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Research Paper

Articulating place: Towards a conjunctural analysis of public health

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'Place' is again circulating as a policy solution to improve health, wealth and wellbeing. But while place-based policymaking is quickly becoming 'common sense', we stress the need to think conjuncturally about the changing place of health. By conceptualising places as open articulations—rather than straightforwardly local territories—much wider geographies come into view. In dialogue with decentred approaches to public health which take seriously competing policy narratives, we therefore situate place-based policymaking within ongoing struggles over places and their pasts. To develop our argument, we look at public health through the lens of Wigan, north west England, which has become an unlikely 'exemplar' for place-based reforms. Framed by different, often contradictory, narratives of loss, control, and hope, it may be the talk of the town, but we reject the politics of self-responsibilisation implicit within recent attention towards purportedly 'left behind' places. Instead, we foreground how Wigan has been shaped by wider forces and relations such as de-industrialisation, postcolonialism, austerity and state restructuring, as well as the COVID-19 pandemic. By locating the many crises, contradictions and antagonisms conditioning public health in this conjuncture, we can start to articulate political alternatives and identify possibilities for making policy otherwise.

Introduction

'Place' is again circulating as a policy solution to improve health, wealth and wellbeing. For those interested in health and care systems – and public policy more broadly – it is becoming hard to ignore growing enthusiasm for localized place-based approaches to health equity, public service reform, and economic development. Echoing the World Health Organization's *Healthy Cities* programme in the 1980s (Ashton 1991), and subsequent translation as part of the *Healthy Municipios* movement across Latin America (Restrepo 1995), it seems even the World Economic Forum (2024) now champions the potential of 'place-based change' for fostering healthy, thriving communities. Across England, for instance, moves towards place-based policymaking are quickly becoming 'common sense', with efforts to reconfigure fragmented health and care services into locally integrated systems of care framed more-or-less explicitly as an alternative to the logics of market competition. And with frequent reference to the social determinants of health (Marmot et al. 2020), place-based policymaking aligns with calls for joined-up, collaborative working to re-imagine health and wellbeing beyond healthcare alone (King's Fund 2015;

Public Health England 2021; Lent et al. 2022). Intensified by fallout from the COVID-19 pandemic, place-based thinking – and demands for decisions to be made locally because 'local people know best' – is an idea that now seems hard to resist.

Yet place is far more than the 'local context' where healthcare reforms happen or policies are enacted (Bishop 2020). Places are lively, contested, eventful – continuously made up through uneven relations and interdependencies with places elsewhere (Massey 2005). Accordingly, we conceptualise places as *open articulations* of multiple stretched-out social relations, from the immensely global to the intimate and bodily, which meet and interweave. Moving away from defining places straightforwardly as local bounded territories, we instead think places – at whatever scale – as 'articulated moments in networks of social relations and understandings', not fully contained within a place itself (Massey 1994, p. 154). Such *extraverted* understanding of place necessitates bringing far wider geographies into view than the narrower concerns which still tend to dominate health policy.

This is a vital analytical and political move: it shifts analysis beyond introspective concerns towards health systems governance and the inevitable challenges of implementing national reforms locally by also focusing on, for example, global climate crisis, regional uneven development, international financialisation of housing, the enduring legacies of colonialism and more. And as the growing reach of certain think-tanks, management consultants and 'superstar' academics promoting globally mobile policy solutions becomes harder to ignore (Peck & Theodore 2015, Temenos & McCann 2013), it should be clear that situating the politics of public policy within bounded state territorial institutions is insufficient (Cochrane and Ward 2012). No longer, then, should health policy researchers assume their 'context' is contained by what occurs within the particular places and institutions they are studying: *place-based* policy is not the same as *place-bound* policy (Hammond et al. 2017, Lorne et al. 2024).

