Bio-spheres of Risk-Aversion and Equitable Health

An Ethnography of Neoliberal Area-Based Public Health Policy Intervention and Physical Activity in a Deprived English Neighbourhood

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by

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Keep me sick to make me well

Come on, what the hell

Short Movie - Laura Marling
The aim of this thesis is to explore the relationships between health, place and inequality. The research focuses on area-based public health policy in a deprived neighbourhood - ‘Kingsland’ - in central England. Kingsland attracted a number of area-based initiatives (ABIs) with the overarching aim of reducing national inequality. Between 2000-2010, significant resources were invested in local projects to promote ‘healthy’ living: most notably through physical activity (PA). Kingsland became a relatively novel place: a deprived area with numerous PA facilities and services. A central research concern is how far these services, particularly a new local leisure centre, impact the lives of people of low-SES. Localities transformed in ways designed to promote ‘healthy’ living are conceptualised as ‘bio-spheres of risk-aversion’ and assessed for their potential to address health inequalities.

This research took place two years after the ABIs were implemented. Data primarily come from sixteen months of ethnographic observation, but also includes interviews, a survey, and document analysis. Relationships between health, place and inequality are considered within the wider context of neoliberal dominance. The example of the global obesity ‘epidemic’ illustrates the ways in which neoliberal ideology promotes individual responsibility. The ‘oppressive’ and ‘emancipatory’ potentials of neoliberal health policy are explored in relation to the ‘choices’ and embodied experiences of people of low-SES.

This research demonstrates that neoliberal policies not only have harmful individual consequences, they also exacerbate structural inequalities. Specifically, analysis indicates the potential for ABIs to exacerbate health inequalities. Findings reveal some direct, detrimental impacts on people of low-SES and highlight the importance of equitable health provision. This thesis makes an original contribution by revealing the paradoxical effects that health policy can have on relationships between health, place and inequality. It offers a set of novel theoretical concepts to better understand this paradox and to guard against it.
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### Abbreviations

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<thead>
<tr>
<th>(ABI)</th>
<th>Area-Based Initiative</th>
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<tr>
<td>(BME)</td>
<td>Black and Minority Ethnic</td>
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<td>(BMI)</td>
<td>Body Mass Index</td>
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<td>(GIS)</td>
<td>Geographic Information Systems</td>
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<td>(HAZ)</td>
<td>Health Action Zone</td>
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<tr>
<td>(KCA)</td>
<td>Kingsland Community Association</td>
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<tr>
<td>(KSAZ)</td>
<td>Kingsland Sport Action Zone</td>
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<tr>
<td>(NAAP)</td>
<td>Needs Assessment and Action Plan</td>
</tr>
<tr>
<td>(NDC)</td>
<td>New Deal for Communities</td>
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<tr>
<td>(NHS)</td>
<td>National Health Service</td>
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<tr>
<td>(PA)</td>
<td>Physical Activity</td>
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<tr>
<td>(SAZ)</td>
<td>Sport Action Zone</td>
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<tr>
<td>(SES)</td>
<td>Socioeconomic-status</td>
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<tr>
<td>(UK)</td>
<td>United Kingdom</td>
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<tr>
<td>(US)</td>
<td>United States</td>
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<td>(WHO)</td>
<td>World Health Organization</td>
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Chapter One

Introduction

‘Healthy’ Living and the ‘Scandal of our Times’

Introduction

At the turn of the twenty-first century the New Labour Government of the UK adopted the strategy of implementing area-based initiatives (ABIs) to reduce national inequality. This thesis is the study of a neighbourhood located in central England which, due to severe levels of local deprivation, became the focus of a number of these ABIs. For reasons that will become apparent in the following chapters, over a period of ten years (2000-2010) significant resources were invested in local projects with the specific aim of promoting ‘healthy’ living: most notably through participation in physical activity (from here on referred to as PA). In short, this deprived neighbourhood, which is fictitiously referred to as ‘Kingsland’, was partially transformed to promote the adoption of ‘healthy’ lifestyles by local residents.

The aim of this thesis is to explore the relationships between health, place and inequality. This research is an ethnographic exploration of Kingsland two years after the ten year (2000-2010) project had been implemented. It explores the ways in which the promotion of ‘healthy’ living affects the lives of people living in Kingsland. It considers how structural (macro-level) factors influence the embodied experiences of individuals and groups (micro-level). It engages with the agency-structure dialectic in order to better understand the practical implications of promoting behaviour modification as a means to improve the health of low-socioeconomic-status (SES) groups. Of central concern is whether this area-based health policy is an effective strategy for reducing health inequalities. This chapter briefly traces the outline of the analysis and how this thesis is composed into chapters.
‘Healthy’ Living and Inequality

This thesis takes as its central concern one of the most prominent and debated contemporary policy issues. The promotion of ‘healthy’ living - as defined as conformity to a limited range of ‘health behaviours’ – is a significant part of the individualism strategy inherent in the neoliberal ideology that has dominated Western politics since at least the 1980s (Harvey, 2007a). The dominant health message is that mass lifestyle-modification is now both an economic and moral necessity. Informing this position is the widely accepted wisdom that we are currently experiencing a global obesity epidemic (Caballero, 2007) which is framed as equivalent in importance to armed violence, war and terrorism (Dobbs et al, 2014). It would appear that ‘Islamophobia’ and ‘fatphobia’ are presently going toe-to-toe in an effort to be crowned the crisis that comes to define our times (Allen, 2010; Lupton, 2013a).

Understanding the relationships between health, place and inequality is essential to the sociological analysis of these issues. Part of my argument shared by many other authors is that the dominance of neoliberal individualism deflects attention away from the vast social inequalities, e.g., socioeconomic, gender, ethnic, that might otherwise be considered to define contemporary debates around health and illness. Dorling (2013: 10), for example, has described the British ‘scandal of our times’ as the nation becoming so unequal that the gap in life-expectancy between places within it is now larger than it was over a hundred years ago, despite significant advances in medical science and living standards. Some research highlights how non-compliance with ‘healthy’ living norms can be seen to cause these disparities in national health and illness (Buck and Frosini, 2012; Loef and Walach, 2012). Other authors argue that there is a need to concentrate on the ‘causes of causes’ because of the ways in which the experience of inequality actually contributes to the vast differences in health that are observable at national level throughout the world (Marmot, 2005; Wilkinson and Pickett, 2010). This research is firmly rooted in the spaces within these lively debates which are picked up on in more detail later in the thesis.

My research is at once classical in its approach and it makes an original contribution to the field. Mills (1959: 8) describes the ‘sociological imagination’ as being ‘fruitful’ in its
application because it allows us to work between ‘the personal troubles of milieu’ and ‘the public issues of social structure’. In conducting ethnography to explore the ways in which health is promoted in a deprived area, I engage with the issues of health inequalities across the agency-structure spectrum. I would suggest that such analysis is rare within the field. However, this has allowed me to consider ‘healthy’ living at both individual and social levels: personal stories from a socially excluded place are given space amongst discussion of the influence of government policy and structural inequality.

Health inequalities between socioeconomic groups are most often defined by epidemiological abstraction – quantitative data concerning the spatial distribution of issues relating to mortality and morbidity – and as such there is a need for these issues to also be informed by ethnographic insight. As Williams (2013: 125) argues, ‘people’s own words thicken and enrich the thin but precise accounts of health inequalities characteristic of social epidemiology’. Mixed methods have been deployed during this research to reveal how the relationships between health, place and inequality connect the personal troubles of those living in severe deprivation and the public issues of ‘what to do’ about vast national inequalities in health and a costly obesity ‘epidemic’.

This research demonstrates how neoliberal policies have harmful individual consequences and exacerbate structural inequalities. Specifically, analysis indicates the potential for ABIs to exacerbate health inequalities and not only because the health gap between SES groups is widened by higher-SES groups disproportionately accessing interventions. Findings reveal some direct, detrimental impacts on low-SES groups and highlight the importance of equitable health provision. This thesis makes an original contribution by revealing the paradoxical effects that health policy can have on relationships between health, place and inequality. It offers a set of novel theoretical concepts to better understand these issues and to guard against future health interventions further exacerbating health inequalities.
Thesis Outline

The first two substantive chapters review the relevant literature in these debates. **Chapter Two** starts with a discussion of Talcott Parsons’ (1951) sick role and traces the socio-political shifts which have ultimately led to this early conceptualisation of health and illness being replaced by the contemporary version of the ‘health role’. This includes a discussion of the rise of neoliberalism as the dominant political ideology of the West and how this has led to the adoption of the ‘new public health’ approach (Petersen and Lupton, 1996). This development is discussed in relation to Foucault’s (1973; 1978) theories of biopolitics and governmentality and the historical process of the (bio)medicalization of everyday life. This highlights the significant ways in which people’s lifestyles and bodies have come to signify not only health and illness but also moral fortitude: what Crawford (1980) conceptualises as ‘healthism’. The notion of the obesity ‘epidemic’ is presented as an exemplar of this historical trend. Because neoliberal individualism deflects attention away from structural inequality, the chapter concludes with a consideration of how social inequalities influence a person’s health status in both medically and socially significant ways.

**Chapter Three** is an exercise to ‘place’ health. Epidemiological and geographical research which addresses the spatial distribution of PA participation and the associated facilities and services is reviewed. As there is a strong association between participation, services and socio-economic characteristics, the differences between ‘at risk’ and ‘vulnerable’ populations are outlined. It is argued that the ‘clustering’ of low-SES groups in areas lacking PA opportunities and the cultural dominance of the ethic of ‘responsible’ creates a climate ripe for victim blaming. The complexity of intervention is addressed by considering the role of the public sector in addressing social and environmental disparities and the tendency for such interventions to exacerbate, rather than to reduce, inequalities: a phenomenon known as the ‘inequality paradox’ (Frohlich and Potvin, 2008). This is followed by a discussion of ABIs – significantly informed by the extensive writings of Nikolas Rose (1996; 1999a; 1999b; 2001) - and the ways that neoliberal governments effectively de-collectivise responsibility by implementing community-based policy. Finally, because of the significant ways in which contemporary conceptualisations of health now alter
people’s perceptions of the therapeutic properties of particular places, I develop the concept of ‘bio-spheres of risk-aversion’ as part of my original contribution to the field. This analytical tool demonstrates how spaces that have been ‘healthified’ are both biopolitical techniques and potentially emancipatory.

The theme of ABIs continues into Chapter Four where the reader is introduced to the severely deprived neighbourhood that is the main setting for this research. This chapter is formed of two main sections to give an impression of the neighbourhood both before (prior to 2000) and after (post 2010) the ABIs were implemented. Chapter Five is a reflexive account that outlines the methodological approach taken during this research to set the context for the empirical research which took place in the post ABI era. It explains how issues of ethics and access were negotiated and it gives details about how data were collected and analysed throughout this process.

Chapters Six, Seven, Eight and Nine present the main empirical research findings. The chapters are ordered so that the discussion starts with findings that address more macro-level concerns and then gradually develops to show how these operate at the micro-level. As such, in Chapter Six the analysis of local policy and evaluative documents is paired with ethnographic observations to assess whether the implemented ABIs achieved their stated aims. The discussion then moves on to consider what the implications are for local residents now that these ABIs have, at least partially, transformed their neighbourhood into what I conceptualise as a ‘bio-sphere of risk-aversion’. Specifically, it is assessed how far the implemented ABIs can be considered to have created conditions which now offer local residents realistic opportunities to comply with the neoliberal construction of ‘healthy’ living. The possibility that interventions have had paradoxical effects on local health and social inclusion is also explored. The findings are used to argue that in Kingsland there has been what I conceptualise as a ‘waning influence of the past’ which results in some useful interventions ultimately having a ‘residual effect’ which - rather than facilitating their PA participation - further marginalises local residents.

Neoliberal ideology predominantly frames ‘healthy’ living as an individual responsibility rather than a social one (Petersen and Lupton, 1996). This has led
government health policy increasingly to drift towards lifestyle interventions: a process known as ‘lifestyle drift’ (Baum and Fisher, 2014; Popay et al, 2010). In Chapter Seven the outcomes of the ABIs that were implemented in this deprived neighbourhood are examined in the context of this wider political culture of individualism. Firstly, the extent to which these interventions represent the State approaching health as an individual or social responsibility is considered. Secondly, how the ABIs increased the risk-averting properties of the physical environment in the neighbourhood is discussed. Thirdly, findings from research on local service providers are used to analyse the legitimacy of employing a strategy of ‘partnership working’ to sustain local service provision and increase local PA participation. Finally, it is argued that these findings suggest it is necessary to extend the ‘lifestyle drift’ concept in order to more accurately describe the policy implementation observed. Therefore, I develop the concept of ‘citizen shift’ to describe how policies that initially address some of the structural factors that inhibit behaviour change can actually facilitate the presentation of lifestyle modification as an individual responsibility.

The process of citizen shift was also observable in the finding that – while there had been a more general waning influence of the past - some interventions emanating from the ABIs have been sustained and could be considered to make PA participation more achievable. This is reflective of the process of citizen shift because such findings demonstrate that sustaining PA opportunities for local residents - and engaging them in these activities - very often relied upon the willingness and capacity of individual service providers to go ‘above and beyond’ the efforts that might otherwise be required of them and to accommodate ‘inappropriate’ behaviour during activities.

Therefore, Chapter Eight begins with some conceptual criticisms of what are frequently described in health promotion literature as ‘hard-to-reach’ groups. A case is made for why efforts to reduce health inequalities, to some extent at least, rely on initiatives that increase the agency of these groups. This is followed by the extended example of swimming at the newly built local Leisure Centre and a demonstration of how and why the local availability of this activity does not necessarily facilitate the participation of local residents. This example is then contrasted with other local activities that do provide accessible services and engage local, deprived residents.
Finally, these examples inform an analysis of whether neoliberal policies provide adequate means to address disparities in adherence to health promoting behaviours.

The final findings chapter completes the route from more macro-level considerations to micro-level observations. Chapter Nine is formed of findings from eleven months of participant observation with three local single-sex weight-loss groups (one male and two female). To varying degrees, these groups are examples of the exceptional interventions - discussed in Chapter Eight - which had been established during the ABI eras but were also subsequently sustained. In this chapter, health is addressed as a reflexively embodied experience. As such, the experiences of weight-loss group participants are used to reveal how the lives of people from low-SES groups are affected by the political and cultural appropriation of obesity as a stigmatised disease state. Particular attention is given to how this approach informs participants’ comprehension of what health is and how someone in their position is able to be(come) ‘healthy’. Of equal concern are the ways in which weight-loss is a gendered practice and how the potentially emotive issue of weight is negotiated in these groups.

Findings reveal how the dominance of neoliberal ideology facilitates participants at the neighbourhood weight-loss groups to simultaneously accept and resist ‘healthy’ living as a personal responsibility: conceptualised as ‘risky resistance’. They also illustrate that rather than helping participants to maintain a concerted effort to lose weight, these groups are more accurately conceptualised as ‘social groups with scales’. More generally, activities at the group meetings formed ‘processes of compensation’ that helped participants to ‘manage’ their stigmatised bodies and cope with the everyday embodied experiences of people of low-SES. On this evidence, the new public health strategy of promoting weight-management as an individual moral responsibility is found wanting on both ‘moral’ and practical levels.

Chapter Ten concludes the thesis by drawing together the findings from the preceding chapters and explaining the relevance of the relationships between health, place and inequality to this analysis. The original theoretical concepts developed in this analysis are revisited in a discussion of the agency-structure dialectic and an argument for the necessity of equitable health provision. Finally, the strengths and limitations of this
research are considered before modest recommendations for future research are offered. This chapter is followed by appendices which include supplementary information referred to throughout the thesis.
Chapter Two

Neoliberalism, ‘Healthy’ Living and the Obesity ‘Epidemic’

Introduction

This chapter reviews literature relevant to understanding contemporary conceptualisations of health and illness. In its original form, Talcott Parsons’ (1951) sick role might now be considered of limited analytical use. It is argued in this chapter however that it provides the basis for understanding the socio-political shifts which have ultimately led to the construction of the contemporary ‘health role’. There is also a discussion below of the rise of neoliberalism as the dominant political ideology of the contemporary West and how this has led to the adoption of the new public health approach (Petersen and Lupton, 1996). This is discussed in relation to Foucault’s (1973; 1978) theories of biopolitics and governmentality and the historical process of the medicalization of everyday life. This highlights the significant ways in which people’s lifestyles and bodies have come to signify not only health and illness but also moral fortitude: what Crawford (1980) conceptualises as ‘healthism’. The notion of the obesity ‘epidemic’ symbolises aspects of this historical trend. In the context of the way in which neoliberal individualism deflects attention away from structural inequality, the chapter concludes with a consideration of how social inequalities influence the health statuses of individuals and groups in both medically and socially significant ways.

From ‘Sick Role’ to ‘Health Role’

To understand contemporary conceptualisations of health and illness it is useful to appreciate how these differ from those familiar from the recent past. Talcott Parsons’ (1951) sick role provides a useful starting point. It should be acknowledged that as well as (re)interpretations of its relevance, or indeed irrelevance, by others Parsons himself
revisited and reconsidered this concept in his later writings (Parsons, 1975; 1978). That a concept outlined over sixty years ago still attracts academic attention, in a period when much has changed in the arena of health and healthcare, suggests there is value in appreciating Parsons’ thinking on the subject of health and illness. Some may argue that the consistent (re)consideration of the sick role suggests stagnancy in sociological thought, but it is perhaps obvious from this revisiting of Parsons that this view is not shared here.

The most logical way to begin is to outline the constitutive elements of the sick role concept. Parsons (1951) proffered that health is largely understood as a capacity, an essential resource for individual achievement and a well-functioning society. The sick role demonstrates how such a conception influences both lay and professional thinking and behaviour associated with illness which, due to its incapacitating influence, is often viewed as an unconscious form of deviance. Illness is framed and understood as the reduction of a person’s healthful capacity or in Parsons’ (1978: 73) terms as an ‘impairment of the normally expected levels of health’. Alongside this understanding of health and illness runs the conventional logic that, when ill, it is both necessary and desirable to return to full health as quickly as possible. Parsons (1951) contended that this societal expectation led him to the construction of the ‘sick role’ concept to describe both the individual and social reaction to illness and the social expectations placed on people who become ill.

Parsons (1978) later stated that there were three primary criteria for accepting the social role of being sick. Firstly, it is accepted that being ill is not a state for which blame should be conferred on the sick person. Secondly, the sick person is exempt from their ordinary daily obligations and expectations of them. The second criterion is premised on the sick person complying with the third criterion which is that there is an expectation that the sick will seek help from an institutionalized health service agency. This third and final criterion also links in with the first and ties everything together because, as Varul (2010: 78) contends, the ‘assumption of innocence’ and exemption from usual obligations and expectations is only realised if the sick person complies with the expectation that they will seek help from, and act upon the advice of, a
professional who can help return them to health. Therefore, Parsons’ (1951) sick role can be considered a ‘transitional role’ (Varul, 2010: 79).

It has been argued that the sick role is no longer an accurate description of the experience of health and illness. Frank (1991: 205), for example, proffers that, what Parsons did not foresee was that ‘soon the healthy person, no less the ill one, would also be adhering to a regime and deferring to competent authority for the definition of that regime’. Avoiding disease is increasingly thought of in relation to managing lifestyle and taking precautions to ‘ensure’ good health (Armstrong, 1993; Gabe, 1995; Howell and Ingham, 2001; Ingham, 1985; Kickbusch, 2007; Petersen and Lupton, 1996). Public health has traditionally looked to social and environmental explanations for the occurrence of illness and disease but increasingly attention has shifted to how individuals ‘choose’ to behave (Armstrong, 2014; Ziguras, 2004). With this focus in mind, adopting a ‘healthy’ lifestyle is now framed as a way not only of avoiding illness but maximising health. This is what is required in contemporary times for the assumption of innocence to be conferred, but it certainly does not free people from their daily obligations; in fact, it adds to them. People are expected to take responsibility for their health and thus incorporate so-called health behaviours (e.g., exercising, consuming a healthy diet) into their daily lives. This expectation led Crawford (1980: 380) to propose the ‘potentially-sick role’, which describes the moral obligation contemporary citizens are under to minimise their risk of becoming ill or diseased by correcting unhealthy habits and conforming to a ‘healthy lifestyle’.

Crawford (1980: 379) has long argued that ‘the no-fault principle contained in the classical sick role formulation, itself a forgery, is being withdrawn. It is being replaced by a “your fault” dogma’. Unlike the traditional sick role, blame is increasingly mobilised and attributed to people who become ill or who are considered at risk of doing so. It is this obligation to avoid risk that led Frank (1991: 205) to extend the sick role and conceptualise the contemporary ‘health role’. Unlike the transitional sick role, the health role is perpetual and forever expanding. Rather than following the peaks and troughs of health and illness which characterise the traditional sick role, for the health role ‘there is no discontinuity between health and illness’ (Frank, 1991: 209). The importance of the physician fades as individual responsibility invades everyday
life. Although medical authority still significantly informs the authority of the self - as people seek information and guidance from the medical sciences - the onus is increasingly on the individual to ensure they access this information and put it into practice. This ‘new health consciousness’ pervades contemporary culture and foregrounds the role of lifestyle and personal choice and thus attributes blame and stigma to ‘unhealthy’ behaviours (Crawford, 2006). Health becomes a matter of self-mastery and thus disease-prevention comes to the fore with the ‘duty to get well’ and exit the sick role now extending to a ‘duty to stay well’ within the health role (Crawford, 1977; Greco, 1993).

Acting on the obligation to be well in the health role is what Varul (2010: 89) describes as ‘moral pre-habilitation’. For example, not smoking, limiting alcohol consumption, being regularly physically active and/or eating a low-fat, high-nutrient diet, could all be considered pre-habilitating techniques that facilitate people avoiding the scorn of others. Crawford (1977) has argued that this culture of individual moral responsibility undermines the relevance of the social conditions and constraints that influence the ‘choices’ people make and is informed by an ideology of victim blaming. Crawford (1980: 379) later described how this logic of ‘healthism’ shares a central tenet of Parsons’ sick role as the ‘failure to maintain health is ascribed to some kind of unwillingness to be well or an unconscious desire to be sick, or simply, a failure of will.’ In the same way, Sedgwick (1994) contends that the boundaries defining addiction have become so elastic and the advocacy for self-control so vehement that social health issues are now viewed as epidemics of will. To be healthy is to exercise ‘healthy free will’ but the parameters are confined to choosing (freely) health (Sedgwick, 1994: 132). The lines between health and illness thus become blurred with the pathologised and stigmatised ‘other’ encouraging self-care in the not yet ill (Crawford, 1994; Ziguras, 2004).

Lifestyle and willpower are now understood as the rudder and the arm steering health, obligating everyone to prove their innocence and worth by taking a pre-emptive approach to avoiding illness. The sick role, as Parsons initially outlined it, could largely be considered a relic from a distinctly different period in history. However, Frank (1991), Shilling (2002) and Varul (2010) all highlight how, despite its limited analytical
use, the thinking behind the sick role is still valid and is reflected in late-modern approaches to health and illness. All of these writers highlight how the productivity ethos which is central to Parsons’ sick role can be observed in late-modern, lifestyle-orientated approaches to health. This is why it is legitimate to extend it rather than discard it altogether.

For Varul (2010: 89) the refusal of those occupying the traditional sick role to give in to illness is analogous to the ‘chronically healthy’ of today who consciously incorporate health behaviours into their lifestyles. Increasingly this has meant people attempting to fit themselves into a definition of health that is almost exclusively the image of a high-consumption, middle-class ‘lifestyle’ (Frank, 1991; Smith Maguire and Stanway, 2008; White et al, 1995) by achieving what Featherstone (1982: 170) has termed the ‘look’. It is this thought which increases the importance and influence of industries such as those promoting health and fitness because, as Shilling (2002: 633) notes, they will often market themselves and be perceived to be ‘producers of health’. This conceptualisation of health and illness and the shift from the demands of the traditional sick role to advocacy for adopting the ‘health role’ are driven by neoliberal ideology. Neoliberalism has significantly altered how health and illness are approached in contemporary societies and this is perhaps most evident in the new public health approach.

The Rise and Rise of Neoliberalism

The establishment of neoliberalism in the 1980s as the dominant political ideology in the West was a defining moment in contemporary politics. Neoliberal ideology has had, and continues to have, major consequences in societies across the world, but the focus here is upon how it has influenced health and illness and ultimately led to the construction of the contemporary health role in the West. It is necessary to start with a broad definition for which Harvey (2007a: 2) can be relied:

*Neoliberalism is in the first instance a theory of political economic practices that proposes that human well-being can best be advanced by liberating individual entrepreneurial freedoms and skills within an institutional framework*.
characterized by strong private property rights, free markets, and free trade. The role of the state is to create and preserve an institutional framework appropriate to such practices.

It should be clear from this quotation that neoliberalism is presented by its advocates as the best option for achieving individual and mass well-being. Neoliberal governments, such as the recent regimes in the UK, advocate minimal State intervention in key areas and encourage citizens to take control of their own destinies by acting astutely in the marketplace. It is an approach that Clark (2004: 30) has described as being ‘hostile to the public realm’. Such an approach characterised the premiership and presidency of two of the initial and main political drivers of this ideology, Margret Thatcher (UK) and Ronald Regan (US) respectively. Their ‘genius’, Harvey (2007a: 63) argues, was to leave a legacy and a tradition where the logics of neoliberalism were so dominant that subsequent politicians became tangled in a ‘web of constraints from which they could not easily escape’. This is how neoliberalism has become the dominant and defining political ideology of the contemporary era. Although, of course, it is an ideology that has evolved out of a broad set of historical and political processes that have encompassed a more general and long-term shift towards moral individualism.

A consequence of its dominance has been the ‘financialization of everything’ (Harvey, 2007a: 33). Neoliberalism prioritises fiscal matters and supports a distribution of wealth that is largely dictated by private investment. Clarke (2004: 30) contends that it should be thought of as a ‘strategy’ which requires significant political work to demobilise alternative possibilities. He goes on to argue that one way in which this has been achieved is by disintegrating the concept of the public as a collective identity. He argues (Clarke, 1997; 2004) that the New Right accomplished this by splitting citizen identity into three differentiated figures: the tax-payer, the scrounger, and the consumer. The informed and astute consumer who pays their taxes is thus presented as a righteous alternative to those who do not prosper in the market, rely on welfare and are thus seen to scrounge off the State. Therefore, neoliberal ideology monetises, individualises and thus moralises social issues and ultimately this influences how social
and personal issues are framed and come to be understood. Public health is a prime example.

The neoliberal approach has led to huge disparities in wealth, power and health (Dorling, 2014; Piketty, 2013; Sayer, 2014) as it informs a system that supports the existing, and unequal, structure of society (Navarro, 2007; 2009). Harvey (2007a: 16) goes so far as to suggest that, from the very beginning, neoliberalism was a ‘project to achieve the restoration of class power’. Dorling (2013) draws on much evidence to show that, perhaps predictably, as income and wealth inequalities rise, so do health inequalities. Specifically referring to Britain, Dorling (2013: 10) describes this phenomenon as the ‘scandal of our times’ because, despite improvements in overall levels of health as medical science and living conditions have advanced with time, we have to go back over a hundred years to the Victorian-era to find disparities in life expectancy as wide as they presently are. Income inequality has consistently been shown to have a detrimental health effect on national populations (Marmot, 2005; WHO, 2013; Wilkinson and Pickett, 2010). However, it has been argued that insufficient attention has been dedicated to the social and political contexts which create these disparities (Coburn, 2000; Navarro and Shi, 2001; Peacock et al, 2014).

For Coburn (2000; 2004), it is the implementation and experience of living through neoliberal policies that accounts for such inequalities in health. This is particularly problematic as the discourse of neoliberalism is now so dominant.

Nafstad et al (2007: 323) argue that ‘people are now engulfed by – hearing, reading and using – the voice of neoliberalism’. This ‘voice’ is so loud that it often drowns out alternative interpretations of the same phenomena which facilitate neoliberal logics becoming ‘common sense’. Developing this point, Rose and Miller (2008) argue that the way populations are now governed in the West has been reinvented because of how dominant the influence of neoliberal conservatism has become. For them, the creation of ‘active citizenship’ within an ‘active society’ has led to a ‘reversibility’ of relations of authority which has meant that ‘what starts off as a norm to be implanted into citizens can be repossessed as a demand which citizens make of authorities’ (Rose and Miller, 2008: 215). They conceptualise this new form of governance as ‘advanced liberalism’ and explain that ‘the agonistic relation between liberty and government is
an intrinsic part of what we have come to know as freedom’ (Rose and Miller, 2008: 216). Therefore, although neoliberalism can be variously described as an ideology, strategy, discourse and much more - each description illustrating something specific about the way its influence is worked out in societies and through historical processes – what is fundamental to understanding advanced liberal societies is recognising how the entanglement of notions of governance and liberty effects social structures and personal relations. What is specifically salient with regards to this research project is the ways in which this context promotes the adoption of the contemporary health role.

Herrick (2007; 2009a; 2009b; 2011) sheds much light on how health and illness are interpreted and governed within advanced liberal societies. She conceptualises common sense understandings of how people should behave in these societies as ‘codes of sensibleness’ which she describes as being ‘inescapable’ (Herrick, 2011: 5). Because neoliberalism is seen to offer individuals greater freedom to choose how to live their lives, codes of sensibleness are promoted in order to remind people that they have a duty to themselves and others to act responsibly. Fullager (2002: 78) refers to this as the ‘moral repertoire of “shoulds”’. For instance, neoliberal discourse supports the notion that sensible, virtuous people avoid ‘unhealthy’ behaviours altogether or incorporate them in moderation as part of a ‘healthy’ lifestyle. People are presented as being free to choose, but each expression of ‘choice’ is liable to moralisation. This moralisation is facilitated by emphasising the economic burden that illness places on the State and the labour market. Herrick (2011: 4) argues that:

...personal responsibility and informed choice may be discursive bedrocks of neoliberal health policy, but the relative influence of people’s circumstances or ‘luck’ has received far too little attention. Given that to be sensible, people need to be able to overcome the effects of their (bad) luck, how responsibility is ascribed is both a thoroughly moral as well as practical question.

For Herrick (2011), by emphasising the consequences of individual behaviours, neoliberal ideology successfully obscures the interpretation of health inequalities as being largely determined by the vastly different social conditions which people live under. As she makes clear, this has the potential to imply culpability and thus suggests
that the poor are acting irresponsibly while the better off enjoy longer, healthier lives as a consequence of their sensible decision making. Herrick (2011: 4) goes on to argue that:

…the realm of being sensible remains an under-theorised and empirically sparse field that offers great potential to shed light on the seeming inability (or unwillingness) of government to address a range of societal and political economic concerns that interlock with health.

It is clear then that, if we are at all concerned about health inequalities and the potential for neoliberal ideology to exacerbate and perpetuate them, there is a need to critically engage with the promotion of health as an individual moral responsibility. Disclosing my concerns in this area, it is necessary now to turn attention to the new public health approach.

**New Public Health, Medicalization and Risk**

There are positive interpretations of new public health, which stress the significant personal and population health gains that can be made through increasing standards of living and facilitating people to live healthy lives (Baum, 2008; Kickbusch, 2003; Tulchinsky and Varavikova, 2010; WHO, 1986), and there are more critical ones (Hawks, 1997; Kottow, 2012; Metzl and Kirkland, 2010; Petersen and Lupton, 1996). Due to the pervasive influence of neoliberalism, it is a critical perspective which is considered most legitimate here. To define what is meant by new public health it is worth quoting Petersen and Lupton (1996: 11) at some length. For them;

*The new public health is, if nothing else, a set of discourses focusing on bodies, and on the regulation of the ways in which those bodies interact within particular arrangements of time and space. Perhaps less obviously, the discourses of the new public health also seek to transform awareness of individuals in such a way that they become more self-regulating and productive both in serving their own interests and those of society at large. By providing norms by which individuals are monitored and classified, and against which individuals may be measured, the emphasis of the new public health is upon persuading people to conform voluntarily to the goals of the state and other agencies. This is a crucial feature of the concept of neo-liberalism.*
Although this lifestyle approach grew out of a tradition which emphasized social context and cultural meanings, its application in health promotion largely ignores systemic influences by almost exclusively focusing on individual responsibility (Ziguras, 2004). McQueen (1989) argued from the outset that while this approach may recognise the affects that social conditions have on health outcomes, the solutions proposed are consistently behavioural in their orientation. This focus saw the concept of risk become central to new public health and the development of a ‘what if’ (Cheek, 2008: 974) approach to health. For Petersen (1996: 49), this approach pervades contemporary Western societies with an ‘endless parade of “at risk” populations and “risky” situations’ implicating everyone and anyone. This has created a sense that public health is ‘omnipresent’, it is ‘everywhere and “everyone’s business”’ (MacKian et al, 2003: 221). Within this context, Prior (2000: 196) affirms that the ‘irregular and random dance of death [can] be no more’ and instead the responsibility is placed on the individual to assess their risks and save themselves by modifying their lifestyle. With emphasis within the literature on how health and illness are now defined by a set of pervasive governing discourses, it is perhaps unsurprising that the new public health approach and the subsequent medicalization of daily life have been fertile ground for the application of Foucauldian theory (Petersen and Bunton, 1997).

We live in an era in which the new public health approach is so pervasive that health and illness infiltrate life in such an all-encompassing fashion that it is logical to write of the ‘pathological life’ (Foucault, 1973: 153). The unbounded ‘medical gaze’ (Foucault, 1973: 30) has become an all-seeing eye as people come to embody prevailing ideas about health and illness. But these processes of medicalization and moralisation have long histories. In The Birth of the Clinic (1973) Foucault charts the rise of medicine’s influence in society. He argues that ‘through the introduction of probabilistic thought’ during the eighteenth and nineteenth centuries ‘medicine entirely renewed the perceptual values of its domain: the space in which the doctor’s attention had to operate became an unlimited space’ (Foucault, 1973: 97). The widening of medicine’s ‘perceptual values’ can largely be attributed to a process of normalisation. Foucault also explained that modern medicine became ‘regulated more in accordance with
normality than with health’ going on to describe the ‘medical bipolarity of the normal and the pathological’ (Foucault, 1973: 35). He later (Foucault, 1995: 180) argued that identifying what is normal and what is pathological re-defines how people assess their bodies and actions as ‘all behaviour falls in the field between good and bad marks, good and bad points’. Morality and health become entangled. This opens up an ‘indefinite domain’, which might otherwise be referred to as a culture, where non-conformity is considered punishable (Foucault, 1995: 178). As well as this establishing the ‘deviance’ of contemporary illness, medical solutions are increasingly sought for illicit conditions or behaviours, e.g., adultery, self-harm, and thus deviance has become medicalized (Conrad and Schneider, 1980). Turner (2008: 48) qualified this point by asserting that modern medicine is therefore ‘essentially social medicine as a policing of populations and a clinic of bodies’.

Foucault (1978: 139) has explained that from the eighteenth and nineteenth centuries the ‘disciplines of the body and the regulations of the population constituted the two poles around which the organization of power over life was deployed’. It was the second of these two poles that he described as supervising the population through a series of interventions and controls that constituted a ‘bio-politics of the population’ (Foucault, 1978: 139). Biopolitics, or more specifically ‘bio-power’ (Foucault, 1978; 140), can be viewed as the mechanism through which discourses become inscribed onto and into bodies. Although biopolitics can be thought of as a form of governmentality which normalises particular ways of being (Foucault, 1991), biopower is realised through the disciplining of the body and this involves individuals having the knowledge to normalise themselves. Foucault (1978: 143) asserted that biopower ‘brought life and its mechanisms into the realm of explicit calculations and made knowledge-power an agent of transformation of human life’. In essence he is explaining here how discourses, such as those that use risk to promote individual responsibility, come to be influential and alter the perceptions and actions of individuals and societies at large. The medicalization critique which originated in the late 1960s/early 1970s picked up this argument with some vigour and it is a position that has since become central to sociological writings about the medical profession (Ballard and Elston, 2005; Lupton, 1997; Rose, 2007).
Like Foucault, Zola (1972; 1983) identified medicine as an institution of social control exerting its influence by proliferating concern about health and illness. He described this process as the medicalizing of daily life. To emphasise his point Zola (1972: 489) stated that he was convinced that merely ‘living is injurious to health’ and that rather than being facetious this was actually because ‘every aspect of our daily life has in it elements of risk to health’. Conrad et al (2010: 1943) more plainly define medicalization as a ‘process by which non-medical problems become defined and treated as medical problems, usually in terms of illnesses or disorders’. Armstrong (1995: 400-1) argued that this process is so expansive because surveillance medicine encourages people to assess their ‘future illness potential’ and that this, to some extent, redefines health as a ‘semi-pathological pre-illness at-risk state’. It is this definition that informs the contemporary health role and the new public health approach.

Ironically (and famously), Ivan Illich (1976) proffered that the pervasiveness of modern medicine thus made the medical establishment a major threat to health: a medical nemesis. His contention was that, in redefining pain, sickness and death, pre-emptive surveillance medicine undermines the attainment of good health and therefore has various iatrogenic consequences. These concerns have been poignantly illustrated by Gillespie’s (2012: 198) research investigating lay uses of numerical risk. He found that ‘at risk’ people developed a sense of ‘measured vulnerability’ that saw them experience risk as an actuality: to all intents and purposes being ‘at risk’ was experienced as being ill. Therefore, these findings echo Beck’s (1992: 33) contention that ‘risks are already real today’.

Ulrich Beck’s (1992) *Risk Society* can perhaps be considered the defining theorisation of risk in late-modernity. Its focus is risks associated with radioactivity and pollution and how these create a ‘catastrophic’ risk society where people are constantly influenced by events that have not, and may never, happen. However, the influence of risk on society as outlined by Beck (1992; 1993; 1999; 2008) is also illustrative of how health is now predominantly framed in the contemporary era. Beck (1992: 21) defines risk as a ‘symptomatic way of dealing with hazards and insecurities’. Undesirable and worst case scenarios are identified and then a ‘working back’ process begins so that
precautions can be taken to try and lessen or ideally (but always elusively) eradicate risk. Significantly, Beck (2008: 25) has argued that in the late-modern era the world’s risks are not self-evident but rather the result of ‘conscious decisions’ made by both private and public organisations in technologically advanced societies which usually stand to gain economically from this selective focus. This theorisation of risk helps us to understand how, through a discourse of new public health, ‘healthy’ lifestyles have become a central message of late-modern biopolitics and why medicalization continues to develop and expand.

The Healthy Option: Lifestyles and Bodies

For Petersen and Lupton (1996: 22), the emphasis within new public health on individual risk and responsibility has meant that both the ‘sick and the well are caught up in a web of observation’. Ill health becomes a reality, not only for those who are ill, or even at risk of illness, but also for the ‘worried well’ (Williams, 2003b: 34). Williams (2003b: 18) describes the prevalence and increased importance of surveillance medicine as a ‘strategic shift to a spatio-temporal calculus of risk factors, crystallized in the moral pursuit of health through lifestyle’. The ‘healthy lifestyle’ has become the biopolitical tool of choice used to delineate the normal and the pathological, the innocent and the blameworthy. Risk is weighed up in the behaviours and appearance of the unhealthy ‘Other’. To take up the ‘health role’, that is to maintain a healthy lifestyle, is to take control, to offer oneself security in a time when health is understood to be in continuous jeopardy. For Crawford (2004; 2006), this combination of a pedagogy of danger and a pedagogy of recommended health practices has sent societies into a spiral of control and anxiety. The health practices that form a fundamental part of neoliberal codes of sensibleness have thus become ‘individual security strategies’ (Crawford, 2006: 416) and the healthy lifestyle a sign of conscientious risk management.

In 2009 the ‘Change4Life’ UK Government health campaign was implemented across England and Wales. It continues to encourage people, with its prominently promoted slogan, to ‘eat well, move more, live longer’ exemplifying lifestyle-orientated health
promotion (Department of Health, 2008; 2009). The slogan is an illustration of the individualist risk-avoiding rhetoric associated with new public health. It promises good health in exchange for compliance with lifestyle advice. It is an example of how the body has become the prime target of numerous ‘new health risk-management strategies’ (Petersen and Lupton, 1996: 22). The carnal-centricity of new public health discourse elevates the significance of health behaviours, the aggregation of which comprises healthy living. As a result, physical form, but also the lifestyle factors associated with achieving a ‘healthy body’, have become identifiers by which people can judge the behaviour, health status and moral standing of themselves and others. Therefore, although it has been shown that people throughout the socioeconomic spectrum will conceptualise and enact ‘health’ differently (Blaxter, 1990; Hughner and Kleine, 2004; Wardle and Steptoe, 2003), those who do not comply with ‘healthy’ norms are likely to be stigmatised in wider political and public domains.

The body becomes, as Lupton (1995: 143) describes, an ‘outward sign of inward moral standing’. Body size and weight and the behaviours associated with attaining physical health are pertinent elements of contemporary identity construction and as such are likely to significantly influence someone’s embodied sense of self and well-being (Crossley, 2001; Evans et al, 2009; Lupton, 2013a; Shilling, 2003; 2005; Turner, 2008). Dominant images of health come to be reflexively embodied and thus they play a crucial role in how people feel about themselves (Crossley, 2006a; Merleau-Ponty, 1962). A combination of the social prestige and stigma attached to what are considered healthy and unhealthy bodies, respectively, will almost certainly influence how people understand and act upon their bodies. At this point the commercial, superficial and medical merge as health frequently reduces to feeling healthy which reduces to looking healthy which often equates, in turn, to looking good (Scambler, 2007). It is at these intersections that the salience of (bio)medicalization is particularly evident.

Despite being a well-established thesis, Conrad (2007) argues that medicalization is still an important point of social enquiry because as societies develop, new areas of life are medicalized. The ‘e-scape’ of medicine into the ‘info-scape’ of the internet (Nettleton, 2004; Fullagar, 2008) and subsequent medicalization of cyberspace, with
its creation of e-health and proliferation of healthism (Lupton, 2013b; Miah and Rich, 2008), is a case in point. The vast and varied realm in which it has been applied has led Metzl and Herzig (2007) to argue that medicalization is now far more complex than it once was. Rose (2007) even contends that its expansive application has led to it now being considered cliché to offer such analysis. However, he does qualify this by proclaiming that medicalization has had a profound existential effect, indeed, it has ‘made us what we are’ (Rose, 2007: 700). It has been claimed amongst the liberal application of the medicalization thesis that there is a lack of recognition for agency and the possibility of the process being reversed. In particular, Ballard and Elston (2005) take issue with the presentation of medicalization as a uni-dimensional, uniform process. Others, primarily Clarke et al (2003; 2010) have argued that with the development of the biological sciences medicalization is now analytically inadequate. Clarke et al (2010: 2) make the distinction between medicalization and what they propose is ‘biomedicalization’:

*Medicalization practices typically emphasize exercising control over medical phenomena – diseases, illnesses, injuries, bodily malfunctions. In contrast, biomedicalization practices emphasize transformations of such medical phenomena and of bodies, largely though sooner-rather-than-later technoscientific interventions not only for treatment but also increasingly for enhancement.*

It is a distinction that has led Downing (2011) to write of ‘biohealth’. He argues that biomedicine now defines health as much as it does illness and this means health attainment becomes largely unthinkable without biomedical intervention. Increasingly, practices and treatments are being designed and promoted to enhance individual health and happiness. This is most obviously demonstrated in the processes of ‘pharmaceuticalization’ and the normalisation of cosmetic surgery (Bell and Figert, 2012; Brooks, 2004; Conrad, 2005). In both cases consumers are sold products and procedures presented as having transformative potential which reinforces the notion that health and happiness are achievable but increasingly require investment in biomedical interventions. Therefore, it is pertinent of Rose (2007: 700) to remind us that ‘some people are more medically made up than others’. In short,
(bio)medicalization is not an even process. As such, as social scientists we must pay attention to how and why (bio)medicalization affects different groups and their bodies.

In an era where good health is demonstrated by the ‘lean, taut, exercising body’ (Lupton, 1995: 71) personal freedom becomes entangled with ‘healthy’ living (Petersen, 1997; Rose, 2001). In this spiral of control and anxiety, risk-averting strategies that (albeit temporarily) alleviate anxiety represent the exercise of agency as well as, paradoxically, complying with a form of governance. A ‘body industry’ extolling ‘the virtues of nurturing the “healthy”, risk averting body’ (Petersen and Lupton, 1996: 24) is the by-product of, but also proliferates in, this culture. Government health advice tends to focus on long term improvements, e.g., lifestyle modification, but commercial companies also prey on the anxieties of the perpetually ‘at risk’ public and generally focus on short term solutions, e.g., over-the-counter (pseudo-)pharmaceutical products such as weight-loss pills (Ziguras, 2004). Either way, health is presented as ‘doable’ (Kickbusch, 2007: 89) and, as such, to not ‘choose’ health or to ‘invest’ in one’s body is to leave oneself open to socially acceptable scorn. This is in line with the more general responsibilisation of neoliberalism that extols the ‘active citizen’ (Nettleton, 1997: 215) who not only can but should be an entrepreneur of their own health (Osbourne, 1997).

In all countries that offer some form of social healthcare, personal health risks are framed as public problems because they are presented as unnecessary economic drains on already strained services. It is at this intersection that politics and science meet and conscious decisions are made by governments about which risks to create and to raise consciousness around. The public perception of risks and how to act upon them will be significantly influenced by the political climate in which they are presented. The almost ubiquitous agreement that we are currently experiencing a global obesity epidemic is a prime example of how ideas about health, illness and the body are framed by political ideology. It also highlights how and why the health role has become such a defining characteristic of contemporary living.
The Obesity ‘Epidemic’

It is a popular truism that late-modernity has created a way of life that promotes weight-gain in the majority of post-industrial, consumer-driven societies. As a result it is regularly reported, in academic research and the popular press that the number of people around the world who are categorised as obese has reached ‘epidemic’ proportions and is continuing to rise (Caballero, 2007; Harcombe, 2010; Halloran, 2014; James, 2008). Obesity is presented as a significant risk to individual and population-level health and is framed as a potentially catastrophic financial burden for many national governments (Dobbs et al, 2014; Wang et al, 2011; WHO, 2000). However, the certainty surrounding the existence of an obesity epidemic and the risks obesity poses for individuals and societies around the world marginalises research and arguments to the contrary.

Crossley (2004) argues that a tension exists between the notions that late-modern societies are more body-conscious than ever before (Bordo, 2004; Pope et al, 2000; Pronger, 2002) and that obesity rates are increasing, despite the obese body contradicting dominant social ideals. He is critical of the predominantly biomedically and psychologically informed obesity discourse that emphasises the agent by framing ‘lifestyle’ modification as the cause and cure of obesity, such as, the aforementioned Change4Life campaign. This leads him to suggest that there is a need for a more sophisticated understanding of the body-society relationship and that therefore, perhaps more than ever before, fat is a sociological issue.

The poignancy of Crossley’s contention is evident in the sociological and other work that is not only critical of the scientific and ethical legitimacy of the obesity label, but also questions whether there is an obesity epidemic at all. Perhaps, the most appropriate place to start is with the measurement that materialises and thus realises the concept of obesity. For Halse (2009), the notion of an obesity epidemic is made possible by the development of a discourse of a normative body mass index (BMI). The BMI, and therefore obesity, is a social construction based on what some have argued is inconclusive, and therefore highly contentious, indicative evidence (Evans et al, 2008; Gard and Wright, 2005; Gard, 2009). Obesity becomes medicalized because the
BMI facilitates a diagnosis which in turn enables something (the obese body) to be cast as problematic while legitimizing and normalizing what is acceptable (Jutel, 2009; Lupton, 2013a; Murray, 2009). Specifically, this facilitates the construction of ‘proper and improper bodies’ (Murray, 2008: 12). It is a measurement that takes the sum of the square root of a person’s weight (kilograms) divided by the square root of their height (metres) and designates outcome measures as a level of risk to health. The categories of risk are as follows:

- 18.4 and below = underweight;
- 18.5 to 24.9 = normal/healthy/ideal weight, i.e., low risk;
- 25 to 29.9 = overweight;
- 30 to 39.9 = obese;
- 40> = morbidly obese.

Both Nicholls (2013) and Fletcher (2014) amongst others highlight how, despite a history of scientific disagreement about the accuracy of the measurement, the use of the BMI and the ‘cut-off points’ used to denote levels of risk were agreed upon in the late 1970s for pragmatic, not scientific, reasons. The decision was made by contributors to the first international conference on obesity in Maryland, US in 1979, after being proposed by obesity researcher George Bray who produced policy documents for the US government (Bray, 1976). Standardisation was deemed essential by early obesity scientists and policy makers in order to track the incidence of ‘obesity’ and therefore the widespread use of BMI was crucial to creating the perception of there being an ‘obesity epidemic’. For Nicholls (2013), the BMI lacks the specificity to be a useful diagnostic tool because standardisation minimises intra-category differences and over-emphasises between category differences. However, establishing the BMI as the standard measure of obesity created certainty where previously
healthy scientific critique had led to a lack of consensus: accuracy was forfeited for the opportunity to create impactful research.

Gard (2011) argues that this lack of scientific rigor both created the obesity epidemic and has led to its ‘end’ going unacknowledged. In his book The End of the Obesity Epidemic (2011) he contends that there had long been concern about the incidence of obesity reaching epidemic proportions but around the year 2000 the rhetoric used to communicate this concern changed and the epidemic was finally ‘realised’. He argues that in an effort to make their work ‘convincing’ researchers are willing to compromise the credibility of their evidence in order to increase the chances of it instigating action (e.g., Goldstein, 2009). This leads to a conflation of the overweight and obese categories, unsubstantiated predictions about the rate at which obesity will continue to rise, and unwillingness to report contradictory evidence in favour of presenting results that induce fear. Gard (2011: 36) asserts that this non-scientific scaremongering creates grave sound-bites which get proliferated in the media and that it is these sound-bites which are the ‘very substance of the obesity epidemic’. An example is the often quoted but unsubstantiated claim that, due to the increased prevalence of obesity, the first generation of children who can expect to live shorter lives, in worse states of health, than their parents has already been born.

Gard (2011) goes on to thoroughly review the obesity literature, questioning the science used to make particular claims but also, and importantly, convincingly argues that the evidence actually shows that obesity levels are no longer on the rise and, as such, the epidemic is over. Although there will be those who reject Gard’s argument and object to the way it is presented on the grounds that this undermines efforts to reduce the incidence of obesity that even Gard concedes has risen in recent history, it should be considered a vital challenge to a discourse that has become dogmatic. Such challenge is required because dominant assumptions about the obesity epidemic, and the necessity of weight-loss on a mass scale, seem impenetrable and thus continue unabated, irrespective of contradictory scientific findings and academic critique.

The BMI index has been criticised both for overestimating and underestimating risk because it only uses body mass to make this prediction, e.g., this is why muscular
people can be defined as obese (Nicholls, 2013). This is such an accepted and publicly known criticism however that the focus will now shift to lesser known ‘obesity paradoxes’. McAuley and Blair (2011) suggest that Gruberg et al (2002) coined the term ‘obesity paradox’ when their hypothesis that obese patients in their study would fare worse in terms of health than normal-weight patients was disproved. McAuley and Blair (2011) outline four obesity-related paradoxes that have been found in research:

- Firstly, the ‘classic obesity paradox’ is that obesity is protective in chronic disease states.
- Secondly, ‘pre-obesity’ which suggests being overweight offers a protective effect in normal populations.
- Thirdly, ‘fat but fit’, where obesity is not a risk factor for mortality in fit individuals.
- Lastly, ‘healthy obesity’ which highlights that a high population of obese adults has normal cardiometabolic risk profiles.

It is important to note that these are only considered to be paradoxes because of the dominance of an obesity discourse that promotes the logic that the existence of a healthy fat person would be remarkable as fat and health have become oxymoronic (Lebesco, 2010).

It is the third and fourth paradoxes that are of most interest here, as they describe a population that Ortega et al (2013: 389) define as the ‘metabolically healthy but obese phenotype’. These authors stress that research indicates this is a frequent condition and the aim of their study was to better understand the possible role of fitness in explaining this ‘paradox’. They measured obesity using both BMI and percentage body-fat and thus avoided merely indicating that fit, muscular people with high BMIs but low body-fat were, as might be expected, metabolically healthy. Their research was conducted on thousands of obese people, participants from a longitudinal study at the Cooper Institute in the US, and revealed that the healthy but obese phenotype had higher levels of cardiovascular fitness than the unhealthy obese: they were ‘fat
but fit’. They found that the metabolically healthy but obese phenotype was a benign condition because, once fitness was accounted for, this group had no higher risk of mortality and morbidity than their normal-fat peers. Therefore, this would indicate that someone’s BMI is relatively insignificant and it is in fact fitness-levels that better indicate physical health and risk of disease.

It is clear that the BMI measure and the notion of an obesity epidemic pathologises bodies that might otherwise be considered healthy and this heightens and proliferates the perception of risk or even a misappropriated sense of ill-health. The reason ‘fatphobia’ (Monaghan, 2008: 100) is so entrenched in contemporary Western culture is because, as Rich (2011: 9) explains, obese and overweight bodies are now understood to represent a ‘future truth’. This is perhaps best illustrated by the World Health Organization (WHO) long having labelled obesity itself as a disease (James, 2008) rather than an indication of the possible risk of disease. This is significant because the ‘obesed subject’ (Rich, 2011: 14) thus becomes ‘diseased’ and as such ‘death is written on the body’ (Prior, 2000: 195). The Department of Health (2010: 19) drew upon this discourse of disease to further stigmatise obese people in England by looking beyond the social determinants of health to warn ‘through social networks, obesity can actually be “spread” by person-to-person interaction’. The resulting focus on combating obesity through lifestyle modification leads to ‘everyone, everywhere’ being considered ‘at risk’ (Gard and Wright, 2005: 36). Evans et al (2008: 54) sum up the all-encompassing realm of obesity discourse in stating that ‘everyone, regardless of size, becomes implicated in the need to be vigilant against weight gain’.

The concept of the ‘dys-appearing body’, proposed by philosopher Drew Leder (1990), is illustrative of how and why obesity is such an effective form of biopolitics. The primary concern of Leder’s (1990) text *The Absent Body* is how people think about and understand their bodies. He contends that we are largely absent from our bodies when we are healthy; the healthy body disappears. However, it is when our status of health shifts and we experience illness that our body (re)appears and we are aware of it. He merges the words dysfunction and appearance to reflect how illness makes the body noticeable. The dys-appearing body then is the body brought into our consciousness by the presence of dysfunction. I contend that the BMI facilitates the
creation of the pathologising discourse of obesity that has the potential to make everybody dys-appear. Therefore, rather than reflecting the severity of risk associated with high BMIs, the attention given and stigma attached to obesity in contemporary culture better illustrates political efforts to individualise risk and responsibility.

Rich and Evans (2005) argue that there is seldom serious discussion within obesity discourse about the morality of representing bodies in particular ways and how this affects people’s sense of self. In his sophisticated engagement with the morality of using stigma within public health, Bayer (2008) considers how opinion has gone full circle. Stigma was commonplace in the nineteenth century with the rise of public health as a profession before the HIV/AIDS pandemic of the 1980s and beyond illustrated how it heightens vulnerability and impedes attempts to treat and control disease. However, evidence of the damaging health effects caused by passive smoking saw stigma become a common public health approach once again. Bayer (2008) argues that stigmatisation is at least defensible in some instances, e.g., drink driving, but indicates a preference for Braithwaite’s (1989: 166) ‘theory of re-integrative shaming’. He goes on to argue that there is no either/or solution, but rather there is a perpetual need to debate the ethics of stigmatisation. Obesity focused research engaging with this task has tended to indicate that stigmatisation has a detrimental and counter-productive effect on ‘obese’ populations (Brewis, 2014; Puhl and Heuer, 2010).

