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Implementation of “Top-Down” Government Policy: Health Promotion Case Studies in NSW

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Description

This study appraises the implementation of the health promotion components of the NSW State Plan and State Health Plan. Four case studies were conducted in a sample of Area Health Services (AHSs). Mixed methods were used and data triangulated where possible. This study found that AHSs share the state policies' vision of a greater focus on health promotion/prevention on paper, but not in reality. Health promotion is not as important to AHSs as the acute care sector. Consequently, health promotion/prevention receives a tiny share of the budget and little attention. While this study has found some routine policy implementation failures, the overarching finding is the need for a rethink of prevention and health promotion delivery. The establishment of a separate prevention agency to deliver standard programs across the state, introduce an appropriate performance-monitoring framework, and have transparent and monitored funding tied to program delivery is the key recommendation.

Location

iC - SBS Teaching Facility

Implementation of “Top-Down” Government Policy: Health Promotion Case Studies in NSW

Liz Develin

Abstract

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This study found that AHSs share the state policies' vision of a greater focus on health promotion/prevention on paper, but not in reality. Health promotion is not as important to AHSs as the acute care sector. Consequently, health promotion/prevention receives a tiny share of the budget and little attention.

While this study has found some routine policy implementation failures, the overarching finding is the need for a rethink of prevention and health promotion delivery. The establishment of a separate prevention agency to deliver standard programs across the state, introduce an appropriate performance-monitoring framework, and have transparent and monitored funding tied to program delivery is the key recommendation.

Introduction and Background

As this is a policy study, before describing the research, it is appropriate to firstly introduce what “policy” is, and some common implementation pitfalls. Policy is commonly used as a label for a field of activity (for example, foreign policy), or as an expression of general purpose or a desired state of affairs - or it can be a specific proposal or decision of government (including programs and legislation) (Barrett & Fudge 1981; Hogwood & Gunn 1984).

A considerable body of literature exists on what is required for successful policy implementation. Lessons learnt include that policies should:

- Be based upon a valid theory of cause and effect.
- Involve an understanding of, and agreement on, objectives.
- Include as few steps as possible between formulation and implementation.
- Allow adequate time for implementation with sufficient resources attached.
- Not involve responsibility being shared among too many players.
- Include a clear chain of accountability.
- Involve implementers in the policy design.
- Be continually evaluated, evolve and become more effective.
- Pay as much attention to implementation as to formulation.

(Hogwood & Gunn 1984; Ingram 1990; Davis & Weller 1993; Sabatier 1988; and Pressman & Wildavsky 1973).

State Plan and State Health Plan

The State Government in NSW has released two policies relevant to the public health system. The first, the State Plan, *A New Direction for NSW*, was released in November 2006. The second, *The State Health Plan Towards 2010, A New*

Direction for NSW, focuses solely on the health system and contains the same health-related indicators as the State Plan.

The State Health Plan articulates, "What we are striving for in 2010 is a health system that puts greater effort and investment into improving health and preventing illness while continuing to treat illness effectively" (NSW Department of Health 2007, p.14). The State Plan similarly expresses a desire for increased focus on prevention, as well as early intervention, stating, "Both early intervention and prevention programs can have benefits at all life stages...They can be universally available, such as health promotion programs...We want 'early intervention' to characterise the way the NSW Government approaches future policy development and program design...." (NSW Government 2006, p.75).

Aims of the Study

The state plans have set a clear direction for the NSW health system. How these "top-down" policies are to be implemented, and their targets achieved, is less clear. This research sought to describe the impact these top-down health promotion policies were having in AHSs, and how they were being implemented "on-the-ground".

Specifically, the aims of this study were to:

- i) Appraise and critically review the implementation of the health promotion components of the state plans in NSW AHSs;
- ii) Identify what facilitated implementation within NSW AHSs;
- iii) Identify what hindered implementation within NSW AHSs;
- iv) Appraise and critically review differences and similarities between NSW AHSs with regard to these facilitating or hindering factors; and
- v) Provide recommendations to enhance current implementation efforts and the future development and implementation of similar policies.

Methodology

Case Study Approach Using Mixed Methods

The impact of the state plans was examined using mixed methods within a case study approach. Case studies of four of the eight AHSs were conducted - involving the analysis of quantitative and qualitative data. By mixing the datasets, the researcher provides a better understanding of the problem than if either dataset were used alone (Creswell & Plano Clark 2007).