In this paper we push this line of inquiry further by stressing the need to think conjuncturally about the changing place of health. Conjunctural analysis is a way of interpreting an accumulation of different crises, contradictions, antagonisms, and potentials condensing in a geographically and historically specific moment (Clarke 2023, Hall & Massey 2010). Informed variously by Gramsci, Althusser and Stuart Hall, conjunctural approaches within critical social policy grapple with the *articulation* of diverse processes into a hegemonic 'common sense' project (Clarke 2010, Newman & Clarke 2015). Though undoubtedly influenced by Marxism, conjunctural thinking refuses economism or reductionism. It is a mode of analysis which takes seriously complexity and multiplicity, wary of seductive claims about novelty—new policies, new solutions, new times—without ever thinking we have seen it all before. 'At its most powerful', Lorne et al. (2024, p. 502) suggest, conjunctural analysis 'should pose politically strategic questions about the different struggles, antagonisms, and forces fusing together' in moments of crisis to help push for alternative articulations.

We argue, both analytically and politically, for thinking *places* in terms of articulation. Our approach is developed by focusing on Wigan, England. The metropolitan borough of Wigan, Lancashire – comprising Wigan, Leigh and other surrounding towns and villages – has been promoted by UK think-tanks as an unlikely 'policy exemplar' for place-based health and care reforms (see, for instance, Ham & Alderwick 2015). Not only is Wigan part of Greater Manchester's high-profile health and social care devolution deal (Walshe et al. 2018), but it is another deal, the *Wigan Deal* ('the Deal'), which has put it on the political map. Where civic pride is talked about as driving change, the Deal is positioned as an informal agreement – a social movement, even – between the local council and residents (Wiganers) to take greater responsibility for themselves, including their own health and wellbeing, in times of austerity (Wigan Council 2014).

Our argument is that current place-based approaches to health and wellbeing are articulated with dominant economic logics and prevailing populist rhetoric surrounding 'left behind' places. As we demonstrate, there are genuine efforts to overcome intensifying pressures and fractures facing public services across Wigan. But by foregrounding how it has been shaped by wider forces and relations such as de-industrialisation, postcolonialism, austerity and state restructuring, as well as the pandemic, we reject the politics of local self-responsibilisation which, we argue, limits the progressive possibilities for place-

based approaches to public health.

The paper begins with an insistence: place matters! By bringing geographical scholarship into dialogue with ongoing efforts to decentre health systems – 'all the organizations, institutions and resources that are devoted to producing health actions' (WHO 2000, p. xi) – we challenge assumptions which equate 'place' with the 'local'. By conceptualising places as articulated moments, we encourage a move towards a conjunctural analysis of public health in search of the social and political transformation so urgently needed. The Wigan Deal is then outlined as a policy held up as offering 'radical change' (Naylor & Wellings 2019), before examining how spatialised narratives of loss, control and hope are bound up with efforts to govern public health in the borough. Contributing towards scholarship rethinking the fragilities and complexities of governing public health after the pandemic (this Special Issue of *Journal of Critical Public Health*), we conclude by emphasising the need to locate the many crises, contradictions, logics, and narratives conditioning public health in this conjuncture to help articulate political alternatives and identify possibilities for making policy otherwise.

Place matters!

It seems health policy research in the UK really is now taking seriously the difference geography makes: from investigating entrenched regional health inequalities (Bambra et al. 2018) and the remaking of devolved health and care systems (Walshe et al. 2018) through to the powerful spaces of hospital reconfiguration (Fraser et al. 2019) and networked place-based integrated care (Bishop 2020). Exhilarating times, then, for those who stress that geographical concepts – such as space and place – are vital for understanding the making of health policy in a globally-connected world.

But renewed enthusiasm is hardly down to geographers shouting loud enough for long enough. Rather, the idea of place is gaining traction among governments, philanthropists, think-tanks and management consultancies that are responding to the crises in which health has become entangled. Looking out from an unsettled Britain, talk of 'left behind' places has taken hold in the shadow of Brexit as a gesture, at least, towards regional inequalities (Johnson 2019). And in the worlds of health policy, 'accountable' or 'integrated care' policies are being assembled into place-based reforms across the English National Health Service (NHS) through Sustainability and Transformation Partnerships and, more recently, Integrated Care Systems (Hammond et al. 2017, Lorne 2024).