The discourses of moral responsibility and lifestyle modification dominant within the obesity debate ‘not only position individuals as blameworthy, but moralize and decontextualize health inequalities by glossing over the social and structural contexts’ (Rich, 2011: 16). This is particularly problematic as obesity, diabetes mortality rates and calorie consumption have all been shown to have a positive correlation with income inequality in developed countries (Drewnowski, 2009; Pickett et al, 2005). As such, Grønning et al (2012: 268) ask an important question: ‘What does it do to people when a (supposed) lack of self-control is manifest “in layers” on one’s body?’ It is important to consider this issue for people throughout the socioeconomic spectrum, but it is reasonable to presume that the most vulnerable to the deleterious effects are those in lower socioeconomic positions. There is a great need for research that understands the relevant inequalities in the obesity debate and demonstrates how
they inform and affect the embodied experiences of those who encounter them. Attention will now turn to a discussion of these issues.

**Individualisation and Health Inequalities**

In Britain, an awareness of health inequalities, and an interest in the socioeconomic factors considered important for understanding and accounting for them, dates back to at least the seventeenth century (Scambler and Higgs, 1999). More recently, the seminal Whitehall Study, and its ongoing follow up Whitehall Study II, have exposed a strong association between social position and mortality and morbidity (Marmot et al, 1978; Marmot et al, 1991). The data collected from British civil servants have shown a social gradient to health: higher social standing has been strongly associated with experiencing better health. It is perhaps understandable that Mackenbach (2012: 761) describes the persistence of socioeconomic health inequalities as ‘one of the great disappoints of public health’. Despite this, the political climate in contemporary Britain, and many societies around the world, has shifted focus away from structural inequality by predominantly framing health as a personal responsibility.

Economic resources and relatively high socioeconomic position are positively associated with health both within and between countries - even in those with highly developed welfare states (Campbell et al, 2013; Mackenbach, 2012; Marmot, 2005; Semyonov et al, 2013; Singh and Siahpush, 2006; WHO, 2013; Wilkinson and Pickett, 2010). What is more, these inequalities are intensifying. Improvements in mortality rates in the late twentieth and early twenty-first centuries have occurred most within socioeconomically advantaged groups and least (or have been non-existent) within disadvantaged groups. In general, a convergence in global mortality rates is observable throughout the 1950s but from the 1980s onwards inequality has increased and this has led to a reoccurrence of the divergent international life expectancy trend (Leon, 2011; Moser et al, 2005).

Britain is a prime example of a nation with stark health inequalities. In a nationally representative post-Second World War birth cohort study from England, Scotland and
Wales, Kuh et al (2002) highlight that the socioeconomic conditions someone is born into has a significant effect on mortality. People from manual classes are shown to be three times more likely to die between the ages of 26-54 than those in non-manual classes. Staying with these countries, Campbell et al’s (2013) study of mortality rates identifies that the ‘health gap’ between Scotland and England and Wales is now at its widest since the Second World War. They argue that although this gap was growing prior to the election of Margaret Thatcher’s Conservative government in 1979 the party’s neoliberal regime exacerbated existing inequalities. Indeed, Coburn’s (2004) comparative analysis supports the notion that governments which adhere to this ideology create far greater inequalities than do their social democratic counterparts (e.g., Sweden, Norway, Finland).

This neoliberal political influence has contributed to the level of economic inequality within the UK increasing on a scale experienced by almost no other Western European nation, with Scotland having some of the lowest life expectancies within this region (Campbell et al, 2013). Even excluding Scotland, significant geographical variation in mortality rates exists throughout England and Wales, with a particularly prominent north-south divide observable in England with regards to premature (<75 years) deaths (Hacking et al, 2011; Wells and Gordon, 2008). Furthermore, inequality can be considered doubly deleterious as research has consistently indicated that, along with its material influence, the psychosocial experience of inequality has a detrimental health effect in and of itself. It is how researchers have explained why the highest levels of health and well-being are associated with the most egalitarian, rather than the richest, countries (Marmot, 2005; Wilkinson, 1996; 2005; Wilkinson and Pickett, 2010). Therefore, at almost any level of income someone would benefit from living in a more equal society. Marmot (2005: 1) terms this the ‘status syndrome’.

With such a strong proven link between socioeconomic inequality and health it is perhaps logical that, at least within academia, there is stronger appreciation of the social determinates of health inequalities than the current socio-political climate may suggest. For instance, The Marmot Review for England (2010) demonstrated how health inequalities are socially determined and argued that addressing them with policy interventions was a matter of social justice. However, Pickett and Dorling (2010)
criticised the review for not doing enough to tackle the root of these social
determinates by showing a true political commitment to redistributing wealth. That
there are apparent geographical variations in these inequalities is predictable, given
the inequitable distribution of wealth, but how physical and social environments
exacerbate existing inequalities is deserving of greater academic attention.

Despite much evidence showing that individual health behaviours only, very partially,
account for the social gradient in health (Marmot, 2005; Wilkinson and Pickett, 2010)
they are consistently brought to the fore in political and popular debates about health
and illness. For instance, the Department of Health’s (2010) *Healthy Lives, Healthy
People* White Paper acknowledges social disparities but emphasises the role of
behaviour change in addressing them. Alternatively, behaviour change is not even
mentioned in Shaw et al’s (2006) policy recommendations for addressing the poor
health of the poor and socially excluded. This is not to dispute the well-established
links between certain behaviours (e.g., not smoking and regular PA) and the protective
influence they can have on mortality and morbidity (Ford et al, 2012; Loef and Walach,
2012; Scarborough et al, 2011; Woodside et al, 2012). However, highlighting this
disparity clearly illustrates the political preferences that lead to the dominance of an
individualist culture of responsibilisation in which these debates typically occur.

Buck and Frosini’s (2012) review of health behaviours reported that, although there
was an overall reduction in unhealthy lifestyle behaviours in England between 2003-
2008, these lifestyle risk factors were unequally distributed as reductions had mainly
occurred among higher socioeconomic and educational groups. Within a culture of
healthism these findings are more likely to be attributed to the popularly accepted
‘deaf ears phenomenon’ (Warin et al, 2008: 99) that casts people of lower-SES as
ignorant, recalcitrant and bad citizens, deserving of contempt or at best education to
better inform them about the risks associated with choosing to behave in such a way.
This is in contrast to making the otherwise apparent link between the social and
environmental restraints experienced by those of lower-SES and how this may limit
their capacity and/or motivation to live a ‘sensible’, ‘healthy’ lifestyle. Indeed, because
it is argued that there is now ubiquitous awareness of the protective effect of ‘healthy’
living and a culture that promotes a moral obligation to act responsibly amongst
citizens, those aligning themselves with the ‘behavioural justice’ movement argue that offering the opportunity to live a ‘healthy’ lifestyle is now a matter of social justice (Baum and Fisher, 2014; Adler and Stewart, 2009). Although Buck and Frosini (2012), who are policy advocates, suggest moving away from simplistic choice-based conceptualisations of lifestyle and a need instead to improve the health of the poorest fastest, their highlighting of a ‘clustering’ of unhealthy behaviours with a class of people can fuel the widespread prejudice that attributes the consequences of being poor to the individual actions of the poor themselves (Dorling, 2010; Williams, 2013).

Scambler’s (2012: 135) concept of ‘clustering’ is more informative: people residing in low-income households and sub-standard housing are the most likely to find themselves in neighbourhoods lacking in social amenities and are therefore often impoverished both socially and economically. He suggests clustering is ‘no surprise’ but has only relatively recently received significant academic attention. Rather than being blameworthy these populations face the double burden of being individually marginalised and geographically/socially disadvantaged (Masuda et al, 2010). Frohlich and Abel (2014) are critical of the fact that much empirical research on social inequalities in health behaviour is entrenched in the social epidemiological approach and thus has a tendency to focus on individuals as passive disease hosts instead of active agents and neglects the relevance of unequal choices as a key element in the distribution of health practices. They advocate focusing more attention on the health inequities, e.g., physical and social environments that are unconducive to ‘healthy’ living, rather than the outcome of inequalities, e.g., ‘unhealthy’ lifestyle behaviours.

Finally, in line with this position, Blacksher and Lovasi (2012: 172) suggest that, contrary to dominant contemporary political discourse, within academia there has been ‘a reaction against the individual-centred biomedical paradigm of preceding decades’ and an eco-epidemiology approach has increased in popularity. This is evident within the literature specifically concerned with PA and obesity. Sharing the sentiments of these critiques and considering the victim blaming approach liable only to exacerbate health disparities, the following chapter will engage with this literature.
Summary

In this chapter, the dominance of neoliberalism and subsequent development of the new public health illustrate the individualist risk-averting rhetoric that has come to frame contemporary health and illness. The effects of this approach are most evident in the modern, moral obligation to adopt the health role. The norms of ‘healthy’ living have been explained with the theories of biopolitics and governmentality and the historical process of (bio)medicalization. ‘Healthy’ norms define and pathologise ‘obese’ bodies and form a significant – and inescapable – part of neoliberal codes of ‘sensibleness’. This is despite convincing research indicating that the obesity ‘epidemic’ is more of a moral panic than public health emergency. The influence of vast social inequalities - that can otherwise be understood to cause health inequalities - are undermined by the dominance of individualism and the promotion of lifestyle modification. This highlights the need to focus critical attention towards the social and environmental factors relevant to understanding the social gradient that is observable in the adoption of health behaviours, e.g., PA. As such, this is the explicit focus on the following chapter.
Chapter Three

Placing Health and Laying Blame

*Physical Activity, Health Policy and Bio-spheres of Risk-Aversion*

**Introduction**

This chapter starts by reviewing epidemiological and geographical research which addresses the spatial distribution of PA participation and the associated facilities and services. As there is a strong association between participation, services and socio-economic characteristics the differences between ‘at risk’ and ‘vulnerable’ populations is outlined. It is argued that ‘clustering’ of low-SES groups in areas lacking PA opportunities and the cultural dominance of responsibilisation creates a climate ripe for victim blaming. The complexity of intervention is addressed by considering the role of the public sector in addressing social and environmental disparities and the tendency for such interventions to exacerbate, rather than reduce, inequalities: a phenomenon known as the ‘inequality paradox’ (Frohlich and Potvin, 2008). This is followed by a discussion of ABIs – significantly informed by the writings of Nikolas Rose (1996; 1999a; 1999b; 2001) - and the ways neoliberal governments de-collectivise responsibility by implementing this policy. Finally, because of the significant ways in which contemporary conceptualisations of health now alter people’s perceptions of the therapeutic properties of particular places, I conceptualise ‘bio-spheres of risk-aversion’. This analytic tool demonstrates how spaces that have been ‘healthified’ are both biopolitical techniques and potentially emancipatory.

**Putting Physical Activity ‘On the Map’: Looking Beyond the Individual**

Before the 1990s there were relatively few studies within health-related fields that paid specific attention to the relationship between physical environments and levels of PA within populations (Harris et al, 2013; Sallis, 2009). However, possibly as a backlash
against the individual-centred biomedical paradigm that has defined the last few decades, Ding and Gebel’s (2012) literature review reveals that since 2002 the number of studies contributing to an understanding of how the built environment affects levels of PA and obesity has ‘skyrocketed’. But Harris et al’s (2013: 536) recent mapping of this research led them to describe the field as being still in a ‘discovery phase’ and to stress that it is fundamentally important for public health that scientific discovery progresses to intervention delivery.

Emphasising the role of lifestyle in the health inequalities debate tends to minimise structural issues, but it has also been argued that biomedical and epidemiological research in this area generally lacks a critical perspective that would highlight their relevance too (Raphael and Bryant, 2002; Raphael, 2000). This has led to recreational PA, or ‘active leisure’, being described as the ‘best buy in public health’ for the obvious reasons that it is relatively cheap for governments and promotes individual responsibility. This is despite governmental efforts to increase participation rates consistently failing to be effective (Fullagar, 2002: 71). Because of this, it is essential that sociologists critically engage with health inequalities debates to challenge the ‘rhetoric of choice’ which proliferates moral judgements rather than a greater appreciation of the causal power of social structures (Scambler, 2007; Williams, 2013). Important questions include:

- Are the distributions of (in)activity and obesity socially and geographically patterned?
- If so, which people within society have the lowest activity levels?
- How might the answers to these questions offer an alternative logic to that proffered by individualised explanations of the distribution of ‘healthy’ lifestyle behaviours?

As such, the geographical variation of PA levels is of considerable sociological significance. The main themes within this emerging field of research will now be considered in greater detail.
Neighbourhood Effects on Health

Amongst others, Curtis and Jones (1998: 647) have argued that when considering spatial variations in health there is a need to distinguish, conceptually and empirically, between compositional effects and contextual effects. Compositional explanations interpret geographical differences in health as the result of the ‘varying distribution of types of people whose individual characteristics influence their health’. Contextual explanations recognise that the ‘health experience of an individual depends partly on the social and physical environment in the area where they live’ (Curtis and Jones, 1998: 648). As such, a compositional interpretation of an area with low levels of PA would be that there is a clustering of people similarly disinclined or unable to exercise who are living in the same area whereas a contextual explanation would assume that the area where these people live influences their inclination and capacity to exercise in various ways. However, Curtis and Jones (1998) acknowledge that the extent to which compositional and contextual effects are clearly distinguishable is open to debate: a necessary caveat which will be considered in greater depth later.

More specifically, Ross (2000) considers the effect that neighbourhoods may have on health-related behaviours. Three approaches, which are not necessarily mutually exclusive, are outlined. The first two can be categorised as contextual in nature. The ‘structural perspective’ contends that in a given area people’s capacity to act in particular ways, e.g. ‘healthily’, is limited or facilitated by the opportunities and resources that are available to them. The ‘contagion perspective’ suggests people are influenced by those around them and therefore behavioural norms spread throughout communities. Lastly, the ‘compositional hypothesis’ contends that the demographic characteristics of residents, rather than the place itself, are the most significant influence. Blaxter’s (1990) seminal study of health and lifestyles in England demonstrates significant contextual effects after accounting for compositional factors. The study recognised that a person’s SES was an important indicator of health but that the situation was also exacerbated by their local environment. Blaxter (1990) demonstrated that the health of people similarly aligned in socioeconomic terms differed significantly depending on the areas in which they lived. This suggests that contextual factors need to be understood as variously constraining and liberating and
that we need to look at how this impacts differentially on people’s capacity to lead ‘healthy lifestyles’.

Giles-Corti and Donovan (2002a) identified that, regardless of how SES is measured, research consistently concludes that low-SES groups engage in what is considered to be an insufficient amount of recreational PA to be beneficial to health. This is a consistent finding throughout studies that use different measures of SES, e.g., income and education (Ball et al, 2006; Black et al, 2010; Gordon-Larsen 2006; Giles-Corti and Donovan, 2002b; Hillsdon et al, 2007; Lahelma et al, 2010; Pascual et al, 2009; Powell et al, 2006; Taylor et al, 2011; Twigg and Cooper, 2010). Such conclusions chime with the research of Ellaway et al (2012) in the West of Scotland which considered the relative effects of SES and level of neighbourhood affluence on self-reported health. In ‘Getting Sicker Quicker’, these authors found that low-SES and neighbourhood deprivation had cumulative, long-term, detrimental effects on self-reported health.

Dominant, contemporary discourses surrounding health are liable to frame low-SES groups as part of a population ‘at risk’. However, Frohlich and Potvin (2008: 218) make a necessary distinction between ‘at risk’ and ‘vulnerable’ populations. For them the distinction is clear:

* A population at risk is defined by a higher measured exposure to a specific risk factor. All individuals in a population at risk show a higher risk exposure. A vulnerable population is a subgroup or subpopulation who, because of shared social characteristics, is at higher risk of risks. The notion of vulnerable populations refers to groups who, because of their position in the social strata, are commonly exposed to contextual conditions that distinguish them from the rest of the population.

Those who habitually smoke cigarettes are part of an ‘at risk’ population. Those with low to no income and/or few educational qualifications are a vulnerable population, particularly if they live in a deprived area. Therefore, a neighbourhood with a high level of low-SES residents is home to a vulnerable population whose vulnerability is exacerbated by the physical and social environment they inhabit. It is for this reason that conceptualising health as an individual moral responsibility is liable to accusations of victim blaming. As Curtis and Jones (1998: 653) poignantly highlight, ‘while society
tends to place equal responsibility on individuals for “compositional” health risks, it offers inequality [as] the means to deal with them.’

Obviously health is measured in various ways, e.g., premature mortality, self-rated, and people participate in PA for numerous reasons – not necessarily to improve health. However, research consistently shows that living environments contribute to the poor health experienced by many in low-SES groups. After controlling for several demographic and socioeconomic characteristics of respondents in their Canadian study, Veenstra et al (2005) reported a significant neighbourhood effect on health. Significantly, too, when Warr et al (2007) were researching residents’ perceptions of health-impairing factors in ‘poor’ Australian neighbourhoods, amongst many other things, a consistent complaint was the lack of local sporting and recreational facilities.

More specifically, Black et al’s (2010) New York study found that, after controlling for individual-level characteristics, neighbourhood-level features, such as a lack of local amenities and PA resources and higher levels of poverty, were independently associated with higher rates of obesity.

Kamphuis et al (2007: 500) offer some explanation for such an association as their research across socioeconomic groups in the Netherlands found low-SES participants ‘perceived more barriers for behaving healthy, specifically barriers related to accessibility, availability, neighbourhood characteristics, and cost considerations’. This is consistent with Badland and Schofield’s (2006) New Zealand-based study indicating that people in cities tend to report broader, more non-specific barriers to PA facility use, such as crime prevalence, aesthetics and motivational barriers. Similarly, other studies have identified that although PA facilities and opportunities were present in some areas, participant’s use of them was stymied by factors associated with deprived areas, e.g., available equipment being of a poor quality, fear of crime, concern for their safety and local aesthetics (Baker et al, 2008; Holt et al, 2009; Giles-Corti and Donovan, 2002a; Nelson and Woods, 2009). Warner-Smith and Brown (2002) explored these themes in their study of women living in an Australian country town. They outlined how where these women lived had created a framework of constraints which were both explicit, e.g., access to work and facilities, and implicit, e.g., cultural expectations, and how this influenced their leisure, health and well-being. As one

These findings are in line with research on the influence of social capital on health. Since the early 1990s a sharp increase in the number of studies drawing, not unproblematically, from the various conceptualisations of social capital provided by Pierre Bourdieu (1986), James Coleman (1988; 1990) and Robert Putnam (1995; 2000) has meant researchers ensured the term entered the public health lexicon (Kawachi, 2004). Generally speaking, Bourdieu’s and Coleman’s conceptualisations are closer in alignment, outlining social capital more as an individual attribute, whereas Putnam defines it as the property of collectives. As others have noted, studies supported by the former position have focused on the varying levels of collective resources an individual could draw from, whereas those supported by the latter emphasise a sense of community variously composed of attributes such as trust, reciprocity and civic engagement (Carpiano, 2006; Edwards and Foley, 1998; Kawachi, 2004).

Islam et al’s (2006) review illustrates that the majority of studies report a positive association between social capital (both at individual and area level) and health and well-being. Interestingly, this effect has been shown to have a comparatively greater role in less egalitarian societies such as the US than in more egalitarian societies such as Sweden. However, as might be expected, these authors also concluded that differences in health were predominantly due to individual-level factors, e.g., SES. Therefore, I agree with Lochner et al (2003), who found only a partial relationship between social capital and mortality rates in Chicago neighbourhoods, and thus concluded that without attending to inequalities in access to other types of capital, e.g., economic capital, social capital is an essential but insufficient ingredient for improving health. This is more in line with a Bourdieusian theorisation of social capital as an individual attribute.

It appears clear, then, that both contextual and compositional considerations need to be taken into account when studying health behaviours. By doing so individualist victim blaming can be exposed by emphasising the differences between ‘at risk’ and vulnerable populations and the significant impact that physical and social
environments have on the capacity of people to lead ‘healthy’ lifestyles. Contextual interpretations of health inequalities add necessary detail to initial compositional findings. However, to come back to the debate that Curtis and Jones (1998) described as being open, it appears clear from the literature reviewed that the boundaries between compositional and contextual perspectives are blurred. Indeed, Macintyre et al (2002: 130) argue that since ‘the collective properties of local residents are part of the context facing any individual living in that place, we no longer think it sensible to view collective explanations as being separate from contextual ones’. This emphasises how the socio-cultural and historical features of an area, such as whether it has traditionally been home to the affluent or the poor, can be just as, if not more so – encouraging of particular behaviours as the absence or presence of accessible facilities/opportunities. However, the opposite can also be considered true because socio-cultural and historical features of areas are established, endure and/or lost in part because of the facilities and opportunities available to the people who live there. As Fitzpatrick and LaGory (2003: 36) eloquently put it, ‘we are who we are and we experience what we do on a daily basis in part because of where we find ourselves. Our physical and mental health is a product not only of how we live, but also where we live’.

Compositional and contextual explanations are thus perhaps best thought of as a dialectic rather than comprising distinct positions. It is for this reason that Frohlich et al (2001: 784) describe the need to conduct research that, unlike the tendency in biomedicine, does not view individuals’ lifestyles as occurring in a ‘behavioural vacuum’. Instead, they argue that it is the theoretical reconciliation of compositional and contextual phenomena that will allow us to comprehend ‘how the social gets under the skin’ (Frohlich et al, 2001: 783). These perspectives will now be considered in relation to how specific places can influence the PA levels of residents.

**Looking Closer to Home: The Influence of Place on Physical Activity**

Contextual explanations for physical inactivity that focus on structural factors, such as the presence of green spaces and facilities, can be considered the least contentious of
those available. Ståhl et al (2001: 3) describe ‘incentive environments’ as being places providing the best access to PA facilities and conversely identify ‘restricting environments’ that constrain access and/or provide attractive sedentary settings. Restricting environments are more widely known within the literature as ‘obesogenic environments’; a term attributed to Egger and Swinburn (1997: 478). This is because in area-based research, PA opportunities are commonly considered alongside the availability of food, namely fresh fruit and vegetables and the prevalence of fast food outlets (Bodicoat et al, 2014; Kamphuis et al, 2007; Nelson and Woods, 2009; Shannon, 2014; Townshend and Lake, 2009; Withall et al, 2009). Taken together with the population characteristics of an area, facilities and organised activities constitute what Ellaway and Macintyre (2010: 400) term ‘opportunity structures’. These are described as ‘socially constructed and socially patterned features of the physical and social environment which may promote or damage health either directly or indirectly through the possibilities they provide for people to live healthy lives’.

If people cannot realistically access PA opportunities then arguably it is unrealistic to expect that, without external intervention, those without physically demanding occupations will meet the recommended weekly levels of PA. In the UK it is currently recommended that adults perform 150 minutes of moderate to vigorous intensity PA spread throughout the week which is predominantly aerobic but also includes two bouts of muscle strengthening activity (Department of Health, 2013). Sallis et al’s (2009: 487) international study indicates that a clustering of PA opportunities, or ‘activity-friendly attributes’, is necessary to increase substantially the number of people meeting the recommended PA levels. In their study there was ‘evidence of a linear gradient in the relationship, such that the more supportive the reported built-environment attributes were for the neighbourhood, the more likely the person was to be sufficiently physically active’ (Sallis et al, 2009: 487). These findings provide further evidence that the responsibilisation of health behaviours would appear to create a climate ripe for victim blaming.

Farrell et al (2014: 61) analysed data from over one million adults in England. Their findings show that physical inactivity has statistically significant income and education gradients and that ‘local area characteristics are significant predictors of physical
inactivity, with inactivity being higher in more deprived local areas’. Other recent research investigating the distribution of PA facilities in particular countries gives more context to these findings. Although not surprising, the results are concerning with regard to their potential to exacerbate existing health inequalities. The general indication is that people living in places with the most limited access to facilities are the same people who could be considered to have most to gain from using them. A geographical study by Hillsdon et al (2007), for example, maps the distribution of a range of PA facilities, both public and private, throughout England and convincingly demonstrates that deprived neighbourhoods have fewer facilities than more affluent areas. Staying in England, Panter and Jones’ (2008) six neighbourhoods study across the city of Norwich indicates that those living within shorter distances of affordable facilities are more likely to report having been physically active at least five times a week.

Gordon-Larsen et al’s (2006) study in the US echoes these findings from England. It reveals that, in a nationally ethnically representative cohort, the most affluent areas are twice as likely to have at least one PA facility compared to areas that are home to the most vulnerable populations. Their study also indicates that the relative odds of achieving the recommended weekly levels of PA increase, and relative odds of being overweight decrease, with each additional facility in an area. They conclude that ‘inequitable distribution is significantly associated with subsequent disparities in health-related behaviours and obesity measured at individual level’ (Gordon-Larsen et al, 2006: 421). Powell et al (2006) similarly found that in the US the median household income of an area is significantly associated with the availability of facilities. They found that not only does the likelihood of having one facility increase as median household income rises but, as in Gordon-Larsen et al’s (2006) study, these areas are also more likely to have access to a variety of facilities. Vanhelst et al’s (2013) study comparing a number of European countries supports these conclusions but also builds upon them by matching their findings with the results of a number of physical fitness assessments. They found that a favourable physical environment is not only associated with increased PA levels but also, as one might expect, increased levels of physical fitness.
In France, Billaudeau et al (2011) found that the type and quality of facility provision is strongly related to the income level of the neighbourhood. Less affluent areas are more likely to have access to multi-purpose facilities with good disabled access (suggested to be an outcome of local social policies), whereas more affluent areas have more comfortable, sport specific facilities, e.g. tennis courts with heated changing rooms and showers. This difference in provision is likely to be due to the reliance of less affluent areas on public sector provision of facilities/services. Therefore, participation maximising, cost-effective solutions that meet legal obligations to equal access are prioritised. But the inequitable distribution of PA opportunities does not stop with availability, variety and quality of facilities. For example, research by Dahmann et al (2010) found that active recreation courses, e.g. sports, dance, fitness, are also unevenly distributed throughout southern California. This even extends to the uneven distribution of public recreation courses which leads to high-income communities being better served than those low-income areas which, arguably, are in greater need of these opportunities. Therefore, all of these studies support the notion that there is a pattern of vulnerable populations being further disadvantaged by the physical environments and opportunity structures they inhabit. This seems especially true in relation to the availability of PA opportunities. However, it is not just the availability of facilities/opportunities that is a particular issue for these populations.

Highlighting the presence of facilities and linking these data to activity levels is important, but some studies (e.g., Billaudeau et al, 2011), are limited in focusing solely on spatial accessibility. This casts a shadow over the relevance of other aspects of accessibility. Many studies have found cost to be a significant barrier to PA participation (e.g., Kamphuis et al, 2007; Kruger et al, 2007; Whithall et al, 2009). Taylor et al (2011) highlight the common practice at public sector facilities of issuing discounted access cards to those deemed sufficiently in need. They suggest though that in areas of deprivation it is more likely that admission prices will be inelastic and if card holders’ discounted/free admission were to increase in cost then facility use will suddenly drop off. Research that focuses merely on the presence of facilities could show that certain areas are well served by facilities but PA levels are low. This could
lead to possible conclusions being drawn based on the assumption that residents have access to these facilities, i.e., people are ‘choosing’ not to use them. However, as cost has been shown to be a significant barrier to participation, especially with people of low-SES, availability of facilities could be deceptive. Furthermore, people could feel that they are being priced out of ‘healthy’ living and local facilities could thus become frequently seen emblems of that felt injustice. Even newly built facilities with good accessibility can go unused because residents perceive them to be ‘too nice’ or ‘posh’ (Larsen and Manderson, 2009: 611) which may further strengthen the notion that ‘healthy’ living is ‘not for the likes of us’ but instead a concern for the affluent classes (Bourdieu, 1984; 1989).

Pascual et al (2009) question the logic of focusing solely on the use of available facilities as a reliable indicator of PA levels. Of course, many types of PA, both for leisure and work, takes place away from dedicated PA facilities. Pascual et al’s (2009) research in Spain offers an interesting insight into this. Their findings support the general view that area affluence is associated with facility availability but, contrary to suggestions that people of low-SES are inactive, it also shows that residents of provinces with the lowest wealth and greatest deprivation have the highest, rather than lowest, frequency of jogging when compared with more affluent areas. Unlike walking (which can show that low-SES groups have similar PA levels to higher-SES groups but fails to acknowledge that this is likely to be the result of a necessity for active transport and is associated with fatigue and psychosocial stress (Bostock, 2001; Green, 2009) - jogging is more indicative of volitional activity motivated by health and fitness outcomes. This finding suggests that people of low-SES, rather than ignoring health recommendations, can be receptive to these messages and, despite their restricted capacity, act upon them.

This notion is supported by several important research findings. Jongeneel-Grimen et al’s (2014) Dutch longitudinal study indicates that the impact a place has on health can alter over time. They found that improving conditions in the perceived and built environment increases the PA levels of local residents. Showing similar transformative signs, the foci of Choitz et al’s (2010) study were two health and fitness centres that had been set up in underserved Philadelphian communities in an attempt to remove
barriers to PA experienced by local residents. The centres addressed geographical, financial, educational and mobility barriers and attempted to provide a comfortable social and physical environment. Without targeting specific groups, the centres attracted regular users from population segments with historically lower than average PA levels. This research also revealed that health concerns ranked highly as a motivating factor for participation. Equally, Lowther et al (2002), in their year-long study with people from a Scottish housing estate, found that by removing the financial barrier to exercise and conducting exercise consultations with this socially and economically deprived, otherwise described as ‘hard-to-reach’, group, a significant participatory impact can be made with sedentary populations. These findings indicate that people in underserved communities are concerned about their health and if barriers to participating in PA are removed they can and will become regularly physically active. This suggests that improving the accessibility of PA opportunities for vulnerable populations living in deprived areas can help to address existing health inequalities.

Increasing activity levels may involve increasing the presence of, and access to, facilities for vulnerable populations and/or facilitating alternative opportunities which do not require the use of a facility, e.g., well-maintained paths for jogging (and taking this activity into consideration when measuring PA levels). For example, Cohen et al (2012) found that installing ‘Fitness Zones’ in parks in a Southern Californian city is a cost effective way of increasing park-based PA. Similarly, Veitch et al’s (2012) observed significant increases in people being either moderately or vigorously active at a park located in the most-disadvantaged area of the state of Victoria, Australia, after the park had been refurbished with the view to making it more accessible. However, it cannot be assumed that it was people from this area who were using the park to be physically active.

The issue of accessibility is clearly complex. The presence of a facility in an area does not necessarily mean it will facilitate residents being physically active in any significant way. The availability of opportunities is just one, albeit fundamental, issue of accessibility. This is perhaps most evident in research which, unlike most other studies, has shown an inverse relationship between available facilities and frequency of PA
participation. Giles-Corti and Donovan’s (2002a; 2002b) studies are good examples. In one study in Perth, Australia, they found that ‘despite having better access, residents of low-SES areas are less likely to use recreational facilities that involve entrance fees (i.e., sport and recreation centres, gym or health clubs, tennis courts, golf courses) even after adjustment for household income’ (Giles-Corti and Donovan, 2002a: 608). They were also less likely to be physically active in free to use space, e.g. beaches and streets. Due to this finding the authors stress that we need to look beyond mere accessibility to explain the relatively low PA levels of residents living in low-SES areas.

Ball et al (2006) similarly found in Melbourne, Australia, that women of low-SES only infrequently mention a lack of facilities as a barrier to PA participation, with several acknowledging that there were good facilities locally but that they lacked the motivation to access them.

A second Australian study by Giles-Corti and Donovan (2002b) in Perth paid closer attention to why this may be the case. This research focused on the relative influence of individual, social and physical environment determinants on achieving recommended levels of PA. They found that use of facilities is negatively associated with lower levels of access, but also that the influence of individual and social environments outweighs the role of physical environmental determinants. Their findings suggest that having good access to facilities is necessary, but insufficient, with regards to members of communities achieving recommended levels of PA. This led them to conclude that ‘it would seem that environmental modification must be complemented by strategies that aim to influence individual and social environmental factors to support participation’ (Giles-Corti and Donovan, 2002b: 1809) if PA levels are to be increased. Ståhl et al’s (2001) international study supports this conclusion revealing that the social, not the built, environment is the strongest predictor of PA. They found that those who perceive themselves to have low levels of social support are twice as likely to be physically inactive. These studies demonstrate that it is necessary to support findings that focus on the physical environment and the availability of local facilities with detailed analyses of individual and social factors. Addressing this need will necessarily involve engaging with the intersections where
agency and structure meet which allows the notion of ‘choice’ to be considered to the level of complexity that is required.

**Taking Agency Seriously**

A consistent criticism of Foucauldian critiques of contemporary conceptualisations of health and illness and the biopolitics of health promotion (Lupton, 1995; Petersen, 2003; Rich, 2011) is the tendency for such critiques to undermine agency. Similarly, highlighting the constraining influence of contextual factors can underplay the decision-making capabilities of individuals inhabiting those areas. Blacksher and Lovasi (2012), for example, argue that research on the social determinants of health needs to take agency seriously. It is important to recognise that people are capable of making decisions and that not all individuals defined as belonging to a particular social group, such as ‘low-SES’, will interpret and experience particular discourses and constraints in the same way. The numerous and varied ways in which individuals think about health, outlined in Hughner and Kleine’s (2004) review of the lay sector, demonstrate that no discourse is all-powerful or entirely consistent in its effects. People can, and do, resist dominant discourses and/or act in ways that defy the powerful structural forces that understandably impede others who are similarly positioned within the social strata.

It must be appreciated, to begin with, that some people may have a preference for behaving in ways considered hazardous to their health. Countering governmentality critiques that overemphasise the uniform influence of dominant discourses, Michele Crossley (2002: 50) powerfully demonstrates how health promotion can have a ‘boomerang effect’. In her study of the ‘barebacking craze’ she describes how some gay men actively seek infection with the HIV virus in an act of rebellion and transgression. Borrowing from the logic of cultural criminology, she argues that telling people what they must not do can heighten, or even create, the appeal of engaging in such activity (Presdee, 2000). This may be an extreme case, but ‘unhealthy’ preferences cannot simply be considered to demonstrate of lack of concern for health. Crawford (2000) argues that it is not a case of either/or with ‘healthy’ and ‘unhealthy’ behaviours but, instead, most people develop a relationship which engages with both.
He argues that those seen to be ‘really healthy’ or ‘really unhealthy’ are each generally considered to be obsessive and pathological and therefore most people attempt to maintain a balance in this respect. Berlant (2010: 27) goes so far as to suggest that the ‘pleasure people take in “letting themselves go” might be a pleasure that’s both for and against health’. The suggestion is that people will differentiate between mental and physical health. Therefore, ‘unhealthy’ behaviour may be engaged in because it helps people to unwind or because they enjoy it. These behaviours are what Beck (1993: 30) might term ‘risky freedoms’.

People may ‘know’ that PA can help them to maintain a ‘healthy’ weight but they may also know that they enjoy relaxing on the sofa or find swimming at their local pool an unbearably depressing experience. Likewise, most people appreciate that working long hours is negatively associated with good health. This is where Freund’s (2011) concept of ‘bioagency’ is useful. He does not differentiate between the mind and the body but instead writes of their melded nature using the term mindbody (Freund, 2011: 64). He argues that it is not just structural elements that have material consequences but agency does too. Freund (2011: 63) explains that bioagency can ‘be seen as a capacity, highly developed in humans, for self-initiating and organizing biological processes’ and states that it works on a ‘conscious-unconscious level’. This is how placebos work: the knowledge that something may positively affect one’s health can have a material consequence. The opposite is also true, e.g., in provoking stress and high blood-pressure. This fortifies Kirkland’s (2010: 195) contention that ‘the way one thinks about something like health really makes a difference in what it is and becomes’. It supports the legitimacy of psychosocial explanations of health inequalities (Marmot, 2005; Wilkinson, 1996; 2005; Wilkinson and Pickett, 2010), e.g., why psychosocial experience of inequality has a detrimental effect on health. It also offers explanations for why there is such variety of lay concepts of health, as it demonstrates that health is relational and thus the importance of the sociocultural norms informing particular groups and communities.

It is important that the agency people demonstrate, particularly those in vulnerable populations, is recognised but not overemphasised. Armstrong (2014) describes how the transition from the sick role of old to notions of patient autonomy stems from a
discourse of medical ethics, deriving from the 1970s, which stresses the importance of individuals taking responsibility for health-related decisions. Although engaging with this situation does, to some extent, demonstrate exercising agency it is an approach that empowers some people more than others and is therefore likely to exacerbate existing inequalities. There is always, to some degree, a convergence of agency and structure, it is never totally one way, but agency is inherently intersubjective and choices are based upon what is considered realistic within given structural restraints (Cockerham, 2005; Veenstra and Burnett, 2014; Williams, 2003a). Horrocks and Johnson’s (2014) research is illustrative of this. They questioned the legitimacy of everyone being labelled as reflexive consumers within the user-led health care system by illustrating how such assumptions affected the lives of people in the UK living in social housing. They argued that far from being empowering, this approach bypasses certain groups while imposing choice on others. Horrocks and Johnson (2014: 180) suggest the necessity of having ‘navigators’ to support low-SES groups through the ‘decision-making’ process to make up for the structurally imposed shortfalls they experience. Although structural determinism should be avoided, reflecting how agency is enabled or constrained for different people is a sociological necessity.

The Public Sector to the Rescue?

With such a disparity in the availability and use of facilities, as well as in compliance with recommended levels of PA between SES groups, it is perhaps unsurprising that the role of public sector provision is significant to this debate. Coalter (2000: 172) argues that ‘leisure services have rarely been provided simply in response to popular demand. Their status as a merit good, which has more to do with social engineering than social citizenship, has been the most consistent strand in leisure policy’. If the demand for these services does not exist, to achieve the goals that they set out, demand needs to be fostered and facilitated. As such, it is likely that building facilities with the specific aim of servicing vulnerable populations will not be enough to significantly increase the PA rates of residents in these areas. As the main provider of health care in the UK, it is understandable that the public sector attempts to influence
people to conform to ‘healthy’ lifestyles. Providing facilities, e.g., swimming pools, leisure centres and well maintained parks, can offer PA opportunities to people who may not otherwise have access to them and this is clearly commendable. However, public sector provision of these facilities is far from unproblematic.

UK public sector leisure services have long juggled the joint goals of operating within an annual budget and achieving some, often vaguely outlined, social objectives (Foxall, 1983). The twin aims of achieving both financial and accessibility objectives remains evident, but Taylor et al (2011) describe a shift occurring post-1989 resulting from the UK Government report: “Sport for Whom?” (Audit Commission, 1989) The report questioned whether local authorities in the UK warranted the subsidies they received for leisure services, considering what they were providing and who the beneficiaries were. A significant issue raised was that ‘poorer people’ were paying taxes to subsidise facilities that were mainly being used by the ‘better off’. After this report, as Taylor et al (2011: 129) explain, ‘considerable efforts went into steering local authorities into a clearer and more evidence-based justification for subsidised sports provision’. Ultimately, this has led to the establishment of ‘conflicting objectives’ for those in charge of public facilities in the UK. They are now ‘under pressure to improve financial performance at the same time as improving access to facilities by disadvantaged groups’ (Taylor et al, 2011: 139). As Taylor et al (2011) go on to argue, the conflict occurs because it is logical to presume that targeting ‘hard-to-reach’ groups is likely not only to cost more but also to yield less, if any, eventual income. This is problematic because, as these authors suggest, prioritising cost recovery and profit has a statistically significant negative effect on access for the lowest SES groups: known as the ‘inverse care law’ (Tudor Hart, 1971; 2010). This could therefore result in public sector facilities, which are likely to be the primary provider of recreation resources and opportunities for low-income communities (Dahmann et al, 2010), actually contributing to the existing disparities between higher- and lower-SES groups.

Even without these conflicting objectives, evidence suggests that public sector facilities stand to widen the health gap between higher- and lower-SES groups. Lorenc and Oliver (2014), for example, describe the range of adverse effects that can result from public health interventions but which are rarely addressed in the literature. They
describe ‘equity harms’ caused by ‘intervention-generated inequalities’ (Lorenc and Oliver, 2014: 289). Interventions may be successful across the population but exacerbate existing inequalities by benefitting privileged groups more than disadvantaged ones. They argue that this is a particular concern with individualistic or ‘responsibilising’ approaches to health promotion. This dilemma is referred to by Frohlich and Potvin (2008: 219) as the ‘inequality paradox’. As they explain:

*It appears from empirical observations that individuals from vulnerable populations are the least able to positively respond to population-approach interventions. This ‘inverse care law’ states that those with the most resources at hand to adapt to new situations will be the first to derive maximum benefits from population-approach interventions.*

In relation to PA facilities, the argument follows that interventions are unlikely to benefit those who are part of vulnerable populations as much as those who are not. For instance, Roberts and Brodie’s (1992) study of inner-city physical recreation in six UK cities indicated that the main effects of increasing or enhancing PA provision seemed to be widening the choice and improving the facilities for those already participating. This facilitates and reinforces disparities in PA levels due to higher-SES groups typically being over-represented in the use of, and having higher perceived access to, these facilities (see also, Kamphuis et al, 2007; Kruger et al, 2007; Taylor et al, 2011). Therefore, it appears that long-standing efforts within public health to ‘make the healthier choice the easier choice’ (Kickbusch, 1989: 266), especially with ‘blanket subsidies’ (Taylor et al, 2011) that approach all potential participants as if they were the same, disproportionately aids those who are already comparatively advantaged and thus have an adverse effect by exacerbating existing inequalities.

Lorenc and Oliver (2014) acknowledge that this ‘paradox’ can lead to complex ethical and methodological questions. No individual is actually worse off as a direct result of the interventions, so overall health improvements are made but the health status of vulnerable populations declines in relative terms. The intent of most interventions may be worthy of praise. However, providing facilities and even attempting to make them accessible to low-SES groups is likely to have limited success, if success is measured in terms of reducing the health gap between low- and high-SES groups by
increasing PA levels within vulnerable populations. For this reason, Sallis et al (1998: 389) argue that if interventions are to be successful, ‘facilities and/or programs must be available to the target population. The environments must also be accessible, both psychologically and logically, considering cost, transportation, and issues such as child care’.

For this reason, Everson-Hock et al (2013) contend that there is a need for interventions that specifically target low-SES groups. In their review of community-based dietary and PA interventions in the UK they found that interventions typically attracted those from affluent backgrounds and thus contributed to the inequality paradox. These authors go on to suggest that interventions that were considered to be effective tended to deal with surface-level concerns (psychological and pragmatic) but failed to address deeper-level social, psychological and pragmatic concerns. These findings are also supported by Cleland et al’s (2012) systematic international review of PA initiatives in socioeconomically disadvantaged communities. Generally the reviewed interventions had a small or no effect on PA levels, but the ones which were more effective were those that used more tangible components to remove barriers to participation, e.g., free gym memberships/exercise vouchers and child-care. Similarly, during a community-based lifestyle intervention for obese African-American women, Yancey et al (2006) found that offering free gym memberships for a participant and someone to accompany them facilitated recruitment of and long-term commitment from this ‘hard-to-reach’ population with high-rates of inactivity. These findings offer credence to Pampel et al’s (2010: 358) contention that socioeconomic disparities now result more from issues of access than education as it is ‘the ability to act on health knowledge rather than the knowledge itself [that] affects health behaviour’. With this in mind, attention will now shift to area-based health initiatives.

**Area-Based Initiatives**

As is evident from the research reviewed above, the social and built environment in which a person resides significantly influences their capacity to engage with health advice. Not only do areas of deprivation present significant obstacles to ‘healthy’
living, Warr et al (2007: 750) found that the ‘psycho-social implications of macro-structural issues’ mean that just living in ‘poor neighbourhoods’ is also liable to impair health. Popay et al (2003) found that in two cities in the North West of England this was in part due to the strategies that many people adopt to cope with the experience of living in these areas, e.g., smoking, heavy drinking, drug use. This led the authors to suggest that living in deprived areas presents people with a ‘lifestyle pathway’ to ill health (Popay et al, 2003: 68). For this reason, Frohlich et al (2001) appropriately argue that the entwined nature of compositional and contextual effects necessitates moving beyond individualist interpretations of lifestyles. The relationship between people’s social conditions and their social practices needs to be appreciated which, they suggest, can be achieved by using the concept of ‘collective lifestyles’ (Frohlich et al, 2001: 785). At least on the surface, it would appear that ABIs that attempt to address the health-impairing qualities of areas of deprivation recognise this relationship and the challenges that it presents.

In an attempt to address the exacerbation of health inequalities brought on by post-industrial modernity, the WHO outlined the notion of ‘Healthy Cities’ in the highly influential Ottawa Charter (WHO, 1986). There has been near universal acceptance of this concept which has been readily adopted by the public health establishment. Since then it has become a significant feature of the discourse of health promotion and the new public health (Petersen, 1996). Cities provide the setting for these initiatives but it is ‘community’ that is their focus. Describing the merits of a community-focused approach around the time, Ashton (1988) argued that the traditional model of public health was paternalistic and in danger of victim blaming. He proffered that community-centred health promotion was the tonic that public health needed as ‘it is probable that the most effective health promoting initiatives will come from within communities rather than from outside them’ (Ashton, 1988: 191). This approach has since significantly influenced health policy and promotion in the UK.

ABIs have been used throughout the post-war period in the UK and US to address urban decline, but they came to prominence in the 1970s (Lawless, 2004; Stewart, 2000). The WHO’s promotion of ‘Healthy Cities’ can therefore be seen as a catalyst rather than the genesis of these schemes. In England at the turn of the twenty-first
century a New Labour government led by Tony Blair championed the use of ABIs as a way of combining action across a number of policy fields, with the grand intention of lessening the scale of national inequality (Social Exclusion Unit, 1998; 2001). In terms of health policy this represented an explicit commitment to closing the health gap between affluent and non-affluent sections of society. Specifically, local authorities with areas in the bottom 20 per cent of a national index of deprivation, known as ‘Spearhead areas’, were required to demonstrate how they were attempting to increase the life expectancies of present and future residents (Blackman et al, 2012).

The area-based impetuous of policy meant that these localities were increasingly viewed as ill health ‘black spots’ that required intervention (Crawshaw et al, 2004: 343). Intervention meant working with local communities to address the environmental factors identified as exacerbating national inequalities. New Deal for Communities (NDCs), Health Action Zones (HAZs) and Sport Action Zones (SAZs) are three examples of ABIs implemented during this time which will now be singled out for closer attention.

The NDC programme was launched in 1998 (Department of Environment, Transport and the Regions, 1998) and targeted thirty-nine of the most deprived areas in England. In aiming to significantly regenerate and improve these neighbourhoods these initiatives were framed as evidence of the government’s commitment to reducing national inequalities (Ellis et al, 2007; Lawless, 2004). Although health and well-being was one of the thematic areas of the NDC programmes a holistic approach was taken to improving the circumstances of people living in these areas. For example, other objectives included improving opportunities in education and employment, reducing crime and increasing a sense of safety, and raising the standard of the built environment, with a particular focus on improving the quality of housing. All of this was to be achieved by working with the community to identify and address issues raised by local residents.

The HAZ initiatives were also launched in 1998. They were narrower in their focus and ran fewer projects, twenty-six (House of Commons Health Committee, 2009). Local health authorities with high rates of morbidity and mortality were invited to bid for fairly modest HAZ status funding (some £4-£5 million per year per zone). The primary
aim was to ‘improve health by developing locally specific projects and partnerships between the public, private and voluntary sectors and the local community’ (Conway et al, 2007: 210). As such, the emphasis was on increasing cooperation between existing services to improve efficiency and effectiveness, rather than providing significant backing through new funds. HAZs were specifically tasked with finding solutions to regional health inequalities but, as with the NDCs, this was to be achieved by adopting a community-centred approach. The initiative was abandoned in 2003 with the evaluator, Professor Ken Judge, stating schemes were rushed, poorly resourced and provided insufficient support and direction to make a significant contribution to reducing health inequalities. In a memorandum given to the House of Commons Health Committee (2009: 93), Judge concluded, tellingly, that the initiatives ‘were born at a time when anything seemed possible for a New Labour Government desperate to make things work and quickly. But the tide of enthusiasm for change outran the capacity to deliver it’.

The SAZ was a programme smaller in scale and with an even narrower set of ambitions. It was in response to the Social Exclusion Unit’s Policy Action Team 10’s recommendations (PAT 10, 1999). The initiatives were implemented in 2001 by Sport England, part of the Government’s Department for Culture, Media and Sport campaign responsible for promoting sport and PA nationally. These initiatives have now ended. The final report was delivered in 2006 (Sport England, 2006). The sites selected for the project were intentionally varied in scale and characteristics as they were seen as ‘learning zones’ to inform future practice (Sport England, 2001: 4). However, all of the 12 sites chosen were home to some of the most deprived sections of English society. The aim was to create more equitable participation in sport and PA and this was to be achieved by helping ‘local communities to help themselves by getting local people to play a role in identifying what was needed in each zone and then involving them in the planning and delivery process’ (Sport England, 2006: 4). A third of the SAZs were located in NDC areas. This is no coincidence, as attracting funds from non-sporting sources, e.g., NDCs, was a significant aim of the project with almost half of the £3,482,638 spent in SAZs sourced from other projects (Sport England, 2006).
The Community

All of these ABIs varied in their scale and scope but they were united by their focus on the ‘community’ and an emphasis on the notion of ‘empowerment’. These are defining characteristics of ABIs from this time and of contemporary UK governments more broadly. Nikolas Rose (1996; 1999a; 1999b; 2001) describes this form of governance as fitting in with a more general shift away from the ideal of ‘the social’ focus of welfare systems of old, to ‘the community’ in what he terms ‘advanced’ liberal forms of government. Rose (1999b: 142) contends that the ideal of the ‘social state’ gives way to that of the ‘enabling state’ as the discussion on neoliberalism in the preceding chapter illustrated. Elsewhere, Rose (1996: 332) develops the concept of ‘government through community’ reasoning that ‘community is not simply the territory of government, but a means of government’ (Rose, 1996: 335, emphasis in original). As such, for Rose (1999b: 136), the community constitutes a ‘new spatialization of government’. This is perhaps never more apparent than when considering the prevalence and rhetoric of ABIs, particularly those whose primary aim is to address health inequalities.

In what seems a paradox, bringing the community to the fore increases the focus on the individual and facilitates what Rose (1999a: 11) terms the ‘government of the soul’. Noting the contradiction of an individualising community focus, Crawshaw et al (2004: 345) explain that responsibility for risk management becomes individualised, but at the community level. Responsibility for risk is ‘decollectivised’ as the focus shifts from whole populations at the level of the State down towards smaller groups in communities and then ultimately to individuals. As a result, these authors argue that ABIs, e.g., HAZs, are designed to ‘empower’ members of ‘risky communities’ to take on the responsibility of managing their risky behaviours under the guidance of established organisations, e.g., public health institutions and third sector bodies (Crawshaw, 2004: 348). To return to Rose (1996: 348), empowerment thus becomes ‘a matter of experts teaching, coaxing, requiring their clients to conduct themselves within particular cultural communities of ethics and lifestyle, according to certain specified arts of active personal responsibility’. Rose (1999a: 262) reasons that this framing of empowerment is accepted and effective because, ‘modern selves have become
attached to the project of freedom, have come to live it in terms of identity, and to search for the means to enhance that autonomy through the application of expertise’. Conformity to the interventions of ABIs thus becomes recognisable as ‘empowering’ because such interventions are seen to facilitate personal development, in order to support a liberating self-project.

The rise of the individual and the increased significance of identity and personal autonomy within contemporary consumer culture make it possible for people to now be ‘governed through their freedom to choose’ (Miller and Rose, 2008: 82). Those with more restricted choices need to be incorporated into the contemporary ‘wars of subjectivity’ (Rose, 1999b: 46). By implementing ABIs, UK governments clearly recognise that even though modernity has led to the expansion of the middle-classes and an increase in living standards there are still many places where the freedoms associated with affluence are not experienced. In order to involve these marginalized ‘communities’ into the ‘regime of choice’ a new range of ‘para-governmental agencies’ supported by grants and volunteers are used in ABIs to ‘empower’ residents by facilitating ‘choice’ (Rose, 1999b: 89). These ‘communities’ become ‘micro-moral domains’, sites where national obligations merge with notions of self-improvement (Miller and Rose, 2008: 214). Therefore, theoretically the local residents of deprived communities become governable ‘at a distance’ as ‘the ways they understand and enact their own freedom’ are shaped in ways that serve to reduce the burden of their risk on the National Health Service (Rose, 2001: 6). In this way, government health recommendations can be framed through community-centred interventions as empowering advice promoting self-improvement and personal freedom, rather than paternalistic bio-political techniques.

For Crawshaw et al (2004: 355) the community can thus be conceptualised as a ‘key tool of neo-liberal modes of governance as it serves the purpose of delegating responsibility without real distribution of power’. It is the pervasiveness of this technique and the widespread acceptance of ‘active citizenship’ which leads Miller and Rose (2008: 215) to argue that this tool is not just the political ideology of neoliberal conservatism, but represents a reinvention of government into a phase they term ‘advanced liberalism’. Although ABIs do not openly blame victims, it is evident that
their success relies upon residents in deprived areas overcoming structural impediments and inferior social statuses and taking responsibility to do what they can to resolve their riskiness. This is why Rose (1999b) argues that ‘communities’ are invented in population surveys. Where there is a clustering of risk - e.g., areas of deprivation, smokers, gay men - ‘imagined communities’ (Anderson, 1983) and accompanying interventions are created in an attempt to achieve governmental control by convincing members of these communities of heightened risk to comply with expertise. Conformity is only possible in areas of deprivation if provisions are made for, and residents perceive that, what might otherwise be considered attributes of a middle-class lifestyle (i.e., acting in ways that generally shows a concern for personal physical and mental health (Bourdieu, 1984)) are being made more accessible and meaningful to them. Therefore, using Rose’s (1999a: 230) conceptualisation, the aim of ABIs can be understood as to create environments that facilitate a heightened sense of autonomy and responsibility, so that residents believe that they can pursue freedom by becoming ‘entrepreneurs of themselves’.

Shortening the health gap between people of higher- and lower-SES is a laudable governmental ambition, of course, but it would be naïve to assume that interventions with this aim are merely motivated by egalitarianism. Mechanic (1997: 93) argues that in general ‘as the costs of medical care mount, placing new obligations on the public purse, risk-taking populations are seen as doubly burdensome’. Community-centred interventions, such as ABIs, that aim to reduce inequality by empowering risky populations are, at least in part, governmental attempts to reduce the financial burden of ill-health. Rose (2001: 18) terms this financially orientated form of governance ‘ethnopolitics’ and explains that ‘if discipline individualizes and normalizes, and biopower collectivizes and socializes, ethnopolitics concerns itself with the self-techniques by which human beings should judge themselves and act upon themselves to make themselves better’. Ethnopolitics, then, is about outlining a way of being and behaving that is culturally creditable and valued in an attempt to align individual pursuits for the ‘good life’ with the outcomes that government wants to achieve (e.g., minimising the health risks of the population).
For Rose (2001: 18), ‘in ethnopolitics, life itself, as it is lived in its everyday manifestations, is the object of adjudication.’ In other words, the life one leads becomes a life of choices and so ‘leisure has been invented as the domain of free choice *par excellence*’ (Rose, 1999a: 231). In these terms, this heightened notion of choice means that people are now, in a sense, obligated to be free and to act upon the advice of experts who present them with ‘therapies of freedom’ (Rose, 1999a: 261). Increasingly, the ‘choices’ somebody makes in their leisure time are open to moral scrutiny. This is how the ‘soul’ is governed as a normative judgement creates a sense of unease in those who deviate from the norm and correcting this aberration becomes a matter of using the advice of experts to manage the self (Rose, 1999a). Promoting health as the outcome of choosing to live a ‘healthy’ lifestyle, at best, undermines the influence of social and environmental factors on health and, at worst, is a calculated move to ignore them.

By focusing on the community and not the wider structural causes of inequality, ABIs can be seen as an ethnopolitics of the environment. This is evident in Sport England’s (2006: 4) stated aim for the SAZs: ‘to help local communities to help themselves’. Therefore, community interventions such as SAZs facilitate a crude dichotomising of the people living in particular areas into those who choose to ‘help themselves’ by engaging with the therapies of freedom that are offered and those who are considered to be their own worst enemy because they fail to. They individualise health and transform disadvantage and social norms that are in part coping strategies for living in a deprived area into the outcome of bad decisions that stunt the development of the self and inhibit personal freedom. It is not inevitable that socio-ecological initiatives take this form, but rather an indication of the ideologies behind their implementation.