It was feasible within the resources of the research to study 50% of the total population, which was a sample of four AHSs. Two criteria were used to determine the cases: a mix of rural/metropolitan, and a mix of large and small AHSs. The two metropolitan cases were Sydney South West (SSWAHS) and North Sydney/Central Coast (NSCCAHS). The two rural cases were Hunter New England (HNEAHS) and Greater Western (GWAHS).

Data Collection and Analysis

Data were collected from the following sources: AHS strategic plans and annual reports, financial reports/information, interviews and focus groups with AHS

personnel. Each of the sources provides a different perspective and allows for comparison and contrast. Such comparative analysis also enhances generalisability and deepens explanation (Miles & Huberman 1994, cited in Butler 2003). Further, using such a mixed methodology also aims to enhance the validity of the data through the process of triangulation (Erlandson et al. 1993; Blaxter, Hughes & Tight 2003). Content analysis, via specifically designed codebooks, was used for the organisational documents and interview/focus group transcripts.

Preliminary data from the annual reports and strategic plans was analysed for the four AHSs not in the sample. This was done to check that there were no apparent significant differences between sampled and non-sampled AHSs.

For the strategic plans, the codebook was based on a program logic model. A program logic model is defined as a picture of how an organisation does its work – the theory and assumptions underlying the program; it links outcomes (both short and long term) with program activities/processes and the theoretical assumptions/principles of the program (W.K. Kellogg Foundation 2004). The program logic model provided a tool to determine whether the strategic plan contained the elements that would be expected to be included in a plan which is well considered, and likely to be achieved.

Content of the strategic plans was categorised and inserted into the codebook, and where possible simultaneously analysed. The criteria used for valuing the presence of a category or lack of, was straightforward in most cases as the categories were generally either present or not.

In regards to the annual reports, the codebook was based on a theoretical framework similar to that used for the semi-structured interview guide (discussed later). Content of the annual reports was categorised and inserted into the codebook against the relevant category, and where possible simultaneously analysed. The concepts and categories related to issues not relevant prior to the release of the state plans were omitted from the codebook when it was applied to annual reports from 2004/5 to 2005/6 (the years before the release of the plans).

The second data source was AHS financial data for health promotion/prevention related expenditure over time. The collection of financial data in this study enabled a quantitative examination of whether AHSs essentially 'put their money where their mouth is'. Data was sourced from annual reports, which provided the total Net Cost of Services [NCOS] for the population health program. Further, internal data was sourced from the Department of Health from the unaudited annual returns (UARs). A number of calculations were made using the financial information, at varied levels of analysis. The time periods of interest were i) each financial year; ii) considering the two years prior to (2004/5, 2005/6) and subsequent to the State Plan and State Health Plan (2006/7, 2007/8); and iii) the four year period.

The third source of data was interviews and focus groups with AHS personnel. One joint interview was conducted with the Chief Executive and Director, Population Health, Planning & Performance (the first two tiers of the organisation). A further joint interview was conducted with the Director, Population Health (or similar) and the Manager, Health Promotion (the third and fourth tier of the organisation). A solo

interview was also conducted with the Director of Finance (or equivalent) of the AHS¹. A focus group was also conducted with staff in each AHS² who deliver health promotion programs. It was anticipated that the interviews and focus groups with a broad range of AHS employees would assist in identifying diversity both within and between the cases.

The study design included the use of an independent research assistant to organise and conduct the interviews and focus groups. The reasons for this included: 1) the potential bias of the chief investigator; 2) the possible perception of a conflict of interest, and 3) the power relationship between the chief investigator and some of the interviewees/focus group participants which may have inhibited candor.³

A theory driven approach was used to develop the semi-structured interview and focus group guide. Based on the aims and research questions of the study and the results of previous research and theories, a set of questions were developed that clustered around the domains of policy, process and resources. Within the policy domain, possible questions were developed around the concepts of 'shared vision', 'targets' and 'results/measurements'. In the process domain, possible questions were developed around the concepts of 'feasibility', 'structures', 'relevance/context', 'competing priorities', and 'monitoring/performance management'. Finally, within the domain of resources, possible questions were developed around the concepts of 'human', 'spending/ring fencing', and 'resource allocation'.