Yet an appreciation of how geography is integral to the workings of power and politics within health policy remains to be fully grasped. One reason is the residual influence of modernism within policy studies (Bevir 2010) whereby 'geography' is often treated as a passive background: once researchers locate their place under investigation and which local institutions or populations to include, work proceeds on the purportedly more important task of analysing what's happening 'on the ground'. Place is often then generalized as constitutive factors in an anonymized case. Another reason for treating geography as a more-or-less static context is the positioning of time as the dimension of change. This is certainly understandable given the perpetual policy churn. Coming to terms with the multiple temporalities shaping health policy is why a focus on 'sedimented governance' holds such analytical purchase (Jones 2017).

But we argue space must also be understood as lively and dynamic. Rather than the residual opposite of time (see Pollitt 2008), we follow radical geographer Doreen Massey (2005) in conceptualizing space as always in the making, an ongoing product of cross-cutting social-material relations from the immensity of the global through to the intimately personal. A *relational* view of space abandons any notion of space as a flat, static surface over which we travel. Space plays an active – yet never wholly determining – role in how society is organised. We might imagine space as a 'simultaneity of stories-so-far' (Massey 2005, p. 9) whereby a task becomes one of investigating how the worlds around us are forged through many powerful connections and relations with places elsewhere. This includes *dis*connections, such as manufacturers relocating overseas or, differently, anti-apartheid boycotts. If space is always being struggled over, then there must always remain a possibility, at least, of the existence of political

alternatives whereby places and their policies might be pushed along other, more progressive lines (Clarke et al. 2015).

Geography is often perceived as a technical discipline concerned with mapping out territories. It is surely exciting that health services research is now concerned with the relationships between health and place, but we are cautious of searching for the 'best algorithm' to apply to health data to meaningfully identify such relationships (e.g. Atkins et al. 2025). After all, even the naming of places can be utterly political and contested, bound up with all kinds of power relations. Rather than being contained by what goes on within local boundaries – whether towns, regions, or even continents – we conceive of places as *open articulations* constituted through the meeting and condensation of multiple social, economic and political relations that stretch out across space; if space is a simultaneity of stories-so-far, then we might imagine places as collections of those stories (Massey 2005). Our concern here, then, is less monitoring and assessing place-based policies, and more to pose fundamental analytical and political questions over how public health is being drawn into the making and reinventing of places – and to ask: on whose terms?

Growing policy enthusiasm for creating 'healthy places' (Ham & Alderwick 2015, Naylor & Wellings 2019, Lent et al. 2022) coincides with recent political interest in others 'left behind'. Crucially, not only does the notion of left-behind places risk implying that economic development is principally a matter of time – concealing the power-laden spatial relations that helped constitute such regional uneven and combined development – but such narratives treat places as more-or-less coherent, singular and meaningful (Massey 1994). After all, let's not forget there is also deep poverty alongside London's super rich. More than simply acknowledging inequalities, we must specifically investigate how and why growing social inequalities directly feed off such spatial unevenness.

This is not only an economic issue; it doesn't take much to see how appeals to champion and protect 'local places' can reproduce politically dangerous notions which romanticise, homogenise, and ultimately, essentialise places and their identities. Consider how politicians in Westminster have adopted the language of left-behind places in often nostalgic, reactionary ways to become "great again". Searching questions about the dominant political and economic logics which have fueled patterns of uneven spatial development remain unasked, whilst such statements help stoke distinctly anti-migrant and English nationalist sentiment through the resurgence of apparent concern for working class communities, or rather more specifically, the 'white working class' (Valluvan 2021).

We encourage an alternative geographical imagination; one largely outside the political and technocratic horizons of current debates. Thinking place in terms of articulation draws us into dialogue with 'decentred' approaches to public health which take seriously competing policy narratives and their consequences (this Special Issue). Attuned to historical specificity, agency and complexity, decentered theories focus on different practices, meanings, and dilemmas involved in policymaking and the workings of the state (Bevir 2010). If we are to pay attention to the wider sets of geographies through which places and regions are struggled over, we must acknowledge how there are always *other stories* alongside dominant narratives, sometimes co-existing harmoniously, often conflicting and competing (Allen & Cochrane 2007). Along with commitment towards anti-essentialism, contingency, and the questioning of universalising claims, both relational geographical and decentring approaches share a wariness towards claims that local knowledge is somehow inherently 'better' (Rhodes 2016). And rather than boxed-in state-centric accounts of governance – what Mark Purcell (2006) calls the 'local trap' – state practices are understood as altogether more fluid, dynamic and contradictory (Newman & Clarke 2015).