**The Politics of Creating ‘Bio-spheres of Risk-Aversion’**

The ABIs implemented under New Labour in the last decade of the twentieth century and first decade of the twenty-first century, (e.g., NDCs, HAZs and SAZs), are prime examples of community-centred ABIs. Profiting from and proliferating the contemporary wars of subjectivity, the weak notion of empowerment that these
interventions pivoted on disguised their potential to, if not blame, certainly expect residents of deprived areas to resolve the issues they face as a result of structural inequality. They can thus be seen as exemplars of a new public health policy and the ways in which ‘community’ is now used to individualise risk and responsibility. Theoretically, ABIs could significantly reduce inequality as they have the potential to recognise and address the structural and environmental factors that constrain the agency of people living in deprived areas. However, the dominance of neoliberal politics facilitates the paradox of an individualising community initiative.

It is, then, perhaps unsurprising that the discourse of New Labour ABIs shares much with the rhetoric of the present David Cameron led Conservative Party’s ‘Big Society’ agenda (Cabinet Office, 2010; Woodhouse, 2013). ‘Stepping up’ and having an appetite for using leisure time to ‘give something back’ to the community are central themes of the Big Society idea and they similarly individualise what are social issues (Such, 2013). This suggests that the potential for ABIs to meaningfully address geographical disparities experienced in the built and social environment is not reliant on the changing of political parties but would require challenges to the dominance of neoliberal politics.

This is not to contest that the neoliberal political context is unaffected by the differing policy approaches of successive governments. Various continuities and discontinuities in the policy environment rest precariously on the political ambitions of elected ruling parties. For example, while New Labour’s strategy of implementing ABIs to reduce national inequality may have ultimately been flawed it did explicitly demonstrate an ambition to redress geographical disparities and vast inequalities in wealth distribution. David Cameron’s Conservative Party have conveniently opted out of taking a similar approach by using an economic rationale predicated on the ‘age of austerity’ to justify and explain huge welfare cuts and other significant fiscal decisions.

In their review of Canadian healthy living initiatives, Gore and Kothari (2012) identified that within the socio-ecological model there were three types of initiatives, the predominant themes are as follows:
• **Lifestyle initiatives** involve raising awareness, education and promoting the uptake of particular behaviours.

• **Environment initiatives** focus more on altering the immediate social and built environments where people spend their time, e.g., schools, workplaces, community spaces.

• **Structure-based initiatives** focus on the various structural roots from which inequalities that lead to chronic diseases grow (e.g., social, political, economic).

Gore and Kothari (2012: 7) found that there was a predominance of lifestyle- and environment-based initiatives, a situation they described as ‘troubling’ because ‘initiatives were expected (and directed) to focus on the social determinants of health’. This tendency within health policy is otherwise known as ‘lifestyle drift’ (Popay et al, 2010: 148). Gore and Kothari (2012: 9) argue that these initiatives place an ‘enormous’ amount of pressure on communities and allow the ‘public health system to abdicate its responsibility to address the social determinants of health directly and in a concrete manner’. Therefore, even when the explicit aim of ABIs is to address structural issues, it is common for the dominance of neoliberalism, or advanced liberalism, to strangle their potential. The consequence is that those most in need are further squeezed, rather than structural solutions being found for their problems. This political influence also frames interventions in meaningful ways that shape how they are perceived and whether, or how, they are engaged with.

Fusco (2007: 49) labels the spatial and material manifestation of contemporary concerns about health and the issues around health, e.g., area-based health initiatives, as the ‘spatialization of healthification’. Her description of how these ‘healthified spaces are lauded as emancipatory and transcendent spaces that are ready for projects of self-responsibility and personal empowerment’ (Fusco, 2007: 58), demonstrates the prominent relationship which exists between ethnopolitics and health and how this is realised through the new public health approach. Brown and Duncan (2002: 366) explain that ‘ideas about space, place and the environment are central to how the “new” public health discourse “works”’. This is evident in the predominance of interventions within ABIs that focus on lifestyle and behaviour.
change rather than wider causes of ill-health. Making a conscious effort to improve one’s health is therefore understood as a fundamental and emancipatory element of self-improvement. As such, someone’s perceived access to healthified spaces and the therapies of freedom that they are perceived to offer is likely to inform their quality of life and sense of well-being.

Fusco’s (2006; 2007) concept helps to illustrate one of the main ways in which healthism becomes effective. Being able to exercise at a gym, order a salad at a café, or cycle to work via a cycle path can all be seen as ways in which particular spaces offer opportunities for people to indicate to themselves and others that they are taking responsibility for their health and achieving a particular quality of life. In both cognitive and corporeal terms, people shape and are shaped by ‘everyday health and fitness space and its discursive and material practices’ (Fusco, 2006: 68). As previously discussed, this is yet another example of the complex ways in which agency and structure are entwined.

This is also where an important early contribution from health geography can add much to this debate. Gesler (1992) developed the concept of ‘therapeutic landscapes’ to capture the subjectivity of place and how it relates to recovering from illness or injury. For Gesler (1992: 473), ‘therapeutic landscape becomes a geographic metaphor for aiding in the understanding of how the healing process works itself out in places’. An everyday example would be when people feel a bit ill and explain, or get told, that all they need is a bit of fresh air. This logic views outside spaces as more therapeutically potent than inside spaces. The term describes the feelings of comfort or discomfort people experience in different surroundings and how this can impact their recovery from illness or injury. As people are increasingly obliged to show they are taking responsibility for their health, places where they can go to comply with the advice of experts can thus be understood as therapeutic landscapes in two main ways:

- Firstly, if someone is considered to be unhealthy, e.g. having a BMI of 25 or above, then the local gym or swimming pool may be perceived as therapeutic landscapes in so much as they are places where a process of ‘healing’ can occur, i.e., achieving good health (e.g. losing weight).
Secondly, those who are considered healthy are likely to attribute their good health, at least in part, to their own actions whilst attending these places. In this sense, these places may be more accurately described as ‘pre-therapeutic landscapes’ as they are not thought of as places of ‘healing’ but rather as places of health maintenance and enhancement, or perhaps more accurately for this metaphor, risk-aversion and ill-health avoidance.

Thus, I argue that healthified spaces that offer people (pre-)therapeutic sites to ‘do’ health should be conceptualised as ‘bio-spheres of risk-aversion’. Conventionally, biospheres are defined as environments that support life. In contemporary societies, achieving a sense of well-being and perceiving oneself to have a reasonable quality of life can, to some extent, be considered to be reliant upon having access to, and attending, places where risks can be managed through performance of the ‘health role’. Citizens in particular societies will then perceive the need to be supported in their capacity to work on their body (e.g., access to healthy food and PA opportunities) in order to manage their risk and exercise their freedom. Therefore, I propose that bio-spheres of risk-aversion are the outcome of the spatialization of healthification, and, as such, are biopolitical tools. But they also offer people the opportunity to behave in ways that they perceive to minimise their personal risk. It is clear that such places are not equally accessible to people at opposing ends of the socioeconomic spectrum. However, for those who can and do access them they have the potential to be emancipatory in the sense that they facilitate compliance with the behavioural and bodily norms that indicate to themselves and others that they are sensible citizens taking responsibility for their health and exercising agency. They are emancipatory because they facilitate the choice to comply and are an archetypal illustration of the complex ways in which agency and structure are entwined.

Bio-spheres of risk-aversion are thus integral to the ethnopolitical projects of governments as described by Rose (2001: 18). However, the private sector is not only in the best position to meet the demand of those who are motivated and capable to ‘do’ health but arguably its success requires creating and making profit from this demand (Smith Maguire, 2008). In a more subjective sense, the relative appeal and usefulness of particular ways of doing health suggests that if someone wants to be
healthy in culturally appropriate and valued ways, the likelihood is they will have to pay for it (Coalter, 2000; Harrington and Fullagar, 2013). Due to this, Fusco (2007: 52) makes the patently clear but necessary point that this means healthy choices ‘are not freely available to all’. It is also likely that what is available to people who rely on public services is unlikely to be experienced subjectively in the same way as those who can afford to use private facilities. As such, for those who perceive themselves to be unable to do health in culturally valued ways it is likely that they will feel disadvantaged and inhibited in their capacity to carve out a culturally-valued, risk-averting identity, which may also lead them to experience anxiety about their state of health. This is why the behavioural justice movement argues that access to these ways of living is a matter of social justice (Baum and Fisher, 2014; Adler and Stewart, 2009). Health promotion and interventions within ABIs in deprived communities can therefore be viewed as attempts to create bio-spheres of risk-aversion for the ‘poor’.

**Summary**

Initial perceptions of ABIs may be that their aim is to interact with residents living in deprived areas to find out how their lives are inhibited by their SES and surroundings and then attempt to address these issues. But it should be apparent from the literature reviewed here that taking a community-centred approach can compromise the achievement of these aims by individualising issues rather than significantly addressing the structural and environmental antecedents of inequality. Who then stands to benefit most from ABIs, in particular, the interventions aiming to improve health? Existing research tends to indicate that the ‘most in need’ or ‘hard-to-reach’ more usually derive fewer benefits from health interventions than those in higher-SES groups – leading many interventions to have paradoxical effects with regards to reducing health inequalities.

The literature reviewed in chapters two and three makes it clear that although reducing societal inequalities was New Labour’s political justification for implementing ABIs, the ways in which New Labour attempted to achieve this, through community-centred interventions, was never likely to significantly redress these disparities.
However, there are still many unanswered questions about how ABIs in deprived neighbourhoods have affected, and been perceived by, local residents. There are more questions still about the lasting impacts of these initiatives once the period of intervention has ended.

What becomes of healthified spaces in deprived areas once the initiatives from which they sprung are wound up? Are these initiatives embraced by local ‘communities’ to the extent that they have a prolonged effect? How have issues around engagement and access for local residents been addressed, both during the initiatives and after they end? And how realistic is it that interventions have a sustained impact when funding is no longer available? How central have the local ‘communities’ concerned been to the sustainability of these projects and how has this shaped the legacies that they have had? Lastly, but perhaps most saliently, how have these initiatives affected the lives of those they were originally implemented to serve and has this, in any way, lessened the health-impairing effects associated with deprived areas? This thesis uses the case study of Kingsland in an attempt to provide answers to these questions.
I don’t know this city, but I want to run. My injury prone limbs have an aversion to concrete so I unfold a map of my surroundings onto the table in front of me and search for green spaces. I find two large pale green patches dissected by a road and decide to head into the unknown, to Kingsland Park. Running away from the city centre I eventually swap the grey of the pavement for an expanse of nature as I enter the park and follow its perimeter. I immediately pass a small skate-park where young people lethargically occupy themselves. Facing them, outdoor gym equipment lays idle. At the bottom corner I find a duck pound where a buggy-pushing mother and her children have brought bread and are met with hungry gratitude. As I round the corner, beyond the road, I see row upon row of red brick houses and sense that this park is surrounded by social housing. There are four football pitches ahead of me where onlookers are separated from players by barriers of concrete and metal. I run towards the familiar sounds of men committed to contest. A bus stop on the adjacent road stands with its shelter shattered on the pavement in front of it. Overlooking these football pitches is a youth centre but its all-weather courts are empty this morning. There’s no room for any more graffiti on the walls surrounding the play area behind it though. I near the road that dissect the two parks and head through some trees. As I bounce up the mound marking the park’s edge I meet a sight that, given the surroundings, seems implausible. A mass of wood and glass, and clean white walls, make a befitting exterior for a leisure centre with stylish modern architecture. But it provides a sharp contrast to the deprivation I sense I’ve run through. Silver lettering shines from the new build: ‘Kingsland Leisure Centre’ and from that moment I’m intrigued by how it came to be here.

(A vignette based on initial experiences and fieldnotes: November 2010)

Introduction

This vignette describes an early turning point in this research project. My research proposal had initially outlined an investigation of whether, and in what ways, people’s lives were informed and influenced by the discourse of new public health. However, it did not specify a site of study. On this particular morning a set of processes started
that saw Kingsland become that site. With an appreciation of the ‘inverse care law’ (Tudor Hart, 1971; 2010), and having run past enough to get a sense of the social deprivation nearby, the new Leisure Centre was a surprising addition to the landscape. Its presence, as well as the number of other sports and PA facilities I saw nearby, seemed at odds with the usual patterning of services and amenities which is prone to leave socially deprived areas underserved. How and why had this otherwise neglected area come to be so well served with PA opportunities?

Tunstall et al (2004: 6) explain that the difference between space and place is that the former simply describes where a location is, whereas the latter describes what a location is. For these authors, ‘place is to space as history is to time and home is to house’. On the morning I searched that map for patches of green, Kingsland was merely space to me. As it was revealed on that run, the gap in knowledge and understanding, between space and place, was all too apparent. There were so many unanswered questions. This chapter fills that space to provide a better understanding of Kingsland as a place and offer a better appreciation of the field where this research was conducted. In order to achieve this aim, some field-data is presented here. Pseudonyms are adopted throughout. A full explanation of the practical and ethical implications of data-collection is forthcoming – in chapter five – but the data presented in this chapter helps to ground this research in a specific location and, in turn, helps to later explain why certain methodological decisions were made.

In 2000 Kingsland was awarded a £49.5 million New Deal for Communities (NDC) grant. A year later in 2001 it was designated as a Sport Action Zone (SAZ). Kingsland was awarded both of these government funded schemes whilst already being a prioritised neighbourhood in a Health Action Zone (HAZ); a citywide initiative that had been inaugurated in 1999. All three of these ABIs were established and implemented by Tony Blair’s New Labour government as part of its overarching aim of reducing health inequalities after the Acheson Report (Department of Health, 1998; Social Exclusion Unit, 1998; 2001). Therefore, it seems obvious to acknowledge that at this time Kingsland was an area severely affected by social deprivation. Such entrenched levels of deprivation were the outcome of long processes of accumulation and neglect.
This chapter is formed of two main sections to convey what Kingsland was like both before, and what it is now like after, these ABIs were implemented. The first section is predominantly based on information derived from local policy documents produced in the periods leading up to and during the initiatives’ implementation. This section is not being offered as an exhaustive account but rather as a snapshot comprised from materials I gained access to in the field approximately a decade after they were written. The facts and figures presented cannot always be sourced beyond these documents, but they reflect an image of Kingsland that was presented in the public domain. The second section combines my own observations from the field with data from Kingsland’s 2013 NHS ward level health profile. After reading the pre- and post-initiatives histories of Kingsland the reader will be better equipped to ‘place’ the findings in later chapters within the locations and lives that comprise Kingsland and its residents.

What Went Before: The Pre-Initiatives Era

The land that houses Kingsland was purchased by the City Council in the 1920s and developed in the 1930s. Two housing estates were built in Kingsland; the first, in South Kingsland, was constructed for artisans and skilled workers; the second, in North Kingsland, was cheaper housing for families evacuated as part of the Inner City Slum Clearance Programme. It is the large, northern estate and its approximately 13,000 residents which is the focus of this research. It is positioned approximately two miles from the city centre. Slum Clearance programmes prioritised moving people from cramped inner-city slums to live in more spacious and green surroundings (Yelling, 1986). As with many British housing estates of this period, the fact that new houses on the North Kingsland estate had large gardens and were built next to a large park was a consequence of design. Social exclusion is a contested term but it generally refers to deprivation that has occurred as a consequence of multiple dimensions of personal and communal resources, or lack thereof, thus inhibiting participation in society

1 In order to protect anonymity, I am unable to fully cite local documents in text and have altered their titles in the bibliography.
(Andersen, 2013; Levitas, 1998; Shaw et al, 2006). Being an outer city estate with poor public transport links meant that, despite its spacious green surroundings, the contextual and compositional characteristics of Kingsland would inevitably lead to it becoming physically isolated and its impoverished residents socially excluded.

In the Index of Multiple Deprivation (IMD, 2000) Kingsland ranked within the top 1% of the most deprived wards throughout the English counties. In an effort to reduce national inequalities, this index was used by government to identify wards most in need of funding and assistance. The NDC, SAZ and HAZ statuses of Kingsland is testament to that policy. It is also worth noting that Kingsland is a socially excluded neighbourhood within an already relatively deprived area. In 2013, out of the 324 Local Authority areas, Kingsland was rated among the 25th most deprived. The IMD considers deprivation levels on a number of criteria, e.g., income, education and health. Some of these will now be outlined with reference to Kingsland to give an indication of the socioeconomic conditions of the area at the turn of the 21st Century.

The initiatives in Kingsland targeted the residents living on the northern estate and in some of the surrounding area. Lawless (2004) maintained that the NDC initiatives placed more emphasis on black and minority ethnic (BME) communities than any other ABI previously implemented. This was due to BME communities making up almost a quarter (24%) of the residents in the combined population of the NDC areas and more than 50% in eight individual NDC areas. The high percentage of BME communities living in NDC areas is to be expected given what is known about racism and the ‘parallel lives’ (Platt, 2002) that the majority of minority groups in Britain live, compared to the population as a whole, mainly as a consequence of greater rates of poverty, deprivation and segregation (Phillips and Harrison, 2009). However, the longstanding nature of deprivation in Kingsland is further revealed by the relatively small (4%) BME population indicated in the national evaluation of 2002-2003. North Kingsland is ‘seen as a “white” estate within a very ethnically diverse city’ (CRESR, 2005: 3). Indeed, in the same year the city in which Kingsland is located had a relatively large (36%) BME population. Unlike many of the other NDC areas, Kingsland had (and has) high levels of deprivation but only a small BME community. Therefore, the deprivation experienced by residents cannot simply be attributed to an influx in
migrants and the associated cumulative disadvantages that BME populations are known to experience.

In 1999 the delivery plan for the Kingsland NDC stated that the average annual household income on the northern estate was significantly less than half the national average at £8,480 compared to £19,977 (ONS, 2013). The figures for the adult population in Kingsland show that 24% were receiving income support in 2001. In relative terms, this was twice as many as the citywide average (12%) and three times the national average (8%). The percentage of people living in socially rented properties in North Kingsland (approximately 63%) surpassed the average for all the NDC areas (55%) which were specifically targeted for their levels of deprivation (CRESR, 2005; ODPM, 2005). A large number of houses on the northern estate also stood empty and were boarded up. The Local Authorities used this decline in the physical environment, partly, to explain the routinely high incidence of local crime.

During this period (1999-2000), local documentary evidence also indicates low educational attainment. Only 15.4% of Kingsland students gained five GCSE A*-C grades at a time when the city and national averages were 35.5% and 43.2% respectively. Additionally, approximately 40% of Kingsland students left school with no GCSE qualifications at all. This performance ranked Kingsland in the bottom 10 wards in the country for educational achievement. Combining this educational profile with high rates of teenage conceptions and child poverty suggests the cyclical nature of deprivation and how these factors are liable to generational perpetuation.

Local documents state that the baseline mortality data during this same period showed that the average age of Kingsland residents at death was below city and national averages. One document refers to significant physical and mental ill-health problems on the northern estate and ‘significantly high rates of years lost’ due to coronary heart disease, stroke and cancer (particularly lung) (NHS, 2001: 2). Consequently, the lack of adequate food shopping facilities and accessible PA facilities were highlighted as being significant contributors to community health problems.

It is clear, then, that local policy documents present a picture of Kingsland as an area with multiple levels of deprivation, with the northern estate most significantly
affected. It was one of the very most deprived areas nationally. Therefore, the NDC, SAZ and HAZ initiatives had the potential at least to offer some much needed social support to the residents living in this impoverished and excluded area in central England.

The SAZ and Kingsland Leisure Centre

The Kingsland Community Association (KCA) was formed in order to deliver the NDC programme and had a democratically elected board mainly comprised of local residents. The KCA was a somewhat ‘controversial’ organisation and numerous allegations about corruption and ineptitude played out in the local press. As well as delivering the NDC, the association hosted the SAZ which meant that the NDC and SAZ initiatives became very closely aligned. As such, facilitating ‘healthy’ living came to play a prominent role within the NDC regeneration more generally. Of all the programmes, Health and Wellbeing activities received the largest share of the NDC budget (22.22%). This expenditure set Kingsland apart from other NDC areas as this was the highest proportion of expenditure on Health and Wellbeing of all thirty-nine NDC initiatives.

A requirement of the SAZ initiative was for the implementation team to conduct a needs assessment and action plan (NAAP) led by community consultation. This supported the notion that the initiative was community driven. It was firmly established in the consultation work that many Kingsland residents did engage in PA and others wanted to but stated that there were significant barriers inhibiting their participation. Such barriers were predictable given the levels of local deprivation. One of the main barriers highlighted related to the physical environment and the paucity of adequate local sport and PA facilities. It was established that improving existing facilities and building new ones was a priority for the initiative. How this was achieved will be considered in greater detail in the chapters which follow.

In line with their community-driven character the NAAP (KSAZ, 2002: 39) stated that, ‘it is important to consider the development of facilities as a response to the sports
which residents said that they played at the moment or would like to play in the future'. The top five sports identified were swimming, football, street sports, aerobics/keep fit, and walking. Swimming was identified as the ‘most important’ as it was the activity most residents wanted and the most popular amongst those who did not currently participate in sport/PA. Accordingly, it is unsurprising that the consultation team found that many local residents expressed an interest in the proposal early in the 21st century to replace the city’s outmoded main swimming baths and leisure facility, the Victoria Baths, with a new pool and leisure centre outside the city centre – in North Kingsland. This proposal did not emanate from the NDC-SAZ initiatives but was rather a City Council project that subsequently became incorporated into the local regeneration plan. The Leisure Centre was to be the city’s largest and its flagship leisure facility. This meant that not only would residents on the northern estate have a high-quality, multi-purpose facility in their local area, but this new centre was also likely to attract people from other parts of the city to this otherwise isolated and excluded area. Significantly, there was also a commitment to the City’s swimming clubs who were promised time and space in the pool wherever the venue was built. The aim here seemed to be to boost leisure provision in Kingsland, but also to stimulate connections between people on the northern estate and residents from other parts of the city. However, there was much local scepticism and discontent about the proposed project.

The proposed site for the Leisure Centre was on the opposite side of the park to the northern estate. It was positioned next to one of the main arterial roads leading in and out of the city on the border of where Kingsland meets a more affluent neighbourhood. At the time the site housed the only secondary school in the Kingsland area, one which was to be closed, demolished and replaced with a new community college built on a site further away from the estate. Many local people felt that this was an inappropriate and unnecessary proposition and they campaigned, unsuccessfully, to keep the school open. Kingsland Leisure Centre opened to the public late in 2004.

The positioning of the site and the occurrence of the school closure, coupled with many years of neglect of the area, meant that there was a lack of trust in Kingsland
about Local Authorities and their policies. A view soon developed that this Leisure Centre was a political manoeuvre which was not being built for North Kingsland residents but rather for more affluent ‘outsiders’. The Leisure Centre cost approximately £10 million to build and accounted for over three-quarters (81%) of the total money associated with sport and PA projects during the SAZ term. The SAZ evaluation reported that in addition to the Sport England funds that supported the core SAZ team, over £12 million was spent on local sport and PA projects during the SAZ tenure. These funds included the entire cost of the Leisure Centre and reportedly came from 13 different sources (the NDC being one) reflecting the SAZ strategy of attracting funds to local projects rather than granting them. Approximately £1 million of NDC money was used to fund this project. The Leisure Centre was one of the most visible signs of the capital regeneration that came out of the NDC and SAZ initiatives.

This is how and why the Leisure Centre and numerous other sport and PA facilities (e.g., outside gym equipment, skate-park, multi-purpose playing courts, football pitches) came to be sited in the Kingsland area in the early years of the new century. The NDC project was implemented between 2000-2010 while the SAZ was hosted by, and contributed to, this initiative between 2002-2007. The sixteen months of ethnographic fieldwork for this research took place in and around the Leisure Centre between March 2012 and June 2013. Therefore, it commenced almost exactly two years after the NDC initiative had finished. It had also been five years since the SAZ initiative came to an end and the delivery team had become, *Keep-Fit*, a registered charity promoting sport and PA. At the time of writing, it is now over a decade since the Leisure Centre had opened. So, how did the field I entered compare to the place that had previously been sufficiently deprived to become the focus of three ABIs?

“Just so you know, this isn’t a very good area”: The Post-Initiatives Field

After having established myself in the field, I was approached one day by Si who was employed at the Leisure Centre as a pool attendant. He asked me how much longer I would be around. When I told him that it was a four year project his reply was telling:
Both of the incidents mentioned here did occur during my time in the field but it was Si’s general dismissal of the area which was more revelatory. It demonstrates a wider perception evident both within and outside the area that, even after the implementation of the ABIs, Kingsland was a ‘dreadful enclosure’ (Damer, 1974; Walter, 1977), a place with a forbidding local reputation. The northern estate has been known locally and historically as ‘Dodge City’: both a ‘dangerous’ place, like the wild west, and also an area notable for its people being adept at ‘dodging’ the rent, the police, debt collectors and so on. The reputations of people from Kingsland were thus also tainted or, as one resident put it, people associated with the area ‘get called’. Other studies have shown how people inherit the stigma associated with the area in which they live and attempt to manage it by differentiating between different geographical areas i.e., making claims about that place being worse than this place (Bush et al, 2001; Popay et al, 2003). This was ingrained in local life in Kingsland. For example, people living in the more affluent adjacent area were quick to distance themselves from Kingsland’s northern estate. As one Leisure Centre user told me ‘I’m a Kingslander, but I live in posh Kingsland; Kingsland Town.’ (Fieldnotes: 9/11/2012)

Even on the north estate, local people often made subtle, but culturally important, geographical distinctions. For instance, one area was known as Paradise because its close proximity to the local police station was deemed to offer some protection from one becoming a victim of crime. The most stigmatised area was the very northern part of the estate, ‘Dodge’. Perhaps predictably, this was where deprivation was most densely concentrated. It was the most dilapidated area of the estate and, unsurprisingly, it attracted the most significant investment from the ABIs. This part of the estate is a short walk from, but on the other side of the park to, the new Leisure Centre.
In their evaluation of the impact of the NDC initiative on national health inequalities, Stafford et al (2014) assessed whether it was successful in narrowing the health gap between the poorest and more advantaged areas. Using data from the Health Survey for England, the authors compared high deprivation areas to NDC areas over a period of six years (2002-2008) during which national socioeconomic inequalities had widened. The findings indicated that whilst the NDC initiative may not have significantly narrowed the health gap between residents of high and low deprivation areas, it had helped to prevent this gap from widening further. The authors suggest that these findings provide cause for some cautious optimism because they demonstrate the potential for well-resourced and constructed ABIs to prevent the health gap between socioeconomic groups growing. This is in contrast to the arguments proffered in The Marmot Review (2010) which criticised the geographic approach for failing to reach those most in need and advised for alternative strategies to be adopted. It must be noted that whilst Stafford et al’s (2014) findings can be seen to represent success and demonstrate the policy’s effectiveness, it also means that levels of deprivation in these areas remained high. In other words, success is measured by how effective initiatives were in stemming the relative decline which could have otherwise been considered inevitable during this period of time. Therefore, this prompts the question of, how vulnerable were the stigmatised residents on the North Kingsland estate when I arrived and after the ABIs had been implemented?

Direct ‘before’ and ‘after’ comparisons are problematic in Kingsland for numerous reasons. Firstly, the IMD measurements for 2004, 2007 and (the most recent) 2010 differed from those used in 2000. Secondly, the ward boundaries have changed during the intervening period, with Kingsland being joined with a more affluent neighbouring area. Despite these qualifications, making comparisons is still a worthwhile exercise.

Independently commissioned evaluations of the Kingsland NDC and SAZ initiatives indicate that, when compared with the same initiatives delivered in different areas, the Kingsland initiatives were relatively successful. The NDC evaluation for Kingsland noted that greater success was achieved with ‘place-based’ outcomes than ‘people-based’ outcomes but this was a general finding throughout NDC areas. For example, the physical environment was significantly improved in Kingsland. Besides the
aforementioned sport and PA facilities, a health and social care centre and various other facilities were built. The area was still without a local dentist practice though, one of the most common features of the inverse care law (Dorling, 2013: 12). I was present at a steering-group comprised of senior members of all the local schools where all present spoke about the need for school-based dental hygiene interventions as it was commonplace for children at the local schools to have rotting teeth. Another place-based outcome was that a significant portion of the least habitable social housing, all located in ‘Dodge’, was renovated leading to almost 98% of all social housing in Kingsland coming up to the Decent Homes standard (Department for Communities and Local Government, 2006). This is particularly significant because, as the local Councillor was keen to point out, ‘People need to remember that the biggest landlord in the area is the City Council’ (Fieldnotes: 25/4/2013). Renovating these houses may have also been one of the factors that accounted for a notable local reduction in recorded incidents of burglary and theft.

It was more difficult however to illustrate that the initiatives had led to significant gains in people-based outcomes, e.g., health, education and combatting worklessness. High levels of unemployment informed the prevailing local identity. This was particularly evident one evening when I was at a football session with young men from the estate. One of the men jovially accused two of his friends of being ‘a couple of dole dossers’ and thus ‘proper Dodge-ites’ before joking with me that ‘You can tell they’re from Kingsland, can’t ya?’ (Fieldnotes: 1/11/2012) In 2012 local long term unemployment was over double the national average (21.8% compared to 9.3%). In the same year, the percentage of Kingsland students leaving school with five A*-C GCSEs was almost the lowest in the country (43.1% compared to a national average of 59.4% and a national worst of 40.9%).

The long-established scepticism and mistrust of local authorities and government interventions was still very evident in Kingsland at the start of the research period. Despite the success of projects that had been funded by the NDC grant, one of the dominant narratives in the local community was ‘Where’s it all gone?’ This was often said in reference to the high levels of deprivation that were still clearly and visibly present in the area. Local scepticism is likely to go some way to explaining why the
independent NDC evaluation found that towards the end of the initiative there was a ‘tailing-off’ of positive perceptions about the improvements that had been made in the area. This tail-off was not replicated across all other NDC programmes and the explanations behind it are open for debate.

Despite this scepticism, many of the older local people, particularly those who had grown up in the area, agreed that Kingsland was a safer, less threatening locale today than it used to be. One middle-aged resident who had lived on the northern estate her entire life said, ‘It used to be that on the estate you had to look after yourself, and you still do have to look after yourself, but it’s better than what it used to be’ (Fieldnotes: 9/11/2012). This encapsulates the relative progress that has undoubtedly been made. Kingsland has been improved, but not transformed and this bears out in the deprivation data. The ward’s 2013 health profile illustrates just how entrenched deprivation is in Kingsland.

The English index of deprivation (2010) showed that over three-quarters (75.4%) of the 13,090 residents in North Kingsland were, at a national level, living in the top 20% of those areas considered most deprived (compared to national average of 19.8% and a national worst of 83.1%). Unsurprisingly, this meant that the proportion of children living in poverty in Kingsland was one of the highest in the country (41.4% compared to a national worst of 45.9%). Ofsted reported in 2013 that 70.7% of the children at the primary school on the estate were eligible for free school meals. During the fieldwork period I was observing the day-to-day activities at one of the sports facilities that had been built as a result of the ABIs. Staff members at the facility deliver some of the physical education lessons for the local primary school which is literally across the road from it. When the children were lined up in silence a staff member introduced me to them as someone who was doing a project about Kingsland. At this point a young girl came forward and broke her silence by telling me plainly, ‘Just so you know, this isn’t a very good area. I’m leaving soon and I can’t wait!’ (Fieldnotes: 20/9/2012)

The young girl’s elation at moving away was unlikely to be informed by how this would likely affect her life expectancy, but had it been she may have considered herself to have even more to celebrate. Based on data from 2008-10, those living in Kingsland
could expect to live significantly shorter lives than people in other parts of the country. Compared to national averages, local men lost nearly six years of life (72.7 compared to 78.6 years) and women over five (77.5 compared to 82.6 years). The normalisation of dying at a relatively young age was something I met quite regularly on the estate. It was particularly evident at the local weight-loss groups (discussed in Chapter Nine). During conversation one evening, Shirley described how she had lost motivation to lose weight. She said the last time she was really motivated was when she was approaching her fortieth birthday and that she did not want to be ‘fat at forty’. I joked that she could always come up with other age-related goals e.g., ‘fit at fifty’; ‘slim at sixty and seventy’; ‘still around at eighty’; ‘not dead by ninety’. She then looked at me and said quite solemnly, ‘You’re just lucky to get to seventy’ (Fieldnotes: 19/11/2012) before explaining that both her parents had died soon after their sixtieth birthdays. Other women in the group had similar experiences and there was general consensus that people from Kingsland were fortunate to get into their seventh decade which is of course significantly below average life expectancy for the Uk\(^2\) (WHO, 2014).

**Healthy Living after the Implementation of ABIs**

The data for health behaviours in Kingsland makes for very interesting reading. Drinking and cigarette smoking make up half of the practices that have traditionally been the focus of the lifestyle approach (Blaxter, 1990). As such, the 2013 health profile for Kingsland suggests that those attempting to modify the lifestyles of the ‘non-conformers’ are losing half their battle. In Kingsland adults consuming more than recommended levels of alcohol (38.8% and 27.3% respectively) and smoking (34.8% and 25.5% respectively) were significantly higher than national averages. Both behaviours are commonly used as coping strategies and have been associated with the well-established stress paradigm (Pampel et al 2010). Therefore, the relatively high levels of smoking and drinking recorded locally may be taken to indicate that local residents regularly engaged in these behaviours as a way of dealing with the stressful realities of their everyday lives. These realities are of course informed by both the

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\(^2\) Which in 2012 were 79 and 83 years for men and women respectively.
personal and social circumstances in which people find themselves and evidence increasingly demonstrates a relationship between area characteristics and inequitable collective lifestyles (Drewnowski, 2009; Frohlich, 2013; Pearce et al, 2010; Pabayo et al, 2011). Findings from fieldwork with local PA groups discussed in chapters eight and nine support the existence of such a relationship.

More positive reading for those promoting the new public health approach comes from the other half of the practices (PA and diet) that are typically the focus of lifestyle modification. The SAZ evaluation indicated that 17% more residents were engaged in some form of PA by the end of the initiative. Possibly as an outcome of this, the ward’s 2013 health profile indicated that PA was one of the few measures for which Kingsland was not significantly below the national average. Some 77.5% of adults living in Kingsland indicated that they were physically active for 30 minutes three times a week compared to a national average of 85%. Data for diet show that a similar percentage of Kingsland adults indicated that they ate five portions of fruit and vegetables compared to a national average (19.7% and 22.9% respectively). In line with these data, between 2008-10 adult and child obesity rates (22.7% and 20.6% respectively) compared relatively well with national averages (19.2% and 18.7% respectively). These figures could be taken to indicate that living in Kingsland did not inhibit the capacity of residents to be physically active and follow nutritional advice more significantly than living in other areas of the country. However, insights from the fieldwork suggest that they should not undermine how significant a challenge it was for many local residents to comply with standard health advice should they had sought to do so.

For example, the access and availability of nutritious food and drink was problematic. The inaccessibility of affordable groceries locally was emphasised during a community health steering-group meeting I attended, where the manager of a third sector organisation supporting vulnerable women spoke about potentially selling the building her organisation operated from on the estate. In rather utilitarian fashion she reasoned “I was thinking that I might be able to get the Co-Op interested in it and they could finally put a fresh vegetable into North Kingsland!” (Fieldnotes: 25/4/2013) Kingsland is still a place without a local supermarket and it has two weekly food banks that are in high demand.
With regards to PA, there was a well-established local perception that the positioning of, and pricing at, the Leisure Centre meant that relatively few local residents were able to regularly use the facility. This perception was most explicitly expressed by Cary, a local resident and community youth worker who told me:

*I don’t use that place, never have, and I don’t know anyone that does. Look where they put it, right on Sharply Road on the side with good access to Westside Park [rather than Kingsland Park], the posher part around here. If they had put it somewhere else, somewhere closer to the estate, the access would have been completely different. They put it there though because they wanted people from the other side to use it.* (Fieldnotes: 8/10/2012)

Additionally, many of the PA initiatives in the area that had previously been established during the SAZ-era, (e.g., one-to-one mentoring, football schemes), are no longer implemented or running in North Kingsland. The stories and explanations behind these potentially activity inhibiting factors are explored in greater detail in the coming chapters.

**Summary**

All of this material indicates that, even with the improvements that have been made through the implementation of the ABIs, the northern estate in Kingsland is still an area with significant levels of social deprivation and personal disadvantage. The hardship faced by a significant portion of the local population is some of the most severe experienced nationally. However, the improvements made to the physical environment are perhaps the most obvious legacy of the ABIs.

This was particularly the case with regard to the PA facilities. Kingsland now bucks the trend of the inverse care law and has become a relatively novel place: a severely deprived area in the UK, but one with numerous PA facilities and services. Kingsland Leisure Centre is the most impressive of them all. It is a landmark that provides the local landscape with a contrast in more than one sense. Firstly, the high-quality nature of the facility and its high visibility perhaps encourages a misplaced sense of relative affluence in a place where social deprivation is otherwise palpable (and not only to the
‘trained-observer’ who happens to run by). Secondly, it could be argued that the new Centre provides (literally, concrete) evidence that Kingsland is ‘better-off’ after the implementation of the ABIs than it had been before.

When I spoke to one of the local Kingsland councillors about the regeneration of the area he took great pride in telling me that Kingsland used to be a place ‘Where you didn’t take your car’ but now, because of the regeneration, over at the Leisure Centre ‘We have a car park full of them’ (Fieldnotes: 30/11/2011). Although this, indeed, might suggest some local improvement, a more critical observation would be that this particular outcome indicates the various initiatives could be proving more beneficial to those living outside of, and travelling to, Kingsland.

Who exactly does this impressive new facility serve and what impact does this have on local health inequalities? Do local people feel empowered by these new developments? These and other key questions form the principle investigation of the following chapters. But first comes a discussion of methodology and methods.
Chapter Five

Methodology and Methods

Introduction

This chapter is a reflexive account that outlines the methodological approach taken during this research. At first I will explain why ethnography was the data-collection technique of choice and what epistemological assumptions informed this approach. Then, issues of access are addressed and ethical considerations explored. An argument is made for the necessity of emancipatory research before more practical concerns become the focus. A description of the practice of taking fieldnotes is combined with an explanation of how the data were analysed and coded throughout this process. There is a discussion about negotiating access to the field and the necessity of recognising ethnography as an embodied practice when doing so. Details are then given of how the research focus narrowed throughout data-collection and how this led to new modes of data collection in order to test and support analytic themes that had been identified. Finally, there is a brief discussion of the writing process itself.

Why Ethnography?

This project has a general sociological relevance, but it is also primarily concerned with a specific place. That place is the North Kingsland estate and this research focuses on the ways in which ABIs implemented there influenced the health behaviours of local residents. As such, it shares features with aspects of local community studies (Brunt, 2001), but its parameters were narrowed from the outset by a primary concern with PA and health inequalities. Ethnography was judged to be the most appropriate, and perhaps the only, approach to adopt in order to collect the data required to capture the complexity of the field and attempt to make sense of it all.
The immersive and malleable characteristics of ethnography best allow for engaging with issues spanning the agency-structure spectrum that have come to characterise debates about health behaviours (Cockerham, 2005; Veenstra and Burnett, 2014; Williams, 2003a). These characteristics also provided a means to understand how the intersections of contextual (place) and compositional (population) factors influence the lives of residents in Kingsland. However, the expansive nature of ethnography means that it is necessary to explicitly state what is meant by ethnographic research in the context of this study and thus outline what came to define this empirical endeavour.

**Epistemological Assumptions**

When seeking academic counsel about conducting ethnography it is evident that there are more possibilities than restrictions (see, for example, Atkinson et al, 2001a; Boyle, 1994; Gans, 1999; Hammersley and Atkinson, 2007; Herbert, 2000; O'Reilly, 2005; Reeves et al, 2008). Rather than having a prescriptive set of definitive rules, ethnographic practice is shaped, primarily, by the research site and the activities that occur there. In this way, ethnographic practice can be understood as a ‘craft’ that is best learned through practical engagement in the field (Li and Seale, 2007; Rachel, 1996). For this reason Atkinson et al (2001b: 5) argue that, although ethnographic studies may differ, observation and participation are characteristic features and mean that ethnographic research is ‘firmly rooted in the first-hand exploration of research settings.’ Therefore, I approached this study with a sense that uncertainty about ‘what to do’ was only to be resolved by gaining access to the field and by beginning my fieldwork. The rest remained to be experienced and negotiated as exposure and early analysis made the salient apparent. In the simplest terms, what defines this research as ethnographic is a willingness to work inductively and inextricably involve the self in the processes of collecting and analysing data.

The epistemological assumptions which underpin this research are that multiple realities are constructed, rather than revealed, by both researcher and respondents. Through the analysis of empirical data the researcher presents an account of the
observed phenomena. This is neither fixed nor incontestable, but if it is to be successfully defended it must be grounded in rigorous and honest academic endeavour. I agree with Hammersley (1992) that rather than present realism and relativism as a philosophical binary and then align ethnography with either tradition, ethnographic accounts more accurately fall somewhere in-between these traditions and should be judged on whether they help us to understand the observed behaviour rather than simply whether they are true or false.

As such, this account does not fall foul of what Van Maanen (1988: 73) termed the ‘doctrine of immaculate perception’, a form of naïve realism which has traditionally led ethnographers to assume that they are attuned to perceiving the most pertinent aspects of a field and to producing objective accounts of them. However, I would contest that acknowledging subjectivity throws ethnography into a ‘crisis of legitimation’ (Brewer, 2000; Denzin and Lincoln, 1998) such that ethnographic accounts languish among any and every other account of the same phenomenon. As justification for this claim it is useful to distinguish, as Spradley (1980) does, between the ordinary participant and the participant observer and extrapolate this difference to ethnographic observation more generally.

Although their appearance in the field may be indistinguishable, the ordinary participant has one purpose for attending - to participate in appropriate activities for the setting - whereas the participant observer has a ‘dual purpose’ (Spradley, 1980: 54): to do so and rigorously to observe, record, and analyse what happens there. The participant observer is a ‘trained observer’ (Wolcott, 1994: 149) or more specifically an ‘agent of induction’ (Lofland and Lofland, 1995: 185) who is not to be so involved as to get lost in their participation but to participate whilst simultaneously doing what is necessary to better understand participation. Therefore, ethnographers operate in the overlap of etic and emic accounts and it is this - what I term ‘distant-intimacy’ - which gives the ethnographic account legitimacy, but not an incontestable, authority. Claims of legitimacy are further enhanced if the methodology’s ‘reflexive turn’ (Brewer, 2000: 127) is followed. Reflexive processes were to the fore throughout this research and details of this will be highlighted at appropriate junctures throughout this chapter.
O’Reilly’s (2005: 26) preferred descriptor for ethnographic research is ‘iterative-inductive’, a concept used to convey how repeated observation over a relatively long period of time allows the researcher to immerse themselves in the field and, through a heuristic process of analysis, attempt to explain ‘whatever is happening there’ (Charmaz, 2006: 21). This description sits comfortably with me and most closely resembles the approach I took during this study. So, although as an ethnographer I was always aware that, what ‘happens’ in the field and how this is understood are the outcomes of processes of selection and interpretation, I was committed to ensuring such interpretations were generated by extensive observations and rigorous analysis of data. More specifically, then, my approach to fieldwork fits within the parameters of what Charmaz (2006) describes as grounded theory ethnography. My previous allusions to constructivism should have established that, although I find much of Glaser and Strauss’ (1967) seminal text instructive and of value, my application of grounded theory aligns more with that of Charmaz (2006), in so much as it is understood that we construct our grounded theories rather than discover them.

Charmaz (2006: 25) simplified the grounded theory strategy as being to: ‘seek data, describe observed events, answer fundamental questions about what is happening, then develop theoretical categories to understand it’. Adopting this approach meant that this research was inductive but gained direction throughout the data collection and analysis phases (phases which when adopting such an approach can only be separated superficially; Bryant and Charmaz, 2007; Charmaz, 2006; Charmaz and Mitchell, 2001; Pidgeon and Henwood, 1996). This enabled me to follow the ‘funnel structure’, which Hammersley and Atkinson (2007: 160) advise that ethnographic research should do, by becoming progressively focused over its course.

Pidgeon (1996: 77) maintains that initially managing the inherent flexibility of the ethnographic method by generating and developing concepts from collected data is a ‘creative process that fully taxes the interpretative powers of the researcher’. It is the generation of theoretical concepts from data that Coffey and Atkinson (1996: 162) have argued allows qualitative researchers to ‘transcend the local and the particular’ and thus offer some ‘generalisable’ findings. Therefore, whilst the simultaneous collection and ‘derivative ordering’ (Lofland and Lofland, 1995: 181) of data may lead
an ethnography premised on grounded theory, such as my own, to take on a funnel structure, the generation of generalisable concepts and analysis and the writing up of findings reflects this structure back onto itself so that the finished ethnographic account better resembles the structure of an hour-glass. This is true of this account, but this discussion is also getting ahead of myself somewhat. Before data collection could begin, I had to negotiate my way into the field and, as is customary, this required negotiating access through a gatekeeper (Denscombe, 2010; O’Reilly, 2005).

Where it all started: Kingsland Leisure Centre

To ensure that my account was generated from extensive, iterative observation, required me to spend an extended period in the Kingsland area. Ultimately, formal data collection took place at various locations in the field over a period of sixteen months, and a mixed methods approach with ethnography at its core was utilised throughout this time period. The reasons behind the selection of research locations and the details of the methods used will be addressed in what follows. I will start by describing how access to the field was gained initially.

The previous chapter outlined the significance of the Leisure Centre within the local context. However, other than in its close proximity to the North Kingsland estate, the ways in which the facility served local residents were not immediately apparent. Assessing the extent to which Kingsland residents’ capacity to participate in PA had been effected by this intervention was thus a formative point of enquiry. Therefore, the Leisure Centre seemed an obvious place to begin collecting data in earnest.

My gatekeeper was an acquaintance of one of my doctoral supervisors and he had worked for the Local Authority, which had Kingsland within its purview. He sent the Manager of the Leisure Centre, Karen, an e-mail to request that she meet with me to give me some context with regards to local health delivery. I later received a reply from Karen expressing that she was happy to meet and ‘help you with your studies’ (e-mail correspondence 3/11/2011). I met Karen and explained my research and how she might help. Noticeably, Karen, initially, let me do all the talking and it became clear
that I was on a ‘trial ‘of sorts. Karen later confirmed during an interview towards the end of data-collection that my access had not been guaranteed. Rather, she had used that first meeting to judge whether I was an academic ‘uni boy’, someone who she felt would have been unable to work well with the staff and locals.

After I had explained my intentions, and why Kingsland was a novel research site, she appeared to warm to me and began excitedly to tell me ‘the story’ of the Leisure Centre. Perhaps as a response to my suggestion that facilities such as this one could exacerbate, rather than reduce, health inequalities, she explained how Kingsland Leisure Centre was run very differently; how it was engaging local residents and facilitating their PA participation.

Karen permitted me to conduct observations at the Centre, but said this would have to be cleared by her managers. This led to a further meeting between myself, Karen and her manager, where, once I had explained my intentions and assured her manager that the identity of the place and people in the study would be anonymised, it was agreed that I could start my observations. A further meeting involving myself, Karen and one of my supervisors strengthened initial relations and seemed to further assure Karen of the legitimacy of this research. The first research observation took place on Monday 5th March 2012.

Before then, ethical approval from the University of Leicester’s Research Ethics Committee was sought. The literature highlights the subjective nature of ethics (Berg, 2007; Murphy and Dingwall, 2001; Neuman, 2007) and thus the inherent ‘ethical situationism’ (Hammersley and Atkinson, 2007: 219) of qualitative research. Therefore, although my ethics application was approved, ethical considerations continued to inform practice at every stage, as will be explained in the course of this chapter.

**Ethical Practice: Transparency and Informed Consent**

Every attempt was made to conduct this research overtly. Of course, it would have been impossible and unnecessary to fully explain who I was and why I was present to
everyone I encountered. I did, though, use prominently displayed notices at two reception areas in the Leisure Centre to identify myself and my intentions (see appendix 11.0). Apart from more generally informing people of who I was, on a number of occasions these notices helped me to demonstrate to people, who had perhaps not realised why I was there, that I had not been attempting to deceive anyone. Ethical dilemmas, such as the previous example, were largely resolved through reflexive practice, but when the potential usefulness of a method (questionnaire survey) I had not initially intended to use was identified, a proposal was resubmitted to the university ethics committee and the method was not implemented until approval was received. Confidentiality has been treated extremely seriously, with every effort being taken to ensure that participants’ anonymity is protected and the location of the estate not made obvious to outsiders. For this reason, throughout this account pseudonyms are used (see appendix 11.1 for list of pseudonyms and corresponding roles).

Murphy and Dingwall (2007) and others argue that it is inappropriate to apply standardised, anticipatory ethical regulations to ethnography. These authors highlight that - if it is conducted overtly - the exploratory nature of the method means that consent is constantly negotiated and renegotiated and data-collection depends on the ongoing cooperation of ‘hosts’. If there is no longer consent the researcher’s access is denied. This process is reflective of my own practice. I told respondents that I was interested in people’s thoughts about health and was attempting to understand how and why people either did, or did not, participate in PA in Kingsland. I was always open with respondents about my intentions and never pressured them into allowing me access to their activities and/or divulging personal and/or emotionally sensitive information. Gaining informed consent was a perpetual process, one which I conscientiously pursued and was achieved in situation-specific ways. These are addressed throughout this chapter.
The Case for Emancipatory Research

Although my awareness of the inequality paradox (discussed in previous chapters) and the contested nature of reality tempered my willingness to accept completely Karen’s ‘story’ about the Centre being run ‘differently’, I was open to the idea that my own analysis may ultimately lead me to this conclusion. This prospect was sociologically intriguing because, if the facility was found to successfully engage residents from its deprived neighbourhood, the findings could make a useful contribution to the field of health inequalities and be potentially illustrative of effective ways of addressing health disparities. If this was not found and ‘successful’ engagement was perhaps considered less inclusive of Kingsland residents than Karen initially made out, the likely outcome would be research that would offer a critique of particular forms of governance and which was informed by in-depth empirical data rather than abstract political arguments. At this point, and taking heed of Okely’s (1992: 4) argument that ‘a reflexivity which excludes the political is itself unreflective’, it is necessary here to acknowledge some of the personal motivations that inform this research.

Choosing to focus on how health behaviours were incorporated into an area-based strategy to reduce national inequalities provided an opportunity to explore the relative nature of agency. By choosing to research Kingsland I was following an ethnographic tradition of ‘giving voice’ to people whose identity and social position may otherwise mean their accounts are muted or even absent (Coffey, 1999; Hammersley and Atkinson, 2007; Skeggs, 2001). This enabled me to analyse how, and in what ways, the ABIs impacted upon the lives of those living in Kingsland and to assess whether they had been successful in reducing inequality. All of these decisions were made in accordance with my belief that creating and sustaining a more egalitarian society is morally and socially preferable to the continuation of socio-political structures that are presently exacerbating the extremes (Dorling, 2013; 2014). As such, I align myself with Humphries et al (2000) who have argued that in an increasingly unequal world ‘emancipatory research’ is not only epistemologically warranted, but is also required.
Research which aims to emancipate has its origins in the Enlightenment but has been associated more recently with critical and feminist theory (e.g., Freire, 1972; Habermas, 1979; Hanisch, 1970). It is concerned with educating people about oppression in order to increase recognition of how particular ideologies serve to protect the power of privileged groups. In this vein, Humphries et al (2000: 6) have argued that research can and should be a form of emancipatory praxis because, for them, ‘knowledge is not only about finding out about the world, but about changing it’. I agree: the more informed and sophisticated our understanding of health inequalities and the ways in which they are addressed, the better equipped we are as a society to resolve them. Achieving such an aim relies on critical research which identifies the causes of inequalities and/or offers practical ways in which such disparities might be reduced. I entered the field with no vested interest in revealing either oppressive or emancipatory practices. Because of the subject matter I recognised that, either way, the findings could make a contribution to reducing health disparities. Therefore, it could be argued that practice was guided by politics. But, once in the field, my perceptual range was not limited by them: I was always ‘open’ to what was happening around me.

**In the Field: Field-Notes and Ongoing Analysis**

Fieldwork took place between March 2012 and June 2013. The table below provides details of the collated figures for: total number of fieldwork excursions; hours spent collecting data; and word counts of fieldnotes and monthly summaries produced during this period (see appendix 11.2 for a more detailed table).

**Table 5.0: Data Collection Summary**

<table>
<thead>
<tr>
<th>Total No’ of Fieldwork Excursions</th>
<th>Total No’ of Hours in the Field</th>
<th>Total Word Count of Fieldnotes</th>
<th>Total Word Count of Monthly analytic Summaries</th>
</tr>
</thead>
<tbody>
<tr>
<td>230</td>
<td>850.75</td>
<td>363,623</td>
<td>46,208</td>
</tr>
</tbody>
</table>
As table 5.0 illustrates, data collection was a lengthy and extensive process. Fieldnotes were written directly, or shortly after, a period in the field. ‘Jotted notes’ were rarely taken in the field and if they were, this was done out of sight. Rather, I preferred to log ‘mental notes’ to act as prompts for later written accounts (Emerson et al, 2001: 356). I worked in this way because I wanted to minimise the Hawthorne effect (French, 1953): overt note-taking provides an unnecessary and regular reminder for participants that they are being ‘watched’. Of course, this approach relies heavily on the researcher’s capacity for recalling information accurately, but I felt this was a pro as much as a con. I played events over and over in my mind in an attempt to ensure that they were not ‘lost’ before being recorded in writing. This also helped me to familiarise myself with my findings which facilitated the making of connections between presently occurring and past events which in turn was beneficial to immediately following analytic leads and refining data collection.

As Emerson et al (2001: 353) advise, I treated fieldnotes as ‘a loose collection of possibly usable materials.’ They provide ‘rich data’ that, as well as initially directing data collection, facilitated the production of thick descriptive accounts which represent the ‘complex specificness’ (Geertz, 1973: 23) of what is being studied and the generation of empirically informed theory. My approach to observations and the practice of writing fieldnotes was informed by the conviction that inductive accounts are fortified by casting a wide net and capturing as much detail as possible before ongoing analysis narrows the horizons of enquiry and ultimately leads to ‘theoretical saturation’ (Glaser and Strauss, 1967: 61). In this sense, I sympathise with Rachel’s (1996: 114) disclosure of entering the field with a sense of ‘frenzy’ to ‘get it all’ in order to legitimate the research as ethnographic. I certainly felt the compulsion to write the sort of extensive notes that others have described (Lofland et al, 2006), and the sense that they are worn as a ‘professional badge’ (Kleinmen and Copp, 1993: 21). It is not merely professional pride I feel when referring to word count in this context. Without mistaking quantity for quality, it seems fair to argue that the reliability and validity of this account are fortified by having such sound foundations as a raw base for analysis.
This amount of data may have been bewildering if I had not adopted the ‘insightful industriousness’ (Charmaz and Mitchell, 2001: 160) which is a fundamental part of the ongoing analysis characteristic of the approach known as grounded theory. This was aided by the organisational and storage functions offered by qualitative data analysis software NVivo 10. Microsoft Word documents were uploaded to, and then coded in, this programme. Possible themes were identified throughout this process e.g., childcare, responsibility, sweat, which led to the construction of a rather large and varied coding framework. Over time some themes appeared more prominently in the data and thus received more attention in the overall analysis.

From the beginning, coding allowed for ‘data-source triangulation’ (Hammersley and Atkinson, 2007: 183). Codes led to the development of ‘sensitizing concepts’ which were used as ‘tentative tools’ for developing ideas and establishing what I felt was pertinent within the field (Charmaz, 2006: 17). Therefore, the deductive-inductive binary was, to some extent, bridged with this ‘flip-flop’ approach of constantly building and abandoning identified themes in order to direct my attention within the field (Bulmer, 1977; Pidgeon, 1996). This sort of analysis occurred day to day, even moment to moment. More formally, I wrote monthly fieldnote summaries in order to revisit the data and highlight key events or conversations. This provided an opportunity to step back and assess the strength of ‘hunches’.

