Social Science & Medicine 190 (2017) 217–226

Contents lists available at ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

The spatial politics of place and health policy: Exploring Sustainability and Transformation Plans in the English NHS

Jonathan Hammond [a, *], Colin Lorne [b], Anna Coleman [a], Pauline Allen [c], Nicholas Mays [c], Rinita Dam [d], Thomas Mason [e], Kath Checkland [a]

[a] Division of Population Health, Health Services Research, and Primary Care, School of Health Science, The University of Manchester, Williamson Building, Oxford Road, Manchester, M13 9PL, United Kingdom
[b] Alliance Manchester Business School, The University of Manchester, United Kingdom
[c] Department of Health Services Research and Policy, London School of Hygiene and Tropical Medicine, United Kingdom
[d] School of Health Sciences, The University of Manchester, United Kingdom
[e] Centre for Health Economics, The University of Manchester, United Kingdom

ARTICLE INFO

Article history:
Received 2 February 2017
Received in revised form
13 June 2017
Accepted 9 August 2017
Available online 11 August 2017

Keywords:
UK
NHS
Place
Post-politics
Relational geographies
Sustainability and Transformation Plans
Health policy
Organizing healthcare

ABSTRACT

This paper explores how 'place' is conceptualised and mobilized in health policy and considers the implications of this. Using the on-going spatial reorganizing of the English NHS as an exemplar, we draw upon relational geographies of place for illumination. We focus on the introduction of 'Sustainability and Transformation Plans' (STPs): positioned to support improvements in care and relieve financial pressures within the health and social care system. STP implementation requires collaboration between organizations within 44 bounded territories that must reach 'local' consensus about service redesign under conditions of unprecedented financial constraint. Emphasising the continued influence of previous reorganizations, we argue that such spatialized practices elude neat containment within coherent territorial geographies. Rather than a technical process financially and spatially 'fixing' health and care systems, STPs exemplify post-politics—closing down the political dimensions of policy-making by associating 'place' with 'local' empowerment to undertake highly resource-constrained management of health systems, distancing responsibility from national political processes. Relational understandings of place thus provide value in understanding health policies and systems, and help to identify where and how STPs might experience difficulties.

1. Introduction

> The NHS is facing growing pressures, with finances deteriorating rapidly and patient care likely to suffer as a consequence. …. providers of services should establish place-based 'systems of care' in which they work together to improve health and care for the populations they serve. (Ham and Alderwick, 2015, p.3)

This quote, from an influential UK think-tank, highlights policy ideas of relevance to many health systems globally. The diagnosis is simple – the NHS, like other systems, faces growing demand alongside severe financial constraint – but the prescription offered may be less so. 'Place-based systems of care' sound intuitively attractive, evoking co-operation, even homeliness, with 'populations' embedded in 'places' where they receive care. Health systems across Europe have responded to the on-going financial crisis with similar strategies, regionalising service planning and management (Toth, 2010), integrating services and shifting care into communities (Mladovsky et al., 2012). However, geographic scholarship insists 'place' is not such a simple concept (Cresswell, 2004; Massey, 1994, 2005; Pred, 1984). In this paper, using current English NHS reforms as an exemplar, we employ relational geographic understandings of place to consider the implications of the making of places in health policy.

Medical geography has long understood the importance of place, not only as a background for people's lives, but as an active determinant of health (Macintyre et al., 2002). Kearns and Moon (2002) plot the field, highlighting a turn from geographies of illness to focus upon health/wellness. They explore place within this literature, identifying three approaches: health in specific

* Corresponding author.
E-mail address: jonathan.hammond@manchester.ac.uk (J. Hammond).

http://dx.doi.org/10.1016/j.socscimed.2017.08.007
0277-9536/

localities; landscape impacts on health; and spatial approaches, including multi-level conceptions of places. Cummins et al. (2007) argue that traditional policy approaches have failed to move beyond a Euclidean conception of space as passive 'lines on a map' to incorporate ideas of relationality, whereby places actively produce, and are products of, social relations. This approach sees places as emergent, continuously constituted by the interweaving of interactions and practices through time and space (Graham and Healey, 1999). Cummins et al. (2007) argue for scholarship of health and place which takes geography seriously and explores how people experience places differently.

In this context, the role of health policy in shaping places becomes important. For example, Learmonth and Curtis (2013) consider local enactment of national policy, focusing upon 'place-shaping', whilst Gustafsson (1997) calls place 'an underdeveloped variable' in health promotion. These approaches take national policy as given, focusing upon local enactment or effects. Population health is the key outcome variable of interest, with places as modifiers or sites of action. Yet, as McCann and Temenos (2015) highlight, health policies are themselves mobile across time and space. Policy adapts as it travels and gets embedded in places (McCann and Ward, 2012; McCann and Temenos, 2015).