But bringing relational spatial thinking into dialogue with decentring theories is not without tension. Decentred approaches are suspicious of talking about structuring material forces which cannot be easily grasped within policy analysis. This sits uncomfortably with geographers concerned with, for example, processes of uneven and combined development connecting stories of industrial decline with the growing dominance of global finance. While decentring approaches don't necessarily assume the 'local' always takes a territorial expression (Bevir 2010), focusing on narratives as both a source of tradition and dilemma among policy actors risks situating dominant 'elite' policy narratives as *national* whilst 'meaningful' policy practices and resistances are deemed *local*. A relational view of space, however,

is alert to how scale is *constructed*, abandoning pre-existing notions of scalar hierarchies whereby the national is assumed to necessarily sit 'above' regions or localities (Allan & Cochrane 2007, Lorne et al. 2019).

To be clear, we are not saying borders and territories no longer matter for understanding place-based reforms. Nor does thinking places as open articulations mean we are only concerned with discourse and identity. Rather, our aim is to emphasise how an extraverted sense of place brings into view wider sets of geographical relations which together condition health, wealth and wellbeing in these turbulent times.

Towards a conjunctural analysis of public health

The COVID-19 pandemic threw public health to the forefront of social and political life. Among politicians, policymakers and academics alike, its outbreak prompted calls to 'build back better'—a more-but-usually-less explicit recognition of neoliberal failures in governing public health, coinciding with renewed interest in the capacity of the state to mitigate crises (OECD 2020, UK Government 2021). However fleetingly, however superficially, the pandemic surfaced the need to talk about a brutal racialised class politics reproducing deep, structural health and social injustices. And yet, those widespread appeals to 'do things differently' soon sat, paradoxically, alongside a yearning to 'go back to normal'.

Interpreting political turbulence isn't easy. It is understandable why moments of crisis prompt epochal claims about change: 'the age of neoliberalism', say, or in a different register, 'post-pandemic' life. But the troubles of the present are shaped by multiple crises with their own temporalities, movements and logics (Newman 2014). As initial statements that 'things can never be the same again' have faded, other crises have taken hold: bombs are dropped, work still makes us sick, micro-plastics are everywhere, and the planet burns. The world keeps moving. So, how should critical public health make sense of it all?

Conjunctural analysis offers one way of interpreting the politics of the present – in all its multiplicity and complexity. Informed by Gramsci, Althusser, and Stuart Hall, among others, thinking conjuncturally grapples with the *combination* and *condensation* of multiple crises forged through different tensions, antagonisms, movements and contradictions in a specific moment (Clarke 2010, Hall & Massey, 2010). As Stuart Hall (1986) insisted, the future is *without guarantees* – we cannot determine in advance precisely which struggles and contending forces at work in a particular political conjuncture might become significant. In this way, the related idea of *articulation* takes on a double sense: in terms of making connections, and giving voice. Beyond recognising there is more than one thing going on at once (Clarke 2018), conjunctural approaches demand working out which analytical and political connections matter to identify potential openings for social and political alternatives (Lorne et al. 2024).

Within critical social policy, Janet Newman and John Clarke have established the possibilities for thinking welfare states conjuncturally. By focusing on the politics of articulation, they draw attention to the unstable relationships between the institutions of policies and states, forged through competing interests, pressures, antagonisms, and potentials (for instance, Newman & Clarke 2009). Thus, when Lorelei Jones (2017, p. 4) evokes the notion of 'sedimented governance' in the English NHS, this speaks to how 'contradictions and tensions are created from the interaction of different discourses, associated with different governance regimes. Such discourses construct subjectivities and political objects in different, often conflicting, ways'. 'Place', we argue, is the latest way in which such contradictory pressures are articulated.