I found that ‘hunches’ could disproportionately be reinforced by recent events I observed, as the present is often experienced as more captivating than the past. The otherwise arbitrary ‘full stops’ monthly summaries provided allowed for longer term reflections and promoted coherence and greater reliability in my analysis. Through this process, other methods of data collection supplemented observations and fieldnotes. These included: participant observation with specific groups; interviews with staff members and group participants; analysis of local documents; a questionnaire survey; and geographical mapping. Details of all are provided below.
Early Exploration, Negotiating Access and Managing Suspicions

Observations took place predominantly within the Leisure Centre. Once in the field it became apparent that there were three local sports and PA services that were fundamental to understanding and assessing the social impact of the ABIs implemented in Kingsland: the Leisure Centre; the former SAZ delivery team which had subsequently splintered into two third-sector organisations promoting sport and PA (Keep-Active and FIT-FRIENDS); and The Elm, a youth club and multi-purpose sports complex with playing fields that had been rebuilt and extended with funds from the ABIs. Alongside developing an extensive understanding of the Leisure Centre, observations were conducted at other local sites and people with different local affiliations were also accessed during this period.

As has been stated, initial observations at the Leisure Centre were exploratory in nature. The facility was open between the hours of 6:30-22:00 on weekdays and 8:00-17:00 at weekends and offered a range of activities. In order to observe the full scope of operations and user participation, observation was undertaken throughout the week in six to eight hour shifts, either from the morning until the afternoon or from the afternoon until the evening. In the first two months observations primarily were to establish ‘what happens here’ before following leads and becoming more focused with my time and attention. Additionally these periods served the auxiliary, but vital, function of allowing me to establish myself in the field. Traversing the outsider-insider divide is a perpetual task that runs the length of an ethnographer’s time in the field (Emerson et al, 2001). I found this was most challenging however, at the very beginning of the research period, when I was still established firmly as an ‘outsider’ attempting to break in.

Hammersley and Atkinson (2001) describe the frequency with which ethnographers are suspected of being ‘spies’ or some other undesirable character that participants may feel wary around. This was something that I initially endured. I felt I needed to manage this perception immediately, but I also realised it would take time and effort to resolve. At the Leisure Centre there was a sense of distrust between those who worked downstairs ‘on the floor’ interacting with users, e.g., receptionists, pool
attendants and gym staff, and the (senior-)management located in upstairs offices or off-site, in Council offices in the city centre. Some of the staff ‘on the floor’ believed me to be a ‘spy’ working for, and reporting back to, management. Being overt about my research intentions won little favour from those who suspected it was all a ruse. Berg and Smith (1988: 23) contend that ‘research relationships are the vehicle through which the researcher comes to understand a social system’. Appreciating this, I understood that the accuracy of my account was to some extent reliant upon my capacity to build relationships with people within the field. This meant that many of my early experiences were as much about ingratiating as they were theory generation.

Throughout the fieldwork at the Leisure Centre I helped out where I could (without unduly altering the environment) and spoke and joked with staff in much the same manner as a co-worker would. I was familiar with the operational duties of many staff as I previously had been employed in similar positions in the fitness and leisure industry. Due to the menial nature of many of these tasks I would suggest that it was my willingness to help, rather than my knowledge and competency at performing the tasks, which was most appreciated. Amongst other things, I helped to: clean the gym; perform poolside operations; do photocopying; and I attended staff training sessions. Performing these tasks provided opportunities to ‘build rapport’ with staff and strengthen my relationships with them. These interactions helped me to establish what the daily operations at the Leisure Centre were and they went a long way to dispelling initial suspicion of me. The simplicity of showing willing when there is scrubbing to be done, or relieving the boredom of shift work by providing company and conversation, should not be underestimated when it comes to breaking down barriers presented to the academic outsider.

I had to accept that it would not be possible to win everybody over. One staff member greeted me on almost every occasion during my sixteen-month stay with a standoffish ‘What are you doing here?’ Another exploited my rotational approach to observation to disguise his own rumour-mongering by telling others that it was I who was spreading his banal, but potentially hurtful, bile. Many others, though, initiated in-depth conversations with me about personal matters that I assume they only brought up because they felt comfortable in my company and appreciated my willingness to
listen and empathise. I was also invited to a number of social events outside of ‘work’. I attended one meal that was limited to staff members, but declined other invitations I felt may unnecessarily align me with particular people or cliques.

Ethnography is an embodied practice and as such, I approached each situation with an awareness that how I appeared (both literally and figuratively) informed my interactions in the field. My actions were designed to put people at ease in a situation which could otherwise have been experienced, by them (and me), as awkward or uncomfortable. This allowed me to negotiate a place for my ‘body-thereness’ (Coffey, 1999: 73) within the field and to manage the sense of aberrance often associated with those who are ‘delicately lurking’ (Van Maanen, 1988: 4). Doing so facilitated the building of trust and ultimately helped blend me into the background murmur of everyday noise that otherwise occurred. I like to think I was open and friendly rather than manipulative. My intentions were always to understand how the social system functioned as a whole, rather than to reveal or to collect information that intentionally, or unnecessarily, hurt the feelings or damaged the reputations of individuals.

My obligation was always to observe practices and interactions which, through a process of analysis, I could relate to wider social issues. This required negotiating a place within the field somewhere past the semi-permeable membrane that exists between etic and emic identities. Possible moral objections to what I perceive to be conscientious and open ways of working are welcomed, of course, as they may improve my future practice.

‘Where have you been?’ Beyond the Furniture Cliché

I have acquired the usual clichéd quotes from people within the field who eventually referred to me as being ‘part of the furniture’, but I would like to eschew giving them primacy in order to propose an alternative ‘litmus test’ for assessing ethnographic adeptness, one grounded in my own experiences. My sense of obligation to produce research that may have a positive effect - or at the very least would avoid impacting
negatively on the people and the area that I studied - increased my sensitivity to perceptions of exploitation and abandonment. I had a responsibility to ensure that participants received a ‘fair return’ (Spradley, 1980: 24). As mentioned previously, there was a distinct lack of trust in Kingsland towards external investigators or ‘do-gooders.’ As such, I initially encountered the perception that I would likely be ‘here today, gone tomorrow’, never to be heard from again. However, the consistency and length of my stay led to a reversal of this perception and, over time, local people came to expect me to be present whenever they were. This led to many of my encounters as I re-entered different parts of the field starting with people asking: ‘Where have you been?’

Of course, my ‘constant’ presence was an illusion, but still this illusion narrowed the tolerance of my absences. I adopted a rotational approach to observing at different times and locations which meant that, from time to time, routines would need to be broken, creating discrepancies in my attendance patterns. Also, the long hours spent in the field decreased as the point of theoretical saturation approached. Sometimes, though, it was the case that local people expected to see me simply because they always seemed to. Being asked ‘Where have you been?’ demonstrated that I had been accepted and I had done what was necessary to have been missed. Although this is not a claim to having achieved insider status, people notice the absence of outsiders as much as they miss furniture that was never there.

**Narrowing the Focus and Taking Part**

Once I had established and familiarised myself within the field I began to follow analytic leads, focus my attention, and more fully participate in proceedings. As well as gaining understanding of how the Centre was run, I wanted especially to understand it from the point of view of the user. I was interested in how accessible it was for local residents and whether, how and in what ways people from Kingsland used this facility. This led me to engage with a number of activities, including regularly using the gym and participating in various exercise classes. As the legacy of the ABIs was of particular concern, my attention was drawn to groups and people who could be traced back to
them. I came to realise that a number of groups that originated from projects associated with the ABIs were still being delivered at the Leisure Centre. These included two daytime women-only badminton sessions and three single-sex weight-loss groups (two female, one male). I negotiated access into all of them as a participant observer.

Through my position and connections at the Leisure Centre I was also able to establish links and spend time with the Keep-Fit and FIT-FRIENDS teams who were largely responsible for establishing and delivering these local groups. This offered an opportunity to get to grips with the role that the SAZ implementation team had during the ABI era and the roles these organisations play now since becoming third sector organisations in their post-SAZ existences. Both groups were managed by and employed people who were formerly part of the SAZ implementation team.

During my observational periods Keep-Fit was a four-person team operating from their base located on Kingsland Park. I formally interviewed the Manager, Julie and also Lindsay, who had formerly been the longstanding instructor of one of the two local women’s weight-loss groups (discussed later) but after being made redundant was later re-employed on a part-time basis to work on new projects. FIT-FRIENDS were commissioned by the NHS to provide city-wide weight-loss education and activities services. Reflecting their shift from a local focus, the FIT-FRIENDS offices were in the city-centre. I formally interviewed the Manager, Matt, and Abbie the Development Officer who was formerly the longstanding instructor at the other women’s weight-loss group, and two of the instructors - Parina and Hyacinth - who led the weight-loss groups during my observations.

All of this is not to overshadow the significant amount of time I also spent away from the Leisure Centre at The Elm. Members of the Keep-Fit team acted as my gatekeepers to this facility. I spent around seven months conducting observations there. This was a much smaller facility but I followed a similar access pattern of negotiation, getting accepted, and rotation to my observations at the Leisure Centre. The Elm more generally offered local residents an opportunity for informal play but two football sessions were also offered on weekday evenings that had their origins in projects.
established through the ABIs. I took the opportunity to attend one of them for seven months as a participant observer (the other clashed with one of the weight-loss groups). I formerly interviewed The Elm’s Operational Manager and Sports Development Officer, Sam. Attention will now turn to data collection techniques during the phases where my analysis became more refined.

**Refining Data Collection and Analysis: Employing Methods**

**Document Analysis**

Through my time in the field, nine key local documents came to light. Analysis of these provided historical context and established criteria by which the social impact of the ABIs and local facilities could be assessed. In this sense they were invaluable to this project. These documents ranged from: those stating the ambitions of what the ABIs intended to achieve; the NAAP, detailing the results of a community consultation conducted at the inception of the SAZ; the business and strategic development plans for the Leisure Centre; reviews of specific local projects; and evaluations conducted by independent research bodies. Each document was coded using content analysis.

Hammersley and Atkinson (2007: 130) suggest that often local documents are not given the attention they deserve during ethnographies. They also advise that they should be examined as ‘social products’ and ‘not relied on uncritically as a research resource’. This advice was followed during this undertaking. These documents thus provided information through which current events could be framed. The NAAP, which was at times frank and forthright about the plight of local people before the ABIs were implemented, became a particularly useful reference point as it allowed current practice to be compared to previously stated needs and aims. The documents provided stable markers to contrast with the moving targets of presently occurring events and local opinion. For assessing these targets, my understanding was significantly enhanced by adopting the role of participant observer.
Participant Observation

There were numerous settings within the field where more detached observation gave way to ‘getting involved in the activity’. In order to achieve integration as a participant observer, each group and activity presents its own unique and ongoing form of negotiation. I was involved in far too many negotiations to cover each in requisite detail here\(^3\). Instead, I will focus on the participant observation that became most pertinent to the current analysis: that in the weight-loss groups.

The weight-loss groups came to prominence during the ABI-era to promote and facilitate ‘healthy’ living in Kingsland. Their continued existence offered evidence of the ABIs’ long term impact. Additionally, their subsidised fees meant these groups could be considered to be reasonably accessible to most Kingsland residents. Participating in these groups allowed me to gain an understanding of the sorts of PA opportunities that were available to local people and how participants engaged with them. This was facilitated by occupying the ‘semi-overt role’ of the participant observer, where I was ‘open’ about my identity and intentions but familiarity, accumulated over time, meant that it is unlikely other participants always kept my identity as a researcher at the forefront of their minds (O’Reilly, 2005: 87).

There were two women’s weight-loss groups. Both met on weekdays, one during the evening, the other mid-morning. The men’s weight-loss group met on a weekday evening. I spent eleven months attending all three weight-loss groups. I seldom missed a session during this time. As the groups were single-sexed it is important to acknowledge and explain my negotiated entry to, and practice in, them.

There are certainly intellectual and other grounds for raising objections to my participation in the ‘women-only’ groups, so it is necessary to offer a rationale and perhaps also a defence. Reinharz (1988: 170) describes a ‘feminist distrust’ of sociology which ‘stems from the insulting, inaccurate, and entirely “other” nature of much theory, methodological instruction, and even humanistic criticism’. This

\(^3\) Indeed, some of these observations only informed the narrative of this thesis in minor or non-specific ways but will be reported on in future publications. For instance, they will reveal the trials and tribulations I encountered as a largely incompetent but self-aware male-body obliged to shake his ‘boom boom’ along with fellow Zumba practitioners.
characterised the feminist critique of methodology circa the 1970s-80s, one that rejected ‘malestream’ sociological practices. Stanley and Wise (1990: 21) state that this led some to argue for a ‘focus on women, in research carried out by women who were feminist, for other women.’ On the other hand, Mazzei and O’Brien (2009) have argued that demography need not be destiny for the field researcher because gender can be strategically deployed to build rapport. Ortiz (2005: 267) also understood this and found that performing what he termed ‘muted masculinity’ was conducive to conducting research with women (wives of professional sportsmen) who he stated were likely to have been reticent otherwise. While I am committed to practicing a version of critical feminism, restricting research on women, to women is unnecessary and problematic (Riessman, 1987). However, negotiation and reflexivity are key issues if male researchers are to enter these spaces and relationships.

My participation in the women’s weight-loss groups was negotiated through the group instructors. I explained my research and intentions and they put the possibility of my participation to the group. If objections had been raised I would have accepted this and re-directed my time and attention. However, the instructors told me that the women were comfortable with the idea of me attending the sessions and so my participation was permitted. My initial approach was to participate in physical activities only if group members were happy for me to do so. Eventually my participation was actually demanded by other participants as the sentiment within the groups was that I should be required to sweat and ‘suffer’ with the rest of them and that merely watching from the side-lines would have produced voyeuristic connotations associated with the male-gaze. This was clear when Jackie explained in interview why she had felt comfortable with my attendance:

...because you were there every week and just took part in everything we did anyway. Now if you’d have not taken part in the exercising and you just sat there and watched everybody, now I think that would have been very disturbing for everybody.

It should be added that although the participants were exclusively female they had previously received instruction from a male nutritionist and they did not use
exclusively female spaces. Negotiating my entry into the men’s weight-loss group was more straight-forward. Again, the instructor acted as gatekeeper and no objections from participants were voiced. Whilst there, my male identity meant I was expected to participate as any other group member did.

Whilst negotiating access for participant observation is never completely unproblematic, my approach with these groups is comparable to those used in other ethnographic studies deemed ethically acceptable. That my body happened to be biologically ‘foreign’ in the women-only groups does not make this any more or less (un)problematic. Access should always rely on reflexive and ethical negotiation. As Callaway (1992: 34) points out ‘one is never just a man or a woman’ and arguments could be made, based on the way I appear corporeally and ‘do’ gender (West and Zimmerman, 1987), that it was actually my participation in the men’s weight-loss group that was more ethically and practically challenging. This is why it is so imperative to act on Francombe-Webb et al’s (2014) encouragement of those who research biopolitical governance to reflect upon the complexity of the presence of their body in the contexts in which they study.

I have an ‘ambiguous’ sexuality, am highly sensitive to gender politics, and broadly speaking, I think I perform something of an androgynous identity. I have the capacity, both physically and in a performative sense, to operate in masculine and feminine roles. Developing Ortiz’s (2005) concept of ‘muted masculinity’, I was able to amplify different aspects of my gendered performance in order to negotiate my participation. What could not be escaped was my slim athletic build that could be considered out of place at any weight-loss group, irrespective of the sex of participants. From my experience though, this was infrequently problematic with the men, and even less so with the women. The women tended to follow conventional wisdom and thus did not compare their corporeality to mine as they understood us to be biologically different. My long hair, willingness to participate in ‘girly’ activities like Zumba and amplified feminine characteristics, e.g., being emotionally open and supportive, led to a consensus that I was ‘one of the girls’. However, the dominance of heteronormativity also led to my embodied male identity being sexualised for comic effect at times.
When I was with the men my body was more easily appropriated as being comparable to theirs. On at least one occasion this led to me being granted moral superiority. When a football we were playing with became stuck in a tall structure I was able to jump up and lift my own bodyweight to climb it and dislodge the ball. This led one man to look on in disbelief and say to the others ‘we should all be able to do that, boys’ (Fieldnotes: 24/10/2012). Although largely innocuous, I considered not repeating the scenario, but it was later expected and encouraged as it prevented an otherwise significant delay in playing time. Additionally, the group’s resident ‘piss-taker’ started referring to me as ‘Clarke’, in reference to the comic book character Clarke Kent, due to my wearing glasses. After this I stopped wearing them to sessions. Although I was far from ‘Superman’, once they were removed my masculinity was asserted through my physical competence during activities, my general confidence and my ability to engage knowledgably in conversations about football, and the like.

Ultimately, I feel my participation was sensitively negotiated and justified. My ability to demonstrate appropriately gendered capital by judiciously amplifying masculine and feminine attributes allowed me to integrate into these gendered spaces. I was able to collect data through observations in all three groups which facilitated the making of comparisons between them derived from a single embodied account. I am unaware of any other study with single-sex weight-loss groups where a comparative analysis has been derived in these ways. The findings demonstrate the merits of adopting such an approach and I would encourage other researchers to go beyond gender ‘restraints’ to achieve similar knowledge. This is possible and legitimate as long as we remain reflexive and ethical in our practice.

*Interviews*

Although there is a lot of scope for the use of the term ‘interview’ in ethnography (Hammersley and Atkinson, 2007) here I am referring to occasions which were arranged in advance and guided by a series of previously written open questions. Interviews were mainly conducted in the final months of fieldwork to provide data for triangulation with observations. They were conducted with staff from relevant facilities and organisations and weight-loss group participants (see appendix 11.3 for
All interviewees provided informed consent and were assured anonymity and confidentiality (see appendix 11.4 for consent form). Following the preferences of interviewees, the interviews took place at a range of locations. In all, 26 interviews were conducted with 31 people (on four occasions interviewees expressed a preference for being interviewed together). The duration ranged from ten to seventy-five minutes (see appendix 11.3 for complete list of participants, locations and durations). This indicates the individualised nature of each interview and the different constraints and/or import of each. This is further revealed by the accommodation of requests for joint and group interviews.

With the permission of participants, all the interviews were audio recorded. This is now generally considered good practice and it allows for later relaying the verbatim quotes that add so much to ethnographic accounts (Fetterman, 2007). Although Kleinman and Copp (1993) highlight a tendency within qualitative research not to (fully) transcribe interviews: this was not followed in this project. All 26 interviews were transcribed by myself. Producing, and later fully analysing, these transcripts to identify significant codes was another time-consuming activity but one that further enhanced my familiarity with my data and contributed to my overall analysis.

All the participants were considered and treated as people; not numbers, but individuals with important accounts to relay. In recognition of this and in search of rich data, the decision was taken to adopt a semi-structured style of interviewing that was open, flexible and encouraged thoughtful and evocative responses (Berg, 2007; Elliot, 2005; Kvale, 1996; Silverman, 2006). To guard against wasting the time of interviewees and collecting data with little pertinence, it was necessary to consider how to conduct interviews so that they could be analysed in a coherent and analytically creative way (Kvale, 1996). Therefore, questions were designed to address themes that had been identified and coded throughout analysis. Very often this led to more concise and eloquent responses to demonstrate themes than those recorded in fieldnotes (this is reflected in the frequency with which interview data is deployed in findings chapters). Interview questions went through several stages of refinement, but were not piloted due to their individualised nature and the time restraints, before eventually being used during interviews.
Qualitative interviews provide a medium for research participants’ views to be explored and granted the ‘culturally honoured status of reality’ (Miller and Glassner, 2004: 127). It must also be acknowledged however that, while interview accounts are always interesting and of merit, in and of themselves, they constitute a ‘reality’ that is neither fixed nor incontestable (Nettleton and Green, 2014; Van Maanen, 1988). It was my role as the researcher to interpret these accounts and to make sense of the ways in which they complemented and contradicted what I had observed in the field. Therefore, interviews were a way of ‘giving voice’ without this source of data ‘drowning out’ others by being considered analytically superior. While interviews foregrounded the accounts of those present in the field, towards the end of the data collection period I began to give greater consideration to how to represent those who were absent from my observations. This led to the decision to conduct a hard-copy questionnaire survey and explore the possibilities offered by Geographic Information Systems (GIS).

*Questionnaire Surveys and Mapping Data*

As this research was centrally concerned with issues of access and participation it became apparent that focusing only on people who were observable at local facilities left important issues relatively unexplored. One of the dominant narratives within the Leisure Centre was that the number of local people using the facility had dwindled since it had opened, but this needed further exploration. Unless I was able to collect data from those who were not present they would remain absent in my account. I came to think of them as the ‘invisible people’ I needed to render visible. Therefore, the decision was taken to generate and collect some quantitative data to test the more qualitative accounts. This led to a survey and negotiating access to user figures from the Leisure Centre archive.

The questionnaire was designed to be concise, clear, and easy to complete and to fit on one side of A4 paper (see appendix 11.7). It included my contact details, the University of Leicester’s logo, explained what the research was for, assured participants of their anonymity and sought their informed consent to use the data. Additionally, aware of lower levels of literacy in Kingsland, I offered to complete the
form with/for participants during collection. Participation was restricted to those of 16 years of age and over. The survey asked for brief personal details (postcode/street name, age, gender) and included questions about health, PA participation and perceptions of accessibility of PA opportunities in Kingsland. The initial aim was to collect a number of completed questionnaires that was comparable to the number of people consulted for the SAZ’s consultation in 2002 (approximately 700). However, after offering to make the findings accessible to the Keep-Fit team for use in their future funding bids I was offered assistance in the collection process in order to increase the sample size. We agreed to target different locations/facilities in Kingsland and approach participants on a one-to-one basis. The target was thus revised to 1500. In the end the Keep-Fit team were only able to collect 58 completed questionnaires at the Health Centre, but my own efforts led to 1210 questionnaires being fully completed and returned. The statistics software SPSS 22 was utilised to input and analyse data.

To assess user figures at the Leisure Centre a large number of questionnaires were collected (614) there. In order to gain a sample representing as far as possible the full range of users, collection took place on seven occasions at various times throughout the day/week. Approximately five-hour shifts took place on three weekday mornings (9:00-14:00) and evenings (16:00-21:00) and a Saturday (12:00-17:00). I stood in and around the Reception area and approached people on a one-to-one basis. The aim was also to access the ‘invisible people’ and so questionnaires were distributed to parents at every local school with accompanying letters of explanation and collected at various local venues and events, e.g., the Health Centre, Sure Start Children’s Centre, library, The Elm, two food banks, a church jumble sale, and a carnival, all in Kingsland (see appendix 11.6 for full breakdown). I collected the vast majority of the questionnaires myself and thus collection turned into a qualitative exercise of sorts. Although generating this relatively large sample was a challenging experience, spending so much time, and meeting so many people, at local locations away from those that I regularly attended frequently informed and extended my sense of place in Kingsland. Meeting local people and collecting questionnaires from them in this way was also a useful,
regular reminder about the deep levels of poverty and the poor health that continue to exist in the neighbourhood.

The GIS software ArcMap 10.2.2 was used to input and transform postcode/street name data into a map illustrating where surveyed Leisure Centre users lived. This enabled me to analyse how well used the Centre was by Kingsland residents and whether the facility could be seen as another example of the inequality paradox by being more readily used by those from more affluent surrounding areas coming into Kingsland. Whilst not asking for specific house numbers and protecting participant’s anonymity, the same postcode/street name returns the same point when plotted on a map. Because this is misleading visually, the decision was made to produce a proportional symbol map which represents multiples of the same point with symbols that increase incrementally in size. Even to perform this relatively simple function of the software, a significant period of training was required.

Schipperijn et al (2013: 127) describe a ‘spatial turn’ occurring in the sciences around the beginning of the twenty-first century accompanied by a ‘rediscovery of the power of maps’. These authors attribute this to the development of GIS software, which they argue is now a ‘central tool’ (Schipperijn et al, 2013: 140) for representing the spatiality of data and their context in any analysis into the health of neighbourhoods - particularly those focusing on social deprivation and inequalities. Using GIS software to utilise cartography greatly assisted the effective representation of significant findings from this research and allowed data uncommon in ethnographies to be integrated into my overall analysis.

**Creating a Narrative: Writing-Up**

Finally, a brief acknowledgement of the subjective and selective nature of ‘writing-up’ is called for. The interpretation and representation of observed and measured phenomena are always subject to human processes. Rather than leave these unacknowledged in the naïve hope of convincing others of our ‘immaculate perception’, Coffey (1999: 127) contends that ‘writing in the self can be a strategy for a
more reflexive practice’. I have done this throughout this chapter but it is essential to extend it as far as the act of writing itself.

For Van Maanen (1988: 8), ethnographers ‘tell tales from the field’ and must recognise that ‘writing is something writers do, and it stands at least one-off from what is written about.’ His point is not primarily about the accuracy of ethnographic accounts but the need to recognise our role in the construction of ethnographic narratives, offering some justifications along the way for how we arrived at them. Given the freedoms of someone conducting explorative qualitative research there is some significance in the decisions they make and how they choose to present their account. I could have written at least two theses with the options available to me by the volume of data and identified analytic themes at my disposal. It would be inaccurate of me to write that I constructed this narrative because it seemed the most logical and it simply ‘felt right’. It did not. As I identified so many analytical themes, some accounts that seemed essential to me because I lived this experience had to be left out. Therefore, irrespective of the astuteness or otherwise of my decisions, writing-up was always going to be an uncomfortable exercise in compromise.

Theoretical decisions were also less than straightforward. As well as generating theoretical concepts from the data collected, existing social theory was drawn upon throughout this analysis. The inductive and explorative nature of the study lent itself to the use of various theorists and traditions. These are comprehensively presented in chapters two and three but, briefly, are chiefly the work of Michel Foucault and subsequent scholars who have applied his analysis to contemporary health and illness issues, Nikolas Rose’s extensions of Foucauldian theory in application to advanced liberal societies, Robert Crawford’s ‘healthism’ critique, social epidemiology and geography, and critical scholars of obesity.

This is an approach that fits in more broadly with cultural studies as outlined by Stuart Hall (1993). Although there are arguments against using concepts deriving from theories with differing ontological and epistemological assumptions, Hall (1993: 37) argues that, although it might be fraught, this is a useful and worthwhile endeavour – one he described as being akin to ‘wrestling with the angels’. Hall (1993: 37) used this
term rather ambiguously but he did suggest that ‘the only theory worth having is that which you have to fight off, not that which you speak with profound fluency’. Therefore, in grappling to understand and explain the observed phenomena, concepts were chosen on the basis of their ‘fit’ with the data, rather than any overarching theoretical doctrine guiding the selection and framing what was observed.

Throughout the writing process I certainly related to Kleinman and Copp’s (1993) description of disturbing images of future audiences looming before the researcher while writing up. What I have attempted to do is, first and foremost, write an account that addresses the issues I felt were most pertinent in my analysis, but that also demonstrates the scope of the project and reads, by anyone other than myself, as if nothing is ‘missing’. Paradoxically, this could only be achieved by excluding some experiences and accounts. This calls for some explanation as to why I made certain decisions which ultimately meant that some events and voices were rendered ‘invisible’ in my final account.

With vast amounts of data collected it was necessary to be selective in their representation. The omission of certain analyses of data and the stories that they told was not one of convenience but of coherency. For example, as previously stated, Kingsland was seen as a ‘white’ estate within a very ethnically diverse city. Perhaps predictably, this environment meant that I collected data relating to race and ethnicity – a significant area for those researching inequalities. However, my main concern was issues of equity and inclusion within a broader, socio-economic context. The analytical themes I considered most apparent, and the data which best represented them, were given primacy in order to achieve the aim of using my observations from Kingsland to develop and advance knowledge of the ways in which health policy responds to and impacts socio-economic inequality. While I acknowledge that the omitted observations and analysis have a specific importance and sociological significance, achieving the overarching objectives of the current account necessitated the inclusion of others at the cost of their exclusion.

4 That will be given primacy and explored in future publications.
What is included creates a narrative that illustrates the significance and effects of political ideology and social policy throughout the spectrum of macro and micro levels of society. This is filtered through a primary concern with health, place and inequality and the relationships between them that accounts for health disparities. Therefore, the following chapters take the reader from the structural influences impacting on organisations and interventions to how these come to affect personal embodied experience. All of the events and interactions included occurred in Kingsland and have been mediated through myself adopting the role, I hope, of diligent ethnographer.
Chapter Six

Stated Ambition and Everyday Reality

The Waning Influence of the Past and the Residual Effects of Interventions

Introduction

In this chapter data from local policy and evaluative documents are paired with ethnographic observations to assess whether the ABIs implemented in Kingsland had achieved their stated aims. It is common practice for ABIs to consult the local community in order to establish what interventions would most improve the lives of local residents. The situation in Kingsland was no different. The initial plans which emanated from this consultation will be retrospectively analysed and compared to the current, post-initiative, situation in Kingsland. This facilitates an evaluation of what the ambitions were for particular interventions and how far these ambitions can be considered to have been achieved.

The discussion then moves on to consider what the implications are for local residents now that these ABIs have, at least partially, transformed their neighbourhood into what I conceptualise as a ‘bio-sphere of risk-aversion’ (see also chapter three). Specifically, attention turns to assessing how far the implemented ABIs can be considered to have created conditions which now offer Kingsland residents realistic opportunities to comply with the neoliberal construction of ‘healthy’ living. The possibility that interventions had paradoxical effects on local health and social inclusion is also explored. Findings are used to argue that in Kingsland there was a ‘waning influence of the past’ which led to some useful interventions ultimately having a ‘residual effect’ which, rather than facilitating PA participation, further marginalised Kingsland residents.
A ‘New (Health) Deal’ for Kingsland?

As already discussed in chapter five, during this study a number of relevant documents shed light on what the initiatives in Kingsland were attempting to achieve. As would be expected, an early document from the NDC project was forthright in acknowledging the central role that the community should have in shaping the agenda, stating that, ‘all projects will develop from what the people of Kingsland feel is important to them’ (NHS, 2001: 1-2). It went on to stress the need for local people to ‘be involved at every stage of the process, from identifying issues through to delivery’. The SAZ’s needs assessment and action plan, compiled from information gleaned from community consultation, can be seen to honour this commitment in stating that the ‘main principle behind the NAAP is that it should be community driven’ (KSAZ, 2002: 5). It was clear from the outset that these ABIs were at least to be community-centred.

The NDC and SAZ implementation teams worked in partnership to achieve joint goals. The community may have played a central role in guiding the actions of these initiatives, but it was also clearly recognised that change would require significant intervention:

*Promoting positive health is a process of enabling people to increase control over, and to improve their health. This process requires investment in people and their environment in order to maximise health opportunities.* (NHS, 2001: 7)

The same document described health as being ‘a shared responsibility between the Kingsland community and agencies’ (NHS, 2001: 8). Rather than adopting the dominant discourse of individual responsibility from new public health promotion there was an evident appreciation here that structural influences also impaired local people’s health. Specifically, SAZ documents acknowledge that ‘the roots of ill health can be traced to social and economic factors, such as income, education and employment, as well as to environment, lifestyle and access to services’ (KSAZ, 2002: 58). This makes it clear that those implementing the initiatives were sensitive to the limitations of adopting an individualistic approach to health promotion in this deprived neighbourhood.
Of course, Rose (1996) and others (Crawshaw et al, 2004) have argued that the implied centrality of the community for identifying local health issues and the necessity to involve them in the delivery of solutions implicitly ‘de-collectivises’ social issues. However, the explicit message in these documents was very much that local people needed to be supported economically, ecologically and socially if their situations were to be improved. Therefore, what becomes significant when attempting to assess the impact these ABIs have had, is outlining what the local community identified as their barriers to better health and what those implementing policy did in order to address these barriers. A comparison can then be made with the situation I found in Kingsland in 2012-13 a little over a decade after these barriers were originally identified, at the turn of the 21st century.

The SAZ consulted approximately 5% of the local population in a survey which was mindful of the high-levels of illiteracy in Kingsland. The majority of those consulted were physically active either through sport, fitness or via less formal pursuits like street games. What was fairly revelatory, however, due to a perception that local people had a reluctance to take part in any activity other than football, was that ‘the majority of people who play no or little sport would like to play more sport but there are a range of barriers which are stopping them from getting involved’ (KSAZ, 2002: 23). Twelve, main barriers to participation were identified which can be summarised as: having young/large families; cost; no transport; lack of local facilities and activities; personal incapacity (e.g., health issues/disability; age; body size; gender stereotypes); lack of information; work commitments; and territorial issues relating to a historical rivalry between north and south Kingsland.

A number of proposals for overcoming these barriers were derived from the community-consultation and they included: setting up a local and affordable crèche; putting on cheap and free activities locally (with concession rates for families and people receiving social benefits); building and improving local facilities that are accessible throughout the day/week; and making activities available that are sensitive to specific needs, e.g., low-impact on muscles/joints, women only, ‘big’ people classes. At the time of the consultation, part of the wider regeneration of the area through the NDC project had meant that a new Local Authority run Leisure Centre was to be built.
in Kingsland. This facility was considered to be, ‘really important for the development of sport in Kingsland. Lots of residents want to use the Leisure Centre.’ (KSAZ, 2002: 45).

Recognition of the Leisure Centre’s central importance in helping local residents overcome the ‘significant barriers’ to PA participation identified in the consultation was obvious in the original Strategic Development Plan (Local Authority, 2002a) and Business Plan (Local Authority, 2002b) for the facility. The Centre was described as a ‘catalyst’ for the regeneration of the area that was to, ‘ensure that issues around social inclusion and equalities are addressed so that everyone has the opportunity to access the facilities and that the local community benefits from the activity generated on the site’ (Local Authority, 2002a: 1-2). Both documents confirm that the identified barriers would be addressed in a number of ways. Specifically, a commitment was made to: offer local residents concessionary admission rates; incorporate an affordable crèche in the building; and offer a range of activities that were ‘diverse and are easy to access, enjoyable, challenging, exciting to take part in and that reflect the needs of the Kingsland community’ (Local Authority, 2002a: 43).

It is against these criteria that the success of the facility will be judged in this chapter. It is important to acknowledge that there were many more needs identified, and that other projects were initiated to address them, but the Leisure Centre can be considered the highest profile and most significant local investment and is thus an interesting case-study worthy of focused attention.

A Sense of Ownership

An awareness of the existence of rather pessimistic local perceptions about the proposed new Leisure Centre and what difference it would make to the local community was evident in the consultation work. This is most obviously demonstrated by the following extract: ‘it is important that residents have a sense of ownership for the Leisure Centre. There is a concern that it will be used mainly by people living outside the area and by middle class people’ (KSAZ, 2002: 47). These concerns
expressed by local residents are telling and were obviously recognised by John, a Senior Manager at the City Council, who was head of sport and leisure services across the city and involved in the original project that involved building the Leisure Centre in Kingsland. In interview he said:

*The people of Kingsland, it’s fair to say, had no trust in the Council whatsoever and they envisaged us building a massive, monolith of a facility that people from Kingsland wouldn’t be able to afford to go to and people from outside the area would just drive into and just drive out of again and that wasn’t what we wanted to try to achieve but you had to spend a lot of time convincing hearts and minds that that wasn’t what we wanted to achieve.*

At once, this dominant local perception demonstrates the sense of isolation experienced by local residents and it reinforced a notion of ‘us’ and ‘them’ between the outsiders (‘haves’) and the insiders (‘have nots’). Although the potential of social class to act as a unifying identifier in late-modern societies has long been questioned (Savage, 2007), it was clear that there was at least some sense of existing collective identity in North Kingsland, shaped along the lines of class, family and locality, and that this was informed and shaped in part by an enduring shared sense of social exclusion.

Numerous people spoke about their initial fears that this local discontent would lead to the new facility being vandalised. These fears were substantiated by the most significant local sports facility previously, a boxing hall/gym, having been burnt down by a disillusioned resident. The threat of violence was not as evident in the NAAP (KSAZ, 2002: 14). Instead it highlighted findings from (unreferenced) surveys that supported the potential for local scepticism to be realised because high-SES groups were shown to face fewer personal, social and environmental barriers to participation and thus they tended to be more physically active than people living in deprived areas. The message was clear:

*The Leisure Centre in Kingsland must be run differently and must cater for its local catchment area otherwise it will be seen as another failure by the Local Authority to provide for its most deprived community (KSAZ, 2002: 47).*
Clearly, it was widely recognised by those implementing the ABIs in Kingsland that this neighbourhood was home to a socially excluded, and perhaps potentially destructive community, that needed to be engaged with, and that these regenerative initiatives were an opportunity to significantly improve the lives of local residents. There also appeared to be a commitment to ensuring this intervention did not have the paradoxical effects associated with other health interventions which end up disproportionately benefiting higher-SES groups (Frohlich and Potvin, 2008; Lorenc and Oliver, 2014). The Leisure Centre came to be understood as a pivotal expression of the success or failure of efforts to provide Kingsland residents with the sorts of opportunities of which they had long been deprived. For instance, the consultation had found that the activity that most residents wanted to participate in, but at the time could not do so locally, was swimming. Now, a modern local swimming pool would be available.

These early documents clearly state that the Centre was to work with other agencies, e.g., the NDC and SAZ teams, in order to have the widest and most significant social impact within Kingsland as possible. How was this to be achieved? It was widely known that £1 million of the NDC regeneration grant was used to contribute towards the costs of building the facility and consequently local people were promised concessionary rates for a minimum of 15 years. This addressed the cost barrier. People in the area were now also within walking distance of a PA facility. This addressed the transport barrier. An onsite crèche provided childcare services. This addressed the childcare barrier. If we combine the removal of these barriers with the reported enthusiasm of local residents to use the Centre and participate in PA, it would seem that everything was in place for the facility to be well used by Kingsland residents and thus it should significantly increase local PA participation. Therefore, the proclamation in the NAAP (KSAZ, 2002: 48) that the role of the Leisure Centre ‘cannot be underestimated in terms of improving the health of the community’ can be read as one expectant of a better future for local people.

In these early local documents, there is a clear appreciation of the need to approach interventions differently in order to ensure that Kingsland residents are prioritised. This approach can be seen as an attempt to protect against repeating the ‘inequality
paradox’ (Frohlich and Potvin, 2008: 216) which, as previously discussed, describes how health interventions can exacerbate health disparities. This would occur in Kingsland if residents were excluded from the new Centre while it remained readily available to people from higher-SES groups whose participation would thus be liable to widen the health gap between these groups. My fieldwork in Kingsland was aimed to find out how far this prioritisation had been achieved and to understand how relationships between the Centre and local people had developed over time.

The ‘Passing of Time’ and Ambitions?

Fieldwork commenced approximately eight years after Kingsland Leisure Centre had opened. The more immersed I became in the field the more evident it became that the Centre was not actually well used by North Kingsland residents; nor was it experienced locally as a place ‘owned’ by the community at large. Echoing fears expressed in the earlier consultation, the Centre I encountered in 2012-13 was a place widely understood as being ‘for them’ – outside users - albeit with some concessions. However, there was a consistent narrative among local people and Centre staff of how things ‘used to be better’ in reference to how, in its early years after opening, the Centre catered well for local needs and, as a consequence, drew in greater numbers of residents from North Kingsland. Tom, for example, had grown up on the northern estate and, after getting his job through a recruitment strategy that prioritised employing local people, had worked at the Centre since it opened. He explained why he felt there were now fewer local residents using the Centre:

I’ve been here since day one, do all the memberships, and the majority of the people coming in aren’t from Kingsland...It’s dwindled down every year and that’s probably because of barriers like cost and the crèche being taken away. The bus that used to come in here don’t come in here no more. So you know I’ve just gave you three barriers why the local Kingsland people are not using the facility and the whole point was for them to use the facility.

So you’ve just took three things away and not gave them nothing back so now, let’s say, the people that come here, probably 15% of them, are from Kingsland...The people that live outside of Kingsland, who have probably got a bit more money, well they’re seeing it as a bonus because it’s cheaper for them. They’re going to take advantage of us now. (Tom, Gym Instructor)
Though his position at the Leisure Centre meant that Tom was more informed than many, his account chimes with the dominant narrative among local people who had lived or worked in the area long enough to recall early promises. Tom’s comments are essentially a lay account of the everyday experience of the inequality paradox. He explains this phenomenon as a result of the resurrection of barriers that had initially been broken down through the implementation of policies mindful of the significant social constraints many local people experienced.

Of course, there is a tendency for people to compare the past positively to the present as the passing of time can weaken the memory of pain and struggle or at least allow for it to be viewed through a nostalgic, rosy hue. However, the quantitative and qualitative evidence collected during the ethnography supports this narrative of increasing local exclusion. In what follows, firstly, quantitative data will be used to demonstrate that numbers of local users have decreased over time and that local residents now make up a comparatively small percentage of daily users. Once this has been established qualitative observations and accounts will be drawn on to provide possible explanations for this shortfall.

A 2008 evaluation of the SAZ project found that although the Centre had removed a number of barriers and this had increased local PA participation, the use of the Centre by Kingsland residents was indeed declining. The Centre opened in 2004 and the evaluation compared use figures from 2005-2006 to 2006-2007. Initially, 69% of all Centre users were from Kingsland but just a year later this had dropped to 43%. Obtaining similar use figures to assess the current situation proved challenging. Despite this, I was able to obtain the admission figures for the targeted Kingsland residents from the first year the Leisure Centre was open (2004-2005) to the most recent full year (2012-2013) and a few years in between. The following figures represent the number of times residents used the Centre (i.e., 1 is equal to one visit not 1 person).
Table 6.0: Visits to Kingsland Leisure Centre by Residents Targeted by ABIs

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Entries</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004-2005</td>
<td>14,648</td>
</tr>
<tr>
<td>2008-2009</td>
<td>10,629</td>
</tr>
<tr>
<td>2009-2010</td>
<td>11,822</td>
</tr>
<tr>
<td>2010-2011</td>
<td>10,804</td>
</tr>
<tr>
<td>2012-2013</td>
<td>9,500</td>
</tr>
</tbody>
</table>

These figures show a reduction of just over one third (35.14%) of local use over an eight-year period. These findings are supported by a basic questionnaire survey conducted for this project in 2013. In total 520 questionnaires were completed by users of the Centre. Of these, only 61 (13.3%) of those surveyed came from the originally targeted SAZ area and were thus from people eligible for the concessionary rate. Notably, this figure is remarkably close to Tom’s (15%) estimation, suggesting some accuracy in both accounts. The questionnaire asked participants for their home postcode or street-name. These data were subsequently mapped using GIS software ArcMap 10.2.2 to produce a proportional symbol map indicating where users lived (see Figure 6.1 overleaf).
Figure 6.1: Mapping the Postcodes of Kingsland Leisure Centre Users
The findings support initial concerns expressed by local residents in the consultation work, and the subsequent commonly expressed perception that, instead of attracting Kingsland residents, the Leisure Centre would be more frequently used by, and thus be of greater benefit to, people who lived in the more affluent surrounding areas. The quantitative evidence and the map indicate that the Centre is more frequently used by people from these areas compared to Kingsland residents despite residents’ entry fees being subsidised. Therefore, these people would appear to derive greater benefits from the presence of the Centre than those who live in the originally targeted SAZ area. And, this process of colonisation of the Centre has ostensibly taken place gradually but inexorably since the Centre opened in 2004.

It is reasonable to deduce from this that the Leisure Centre in Kingsland provides another example of an intervention which reproduces the inequality paradox. It is thus likely to contribute to the sort of ‘equity harms’ that Lorenc and Oliver (2014: 289) have described. However, why, when initial documents clearly flagged up that policy implementers were aware of, and intent on resolving, the potential for this to happen has this situation eventually been reached? Was it inevitable, despite the efforts made as part of the ABIs and those implementing policy, due to the local demographic they were attempting to engage? Such questions necessitate a return to the barriers that Tom, quoted above, argued had been resurrected since the Centre first opened.

**Still Accessible?**

The initial consultation work for the Leisure Centre identified the necessity of providing on-site childcare facilities. The Strategic Development Plan for the Leisure Centre stated that if the facility was to achieve its objective of ensuring that participation in sport and PA was within the financial reach of all groups in the community, it would need to provide crèche facilities at a nominal charge (initially £0.30). The message was clear.

Originally the childcare facility accommodated a daytime nursery and a sessional crèche. Eight years on and the sessional crèche facility was no longer available. In a
citywide cost-saving strategy, between 2010-2011 the Council closed the childcare facilities at all of its sport and leisure sites. In the case of Kingsland Leisure Centre the childcare facilities were subsequently rented to a private-firm who used the space to run a nursery: the sessional crèche service was no longer offered. These on-site childcare facilities are now merely incidental, as they do not provide the sort of sessional service that could facilitate local (particularly single) parents using the Centre.

The closure of the crèche was described by many people as pivotal to the Centre’s capacity to offer accessible activity opportunities to North Kingsland residents. Those involved in organising local initiatives for the SAZ with the aim of engaging local residents to increase their PA participation levels, argued that the crèche closure had made the services at the Centre less accessible and consequently that participation rates had significantly fallen. Exercise class instructors, in particular those involved in these SAZ initiatives, spoke about how their class numbers had significantly decreased once the sessional childcare service was no longer provided.

The question of cost was another significant feature of local narratives about why local residents now used the Centre less frequently and how ‘things used to be better’. Understandably, cost was one of the most referenced barriers in the SAZ consultation, both for those who were currently physically active and those who said they would like to do more PA. The 15-year subsidy commitment to local residents made them eligible for a concessionary rate of 25% of the full admission price. People eligible for social benefits (e.g., the unemployed, single parents, pensioners) were to receive a 50% concessionary rate and if they were also from North Kingsland this would be added to their 25% concession - meaning that they would pay 75% less than the standard price.

Although these concessions have generally been honoured, the most significant price increases have been for those receiving the most substantial subsidies. When compared to prices set out in the Centre’s original business plan (Local Authority, 2002: 48), those who were previously eligible for a 75% concession are now, in some cases, paying more than double what they used to. Price increases have been less
steep for other users. Those originally eligible for a 25% discount are actually now relatively better off. Admission fees for the pool and gym are provided in the table below as examples.

Table 6.2: Kingsland Leisure Centre Prices 2003-2004 and 2012-2013

<table>
<thead>
<tr>
<th>Year</th>
<th>Standard Price</th>
<th>Kingsland Resident</th>
<th>Resident Receiving Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003-2004</td>
<td>£2.85</td>
<td>£2.20</td>
<td>£0.75</td>
</tr>
<tr>
<td>2012-2013</td>
<td>£3.70</td>
<td>£2.30</td>
<td>£1.60</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year</th>
<th>Standard Price</th>
<th>Kingsland Resident</th>
<th>Resident Receiving Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003-2004</td>
<td>£4.00</td>
<td>£3.00</td>
<td>£1.00</td>
</tr>
<tr>
<td>2012-2013</td>
<td>£5.50</td>
<td>£3.00</td>
<td>£1.50</td>
</tr>
</tbody>
</table>

Therefore, those who could be considered the most ‘hard-to-reach’ residents in Kingsland, and the most susceptible to increases in price, are now paying significantly more than they were previously. From this evidence, other local residents appear to have been almost unaffected by the price increases. This provides another example of how interventions can exacerbate inequitable access to health promoting/protecting services.

Cost has been shown to be a significant barrier to PA participation and Taylor et al (2011: 138) have described concessionary rates in areas such as Kingsland as being ‘inelastic’. This suggests that any increase in these rates is likely to have a detrimental effect on local participation. The drop in attendance figures in Kingsland support this contention. Nevertheless, it is clear from my observations that the significance of
these price increases needs to be considered alongside the decline in cheap and free local activities initially set up as part of the SAZ project.

Kingsland Leisure Centre initially hosted numerous SAZ initiatives that attempted to address the multiple, not merely financial, barriers that had been identified, e.g., one-to-one mentoring, weight-loss groups, youth activities. A local resident and youth worker, Cary, who was part of a, no longer funded, NDC initiative for young people now run by volunteers, was one of many people who expressed their frustration at the way the Centre is now run. Cary said:

_The Leisure Centre doesn’t run any different from any other place like that in the city; it’s just trying to make money. They’re not worried about getting people from here [North Kingsland] to use it...I’ve tried to book things for us [Youth Centre] actually but their prices are out of our price range...It’s definitely not as cheap as it used to be. That’s because you had the NDC putting in like, say, a million pounds and for that money they said ‘We’ll give you it cheap for a certain amount of time’ but after that it doesn’t go on so things like that just stop._

(Fieldnotes: 8/10/2012)

Cary’s comments can be read as an indictment of the Centre: another failure by the Local Authority to provide adequately for one of its most deprived communities, even though, the original consultation work had warned that the Centre needed to be ‘run differently’. Meeting these needs was never solely about financial accessibility as it was recognised that supplementary initiatives were required to engage local residents and assist them to overcome the multiple barriers that vulnerable populations living in deprived areas face. Being ‘run differently’ can at least in part be read as ensuring that partnership working with local initiatives was sustained, despite financial pressures to increase revenue.

Prioritising financial goals over social ones has led to fewer partnerships between the Leisure Centre, local initiatives and the residents that they serve. For example, a breakdown in relations led to only one of the original three weight-loss groups still meeting at the Centre. These initiatives engaged with local residents and increased their access to the Leisure Centre but also to PA more generally. As local initiatives disappear and partnerships break down, a reduction in local admissions to the Centre
is predictable even without increased admission fees and the loss of the crèche facility. Focusing on barriers that have been resurrected at the Leisure Centre, e.g., cost and childcare, can deflect attention away from the wider reduction in public services in the area and offered at the Centre, e.g., mentoring schemes and subsidised activities. The demise of the majority of these local initiatives is a significant factor in explaining why fewer local residents now use the Centre and can be argued to have exacerbated the decline in local attendance.

Although all of these factors have a significant contributory effect, the reduction in local usage cannot be explained by highlighting any one single issue. All of these factors can be seen to have negatively impacted on local residents’ accessibility to the Leisure Centre and PA opportunities more generally. They constitute a general trend that is more significant than the sum of its parts. These issues reflect a broader shift in the organisational objectives of local service providers that incorporates both financial and non-financial factors and helps explain the resurrection of barriers North Kingsland residents faced before the regeneration interventions. This shift is conceptualised here as the ‘waning influence of the past’.

The Waning Influence of the Past

It must be recognised that the reduction in targeted service provision in North Kingsland can be understood as predominantly arising from increased financial pressures bearing on local service providers. As NDC and SAZ funding became scarcer the influence of an initially explicit ‘socially-conscious’ approach, sensitive to the multiple barriers identified by Kingsland residents as being between them and ‘healthy’ living, diminished. This was evident from the reflections of John, Head of Sport and Leisure Services at the City Council, on changes in the accessibility of the Centre for local residents in harder economic times today. Other issues apart from local health are now clearly in play:

Doing more often costs more and in the current [economic] climate that’s difficult to do. Really difficult to do. It’s the toughest time I’ve known in 30 odd years...It’s a fine balance in Kingsland because, in terms of the income, for every
Kingsland resident you have you need to spring someone from outside Kingsland to balance the books and it is that fine line. I’d like to see us do more for Kingsland residents but on the other hand I have to consider the sustainability of the Centre and make sure that it still washes its face and that’s a tough social dilemma at times.

Julie, the SAZ project Manager has been involved since the start and still has a significant influence over local PA opportunities. She now manages, Keep-Active, the charity that the SAZ team became once the funding had been spent. She echoed John’s sentiments, but also pointed to competing local priorities:

*If you are only sort of concentrating on one particular area within a city, then there’s going to come a time when they’ll see that that injection of capital or revenue, funding is a higher proportion than other areas. So it’s about looking at ‘Well there is still a need here, there is still a hell of a lot to address here. However, there are other areas.’ So it’s about bringing those other areas in to be able to then sort of look at your vision and write your funding applications.*

Here it is clear that the financial pressures of providing a sustainable service for all can be seen to direct attention away from North Kingsland and its residents. This is of course a complete reversal of the ABI approach. At the Leisure Centre this has recently meant prioritising people from more affluent areas. Meanwhile, other socially deprived areas in the city are now deemed more likely destinations for further funding and thus they direct focus and resources away from Kingsland. These financial pressures led to rising admission fees, the closure of the crèche and fewer local initiatives: all have an accumulative inhibitory effect in Kingsland.

These examples demonstrate how intentions that were clearly outlined in initial consultation and intervention documents have become less influential as political priorities have changed and financial pressures have increased. As such, financial factors have played a key role in diminishing the commitment to the original socially-orientated approach that recognised the need to address local issues associated with deprivation. However, alongside these financial pressures there are other significant factors which have contributed to the overall effect of what I conceptualise as the ‘waning influence of the past’.
It is evident in the initial discourse of Kingsland’s ABIs that there was a commitment to providing interventions that recognised and attempted to address how the socio-economic circumstances and social exclusion associated with living in a deprived area restricts the agency of local residents. As the ABIs were delivered, there was an initial surge in socially-conscientious interventions designed to address these issues. This surge was followed by a prolonged period in which this initial influence waned. The concept of ‘the waning influence of the past’ describes and explains how this initial commitment weakens over time. This is of particular importance here because, ultimately, this process can lead to a reversal of initial intentions and thus the defining impact of deprivation being largely ignored. Consequently, previously implemented interventions can actually facilitate, rather than address, victim blaming (as will be demonstrated with further findings).

These developments are, of course, partly a consequence of the limited nature of ABI funding and the problematic sustainability strategies that community-centred ABIs employ (e.g., relying on volunteers drawn from vulnerable populations or on attracting further funding). The dominant local narrative of how it ‘used to be better’ was consistent both within and outside the walls of the Leisure Centre and to a large extent it was explained by service providers as a consequence of the harsh impact of a more general reduction in financial support for local public services. To this end, this study supports what is a consistent finding in the field. The benefit of ethnographic research, however, is that it can offer a much greater depth of understanding of the emotional, psychological, social and economic impact that quantitative studies can only hint at or assume. In this research there was evidence that this ‘waning influence of the past’ was about more than just reduced financial support and herein lays one of the original contributions to the health policy field which will now be discussed.

**More than Money**

After the ABI’s funding was spent and local initiatives struggled to attract further support to continue their work locally, the financial pressures associated with providing accessible services for ‘hard-to-reach’ groups became more apparent.
However, as we have seen, from the inception of these ABIs there was a recognition that the Leisure Centre needed to be ‘run differently’ in order to accommodate North Kingsland residents. Doing so relies not only on consistent funding, but also on the Centre’s management taking social goals seriously and thus delivering services that are sensitive to issues of accessibility. Financial pressures clearly restrict the capacity to provide these services and this was evident from Karen (Leisure Centre Manager):

\[\text{At the beginning, we had all this money and they would just give it to us when we wanted it. It was like we’d won the lottery. But it’s different now, things have changed and we have to do things differently. (Fieldnotes: 27/7/2012)}\]

Doing things ‘differently’ in this new context meant reducing expenditure and increasing revenue as a matter of urgency. With rising financial pressures from annual budget cuts, it would be logical for management at the Centre to be more reliant on work with other local initiatives to achieve social goals. However, there was an evident reluctance to continue partnership working, given the new financial priorities. This was made clear by Sam, who grew up in Kingsland and initially got involved in local PA provision by volunteering on the SAZ initiative. He is now the Operational Manager of The Elm, a local facility positioned next to the northern estate, and he readily identified the impact of changing times in Kingsland:

\[\text{When the Leisure Centre was first built there were times when, you know, you could do all sorts of stuff in there. You used to be able to play football in there, basketball in there, there was you know a massive influx of young people going there to do the swimming and it was a positive influence for them to be engaged but the Leisure Centre sort of put boundaries up to prevent further people from going in there. They didn’t want football in there so they just, you know, made excuse after excuse and we stopped doing projects there ourselves, because we weren’t able to work with them because of that. Because they would not let us do projects in there. That has a knock on effect with the community that they don’t want to go there. And they feel that there is a barrier stopping them from participating in sports over at that facility.}\]

It is clear from Sam’s comments that after a time there were problems establishing effective local partnerships. But what is also evident in Sam’s account as well as in Cary’s comments previously, is the widespread knowledge about the Leisure Centre
being partly-funded by NDC funds, knowledge that certainly created a sense of expectation and entitlement in the local area. People in Kingsland believed the Leisure Centre was bound by a primary commitment to fulfil the PA needs of local residents. This came across most powerfully in conversation with, Julie (SAZ/Keep-Active Manager). Speaking about the new Local Authority priorities she argued that things had changed in ways which offered little local flexibility for working with residents from deprived areas:

_They [Leisure Centre Management] don’t think about the community over there, they just think about making money. There is time over there when it [Leisure Centre] is empty and if it were me I would think: ‘Well I have to have the lights on and pay the staff so I may as well get people in here’. Obviously they have to make money but they can’t just treat it as a cash cow. It has to be a case of ‘this’ can be a cash cow and ‘this’ can be a cash cow but in this other time I can let people in for free. Obviously there have been cuts and people have to adapt but it should always be accessible to the people who live here; that was the point of it in the first place!_ (Fieldnotes: 11/5/2012)

Julie understood the financial pressures placed on the Leisure Centre but it was clear that she felt these could, and should, be balanced with achieving social goals. This is in line with initial discourses about the Centre and the needs of the local community. Some flexibility could mean pursuing both financial and social goals and the latter need not negatively impact the former. However, this strategy may rely on partnership working, which had evidently broken down over time (discussed in chapter seven).

