Area County Council | 2011a | Census report on population by ethnicity |
| NW | NW Area County Council | 2011b | Census report on workday population |
| NW | NW Area County Council | 2019a | The English Indices of Department for Levelling up Housing and Communities, 2022) – key findings for borough areas |
| NW | NW Area County Council | 2019b | Insight report on fuel Poverty |
| NW | NW Area County Council | 2019c | Average earnings and hours of work |
| NW | NW Area County Council | 2020a | Insight report on working age benefits |
| NW | NW Area County Council | 2020b | Insight report on state pension and pension credit. |
| NW | NW Area County Council | 2020c | Insight report on 2019 deprivation analysis: |
| NW | NW Area County Council | n.d. | Lancashire Health and Wellbeing Strategy |
| NW | NW Area County Council | n.d. | Social Value Policy and Framework |
| NW | Public Health England | 2014 | NW Area District Health Profile 2014 |
| NW | Public Health England | 2016 | NW Area District Health Profile 2016 |
| NW | Public Health England | 2018 | Local authority Health Profile - NW Area 2018 |
| SW | Public Health England | 2016 | SW Area Health Profile 2016 |
| SW | Public Health England | 2019 | SW Area Health Profile 2019 |
| SW | SW Area Borough Council | 2011 | SW Area Profile 2011 Census Data |
| SW | SW Area Borough Council | 2016 | A Healthier Future Improving Health and Wellbeing in SW Area (refresh) |
| SW | SW Area Borough Council | 2018 | SW Area Flying Start Strategy 2014–2024 (refresh) |
| SW | SW Area Borough Council | 2019 | 2019 Indices of Multiple Deprivation Summary |
| SW | SW Area Borough Council | 2020 | A town-wide vision for SW Area 2020–2040 |
| SW | SW Area Borough Council | 2020 | SW Area Population Wellbeing Strategy 2019 to 2024 |
| SW | SW Area Borough Council | n.d. | SW Area Corporate Plan 2014–2017 |
| SW | SW Area Borough Council | n.d. | SW Area Health Inequalities Strategic Plan, 2015–2020 |
| SW | SW Area Clinical Commissioning Group | n.d. | Wellbeing & Healthy Lifestyles Needs Assessment |

## Appendix B. Interview Topic Guide Stakeholders

Introduction to study (place-based strategies to reduce health inequalities in times of reduced financial resources).
Consent.
Reminder: recording interview.

1. Before we get into the work of the LA, can you tell me about changes in the area, over the last decade, that may have influenced the lives of people who live here?
   - Probe around:
     - o Population changes
     - o Employment
     - o Housing
     - o Political affiliation
2. Thinking now about the work of the local authority – what do you think are the biggest issues, or major changes that we should know about – again over the last 10 years.
   - Probe around:
     - o Budgetary cuts – central and local sources of income
     - o Political make-up
     - o Position of PH within the council
3. (If not answered above): How has local authority been affected by the budget cuts (or changes)? Was there a time – a year – where the LA really started to see a change?
4. Within the context of these budget cuts, how has the local authority tried to prioritise its resources?
   - Consider:
     - o Council as a whole
     - o Public health in particular
   - Probe around:
     - o Service cuts
     - o Service redesigns
     - o Using budgets from different departments
     - o Changes in eligibility criteria
     - o Personnel
     - o Partnerships (with different departments, 3rd sector/community organisations, universities, East London Foundation Trust etc.)
   - (other possible question): Has the LA attempted to identify effective public health interventions that are low cost to the public purse? Has the evidence base been useful in helping you identify these?

5. What has the local authority done that has a specific aim to reduce health inequalities?
   - How does Council leadership consider inequalities and prioritise resources/policies to focus on this?
     - o Elected officials
     - o Senior management
   - What were the main challenges during that time?
   - What was particularly successful during that time?
   - Consider:
     - o Strategies
     - o Specific programmes or policies
     - o Any particular initiatives on mental health (if not already covered)?
     - o How the pandemic has been affecting their efforts to reduce health inequalities this year?
6. (If not answered above) Thinking about the better than expected outcomes in [Area], are you aware of work in other directorates or organisations in the borough that might have influenced health through the wider social determinants?
   - Probe around:
     - o Welfare and benefits
     - o Housing
     - o Education
     - o Environment
     - o Limits to public health control (i.e. what can PH does and what can't it do?)
7. Is there anything particularly unique that the local authority has tried that may not have been done in other LAs, given its better than expected performance on life expectancy (or are there other explanations)?
8. What impacts do you think that LA's efforts to reduce inequalities have had on local residents?
   - Probe around different population groups (age, ethnicities, etc.)
9. How do residents in [Area] get involved in making decisions?
   - Is there work targeting specific groups?
   - What is the impact of their involvement?
10. Anything else you wanted to discuss about addressing health inequalities and austerity in [Area]?
11. Anyone else you would recommend us interviewing in [Area] or [LA] as part of this work – e.g. long-standing external stakeholders?
    - Refer back to any key examples from Q5

## Appendix C. Interview Topic Guide Public

Introduction to study (place-based strategies to reduce health inequalities in times of reduced financial resources).

1. Before we get into the work of the LA, can you tell me about changes in the area, over the last decade, that may have influenced the lives of people who live here?
   - Probe around:
     - o Population changes
     - o Employment
     - o Housing (new housing in Bacup)
     - o Political affiliation (RBC to borough)
2. What are your expectations of the council and other local organisations? What is their role or purpose?
   - Probe around:
     - o Service delivery
     - o Place shaping
3. Have your expectations this changed over time?
   - Probe around:
     - o Last 10 years
     - o Since Covid-19
     - o History of low expectations in Rossendale
4. How have you been affected by changes to services in Rossendale as a result of budget cuts?
   - Probe around:
     - o Eligibility criteria – early intervention
     - o Finances
     - o Health and well-being
     - o Connection to local area
     - o Connection between services/service providers
     - o Increasing role of VCFS
5. How have these changes affected other residents? – Specific groups?
   - Probe around:
     - o Eligibility criteria
     - o Finances
     - o Health and well-being
     - o Connection to local area
     - o Connection between services/service providers

6. To what extent do you feel you are involved in the decisions that service providers like the council make?
   - Probe around:
     - o Current participation – community meetings, notice boards, social media
     - o Impact of participation – examples of council decisions being overturned e.g. regeneration project in Rawtenstall
     - o Levels of trust
     - o Ideas for future participation
7. What changes would you like to see in Rossendale?
   - Probe around
     - o Service provision
     - o Regeneration
8. Is there anything else that might explain the better than expected health outcomes in Rossendale?
   - Probe around
     - o Resilience of people and community
     - o Sense of pride in the area
     - o Strength of VCS
9. Is there anything I've missed or you would like to add?

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