Tracing commonalities with decentring approaches, we can appreciate the importance of examining contingency and openness (Bevir 2013). For example, only focusing on dominant policy narratives runs the risk of treating such paradigms as omnipresent and all-encompassing. But as Bevir et al. (2017) note, 'there are, of course, webs of meaning other than neoliberalism that are important to understanding contemporary governing practices'. These attempts are not stable and risk being unsettled by latent residual meanings and commitments as well as alternative emergent politics (Clarke 2007). It is

precisely in spaces between the residual, dominant and emergent that we seek to establish what struggles over places and their pasts might mean for critical public health. But as a 'rather enigmatic practice' deemed 'too modish for methodological rules' (Peck 2024, p. 461), it is best to illustrate conjunctural analysis in practice.

What's the deal with Wigan?

As policy mobilities scholars have observed, it's not wholly surprising that the same self-proclaimed 'global cities' are routinely lauded as 'policy exemplars' (Temenos & McCann 2013). In public health – at least in Britain – one seemingly unlikely place has taken the spotlight: the metropolitan borough of Wigan, Lancashire. Comprised of former coalmining and cotton milling towns and villages surrounding Wigan, its largest town, beyond the writings of George Orwell and the sounds of Northern Soul, Wigan has few claims to fame. In policy circuits, however, Wigan has attracted remarkable attention through its 'asset based' and 'citizen-led' place-based approaches to health and wellbeing (Ham & Alderwick 2015).

Back in 2010, Wigan Metropolitan Borough Council was at the sharp end of austerity measures imposed by the Conservative-led Coalition government. The Council saw over half its central funding cut, more than almost any other local authority in England (see further Gray and Barford 2018). Austerity politics still cut deep. United Nations Special Rapporteur Philip Alston condemned the normalisation of extreme poverty across Britain, concluding: 'much of the glue that has held British society together since the Second World War has been deliberately removed and replaced with a harsh and uncaring ethos' (Arie 2019). This, arguably, understates the brutality of the state we are in.

It is from the very real prospect of local government collapse that the *Wigan Deal* emerged. At its heart was the idea of a new social contract between local government and Wiganers around key pledges: keeping council tax low, cutting red tape, providing 'value for money', and helping communities support each other (Wigan Council 2014). In return, local citizens were expected to take responsibility for their own health and wellbeing, be healthy and active, support local businesses and be involved in the community. Held up by both the UK Government and the King's Fund – gaining traction before Integrated Care Systems took shape elsewhere in England – the changes in Wigan are talked about as a transformative re-imagining of health, wealth and wellbeing.

But pinning down the Wigan Deal is not entirely straightforward. Part of its intangibility relates to the emphasis on 'cultural change' in the organisation of public services through new models of collaborative working between the council and 'partners'. Based on a series of informal agreements, core principles are orientated towards 'asset-based' approaches and pushing back against new public management logics through investing in communities, prevention, and touting permission to innovate. Emotive stories of what's possible if local people get the chance to go their own way are important. By 2019, the King's Fund published the 'lessons from the Wigan Deal' to promote a 'citizen-led approach to health and care', whereby local government and NHS figures from across Wigan were frequently invited to share their experiences for others to emulate.

As authors, we have both spent many years researching how Wigan is changing. For one of us, it has been through exploring the town's modern economic and social histories in relation to child poverty and welfare (Lambert 2017) along with the shifting territorial frontiers of the NHS in north west England, with Wigan sitting awkwardly between Manchester, Liverpool and historic Lancashire (Lambert 2024). For the other, interest began through studying Wigan, as one of two localities in Greater Manchester, as part of a three-year policy ethnography of the city-region's politically high-profile health and social care devolution deal (Walshe et al. 2018, Lorne et al. 2021).[1]

[1] Projects which informed this paper received ethical approval from Lancaster University and University of Liverpool as well as the University of Manchester ethics committee (ref AMBS/15/01) and received coordinated NHS research governance approval from the Health Research Authority (ref IRAS 192503).