The prescribed social goals in Kingsland had previously been clearly delineated and, as part of the ABIs, a local steering group involving the relevant service providers regularly met up as part of the effort to achieve these goals. Once the ABIs finished, however, this targeted attention diminished as the group disbanded. This was seen by some to have been a key moment in the shift away from the early philosophy around Centre use. Without the steering group the relevance of social goals has become less clear to the Leisure Centre’s management. For Karen, the Centre Manager, the pressures of attempting to achieve both financial and social goals had produced a very different understanding of what now constituted the ‘social’ goals of the Centre:
I think we do provide for people here and we do get involved with the social side. It’s like with the classes: that lady Janet [Centre User]. She’s clearly not right that woman, she’s got some sort of mental health issues. She told me how wonderful Jen’s Pilates class is and how good it is for her. Now the numbers for that class are shit, but I keep it running because I know if I didn’t she’d kick off and complain and there’d be a whole lot of trouble. She brings me in fuck all in revenue, but I keep that class going to keep her happy. So, we do do the social side of things too.

It’s like with swimming lessons and all the yummy mummies. We could make it so that it’s only those people who come in, but we don’t. We make sure we cater for other people too, but they’re [‘yummy mummies’] not usually members. They come in and pay and they generate a lot of revenue. But, I know I’ve got to keep people happy, I’ve got to keep members happy because I can’t make decisions which are going to cost me loads of £31 a month [membership fee].

These comments further highlight what I have called ‘the waning influence of the past’ and they add weight to Julie’s accusations about local residents no longer being prioritised at the Centre. Karen’s ideas about achieving ‘social’ goals are much more directed and narrow: keeping paying members happy and attracting people who are not facing the accessibility issues that many Kingsland residents do. Her notion of accessibility was more obviously based on equality of opportunity rather than equitable provision – something previously considered a necessity. Lacking the influence of a local steering group and/or close partnerships with local initiatives, Karen’s more limited notion of achieving social goals has led her to approach the initial commitment to Kingsland residents rather differently:

*I don’t actively have to go out there and find them, you know. Also I don’t actively have to go to [local initiative implementers] and say: ‘I need x, y and z groups can you get them in?’ We know what we want to do and I just think that all the barriers were taken down, so I don’t have to coax people in here anymore. We’ve been here 8 years, people have come in, they understand that it’s a friendly and open environment and I don’t think that for us there is an actual need to [make a concerted effort to engage with local residents].*

A previously strong public message about the necessity of ‘supporting’ the local community and effectively ‘targeting’ local residents increasingly either has been de-prioritised, forgotten or ignored. A rhetoric of recognising that the Centre must be ‘run differently’ in order to ensure the social goal of providing accessible PA opportunities
for local residents has given way to a situation where the Centre’s management no longer considers it necessary to do so: the waning influence of the past. The consequences of this waning influence constructs and inform the enduring ‘used to be better’ narrative dominant in the area.

The waning influence of the past goes beyond describing the detrimental impacts that reduced funding has had on health promotion by highlighting the attitudinal and political shifts which also contribute to this process. A collective and social approach to transforming local lives has been transformed into a more individually focused one. Importantly, previous interventions that prioritised creating accessible PA opportunities for local residents but are now no longer in operation or have been diminished contribute to this transformation. This can be seen in Karen’s comments (‘I just think all the barriers were taken down’). This assumption about barrier-free inclusion plays a significant role in the shift from a community-centred approach to a more individually orientated one (‘So I don’t think we need to coax people in here anymore’).

There has been a decline in accessible and engaging services provided locally, but their absence now stands on the foundations of what previously had been provided. The memory or lasting signs of previous interventions facilitate the individualisation of health behaviours which, although predominantly framed as individual responsibilities in wider health promotion, were previously acknowledged in these ABIs to be essentially social issues. As the political significance of the social became less prominent, so the discourse of neoliberalism more strongly came to the fore.

A 2009 evaluation of the Kingsland NDC initiative (Broughton et al, 2009) highlighted that, unlike in other NDC areas, there had been a tailing-off of positive local perceptions about the project and the work that had been done. The report contends that as funding was spent there was an expectation (at the level of policy makers) that there would be diminishing rates of change. However, it would appear that the root of local dissatisfaction might well be less about the lack of continued progress and more about the reduced accessibility of existing interventions for local residents. It is what I
have conceptualised as the waning influence of the past and not the diminishing rates of change that is significant here.

It will be argued that this process can actually lead to ABIs applying the tenets of moral individualism to populations that are particularly vulnerable, given that selection criteria for ABIs tends to be based on levels of deprivation. In the following section I will discuss in more detail how the partial transformation of target areas into what I conceptualise as ‘bio-spheres of risk-aversion’, combined with the ‘residual effect’ of past interventions, can lead to ABIs potentially blaming vulnerable people for their supposed failings, rather than empowering them via community-centred regeneration.

**Bio-spheres of Risk-Aversion and the Residual Effect of Past Interventions**

The ABIs in Kingsland largely removed the transport barrier to PA for many residents by significantly improving local facilities and opportunities. By improving these PA opportunity structures the obesogenic properties of the area were reduced (Ellaway and Macintyre, 2010; Townshend and Lake, 2009). A distinctive outcome of this regeneration policy was the ‘healthification’ of local space. This transformed the physical environment into a largely foreign land in the sense that, contrary to what typically is observed, Kingsland became a deprived area relatively well-served by PA facilities (Hillsdon et al, 2007; Gordon-Larsen et al, 2006). This contradicts the inverse care law which states that the influence of the market leads to services being distributed because of affluence, not need (Tudor Hart, 1971; 2010). Market-driven distribution tends to exacerbate health inequalities supporting the notion that, in capitalist societies, issues of equity are, to a considerable extent, reliant upon State intervention. ABIs can be seen to respond to this need.

Importantly, improvements to aspects of the physical environment in North Kingsland were undertaken in conjunction with offering new services, (e.g., free/subsidised activities, sessional childcare) and establishing local initiatives, (e.g., one-to-one mentoring, school holiday youth schemes, football sessions, and single-sex weight-loss groups) that were sensitive to the restraints of the local social environment. This was
done in order to address some of the other local accessibility issues that went beyond the restrictions of the physical environment. These schemes served the function of making the newly acquired local facilities more accessible to ‘hard-to-reach’ groups. To some extent, then, these initiatives can be understood as conscious attempts to avoid reproducing the inequality paradox phenomenon. This commitment to ensuring that local facilities were accessible to local residents indicates the social approach taken by the Local Authorities implementing these ABIs, in contrast to the dominance of the sort of neoliberal responsibilisation more characteristic of the new public health approach (Petersen and Lupton, 1996).

Increasing the number of PA opportunities in an area alters the ways in which it is possible to define and perceive this place. Rather than being a place where a lack of facilities and services is seen to significantly impair the capacity of local residents to ‘do’ health, the space is transformed, partially at least, into a bio-sphere of risk-aversion. An area can be defined as such if the facilities and services associated with risk-averting, ‘healthy’ behaviours are present. They become places that facilitate people exercising particular bodily operations that are culturally recognised as ‘doing’ health. As such, bio-spheres of risk-aversion are typically associated with affluence, not deprivation and social exclusion. Bio-spheres of risk aversion do not necessarily provide an environment that promotes positive states of health and well-being, but rather they facilitate ‘doing’ health in culturally recognised and morally approved ways. The argument that the cultural exultation and pursuit of rather narrow ‘ways of being’ (made up of specific ‘sensible’ conformity to ‘health behaviours’ focused around diet, PA, body size/shape, smoking and alcohol consumption) may have a detrimental effect on someone’s psychosomatic health is an entirely valid, but separate, matter.

The behavioural justice movement argues against indiscriminately applying the responsibilising discourse of new public health while there is inequitable distribution of wealth and services (Adler and Stewart, 2009). This is because, as has been shown, these structural factors significantly influence people’s capacity to comply with health advice (Drewnowski, 2009; Pickett et al, 2005; Scambler, 2012). However, the ABIs in Kingsland initially transformed parts of the physical and social environment in this deprived area in such a way as to provide significant PA and ‘healthy’ living
opportunities considered to be accessible, even for ‘hard-to-reach’ groups. It thus became a place where ‘doing’ health came to be understood as a possibility even for members of this vulnerable population. As such, this transformation of the physical environment also altered the moral climate of the area. To put it simply, these interventions mobilised the notion that there was now simply ‘no excuse’ to be sedentary and thus lead an ‘unhealthy’ lifestyle.

So in what seems like a paradox, ABIs recognising the social nature of health behaviours by facilitating more equitable accessibility to health services actually heightens the importance of agency and promotes the individual obligation to be autonomous and free (Rose, 1999a). This particularly can be considered to be the case with initiatives that focus on improving physical health because good health visibly displayed on the surface of the body is vital to contemporary conceptions of freedom and identity. This is not something that the behavioural justice movement is particularly critical of as it does not necessarily advocate people not taking responsibility for conforming to culturally exulted understandings of health. Rather, advocates of this approach such as Adler and Stewart (2009) argue that ignoring how social and environmental influences restrict people’s capacity to conform to health norms and thus dividing moral duties equally is tantamount to victim blaming. However, they also argue that if issues of equity and accessibility are considered and catered for, the application of the victim label will be revised.

Such a position aligns with Conrad and Schneider’s (1980) advocacy for the construction of a ‘victim role’ which, unlike the sick role (Parsons, 1951) or health role (Frank, 1991), addresses the issues of both agency and structure by considering the individual to be a victim of their life circumstances. But here the ‘deviant’ behaviours these circumstances are likely to promote are not entirely determined, so people still have a level of accountability for maintaining good health. If socially-conscious interventions provide vulnerable populations with realistic opportunities to ‘do health’ this could go a long way to narrowing the gap in conformity to health behaviours observed between higher- and lower-socioeconomic groups (Buck and Frosini, 2012).
However, creating a bio-sphere of risk-aversion that is accessible to a vulnerable population also promotes the application of neoliberal politics to ‘hard-to-reach’ groups. To use the SAZ slogan, it is seen to help people help themselves. Of course, this simplifies the complex and deeply ingrained nature of inequality and poverty, but this is how ABIs function as bio-political devices. How this phenomenon was manifest in North Kingsland gives considerable insight into the dominance of neoliberal discourse and how it operates in local settings.

As might be expected, economic factors played a crucial role here. The budget of the Leisure Centre, and subsequent income aims, were subject to annual reductions and increases, respectively. The financial pressures were evident in the day-to-day running of the Centre. This covers the well-documented and perhaps expected features – e.g., increased admission fees, crèche closure, staff redundancies, casual contracts, the necessity of operating with a skeleton staff, attempting to reduce fuel bills by investing in energy saving measures,– to the seemingly desperate elements – e.g., the constant need for building maintenance leading to the adoption of emergency ‘in-house’ measures such as the life-guard’s perpetual task of fixing broken pool tiles using putty that would quickly erode when in contact with chlorine, and an assistant manager’s futile attempts to repair a giant inflatable ‘sea-monster’ with a tube of superglue.

Similarly, as NDC and SAZ funding ran out the sports development charity that it had established - Keep-Fit - was required to broaden its focus as it struggled to attract funds for projects that would only serve the local area. These financial pressures led to local accessibility falling down the policy agenda and, ultimately, to the reappearance of barriers that previous interventions had attempted to address. Perhaps as a means of defence, those who managed the Leisure Centre spoke about what had been achieved in the past as if this was still the case in the present. This now meant emphasising the role of personal choice as a way of explaining local residents’ (non-)participation. The following illuminating comments come from John, Head of Sport and Leisure Services at the City Council. On what had been done to ensure that the Centre remained accessible to local residents:

*When people ask you what are the barriers to participating in sport they will tell you cost, transport, childcare, time. Not much I can do about time, but we put in...*
the nursery for the childcare. We had a bus stop right outside the Leisure Centre. Part of the deal with the [NDC] was that Kingsland residents would get a discount on entry fees...We got rid of potentially three barriers. I think when you get rid of those barriers you come up with people’s real barriers: the water’s too cold, I don’t like the changing rooms, I feel embarrassed about my body, I don’t want to go around with wet hair for the rest of the day. You know the real reasons why sometimes people don’t do it and so we’ve tried very much to get rid of as many barriers as we could...It’s there for people if they want it. Hopefully, they can afford it and if they can’t there is free stuff going on, which they can afford. I still go back to that thing about time; people just don’t seem to be able to find the time.

What John implies here is that, everything had been done to ensure the Centre is accessible and it is factors out of Local Authority control that are the issue now. John talks as if initial policies are still in place and of the key role that ‘choice’ now plays in local participation. In this sense his words most powerfully demonstrate the waning influence of the past and the ‘residual effect’ these interventions carry into the present.

The ‘choice’ he proposes that Kingsland residents are making is in turning down the opportunity to attend a facility that has ‘removed’ the barriers to participation identified in initial consultation work: the Centre is accessible to them, they are just not making the time to attend. John articulates a level of a continued commitment to accessibility which, although it may have been evident in the past, is no longer so in the present case. Referring to past interventions in this way facilitates the use of the rhetoric of choice for a vulnerable population. This is what I am conceptualising as the ‘residual effect’ of past interventions which was a consistent finding during fieldwork. It was never more evident than in discussion with Karen, the Leisure Centre Manager. The following comments were typical:

I think it’s their own choice now, that’s the barrier. And that might sound really controversial but I believe it’s a lifestyle choice now. Every barrier that we’ve thought about has been addressed. You know, the cost, the transport, the childcare, the mentoring. We’re part of [this initiative], we’re [that initiative]: we’re everything. I believe now it’s about choice because I don’t believe this estate is as poor as it was...I don’t believe that it’s unattainable to get here now, no matter [where] you’re from...I believe that you can have access to this should you choose to.
Karen’s comments powerfully illustrate the residual effect of past interventions. She uses examples of interventions that have long since been downgraded or stopped entirely to ‘demonstrate’ that the Centre is accessible to all. This facilitates her framing of the issue of local participation within the discourse of neoliberalism. Essentially, local residents are being accused of not taking advantage of opportunities that are not actually there. This residual effect also evidently informed the perceptions that people living in and around North Kingsland had of each other. The childcare services are a good example of how this was manifested locally.

Despite no longer fostering the accessibility of the Centre, the childcare facilities still had a prominent physical presence in the building. One of the nursery’s walls was glass and looked out into the main communal area in the Centre. During the daytime, behind the glass was a busy scene of infants at play that most people would pass as they used the Centre. This daily experience prompted some local people to talk about a ‘missed opportunity’ and, again, to rehearse the narrative of how things ‘used to be better’. However, it also ‘confirmed’ for others that the Centre still had a drop-in crèche. The following field-note from an evening weight-loss session describes a typical encounter:

*Sunita says: “That’s the thing with the classes, I can’t do mornings. A lot of the classes are during the day and I can only come in the evening because my husband looks after our baby… I used to go to lots of classes before, but then you have a baby and your life changes and you have to change too. But I miss going to things like Zumba and Body Combat.” One of the women in the class responds saying: “Well just put your child in the crèche, they have a crèche here” and Sunita replies “No they don’t, it’s a nursery. It would be great if it was a crèche, but it’s not”. (Fieldnotes: 2/7/2012)*

Despite this service no longer being available, the memory of past efforts to remove barriers stays in the minds of those who do not rely on the service themselves. This residual effect can lead to those who continue to face barriers being recast as people who are abjectly failing to ‘help themselves’. Interventions that had once implicitly recognised and explicitly addressed the limits of applying standards of moral individualism to residents living in this deprived area are now being used to apply the very same discourse to this vulnerable population. In this sense this vulnerable
population are triply, rather than doubly, disadvantaged. On top of being socially disadvantaged and individually marginalised, socially-conscious interventions that could potentially help vulnerable populations are comprehensively failing to do so and are then being used to frame non-participation as unwillingness on the part of people in ‘hard-to-reach’ groups to help themselves.

Another way in which the residual effect of these ABIs disadvantaged local residents was the nature of local funding and the detrimental effect a sharp injection of funds appears to have on the possibility of attracting further funding for local initiatives. Many local service providers questioned the logic of stipulating in the NDC policy that funding had to be spent within a set ten year period (2000-2010). This encourages investment in infrastructure but makes it more difficult to sustain accessibility to these services for local residents. The commonly expressed preference was to have been able to stretch the funding out further in order to bring greater longevity to the supplementary, but essential, interventions that addressed local needs.

The perception of local charity workers was that funding bodies were reluctant to invest more money into an area that had already received such a significant investment. This led to local service providers directing their attention and services elsewhere in order to attract funds to continue their work. This is summed up well by Matt, Manager of the Public Health service for the city FIT-FRIENDS, who was previously part of the SAZ team that established many of the local initiatives specifically tasked with increasing local PA participation:

_There was a difference way back when the NAAP was done with the New Deal funding that was available. In terms of the team, there was multiple projects, you know there was a strong focus on Kingsland. And so I do think that it has perhaps dropped off. But I think that’s all to do with the nature of how much funding was available at the time. I think in terms of what’s been left is an infrastructure that, you know, allows for increased participation._

Questioned about the accessibility of the infrastructure that had been left, Matt too fell into using evidence of previous interventions (building local facilities) to apply the rhetoric of choice to local people today:
I kind of see it in two ways really. Again it comes down to choice and what you spend your money on in some ways. I think obviously with the new benefit changes, you know the bedroom tax and all the stuff that’s come in, I think it has made people reassess what they spend their money on and we’re starting to see some of the impact of that. And I think there’s probably less people that think that four pounds fifty [to exercise at the Centre] is affordable. My other question is, you’ll spend eight pounds, nine pounds on a packet of cigarettes? You could have had two gym sessions for that and again it comes down to choice. So it works in both ways I think.

Although he recognises that some residents will consider using the Centre as outside of their means, Matt’s assertion that something like buying cigarettes or going to the gym is essentially a choice that North Kingsland residents are (wrongly) making frames these matters as individual rather than social issues. Research has consistently shown that behaviours that are considered detrimental to health are commonly socially accepted and expected within vulnerable populations and are often used as coping strategies to deal with the social consequences of inequality (Pampel et al, 2010). As such, smoking or going to the gym can be considered as social rather than, solely individual issues of choice. This was clearly outlined in the initial consultation work – work that Matt was himself involved in. Despite his familiarity with the area, and the social issues associated with living in a place like North Kingsland, Matt’s comments demonstrate above all his willingness to bring the individual to the fore as to him neoliberal ‘codes of sensibleness’ (Herrick, 2011: 5) seemed to be common-sense. The mere presence of the Leisure Centre facilitates the application of a healthist discourse to this vulnerable population. Again, this demonstrates how past efforts to reduce barriers to PA, have a residual, detrimental effect on present residents by facilitating the application of a ‘moral repertoire of “shoulds’” (Fullagar, 2002: 78) to this vulnerable population.

Previous interventions have a residual effect in the present by being used in the construction of a façade of accessibility as part of a bio-sphere of risk-aversion. The mere presence of the Leisure Centre and the perception that it is accessible to local residents, despite the reduction in socially-conscious services and subsidies, allows local behaviour patterns to be recast in the wider discourse of the new public health. Unlike the period before the Centre was built, the possibility now exists that North
Kingsland residents could make different ‘choices’: they could have chosen to be physically active; to ‘do’ health. The significance of the waning influence of social interventions falls into the shadow of the ‘choices’ local individuals are now perceived to be making, demonstrating the dominance of neoliberal ideology in wider socio-political culture and the ease at which it can be used to subvert a more egalitarian approach.

Conclusion

As these findings illustrate, the dominance of neoliberal moral individualism compromises the scale of equitable outcomes that socio-ecological initiatives (i.e., ABIs) could possibly instigate. Existing societal inequalities are such that in order for people from vulnerable populations to attempt ‘healthy’ living they are reliant upon equitable, effective and sustainable social policies being delivered within their communities. The finding that even these initiatives can further entrench an individualist logic in a way that exacerbates the existing inequalities that these interventions had been designed to address is one that calls into question current practices of health promotion.

That the cultural dominance of neoliberal ideology facilitates a form of victim blaming as a consequence of ABIs that initially warned against doing so, can be considered to be demonstrative of the power of this discourse. The concerns expressed in the NAAP report (KSAZ, 2002: 78) now seem to be largely forgotten:

*The key to regeneration is about seeing an individual as a whole person and not just the part which we are interested in i.e. the ability and motivation to play sport. The majority of them have been failed by a wide range of service providers over a number of years and this has built up levels of deprivation and social exclusion to current levels on the estate.*

It is also illustrative of just how severe and relatively swift the waning influence of these initial ambitions has been. In approximately ten years, ABIs that once had explicitly addressed the need to provide equitable, rather than equal, opportunities
now have a legacy which better serves those attempting to promote health as an individual moral responsibility.

These finding beg the question: given the pervasive influence of neoliberal discourse, how robust do socio-ecological initiatives need to be in order to avoid reproducing the inequality paradox and instead have a significant impact on reducing inequality? Based on these findings, there are some clues. For instance, ensuring steering groups that bring together local service providers are an indefinite commitment and work towards achieving clear social goals. Additionally, there is merit in basing sustainability structures on strong partnership working rather than relying heavily on initiatives attracting further funding. Both of these suggestions require local service providers to work in cooperation but, as is discussed in chapter seven, there is rather a tendency in North Kingsland and elsewhere for increased competition between them. There are of course bigger questions relating to public health policy and the governmental commitment to reducing social inequalities. After all, the limited nature of funding which placed such pressure on these initiatives is a product of the political approach and priorities of recent and present ruling parties. Addressing such macro-policy issues is beyond the scope of this chapter.

Achieving the aims of the behavioural justice movement is about addressing the association between obesogenic environments and areas of deprivation. To this end, investing in the physical environment of deprived areas in order to construct biospheres of risk-aversion is a necessary, but not sufficient, aim. Without addressing inequitable accessibility _over time_, such an intervention is liable to _exacerbate_ population level health inequalities and thus further _disadvantage_ those who can already be described as being doubly disadvantaged. Additionally, this research has demonstrated the latent, residual effect that can occur as a consequence of the healthification of space in deprived areas. This effect is liable to stigmatise people from vulnerable populations further by blaming them for not conforming to the ‘sensible’ norms of ‘healthy’ living. This highlights the significance of this research and similar projects that analyse the potential equity harms to which social interventions can contribute.
Currently, there is a dearth of research of this kind and if this policy direction is to persist the effectiveness of social interventions will continue to be severely limited (Baum and Fisher, 2014; Lorenc and Oliver, 2014). At a time when national inequalities are widening, and there is a greater appreciation for the detrimental health effects of the psychosocial experience of inequality, the importance of such work cannot be underestimated. The notion of ‘responsibility’ is central to this debate and this will be the focus of the following chapter.
Chapter Seven

“People should be in here”

Where does the Responsibility Lie for Sustaining Equitable Provision?

Introduction

The new public health approach has ensured that the notion of responsibility has become a central topic for the sociology of health and illness (Brownell et al, 2010; Harris et al, 2010; Lupton, 2013b). By pairing moral arguments with the association of non-communicable diseases (particularly diabetes, heart disease and cancer) and certain behaviours (i.e., those associated with ‘healthy’ living) the individual is brought to the fore of public health debates, such as those focusing on obesity (Department of Health, 2008; 2010). As outlined in chapter two, by framing health in this way ‘healthy’ living can be cast predominantly as an individual responsibility rather than a social one. This has led to the focus of government health policy to drift increasingly towards lifestyle interventions: a process known as ‘lifestyle drift’ (Baum and Fisher, 2014; Popay et al, 2010).

In this chapter the outcomes of the ABIs implemented in Kingsland are examined in the context of this wider political culture of individualism. Firstly, to what extent these interventions represent a State approach to health as an individual or social responsibility is considered. Secondly, how the ABIs increased the risk-averting properties of the physical environment in Kingsland is discussed. Thirdly, findings from research on local service providers are used to analyse the legitimacy of employing a strategy of partnership working to sustain local service provision and increase local PA participation.

Questions are asked here about where the responsibility lay for ensuring that North Kingsland residents had sustainable and accessible PA services even after the ABIs ended. Within this, how the relative influences of competition and cooperation inform
relationships between service providers in Kingsland and how this effects local provision are also analysed. Particular attention is paid to the potential these relationships and the service provision they foster have either to help address health inequalities or exacerbate them. Finally, it is argued that the findings from Kingsland suggest it is necessary to extend the ‘lifestyle drift’ concept in order to more accurately describe the policy implementation observed. Therefore, I develop the concept of ‘citizen shift’ to describe how policies that initially address some of the structural factors that inhibit behaviour change can actually facilitate lifestyle modification being presented as an individual responsibility.

Community Initiatives: Empowering Individuals or Abdication of Social Responsibility?

The strapline for the UK government’s ‘Change4Life’ health promotion campaign: ‘eat well, move more, live longer’ (Department of Health, 2008; 2009) encapsulates the rhetoric of choice that characterises the new public health approach to reducing obesity. Such an approach, arguably, deflects attention away from the social causes of ill-health and the statistical correlation between wealth and social status and health (see e.g., Campbell et al, 2013; Marmot, 2005; Semyonov et al, 2013; WHO, 2013; Wilkinson and Pickett, 2010). As was discussed in chapters two and three, emphasising individual ‘choices’ casts a long shadow over the social determinants of health. Such a policy neglects to recognise that health inequalities generally stem from avoidable social inequities, which Frohlich and Abel (2014: 201) argue ‘can make certain choices easy and accessible for some, but costly and difficult for others’. It is for this reason that Baum and Fisher (2014: 216) argue,

...when people behave in ways that are not good for their health it is generally not because they are unaware of the risk but rather that the constraints of their life and accumulated dispositions over the life-course means they are unable or unwilling to change their behaviour.
This is why research consistently indicates that those of low-SES more commonly engage in more ‘unhealthy’ and fewer ‘healthy’ behaviours than their high-SES counterparts (Buck and Frosini, 2012; Pickett et al, 2005). For this reason, Frohlich et al (2001: 785) argue that it is necessary to refer to ‘collective lifestyles’ rather than focusing on individual ones. However, this is not a popularly accepted proposition. Rather, the current political and cultural climate casts individual behaviours as ‘choices’ deriving from self-control and will-power (or lack thereof). That is, explanations attributed to agency routinely out-muscle structural arguments in popular and political discourse. More broadly, this is the consequence of neoliberal regimes depoliticising the social in order to promote notions of individual choice and responsibility. This is why the simplified strapline of ‘Change4Life’ does not read: redistribute wealth, better fund public services, have a healthier population. Although it might within an alternative political culture (Wikler, 2002; 2006).

The dominance of neoliberal ideology today means that the targeting by governments of deprived areas for regeneration and health promotion can, on the one hand, be considered to go against the grain of contemporary politics in Britain and elsewhere. This is because ABIs, such as the NDC and SAZ implemented in Kingsland, can be seen, at least superficially, to recognise the detrimental impact that social inequalities can have on the health and well-being of different populations and, to some extent, can attempt to address them. On the other hand, these interventions can be viewed as ways of applying the logics of neoliberalism to sectors of society that have been socially excluded and are considered disengaged. Therefore, more broadly, these initiatives are reflective of a shift away from a political concern for, and commitment to, ‘the social’ and a move towards ‘the community’ as a technology of government (Rose, 1996).

Echoing Rose, Crawshaw et al (2004: 355) have argued that ‘the community becomes a key tool of neoliberal modes of governance as it serves the purpose of delegating responsibility without real redistribution of power’. These developments led Baldock (2003: 68) to argue that there has been a ‘declining publicness of public services’ and Gore and Kothari (2012: 11) to describe community initiatives which allow the public health system to ‘abdicate its responsibility to address the social determinants of
health directly and in a concrete manner’. Adopting such a form of governance presents the façade of empowerment which facilitates the State avoiding the accusations of paternalism that are associated with previous, power imposing, approaches to health and illness (e.g., Parsons’ (1951) ‘sick role’). It is argued in this chapter that it also facilitates service providers shifting responsibility to citizens living in these targeted communities, despite residents still facing significant social inequalities even after ABIs have been implemented (Stafford et al, 2014). Therefore, this poses questions about whether community initiatives are liable to reduce health inequalities or exacerbate them.

Whilst researching the impact of the targeted regeneration and health promotion in Kingsland the interpretations of responsibility that were given, and the consequences they had on local service provision, provided important points of enquiry. Probing to ascertain how responsibility was operationalised through these initiatives, and whether this was informed by the framing of health primarily as a social or an individual issue, helped to establish the potential these interventions have for achieving the initially stated long-term aim of NDCs - to reduce national inequalities. To begin this analysis, I consider the centrality of lifestyle drift for explaining policy implementation in Kingsland.

Drifting into Kingsland

There is a tendency for health policy, initially, to recognise the need to address the social determinants of health, but over time, and in policy delivery, to go through a process of ‘lifestyle drift’. This process describes how health policies slide from various points along the agency-structure spectrum towards the agency pole, which facilitates the de-collectivizing of responsibility by focusing on individual behaviour. It both describes a general historical drift in policy direction associated with neoliberalism, but also how specific policies, which may initially buck this trend, gravitate towards individualism over time. Lifestyle drift is a specific example of how responsibility is moved away from the State and other agencies and towards communities and ultimately to individual citizens. The ABIs in Kingsland illustrate this.
The NDC and SAZ initiatives in Kingsland significantly invested in the physical environment. Local service provision was increased by, amongst other things, a medical practice and a leisure centre being built. This can be viewed as an attempt by the State to address the ‘inverse care law’ (Tudor Hart, 1971; 2010). However, as Tudor Hart (1971: 412) warned over four decades ago:

*The more health services are removed from the force of the market, the more successful we can be in redistributing care away from its “natural” distribution in a market economy; but this will be a redistribution, an intervention to correct a fault natural to our form of society, and therefore incompletely successful and politically unstable, in the absence of more fundamental social change.*

Therefore, although an initiative such as the NDC might receive praise for its original objectives and initial impact, without significant long-term investment in socially deprived areas, interventions of this kind are unlikely to significantly reduce societal inequalities and specifically those relating to health. Tudor Hart’s (1971) words also make clear that reducing inequalities requires wider social and political change as the dominant, market-based neoliberalism that has defined recent history promotes inequality through, in this instance, uneven distribution of health services. This suggests that efforts to reduce health inequalities will inevitably be compromised if they take place within a political culture that is reluctant to recognise the need to address core issues of equitable access to services of various kinds.

Realistically, after acknowledging the shortfalls of short-term community investment, any retrospective assessment of these initiatives needs to consider what was left behind after funding was spent and whether/how this benefits current local residents. Did the interventions in North Kingsland promote greater equality by providing residents with a bio-sphere of risk-aversion that meets their needs and is accessible to them? Alternatively, do the new local services provide yet more examples of services that will ultimately contribute to the inequality paradox because issues of equitable access have not been adequately addressed (Frohlich and Potvin, 2008)?

Of course, even if newly provided local services do not adequately address equitable provision, some Kingsland residents may access the services and benefit personally as
a result. This could lead to average health within Kingsland increasing as a result of these interventions. But even with this increase, these services would be liable to simultaneously exacerbate inequalities at a city and national level. This is because benefits derived from new services are disproportionately experienced by those from more affluent neighbourhoods whose access to them is less restricted (as demonstrated in chapter six). Despite this, the argument could be made that, as the overall impact is that average health increases, these interventions are beneficial even if they do increase health inequalities. However, if the arguments of those who proffer psychosocial explanations of ill-health are accurate (Marmot, 2005; Wilkinson, 1996; 2005; Wilkinson and Pickett, 2010), even those who do directly benefit from these interventions will experience detrimental health affects as a result of them further polarising social statuses at a city and the national level. The argument here is that any intervention that increases inequality ultimately has a paradoxical health effect because the detrimental psychosocial experience associated with increased inequality has a negative health effect on the population as a whole.

In their research on PA participation, Ellis et al (2007) found that people living in NDC areas were significantly less likely than the population as a whole to meet the levels recommended for good health. This would suggest that these physical and socio-economic environments act as significant inhibitors of PA and this was observable in North Kingsland. Before NDC investment the most significant local leisure facility (an old, male dominated boxing hall) was burnt down in an act of arson, there was a concrete football pitch with makeshift goals known as ‘the cage’ (because it was enclosed by rusting metal fencing), and the local park was widely perceived to be a rather sparse and occasionally dangerous place. With NDC funding, a high-quality leisure centre with a fitness suite, sports hall and two swimming pools was built; ‘the cage’ was replaced by two multi-purpose, all-weather pitches attached to a youth centre and accompanied by four Football Association standard grass pitches; the park was improved to encourage walking/jogging and outdoor gym equipment and a skate park were installed. These changes were in no small part due to the close partnership between the teams implementing the NDC and SAZ initiatives.

The initial community consultation report (KSAZ, 2002: 34) stated:
The majority of facilities used for sport are inadequate and need improving. New/adapted/improved facilities are needed for many of the sports which residents want to play. Facilities are an important part of the sporting infrastructure for Kingsland – they must be good quality, appropriate for the sports played and affordable.

Therefore, given the significant improvements to the physical environment, the NDC and SAZ initiatives were successful in addressing the barrier that the physical environment presented to North Kingsland residents’ PA participation. High quality facilities were built to cater for a wide range of activities that during consultation local residents stated they wanted. This transformed North Kingsland into a relatively rare location: a deprived area that is well served by PA facilities. Given its new resources, North Kingsland offers a rather novel research site. However, the concern expressed in the above quotation about the affordability of facilities reflects a broader concern that ran through initial policy documents and which fuelled local scepticism: how accessible would these facilities be to poorer residents predominantly living in North Kingsland?

As demonstrated in the preceding chapter, it was clearly recognised in initial local documents that building and improving local PA facilities was a necessary but insufficient intervention in order to significantly increase PA participation among local residents. It was identified that there needed to be a commitment to ensuring that these facilities were culturally and financially accessible to people living in North Kingsland. Despite this, an independently produced evaluation report of the SAZ initiative (Hall Aitken, 2008: 4) questioned the long-term sustainability of a number of the established interventions and reiterated that ‘high visibility facilities are important, but they need to be backed up with human resources and other projects – facilities alone will not increase participation’. The alterations to Kingsland’s built environment may have improved its risk-averting properties, but the inhibitory effects of inequality and social exclusion extend well beyond the physical environment.

This focus on the community in North Kingsland and specifically their PA participation is illustrative of the lifestyle drift that commonly occurs in health policy. As argued previously, this has the potential to exacerbate, rather than reduce, inequalities. However, even in unequal societies there are benefits to promoting lifestyle
modification alongside addressing more structural determinants of health. Because there is now broad public-awareness of the protective effect of ‘healthy’ living and society is pervaded by a culture that promotes a moral obligation to act responsibility among citizens, some commentators argue that offering the opportunity to live a healthy lifestyle is now a matter of social justice (see e.g., Baum and Fisher, 2014; Adler and Stewart, 2009).

In this sense, attempting to facilitate ‘healthy’ living in deprived areas can be seen to help local residents assuage some of the many concerns that are potentially produced by being culturally included in, but socially excluded from, a health conscious society imbued with the logics of neoliberalism. Such interventions could facilitate residents engaging in contemporary ‘therapies of freedom’ (Rose, 1999a) which may improve their sense of well-being and quality of life, as well as their physical health. This argument can only be made if it can be assured that the interventions are accessible to and accessed by residents living in these areas who might otherwise not engage in such behaviours. Such an approach requires health policies that assume a collective responsibility and therefore address issues of equitable service provision, even after ABIs have finished.

Drifting away from concerns about shared social issues and focusing on individual ones has great potential to contribute to inequality. What is often overlooked is how this potential is exacerbated if an initial commitment to addressing the structural factors that inhibit lifestyle alteration is not maintained. For instance, building PA facilities in deprived areas but not ensuring that they are accessible to and accessed by local residents. As such, the question has to be asked: after the implementation of the NDC and SAZ initiatives in Kingsland, who is responsible for ensuring that the risk-averting services that have been provided are accessible to, and accessed by, local residents? In short, where does the responsibility lie for achieving the aim of reducing inequalities by producing the conditions in which North Kingsland residents might live ‘healthy’ lifestyles? I sought answers to these questions by undertaking research on the service providers in North Kingsland.
Exercising Responsibility: Precarious Partnerships

As discussed in chapter five, on entering the field, there were three key local service providers of interest: the Leisure Centre; The Elm (a multi-use games area, a youth centre and football pitches); and the SAZ team (that had splintered into two separate groups since the end of the SAZ project: Keep-Fit and FIT-FRIENDS). These service providers came about as a consequence of the NDC and SAZ initiatives, and to varying degrees, each was established to facilitate more local ‘community’ participation in PA. Their existence significantly improved the ‘opportunity structure’ (Ellaway and Macintyre, 2010: 400) in Kingsland. The Leisure Centre and The Elm were explicitly built to offer local residents accessible PA facilities. The SAZ team was intended to promote participation by bidding for funds for local projects, including various activity/health interventions, such as one-to-one mentoring; single-sex weight-loss groups; women’s only activity sessions.

During the terms of the NDC (2000-2010) and SAZ (2002-2007) initiatives, local residents were approached as a hard-to-reach group and targeted through the types of social interventions considered necessary to increase their participation. For example, the one-to-one mentoring scheme recognised that economic restraints and a lack of knowledge and/or self-confidence inhibited residents’ participation and that these required free/cheap, focused attention and support to overcome. To some extent, then, these interventions attempted to address some of the mutually experienced barriers that go beyond the physical environment but are likely to be influential, particularly in deprived areas such as North Kingsland, in contributing to collective lifestyles in which ‘unhealthy’ behaviours are the norm (Buck and Frosini, 2012; Frohlich et al, 2001). As such, these interventions are examples of service providers approaching PA as a collective responsibility rather than de-collectivising the issue.

In this sense, these service providers did much more than improve the physical environment and then just simply expect residents to ‘choose’ to do the ‘right’ thing. As can be seen from the following statement taken from the initial SAZ consultation (KSAZ, 2002: 78), addressing the structural restraints to PA that Kingsland residents
experienced was considered a long-term project with joint responsibility lying between local service providers:

*It has taken over fifty years to reach this level of deprivation and it will take more than two or three years to regenerate it. It will mean that agencies must work together in a joined-up way and must involve residents in this regeneration process, otherwise it will fail again.*

This statement makes a number of things clear. Firstly, it recognised the entrenchment of deprivation in the area and that this relatively short period of regeneration had the potential to have a fairly insignificant impact on local PA participation. Secondly, having a meaningful impact was, to some extent, reliant upon developing strong, cohesive service provision within the area. Thirdly, in order for this to be achieved there was an ongoing need for local service providers to involve local residents and respond to their needs. This is in line with the NDC design more broadly, which Lawless (2004: 389) has described as being ‘fundamentally rooted in partnership working’. For, Crawshaw et al (2004: 344) these partnerships can become ‘a new mode of governance that attempts to break down barriers between organisations with the ultimate aim of governing deprived populations in new ways’. In Kingsland, the aim is to increase local PA rates. Given the emphasis that is placed here on partnership working, it is perhaps surprising that the relationships between service providers that were observed in Kingsland in 2012-13 had become fractured and characterised by a lack of co-ordination and cooperation.

As was discussed in the previous chapter, a waning of past influences has led to there being fewer interventions aimed at engaging North Kingsland residents and ensuring that the local PA opportunities that are now available are accessible to them. The financial pressures on service providers, which increased as regeneration funds were spent, were significant in this waning process but there were also factors which were not primarily financial in their orientation but which also appeared to compromise local residents’ accessibility to PA services. One of the most notable was the different ways in which local service providers interpreted ‘partnership working’. For example, it was common for those involved to speak of previously useful relationships
deteriorating during and after the NDC-era to the point where they are now actually a hindrance.

These comments from Julie (previously SAZ, but now Keep-Fit, Manager) were typical:

There’s pockets of good examples of partnership working and then there’s pockets where it certainly could be better. You used to have a Community Sports Network and that was for Kingsland you know and you had all the sports providers and physical activity providers sitting around the table and looking at how they develop things and that massively [deteriorated]. When we did the first sports festival we had so many partners that were involved in that and now we certainly don’t have as many, but I think that’s because of lack of funding. You know, probably they’ve disbanded or they might have gone into other areas. Also I think that people are very like, now that they are having to protect their service, they’re becoming very insulated. I think that’s the worst thing to do because, actually you know, if you worked more with partners you’d have more of an existence and profile and you might also be able to have a bigger impact as your service shrinks. I think a lot of services are becoming very insular and trying to protect, which in turn has a knock on effect of how you work together.

What Julie describes here is a realisation of problems foreseen in the initial consultation work: failing to work in a joined up way and involving residents inhibits the capacity of services to have a significant, long-term effect on local PA participation. Julie acknowledges that finances clearly play their part but that this deterioration was not necessarily inevitable. She describes services losing touch with one another, prioritising their own interests and demonstrating a reluctance to cooperate with similarly aligned services. Analogous findings are highlighted elsewhere (e.g., Buckingham, 2009; Carlisle, 2010; Milbourne, 2009). One explanation for such a shift in approach is that, as services prioritised their own interests in order to survive, the aim of increasing local PA participation slipped down the policy agenda.

An initial business plan for the Leisure Centre (Local Authority, 2002a: 1) clearly outlined the stance taken towards partnership working:

The facility will act as a catalyst for the regeneration of Kingsland and will be recognised for its achievement in forging close partnerships with agencies such as the Police, Governing Bodies of Sport, the NDC through the SAZ team, local schools and the community.
Planning documents also stated that in order to ‘ensure the establishment of a strong working partnership’ community sports development officers would be based at the facility, a ‘prime position’ to implement programmes that ‘directly answer needs identified by and for the local community’ (Local Authority, 2002b: 12). It was clear at this time that a commitment was made with regards to the facility working in partnership with external agencies and the local community in order to offer equitable service provision.

Despite these initial plans, community sports development officers were never actually based at the Leisure Centre. Hence, meeting the needs of the local community relied instead upon separate organisations having the opportunity to meet, clarify joint goals and/or work together to ensure that an effort was being made to increase local PA participation by providing services sensitive to the needs of those living in Kingsland. As previously alluded to by Julie, the opportunity to meet was previously facilitated by a local steering group, but this was disbanded once the NDC and SAZ initiatives ended. In effect, the responsibility for maintaining this commitment fell to the management of individual service providers. At that point, partnership working for the purpose of engaging local residents became particularly vulnerable because, without the local focus of the NDC and SAZ, service providers appeared to prioritise using their limited resources to achieve other aims – most evidently, having a continued existence.

In part, partnership working declined because local residents became less important to the existence of local service providers: North Kingsland residents were no longer a specifically targeted group. As previously discussed, there was a sense at the Leisure Centre that ‘enough’ had been done to address local accessibility issues. After the term of the initiative, the SAZ team split into Keep-Fit (a charity aiming to increase PA participation) and FIT-FRIENDS (a public health weight-loss service). Both services had to broaden the foci of their work in order to attract funding and thereby became city-wide services rather than ones solely targeted at North Kingsland. Previously, patterns of local deprivation had helped these providers to secure funds for local projects, but in this new situation this kind of deprivation was now interpreted as making residents rather costly consumers with whom to engage. As such, attention and resources
moved away from the area. Lawless’ (2004) research suggests that this sort of development was generalisable throughout NDC sites, as these areas came to be thought of as ‘cash-rich’ and, as a consequence, funding agencies reduced their expenditure in them.

In Kingsland, rather than be critical of the effect this would have on issues of local accessibility, service providers tended, instead, to talk up the positives. For example, for Julie, services that were offered previously in Kingsland but were now being moved to other areas was an opportunity to promote local successes:

*Well I think it complements Kingsland, it puts Kingsland on the map more because it enables us to showcase what impact we’ve had in this area and learn from, you know, the good practice that’s been implemented in this area and how you can then transfer that or replicate that in other areas.*

It is possible to advance such an argument because it is made in a vacuum that neglects to consider the wider social implications of removing services from this deprived area. The language of the market (‘good for public image’) effectively blunts the criticism that would otherwise come from adopting a social approach (‘good for society’). The Operational Manager of The Elm, Sam, who had seen projects previously run at his facility move out of Kingsland, was more critical:

*They’re not here anymore! It’s bad that is, isn’t it? It would be better if when it started up somewhere else they could say that this is based on the successful project in Kingsland, instead of having to say ‘this is based on the successful project in Kingsland that’s not running anymore.’ It doesn’t make it sound very successful does it?*! (Fieldnotes: 1/11/2012)

But such criticism was rare among service providers as the focus of this initially targeted intervention moved away from local participation. Once Kingsland residents were no longer a mutually targeted population, their participation seemed largely to be left to the vagaries of the market economy or the responsibility of local residents themselves. The majority of service providers no longer prioritised local residents’ participation over that of someone else from another area. It was clear that increasing financial pressures played their role in this process but, nonetheless, they did not
make straying from an initial commitment to work in partnership for the benefit of local residents inevitable.

This was perhaps most evident in an exchange between the Leisure Centre Manager, Karen, and her Manager John (City Council – Head of Sport and Leisure Services). John had previously said in interview that, due to financial restraints, the Leisure Centre now largely relies on outside agencies (e.g., Keep-Fit and FIT-FRIENDS) to bring North Kingsland residents into the Centre. Karen had been instructed by John to attend a public health meeting that was attempting to explore how all local services (e.g., schools, medical practice, PA facilities) could reduce health inequalities by improving partnership working. In the week after the meeting Karen and I had the following exchange:

_I see Karen at Reception and have a chat with her about the recent public health meeting. Karen says to me ‘Yeah I’ve had John going mental about that calling me up going “I don’t know fucking anything about this” and I’m like “well you told me to go to it in the first place!” When I asked her what he was worried about she said ‘Oh he was saying stuff about whose agenda was it following, because I mentioned in the meeting that all the providers should get together and find out what each other do and see if we could help each other out, because I don’t know what they all do. I think that would be really good for the estate if that happened. He was saying “You’re just fucking running Keep-Fit’s agenda, don’t you be fucking putting Keep-Fit first” and I’m just like “How am I putting fucking Keep-Fit first?”’ Karen later continued “I’m not working to Keep-Fit’s agenda; there is no danger of that!”_ (Fieldnotes: 26/10/2012)

Pressure was applied to Karen by senior management within the Local Authority to ensure that she did not prioritise working with agencies tasked with increasing PA levels, usually within ‘hard-to-reach’ groups (e.g., low-SES groups, those classified as obese, mothers). This is the same Local Authority which, less than a decade previously, had stated that the Leisure Centre would be _‘recognised for its achievement in forging close partnerships’_ with such agencies.

Providing equitable access to the Centre, and for PA more generally, after the NDC-SAZ era relied on these partnerships being maintained. This is because the initiatives these agencies implement are designed to break down the participation barriers that many local residents face and which the Leisure Centre management is less concerned with
addressing. Breaking down these barriers and engaging residents from North Kingsland would have been of great concern if local PA participation was approached as a collective responsibility and if service providers were committed to achieving the NDC aim of reducing national inequalities.

The consequence of the pressure Karen was under was evident in her reluctance to establish and maintain partnerships that increased the accessibility of the Centre. It was often the case that external service providers relied on the Leisure Centre as a venue from which to deliver their activities, but successfully negotiating venue hire with Karen was far from assured unless they could pay the going rate. As Karen told me:

*Julie, she’ll ring me up and say ‘Can I have this space? We’ve not got any money’, and I’ll say ‘Well no, then.’ Because that’s not how it works, is it? (Fieldnotes: 8/3/2013)*

This may have been ‘how it works’ if engaging North Kingsland residents was still a top priority, but because this was palpably not the case, such ventures no longer made financial sense to Karen. The FIT-FRIENDS Manager, Matt, agreed with Karen’s stance that external agencies, like his, needed to do more to support the Centre, but argued that the work they do with the community should also be taken into consideration:

*I think what the other organisations have got to do is not expect everything for free. We’ve got to get together and say ‘Right, how can we scratch each other’s backs? You’ve clearly got this as your barrier, you know, you can’t give free rooms, ok fine. How locally are we going to ensure that that community group can use it for less?’ Like actually let’s not just sort of agree that there’s no way forward, because it’s money. I don’t agree with that. I think that there is a way that we can work together to increase participation and to stop people feeling like you’re just coming to me for a free room. Because that’s the way it is at the moment.*

The issue, evident in the previously quoted comments from Karen and Matt, is that local participation is no longer really valued at the Centre beyond its potential to generate income which, given local levels of deprivation, is low. There are some long-standing commitments with external providers that had been maintained at the
Centre but, even during the 16 months fieldwork for this research, two of these four groups ceased to exist locally: one weight-loss group stopped being run altogether and another moved out of the area to a cheaper, more hospitable, venue. The former will now be discussed.

The story of the women’s weight-loss group on a Monday evening is particularly illustrative of the evolving problematic relationship between the Leisure Centre and other service providers. This group was one of the initial partnerships established between the SAZ team and the then newly built, Leisure Centre. Its main purpose was to offer an accessible local opportunity for people to learn about, and be supported through, losing weight. Lindsay, a previous instructor of the group, described Karen to me as having initially been an ‘advocate’ of the group. However, on what proved to be one of the last group sessions it was clear that things had changed. There was much confusion caused by a local bridge club claiming to have booked the room where the weight-loss group had met for the last six years. Retrospectively, it was established that the Leisure Centre management had taken the decision to hire the room to the bridge club and had failed to relate this information to FIT-FRIENDS, the provider who ran these sessions.

Matt, FIT-FRIENDS Manager, brought this up unprompted when we spoke about local partnership working:

I think we’ve often been forgotten about, you know. We had [the women’s weight-loss group] that was there for six years and then all of a sudden the meeting room space was booked out and we couldn’t have it. It wasn’t negotiated - which was really sad in some ways.

This narrative is consistent across service providers and there is an evident sense that the Leisure Centre is no longer ‘doing what it was built for’ by not honouring the commitment to work in partnership with, and accommodate, the other service providers and members of the local community. This was particularly problematic as the sustainability of services provided through the NDC and SAZ initiatives and offering more equitable participation opportunities, was highly dependent upon these partnerships.
There is plenty here to indicate that the service providers feel a responsibility to work together but, significantly, none seem to feel it is their responsibility to ensure this happens. This may have been a consequence of previous attempts to form successful partnerships consistently failing. However, the overarching theme appeared to be that they all had different priorities now that the NDC and SAZ initiatives were over, whereas previously working together to facilitate local residents’ participating in PA was an important joint ambition.

Karen’s interpretation of how working partnerships had changed was particularly illuminating:

There are different levels now and there are different things. It’s like the [weight-loss groups], you know, they want their independence away from the Centre. They want to break free from the Centre and that’s fine because we’ve helped them grow. Whilst sometimes it’s a shame that they’re not supporting the Leisure Centre, you can put a positive spin on it. It’s time for them to go out on their own and see what they can achieve because we’ve set them up, we’ve had them here. Good luck to them if they find somewhere cheaper. Good luck to them if they find somewhere that suits them better, but I just think it’s a shame because if anybody wants anything that we’ve got it’s all [sharp inhalation of breath], ‘Karen can you help us with this, Karen can you help us with that?’ and I just think to take groups away from the Centre like that was not helpful.

Instead of viewing the groups run by agencies, e.g., Keep-Active, as necessary and essential ways of making the Leisure Centre, and PA more generally, accessible to North Kingsland residents, Karen treated them no differently to any other group which uses the Centre. As such, hiring space at a subsidised rate, or even for free, which had happened previously was no longer something offered to these providers. Partnership working was interpreted as something that was only worthwhile if it benefitted ‘the business’; a business partnership, rather than being something that was to benefit local residents. However, the majority of service providers who had previously formed partnerships with the Centre were no longer focusing on drawing in funds for local projects. Consequently, the funds necessary to maintain these relationships and sustain accessible services for North Kingsland residents were lacking.
By arguing that it was *unhelpful* for groups to be *taken away* from the Centre, Karen challenges local accusations that the Centre was no longer fulfilling the social responsibility it was widely considered obligated to provide. She went on to argue that the other service providers actually had a responsibility *to the Centre* that they were now failing to keep:

*It is the one way thing and it’s almost that we’re an afterthought unless they want something, you know? And whilst it sounds harsh, that’s my professional opinion...*I think that we all should still, still, still be working together and still be able to help each other’s aims and objectives. *But, you know, I’ve not got a clue what Julie’s project is. You know, Matt came to see me, didn’t really have much to say. I mean and I’m thinking ‘Ah!’ But maybe they are under great pressure as well* [laughs].

It was clear that Karen felt other service providers had a responsibility to support the Centre financially by paying to hire the facility to run their sessions. The reasoning behind this was that if the financial targets that she is set by the Local Authority are not achieved the facility will be closed down and then local residents will lose a local resource.

So, the argument can be made that, to some extent, the formation of the partnerships, which were identified as ways of sustaining local service provision once NDC funds ran out, were actually dependent on more funding becoming available. If all the local service providers continued to target local residents as a ‘hard-to-reach’ group beyond the NDC-SAZ era one would suggest that they would all be more inclined to sustain services by working in partnerships that did not prioritise financial gain. This would be what would have happened if local participation was approached as a collective responsibility, but this was not the case. Instead, a short-term focus on the ‘community’ that characterised the NDC-SAZ initiatives, and emphasised partnership working as a sustainability strategy, created conditions that were not conducive to the establishment of such relationships. What actually transpired was a set of conditions that, rather than facilitate partnership working, led to service providers seeing each other as local competitors for custom.
**Competition not Cooperation: Promoted Interventions or Open Secrets?**

When other service providers organised, or even planned to organise, activities outside of the Centre, or even subsidised activities within it, Karen increasingly interpreted this as potentially threatening the Centre’s capacity to achieve its financial targets. This created the impression between service providers that they were in competition. Karen regularly adopted this narrative:

*There’s a problem with this place being flooded with things. Me and Julie have been friends since school, but professionally we will fall out if she puts classes on [in the Park]; I’ll get a meeting with her and her boss and say ‘What are you doing?’ Because we offer that and if they put things on there, it will be competing with us and that messes up everyone’s figures, because no one hits the numbers that they want, or need.* (Fieldnotes: 28/6/2012)

The irony here is that it was Karen’s reluctance to work in partnership with these providers, unless it generated income for the Centre, which left them with few other options but to utilise other sites, e.g., The Park, if they were to provide activities for local residents. However, because these providers were no longer targeting North Kingsland residents they did not dedicate their limited time and resources to doing so. Therefore, these tensions simmered rather than ever really boiled over during my period of fieldwork.