The codebook for the analysis of the interviews and transcripts was based on the domains of policy, process and resources also. This is consistent with Crabtree and Miller's (1992) advice that a structured and closed approach to developing codebooks should rely on a-priori codes being based on the research question or theoretical considerations (Crabtree & Miller 1992). Theory driven code development is probably the most frequently used approach in social science research (Boyatzis 1998).

The process for the analysis of the transcripts was as follows: i) formulating the research questions (ie through the semi-structured interview schedule development); ii) selecting the sample and material for analysis; iii) developing the codebook based on the theoretical framework; iv) testing the codebook on a transcript; v) refining the codebook after the testing; vi) applying the codebook to all data in the sample; vii) adding further categories to the codebook if they emerged; and viii) interpreting the results.

Strengths and Weaknesses of the Methodology

The strengths of this study's design are summarised as:

- The benefit of varied and mixed data sources – providing both qualitative and quantitative data.
- The selection of participants with varied experiences to increase the possibility of shedding light on the research questions from a variety of aspects. In addition, the cases in this study were selected to highlight potential differences in that they include both big and small, and metropolitan and rural AHSs. Mays and Pope

¹ There were varied response rates in each Area Health Service.

² No focus group was conducted in GWAHS.

³ The chief investigator was the Director, Centre for Health Advancement, NSW Health at the time of the study.

(2000) suggests that this incorporation of a wide range of different perspectives is an explicit technique to improve the quality of the research.

- The richness provided by the case study methodology.
- A clear grounding within a theoretical framework - that of the three steams model (policy, processes and resources). This framework provided for a consistent organisation of the collection of data, the presentation of findings and the discussion of results.
- Its relevance to current activities. This study has been undertaken while there is still time to influence the implementation of policy. This relevance is considered a quality indicator of qualitative research (Mays and Pope 2000; Horsfall, Byrne-Armstrong and Higgs 2001).

The study's weaknesses relate to both inherent and expected methodological weaknesses, as well as some unique to this particular research project:

- There was no measure put in place to enhance reproducibility (that is when the same coder gets the same results try after try) (Weber 1990); as there was only one coder.
- The chief investigator's experience and knowledge have potentially influenced the analysis of the data and subsequent findings, which Mays and Pope (2000) describe as "reflexivity". While this may be considered a weakness due to the potential bias, it could also be considered a strength - in that having a first-hand familiarity with the health promotion system allows for a more contextualised interpretation of findings and production of more well-rounded recommendations.
- A varied response rate within the case studies.
- The six month period of time between the conduct of interviews and focus groups in the first AHS (HNEAHS) to those in the last (GWAHS). It is recognised that informants, while asked to comment on current and past processes, are doing so in a current context, which may have changed over the data collection period.

Results

The state policies expressed a clear vision of a greater focus on health promotion, or prevention and early intervention across government, and across the health system. The findings of this study are that NSW AHSs may share this vision on paper, but not in reality.

The Policy

AHSs in NSW have all aligned their strategic plans and annual reports for the most part, to reflect the strategic directions of the state policies. Further, all AHSs are reporting against an array of indicators relevant to health promotion (although they were doing this prior to the state policies). Overall there was general agreement with the state targets, noting that some informants did suggest additional target areas.

While AHSs are actively reporting the indicators for the targets, it is recognised that population health indicators are inherently problematic. They are not sensitive indicators; they do not change quickly, and may not adequately distinguish between AHSs that are directing a lot of efforts towards health promotion from AHSs that do little.

Aside from HNEAHS, staff from the other three AHSs generally considered that health promotion is not as important to the AHS given the pressure to focus on the acute care sector. A practical measure of importance may be the resources directed towards population health, and in every AHS case study, this was no more than 2.5% of the AHS's total Net Cost of Services (NCOS). While all AHSs generally agreed with the priority areas, no AHS expended more than \$10 per head per annum on the State Plan health promotion priority areas.

The state policies were considered to be beneficial for the fact that they provided focus, and for the most part the priorities of the plans were agreed with. This agreement is despite the finding that reasonably few informants personally participated in the development process of the state plans.