Looking back on these projects, we draw together insights from research materials which include unpublished government archives and policy documentation, NHS and local government meeting observations, regional newspaper articles and semi-structured interviews with officials. By combining our different perspectives through a conjunctural analytic, we bring into view different issues and unsettling dynamics not always brought together within critical public health, including austerity politics and state restructuring through to postcolonialism, de-industrialisation and labour organisation. The remainder of the paper focuses on the articulation of these different practices and processes as they take hold in the remaking of Wigan as an 'exemplar' for place-based reforms.

Rekindling hope?

It is hard not to begin the story of the Wigan Deal without talking about austerity. And this is precisely what leaders in the borough did when it became apparent Wigan Council were not going to resist budget cuts of more than £140m from central government in 2011. Just as the Conservative-led coalition government hoped, the politics of austerity compelled local authorities to do things differently. The reductions in Wigan were brutal – more than a fifth of the workforce were cut. In a striking echo of Margaret Thatcher – a politician long unpopular in northern industrial towns – and her claim that 'there is no alternative', a senior figure from the Labour-led council insisted in an interview: 'We don't have a Plan B, we genuinely don't'.

Despite being on the receiving end of punishing cuts, however, almost relentless positivity surrounded the Wigan Deal. Rather than repeatedly cutting public services to the bone, we encountered managers rehearsing the prevailing narrative of undertaking much-needed 'radical transformation', akin to what Kiely (2025) terms 'austerity optimism'. It was suggested that at the heart of this change was the reconfiguration of relationships between citizens and the local state. Pushing back against disempowering bureaucracy and the protectionist organisational logics narrowing the horizons of those coordinating – if no longer delivering – public services, in interviews, policy documents and public talks, we frequently heard reforms framed in terms of 'changing mindsets' and fostering 'radical ambition'.

Pride in place was integral to these narratives. 'Believe in Wigan' became the mantra. This phrase adorned the lanyards of managers, only later to be ceremoniously (or, at least, metaphorically) placed to one side because the logic for transformation compelled working together as 'one team, one borough, one Wigan'. Significant energy went into talking about Wigan as unified. Much was made of the 'proud labour tradition' upon which Wigan was built: of coal mining and cotton manufacturing, if much less explicitly, extensive unionization (Griffiths 2001). While cognisant of this history – and its reformist rather than radical genealogy (Catterall 2000) – in public events, council leaders often stressed that the spatial imaginary of bleak working conditions and depressed landscapes cultivated by Orwell in *Road to Wigan Pier* did not define, nor delimit, its future. Having pride in place wasn't simply looking to the past, local state managers suggested: it was about fostering potential and engendering a bold new vision.

Impressed by the scale of ambition surrounding changes in Wigan, the King's Fund (Naylor & Wellings 2019) promoted the work as 'rekindling hope'. Freed from the bureaucratic constraints of a burdensome local state and medicalized health service, the Wigan Deal was positioned as a chance to focus on people 'as a whole'. Rather than treating discrete parts and repeatedly asking the same questions, the Deal was seen as a citizen-led approach which would realise truly *public* health, bringing about new place-based ways of working through a wider cultural shift.

Health became an 'asset' rather than something in deficit or needing treatment. As the Director of Public Health put it in a public talk, everyone at the council was to hold 'strength-based conversations' instead of following protocols: the task was to ask 'why do you and I want to be healthy?'. As such, the Deal was orientated towards fostering hope and confidence in people with their own desires and passions. As they later put it: 'We often talk about public health as policy, as statistics, as epidemiology. No! It's you, me and our fellow citizens – the real directors of Public Health'. More than thinking about health in

terms of healthcare, place-based reforms were narrated as the whole borough of Wigan together to change the story about health, wealth and wellbeing.