The combination of a reduced focus on residents from North Kingsland as a requirement of funding and the simmering tensions between service providers, effectively shifted responsibility for local participation to the ‘community’ and ultimately to individual residents themselves. The shortcomings of relying on residents living in deprived areas to volunteer time and resources in order to sustain the impact of community initiatives are well established (Conway et al, 2007; Gore and Kothari, 2012; Marent et al, 2012; Such, 2013). This is true in supportive environments and so is even more problematic in non-supportive environments, such as Kingsland. It was argued by some that such heavy reliance on the ‘motivation’ of local residents was not necessary as there was far greater potential for local partnership working. Matt, Manager of FIT-FRIENDS, disputed whether service providers outside of the Leisure Centre should be perceived as competition and he put forward arguments about the
potential mutual benefits of partnership working. This was evident in his comments on why he thought his service was seen by Karen as a competitor:

*It can only be financial, because if you put an exercise class on the Park and you know they lose the money on the tills. But it’s kind of that ‘Well what’s your business plan?’ because really what would be the harm in paying at the Centre to come over to the Park and do a Boot Camp? And therein lies the problem doesn’t it?*

*Let’s be open to a bit more enterprise, let’s be open to, ‘Actually that could draw people in?’ rather than put people off. I think it comes back to part of the problem is that if you don’t go and sort of be open to people, yeah for a time by having a discount or encouraging them to come in, you’ve not got two pound coming in the tills that wouldn’t have been there otherwise.*

This reference to the ‘two pound coming in the tills’ is to the price people paid when using a Council subsidised discount card that can be obtained by participating in the weight-loss sessions that Matt’s organisation runs. These cards were a point of frustration for Karen because she saw this intervention not as a means of bringing non-users to use the Centre, as Matt did, but rather as a way of reducing revenue by discounting entry fees. Using Local Authority subsidised discount cards to facilitate access to leisure centres by disadvantaged groups is a common public sector strategy in England (Taylor et al, 2011). Previous studies have shown that interventions that reduce the financial burden of participating in PA are particularly successful in facilitating participation by people from deprived neighbourhoods (Cleland et al, 2012; Lowther et al, 2002; Yancey et al, 2006). ‘The Card’, as it was known locally, could indeed have offered Kingsland residents better access to the Leisure Centre. Instead, the effectiveness of this strategy was undermined by the tensions that existed between these ‘partners’. ‘The Card’ became an ‘open secret’ in that it was not commonly known about or openly promoted at the Leisure Centre or local area. This was also the case with the weight-loss sessions themselves. One local woman, whose comments are more generalisable, told me:

*When I called [the Leisure Centre] to find out about it they said to me ‘It’s got nothing to do with us’ and [they] couldn’t tell me anything about it. So I had to ask around at the FIT-FRIENDS course. (Fieldnotes: 3/9/2012)*
Although limiting the success of these subsidised groups kept relations between the service providers in tact it also severely restricted the impact these intervention might have otherwise had. The fact that local residents ‘could’ sign up for one of these cards by joining a weight-loss group was, however, a performative mechanism for both the Leisure Centre and FIT-FRIENDS since it enabled them to argue that they were ‘doing community’ (Conway et al, 2007: 224). Moreover, and significantly, it encouraged the construction of a narrative that it is now local residents who are failing to take responsibility for their own participation. It is for reasons such as this that Horrocks and Johnson (2014) argue that rather than being ‘reflexive consumers’ people who are eligible to receive social support would benefit from a ‘navigator’ to guide them through what is available to them. This would help ensure ‘open secrets’ such as ‘The Card’ and weight-loss groups are better known about by the people who would most benefit from them.

A willingness for service providers to ‘scratch each other’s backs’ by engaging in the type of ‘enterprise’ that Matt refers to relies on local residents being recognised as a hard-to-reach group that is targeted by local services. This would create a mutual goal, which in turn would encourage partnership working. Without this joint goal, these partnerships are precarious and, as a consequence, so is the sustainability of any interventions established during the NDC-SAZ era to facilitate local people being physically active. These findings from Kingsland chime with Marent et al’s (2012: 196) critique of models that advocate community participation because, they argue, these ‘often take lay people’s motivation, availability and competence for granted. Yet, problems arise if lay actors lack motivation, resources or the ability to take part or if professionals are ambiguous about why they should engage with them’. In Kingsland, the ambiguity came from the erosion of a sense that facilitating local participation was a priority for service providers.

The core responsibility that Karen, Julie and Matt all felt as a priority was to sustain their own services. Because engaging North Kingsland residents was now interpreted as both costly and unpredictable, the sorts of partnerships which community interventions are reliant upon if they are to reduce social exclusion and inequality in the long-term were either not formed or were perilously fragile. Ultimately, it is North
Kingsland residents who have the most to lose from the failure to establish or to maintain these partnerships of course. Saliently, without local services sustaining a sense of social responsibility and forming these partnerships to ensure equitable provision, the previous investment during the NDC-SAZ era is, ironically, liable to exacerbate existing inequalities rather than reduce them.

Service providers would frequently speak about how others were not fulfilling their responsibility to local residents whilst not acknowledging that they also leave themselves exposed to precisely the same accusations. In this sense, responsibility for engaging with Kingsland residents and providing equitable services was ever present in rhetorical form, but rarely enacted. The willingness to de-collectivise responsibility was perhaps best summarised by Karen’s lament:

_This place should be having a bigger impact; it’s a fucking massive, fucking Leisure Centre for Christ sake. We should be more involved with it. People should be in here._ (Fieldnotes: 30/8/2012)

Karen did not consider it _her_ responsibility to ensure local people were ‘in there’, but she felt they should be. Other service providers felt that it was indeed _her_ responsibility to make the Leisure Centre more accessible – but they did not or could not actively form partnerships with her in order to facilitate this.

In the absence of effective partnerships between local service providers, formed with the aim of engaging residents from North Kingsland, over time the responsibility for participation increasingly came back to the residents themselves. This is one way that community initiatives function as a neoliberal device. Shifting responsibility, and ultimately individualising it, is of course an implicit aim of ‘government through community’ (Rose, 1996: 332). This is why Conway et al (2007: 225) term ‘community’ a ‘bargain discourse’ and Fullagar (2002: 71) states that governments view PA as the ‘best buy in public health’. Almost inevitably, fingers are pointed at individuals, whether that is the manager of a service provider, or a sedentary resident. These findings from Kingsland indicate that this tendency compromises the sustainability strategies that community initiatives in their current
form rely upon if they are to stand any realistic chance of reducing national inequalities.

Despite the stated aims to reduce inequality, responsibility for PA participation in Kingsland was progressively shifted down the hierarchy, from providers to local (non-)participants. This is in contrast to the initial services offered during the NDC-SA region that approached PA participation as a social issue and thus prioritised providing equitable access to services. During this early period, there is evidence that many services were provided through local partnerships that attempted to address the structural barriers that contribute to collective lifestyles where unhealthy behaviours are the norm. However, it would appear from the situation in Kingsland that available funding determined such partnerships and without such funding partnership working was, at best, precarious and, at worst, non-existent. Therefore, along with highlighting the ‘lifestyle drift’ in public policy, it is also important to recognise the processes through which lifestyle-orientated policies further individualise social issues in delivery: a process I conceptualise as ‘citizen shift’.

Citizen Shift: Passing Responsibility to the Participant

Non-targeted health interventions consistently exacerbate social inequalities because they merely offer equality of opportunity and not equitable provision (Frohlich and Potvin, 2008; Lorenc and Oliver, 2014). Thus it follows that a prerequisite for initiatives with the explicit aim of reducing national inequalities - e.g. NDCs - would be that they must address the issue of equitable access. Failing to do so not only compromises efforts to reduce inequality, but are liable to contribute to it. Given this potential, ABIs that take a ‘community’ approach need to face close scrutiny.

One of Lawless’ (2004: 392) criticisms of NDC initiatives is that ‘there is a sense that longer-term planning at the partnership scale is characterised by ad-hoc, reactive decisions rather than by any sense of rationality’. In lieu of long-term planning, Lawless observes that there is a tendency for decision makers to go after ‘quick wins’. In this
context it is essential that decision makers and service providers appreciate the paradoxical effects that short-term interventions can have. Of course, not all unsustainable ‘quick fix’ interventions are liable to exacerbate existing inequalities but some will. For instance, if a service that loaned sports equipment to deprived neighbourhoods stopped being funded the status-quo is likely to resume. But, if interventions that address issues of access to ongoing services are not sustained they are liable to exacerbate existing inequalities. This is because these interventions protect against the disproportionately high participation of people from the higher-SES groups. Without these interventions the capacity of people of low-SES to access these services is significantly reduced and thus the continued and more frequent participation of people from high-SES groups combined with the associated health gains is likely to widen existing disparities. Therefore, it is essential that local partnerships in Kingsland ensure issues of equitable access are addressed and sustained if the Leisure Centre is not to compromise the NDCs overall aim of reducing inequalities.

Lawless (2004: 393) specifies that one of the ways in which NDC partnerships are problematic is that on occasion they seem ‘not to have thought out inherent contradictions in proposals’. These inherent contradictions are evident in many of the services provided in Kingsland. Perhaps the most striking example is the sustainability strategies of many services. These usually involved conflating the capacity to pay for services with a willingness to pay for services. When I spoke to service providers and a local councillor about the reduction in local subsidies at the Leisure Centre they told me that this had always been intended. The narrative was consistent: local subsidies were initially substantial in order to entice residents from North Kingsland to use the facility in the hope that these people would then come to ‘value’ what they did there enough that they would then be willing to pay more when the subsidies were less substantial. Similarly, SAZ management advised their instructors to introduce participation fees at groups which had started out offering free services. The discourse used here was one of participants ‘taking ownership’. There may be some legitimacy to this argument in the wider society, but in the context of the initiatives in North
Kingsland it would appear detrimental to achieving the aim of facilitating local PA participation among an impoverished and vulnerable population.

This sustainability strategy seems in a fundamental way to misunderstand the powerful ways in which economic restraints limit the choices people make – something which is particularly relevant for ‘hard-to-reach’ groups. It is however entirely in keeping with a community approach, which, under the guise of ‘empowerment’, has been designed to de-collectivise responsibility. It is indicative of the process I am conceptualising here as ‘citizen shift’. This process describes how the dominance of neoliberal discourse encourages and allows service providers to emphasise individual agency even after the necessity of approaching lifestyle modification as a collective responsibility has been explicitly stated.

Even the responsibility for the promotion of available local services was shifted from the provider to the participants. When Julie spoke about the few services Keep-Fit still ran in Kingsland, for example, she provided another example of how initiatives that previously addressed barriers but have subsequently stopped or been diminished have a ‘residual effect’ that facilitates shifting responsibility to local residents. She did this by acknowledging that Keep-Fit relied heavily on participants to raise awareness about the services they ran:

*We have met all the barriers that women face to participating. We’ve addressed cost, transport, childcare, self-confidence, going with a friend. We addressed all of these things because of the consultation work. So we’ve addressed all these barriers that a woman could face. But do all women know about us? No, and that’s something we need to work on. At the moment, it is mainly word of mouth.* (Fieldnotes: 10/9/2012)

It is common practice for ‘word of mouth’ to act as the most utilised form of awareness-raising for local services (Everson-Hock et al, 2013). But in the context of questions around responsibility, this offers another example of how responsibility is shifted to the citizen in community initiatives. I was told that when funding was more plentiful, community consultation and outreach work to engage Kingsland residents was common practice. However, there was no evidence of this during my fieldwork. Rather, the numbers of participants attending the few remaining groups were left to
dwindle. It was common for a few core group members to reflect each week about the contrast between the present and the ‘glory days’ of the past when groups would attract large numbers of local people.

The shifting of responsibility from provider/partner to citizen was perhaps best illustrated by the story of the mobile phone which the SAZ team had used to promote the women’s weight-loss groups. The number for this phone-line was put on promotional leaflets but when I spoke to one of the group’s past instructors, Lindsay, about these leaflets not being distributed she told me that they would be little use now anyway. She explained that this phone was now switched off and abandoned in a desk draw in her old office. Lindsay had grown up in North Kingsland and had worked hard to establish the weight-loss group by engaging with the local community. She had since been made redundant and replaced with another instructor. When I spoke to her she was angry that a previously successful group had been left to ‘die’ by Keep-Fit and FIT-FRIENDS:

*I can’t believe none of them actually sat down and thought ‘Well, why was the numbers dropping, what’s not working, how can we make it better?’ I can’t believe that and it feels, not personal, but I’m like, ‘That’s my group’ and they’ve killed it...I think what they need to look at is if a popular group dies, why is that? I don’t think that’s been looked at. What’s gone wrong? Have you even asked these women? You’ve just let it die. You haven’t actually said ‘Well actually there was twenty [regularly attending participants] and now there’s only four’.*

Lindsay’s accusation that a previously well attended group successfully engaging with Kingsland residents had been left to wither is a fitting description for how the responsibility for local PA participation was increasingly individualised. Due to the socio-economic characteristics of Kingsland, facilitating local participation is to some extent reliant upon the needs of residents being met by the services that came about as a result of the NDC and SAZ initiatives (Ellis et al, 2007). However, sustainability strategies for these services increasingly have shifted responsibility to residents alone - and thereby ensured their own failure as barriers that the initiatives had once attempted to address were subsequently resurrected.
Partnerships between local service providers that may have offered alternative sustainability strategies were compromised by the lack of commitment from the service providers involved to approaching local participation as a collective responsibility. As funding ran out and the local steering group disbanded, meeting the needs of Kingsland residents was no longer addressed as necessarily a collective responsibility. The following comments from Karen demonstrate how at ease she now is with shifting responsibility to residents:

*I believe there is a clear pathway to every single person's house in Kingsland to [the Leisure Centre], to the [SAZ Team], to the [Library], to The Elm, you know, to everything. And it is their responsibility - and people do need to take responsibility for their health, you know.*

After the implementation of the ABIs it may now be the case that some local people are better equipped with the knowledge and resources necessary to access such facilities and activities. But when local service providers serving this vulnerable population demonstrate such little awareness of, or concern about, the potential a de-collectivised approach has to exacerbate social inequalities it can be argued that this is likely to contribute to growing health disparities at a local and national level.

Of course, shifting responsibility to local residents after initially addressing structural issues, a process I am conceptualising as ‘citizen shift’, can be considered to be part of the ‘community-civility’ game of ethnopolitics - discussed in chapter three - identified by Rose (1999b) and criticised by many others (Conway et al, 2007; Crawshaw et al, 2004; Gore and Kothari, 2012). The argument presented here, however, is that this form of governance, and the interventions it inspires, must be seen in the light of what we now know about the potential for non-targeted interventions to exacerbate existing inequalities (Frohlich and Potvin, 2008; Lorenc and Oliver, 2014). This is particularly the case when the community initiatives in question have, as their explicit aim, *reducing* what are national inequalities.
Conclusion

The process of lifestyle drift is problematic because it fails to deal with the structural roots of health inequalities. It has been argued in this chapter, however, that lifestyle interventions do not necessarily exacerbate existing inequalities. There is a social gradient to behaviours which have been shown to have a significant effect on health, illness and wellbeing, with low-SES groups both less likely to perform beneficial behaviours (e.g., PA) and more likely to perform detrimental ones (e.g., smoking cigarettes). Therefore, promoting behaviour change without altering social conditions will do little to lessen these enduring inequalities and is highly likely to exacerbate them. However, approaching health behaviours as products of collective lifestyles with interventions that address the structural antecedents of ‘unhealthy’ behaviours could help to reduce, although not resolve, the health inequalities between socio-economic groups. Initial interventions in Kingsland, e.g., in improving the built environment; offering subsidised activities; providing one-to-one social support; all offer some evidence of this approach being taken.

Despite this, a process I conceptualise as ‘citizen shift’, which can be understood as a calculated aspect of the community-civility game, compromised efforts in Kingsland to provide sustainable local services which address issues of equitable access in the long-term. The short-term nature of funding; the precarious partnerships that were supposed to offer possibilities for sustainable services; and the seemingly irrational sustainability strategies of service providers, are all consequences of a neoliberal de-collectivising version of responsibility which places the onus on individuals (both residents and those working for service providers). The discourse of ‘community’ legitimises such a process.

Clarke (2004: 30) argues that ‘thinking of neoliberalism as a strategy allows us to explore the gaps between ambition and achievement’. These findings from Kingsland highlight this gap and thus prompt us to question whether using a ‘community initiative’ such as the NDC and/or SAZ to promote lifestyle modification and/or reduce national inequalities is actually an achievable aim. Therefore, these findings also support Baum and Fisher’s (2014) argument that too little attention has been paid to
the importance of ideology in efforts to create policies that can address the social determinants of health.

Building local partnerships was fundamental to the long-term success of the NDC and SAZ initiatives. However, in Kingsland to a large extent the persistence of these partnerships was dependent on the availability of funds. Service providers would ‘do community’ for as long as funding was available, but partnerships broke down when funds became scarcer. This meant the prospect of these initiatives having a beneficial, long-term, impact for local residents was at best precarious and at worst improbable. More broadly, the precariousness of these partnerships can be interpreted as a consequence of the incongruity between ‘community’ as a technology of government and approaching ‘healthy’ living as a social, rather than an individual, responsibility. Ultimately, these initiatives individualise responsibility and this compromises their capacity to provide vulnerable populations with the sorts of sustainable services that might lead behaviour change policies to meaningfully reduce health inequalities. It is for this reason that Gore and Kothari (2012: 10) argue:

> If programmes cannot directly affect lasting, broader societal conditions, interventions should be focused around advocacy and education about the social determinants of health – advocacy at the level of the population, service providers, health organizations, and government in order to build political will to address them.

This argument is clear: it would be more beneficial to promote a discourse which positions health as a social responsibility than to advocate a welfare policy that funds what are ultimately short-term interventions. This alternative approach would offer opposition to the dominance of neoliberalism and as such could stymie the process of citizen shift. Such a discourse could incorporate health behaviours, but will not prioritise them. For instance, Scandinavian governments have a long history of offering social support to ensure all communities have access to PA opportunities (Rafoss and Troelsen, 2010).

The prudence of approaching health as a social responsibility from the outset is evident in highlighting the potential for existing social inequalities to be exacerbated
by interventions which fail to offer equitable access to services in the UK and elsewhere. The ineffectiveness of neoliberal community initiatives to address social inequalities, and the frustration this can cause, was most affectively communicated by Matt:

I’m passionate about [Kingsland] and the work that we started here. [The First SAZ Manager] is a bit of a silent inspiration if I’m honest. She fought blood, sweat and tears to get SAZ, to get The Elm, to get the Leisure Centre in Kingsland and to get this community feel to the whole project. And I just think that’s been wasted now and that really pisses me off. People don’t have that same sense to improve this area anymore. We used to have a really great team here, full of people passionate about helping people to be physically active. But people move on and funding stops or pushes you in other directions and it just isn’t the same as what it was. And it feels like all that blood sweat and tears has been wasted. (Fieldnotes: 7/6/2013)

An alternative political discourse which supports approaching all health issues, specifically those related to individual behaviours, as social responsibilities would have seen the ‘blood, sweat and tears’ that Matt spoke of, contributing to the capacity of ABIs in Kingsland to provide equitable services rather than perhaps unwittingly exacerbating existing inequalities. Instead, these efforts have facilitated a shifting of responsibility to individual citizens and perhaps, in relative terms, this has left many Kingsland residents worse off than if such efforts had never been invested in their neighbourhood.
Chapter Eight

Providing for the ‘Hard-to-Reach’

The Necessity of Going ‘Above and Beyond’

Introduction

In the two preceding chapters, I have established that although the ABIs implemented in Kingsland were initially designed to address a number of social and environmental barriers to ‘healthy’ living, this commitment waned over time. Kingsland has thus been partially transformed into a bio-sphere of risk-aversion that increasingly better serves those travelling into the area rather than local residents. This paradox is explained in part by local service providers being comfortable with and encouraged to shift responsibility for PA participation to local residents: the process of citizen shift. The culmination of these interconnected and perhaps inevitable events is that local PA provision has become less equitable. Ultimately, this has created conditions which exacerbate, rather than reduce, health inequalities. Despite this, there are also some examples of interventions emanating from these ABIs that have been sustained and could be considered to make PA participation more achievable for some Kingsland residents.

This chapter focuses on accounts of these interventions and considers how they facilitate North Kingsland residents’ PA participation. It begins with some conceptual criticisms of what are frequently described in health promotion literature as ‘hard-to-reach’ groups. A case is made for why efforts to reduce health inequalities, to some extent at least, rely on initiatives that increase the agency of these groups. This is followed by the example of swimming at Kingsland Leisure Centre and a demonstration of how and why the local availability of this activity does not necessarily facilitate the participation of local residents. This example is then contrasted with other local activities that do provide more accessible services and engage local residents. In these cases PA participation is heavily reliant on service
providers’ willingness and capacity to go ‘above and beyond’ the efforts that might otherwise be required of them and to accommodate ‘inappropriate’ behaviour during activities. Finally, these examples inform an analysis of whether neoliberal policies provide adequate means to address disparities in adherence to health promoting behaviours.

Engaging the ‘Hard-to-Reach’

The socio-economic inequalities which exist within and between most Western societies are stark and have been exacerbated since the last quarter of the twentieth century by the rise and dominance of neoliberal politics (Coburn, 2000; 2004; Dorling, 2010; 2013; Navarro, 2007; 2009). Harvey (2007b: 12) describes, for example, how as a result of this political ideology cities have ‘dissolved into micro-states of rich and poor’.

There is a long history of city space being segregated along class lines (Engels, 2009 [1845]), but this ‘clustering’ of health inequalities, whereby vulnerable populations most in need of health services predominantly reside in neighbourhoods lacking in social amenities (Scambler, 2012: 135), has an accumulative effect which has been exacerbated by neoliberal policies (Tudor Hart, 1971; 2010). The policies of neoliberal regimes that reduce welfare expenditure by promoting self-governance have led to the rise of the ‘community’ as a biopolitical device and to social spaces being idealised as bio-spheres of risk-aversion that facilitate compliance with neoliberal ‘codes of sensibleness’ (Herrick, 2011: 5). For this reason, Armstrong (1995: 402) has argued that the community has become ‘the new space of illness’.

The NDC policy can be seen as New Labour’s attempt during the first decade of the twenty-first century to reduce health disparities by offering more support to address local problems in what were considered to be the UK’s ‘ill health black spots’ (Crawshaw et al, 2004: 343). Such ‘communities’ have come to be defined by their risk and are thus imagined into a collective. SAZs are overt examples of this bio-political technology. Between 2001-2005 these initiatives attempted to regulate the conduct of residents living in deprived areas by encouraging them to conform to health promoting PA behaviours. Rather than taking a broader social approach, a more
specific focus on ‘the community’ in contemporary political discourse has seen neoliberal logics transform vulnerable populations. Vulnerable populations requiring social support have now become communities of risk in need of a disciplining influence (Frohlich and Potvin, 2008; Rose, 1996). Rose (1999b: 89) explains well how these marginalised groups which are

...excluded from the regime of choice, no longer embraced within a social politics of solidarity, are allocated to a range of new para-governmental agencies – charities, voluntary organisations supported by grants and foundations.

Collectively these agencies are commonly referred to in the UK as the ‘third sector’: that is additional to the public and private sectors (Baggott and Jones, 2014). They play a key role in attempts to reduce health disparities. As such, it is no coincidence that all of the examples of providers actually attempting to engage North Kingsland residents analysed in this chapter are the outcome of work undertaken by such agencies. But how pivotal these often financially precarious agencies are, and what this tells us about the priorities of new public health, requires further sociological attention.

While various recent neoliberal governments have left the social and economic structures which produce and sustain social inequalities largely unchallenged, attempts to reduce health inequalities within existing structures have revealed the persistence of disparities. We know that those most likely actively to participate in health interventions are the relatively low health-risk group of white, middle-class women, rather than those who are considered to be in greater need (Marmot, 2010). More specifically, Everson-Hock et al’s (2013) systematic review of community-based PA and diet interventions highlights the tendency for participants to come from less deprived backgrounds when compared with non-participants. Therefore, it follows that in reviews of interventions that attempt to improve public health it is generally found that such interventions are unlikely to reduce health inequalities (Cleland et al, 2012; Withall et al, 2011).

Given that research indicates that many interventions are actually liable to exacerbate pre-existing inequalities (Frohlich and Potvin, 2008; Lorenc and Oliver, 2014), it is perhaps unsurprising that Blackman et al (2012: 56) found that in the UK health
inequalities are widely considered as a ‘Cinderella area’ within public health. They explain that, in part, this is because of the present lack of political will to combat health disparities, since demonstrating that interventions are ‘value for money’ is considered to be far more difficult to achieve than in other competing areas of public spending, e.g., reducing hospital waiting times.

In this context it has become increasingly common for groups that do not generally access health services to be referred to as ‘hard-to-reach’. As Sinclair and Alexander (2012: 88) explain, the term ‘is often used within the service and marketing sectors with reference to individuals who prove difficult to involve in or who do not access the services that are available to them’. In the main ‘hard-to-reach’ is considered to be an unproblematic term, but when viewed in more critical light can be seen - perhaps inadvertently in some cases – to be part of the disciplining discourse of moral individualism. Therefore, the use of the term itself could be detrimental to the endeavour of engaging vulnerable populations.

Hard-to-reach groups come to be thought of as ‘at risk’ because their lack of access to health services reduces the extent to which they can be ‘managed’. Defining particular groups as ‘at risk’ rather than vulnerable forms part of an ‘Othering’ process that facilitates the delivery of specific messages to these groups and others about acceptable and unacceptable ways of being. As Sanford and Ali (2005: 118) argue:

...experts that define problems, whether they relate to health, the environment, economic issues, and so forth, are conveyors of a political discourse that substantiates their official privilege through their alleged neutrality.

These authors remind us that groups identified as ‘hard-to-reach’ are usually those who, not inconsequentially, are the least powerful in society. If we consider this in the context of PA initiatives such as SAZ, those who are most sedentary will often be referred to as ‘hard-to-reach’ and ‘at risk’ whilst simultaneously being positioned as ‘morally suspect and lacking in responsible self-management’ (Fullagar, 2002: 80). The matter-of-fact way in which the status of hard-to-reach is conferred infers, in turn, that the individuals forming these socially constructed groups are recalcitrant rather than part of a vulnerable population comprised of people facing contextual factors
which restrict their access to services, e.g., economic strife, lack of realistically accessible local services. It also deflects attention away from what might otherwise be considered the inadequacy of the largely behaviour-focused initiatives tasked with reaching them. This is a technology of governance that reinforces the logics of neoliberalism.

The research of Lowther et al (2002) demonstrates how inaccurate this ‘hard-to-reach’ label can be. These authors had considerable success in facilitating the PA participation of poorer people living on a Scottish social-housing estate. This was achieved by using ‘exercise vouchers’ to remove the inevitable financial barrier. They concluded:

_We have shown that, contrary to the popular belief of many researchers that those who are socially and economically deprived are ‘hard to reach’, this population not only responded well to study initiatives but also responded well (comparable with other populations) to the interventions_ (Lowther et al, 2002: 587).

Other initiatives have achieved similar successes with populations sharing common socio-economic characteristics (Yancey et al, 2006). Choitz et al (2010) did not even target such populations, but found that by providing affordable, local facilities in an underserved urban setting they were able to attract ‘hard-to-reach’ people who then engaged in health-promoting behaviours. This indicates that, when significant barriers are removed by health initiatives, groups that are commonly perceived to be ‘hard-to-reach’ can be engaged relatively easily and will often adopt health-promoting behaviours. Such a finding indicates that the capacity to reach such populations is to some extent determined by the approach taken by those planning, funding and delivering initiatives. This reminds us that ‘reaching’ is a dual-dynamic whereby the limitations of those ‘reaching out’ are at least as significant as the characteristics of those considered to be hard-to-reach.

For example, Mummery and Brown’s (2009: 41) somewhat tautological acknowledgement that during the delivery of their community walking scheme, ‘reaching hard-to-reach population groups was a constant challenge’ seems to reveal
as much about the limitations of their intervention as it does the characteristics of these groups. It also suggests that certain interventions will almost inevitably exacerbate health inequalities, as the techniques for recruiting participants from the most vulnerable population groups are at best ill-suited for the task and at worst unconsidered. Indeed, we might argue that the inadequacy of the initiatives designed to reduce health disparities contributes to the hard-to-reach status being conferred on poorer people. Borrell and Joseph (2012: 569) support this conclusion in arguing that the health gap persists in part because, ‘if the intervention does not work, we blame the victim, say the program failed, discontinue and move on to the next one’.

It seems appropriate in this context to return to Sinclair and Alexander (2012: 88) who argue that although engaging ‘hard-to-reach’ groups may prove challenging, ‘where sufficient financial resources allow the development of more creative approaches it should be possible to engage with anybody’. They explored the use of outreach workers to recruit members of a ‘hard-to-reach’ group who had previously been invited to have a free health-check but had failed to attend: thus, this group could be considered especially ‘hard-to-reach’. The use of outreach workers significantly improved recruitment. Mack et al (2006) similarly found outreach workers to be an effective way of helping members of a deprived community to access health services. When interviewing recruits who had previously not taken up the offer of the free health-check, Sinclair and Alexander (2012: 93) found that rather than being strongly antagonistic towards the health screening as implied by the ‘hard-to-reach’ label, recruits were amenable to it but ‘something more’ was required to ‘give them an additional push’. For Mack et al (2006: 22) this ‘something more’ included the development of a relationship with an outreach worker that they described as being ‘necessary in order to support individuals making healthy decisions and to help them overcome personal and structural barriers to achieving good health’. The success of utilising outreach workers led Sinclair and Alexander (2012: 94) to suggest that the people they encountered were better characterised as being ‘hard-to-contact’ and/or ‘hard-to-engage’ but amenable nevertheless to accessing health services.

If the structural conditions of a society are such that it is considered necessary for those living in deprived areas to receive additional support in order to reach a
reasonable health status then, perhaps, the label attributed to these people should better reflect the relative lack of support they receive with respect to achieving this outcome. In two studies that could have otherwise employed the ‘hard-to-reach’ label the terms ‘medically underserved’ (Schrop et al, 2006) and ‘underserved communities’ (Choitz et al, 2010) were alternatively deployed. Such labels could be considered to better represent the characteristics of these people and to shift focus towards the services, or lack thereof, which may otherwise reduce health inequalities. Aside from the potential for the ‘hard-to-reach’ label to stigmatise certain people as recalcitrant, pathological others it also compromises efforts to reduce health inequalities. The changes that would support health services to provide the ‘something more’ that has been argued to be necessary to engage and improve the health of the underserved are undermined by this outward facing label.

To highlight the significance of the agency-structure dialectic is not to undermine the decision-making capabilities of individuals and groups often referred to as hard-to-reach; in fact, much the opposite. Opportunities for victim blaming are limited when we acknowledge that someone’s social position will constrain or enhance their capacity to demonstrate agency. Such an acknowledgement sees the potential for engaging ‘hard-to-reach’ groups through health promotion. After all, what use would it be to argue that governments should provide more adequate services for underserved populations if the actions of these groups were considered to be determined entirely by the structures of their existence? ‘Doing’ health is not simply about people choosing to conform to health promoting behaviours, but about choice being a realistic and feasible possibility for all. This is what those making the argument for behavioural justice advocate (Baum and Fisher, 2014; Adler and Stewart, 2009). It is also the reasoning behind why Conrad and Schneider (1980: 258) envisioned the necessity of shifting focus from the ‘sick role’ to a ‘victim role.’ The latter conceptualises the individual as a ‘victim’ of their life circumstances by recognising that certain conditions increase the likelihood of people performing health promoting behaviours. Because behaviour is not considered to be determined, people are considered accountable for their actions, but it is fully recognised that social context is
also an extremely influential factor. Therefore, in unequal societies, responsibility and blame should not be distributed evenly.

This is particularly important because research on the socioeconomic disparities in health behaviours has consistently indicated that people from lower-SES groups have health knowledge but are limited in their capacities to act upon it (Baum and Fisher, 2014; Dallaire et al, 2012; Pampel et al, 2010). The findings from the survey conducted in Kingsland for this research shows this (see appendix 11.7-11.9). The analysis shows that Kingsland residents and those from areas outside of Kingsland were comparable in their attitudes towards the importance of maintaining a healthy lifestyle (94.3% and 96.5% respectively) and in their ability to correctly identify if they currently did enough PA to meet government guidelines (70.9% and 70% respectively). However, the difference between them is more pronounced when we compare how many people answered ‘yes’ to whether they felt anything was stopping them from doing more PA: Kingsland residents 58.9% compared to 52.6% outside the area.

It needs to be acknowledged that the majority of ‘outsiders’ involved in the survey filled-in the questionnaire at the Leisure Centre, attendance of which may suggest a concern for health, whereas due to their relative absence from this venue Kingsland residents were drawn from more varied locations (e.g., schools, public facilities, food banks). These findings can be seen to further support the notion that lower-socioeconomic groups are informed about health and wish to be ‘healthy’ but perceive more barriers than higher-socioeconomic groups (Kamphuis et al, 2007). The example of swimming at Kingsland Leisure Centre will now be used to illustrate how and why residents may feel more restricted in their capacity to participate in PA and how little was done at the Centre to actively reach out to them.

**If you build it, they will come? Swimming in Kingsland**

The swimming facilities at Kingsland Leisure Centre demonstrate how policies which may at first appear ‘naturally’ to increase the accessibility of services for ‘hard-to-reach’ groups can be viewed differently upon closer inspection. These findings support
the case for pairing geographic research that analyses the number of ‘available’ PA facilities in particular areas with ethnographic analysis so that the accessibility of these services for particular social groups can be more accurately assessed. The initial SAZ consultation in Kingsland declared that the ‘most important’ activity was swimming because ‘it is the sport which most residents want and it is the most popular sport for people who do not play sport at the moment’ (KSAZ, 2002: 29). Therefore, the proposal to build a new Leisure Centre in Kingsland with two swimming pools was presented as a significant opportunity to meet the needs of the community and promote local PA participation. It was known from the beginning that the facility would be the training base for the city’s premier swimming club. A local club was also set up and incorporated into this system. During fieldwork I found that many people felt that the commitment to host these clubs at the Centre presented a significant barrier to the participation of local people and the wider public.

Whilst collecting questionnaires towards the end of my fieldwork I approached a man leaving the Leisure Centre. It soon transpired that he had been unable to use the facility and was understandably frustrated. After completing the questionnaire he was still visibly annoyed and curtly said ‘They might as well not have a pool here because I’m never able to get in it!’ (Fieldnotes: 15/4/2013). This was a common complaint throughout the research. Hosting the swimming clubs was a significant commitment for the Centre: the clubs needed a significant amount of pool time and space. The Local Authority heavily subsidised the pool hire by the clubs and provided funds to pay two full-time coaches to run them. The clubs trained in the main pool during the mornings and afternoon/evenings throughout the week. During my time at the Centre the clubs trained from 5:00 until 7:15 and 16:30 until 20:00 six days a week. During this time they would be given five of the available eight lanes. The pool was also kept at a cool 27°C to create the conditions necessary for elite training (more usually pools are heated to a temperature closer to 30°C).

Although a ‘community pool’ is available to the public it is much smaller, shallower, does not provide the opportunity for lane swimming and is also regularly used to provide swimming lessons for children. When the clubs are not in the main pool, public access is often still restricted by other activities such as synchronised swimming.
and women’s only swimming. Additionally, it is common for the pools to be booked for swimming galas, which means the public are unable to access either pool for an entire day or weekend. Quite simply, elite swimming is prioritised over public swimming and very often this means that people who want to swim at Kingsland Leisure Centre either cannot or have to endure far than inviting or ideal conditions to do so.

Given this arrangement, it is understandable that at a Leisure Centre staff meeting, where Management put pressure on staff to come up with ways that they could reduce complaints, Andy, a Pool Attendant, eventually broke the silence to suggest:

*Get rid of the swim club. They piss everyone off and if we didn’t have them everyone would be much happier.* (Fieldnotes: 27/7/2012)

Although this was not an option, Karen, Leisure Centre Manager, did appreciate the point Andy was making. After a new pool had been built at a university in the city she told to me:

*If I was manager here from the start, I wouldn’t have wanted the swimming club in here. I was hoping they’d clear off to [the new pool] actually. They come in here prime time but it’s also other things, like I have people who will not swim in the pool because it’s too cold but it has to be that cold for the club. Why would you make a deal with a club if you want people to come in and use the pool?* (Fieldnotes: 28/6/2012)

Here, Karen acknowledges that the accessibility of the Centre’s swimming opportunities is severely limited due to the commitment to the swimming clubs. In a broader context, this further questions whether building this facility in North Kingsland can be viewed as an example of policy facilitating access to PA for this neighbourhood and the ‘hard-to-reach’ groups it is ‘home’ to. In this sense, no real effort is being made to engage local people and thus the availability of swimming locally is inconsequential if this activity is not accessible to local residents. Accessibility incorporates both availability and experience and even when the public could get in to swim, participation was often to be endured rather than enjoyed. Tyler, another Pool Attendant, described the cramped and hectic conditions the public face when sharing
prime time hours with the swimming clubs: two or three lanes with a maximum capacity of eight swimmers per lane. He observed:

_It doesn’t matter what kind of level of swimming you are, you are going to feel claustrophobic and that you can’t really get the most out of your swimming._

The Centre did offer free swimming for all city residents every week on a Sunday between 12:00 and 13:00 and more regularly during school holidays but this was not explicitly promoted at the Centre. This concession pales into insignificance when compared to how the opportunity to swim at the Centre is more generally inhibited by the commitment to providing for other, elite groups. However, this slot was used by local officials to demonstrate that the Centre is accessible to local residents and thus facilitated the process of ‘citizen shift’ – as discussed in chapter seven. Therefore, although building the Leisure Centre in Kingsland did theoretically facilitate the participation of ‘hard-to-reach’ groups in PA as a local facility was now ‘available’, overt efforts to engage these groups were largely absent. Rather, the pre-existing commitment to host the swimming clubs actually presented numerous barriers to participation.

Swimming at Kingsland Leisure Centre provides another example of the rather passive ways in which ABIs and service providers attempt to ‘reach’ the ‘hard-to-reach’. Although this is a common finding within this field and indeed my own fieldwork, it was not the only way PA services were provided in Kingsland. The following sections provide thick-descriptive accounts, and some analysis, of the exceptional ways in which local residents seemingly are provided with realistically accessible PA opportunities. Consideration is given here to how and why certain services met the needs of local residents and what this indicates in terms of the measures necessary to engage so-called ‘hard-to-reach’ groups.
The Importance of Going ‘Above and Beyond’

It became clear quite quickly during the fieldwork that service staff in Kingsland differed significantly in their relative willingness to provide the ‘something more’ that Sinclair and Alexander (2012: 93) described as being necessary to engage ‘hard-to-reach’ groups. One of the senior members of management at the Leisure Centre, who had worked for the Local Authority for the entirety of her working life, described two distinct groups of local providers that she characterised as the ‘old’ and ‘new’ schools. She described those who went ‘above and beyond’ what was required of them in order to provide a good service for people as the ‘old school’. Those who treated work more narrowly and instrumentally as a means of income, and so were unlikely to go beyond what could reasonably be expected of them from their employers, were characterised as the ‘new school’. By her (perhaps nostalgic) assessment, the ‘old school’ was a dying breed. These perceived approaches to work may be said to be rooted in changing relations between how leisure, employment and consumption inform identity construction in late-modernity (Bauman, 2005). In this specific setting, however, reflections on these different ‘schools’ can offer some insight into the precarious ways in which community-based initiatives in Kingsland attempted to meet the needs of, and engage with, the vulnerable population they served.

When I spoke to people in North Kingsland about local PA service provision it was common for residents to highlight the significance of a contribution by a particular individual. Illustrating the effects of the waning influence of the past, discussed in chapter six, very often this would reference how a service had declined or even ceased to exist after this person stopped working in the area. Sometimes, it would be to highlight someone’s continued commitment and the difference that they made to local provision. This is perhaps an inevitable outcome of a form of governance that de-collectivises responsibility and thus relies upon the good-will and enthusiasm of individuals (Miller and Rose, 2008; Rose, 1996; 1999a; 1999b). In the absence of public spending that meets the needs of vulnerable populations, if the para-governmental agencies aiming to combat health disparities in places such as North Kingsland are to achieve their aims, the responsibility for making up this shortfall seems to lie with individual staff members.
The long shadow of Samantha, who had previously helped to establish the SAZ project in Kingsland through her managerial position at The Elm, is a good illustration of this. A previously well attended local football project lost its funding and this was largely attributed to the absence of Samantha. She was widely characterised locally as someone who would go ‘above and beyond’ the efforts of others in an attempt to engage local residents. It was common for those who had worked in the area for a long time to reminisce about ‘when Samantha was here’ and how she was the driving force behind establishing local partnerships and attracting funding. Many attributed her leaving the area for a more senior job elsewhere, as the turning point in the deterioration of local service provision. For example, when I spoke to Stu, a local resident and SAZ/Keep-Fit employee, about this view he told me:

*If Samantha was still there I know [the football project] would still be running. A lot of projects stop after their funding runs out, but I know she would have been able to attract more funding. So I just think it’s been unlucky with how things have worked out.* (Fieldnotes: 17/10/2012)

Sam, the current Operational Manager at The Elm, supported this by saying:

*My old boss, Samantha, she was always getting involved in everything and trying to make things work and thinking about how we could do things better and get more people involved. She’s left now. She got a job somewhere else, but the people who are involved now aren’t as enthusiastic as she was about it.* (Fieldnotes: 2/10/2012)

Rather than the deterioration of this service being a case of misfortune, as suggested by Stu, it could be argued that it was more or less inevitable. The short term and limited nature of funding for community initiatives makes long-term employment opportunities exceptional. This is one of the reasons why sustaining services established by para-governmental agencies places such heavy demands on local residents. Despite this demand, it was not clear how even willing volunteers in Kingsland could have compensated for such funding and staffing losses.

One of the ways that services for local residents continued to be provided was through the exceptional efforts of those who were still employed or became volunteers.
Despite the absence of Samantha and funds for the football project, two of the sessions that had been established through this initiative continued to be run at The Elm. This was made possible by the interest and efforts of its Operational Manager Sam, who had grown up in Kingsland on the notorious northern estate and was initially one of the young people this football initiative had recruited as a participant. Previously, funding was available to run football sessions throughout the week with the aim of using PA to occupy the time and attention of predominantly young men from the local estate in an effort to reduce local crime. When the project lost its funding, Sam went ‘above and beyond’ the requirements of his job to ensure that two of the sessions that had specifically targeted young adult males continued to be run. When I asked him why, he explained:

*We try and fill the void, as such, but there is only so much delivery you can do when you’ve lost a project that offers ten staff a week engaging in probably 12 hours of sessions a week... The community group that still come in on a Thursday, we engaged with them from the early days of when this facility was built. We identified them as a core user and we wanted to keep that core user going... If we can just run that session, and they’re going to come every week, it’s a great example of the community being involved still. Even though the funding ended, it’s a way of us engaging them still and hopefully we can expand from that.*

Instead of accepting that the service would stop after the project lost its funding, Sam was committed to ensuring that local people were still provided for. This approach was facilitated by The Elm, unlike the Leisure Centre, being a service with relatively low running costs that prioritised engaging with local residents. Sam took it upon himself to organise and deliver evening football sessions, using the equipment they had at The Elm. He was reluctant to accept that all of the work that had previously gone into engaging with this group might be lost and he understood that the local community stood to lose a significant service. He said of external perceptions of the young men (typically 18+) who attended:

*Rain, snow, whatever, they are always here and that’s one of the reasons I kept this session going: because they want to come here. A lot of them will still live with their parents and have not got a lot going for them. Like, no one wants to work with these lads, no one wants to give them anything, so a lot of them struggle to get work because people don’t want them. That’s why this session is*
so good because, no matter what, they can turn up here on a Monday or Thursday night and play football for free and it gives them a chance to socialise. (Fieldnotes: 4/10/2012)

The group may more broadly be categorised as ‘hard-to-reach’ but Sam described them instead as being pushed away and thus he felt it necessary to reach out to them. A large group assembled each week, even in the most unwelcoming weather conditions. This was just one of numerous ways that Sam’s commitment to engaging local residents was made manifest. For example, he also ran an informal deposit scheme which allowed local people to swap personal belongings, e.g., bikes, phones and keys, in order to borrow equipment. He reasoned that in North Kingsland a financial deposit was not appropriate as residents would not have the required money. It was Sam’s local knowledge and understanding of the characteristics of North Kingsland and its residents and his personal commitment to ensuring services were made available and accessible to them which facilitated his engagement with ‘hard-to-reach’ groups. This helped to combat the short-term nature of grant-reliant initiatives, which often lead to the a loss of services and a tendency towards victim blaming (Borrell and Joseph, 2012; Conway et al, 2007)

The differing ‘fortunes’ of the FIT-FRIENDS run weight-loss groups that originated from the SAZ initiative also illustrate this theme. As already outlined, there were three single-sex weight-loss groups established during the NDC/SAZ initiatives in (2001-2005): one male and two female. When I started my observations with the weight-loss groups in (May, 2012) all three groups were still operating in Kingsland, but 16 months later only one was still a local group and even that had an uncertain future as funding was soon to run out. The differing characteristics of these groups, and the people that led them, demonstrate the importance of service staff being willing to go ‘above and beyond’, to give ‘something more’, in order for these groups to be sustained and appeal to participants.

The two women’s groups demonstrate the ‘old’ and ‘new’ schools and the influence that they can have. Both groups had previously attracted large numbers (in the region of thirty to forty people in each weekly session). Numbers had significantly dropped by
the time of my observations but the drop was far sharper at the Monday night group (usually fewer than five attended) compared to the still relatively well attended Thursday morning group (between ten and twenty). The differences between the groups were, again, largely attributed to the actions of individuals. When the Monday night group previously attracted lots of participants the long-time instructor was Lindsay. Funding cuts led to Lindsay being made redundant and three different instructors came and went in the year that followed before the decision was taken to stop running the group. Speaking to participants who had regularly attended for many years it was clear that they attributed the demise of the group to Lindsay’s redundancy. Jackie, and many other people locally, put the group’s demise down to the instructors who followed and who lacked Lindsay’s commitment and passion:

*I don’t get the feeling of enthusiasm that comes out from Lindsay and it just seems a bit like ‘Oh it’s a job’ and we’ll get you down there and do a bit of exercise and that’s your lot.*

Jackie was not complaining that the other instructors did not do their job, but that they did not go beyond this basic input – they failed to offer something more. Of course, employers cannot legally expect that those they employ will go above and beyond what is required of them to fulfil the terms of their contract. But the implication here was that this was what was required in order for the group to attract and engage participants in areas such as North Kingsland. Another Monday evening participant, Fran gave an indication of what Lindsay did that was different from the others:

*You knew where you stood with Lindsay. She was always here and she always organised everything for us. She would organise events and get funding for things like the Race for Life*\(^5\) *and get us to do it. We’ve not had that for years now. When she left it was more like ‘Well it’s up to you lot now’, so it was down to the ones that came to get it all sorted.* (Fieldnotes: 5/11/2012)

Jackie clarified why this was felt by the women to be an inadequate solution:

\(^5\) Nationally organised women-only charity races in support of Cancer Research UK
I know it’s nice to get individual people doing it themselves, but you still need to have the support of somebody behind you to encourage people to go forward and do it.

These comments highlight the constrained agency and need for additional external support often characteristic of people living in vulnerable populations. There is an acknowledgment here that they are capable of taking on responsibility, but it was also felt that there was a need for support in their efforts. These comments imply that, without this support, the potential of participants can go unrealised, something which was observable in the demise of this group.

Lindsay was ‘reliable’ and consistently went ‘above and beyond’ merely offering a standard weight-loss service, e.g., she organised motivational events which acted as goals to keep the participants interested and engaged - this also created a strong climate of social support. After organising a mountaineering expedition for the group, for example, Lindsay drove from the Midlands to Wales on a day she was not working just to congratulate her group on climbing the mountain. This was typical of her commitment to them. Lindsay explained to me that she did not experience working with these women as a job but that she enjoyed their company and took genuine satisfaction from helping local women achieve their goals. Lindsay did not have to adopt this approach to meet the basic requirements of her job, but it was evident that it was considered to be an essential factor in her success at engaging and attracting participants. Building this rapport and reputation is particularly significant as local initiatives heavily rely upon word-of-mouth to attract new participants.

The relative success of the Thursday morning group was also attributed to the approach and individual attributes of the instructor. Parina was ‘loved’ by her group and it was common for participants to concede that she was one of the main reasons why they were able to engage in what many of them experienced as the emotional and arduous endeavour of losing weight. Parina established friendships with many of the women and her support went beyond the confines of the group. For example, she receives messages from the women via social media sites and she feels compelled to offer them advice and support outside of her role as group instructor. It was evident
that Parina committed many more than her contracted hours to ensuring that the women who attended her sessions (the initiative started in Kingsland but was spread citywide) felt supported.

When I spoke to Parina about other instructors she worked with, such as those who worked on the Monday evening, she suggested that ‘for most of them it’s just a job’. It was evident that it was far more for her:

*If it wasn’t for them [the group participants], I don’t think I would get out of bed in the morning if I am honest. D’ya’know, you meet so many ladies, people don’t see it as an important job but it really is. And you know when you get somebody that has got no confidence, don’t socialise, you know, they’re snowed under with so much responsibility at home and duties and what not. And then they get that little hour to themselves when they’re with you and you see them flourish. And you really do, through physical activity, and it does happen. And you just think ‘Wow’. D’ya’know what I mean? They’ve done this and it’s because you gave them the opportunity.*

It was clear that Parina had personally and emotionally invested in the group and its participants. This investment meant that she offered participants ‘something more’ which facilitated the engagement of a vulnerable population and ultimately helped sustain the service. This was, of course, in stark contrast to the Monday evening session after Lindsay’s redundancy. As the demise of the Monday evening group indicates, without this sort of personal dedication on Parina’s and Lindsay’s parts, the level of support necessary to engage groups considered to be ‘hard-to-reach’ would have been absent. Without Parina’s efforts it is very likely that numbers would have dropped and, as with the Monday group, the decision would have been taken by FIT-FRIENDS to remove funding. Understandably, going ‘above and beyond’ the requirements of one’s job like this eventually took its toll on Parina and this left the future of the group in a precarious position. She told me:

*Another thing that gripes me and is probably why I’m going to opt out of getting my contract renewed is, I can’t, me, one, make this whole project work, all of the elements that we’re looking at. That’s how I feel. I feel like I’ve carried everybody and I can’t do it. I’m getting tired, and no one’s actually recognising that, if I’m honest. They say ‘Your numbers across the board [need to increase]’ It’s like ‘Do something about it then!’ You know, it’s like I’ve carried it all on my own and it’s tiring.*
Much more was required from Parina and Lindsay than could reasonably be expected of someone on a part-time contract and a relatively low wage. Their cases add weight to Conway et al’s (2007: 217) contention that ‘without enough funding, enthusiasm and voluntarism are necessary but insufficient conditions for community development’. Their enthusiasm and voluntarism are necessary and relied upon to compensate for community initiatives being ill-equipped to comprehensively address the social factors which contribute to disparities in adherence to health behaviours.

The continued existence of the men’s weight-loss group also relied heavily upon the efforts of a single person. Carl Simpson. ‘Simps’, took over as the leader of the group when its funding was significantly reduced and so the previous instructor left. The women’s groups continued largely because funding for a new initiative with overlapping targets was used to replace funds from the SAZ era. The men had a much more precarious and meagre funding arrangement, so they relied on Simps volunteering to run the sessions as well as drawing from the collective resources of the men in the group to make up for other shortfalls. For instance, the men organised a Christmas party for the old people’s home on the north Kingsland estate in exchange for using one of their rooms to weigh-in. Such an arrangement was necessary because the Leisure Centre expected the group to pay to hire the room where they previously weighed-in for free and funding was no longer available to facilitate this.

Simps became involved with the group at the beginning when the SAZ project had funding to run one-to-one exercise sessions for local residents. He was overweight and uninterested in changing his lifestyle. He only got involved initially to support his wife’s efforts to combat depression. As a consequence of the programme, he lost a lot of weight and was able to quit his job painting cars to become a fitness instructor at a mental health institution. It, quite literally, changed his life. However, the service severely declined over the years until it came to a point where, without volunteers, the group would have folded. Simps told me:

*I was a participant at first and then basically I got so much out of it that I thought ‘Right, I might as well put something back.’ That’s the main reason that I volunteer.*
To keep the group going Simps had to take on a lot of additional roles and responsibilities as the majority of the other participants either did not or could not commit their time to these tasks. It became clear in a conversation with Jackie, Simp’s wife, what sort of strain this put on him and his family:

*I keep giving him a hard time because we have to keep all that bloody equipment in our spare room. I told him, I want that spare room so you best tell [the group] to buy you a shed or something. I won’t have it anymore. It’s like the minutes for the meetings. He always has to do the minutes because no one else will do them. And who ends up doing them? Me! I have to wash their bibs every week too. You don’t get any thanks or credit for it either!* (Fieldnotes: 5/11/2012)

It was clear that the other participants understood that the future of the group lay precariously within the willingness of Simps and his family to perform a range of unpaid functions. As one group member put it when asked about instructors the group had had in the past:

Yeah...but they stopped and we’ve got Carl Simpson now. If it weren’t for him coming over here and doing it I don’t think there would be a group anymore.

Each of these weight-loss groups demonstrate the precarious nature of sustaining services in areas where community initiatives have been funded and implemented but where resources have since come to an end. What can be seen in North Kingsland is how heavily reliant vulnerable populations are upon the extraordinary efforts and sacrifices of individuals. It was clear, though, that these efforts alone were insufficient to sustain the sorts of services that would increase the opportunity structure in North Kingsland enough to offer something approaching equitable access and thus have the potential to facilitate the agency of local residents.

These examples also illustrate how labelling residents from deprived neighbourhoods as ‘hard-to-reach’ defines the limits of neoliberal governance as a means of effectively supporting vulnerable populations. The experiences of those providing services in North Kingsland illustrates that, to a certain extent at least, these groups may be hard-to-reach precisely because the hands of those trying to reach them are effectively tied by the constraints of the para-governmental agencies tasked with doing so. Engaging
North Kingsland residents relied heavily upon the willingness of individuals to go beyond what could be provided within the existing, but diminishing, services. In some cases, too, it was also a matter of these committed and resilient individuals challenging existing power structures and tolerating ‘inappropriate’ behaviour to achieve this goal.

**Rule breakers: Re-appropriating the ‘Inappropriate’**

One of the many critiques of the medicalizing risk discourse is of its tendency to create behaviour binaries; healthy and unhealthy: good and bad; acceptable and unacceptable (Cheek, 2008). This discourse informs ideas about the ways in which health should be ‘done’. Appropriate ways of appearing and behaving are also informed by socio-economic position. Social norms and what is considered acceptable behaviour differ throughout the social structure and intersect with health and the body at numerous points (Bourdieu, 1984). It is at one of these intersections that we find health interventions with the, at least stated, aim of attempting to engage hard-to-reach groups. The groups in North Kingsland that still engaged local residents offered insight into the tensions posed at these intersections and how perceptions of ‘appropriate’ behaviour can be detrimental to initiatives attempting to engage vulnerable populations.

It has been established in chapter six and seven that local attendance at Kingsland Leisure Centre decreased over time and this can be attributed at least in part to the decline in partnerships with initiatives that sought to engage Kingsland residents. The activities offered by the Leisure Centre also played a key role. One activity that was initially offered there was boxing. It was seen as a way, especially, of encouraging young local males to use the Centre. It also compensated for the loss of the main facility in Kingsland that pre-dated the Leisure Centre, and included a boxing hall, but was burnt down. The absence of boxing from the activities at the Leisure Centre during my fieldwork helps to illustrate a more significant issue.
Some years after the Centre had opened, a local voluntary group found through their outreach work that local residents wanted more opportunities to engage in training for boxing. The group approached the Leisure Centre’s management and it was decided that the Leisure Centre would donate their boxing equipment, which had been bought to offer the activity but was currently not being used, to a local boxing club. This equipment was used to run fitness sessions for the community in a building on the estate that had been acquired using NDC funds. In interview when I asked Karen, Leisure Centre Manager, why the decision was made not to offer boxing at the Centre, she told me that she had gone to great lengths to make the Centre ‘member’s friendly’ and that boxing was:

...not something that I would have wanted to encourage here because people already had an idea that Kingsland Leisure Centre would be a rough, tough thing.