Those aspects which an AHS can do easily to be aligned and agree with the state policies have been done – their plans and indicators align, and staff generally agreed with the directions. However, what is arguably far harder and more reflective of true commitment has not been achieved. AHSs spend a very small proportion of their funds on health promotion, and there is a general sense amongst the staff that it is the acute care part of the system which is truly important to the AHS.

The Process of Policy Implementation

In regards to implementation, HNEAHS was the only AHS where feasibility was not identified as an issue by informants. For this AHS, the state policies meant little change and hence it was business as usual. For the other three AHSs, while it was found that they were also following the directions of the state policies prior to their release; barriers to implementation of health promotion policy were identified. The barriers presented were high-level, such as the ability and role of the health system in addressing individual risk factors where there is a requirement for much activity outside of the health sector. Lower level barriers were also presented, which included queries about whether some of the strategies being pursued were effective, planning processes not being synchronised, poor communication, and ad-hoc funding making it difficult to implement programs.

In response to the state policies, no AHS made structural changes, and there was little workforce development. Aside from the development of strategic plans (but not by NSCCAHS), and the establishment of a performance monitoring framework (albeit weak), there is little that has been identified by way of state plans' implementation. This raises the issue of what was expected of AHSs. It would seem that the Department's expectations were limited to the development of a strategic plan and reporting against the relevant indicators.

All the AHS strategic plans are flawed from a program logic perspective. The template for these plans was provided by the NSW Department of Health, and hence are a result of the direction provided by the Department. Further, while the Department may have been providing some funds directed toward priority projects, there is a sense that the Department itself was not following the directions of the state policies. AHSs still consider the pressure on them from the Department is to focus and perform within the acute care component of the health system, with little pressure exerted to focus on health promotion and prevention.

While there has been little done by way of implementation of the state policies, they do have some value. This value was considered by all AHSs to provide advocacy for the work they do in health promotion. In some AHSs, the state policies were also perceived to have enhanced relationships with external stakeholders. Further, in some AHSs, the state policies were beneficial because they articulated a clear focus; noting however, that for some health promotion staff this focus is undesirable – and there is a preference for greater flexibility.

Resources

In regards to resources, health promotion and population health are a very small part of the resources expended by an AHS. Staff in AHSs generally perceived the funds available for health promotion/prevention to have either been decreasing or holding steady over time, and few staff considered that funds available are sufficient.

While the overall funding picture presented by staff was inconsistent with a required policy focus on health promotion/prevention, funding appeared in most AHSs to have been directed towards the priority areas of the state policies according to staff. AHS staff recognised there are numerous competing priorities for funds within an AHS, which may be related to the finding that in both SSWAHS and NSCCAHS, there was a sense from some staff that funds were not always ring-fenced.

Even if just the objective financial information are considered (NCOS and UARs data), a clear pattern of greater investment towards health promotion did not emerge. The only clear pattern across all AHSs was an increased proportion of the population health expenditure being directed towards state policy focus areas since 2004/5. However, the figures for each AHS fluctuated over time, and in some cases the recorded expenditure for a priority area seems ridiculous; for example \$3 of expenditure in illicit drugs in a year or none recorded at all in some years. Difficulties in finding designated budgets, being sure that funding is being used for its original purpose, and reallocation of funds at local levels is not unique and has been described in other studies (Fulop et al. 1998; Glennard & Maina 2007; Moore & Keen 2007).

Additional staff capacity has not come with the state policies' required focus on health promotion/prevention. Staffing may have come with specific programs, however, overall AHS capacity in this regard has not grown, and for some AHSs it has been frozen (GWAHS) or actively reduced (NSCCAHS).

From a policy implementation perspective, the only reassuring finding in regards to resources is that if there has been any change in AHSs, it is that funding is being directed towards priority areas. However, this is against a backdrop where at best funding and staffing is stable overall, or in the worst case scenario – actually declining.

Discussion

This study has found some basic, and not unusual, policy implementation failures with the state policies. These could lead to some routine recommendations about improved planning processes, a better performance monitoring framework, and

sufficient resources within an enhanced financial monitoring environment. To do so however, would ignore the significant findings of this study, which point to the need for a re-think of how prevention and health promotion is delivered by the NSW Government. Expecting health promotion and prevention to achieve its potential in a health system obsessed with acute care is flawed. It is well recognised that health care inevitably takes precedence over population health in political priority, resource allocation and public affections (Wills, Evans & Samuel 2008).