Stressing the *localness* of transformation gave meaning to reform. But the ideas constituting the Wigan Deal came from all over. In an interview with the King's Fund, the Chief Executive of the Council, stated: 'We kind of beg, stole and borrowed little bits of it and pulled it together, from the Nesta work, from Hilary Cottam's work, from the fact we've got no money, so we had no choice really. We had to create something different, but the passion has really come from the community, from the way it's been embraced by our residents' (King's Fund 2018, np). Not only were ideas from elsewhere drawn into the making of the Wigan Deal, but the borough itself came to be identified as an exemplar in its own right. In an interview for the BBC asking whether Wigan offered the solution to Wales' reduced council budgets, the Chief Executive suggested: 'We had a Local Government Association peer review last week and [the chief executive of Leeds City Council], described the deal as the best approach to re-modelling public services that he's ever seen which should be rolled out nationally as a template for a different way of working' (Easedale 2017). Rather than rising from the Lancashire coalfields, the Wigan Deal was forged through a configuration of different circulating ideas assembled into a particular local vision: working-class northerners working together to improve their own health and wellbeing, and that of the borough as a whole.

Instead of viewing health through a medicalised lens of illness, narratives centred on cultivating pride and belief in Wigan to enable cultural change. Yet, such 'asset-based' approaches to public health can conceal contradictions, smoothing over frictions rather than surfacing them (cf. Friedli 2013, Roy 2017). Whilst moves to talk about health in more 'holistic' terms exposed the problems of new public management logics conditioning local government and the NHS, responsibility for health and wellbeing was now firmly located within *local places*. Despite the structuring forces entrenching regional economic and social inequalities, which stretch well beyond Wigan's boundaries, local citizens were being asked to resolve 'their own' problems and dilemmas. For all the talk of empowerment, power would also appear to be out of reach.

Taking charge, taking control?

In a sleek corporate office suite located on a 'health innovation campus' in central Manchester, a dozen NHS and local government managers discussed Greater Manchester's recent transfer of powers through health and care devolution. As discussion turned to prioritising 'population health', one of the authors listened. Empowering people and places to 'take charge' of their health and wellbeing – the overarching narrative for Greater Manchester's health and social care devolution deal – was central to 'closing the financial gap' across the city-region. Put in these terms, reforms may be characterized as rather neoliberal: reducing demand for public services by shifting responsibility onto individuals and communities to look after themselves, thereby 'preventing' costly illness.

Where the devolution deal had encouraged an unusually celebratory atmosphere, this meeting was punctured by discomfort over the 'taking charge' narrative. It felt too similar, for some present, to the 'take back control' slogan of the recently successful *Vote Leave* campaign for the UK to exit the European Union. Disrupting the meeting agenda, the room speculated on whether momentum behind Greater Manchester's devolution agenda would slow following the recent departures of Prime Minster David Cameron and the Chancellor, George Osborne, one of the architects of their devolution deal. The apparently uncomfortable, if seemingly unconnected, parallels between calls to 'take charge' and 'take control' warrant closer attention.

The borough of Wigan was one of the highest 'leave voting' areas in the United Kingdom. Unlike staunchly remain-voting Manchester – a rapidly changing city attracting swelling numbers of students, middle-class professionals, and property developers (Rose 2024) – Wigan and Leigh were precisely the kind of towns now talked about as 'left behind'. Analysis of the Brexit vote has subsequently been

dominated by belated attention towards economic decline and social alienation within deindustrialized towns across northern England long left 'on the scrapheap' (Singleton 1991), usually coupled with an emphasis on migration, national identity and loss. Undoubtedly, dominant accounts of social alienation have largely been at the expense of examining racism and its entanglements with uneven development across capitalist societies.

This poses intriguing questions over how the different tensions and movements which propelled Brexit relate to public health. In the stories told about Wigan so far, the NHS has barely featured. This might be expected given public health responsibilities sit primarily within local government in England. But it also reflects a wider policy concern which has actively encouraged geographical *detachment* of the local NHS. We should not forget that the *Vote Leave* campaign rallied around high-profile demands whereby: 'We send the EU £350 million a week, let's fund our NHS instead'. Collective feelings of loss, disempowerment, and nostalgia for the post-war welfare state – wrapped up in red, white and blue – have become familiar frames for interpreting Brexit.