In order to attract custom from outside Kingsland, where it was perceived to be a ‘rough, tough’ place, Karen wanted to distance the facility from the area’s ‘spoiled identity’. Arguably, in so doing she contributed to the stigma that residents of socially deprived areas often face (Bush et al, 2001; Goffman, 1963). This was a consistent theme and it became evident that the perceived ‘inappropriateness’ of the behaviour of some local residents was considered to compromise efforts to attract more affluent outsiders to the Centre – to make it a place they considered to be ‘for the likes of us’. For instance, heavy weights were removed from the gym to discourage male bodybuilding, and it was decided that football, as well as boxing, should not be permitted in the sports hall. What became increasingly clear, both inside and outside the Leisure Centre, was that when local residents (perhaps especially younger males) were successfully engaged it was in part due to a willingness to tolerate what might otherwise be stigmatised ways of being. The weight-loss groups at the Centre offer good examples of how there are pockets of acceptance for these ways of being and how this facilitated the engagement of local residents. However, they also show how such accommodation was not necessarily supported by Leisure Centre policy.
A shared characteristic of the men’s and women’s Thursday morning weight-loss group was commonplace swearing among users and for the authority of instructors to be playfully undermined on a regular basis. Although this was more common in the men’s group, it was also notable amongst a number of the local women who attended sessions. This behaviour was an accepted part of interaction in these groups. For example, amongst other things, the men would often call each other ‘fat bastards’, deliberately wind each other up, ignore instructions from the group leader and insinuate that, due to his inadequacies as a man, either they, or someone else, was ‘shagging’ his wife.

In the women’s group, Parina turned to revelling in the ‘hate’ she received from the women in the group when she instructed them to do something physically demanding. She was ritually told to ‘Fuck off’, for example, and usually responded with playful retorts such as, ‘I know you love me really’. When I spoke to Shannon, one of the Kingsland residents about this she told me:

*She knows how I am and she knows that I don’t mean anything by it. Like the saying goes: What you see is what you get, but she knows what I am like so [she is not offended by this].*

Group leaders Parina and Simps had both previously lived locally, which may explain their accommodation of both behaviour and language that elsewhere might be discrediting. This enabled them to create conditions within the group conducive to incorporating, rather than stigmatising and excluding ‘challenging’ Kingsland residents (Goffman, 1963). When I asked Parina about this and whether she felt this approach helped her to engage with Kingsland residents she told me:

*I think it does, because I kinda know the lingo, you know what I mean? Because you’ve got to become like your community that you are working with. You’ve got to know how to relate to them and sympathise with them, empathise and all the rest of it. And I think coming from Kingsland, you know, those ladies on the Thursday morning - I can relate to them. And it does have a massive effect on getting on with that class, yeah, and the success of it.*
Knowing the ‘lingo’ allowed both Parina and Simps to negotiate ‘inappropriate’
behaviour and language and this facilitated forging relationships with residents on
their own terms and in ways which were conducive to engaging them in PA. In turn,
this allowed them to create opportunities at a facility that was more widely
understood locally as not being ‘for the likes of us’. But more than a willingness to
accept local residents as they were, it was also evident that there was a willingness on
the part of the instructor to covertly challenge the existing power structures and value
judgements by ‘breaking the rules’. This was also important in order to offer more
inclusive and engaging activities for local residents.

The Leisure Centre placed various restrictions on the weight-loss groups. For instance,
the men were not allowed to play football and Parina was told not to deliver Zumba
for the women because the Centre had their own Zumba classes and offering a
subsidised class was considered a conflict of interests (further evidence of the
competition between local service providers analysed in chapter seven). It was often
the case that providing activities that engaged local residents relied upon the
willingness of an instructor to risk upsetting relations with the Leisure Centre
management by breaking the ‘rules’ that had been set out. Examples include Simps
succumbing to pressure from the men to allow them to play football in the sports hall
and Parina doing the same to deliver Zumba classes. Lindsay responded to being told
that her group could not have more hall space because badminton courts needed to
be open to public booking, by using a false name to book out the badminton courts. All
of these minor acts of resistance were done covertly, in acknowledgement of the
fragile relations between the groups and the Leisure Centre management. But this risk
was taken because the instructors were acting in what they perceived to be the best
interests of the group. Having an instructor who was willing to bend the rules and
challenge the existing power structures created PA opportunities for local residents
that would not have existed otherwise.

The activities at The Elm provided the most extreme examples of otherwise
stigmatised behaviours being accommodated by service staff in an attempt to engage
residents from North Kingsland. The previously referred to Thursday evening football
sessions were a longstanding and well attended initiative, one almost exclusively
attended by young men who lived on the northern estate. The successes achieved by engaging this group can be largely attributed to behaviour being accommodated that would have been reason for exclusion elsewhere – including at the Leisure Centre. The sessions were characterised by the sort of ‘rough and tough’ behaviour that Karen had made clear was unwelcome at the Centre. Matches were physical affairs and although aggression was largely contained it did at times boil over into confrontation and violence. Rather than being an overtly instructive and ‘encouraging’ environment that might be considered as fundamental to supporting PA participation, the following exchange was more typical of the culturally constituted local interaction within the group:

One of the lads kept doing things that impeded his team’s ability to win, e.g., not playing well, getting in the way of others, etc. A number of the other lads were quick to say to him that he was “shit” or “the worst player down here by far”. Lots of the lads laugh at this abuse and then one of them says, jokingly, that they should leave off him, another replies “What the fuck? We’re not at school now, we don’t need to build him up. He’s shit and I’ll tell him he’s shit.” All the lads laugh at this. (Fieldnotes: 10/1/2013)

Sam and Robbie (the other member of staff who supported Sam in these sessions) were themselves recruited from the northern estate by the initiative. During these sessions Sam and Robbie facilitated the group by providing a ball and bibs and timing the games, but rarely acted with any real authority. They mainly reverted back to being ‘one of the lads’ and adopted the physical style that was required to participate. It was their willingness to allow the smoking of cigarettes and joints (cannabis) which perhaps best demonstrated their approach to engaging this group.

It was usual for participants to smoke whilst waiting to play. Very often the unmistakeable smell of cannabis would weigh heavy in the air and it was common to hear the men say ‘Who’s on this?’ as they passed a joint between themselves both on and off the pitch. This was done overtly, with Sam even joking one week with some of them, ‘You boys just can’t stay off it can you?’ to which one replied ‘Nah mate. Why would we?’ (Fieldnotes: 21/2/2013). Although Robbie sometime smoked cigarettes at sessions, neither he nor Sam encouraged the other lads to smoke but, as with the
wider policy at The Elm, it was accepted that many local people did smoke and use drugs and that to exclude people on the basis of this would be to turn away those they were attempting to engage.

Accommodating, whilst not promoting, behaviour which may otherwise be considered ‘unhealthy’ seemed a pragmatic and effective strategy for engaging this, commonly labelled hard-to-reach, group in PA. I asked Sam if he felt this level of tolerance was required to make an impact with the local community:

_Oh definitely. You know, you have to kind of speak on their terms and engage with them in that way, otherwise you’re not quite getting their understanding of why they are doing stuff. I mean, if they’re arguing and shouting and swearing it’s in their culture. You don’t want to be intimidating or belittle them. They need that self-esteem, they need that confidence. They want to be engaged. You going and saying ‘Right you can’t do this, you can’t do that’, building barriers and building walls. It’s going to make participation less in the area. If you are not tolerant of some misbehaviour you’re never going to get wider participation._

The effort of these individuals in Kingsland demonstrates that, via some rule bending and extended tolerance, reaching the ‘hard-to-reach’ is not necessarily beyond the practical capabilities of services. However, their exceptional efforts were required, not necessarily because the groups were ‘hard-to-reach’ but because the new public health approach provided insufficient and inappropriate means for doing so effectively and on a large scale. What was clear in North Kingsland was that many of the local service providers who could potentially offer PA opportunities to the hard-to-reach were often unable or unwilling to accommodate the social norms of these groups. This means that the partial transformation of Kingsland into a bio-sphere of risk-aversion did not necessarily do much actually to support local participation. This is particularly problematic as the stigma faced by those living in deprived areas is liable to impact detrimentally on efforts to (re)construct a positive identity by, for instance, acting in health promoting ways (Popay et al, 2003). Reaching out to these groups was often beyond the stretch of, or unsupported by, the services that could have otherwise engaged them. This was true both financially and logistically.
Conclusion

These examples from Kingsland demonstrate that the ‘hard-to-reach’ label is at best a clumsy term. It appears to tell us as much, if not more, about the inadequacy of the bio-political strategies used in an attempt to govern these groups as it does the supposed characteristics of those so labelled. In the exceptional cases in Kingsland where the conditions offered were conducive to engaging with residents, this success was largely attributable to individuals who took it upon themselves to go ‘above and beyond’ what may be expected of them and to challenge, albeit covertly, the established power structures. These individuals embraced those considered hard-to-reach, while other services kept these stigmatised groups at arm’s length. Their efforts were in contrast to services offered by the Leisure Centre and the wider social and political structures which identify risk groups and advocate self-management. Their occurrence and necessity is indicative of the process of citizen shift analysed in chapter seven.

Not only is the responsibility for PA participation increasingly shifted to individual citizens, these examples show that this is also the case for the responsibility to provide services that engage the ‘hard-to-reach’. Sinclair and Alexander (2012) argued that where sufficient funds are available, creative approaches can be developed to engage vulnerable populations. The examples from Kingsland demonstrate that this is also possible when little funding is available and they indicate the potential for reaching those considered ‘hard-to-reach’. They also highlight how efforts to engage the ‘hard-to-reach’ are compromised by short-term community initiatives that have drifted into promoting lifestyle modification and continue to explicitly and implicitly shift responsibility for health to individual citizens. These local projects are largely unsupported and their future existence is thus precarious and overly-reliant on the capacity, willingness and dedication of a small number of committed individuals who actively engage local people.

It must be acknowledged that despite the exceptional efforts of a few individuals to accommodate and engage the local residents that did access services, many local residents were largely untargeted. As such, without the outreach work that could be
considered necessary to facilitate access to PA services by vulnerable populations, the efforts of these individuals essentially kept afloat initiatives that were liable to be more readily accessed by participants (e.g., ‘outsiders’ with higher-SES) whose disproportionate participation is liable to exacerbate health inequalities. With regard to reducing health inequalities, the examples from Kingsland illustrate two key points. Firstly, if the appropriate level of support is present - and even in some cases where it is lacking - it is possible not only to reach vulnerable populations but to facilitate their engagement with health promoting PA behaviours. This indicates that the disparity in adherence to health behaviours is not merely a matter of agency being enacted through recalcitrance, but a reflection of the constrained life chances of lower socio-economic groups. Secondly, it illustrates that the limits of community-based initiatives compromise efforts to engage those considered to be hard-to-reach.

The argument presented here is not aimed at encouraging conscientious individuals to take on ever more responsibility for managing the deleterious effects of the largely unaddressed social determinants of health. Rather, it is an illumination of how service provision will be routinely insufficient to engage vulnerable populations while the new public health debate is dominated by the logics of neoliberalism. The need to be critical here is highlighted by the contradictory arguments of Taylor et al (2011: 141). Although, in conclusion, they suggest that increasing the usage of sport centres by hard-to-reach groups relies upon ‘specifically targeted activity programming and promotion, and more outreach provision rather than expecting the socially excluded to attend’, they previously argue that ‘the very nature of hard-to-reach groups means that we have to caution against over-criticism of public facilities for not reaching [them]’ (Taylor et al, 2011: 138). From these statements it is clear that, perhaps inadvertently, Taylor et al (2011) position the ‘nature’ of the group, rather than the shortfall of public services, as the problem. The examples from Kingsland included in this chapter demonstrate what other authors have also argued (e.g., Blackman et al, 2012; Conway et al, 2007), that the hard-to-reach are categorised as such because public services often lack the means to implement the sorts of suggestions Taylor et al (2011) make. Therefore, arguably, to hold back criticism of the inadequacies of public
facilities is to be complicit in the positioning of health behaviours as personal, rather than public, responsibilities.

Although New Labour’s ABIs and the Conservative’s ‘Big Society’ differ in their proposed solutions to addressing deficiencies in local service provision, the rhetoric of both promote individual responsibilisation. Both expect individuals to ‘step up’ in order to close the gap between what is needed in local communities and what is actually provided in terms of services. Both of these neoliberal approaches rely on that ‘something more’ coming from the energy, enthusiasm and philanthropy of individuals, especially those working with para-governmental agencies. This research in Kingsland demonstrates that adopting such a strategy often fails to engage those most in need.

Those who go ‘above and beyond’ in Kingsland reveal the great strain placed on a few individuals without adequate means to resolve a deeply embedded social problem. Even the most willing and conscientious people are limited by the structures they work within. This was well summarised by the lament of one of the local men at the weight-loss group one evening:

Everything we do is about money now and raising funds. We’re doing something for the community but nobody’s helping. You’d think that the NHS would want to help us. We’re saving them money, we’re making unfit people healthier, but no. (Fieldnotes: 30/5/2012)

The logics of neoliberalism have both created, and support, a system of reticent and restrained ‘reachers’. Such a system blames the victim by labelling them ‘hard-to-reach’ whilst simultaneously offering insufficient means for reaching them. These examples from Kingsland are illustrative of how this paradox can exacerbate social disparities in health behaviour adherence.
Chapter Nine

Something to Cry About?

‘Ladies’ and ‘Fat Bastards’ Responding to a Crisis in Morality

Introduction

This final fieldwork chapter completes the route from more macro-level considerations to micro-level observations. Up to this point, the example of Kingsland has demonstrated the limits of addressing health inequalities through neoliberal community-based initiatives partially transforming areas of deprivation into biospheres of risk-aversion but largely failing to sustain equitable service provision. At a population level, these initiatives are thus inclined to exacerbate existing inequalities. The example of Kingsland has also demonstrated that, in exceptional cases, services do target and engage those most in need – as was demonstrated in chapter eight. Despite this, the influence of the new public health has encouraged the processes of lifestyle drift and citizen shift and thus served individual solutions to people who face significant social disadvantage. What are the consequences of this? Findings from participant observation and interviews with three single-sex weight-loss groups who met at Kingsland Leisure Centre are used to argue that outcomes are counterproductive to the aims of the new public health.

In this chapter, health is understood as a reflexively embodied experience. As such, the experiences of weight-loss group participants are used to reveal how the lives of people from low-SES groups are affected by obesity being appropriated, both politically and culturally, as a stigmatised disease state. Particular attention is dedicated to how this approach informs participants’ comprehension of what health is and how someone in their position is able to be(come) ‘healthy’. Of equal concern here are the ways in which weight-loss is a gendered practice and how the potentially emotive issue of weight is negotiated in these groups. These findings reveal how the dominance of neoliberal ideology means that participants at the weight-loss groups in
Kingsland simultaneously accept and resist ‘healthy’ living as a personal responsibility: conceptualised here as ‘risky resistance’. On this evidence, the new public health approach to reducing the incidence of obesity is found wanting on both ‘moral’ and practical levels.

**New Public Health, Obesity and Reflexive Embodiment**

As delineated in chapter two, the aim of the new public health is to persuade people that it is beneficial to act in accordance with the interests of government, i.e., to minimise public health expenditure and increase productivity. Norms are created to provide a measure that people can be judged against, by themselves and by others. Conforming to these norms is not only presented as advantageous for the individual but also as morally superior. As such, being a healthy citizen becomes a moral obligation. In short, new public health is a form of governmentality or, more specifically, an example of biopolitics. It is an approach that brings health behaviours to the fore of public health debates and it is within these debates that we find the obesity ‘epidemic’ mainly positioned.

Reports about the exponential rise in the incidence of obesity over time may not be entirely accurate, but they are popularly accepted (Gard, 2011). The WHO (2000) defines obesity as a chronic disease state and the BMI scale uses risk as a means to normalise it. Everyone is implicated and because weight-gain is presented as merely the consequence of a positive imbalance in the energy-in-energy-out equation the responsibility for managing this ‘risk’ is individualised. Rail (2012: 240) argues that through ‘bioprocesses such as biomedicalization, bioeconomics, and the circulation of biocultural discourses’ societies become a borderless clinic where people are encouraged to confess their culpability and take corrective action in order to become upstanding bio-citizens. Of course, in image obsessed consumer societies svelte and toned bodies are not only, or even, prized for their supposed health-affirming properties (Baudrillard, 1998; Pronger, 2002; Smith Maguire, 2008). The lines between health and beauty are blurred and achieving ‘the look’ within this culture of
‘fatphobia’ relies upon demonstrating a capacity for self-regulation via a lean, taut and exercised body (Featherstone, 1982; Lupton, 2013; Monaghan, 2008).

Large numbers of people in the UK and beyond currently fail the bio-citizenship test presented by the BMI. On top of this everybody, irrespective of whether they meet the ‘healthy’ weight criteria and/or present an outwardly ‘healthy’ image, will encounter some degree of both internal and external moral scrutiny (Gard and Wright, 2005). As biomedical influence increasingly encompasses and moralises more of everyday life, the complexity and nuance of our every decision and behaviour is undermined by the possibility of them being dichotomised into healthy and unhealthy, good and bad (Crawford, 2000; 2004; 2006; Zola, 1972). People who fail to attain the health, happiness and freedom that supposedly lie in wait for those virtuous enough to ‘choose’ to live a healthy lifestyle are popularly understood to deserve the stigma, blame and ill-health that is otherwise theirs. For this reason, Evans et al (2008: 57) describe how feeling/being fat carries personal stigma and evokes feelings of guilt, sadness and shame. They go on to argue that as a result ‘body perfection codes’, to some extent, determine ‘the positive and negative values of different possible behaviours of and on the body’. Therefore, it is clear that the body and decisions/behaviours associated with its modification/maintenance are central to contemporary conceptions of what health is and how it is ‘done’.

Research indicates that inequality has a detrimental effect on health that is independent of the associated social determinants of health (Marmot, 2005; Wilkinson and Pickett, 2010). This has been conceptualised by Marmot (2005) as the ‘status syndrome’ and explained as the deleterious biological effects of the psychosocial experience of inequality. Research also shows that obesity has a social gradient – incidence increases as you move down the social spectrum (Drewnowski, 2009; Pickett et al, 2005). In this regard, it seems reasonable to argue that the detrimental psychosocial experience could be informed by a perception by those lower in the social hierarchy that higher social positions offer greater opportunity to control anxieties and the stigmatising effects associated with demonstrating a lack of ‘self-control’. What are the biological effects of holding this perception whilst also finding oneself in a relatively low social position? In short, does the anxiety and stigma
associated with non-conformity, e.g., being overweight or obese, have a detrimental health effect, independent of those associated with a positive energy imbalance? Whatever the answers to these questions, if the argument that the psychosocial experience of inequality is, in and of itself, detrimental to health is accurate it can only be as a result of recognising that social structures and labels are embodied (Krieger and Davey Smith, 2004).

Crossley (2006a: 2) succinctly outlines the notion of ‘reflexive embodiment’ by explaining that ‘human bodies exist in two dimensions. We are our bodies (being) but sometimes perceive them as an object that we possess (having)’. Bodies are both subjectively and objectively experienced. This is how social influences can make bodies feel particular ways and impact on physical health. For Freund (2011), this process means we are all ‘mindbodies’ with the potential to self-initiate health states on a conscious-unconscious level. For example, this is how the depression someone experiences as a result of being/having a stigmatised body may detrimentally impact their physical health. It is because social influences are reflexively embodied that Kirkland’s (2010: 195) contention that ‘the way one thinks about something like health really makes a difference in what it is and becomes’ is so salient in obesity and health inequalities debates.

Frank (2006) contends that health consciousness comes as a result of people being differently influenced by various stories and messages that they encounter. As such, it is imperative that sociologists continue to research the social consequences of public health and popular messages that define particular bodily forms as both risk-inducing and morally repugnant. How do the individualising discourses of the new public health and, more specifically, the obesity ‘epidemic’ influence the ways in which people understand health, themselves and their everyday experiences? And how does this influence the ways they behave? Specifically, how do these messages inform how people think about and actively approach body modification through PA and dietary practices? This chapter draws on eleven months of participant observations and interviews with three NHS-subsidised, single-sex weight-loss groups (one male and two female) that met at Kingsland Leisure Centre. The following section engages with
the ways in which health was defined by participants and whether they considered health to be a personal responsibility.

**Risky Resistance: Taking ‘I’ Out of BMI**

It may be assumed that those with the means to act upon health advice will more readily accept the notion that they are personally responsible for their health when compared with people who feel more constrained in their capacity to comply with such recommendations (Bourdieu, 1984). Such logic implies that people from low-SES groups would be more inclined to question the discourse of moral individualism. Despite this, those attending the Kingsland weight-loss groups tended uncritically to accept the notion that health was a personal responsibility. Generally, health was spoken about in functional and negative terms; as a capacity, being able to provide for others, the absence of illness and disease, and not wanting to become a burden. These are long-established lay health views (Blaxter, 1990; Cornwell, 1984; Hughner and Kleine, 2004). Alf’s and Jackie’s comments are typical:

*Alf:* Well I just think you’ve got a responsibility to yourself. Obviously you need to be responsible yourself because if you don’t then you’re not well are you and that impinges on your family don’t it. But I think to yourself, more than anything.

*Jackie:* Yeah you do [have a responsibility to be healthy], to yourself more than anything and to make sure you are living healthy enough so you can look after your family to start with. To be able to continue working and then obviously, not to be going back to the doctors every five minutes with another complaint.

To explore whether the largely uncritical acceptance of personal responsibility remained consistent once health was addressed as something less abstract, the participants were asked about how achievable they felt ‘healthy’ living was for them personally. The simplified logic implied in the UK Government’s *Change4Life* campaign slogan was used to ask: is living a healthy lifestyle as simple as eat well, move more, live longer? Becky provided the sort of critical response that may be expected of a participant of low-SES who feels it necessary to attend a weekly weight-loss group:
It’s just not that simple and I don’t agree. For people who have got the time then, yeah. But for me I don’t feel it applies and I don’t think that people who sit down and put this together actually live that sort of lifestyle. They’ve probably got people looking after the kids, they’ve got nannies or their wife’s doing it and they’re just putting something together that, in theory, works but practically it doesn’t.

Becky does not deny that complying with this logic would lead to better health but felt it was not appropriate to apply it to herself because the everyday realities of her life added complexity that such simplification could not accommodate. However, notably, Becky’s comments were a rather lone critical voice. Others of the same SES were more inclined to attribute ‘healthy’ living to the effort and willpower of the individual. This was evident when Jonny and Phil were asked the Change4Life inspired question:

Jonny: If you wanted to, yeah. But I think it’s all down to the individual and what they like to...

Phil: ...Eat and do.

Jonny: Yeah.

Phil: It’s all down to that person really, if he puts his mind to it then he can do it and if he can’t, he can’t.

This acceptance was also evident when speaking to Etta who, like Becky, was a mother of young children:

I think that some people are lazy and it’s easier to go and do a £25 shop at Iceland.6

Personal characteristics were considered to be the crucial factor. Like the lower-SES respondents Peacock et al (2014) spoke to about social mobility in their study Dependency Denied: Health Inequalities in the Neo-Liberal Era, the perception amongst participants was that someone occupying their social position can succeed and so inhibitory social factors were not considered a legitimate excuse for ‘failure’.

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6 Iceland is a British supermarket chain that sells inexpensive frozen fast-food
This illustrates the pervasiveness and persuasiveness of neoliberal logics - but it also presents a paradox.

All but a few of those who attended the weight-loss groups were classified as either over-overweight or obese. Despite considering themselves responsible for their own health, and perceiving themselves capable of ‘healthy’ living, only a few participants actually seemed to make a concerted effort to lose weight. While weight-loss was overwhelmingly seen as a positive achievement, regular weight-loss was not common. Most participants fluctuated, week-to-week, but in the longer-term they maintained a relatively stable (over)weight.

It has long been recognised that people hold a variety of views about health and that these views can differ significantly from the biomedical perspective (see e.g., Herzlich, 1973; Hughner and Kleine, 2004; Wardle and Steptoe, 2003). That the behaviour of weight-loss group participants in Kingsland deviated from biomedical definitions of health is, to some extent, to be expected. But how did participants reconcile moral individualism and behaviours/bodies that are stigmatised by this discourse? The process illustrates something particularly telling about the influence of new public health and neoliberalism more broadly. This will become clearer as examples from the weight-loss groups reveal what can be conceptualised as ‘risky resistance’.

It was common for participants to target, or to be content to maintain, weights that they understood would lead them to being categorised as overweight or obese. Many spoke about using the weigh-ins held at each weight-loss session as an opportunity to ‘keep an eye on’ their weight and to ensure that they ‘don’t get any worse’. They were able to reconcile the paradox of feeling a personal responsibility to be healthy but maintaining an ‘unhealthy’ weight by drawing on the logic of dominant obesity discourse, but redefining the parameters of the measurement. Jackie’s seemingly contradictory reasoning is illustrative of this reconciliation:

According to the BMI I am obese, just into the obese section, and I think I’m walking around and I see people about 20 stone and I think ‘He’s obese’ I’m 13 [stone] it’s overweight...If I put on say another two stone, three stone then I will accept that I am obese. But at the minute I don’t accept that because I don’t feel it. I don’t know how you’re supposed to feel when you’re obese, I’ve never been
obese - but to me I don’t think I should be labelled as that, otherwise 60% of the population are obese.

Jackie rejects the obese label and adopts the less ‘at risk’ status of overweight. Jonny, who’s BMI also classified him as obese, adopted a similar line of reasoning when discussing his target weight:

I think 16 [stone], for the size I am, because when I went down to 14 it was basically that I was ill. So to me, I’ve been 16 [stone], my clothes did fit and I felt comfortable ...You see 16 stone to me probably still is overweight but it doesn’t look bad on me.

Feeling comfortable and being able to play football were more important to Jonny than being within the healthy BMI range. The comments from Jackie and Jonny demonstrate a common line of reasoning - the need to maintain a ‘healthy’ weight but with the important caveat that participants felt qualified to redefine biomedical definitions of health to produce a personalised definition, one based on their lived realities and embodied experiences. A consistent research finding is that even when people who are categorised as obese are well-informed they will disassociate themselves with the label (Gray et al, 2011; Johnson et al, 2014; Volger et al, 2012). Similarly, Kwan (2012: 70) found that overweight/obese individuals felt that the BMI failed to consider people’s unique needs and histories and so they pursued ‘idiosyncratic health’. However, participants in Kingsland did not just reject these measures but they redefined them in an act of ‘risky resistance’.

They would accept that they may be overweight, and losing weight may be beneficial, but if they felt the obesity tag did not apply to someone of their size they would simply reassign it. In biomedical terms this is akin to manually altering the dial that indicates a car is low on fuel: the objective risk is the same but the warning sign is ineffective in instigating a resolution. Participants felt they had the authority to decide who was obese based on the culturally accepted view of obese people as being extraordinarily large and lazy. As Jackie and Jonny’s comments illustrate, if they did not perceive themselves to look and feel obese group members felt justified in redefining the biomedical risk state they are otherwise ascribed through categorisation by BMI.
Deviating from biomedical definitions of health generally was justified on the grounds that people knew the BMI was not a reliable form of measurement and that, even if it was, there were other elements of life that were more important and beneficial to their overall health. The following comments were typical:

**Amy:** Well [your BMI]’s supposed to be between 18 and 25 and I think the lower the better but you’ve got to take into consideration your lifestyle that you have and other factors in your life. It’s not the be all and end all.

**Shirley:** I mean they tell you what you should be, but there’s a lot of talk in’t there, just lately, that BMI doesn’t mean an awful lot. I think you know in yourself how you feel rather than what you should be, because if I was right down at the bottom of where I should be I’d be really skinny and I don’t think I’d want to be that skinny.

As with other overweight and obese people, participants in Kingsland understood that there were competing health discourses. As such they tended to be more strongly influenced by personal experience and thus to ‘trust the self as authority’ (Kwan, 2012: 72). The same individualised discourse which convinced them of their personal responsibility to be healthy facilitated their partial rejection of biomedical definitions of health in preference for a personalised conception. This was motivated in part as an attempt to avoid the stigma that is associated with being labelled obese: the obese were understood as the ‘grotesque Other’ (Warin et al, 2008: 102). This is why not looking or feeling obese was of particular importance to participants. But it also demonstrates a disregard for the legitimacy and reliability of biomedical evidence and advice. If the medical professionals have accurately appropriated risk to BMI categories, the participant’s resistance is risky because it supports the status quo. However, if those sceptical of obesity science are correct, and the ‘obesity paradox’ allows for the possibility of the ‘metabolically healthy but obese phenotype’ (Ortega et al, 2013: 389), this resistance could limit the detrimental psychosocial effects associated with being defined as an ‘at risk’ and stigmatised body without increasing their risk in biomedical terms.

Risky resistance meant legitimising the maintenance of ‘unhealthy’ weights because the science did not match up with the embodied experience. This appeared to help
subjects to achieve a sense of wellbeing that would have been denied if they had accepted the biomedical identity of obese. The obese label did not motivate weight-loss but rather promoted personal reclassification. In an intriguing paradox, accepting some of the logics proliferated by new public health, but not others, led many to feel that their personal responsibility to be healthy could be achieved whilst maintaining a redefined ‘unhealthy’ body mass. Therefore, emphasising personal responsibility and stigmatising the obese seem to be ineffective bio-political technologies with regards to normalising those of low-SES that do not conform to a healthy BMI. Once recognising this, it became evident that the participants’ conceptualisation of health encompassed much more than had been indicated by their initial, more functionally-orientated definitions of health, e.g., avoiding illness and maintaining productivity. Much more insight was generated by exploring their everyday embodied experiences as people of low-SES.

**Incorporating the ‘Good but Bad’: Coping and Processes of Compensation**

Due to the nature of their lives, the affordable pleasures that the majority of participants spoke about were understood to be detrimental to maintaining a healthy weight, e.g., eating and drinking and inactive forms of leisure. When used to describe behaviour, ‘good’ had a dual meaning at group sessions. It was used to describe both weight-gain and weight-loss. For instance, it was common for participants to ‘measure’ how ‘good’ a particular social occasion had been by referring to how much weight they had put on. Good, in this sense, referred to how liberated from the confines of recommended health practices they had been. This was most obviously demonstrated when weigh-ins followed nights out, parties, eating at all-you-can eat restaurants, trips away and Christmas. On these occasions participants would often use words to the effect of: ‘Let’s see how good it was’ before getting on the scales. In the women’s group these occasions would often be referred to as ‘good but bad’: pleasure versus the moral judgement associated with weight-gain. This was a quotidian logic that informed the participants’ lives and was brought to the fore at group sessions.
Incorporating ‘good but bad’ behaviour into their lives was spoken about predominantly in terms of being necessary to improve one’s quality of life. Jonny offered a good example. He spoke about how he had significantly altered his diet since coming to the group, but was unwilling to give up drinking beer:

*I suppose if I needed to by choice then I could do it, but if I had to start cutting things I might say ‘What’s the point in living?’ You’ve already stopped one part of your life and now you’ve got to stop that part. What’s the point? You might as well say, ‘Alright I’ll stop that and go back to my eating’.*

As with the critical dieters of Lupton and Chapman’s (1995) research, establishing and maintaining good health was perceived to be difficult because denying behaviours they enjoyed required constant vigilance and discipline. Conceptualising ‘healthy’ living within the control versus pleasure paradigm is common amongst those who experience a fraught relationship with diet and weight (Vogel and Mol, 2014). Berlant (2010: 27) eloquently captures this when writing that the obesity moral panic has culturally framed health as something to ‘dread’ because it has become a ‘pleasure buzzkill’. Participants in Kingsland felt they had a responsibility to be healthy but also that being completely disciplined to health norms would ultimately have a detrimental impact on their health. This was because strict self-surveillance was felt to damage their quality of life and their sense of wellbeing, which had an adverse effect on their capacity to cope and carry on.

Such an approach to health fits more broadly within the well-established stress paradigm. Research has consistently shown that, as a form of coping strategy, people will engage in behaviour that they are aware has been shown to have a detrimental effect on health (Crawford, 2004; 2006; Lyons et al, 2014; Pampel et al, 2010). Unsurprisingly, this is especially common within low-SES groups (Bancroft et al, 2003; Devine et al, 2003; Graham, 1993; Watt et al, 2014) because, as Pampel et al (2010: 353) have explained, a ‘disadvantaged social position is both a source of adversity and a drain on the capacity to cope’. Smoking, drinking, drug-use, overeating, inactivity, all constitute forms of pleasure and relaxation that people with narrow parameters for agential expression use to cope with everyday life. The stress paradigm thus gives
great insight into how the ‘tastes of necessity’ (Bourdieu, 1984) come to incorporate ways of being that are widely considered to be detrimental to health but are reconceptualised, by people occupying low socio-economic positions, as restorative (Marmot, 2005; Wilkinson and Pickett, 2010).

Jonny’s comments illustrate how he ‘chose’ to incorporate ‘unhealthy’ but pleasurable behaviour into his lifestyle. The following, from Etta, powerfully demonstrates how such decisions were not always felt to be acts of volition:

Etta: Our kids have got ADHD and we are always aware that there could be a problem. You know you’ve got things where there’s trouble at school, getting to school, getting up, not sleeping. Do you know what I mean? And that all tells on your body and how you feel. I mean, sometimes when my son leaves in the morning I could quite happily strangle him.

OW: [chuckles, sensing that she is joking] Yeah

Etta: No seriously, I could and I wouldn’t feel, you know what I mean, I would think ‘Thank fuck for that he’s gone’ you know. Sometimes that’s how they get you and then you’ve got to sort that out and carry on, because later on they’re not at school and they’re at home all day. You’ve got to try and be nice to your son, even though he’s really pissed you off and you think ‘Oh fuck it, I’m going for a fag or going to get something to eat’.

Etta here brings to life the reflexive processes that constitute bodies. She understands that her body, as an object, is partly under her control but is also subject to the influence of exterior forces. In so doing she exposes the fallacy of simplistic choice-based health rhetoric. Jonny’s and Etta’s accounts illustrate how complying with the constant vigilance and control associated with ‘healthy’ living was compromised by the realities of their embodied experiences as people of low-SES. The need to stay disciplined was perceived as ‘something else’ to contend with and as such, a disciplined performance of health was considered to be largely incompatible with their lives.

Significantly, too, rather than reject the responsibilising discourse of new public health outright, group participants incorporated this logic within their resistance. As Henwood et al (2011: 2031) also found in their study of health practices in the UK and Canada, participants accepted healthy living as a ‘situation of choice’ and when they
resisted healthy living messages they did so ‘largely within, rather than outside of, this logic’. They achieved such reconciliation by conceptualising health as a psychosomatic state that facilitated coping with life through what I conceptualise as ‘processes of compensation’.

Although a culture of healthism presents a binary of good and bad behaviours, people will often attempt to reconcile pleasure and health by maintaining that there must be a healthy compromise (Crawford, 2000; Will and Weiner, 2014). In Kingsland, the weight-loss group provided practices, e.g., public weigh-ins and physical activities that were felt to compensate for ‘good but bad’ behaviours, even if participants did not lose weight. This approach can be aligned with conceptualisations of health that focus on the achievement of balance (Herzlich, 1973). These fit more broadly within Bauman’s (2001) extension of Freud’s theory of happiness. For Freud (1979), the quest for happiness involves attempting to reconcile the needs of freedom and security. He argued that these needs are irreconcilable as each impinges on the attainment of the other, e.g., employment offers security but also restricts freedom. Bauman (2001) maintains that, despite being irreconcilable, the uncertainties provoked by the individualising processes of liquid modernity lead contemporary existence to be characterised by perpetual attempts to reconcile these needs. Thus health can be conceptualised as a capacity to cope and we can identify the processes of compensation that characterised the participants’ attendance of the weight-loss groups.

Rather than imply an overly rational view of the actor, Will and Weiner (2014) suggest that Mol’s (2008) metaphor of attempting to balance on a high wire is a more suitable description of many people’s engagement with health practices. Mol (2008) captures well how the unpredictability of the exterior environment influences the precariousness of people’s situation. This is particularly apt for the present analysis as I suggest that it delineates how social and environmental factors compromise people’s capacity to ‘stay upright’ (i.e., to fulfil their moral duty as a biocitizen). However, describing the way the weight-loss groups in Kingsland approached health practices, e.g., diet and exercise, as an attempt to achieve balance seems far too conscious and exact. Instead they appreciated and operated within their limited freedom to loosely
keep their physical health in check, whilst maintaining their capacity to cope. This did not necessarily involve balancing ‘good’ and ‘bad’ behaviours, but more engaging in ‘processes of compensation’.

The irreconcilable pairing of freedom and security in pursuit of health and happiness means that if someone’s life is experienced as offering a relative lack of freedom and/or security then the disciplined performance of a healthy lifestyle may present an unwelcome and unrealistic restriction of their already limited freedoms. For example, in Kingsland a woman at a weight-loss session was particularly pleased after having unexpectedly lost weight on consecutive weeks. As she stepped off the scales the instructor said to her in a friendly manner ‘Yeah well just don’t get confident because, you know what they say, when you get confident you’ll put on the next week’ (Fieldnotes: 20/8/2012). There was general agreement within the room that this was accurate and useful advice.

This sort of logic helps to illustrate how ‘healthy’ living offered neither freedom nor security for these participants: it restricted freedom and fed insecurity by presenting a perpetual fear of nonconformity which was considered to be to some extent inevitable. This was how, paradoxically, ‘unhealthy’ living became a ‘healthy’ option for weight-loss group participants because it was felt to support their capacity to cope. That is, unlike the middle-class French people researched by Herzlich (1973), participants at the Kingsland weight-loss groups did not necessarily understand health and freedom as being synonymous. In the ‘health-promoting’ and ‘health-endangering’ dichotomy of practices presented by individualised discourses of health, ‘good but bad’ behaviours straddled the divide. These transgressive behaviours were understood to be both for and against health. Framing transgression in this way meant the reconceptualisation of ‘irresponsible’ behaviour as responsible by broadening the narrow parameters of ‘healthy’ living.

Participants knew the realities of their everyday lives compromised committed attempts to lose weight. This did not stop some from trying to manage their weight, but generally the consensus was that it was better to adopt a less rigorous approach. It was better to be overweight and physically active than overweight/obese and
sedentary. Becoming obese was generally considered inevitable without attending group sessions. It was common for the women to express this by referring to themselves, e.g., ‘Imagine if I didn’t come!’ whereas the men more regularly referred to others who had previously attended but no longer came ‘Have you seen Graham lately? He’s massive now’. These differences can be explained by the men generally being far less comfortable with openly expressing a conscious effort to manage weight. However, both expressions illustrate how the groups functioned as a demonstration, to themselves and others, that the participants were taking responsibility for their health, albeit incorporated within processes of compensation. They were not letting themselves become the grotesque ‘Other’ (a potential future self or, indeed, Graham) or being entirely disciplined.

Concerted efforts to lose large amounts of weight were uncommon. Instead, the following comments from Fran and Carl summarise most people’s stances:

Fran: If I do lose weight a few weeks it gives me a bit of an incentive but then the next week something happens at home. I’m a comfort eater, and I get stressed out and then I go back [up in weight]. But at least I know that I’ve lost two pounds so I can put a few on, you know what I mean?...I think as long as you’re doing something it’s good.

Carl: I love puddings. My trouble is like tonight I’ve worked hard, I went work on my bike, I’ve done a session here. I get home, I have my food and that lot and I think to myself ‘Well I deserve that pudding’.

These comments illustrate how, despite being defined as a weight-loss group, participants used sessions to support their capacity to cope with or enjoy life. Gillespie (2012) proposes that one of the most significant effects of being medically defined as ‘at risk’ is that it removes the ‘buffer’ that people feel they have to illness and ultimately to death. Attending the weight-loss group allowed participants to at least partly resurrect this buffer. Therefore, the sessions provided participants with ‘individual security strategies’ (Crawford, 2006: 416), or what Rose (1999a: 261) terms ‘therapies of freedom’. Active participation was felt to compensate, but not necessarily counterbalance, transgression from health norms.
Within a culture of healthism, PA functions as a powerful compensatory device for anybody, but particularly for those who do not corporally comply with health norms. Firstly, it undermines the notion that fat people are lazy. Secondly, as an energy-in-energy-out discourse has become dominant, PA has become increasingly medicalized and now demonstrates moral uprightness and a ‘step in the right direction’ for subjects of stigma (Neville, 2013; Wheatley, 2005; Zanker and Gard, 2008). Becky and Phil succinctly summarised how most participants engaged with the groups:

Becky: *I’m happy that I’m doing some exercise, it’s better than not doing any. So, if I lose weight it’s a bonus but if I don’t... [Shrugs]*

Phil: *We’re all here for the same reason: probably not to lose weight, but just to be more active.*

Despite Becky’s stated nonchalance, she still experienced weight-gain as an unwelcome and often upsetting part of attending the group. However, prioritising PA over weight-loss is a good illustration of how participants positioned their weight management within the contexts of their everyday lives. Conforming to health norms had to be considered secondary to being able to cope with the restricted freedoms that structured their everyday experiences. The capacity to cope with such circumstances was abstracted from the simplistic imposition of healthism - that one must choose freely and to freely choose health (Sedgwick, 1994). Biomedical norms were redefined and processes of compensation, such as being physically active, were engaged in so that participants felt they were doing what they could, as a bio-citizen, within the constrained choices that their SES presented them.

In the Kingsland weight-loss groups, participants broke down the binaries of ‘healthy’ living, embraced the ‘good but bad’, maintained ‘unhealthy’ weights and engaged in some counter-balancing compensatory processes. As such, paradoxically the weight-loss groups played a significant role in relegating weight-loss as a priority. This approach to health may seem to liberate people from the forces of biopolitics - and it certainly is an instance of resistance - but Fran’s comments help to illustrate that this ‘resistance’ operates within the assumptions of individual responsibility:
You only live once and what’s the point of being the fittest person in the cemetery, do you know what I mean? I’d rather just go enjoy meself. And if I want to lose weight I will do it and if I don’t, then it’s all up to me, in’it?

Participants well understood that it was theoretically possible for them to lose weight and hence corporeally comply with health norms. Whether this was achieved or not was predominantly understood as a matter of personal resolve: it was up to the individual to overcome social and environmental impediments. Despite this acceptance of personal responsibility, they were also realistic about the challenges presented by simultaneously complying with health norms and coping with the restricted freedoms that characterised the day-to-day lives of people of low-SES. Combining ‘good but bad’ behaviours with ‘processes of compensation’ went some way towards generating feelings of being able to achieve a compromise or reconciliation between control and release. However, this did not protect subjects from experiencing negative emotional responses to the stigma associated with weight-gain. This was particularly evident when participants felt they had been disciplined and had complied with the logics of weight-loss, only to be told that their endeavour did not show up on the scales. However, as participants prioritised a capacity to cope over weight-loss, it is perhaps unsurprising that the groups also functioned as means to manage the negative emotional effects associated with gaining weight and being overweight and obese.

Social Groups with Scales: Managing the Emotion of Weight-Management

There is a long history of using stigma for the stated purpose of improving public health. Bayer (2008) argued that, although in some instances it may be morally justifiable, there is a perpetual need to debate the ethics of stigmatisation. Engaging in this debate, Brewis (2014) and Puhl and Heuer (2010) argue that the available evidence strongly suggests that stigma perpetuates rather than addresses obesity. Despite this, outside insightful critical academic debates (e.g., Campos, 2004; Evans et al, 2008; Gard, 2011; Rich et al, 2011; Gard and Wright, 2004), the seemingly ubiquitous public acceptance of the legitimacy to ridicule and shame to ‘correct’
bigger bodies indicates that dominant obesity discourse promotes the denigration of people who do not conform to the ‘healthy, risk-averting body’ (Petersen and Lupton, 1996: 24).

Led by Mol’s insight (2002), I will argue that the ineffectiveness which follows from stigma and fear is in no small part a consequence of the tendency within biomedicine to treat individual bodies as objectively and subjectively separate. Recognising that experience is reflexively embodied, Mol (2002: viii) argues that the body must be appreciated as an ‘intricately coordinated crowd’ or what she terms ‘the body multiple’. Here, ‘disease’ may be inside the body but what is said about it is not and thus the medical fraternity has a responsibility to consider how people are affected by objectification. Although not directly referring to the stigmatisation of bigger bodies, Mol (2002: 10) eloquently captures the way in which medical discourse causes contemporary bodies to ‘dys-appear’ (Leder, 1990) when she writes, ‘bodies only speak if and when they are made heavy with meaning’. The similarities and differences of the male and female weight-loss groups in Kingsland offer an insight into the social consequences of weighing down the bodies of people from lower-SES groups with social stigma. This insight problematises the use of moral individualism as a means of reducing the incidence of obesity.

There was considerable evidence of weight-management being treated and experienced as a moral issue in all three groups. Instructors and participants framed behaviour and weight in terms of ‘good’ (health-enhancing) and ‘bad’ (risk-inducing). As a result, public weigh-ins commonly took on a confessional nature. In both the men’s and women’s groups participants would regularly talk about what they had or had not done that week and how this accounted for whether they had put on or lost weight. However, this sense of panoptic self-surveillance was not enough to ensure they remained disciplined. Rather, it led participants to develop strategies for coping with their embodied sense of sin. There were numerous examples of this, but there is only space here to consider two: participants ‘knowing’ that they had put on weight before being weighed, and the significance associated with sweat.
i) ‘Knowing’: The Weight of Expectation

Before being weighed at sessions, participants often spoke about ‘knowing’ that they had put on weight. This certainty was generally absent with perceptions of possible weight-loss. Participants routinely would say, ‘I know I’ve put on this week’ and it was usual for them then to list numerous reasons why, often referring to having ‘indulged’ in the aforementioned ‘good but bad’ behaviours. As Jackie put it: ‘It’s just the feeling: you feel heavier somehow’. This embodied sense of weight-gain was evident when participants answered questions about how they ‘knew’:

Alf: Well, I know because I’ve had a bad week at home ‘avn’t I? [laughs]. I’ve been eating things I shouldn’t do. I know that if I didn’t go to the gym and play squash with Rob and all the rest of it this week and then I had fish and chips and stuff, I know pretty well that next week I’ll have put weight on.

Amy: If I’ve been out at the weekend and had quite a few pints of lager [laughs] and had a few takeaways then you think ‘OK, yeah I can accept the fact that I’m going to have put a couple of pound on’.

This seems rational within the cause and effect logic established by the rhetoric of energy balance. Significantly, though, participants were often wrong in their predictions. It was very common for participants to ‘know’ they had ‘put on’ only for this embodied sense to be proved quite wrong when they were told their scale reading. Often this led to flippant comments such as: ‘I’ll stop going to the gym and carry on eating cake then’, but it also led to expressions of relief: a sense that they had not been punished for their sins.

They were so often wrong in their predictions that it was widely appreciated within the groups that weight-management was not accurately captured by the lifestyle-focused ‘energy-in-energy-out’ equation. This tended to fuel the belief that it was best never to be confident about losing weight rather than reduce the sense of personal responsibility they felt. The fact that participants felt heavier - based on their calculation of an imbalance of good and bad behaviours - but were often wrong, is particularly significant because it demonstrates how they embodied the moral discourses: they felt the effects of stigmatised ill-discipline. They did not just know
they had been deviant they felt it and this was the case even when the ‘evidence’ (added weight) was absent.

In this sense there was a ‘weight of expectation’ that did not register on the scales. This is analogous to the ‘phantom limb’ phenomenon that Merleau-Ponty (1962) used so successfully in order to reject Cartesian dualism and illustrate that perception is embodied. In the same way that the absence of a limb does not stop the experience of pain, the absence of weight did not stop participants feeling the weight they expected their ill-discipline would equate to.

It was also apparent that predicting they had put on weight was a form of confessional, one designed to protect self-esteem and in turn protect a capacity to cope. When I asked Becky about incorrectly ‘knowing’ she explained how it can function as a defence mechanism:

Yeah, that surprises me; I’ve had that happen to me. You probably just assume that you’re going to have put weight on. So if you think it’s going to be bad anything less than that is better.

Although many of the participants were not making concerted efforts to lose weight they appreciated that engaging in behaviours that deviated from the discipline of weight-loss could make them feel bad. In short, the stigmatisation of weight-gain was embodied and led participants to experience psychosomatic stress. For instance, a number of the women pre-weighed themselves while the instructor was out of the room before deciding if they were going to be weighed ‘officially’. At the Monday evening group in particular, it was understood that the women may not want to get weighed ‘officially’ because the ‘black mark’ against their name was considered to be too much of an emotional body blow. This experience of stigma was not enough to ensure conformity, but it encouraged participants to engage in processes of compensation. One such process was to assume to have put on weight after transgressing health behaviours and to take precautions to protect themselves from the emotional consequences. Another self-preservation strategy related to how signs of physical exertion helped participants to manage the experience of being a stigmatised body.
ii) Getting a Sweat on

Just as lean and taut bodies signify moral excellence, the overweight and obese body has become a 'visual representation of non-control' (Evans et al, 2008: 38). The stigma the majority of participants felt by occupying this role was well summarised by Etta who described the emotional impact of fat bodies being popularly recognised as (morbidly) obese:

*I think sometimes you get called that and it just makes you feel worse than what you already feel do you know what I mean... I think people accept you better slimmer than as you are. People look at you and think, I think, ‘fat cow’.*

This is problematic for people who maintain bodies that do not conform to body perfection codes and yet are physically active. Such people, including the majority of Kingsland weight-loss groups’ participants, can go to a facility and push themselves to the limits of their physical capabilities but be considered lazy and morally inferior as soon as they step out into the car park. In a culture in which weight-loss and corporeal conformity are championed over physical fitness, those who regularly engage in PA but are also overweight/obese still endure spoiled identities. This is particularly problematic as physical fitness has been shown to be a more reliable indicator of metabolic health than BMI (McAuley and Blair, 2011; Ortega et al, 2013). As the weight-loss group participants incorporated PA into their processes of compensation, visible physical signs of exertion took on great personal and social significance. In this regard, sweat provided a moral correlative to the embodied sense of stigma that they tended to experience when they had engaged in 'good but bad' behaviours. This is reflected in arduous, sweat-inducing activities being commonly referred to as 'bad but good'.

Participants would explain that visible sweat means ‘you know you’ve done something’ and it was this embodied sensation that encouraged participation. The following comments were typical:

*Amy: You feel much better when you’ve sweat and you feel tired, you feel as though ‘OK, that was a good one, I’ve done something worthwhile’.*
Sweat was representative of effort and its presence allowed the participants to feel good about themselves in spite of their size/weight and whether they had put on weight that week. They gauged the relative worth of different activities against whether they would/did ‘get a sweat on’. This was an expression commonly used by the men and women in the weekly dialogue at group sessions. Sweating as a consequence of PA was an important part of the compensatory processes that participants engaged in.

In a healthist culture, sweating and other physical signs of exertion, such as aching muscles and red faces, visibly demonstrates taking responsibility for health. It is ‘evidence’ of effort and moral uprightness (Crossley, 2006b). This evidence is particularly relevant for those who are stigmatised. After exercise people with bigger bodies can use sweat as a sign to themselves and others that they have put in the effort they are assumed to have shirked. Sweat allows group participants in Kingsland subjectively to repudiate the notion that they are the gluttonous, morally inferior, obese, Other. This suggests that, if the dominant obesity discourse was challenged by a wider knowledge of the role PA plays in producing the metabolically healthy but obese phenotype (Ortega et al, 2013) – as discussed in chapter two - there would be less need for these processes to be conceptualised as compensatory. Rather, participation in PA could be a more overtly positive experience for ‘overweight’ and ‘obese’ people.

These findings – around ‘knowing’ about weight gain and the importance of sweat - help to illustrate that the weights/sizes of group participants, and the lack of concerted efforts to alter them, do not indicate that participants were unaffected by moralising health discourses. Rather, just as someone who consciously conforms to health advice might, they embodied this discourse and developed strategies for coping with the anticipated moral-backlash of non-conformity. Both the men and the women were affected by this stigma but the ways in which the emotional consequences were
dealt with at the groups were markedly different. The most obvious way to illustrate this is to start with thick descriptions of the weigh-ins at the men’s and women’s groups.

**Weighing-In**

i) ‘Ladies’

As outlined in chapter five, there were two women’s weight-loss groups with different instructors. The weigh-ins at both however followed a similar pattern and upheld the same etiquette. The women were weighed before they exercised. Typically, participants gathered in a private room at the Leisure Centre to sit around tables. The instructor set up the scales, ensuring they were on level ground. This was done away from the group in order to create a discreet weighing area. Once the instructor indicated that she was ready, the majority of the women queued up behind the scales. A respectful distance was left between the weighing area and the next in line. The women then removed their shoes and any unnecessary clothing or accoutrements and encouraged those who had not done so to do likewise. For the same reason, a number of women paid visits to the toilet immediately before being weighed. When the women approached the scales they handed their weight-tracking card to the instructor. The instructor recorded their weight and usually had a quiet interaction with the participant where advice and encouragement were offered. Participants then took their cards and returned to where they had previously been sitting.

There was tacit appreciation within the room that whether someone had put on or lost weight was a private matter and it should be for the individual to decide if they wanted to disclose this information. Very often women discussed the outcome of the weigh-in with their friends. Thus weight was understood and dealt with as an emotional issue, with the instructors and participants quick to console or congratulate each other. It was an overtly supportive environment as encapsulated by one of the instructors referring to the group as ‘my ladies’ and acting with a real sense of pastoral care.
ii) ‘Fat Bastards’

The private nature of the women’s groups was the whisper to the public cry of the men’s weigh-ins. These were almost as animated and participatory as a pantomime. This was fitting as they took place in the lounge of an old people’s home on the estate, a short distance from the Leisure Centre and this space was used for free as a result of a ‘gentleman’s agreement’ to organise an annual Christmas party for the residents. Such an agreement was necessary because they had been priced out of using the room that the women used at Leisure Centre, as discussed in chapter eight. The men drove the two minute journey directly after their hour of PA. They sat in lounge chairs while someone, usually Phil, fetched the store-cupboard key from the dartboard cabinet and brought the scales over to their usual place. They were set on a flat board of MDF in the middle of a circle of seats, from where the men’s group looked on. Simps, the group leader, sat next to a coffee table, consulting the spreadsheets on which the men’s weights were recorded. The men removed their shoes and some even took off their sweat-soaked t-shirts to be weighed, topless.

When men took to the scales, it was quite usual for others to look on and loudly jeer, almost as if this was the night’s main entertainment. The men shouted out their weights to Simps, who simply called back either ‘on’ or ‘off’ and a number that related to pounds in weight. The other men would freely comment, joke, laugh and/or congratulate each other throughout. Weight-loss was often reacted to as something that was positive but not consciously achieved. The men’s weigh-in was a very public, interactive affair and from the outside it could seem an intimidating environment if someone was self-conscious about their weight, particularly as the most common refrain heard throughout male weigh-ins was ‘You fat bastard!’

In one sense these occasions seem very different, but there are also many shared characteristics. For instance, attempting to get the lowest possible scale reading was clearly important to both the men and women. The key differences between the groups seemed to stem from whether the weigh-in was explicitly addressed as an emotional issue or not. The differences follow gender norms that informed the participants about the appropriateness of being body-conscious and openly expressing
emotion as a man or woman. Gender is performed, it is something that people ‘do’ (Butler, 1990; West and Zimmerman, 1987). Appropriate performances tend to be constructed in opposition as what is conventionally masculine or feminine comes to be defined by their opposites (Bourdieu, 2001; Connell, 1995). By appreciating this and spending a prolonged period with the groups, it became apparent that both the men’s and women’s weigh-ins were supportive occasions, but that such support was highly gendered. The jeering of ‘fat bastards’ and the more private pastoral care offered to the ‘ladies’ were largely different expressions of the same behaviour. I argue that the aims of both were to manage the emotion attached to the embodied experience of being a bigger body. To fully appreciate this I want to briefly demonstrate how engaging with emotion was gendered at group sessions.