In social policy more broadly, geographical understandings of place have informed investigations of 'localism'. Clarke and Cochrane (2013, p.11) explore geographies of localism in UK Coalition government policies after 2010, arguing that:

> When localism is used in political discourse, its meaning is often purposefully vague and imprecise. It brings geographical understandings about scale and place together with sets of political understandings about decentralisation, participation, and community, and managerialist understandings about efficiency and forms of market delivery – moving easily between each of them, even when their fit is uncertain. It is often intentionally associated, confused, or conflated with local government, local democracy, community, decentralisation, governance, privatisation, civil society etc. for political effect. This is part of what makes localism such an attractive concept capable of being mobilised by all three of the UK's main Westminster-oriented political parties.

Ideas of localism are, thus, closely tied to notions of decentralisation. Allen (2006) highlighted the shifting ideologies underpinning the UK government's calls for greater public service decentralisation in the early 2000s. She identifies fluctuating policy narratives, between a utilitarian claim that services responsive to (an assumed to be unproblematic and fixed) 'local' population would be more efficient, and a more critical view, focusing upon the democratic empowerment of local communities. However, what constitutes a meaningful 'community' is unaddressed in such policy rhetoric, and 'empowerment' in practice may simply mean shifting responsibility for cuts to local level (Lowndes and Pratchett, 2012).

Moon and Brown (2001) found local place was evoked politically to 'sell' – and resist – a particular policy. Studying proposals to close St Bartholomew's Hospital in London, they explored discursive representations of the hospital in ensuing debates. Rejecting apparently rational delineations of services required to 'meet local needs', campaigners highlighted the hospital's social and symbolic significance, historic embeddedness and links with local identities. Moon and Brown (2001, p.58) analyse the eventual decision to reprieve the hospital, arguing:

> … the Barts case was not just about local residents fighting to save their hospital, it was about a fight over a symbol of place, however imaginary.

This research emphasizes how notions of place in reconfiguring health care landscapes are *contested*. We build on this, using relational geography (Massey, 1994, 2005; Painter, 2008, 2010) to consider the effects of defining and maintaining geographically-bounded places within current NHS policy. We focus not upon the impacts of such places on the population, but on the work of place in policy-making.

Our contribution is twofold. Firstly, we combine geographical understandings of place with health policy analysis, using a relational geographic approach as a lens through which to make sense of current health policy. We extend Moon and Brown's (2001) approach by considering a broader sweep of policy over time. Secondly, we respond to calls by Andrews et al. (2012) for a publicly-engaged, policy-aware and practically-focused approach to health geography. Taking a multidisciplinary approach, combining geography with health policy scholarship, we provide a rich and empirically grounded account of English health policy enactment. Our geographical lens offers novel insights for addressing the serious issues facing health systems in the aftermath of the global financial crisis.

Our policy focus is on 'Sustainability and Transformation Plans' (STPs) in England. Recently introduced to reduce system fragmentation, these require delineation of 'footprints' within which the 'sustainability' of the health and care system must be addressed. Without altering statutory accountabilities or competition regulations, STPs require organizations to establish 'local' consensus around planning and delivering health and care. This triggers additional funding to address financial deficits and develop new services. In England, the NHS provides most health care, whilst local government subsidizes social care. STP policy is being driven by NHS organizations, but intends to address both health and social care (NHS England et al., 2015). Whilst acknowledging the importance of local government/social care, in this paper we have chosen to reflect this imbalance by focusing on healthcare and the NHS. The process has been criticised for the limited involvement of patients, local government, and the Third Sector, which makes the development of a consensus position for any given footprint problematic and inevitably partial (Ham et al., 2017). Drawing upon evidence from several sources, including an on-going study of English NHS commissioning, we demonstrate how the boundedness of places evoked through STP policy rhetoric is problematic by focusing upon the practices of managers, clinicians, and policy makers involved in the spatial reorganizing of health and care systems. We discuss the political effect of this notion of place within health services. We do so by extending links between Massey's (2005) theorisation of place as produced through a multiplicity of spatial relations with Mouffe's (2005, p.9) theorisation of the political as 'the dimension of antagonism … constitutive of human societies' which she distinguishes from politics understood as 'the set of practices through which order is created.' We suggest the hegemonic spatial ordering in the STP policy process treats places as bounded, coherent and singular excluding in the name of consensus, repressing other possibilities.

This paper comprises five sections. First, we provide an historical account of the ways place has figured in UK health policy. Second, we set out our theoretical framework before describing our current study. We then draw this evidence together with observations from public meetings to consider the spatial and political implications of 'place' within health policy. We conclude by considering current STP developments, and explore the value that theoretical insights from geographic scholarship provide in understanding the implications of health policy orientating around place-based systems of care.