There are three components required for a greater focus on prevention and health promotion: 1) the delivery of standard programs across the state; 2) performance monitoring reflective of a standard set of programs; and 3) transparent and monitored funding tied to the programs. These however, are likely to be insufficient if delivered with an acute care obsessed system. Hence, these three components need to be delivered through a different organisational structure, where prevention is the 'main game'.

An organisational redesign needs to be conceived which allows and encourages prevention and health promotion to flourish – to become the 'main game' of the organisation. There are alternative ways to do this. Most radical, would be the removal of health promotion and prevention from an environment where it is competing against emergency departments and waiting lists. In some jurisdictions in Australia, to some degree health promotion has been excised from the acute care system, and established in organisations such as VicHealth in Victoria. Overseas, some countries have public health agencies such as the Public Health Agency of Canada, Health Scotland and Public Health Copenhagen. However, NSW has a unique health care delivery infrastructure with AHSs that contain population health divisions, incorporating health promotion units. NSW needs a model that, while excising health promotion or population health, maintains a central agency with regional delivery infrastructure.

To make health promotion more important, one model may be the establishment of a separate agency responsible for "prevention". The function of the separate agency could be population health, or it could bring together a range of human service functions where the focus is on prevention. Key determining factors for a population health agency, versus a human service prevention agency, would be the need to garner a sufficient budget to make a stand-alone agency viable, as well as ensuring synergism between human service prevention activities should they be brought together.

In addition to the agency, clearly spelt out roles, tasks and responsibilities are required. To clearly spell out health promotion or the prevention field's role more broadly requires a defined and agreed set of programs to be delivered. In NSW, each AHS can design and deliver at its discretion any health promotion program targeting the priority health issues. There are funded statewide programs that AHSs can participate in, but this is at their choice. Hence, from a high level perspective, there is no core set of health promotion programs that are delivered across NSW. From a management perspective, this leads to part of an organisation which is ill-defined, and infinitely harder to hold to account. It also means that one AHS is not comparable to another, and hence health promotion is essentially excluded from

performance monitoring frameworks which are about identifying problems and triggering management responses.

The desire for flexibility and innovation was raised by health promotion staff in this study. But at what price does this flexibility and purported innovation come? It is difficult to determine if the flexibility is required to meet the policy outcomes, or whether it is just more interesting for an individual staff member to design whatever program suits them. Regardless, there is a key government principle at stake, that being, that the residents of NSW, regardless of their location, should expect the same services being delivered across the state.

Having an agreed, core set of health promotion programs is necessary to overcome the other key policy implementation failures associated with the lack of a meaningful performance monitoring framework and funding accountability. The current NSW Health Performance Management Framework (NSW Health 2009) currently excludes key state plan target areas, such as illicit drug use, overweight and obesity, and alcohol use. This is because the indicators for these programs areas are population level outcomes, and not necessarily reflective of the performance of the service. This emphasis on performance inevitably skews policy and practice to that which is easily measured (Wills, Evans & Samuel 2008). In other countries, because success in population health is difficult to measure and often not visible to the public or elected officials, local health authorities have found their funding decreased (Pierce & Blackburn 1998).

To get noticed, health promotion and prevention needs to include measures that indicate performance of the unit, service or AHS that delivers the programs. These will necessarily sometimes be program outputs and outcomes – not population health outcomes. Such program outputs and outcomes can only be designed when the same programs are being delivered across the state. These measures would consider factors such as program access, reach, client satisfaction, and client outcomes. These measures could then be aggregated for a unit, service or AHS, and be meaningfully compared across the state by the prevention agency.

Finally, this study illustrated the lack of mechanisms in place to appropriately track and account for funds being spent on prevention or particular health promotion priorities in NSW. Implementing standard programs with standard performance measures will provide the system perspective of what is being done and what is being achieved. The third required aspect is how much is being spent. This would not only provide information about financial efficiency against defined programs, but also provide greater accountability and transparency to ensure that funds earmarked for health promotion and prevention are spent on it. To do this would require the prevention agency if established, or NSW Health, instituting a chart of accounts that has the flexibility to change as strategic priorities change, as well as going into greater program detail.

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