**Something To Cry About?**

Was weight something to cry about? On occasion female participants were literally brought to tears by the outcome of the weigh-in. Indeed, they approached the weigh-ins with an appreciation that this was a perpetual possibility. The men could not be seen to do the same. Amongst others, Dolan (2014) found while researching working-class men’s attitudes towards health that there was reluctance to ‘open up’ for fear of being perceived as emotionally frail and thus further marginalising one’s social position. These findings were reflected in Kingsland. The men clearly understood body size and weight as potentially emotional issues, but they also understood that their masculinity would be compromised by approaching their participation with the group as if this was the case. For instance, when I asked Jonny, perhaps the group’s chief ‘piss taker’, about the public nature of the weigh-ins he acknowledged that the openness of their disclosure was not due to nonchalance:

> We don’t mind people, what with the group that we’ve got up there [at the old people’s home], but if the group were somewhere like in this environment we’re in right now [a busy, public place] then I wouldn’t like [my weight being called out]. No, I’d like it to be kept quiet.
Jonny indicates that he felt supported in the way the men approached the weigh-in and this allowed him to overcome his insecurities, to some extent. The men did not treat weight as an overtly emotional issue – something to cry about - because this would have undermined their capacity to perform an appropriately masculine identity. Managing emotion thus becomes a case of observing appropriately gendered ‘feeling rules’ (Petersen, 2004; Hochschild, 2003). These rules are ‘standards used in emotional conversation to determine what is rightly owed and owing in the currency of the managing act’ (Hochschild, 2003: 18).

Because the men perceived being openly body conscious as inappropriate they belittled the significance of size and weight. This facilitated the men personally maintaining an appropriately masculine identity whilst simultaneously attending a group that threatened to compromise it. Before joining the group Arthur was the sole male member at his local Weight Watchers. When I asked him whether he felt attending the group was a threat to his masculinity he told me ‘The other one [Weight Watchers] was, but this isn’t you know, this is appropriate’. I asked Arthur whether he liked that the weigh-in was characterised by a lack of discretion:

...I think that’s fine, that’s all part of the camaraderie within the group. You know we take the micky out of each other. If you’ve put on weight or if you’ve lost weight, you know, they’ll call you a couple of names...Nobody is demanding but the [main] difference between weighing in here and Weight Watchers is that [at Weight Watchers] they’ll say ‘Oh very good’ you know ‘Well done’, ‘Half a pound is still a loss’ all this sort of thing. But here you know it’s done in a sort of macho way [laughs].

It was clear that Arthur found comfort in gendered feeling rules being observed. The male weigh-in environment normalised non-conformity, promoted acceptance and downplayed emotional responses. This was necessary precisely because there was tacit appreciation that weight can be a potentially sensitive issue for both men and women. The men in Kingsland managed their stigmatised identities by developing ‘knowledgeability’ and utilising vocabularies that enabled them to construct ‘situationally “fitting” identities’ (Monaghan and Hardey, 2011: 72). Monaghan and Hardey (2011: 84) suggest that adopting the identity of a fat bastard is the prime way
to achieve this because it aggressively frames ‘fat’ and ‘to be “hard” is to be male while “bastard” marks an otherness from middle-class, biomedical and state expectations about the good consumer’. It was an identity to otherwise combat that of a man who spends time and money in a conscious effort to manage his weight.

While the feeling rules which influenced the men’s group led them to address emotion in an implicit manner, the women’s groups observed feeling rules that led to weight-management being approached openly as an emotional issue and this encouraged overt mutual support. This approach was facilitated by both body-consciousness and an emotional response to weight-management being a normalised part of feminine identity construction (Bordo, 2004; Rice, 2007). For the women, the weigh-in was not just a time to be weighed but a rare opportunity to socialise and discuss the challenges they were facing both generally in day-to-day life and specifically with weight-management. Lindsay, a former instructor, described how important this was:

*The first half hour, while they’re being weighed, is a clearing session. Do you know what I mean? So everyone tells each other what they’ve been up to or what’s been stressing them out or ‘Oh God I missed the bus’. And they are there to ‘Woah, woah, woah’ [mimics venting frustrations] and then they are dedicated to what they are there to do.*

This opportunity for ‘clearing’ seemed to fortify the women’s capacity to cope, which in turn directly supported their efforts to manage their spoiled identities. Group members were comforted by being able to position themselves relatively within the group; especially when personal ‘failures’ were revealed to be ‘shared failures’. For instance, it was common for the women to sit in groups discussing all the things they had done that week considered detrimental to losing weight. But these did not tend to be morose conversations, as Emily’s comments illustrate:

*When you come in and everybody is quite, I don’t know, laughy, jokey and you know they are not like that all of the time. But it’s almost as if they get an hour just to lift themselves up, do you know what I mean? And they ain’t got to worry about the kids and all the problems that they’ve got at home.*
The women would often find themselves laughing at each other’s tales. There was a sense that they were all there for each other which seemed to be informed by a shared knowledge that a strong emotional state was fundamental to managing weight. This was emphasised by the description of the morning group by one of the women as ‘My little fat family’. The colloquial name for the groups, ‘fat club’, perhaps better reflected the function they fulfilled. The women’s groups may not have necessarily facilitated participants to lose large amounts of weight, but they helped women to cope with the stresses encountered in their lives and experienced as a consequence of the moral-backlash against those who transgress body perfection codes.

Respecting each other’s privacy during the weigh-in was one of the ways the women demonstrated their recognition of weight as an emotional issue and their willingness to support each other. While the majority said that a less discreet weigh-in would not have bothered them, there was general agreement that the most appropriate way for the weigh-in to be conducted was in private. As Shirley explained:

*It doesn’t bother me, weighing in front of other people. Like we’ve been coming a long time; we’re amongst friends now.*

*OW: But do you prefer getting told quietly?*

*I think it should be like that, because then it’s your choice if you discuss it with other people. I think it’s a personal thing and I think it should be kept private.*

The group instructors and participants understood the potentially upsetting nature of the weigh-in and therefore conducted it in such a way as to manage this emotion. Shaming these women in public was not considered an effective way of encouraging them to lose weight. There was an appreciation that failure to lose weight was not due to health advice falling on deaf ears but instead the outcome of the women prioritising and coping with other responsibilities. Unlike the men, the feeling rules guiding the women allowed them to treat weight openly as ‘something to cry about’ which prompted them to create an overtly supportive environment. The following comment from Jackie captures this:

*I look at them and I think ‘Well, they’re a lot heavier than me’ so what I am might spur them on to come down to what I am, even though I am heavy. So it is*
building confidence within yourself to not be worried about that sort of thing, so that they can see that you’re not bothered about it. And so they won’t be too bothered about it, because obviously when you come in you are worried about what you do weigh on those scales. And you think ‘Oh God I don’t want people to know’.

As this quote illustrates, attending the group was as much, if not more, about managing emotions as it was about weight-management. Officially, these were weight-loss groups which required weights to be recorded and for women to be working towards weight-loss targets based on eventually achieving a healthy BMI. However, the instructors appreciated that for many of the participants this was ‘fat club’: a group they attended to engage in compensatory processes in an effort to manage their spoiled identities, rather than actually comply with biomedical standards of health. Managing emotions was thus an integral part of the service.

Hochschild (2003) has argued that jobs increasingly require employees to perform ‘emotional labour’. This entails staff being monitored to ensure that they manage the emotions of the public in such a way as to produce a certain state of mind in customers. The emotional labour of the group instructors was not closely monitored but, nonetheless, they supervised ‘their own emotional labour by considering informal professional norms and client expectations’ (Hochschild, 2003: 153). Instructors were predominantly empathetic fitness trainers on part-time contracts, not counsellors, so this emotional support fell into the ‘above and beyond’ bracket of their work discussed in chapter eight. Their commitment to supporting their ‘ladies’ emotionally was perhaps best encapsulated by Lindsay when she described what she felt was necessary to run a successful group: ‘It is down to the instructor. Once you’re there, you’re theirs’.

Lindsay was implying that participants required the instructor’s undivided attention and concern. This emotional labour often led to interesting paradoxes similar to the ‘truth tricks’ noted by Wheatley (2005) when researching technicians attempting to encourage cardiac patients to modify their lifestyles. Wheatley (2005) noted that instructors would strategically shift between the logic of lifestyle and the logic of biological fate in order to emphasise individual responsibility and downplay uncontrolled risk-variables. A number of the weight-loss group instructors used a
similar strategy by simultaneously attempting to reinforce the notion of personal 
responsibility and absolve participants of blame and/or positively frame 
transgressions. For instance, it was common practice for women who had put on 
weight to be asked what they had done that week that would have caused weight gain 
and then to be advised to abstain from the same behaviour next week. This was 
usually followed by the instructor acknowledging the important function that these 
transgressions played by reassuringly saying such things as: ‘As long as you enjoyed 
yourself. That’s the main thing’. They would also regularly deflect disappointment by 
saying things such as: ‘It’s probably muscle babe, you’ve been working hard recently’. 
This sort of emotional labour was felt necessary because the instructors appreciated 
that becoming disheartened was likely to impair these women’s capacity to cope, 
which in turn might be detrimental to weight-management. This was clear when 
Parina spoke about having to tell the women they had put on weight:

_I don’t like to go on weight, I would rather go on their inches and their dress 
sizes, how they’re feeling, rather than weight. Every week as well, that’s not 
good. You can get so hooked up on that and again a lot of women do get hooked 
up on it and they are like ‘Aaarrrrgghhhhhh!!!’ [disappointed] you know. And I 
just think that a weekly weigh-in is not giving them anything at all._

Parina felt compelled to compensate for this weekly focus on weight by performing 
emotional labour. For instance, it was common for her to advise women in her group 
to also use alternative measurements, e.g., waist, thigh and bicep circumferences, and 
to focus on how they felt. This was meant to protect women from the stigma of 
weight-gain because, in the long-term, she felt that emotional stability would help 
them to do what was necessary to lose weight. This logic runs counter to the 
arguments for moralising and stigmatising overweight/obese people and supports the 
arguments that so doing blames the victim. With research indicating that lifestyle 
initiatives delivered in communities are more effective when they offer counselling 
and would be further improved if stigmatised terms, e.g., obesity, were not used 
(Cleland et al, 2012; King et al, 2011), the emotional labour performed by the women, 
and implicitly by the men, in these groups can be seen as an attempt to make up for 
the shortfall of a society that stigmatises and blames the overweight/obese.
A comparison of the men’s and women’s groups demonstrates how gender norms influence attempts to manage identities that have been spoiled by the stigmatisation of weight-gain. Making weight a moral issue also makes it an emotive one. The feeling rules that inform men and women about what is appropriate when it comes to feeling, displaying and managing emotion led the men and women in Kingsland to have markedly different approaches to the weigh-in. However, these can be seen as different expressions of the same behaviour. The ‘fat bastards’ and the ‘ladies’ labels were both attempting to manage spoiled identities while observing gendered feeling rules.

While the men’s approach allowed them to engage in what was more widely understood as a feminine practice in an appropriately masculine way, their surreptitious management of emotion was mutually supportive but left the open wound of body-consciousness largely unaddressed. This wound was no less open for the women, much the opposite, but their open acknowledgement of weight and body-consciousness as emotive issues led to the provision of more adequate emotional labour. All of the groups were perhaps more accurately described as ‘social groups with scales’ than weight-loss groups. The lack of weight-loss and the desperate need for emotional labour illustrates the counter-productive nature of making weight an emotive issue and blaming the victim.

**Conclusion: Against Stigmatising Weight**

The findings of this chapter go some way towards illustrating the detrimental impact that the new public health approach can have on low-SES groups. There are well established arguments against addressing health as an individual moral responsibility (e.g., Crawford, 2004; 2006; Dorling, 2013; Wilkinson and Pickett, 2010) and thus stigmatising those who fall outside of the narrow parameters that come to define how health is ‘done’. Opposing such an approach on moral grounds seems more than reasonable on this evidence. Whilst it is considered to be legitimate here, arguing that this approach blames the victim can of course be refuted as merely revealing a political disposition. One of the reasons why neoliberal politics are so robust is that
discourses of individual empowerment and choice typically undermine the impact of structural inequality. This leads those who might otherwise be considered to be being blamed for their disadvantage to distance themselves from such victimisation. For Miller and Rose (2008: 211) this is because, informed by these discourses, ‘individuals come to reconceptualise themselves in terms of their own will to be healthy, to enjoy a maximized normality’.

This was evident at the Kingsland weight-loss groups, given how readily participants accepted personal responsibility for health, despite their reduced social status and how this compromised their capacity to follow health advice. However, accepting responsibility rarely led to normalisation, which is, after all, the objective of governmentality. In illustrating just how unsuccessful this approach is in altering the conduct of non-conformers, these findings provide a second argument which supports objections made on purely moral grounds. The experiences of the men and women at the weight-loss groups in Kingsland illustrate not only that the new public health approach can be considered morally dubious, but that it is ineffective.

The ‘risky resistance’ identified here - redefining risk categories in order to avoid the stigmatised obese state - meant that ultimately subjects in Kingsland felt a personal responsibility and motivation to maintain sizes/weights that would be biomedically defined as ‘unhealthy’. Alongside this linguistic reassignment of risk, prioritising a capacity to cope with the everyday challenges of their restricted freedom, rather than making a concerted effort to comply with health norms, was informed by the rhetoric of choice. Participants felt they had the authority, and were acting responsibly by choosing to resist conformity because it was considered unrealistic, undesirable and ultimately detrimental to their health and well-being. Participants perceived that putting themselves at the mercy of a moral, medical discourse almost inevitably led to further stigmatisation. Therefore, their understanding of the best way to comply with the responsibility to be ‘healthy’ was informed by their embodied experiences of stigma. Combining resistance with processes of compensation thus became the ‘healthy’ option, as doing so facilitated managing and/or avoiding stigmatisation.
Illich (1976) famously argued that the medicalization of life is a ‘medical nemesis’ because it has iatrogenic consequences. The weight-loss group participants seemed to appreciate the iatrogenic potential of getting too caught up in the pursuit of weight-loss because transgression led to the acute experience of a sense of immorality. It is this logic that led ‘bad’ behaviours to be redefined as ‘good but bad’. Participation at the groups was characterised by such processes of compensation and attempts to manage external perceptions, guilt and other negatively experienced emotions. These were necessary because the embodied experience of stigma provoked such negative emotional responses. But conformity was considered to be largely unattainable. The stigmatisation of people who feel incapable of complying with health norms whilst simultaneously coping with the realities of their everyday lives does not encourage conformity but merely creates the need for emotional labour.

As the moral dimension of the obesity ‘epidemic’ is primarily fuelled by the economic implications of obesity, e.g., the reported £6 billion annual burden to the UK’s NHS and significant losses in productive life years due to illness and ‘premature’ death (Dobbs et al, 2014), it would be puerile to argue too strongly here that if stigmatisation does not resolve the issue of obesity but does create a demand for emotional labour it should be considered to be failing on all fronts. The need for emotional labour creates another avenue for obesity to contribute to health inequalities. Those with the means have access to the appropriate services, while others – as discussed in the chapter eight - rely on public services and the well-meaning, but perhaps sometimes ineffective, efforts of those willing to go above and beyond by helping them readdress their energy imbalance.

Findings from the participant observations and interviews with these weight-loss groups in Kingsland offer further evidence of the ineffectiveness of stigmatising obesity as a biopolitical technique. Not only is stigmatisation problematic because it creates a need for more not less services and inhibits prevention strategies, but because it also exacerbates existing inequalities. As such, it further entrenches social inequality which has been shown to have an independent and detrimental effect on the health of populations. Therefore, these findings support the notion that the new public health approach has iatrogenic consequences and thus arguments against the
use of stigmatisation and meagre community-based initiatives as a form of mass weight-management on both moral and practical grounds.
Chapter Ten

Conclusion

Bio-spheres of Risk-Aversion and Equitable Health

Introduction

This concluding chapter initially explains why and how the relationships between health, place and inequality are necessarily incorporated into this analysis. Here I discuss and clarify why one of the primary theoretical concepts to emerge from this analysis – bio-spheres of risk-aversion – was developed. A partial defence of area-based health policy is then offered through a reflection on the relative nature of agency and how – in neoliberal societies – being able to ‘choose’ to conform to health norms can, paradoxically, be emancipatory. The insights of Nikolas Rose inform this reflection. Attention then very much returns to Kingsland as the necessity of equitable access is discussed in relation to the residual effect that numerous interventions have had. This leads to a discussion of how lifestyle drift ultimately led to the process of citizen shift and how this placed the responsibility for health firmly within the realm of the individual. The problematic nature of this process is discussed in relation to health inequalities and the potential for such inequalities to be exacerbated rather than reduced by interventions designed to have the opposite effect. Finally, the consequences of the ‘big, bashed drum’ in Kingsland falling silent are debated before the strengths and limitations of this research are identified and modest recommendations for future research are offered.

Placing Health

The central concerns of this thesis are the relationships between health, place and inequality and whether area-based health promotion can be considered to be a legitimate way to address health inequalities. Public health has a long history of
locating health and illness issues in specific places and it is often the case that health inequalities are rendered knowable by social epidemiology (House, 2002; Paneth, 2004). For example, it is stark geographical disparities in life-expectancy which prompt Dorling (2013) to define what he has called ‘the scandal of our times’. Despite this, socio-political debates which encompass health often centre on whether responsibility for the maintenance of health primarily lies with the individual or with wider social forces such as the State and/or the market. The original contribution I make with my analysis is via the development of a set of novel theoretical concepts which help us better understand the relationships between health, place and inequality in neoliberal societies; and how and why area-based health promotion alters the ways in which health is both conceptualised and performed.

As discussed in chapter three, the turn of the twenty-first century has seen the rise of a form of eco-epidemiology which highlights the links between the properties of physical environments and the health characteristics of local populations (Blacksher and Lovasi, 2012). Of particular interest to my analysis is the growing field of research exploring the ways in which the properties of physical environments can promote inactivity and obesity (Ding and Gebel, 2012; Gordon-Larsen et al, 2006; Harris et al, 2013; Sallis, 2009). This is because the focus on ‘healthy’ living demonstrates how the dominance of neoliberalism firmly positions health as an individual responsibility but spatial analysis highlights the importance of structural inequalities.

Now, more than ever before, attention is focused on the ‘obesogenic’ properties of places (Kirk et al, 2010). Shannon (2014) argues that this focus encourages policy makers to prioritise the engineering of physical environments to make ‘healthy’ eating and PA the most accessible and attractive choices. Herrick (2009b) picks up on this point in the UK context and argues that this increasingly leads policy makers to take an instrumental approach towards health behaviours and space: how can policy best alter the environment to promote ‘healthy’ living? When viewed uncritically, this policy position could be taken as an example of how health is being approached as a ‘social’ or collective responsibility.
Research shows that there tends to be a clustering of low-SES groups in obesogenic environments which are lacking in social amenities such as PA facilities (Farrell et al, 2014; Scambler, 2012; Townshend and Lake, 2009; Tudor Hart, 1971; 2010). This led Shannon (2014: 259) to go on to argue that - although perhaps well meaning – research that highlights these environmental characteristics, and the place-based health policies designed to promote ‘healthy’ living, tends to place blame in poor neighbourhoods and to represent a paternalistic and ‘spatialized form of neoliberal governance aimed at producing slim consumers [who are] less burdensome to the state’. My analysis reveals that this is, at least partially, the case in Kingsland. However, while I largely agree with this assessment, in this context we also need a much more sophisticated engagement with the agency-structure dialectic. Such an engagement needs to consider, for example, the ways in which people ‘do’ health and enact freedom in neoliberal societies.

Bio-spheres of Risk-Aversion

The primary theoretical concept that emerges from my analysis is that which defines *bio-spheres of risk-aversion*. Bio-spheres of risk-aversion are the outcomes of policies that actively attempt to alter the physical environment in order to improve the opportunity structures of places in ways that promote ‘healthy’ living, e.g., building PA facilities, making ‘healthy’ dietary options readily available and so on. They are a projection of the ultimate achievement of those neoliberal policies that promote the ‘spatialization of healthification’ (Fusco, 2007: 49). Such policies are a reflection of the ever-expanding realm of (bio)medicalization and the establishment of neoliberal codes of ‘sensibleness’ as simply common-sense (Conrad, 2007; Herrick, 2011). This concept can be applied at a national level, i.e., to describe how the promotion of ‘healthy’ living is increasingly incorporated into the design and architecture of public and private places. It can also be applied to a more specific locale, as I have done in this research with Kingsland.

Reflecting the very nature of (bio)medicalization and neoliberal progress, bio-spheres of risk-aversion remain in a perpetual state of becoming as there is always more that
could be incorporated into the pursuit of health maximisation. Kingsland is an example of a place that has been partially transformed into a bio-sphere of risk-aversion and I contend that my analysis offers insight into the potential for these policies to ‘burden’ and/or ‘emancipate’ people living in areas of deprivation. All health interventions have the potential to exacerbate, reduce or have a neutral effect on health inequalities and transforming the physical environment in this way is no exception. The crucial concern with ‘healthy’ living policies is participation: positive health outcomes only result from participation. Therefore, unless these area-based health policies can offer equitable provision and engage so called ‘hard-to-reach’ groups they are liable to exacerbate inequalities rather than reduce them (Frohlich and Potvin, 2008).

This is precisely where the policy focus on health behaviours is limited in comparison to policies which aim to reduce poverty and redistribute wealth, e.g., welfare reform, extending healthcare provision, improving living conditions, increasing employment and education opportunities. As discussed in chapter three, by focusing on the community and not the wider structural causes of inequality, ABIs can be seen as an ‘ethnopolitics’ of the environment and this is especially the case when the aim of these initiatives is to promote ‘healthy’ living (Rose, 2001). While I agree that redistributive reforms are fundamental, because there is a current policy trend to ‘drift’ towards lifestyle interventions (Baum and Fisher, 2014; Popay et al, 2010), it is necessary to apply sociological analysis to the ways in which more individually focused policies effect social inequalities. My analysis indicates that the salient factor in this regard is whether policies place the responsibility for increasing compliance with ‘healthy’ norms primarily within the individual or social realm. This is where it is necessary to discuss and appreciate the contingent nature of agency.

Exercising Agency through Therapies of Freedom

When highlighting the significant ways in which expressions of agency are restricted by structural inequalities it is necessary to clarify why such arguments do not themselves undermine or underplay the agency of low-SES groups. Of course, those living in deprived neighbourhoods have the capacity to make choices and to resolve certain
issues that they face in life – this is clear from the findings presented in chapter nine. Indeed, not conforming to a definition of health that has been established and promoted by powerful agents could itself be the outcome of agency being exercised (Crossley, 2002). However, in order better to reflect the balance between the significance of agency and structure in determining patterns of (ill-) health, a consideration of how each of these influences may shape the behaviour of individuals is required.

Through the rhetorics of ‘responsibility’ and ‘choice’, neoliberal discourse emphasises the influence of individual agency in determining the state of someone’s health. Despite (or perhaps because of) this, attempts to influence government health policies continue to stress the need to address the social determinants of health in order to improve overall health and reduce health inequalities (e.g., Marmot, 2010; Pickett and Dorling, 2010; Wilkinson and Marmot, 2003 Wilkinson and Pickett, 2010). As such, Cockerham’s (2005) ‘health lifestyle theory’ is a useful conceptualisation, focusing as it does on the convergence of agency and structure. To some extent echoing the famous words of Marx (2001 [1852])7, Cockerham (2005) proposes that we all have the capacity to make choices (agency) but that what we choose to do will largely be determined by the opportunities that are available to us. Thus, whether or not one ‘chooses’ to perform particular health behaviours is not only a matter of taking responsibility for oneself, but it also reflects decision making within the parameters of one’s life chances. For Cockerham (2005: 64), therefore, ‘there are times when structure outweighs but does not negate agency and other times when structure overwhelms agency.’

As discussed in chapter three, this is why living in particular places has such significant effects on people’s health, as compositional and contextual effects are mutually reinforcing and influence how ways of behaving are considered possible and desirable within certain populations (Curtis and Jones, 1998; Frohlich et al 2001; Scambler, 2012). It is thus more accurate and useful to speak of ‘collective lifestyles’ rather than

7Men [sic] make their own history, but they do not make it just as they please; they do not make it under circumstances chosen by themselves, but under circumstances directly encountered, given and transmitted from the past. (Marx, 2001 [1852]: 7)
individual ones (Frohlich et al, 2001: 785). Therefore, altering the physical environment in order to transform areas into bio-spheres of risk-aversion has the potential to facilitate the agency of people of low-SES living in underserved parts of the country because it opens up possibilities for performing health in ways that are culturally and medically exalted.

Of course, for those who adopt the orthodox Foucauldian medicalization critique, arguing for the necessity of increasing the scope of promoting lifestyle behaviours is tantamount to encouraging further intrusion into personal freedom. Petersen (1997: 194) is one such critic who concedes that neoliberalism has created a sphere of ‘freedom’ for subjects whereby the pursuit of health and fitness has actually become the very way through which individuals demonstrate agency and meet the needs of competition – he terms this, somewhat paradoxically, ‘regulated autonomy’. So, rather than the partial transformation of a deprived area into what I have called a bio-sphere of risk-aversion necessarily burdening a place with blame, such a transformation could increase the quality of life available to the low-SES groups clustered in these locations.

At this point the work of Nikolas Rose helps to extend Foucauldian theory and its application in contemporary societies. His theoretical insights help to demonstrate why, while extending the scope of health promotion may narrow the parameters of what is defined as freedom it could also increase the experience of a sense of autonomy amongst those in underserved communities. Given the assumption today that people should demonstrate individual responsibility by governing themselves in health-promoting ways, Skeggs (2004: 73) argues that, ‘the self becomes obliged to “become” in a particular way.’ But, as she points out: ‘all the ways are not open to all, and some positions are already classified as in need of help, of being irresponsible, of having deficit culture, or of being pathological.’ Therefore, respecting and facilitating the agency of low-SES groups is, to some extent at least, reliant upon ensuring the construction of bio-spheres of risk-aversion which provide equitable opportunities for people to engage in what Rose (1999a: 261) terms ‘therapies of freedom.’

The language of lifestyle is one of independence and self-sufficiency, a discourse which promises a share in the good life if one conforms to the demands of contemporary
living (Howell and Ingham, 2001). ‘Self-work’ in non-work time is presented as an emancipatory path to health and happiness (Smith Maguire, 2008; Smith Maguire and Stanway, 2008). However, this realm of ‘active leisure’ comes with a ‘moral repertoire of “shoulds”’ (Fullagar, 2002: 78). As such, PA achieved through sport and fitness becomes part of what Zanker and Gard (2008) term a ‘moral universe’. Bodily maintenance has become one of the most visible signifiers that one lives ethically (Lupton, 1995; 2013a; Murray, 2009). We are all then ‘bio-citizens’ (Halse, 2009) in this moral universe, and not being able or willing to conform to its demands marks one out, not only as a bad citizen but as someone who does not want to help themselves and is therefore deserving of little more than scorn (Rich, 2011; Rich and Evans, 2005).

This is where Rose’s theoretical insights come into their own as health behaviours became therapies of freedom. He argues that these technologies of governmentality are so pervasive because the logics of individualism create a kind of ‘government through freedom’ (Rose, 1999a: xxiii). It is worth allowing him (Rose, 1999b: 87) to elaborate here on how:

...modern individuals are not merely ‘free to choose’, but obliged to be free, to understand and enact their lives in terms of choice. They must interpret their past and dream their future as outcomes of choices made or choices still to make.

For Rose (1999a; 1999b), this is where the project of the responsible citizen and an individual’s self-project fuse and people become governable through their freedom to choose. Demonstrating agency is thus, to some extent, dependent upon being able to access the therapies of freedom (of which PA is one of the most prominent) that promise health, happiness and independence for everybody. This is why arguing for increased provision for low-SES groups is so salient – not primarily so governments can reduce their expenditure on ill-health, but because otherwise underserved groups are severely limited in their capacity to make ‘choices’ and to avoid the stigma of being the pathological and deviant Other. This argument is in alignment with those of the behavioural justice movement (Baum and Fisher, 2014; Adler and Stewart, 2009). In this context, justice is not promoting acceptance for noncompliance with health
norms, but rather making culturally and medically exalted ways of ‘doing’ health more readily available and accessible to all.

Therefore, therapies of freedom are effective forms of governance because they encourage people to ‘do’ health in ways that are medically valued and support attempts to reduce public health expenditure. However, they also have a cultural significance which enables people to demonstrate agency to themselves and others, and thus they have the potential to inform a subjective sense of wellbeing and quality of life. This is of particular importance as research on the socioeconomic disparities in health behaviours has consistently indicated that people from lower-SES groups have health knowledge but are limited in their capacities to act upon it (Baum and Fisher, 2014; Dallaire et al, 2012; Pampel et al, 2010). This was very evident in Kingsland. Arguing that transforming areas into bio-spheres of risk-aversion necessarily burdens a place with blame, as Shannon (2014) can be seen to, fails to recognise the significance of pre-existing inequalities and the potentially emancipatory role of performing ‘healthy’ living in neoliberal societies. However, while it is not necessarily the case that such spatial transformation is burdensome my analysis has shown that the dominance of neoliberal individualism makes this eventuality a highly likely outcome of area-based health policy.

**Equitable Access or Residual Effect**

While I broadly agree that ultimately the best way to resolve health inequalities is to address the social determinants of health by reducing structural inequality (Marmot, 2010; Wilkinson and Marmot, 2003; Pickett and Dorling, 2010; Wilkinson and Pickett, 2010), my argument is also that health behaviours must be recognised as at least culturally significant ways of ‘doing’ health that are not realistic ‘choices’ for all. Promoting ‘healthy’ living as an individual responsibility - e.g., the UK Government’s Change4Life campaign - in a severely unequal society is more likely to exacerbate than to reduce health inequalities (Frohlich and Potvin, 2008; Lorenc and Oliver, 2014). This is due to the relative structural restraints that impact differentially on people throughout the social strata and is evident in the social gradient observable in health
behaviours (Buck and Frosini, 2012; Wilkinson and Pickett, 2010). If increasing provision for low-SES groups is approached as a ‘social’ responsibility there is greater potential to engage what are otherwise known as ‘hard-to-reach’ groups. In this sense, social responsibility involves adequate measures being taken to ensure equitable service provision. Making the practices of ‘healthy’ living more accessible to - and more realistically achievable for - low-SES groups is unlikely to significantly reduce health inequalities without significant structural change. However, as was observable in chapters eight and nine, this policy can significantly improve the health and wellbeing experienced by people living in deprived areas who are engaged.

Thus, I am not presenting the concept of bio-spheres of risk-aversion as an overtly positive or negative transformation of the physical environment. Such an assessment can only be made by considering each empirical case on its own terms. Biospheres are more traditionally defined as environments capable of supporting life. A bio-sphere of risk aversion should be assessed by making judgements about how adequately it supports the people who call it home to adopt ‘healthy’ lifestyles and therefore whether it is liable to exacerbate or reduce health inequalities. In short, we are led to ask, does the (partial) transformation of the local environment provide evidence that the responsibility for ‘healthy’ living is placed predominately within the individual or within the social realm?

As discussed in chapter two, prioritising a reduction in the incidence of obesity is evidence of a moral panic which is deserving of more widespread criticism. The focus on BMI appears to be medically unfounded and morally indefensible. However, research convincingly demonstrates that there is a significant link between PA participation and metabolic health (Ortega et al, 2013). This suggests that - while the necessity of weight-management is overemphasised - policies that facilitate PA participation are potentially beneficial to individual and collective health. Research also demonstrates that PA participation has a social gradient, with low-SES groups the most likely to be inactive (Farrell et al, 2014). Additionally, studies show that this is at least in part due to the inequitable spatial distribution of PA facilities and services (Farrell et al, 2014; Hillsdon et al, 2007; Gordon-Larsen et al, 2006). Rather than burdening poor neighbourhoods with neoliberal governance, then, it is possible to
view attempts to increase access to PA in areas of deprivation as an effort to correct the inverse care law (Tudor Hart, 1971; 2010). If this is considered objectionable, as Shannon (2014) seems to suggest, then it can only be because opponents are content to romanticise working-class cultures by assuming non-compliance with health behaviours are freely chosen rather than at least partially informed by structural disadvantage.

For all of the above reasons, increasing PA facilities and services in Kingsland can be seen as a positive - though not socially transformative - outcome of the ABIs. It is highly questionable whether funds specifically allocated to reduce national inequalities should have been spent on promoting lifestyle behaviours. It is however entirely in keeping with the problematic tendency for health policy to drift towards lifestyle-orientated interventions (Baum and Fisher, 2014; Popay et al, 2010). This trend is harmful because it deflects resources and attention away from the social determinants of health but if specific interventions are targeted they will not necessarily exacerbate existing inequalities. If interventions in Kingsland proved capable of offering local residents sustainable, equitable access to PA they might at least be able to alleviate some of the inhibitory influences that disproportionately act upon low-SES groups.

The reason my analysis is so critical of the service provision I observed in Kingsland - specifically that of the new Leisure Centre - is because the initial notion that local service providers have a social responsibility to target and offer equitable opportunities for poorer citizens to participate in PA seemed to be part of a memory faded by the waning influence of the past. This process was powerfully described in an interview with Tom, a Gym Instructor and local resident who had worked at the Leisure Centre since it had opened:

*The purpose of the Centre I feel, my opinion, what has always been set out was to get people from this area, give them something, for them to come in and be a part of this. And it happened. And it finished. And it’s done.*

Initially, local interventions in Kingsland appeared to address numerous structural factors which a local consultation found had inhibited residents’ PA participation, e.g.,
local availability, subsidised/free activities, childcare, social support. As funding became scarcer, the sustainability of these initial interventions relied precariously upon local providers working in partnership to offer equitable opportunities. My analysis reveals that these partnerships, to a large extent, rely upon the availability of funds. Consequently, it is almost inevitable that service providers increasingly shift responsibility for participation to individuals: a process I call citizen shift. This is an extension of the lifestyle drift policy trend, but it more firmly places responsibility for participation within the realm of the individual. Doing so makes interventions liable to exacerbate existing inequalities. Therefore, it is this process of citizen shift which is inherently detrimental to policies which attempt to reduce health inequalities.

Recognising the need to redress inequitable service provision with ABIs can at least partially be viewed as placing the responsibility for health within the social realm. Having acknowledged this, pre-existing structures of inequality ultimately mean untargeted interventions more usually have paradoxical effects (Frohlich and Potvin, 2008). Approaching health as a social responsibility necessitates ensuring not only equitable spatial distribution of services but also equitable provision once spatial disparities have been addressed. This involves providing the sorts of services that were initially built into interventions in Kingsland, e.g., free/inexpensive activities and mentoring, inexpensive on-site childcare. If these needs are not addressed, then lifestyle drift in health policy stands to progress into citizen shift. This process was clearly observable over time in Kingsland.

Although rectifying the paucity of available PA facilities and opportunities in Kingsland transformed it into a relatively novel place – a deprived area with numerous and varied PA facilities and services – this transformation of the physical environment was not reflective of health, more broadly, being approached as a social responsibility. My analysis reveals that the process of citizen shift is a consequence of the dominance of neoliberalism and the ways in which this ideology undermines health being approached as a collective responsibility. Outwardly, Kingsland now appears to be an area well-served by PA services. However, rather than this intervention significantly supporting local residents to be physically active, it did indeed appear to burden them with responsibility and blame, but not just in a symbolic way as suggested by Shannon
Instead, these interventions had a *residual effect* that occurred as an outcome of Kingsland having been partially transformed into a bio-sphere of risk-aversion. This transformation enabled people in positions of power to draw on examples of past intervention and present, but inequitable, services to argue that non-participation by local residents was thus evidence of their recalcitrance.

This firmly positions what is a vulnerable population as ineffably ‘hard-to-reach’ and morally suspect without recognising that ‘reaching’ is a dual-dynamic requiring social responsibility that service providers in Kingsland were assumed by their public to have. Paradoxically, increasing the local availability of services facilitates the framing of health as an individual responsibility that this vulnerable population are largely failing to abide by. This demonstrates how the dominance of neoliberal individualism leads to modifications of the physical environment altering the ways in which the collective health and moral fibre of the people who live there are perceived. Policy-makers and implementers need to be aware of this potential and to ensure the design of health-interventions guards against it happening.

**Citizen Shift: Indefensible and Ineffective**

Research indicates that implementing area-based policy in areas of high deprivation can protect against widening health inequalities (Stafford et al, 2014). As the same cannot be said about non-targeted interventions (Frohlich and Potvin, 2008) and ‘hard-to-reach’ groups have been shown to respond positively to interventions (Choitz et al, 2010; Lowther et al, 2002), I argue that targeting areas of deprivation in an effort to redistribute wealth and address structural inequality is one of the ways in which the negative social determinants of health can be effectively addressed. A significant caveat to this argument is that such policies need to ensure that specific investment and efforts are made to actually engage so called ‘hard-to-reach’ groups. If health policy is designed in this way it could be argued that health is being approached as a ‘social’ responsibility.
The tendency for policy to drift into lifestyle-modification is a worrying one. This is because lifestyle modification is more usually approached as an individual responsibility and individualist health promotion is liable to exacerbate inequality. A significant but as yet under-researched area is the processes through which health interventions have paradoxical effects and create ‘equity harms’ (Lorenc and Oliver, 2014: 289). Responding to this dearth in knowledge, this analysis highlights the residual effects that interventions can have and conceptualises citizen shift to describe and explain the ways in which interventions detrimentally impact on low-SES groups and exacerbate existing inequalities.

The dominance of neoliberal individualism led to a number of service providers in Kingsland shifting responsibility for ‘healthy’ living to individuals rather than working together to address the needs of the vulnerable population they serve. This finding reminds me of Crawford’s (2006: 410) reflection on his earlier work that was vehemently critical of the culture of healthism established through the rise of neoliberalism:

…what became clear in hindsight is that individual responsibility for health, although not without challenge, proved to be particularly effective in establishing the ‘common sense’ of neoliberalism’s essential tenets.

His argument is that the simplistic logic that those who do not ‘help themselves’ ultimately – and deservedly - suffer ill-health as a consequence helps to establish the tenets of individualism in the minds of the masses. This was observable in Kingsland. Low-SES respondents generally conceptualised health as an individual responsibility and the ABIs did not seem to highlight local disadvantage and thus offer challenges to rhetorics of choice and moral individualism. Instead, lifestyle drift facilitated and encouraged such logics. The main outcome of this is a shifting of responsibility to individuals, which in turn mobilises victim blaming. Highlighting these outcomes demonstrates the need to (i) pay more attention to the paradoxical effects of health interventions (ii) and to develop concepts which can help future policy-makers and implementers to reinforce their interventions against producing similar paradoxical outcomes. This research makes an original contribution to both of these ends.
Bonell et al (2014: 3) argue that the achievement of these aims is essential but currently largely ignored. These authors advocate developing models and theories which can be used to ‘anticipate the most plausible and most harmful unintended harmful impacts and associated mechanisms’ of health interventions and therefore to guard against them. They term these ‘dark logic’ models. My analysis offers the waning influence of the past, precarious partnerships, citizen shift, residual effects, risky resistance and processes of compensation as a means of achieving these aims.

In chapters eight and nine I illustrated the full extent of the paradoxical effects of shifting responsibility for maintaining good health to individuals in low-SES groups. Chapter eight reveals the extraordinary lengths that a few socially-engaged and empathetic individuals went to in order to engage ‘hard-to-reach’ groups. They must go ‘above and beyond’ the requirements of paid work because they are working against wider individualising processes of citizen shift. Chapter eight also reveals how it is sometimes necessary to accommodate and understand behaviours which could be considered to be detrimental to ‘healthy’ living in order to encourage low-SES groups to participate, e.g., smoking and soft-drug use at football sessions. However, it is the insights from the weight-loss groups in chapter nine which best illustrate the ineffectiveness of policies that facilitate the process of citizen shift by promoting health as an individual responsibility.

Dobbs et al (2014) reveal that the UK government’s largest annual investment in obesity prevention strategies is a meagre £11million for the Change4Life campaign. This is a public awareness campaign that promotes the simplistic ‘eat well, move more, live longer’ message (Department of Health, 2008; 2009). Both the insignificance of this investment (when compared to the £6 billion that Dobbs’ et al (2014) report obesity costs the NHS) and the message it promotes illuminates that, as well as having all the features of a moral panic – obesity is promoted as very much an individual responsibility. This is, of course, in stark contrast to the situation in Japan, where Lawler (2010) has described legislation which includes; a mandatory annual health screening which measures risk in more nuanced and accurate ways than can be achieved using the BMI; provides counselling for the ‘at risk’; and, significantly, imposes fines on health-insurance providers with high numbers of clients defined as
being ‘at risk’. The fine system has led to numerous examples of proactive prevention and management strategies provided by the private sector, e.g., employers providing exercise and dietary services to employees. From a health inequalities perspective, promoting obesity as an individual moral responsibility disproportionately disadvantages low-SES groups. My analysis reveals that this policy is not only questionable on medical and moral grounds, but is also counter-productive.

The weight-loss groups in Kingsland function more as social groups with scales than as effective strategies for supporting weight-loss. The groups provide opportunities for processes of compensation and offer what appears to be necessary but ad hoc emotional labour. The necessity of this provision is largely attributable to participants’ response to their embodied experiences as stigmatised bodies with low-SES by adopting strategies of risky resistance. These include not only rejecting but redefining the risk associated with BMI measures and conceptualising health more broadly as a capacity to cope. Coping with the limited freedoms of their everyday lives was also evidently made more challenging by them having to manage the social stigma associated with corporeal nonconformity. This creates the need for emotional labour and, inadvertently, promotes coping strategies which include behaving in ways which may be considered more widely to be detrimental to health, e.g., over-eating and excessive alcohol consumption. Significantly, participants framed these strategies as ways of complying with the responsibility to be ‘healthy’ within the narrow parameters of agential possibility that they experience in typical low-SES groups contexts.

The approaches to weight-management revealed in this analysis highlight the iatrogenic consequences of pathologising and stigmatising obese people. These iatrogenic consequences are liable to be replicated throughout the social spectrum. However, this analysis specifically reveals how ineffective the victim blaming strategy of promoting health as an individual moral responsibility is with people from low-SES groups who do not already conform to dominant health norms. More broadly, these findings reveal how even ‘healthy’ living policies that do address issues of equity and do engage low-SES groups offer insufficient means for sustained compliance with ‘healthy’ norms for people of low-SES.
When the Big, Bashed Drum Falls Silent: New Research Priorities

I agree with Gore and Kothari (2012) that the dominance of neoliberal ideology means that there is an urgent need for advocacy and education about the social determinants of health in order to increase political will to address them. However, such awareness would have also been likely to have led to more equitable PA service provision in Kingsland. Social intervention to create more equitable service provision is both necessary and recommended if health inequalities are to be addressed. As such, partially transforming deprived neighbourhoods into bio-spheres of risk-aversion is not in and of itself problematic. However, my analysis from Kingsland reveals that such a transformation can have detrimental effects at a local and national level. Because equity seems not to be a priority, the ABIs in Kingsland increase the moral burden and social exclusion that local residents endure. Therefore, local services are liable to exacerbate existing inequalities by being disproportionately accessed by ‘outsiders’.

My analysis indicates that both of these outcomes are consequences of the promotion of health as an individual responsibility. As the waning influence of the past reveals, this was not always the case in Kingsland. However, lifestyle drift appears, in this instance, to have progressed further along the continuum of individualisation to citizen shift. This has led to initial interventions in Kingsland going on to have paradoxical effects, including facilitating victim blaming. Speaking to Sam (Operational Manager at The Elm) one evening at a football session about how local services have diminished over time he eloquently summed up this problematic process:

> When the money was there everything was successful, but the big, bashed drum isn’t in Kingsland anymore. They used to go out and get people involved but now it’s different. (Fieldnotes: 16/11/2012)

The ‘big, bashed drum’ here is representative of health and community engagement being approached as a social responsibility and as a matter of priority. As funding was spent and the more dominant influence of neoliberalism came to prominence the responsibility for health and community engagement has been increasingly placed in the individual realm. The partial transformation of the neighbourhood even supports this process of citizen shift as past and present interventions now have detrimental
residual effects. The big, bashed drum fell silent and – through a process of citizen shift - the responsibility now is for each individual to become a one-man or one-woman band so that the show can go on. This is asking a lot of what is a vulnerable population and thus the ABIs implemented in Kingsland can, to some extent, be seen to have burdened the North Kingsland estate with blame and set local people up to ‘fail’.

My analysis indicates that the policy to partially transform Kingsland into a bio-sphere of risk-aversion provides another example of how health interventions can have paradoxical effects. As research increasingly indicates that the psychosocial experience of inequality is in and of itself detrimental to health (Marmot, 2005; Wilkinson and Pickett, 2010), based on this research I no longer consider it legitimate to defend health interventions which may increase health inequalities but ultimately have a positive effect on average health at a population level. The message is clear; increasing inequality indirectly increases ill-health and, correspondingly, interventions which produce ‘equity harms’ (Lorenc and Oliver, 2014: 289) are harmful to health, even if their only direct outcome is to increase overall health (by improving the health of higher-SES groups). We need more research that not only interrogates neoliberal health strategies but also increases awareness and understanding of the potential for health interventions to have (perhaps) unintended, but harmful, health outcomes.

**Strengths and Limitations**

To better guard against further exacerbation of existing health inequalities requires research which engages with the under-researched issue of the inequality paradox; offers insightful analysis of the experience of inequality; and provides a set of conceptual tools which can be used to advocate an approach to health as a social responsibility and strengthen the design of subsequent health interventions. The original contribution I make with my analysis is a set of theoretical concepts which fulfil these criteria and are grounded in in-depth ethnographic research that connects the macro with the micro. This wide-ranging approach strengthens my analysis and I would suggest that such analysis is rare within the field of health inequalities. It has
allowed me to engage with the agency-structure dialectic to reveal how political policies actually affect the lives of marginalised groups whose social standing often means their stories go unheard. However, my research also has its limitations.

My wide-ranging focus allowed me to demonstrate how a significant investment in health promotion had not necessarily increased the opportunities or improved the lives of residents in North Kingsland. However, a focus on the potential accessibility of local services, and the embodied experiences of those from marginalised groups who \textit{did} engage with them, deflected attention away from the stories of those I came to think of as the ‘invisible people’: those who did not/could not access local PA services. If time and resources had allowed for data collection to more fully represent their accounts I would have certainly engaged with this task. These accounts would have enriched my analysis and better informed my discussions about ‘choice’. The relative absence of these accounts does not represent a relegation of their importance, much the opposite. Rather it is an acknowledgement of the limitations of ethnographic research; by dedicating my time and attention to capturing the complexity of certain aspects within the field I was unable to do what was necessary in order to do the same in others.

Taking the strengths and limitations of my research into account, I would recommend that future studies exploring health policy and inequalities adopt similarly ethnographic, but wide-ranging, approaches. Connecting macro and micro elements is the most effective way that sociologists can demonstrate the relationship between personal troubles and public issues (Mills, 1959). This is of vital importance as these issues tend to be dichotomised in societies where neoliberalism is the dominant political ideology. One way of making this connection is to explore how low-SES groups are underserved by health provision and to illustrate the ways in which this problematically impacts upon the embodied experiences of people’s everyday lives and exacerbates existing inequalities.

I am open to scholarly critique of my contribution to the field but am confident that my analysis increases understanding about the ways in which health inequalities are
created, personally experienced and exacerbated. My ambition now is to ensure that this insight usefully contributes to the promotion of more equitable health.
Appendix

Figure 11.0: Sign Displayed at Kingsland Leisure Centre

To Kingsland Leisure Centre User,

This is Oli Williams. He is a postgraduate student at the University of Leicester and is interested in the health and physical activity of people in Kingsland. He is spending time in the Leisure Centre, as part of a research project, to see how it is used. Feel free to talk to him; he’s interested in what you have to say.
<table>
<thead>
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<th>Pseudonym</th>
<th>Role</th>
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<td>Kingsland Resident and Women's Weight-Loss Group Participant</td>
</tr>
<tr>
<td>Cary</td>
<td>Kingsland Resident and Local Community Youth Worker</td>
</tr>
<tr>
<td>Karen</td>
<td>Manager at Kingsland Leisure Centre</td>
</tr>
<tr>
<td>Julie</td>
<td>Former member of SAZ Implementation Team and present Manager of Keep-Fit</td>
</tr>
<tr>
<td>Lindsay</td>
<td>Former Women's Weight-Loss Group Instructor and present Keep-Fit Staff Member</td>
</tr>
<tr>
<td>Matt</td>
<td>Former member of SAZ Implementation Team and present Manager of FIT-FRIENDS</td>
</tr>
<tr>
<td>Abbie</td>
<td>Former Women's Weight-Loss Group Instructor and present FIT-FRIENDS Development Officer</td>
</tr>
<tr>
<td>Parina</td>
<td>Born and raised in Kingsland, Women's Weight-Loss Group Instructor and FIT-FRIENDS employee</td>
</tr>
<tr>
<td>Hyacinth</td>
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Table 11.2: Data Collection Figures

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<td>Becky</td>
<td>Women's Weight-Loss Group: AM</td>
<td>Participant</td>
<td>Pub</td>
</tr>
<tr>
<td>18 &amp; 19</td>
<td>Shannon &amp; Suzie</td>
<td>Women's Weight-Loss Group: AM</td>
<td>Participants</td>
<td>Leisure Centre</td>
</tr>
<tr>
<td>20, 21 &amp; 22</td>
<td>Emily, Debs &amp; Blaze</td>
<td>Women's Weight-Loss Group: AM</td>
<td>Participants</td>
<td>Leisure Centre</td>
</tr>
<tr>
<td>23 &amp; 24</td>
<td>Tracey &amp; Nadine</td>
<td>Women's Weight-Loss Group: AM</td>
<td>Participants</td>
<td>Leisure Centre</td>
</tr>
</tbody>
</table>

Table 11.3: Interviewee Information
<table>
<thead>
<tr>
<th>No.</th>
<th>Name</th>
<th>Group Type</th>
<th>Role</th>
<th>Location</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>25</td>
<td>Matt</td>
<td>FIT-FRIENDS Manager</td>
<td></td>
<td>Kingsland Park</td>
<td>63.51</td>
</tr>
<tr>
<td>26</td>
<td>Carl</td>
<td>Men's Weight-Loss Group</td>
<td>Group Leader - Volunteer</td>
<td>Leisure Centre</td>
<td>38.29</td>
</tr>
<tr>
<td>27</td>
<td>Arthur</td>
<td>Men's Weight-Loss Group</td>
<td>Participant</td>
<td>Leisure Centre</td>
<td>30.03</td>
</tr>
<tr>
<td>28</td>
<td>Alf</td>
<td>Men's Weight-Loss Group</td>
<td>Participant</td>
<td>Old People’s Home</td>
<td>18.22</td>
</tr>
<tr>
<td>29 &amp; 30</td>
<td>Jonny &amp; Phil</td>
<td>Men's Weight-Loss Group</td>
<td>Participant</td>
<td>Leisure Centre</td>
<td>34.53</td>
</tr>
<tr>
<td>31</td>
<td>Sam</td>
<td>The Elm Operations Manager</td>
<td></td>
<td>The Elm</td>
<td>39.22</td>
</tr>
</tbody>
</table>
Figure 11.4: Consent Form

Researcher: Dhi Williams
Department of Sociology
University of Leicester
University Road
Leicester
LE1 7RH
Telephone: 0116 2231085   E-mail: osw1@le.ac.uk

Investigating Sport and Physical Activity Promotion in Kingsland

Purpose of Study:
To find out what sort of local sport and exercise goes on in this area and your views about it.

What does it involve?
An informal interview to discuss what you think about the sport and physical activity opportunities around your community. The informal interview will take place at a time and place most convenient for you. It will probably last about 30 minutes but it might be slightly longer. For you to be involved I need to confirm a few things:

- That you understand what you are being asked to take part in and that any questions you have about the research have been fully answered
- That your participation is voluntary and you can choose to stop the interview whenever you like without explanation
- That the interview will be audio-recorded (so that your opinions are gathered accurately) and you are happy for this to happen. Your views will be confidential and used only by the researcher.
- Nobody will be identified by name in the research so your anonymity is guaranteed. The recording will be stored securely and erased after use.

I have read the information on this form. I understand the research and I am happy to participate in it:

Participant’s Name: __________________________________________

Participant’s Signature: ________________________________________

Date: ______________________
Figure 11.5: Questionnaire

Physical Activity in Kingsland

If you are **16 years old or older** please fill in this short questionnaire. It is for a University of Leicester research project about physical activity in Kingsland. All answers are anonymous. Your input would be much appreciated. Follow the instructions and answer all applicable questions.

Home Postcode OR Street Name: __________________________ Age: ______ Gender: __________

1) Would you say that living a healthy lifestyle is important to you? [ ] Yes [ ] No

2) Do you think you do enough physical activity to be healthy? [ ] Yes [ ] No

3) Do you currently do any exercise or sport in Kingsland? [ ] Yes [ ] No

If you answered **YES**, where do you do it? (Please tick all that apply)

- Kingsland Leisure Centre
- The Elm
- Acorn Centre
- Kingsland Park
- At home
- Exercise equipment in the park
- Football pitches in the park
- Other (write where below)

4) Please mark on the line below how much exercise or sport you do in an average week:

<table>
<thead>
<tr>
<th>0 mins</th>
<th>30 mins</th>
<th>1 hour</th>
<th>1 ½ hours</th>
<th>2 hours</th>
<th>2 ½ hours</th>
</tr>
</thead>
</table>

5) How would you describe the cost of using Kingsland Leisure Centre? (Please tick one)

- Expensive
- Reasonable
- Cheap
- Don't know

6) Is there anything stopping you from doing more exercise or sport in Kingsland?

[ ] Yes [ ] No [ ] Don’t know

If YES, what is it that stops you doing more exercise or sport in Kingsland? (Tick all that apply)

- Children & family commitments
- Lack of local facilities
- Lack of local activities
- I’m too old
- Cost
- Work commitments
- Health problems
- Lack of information
- I can’t do what I want to do at the facilities in Kingsland [please write why below]
- I feel self-conscious about my body
- Other (Please write why below)

7) Finally, in your opinion what could be done to help you personally to do more exercise or sport in Kingsland? (Please write as little or as much as you like below)

What would help: __________________________

What activities do you want: __________________________

Where/when would you like to do this: __________________________

Oli Williams: University of Leicester: osw1@le.ac.uk
Table 11.6: Questionnaire Sample Breakdown

<table>
<thead>
<tr>
<th>Location</th>
<th>No' of questionnaires</th>
<th>Percentage (%) of overall sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kingsland Leisure Centre</td>
<td>614</td>
<td>50.7</td>
</tr>
<tr>
<td>The Elm</td>
<td>57</td>
<td>4.7</td>
</tr>
<tr>
<td>Health Centre</td>
<td>58</td>
<td>4.8</td>
</tr>
<tr>
<td>Sure Start Centre</td>
<td>101</td>
<td>8.3</td>
</tr>
<tr>
<td>Local Schools</td>
<td>225</td>
<td>18.6</td>
</tr>
<tr>
<td>Community Groups</td>
<td>122</td>
<td>10.1</td>
</tr>
<tr>
<td>Kingsland Carnival</td>
<td>33</td>
<td>2.7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1210</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Table 11.7: Questionnaire data – healthy lifestyle

<table>
<thead>
<tr>
<th>Question: Is living a healthy lifestyle important to you?</th>
<th>Kingsland Resident</th>
<th>Percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>94.3</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>5.7</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Question: Correctly identify weekly PA</th>
<th>Kingsland Resident</th>
<th>Percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>70.9</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>29.1</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Correctly identified if currently met government guidelines for weekly PA</th>
<th>Kingsland Resident</th>
<th>Percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>70</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>Non-Resident</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>70</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>30</td>
<td></td>
</tr>
</tbody>
</table>
Table 11.9: Questionnaire data – perceived barriers to PA

<table>
<thead>
<tr>
<th>Question: Is there anything preventing you from doing more PA</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Kingsland Resident</td>
<td>Percent (%)</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>58.9</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>36.8</td>
<td></td>
</tr>
<tr>
<td>Don’t Know</td>
<td>4.3</td>
<td></td>
</tr>
<tr>
<td>Non-Resident</td>
<td>Percent (%)</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>52.6</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>43.2</td>
<td></td>
</tr>
<tr>
<td>Don’t Know</td>
<td>4.2</td>
<td></td>
</tr>
</tbody>
</table>
Bibliography


Conway, S. Crawshaw, P. and Bunton, R. (2007) “There is a mantra of: “community involvement is good”, and we all tick the boxes and say we have done the consultation’: health action zones and the normative principles of government’, Social Theory and Health 5 (3): 208-227.


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