At the heart of the Wigan Deal is an affective *attachment* cultivating local pride and calls to believe in the borough which can succeed in spite of Westminster politics. We are not suggesting the Brexit vote and the Wigan Deal derive from the same political currents, even if Wigan's (now former) Shadow Levelling Up Secretary, Lisa Nandy (2018), holds up the town as exactly the kind of 'left behind' place which characterises a divided England. What we *are* suggesting is that different appeals to 'place' are articulated through distinctly protectionist, romanticised, and – sometimes explicitly – racialised notions of 'community'. The arrival of a new Labour Government floated legislation to redistribute power to towns and cities, including for public health. Keir Starmer, writing in *The Telegraph* shortly before becoming Prime Minister, hailed the Labour Party as the 'true party of English patriotism' (Starmer 2024), with the Wigan Deal precisely the kind of 'solution' envisaged by his Labour Party 'powering up' people and places to find new ways of governing and fostering economic growth to counter regional inequalities in their historic political heartlands.

But empowering communities to solve entrenched social issues and dilemmas – such as looking after their own health and wellbeing – must confront the powerful forces and conditions that gave rise to, and sustain, current circumstances, as well as where they may lead. Consider the *Wigan Deal for Health and Wellness* (Wigan Council 2018) which stresses the requirement for 'setting high aspirations for yourself and your family' said to be vital for the deal to work. This agenda reproduces the politics of self-responsibilisation and dominant economic logics that have given rise to the entrenched social and spatial inequalities such asset-based approaches now purport to resolve. We can, though, also hear echoes of older Victorian civic paternalism integral to the establishment of Wigan's health services within moves to reconfigure the reciprocal relationships and expectations between citizens and local government (Pickstone 1986).

Thinking conjuncturally about the powerful geographies and shifting balance of forces articulated through the Wigan Deal, we can see how the governing of public health is animated by different, sometimes contradictory, claims. Far from being solely defined by what goes on within local authority boundaries, there are *multiple* spatial imaginaries entangled within the remaking of Wigan. Calls for Wiganers to work together as 'one place' coexist alongside longstanding tensions between constituent towns and villages of the borough (Fletcher 2005). The health and social care devolution deal may well have reenergized political strategies across Greater Manchester (Walshe et al. 2018), but nearby cranes over Manchester all felt rather distant. Quite different political demands to better fund the NHS sit awkwardly alongside efforts to reimagine a divided nation – with constant slipperiness between England and the UK – whilst regional inequalities only continue to intensify. Yearning for a buoyant industrial past has brought much political attention to Wigan; much less is said about the imperial connections and extractive relations which powered this earlier economic development.

Places and their pasts are forged through many uneven geographies (Massey 1995); governing public health sits amidst all these unsettling dynamics. While neoliberalism may still be ideologically dominant (Bevir et al. 2017), we nonetheless run the risk of adopting monolithic explanations for

understanding place-based reforms. It is necessary to consider other political stories emerging alongside – if not necessarily against – those neoliberal logics and rationalities.

Building back fairer?

Despite the British government declaring the outbreak of the COVID-19 a great leveller that does not discriminate (Milne 2020), the pandemic soon revealed the brutalities whereby some people and places were exposed to infection more than others. Yet for all the fear and anxiety, the pandemic also prompted renewed declarations of love for 'our NHS' across Britain (Stewart 2023). Weekly claps soon echoed down rainbow-adorned streets as a loud public expression of solidarity with 'key workers' in the health service and beyond. As the pandemic foregrounded deep inequalities across a divided Britain – characterized by chronic underinvestment and holes in welfare services and other support systems – it was also hailed as a moment when things *had* to change.

After a decade of harsh austerity, the pandemic sparked demands to 'build back fairer' (Marmot et al. 2020). For Wigan Council, this surfaced something of a contradiction: the hardship and inequalities across the borough made it impossible not to declare that things couldn't go back to how they were. And yet, the solution on offer for getting out of this crisis looked rather like a call to keep doing more of the same: 'In order to meet the financial challenges facing us and the social and economic challenges facing the borough, we must fundamentally transform as a council through deeper application of our Deal principles and behaviours and accept there is no going back to how we operated prior to the crisis' (Wigan Council 2021). The Wigan Deal had, after all, been in place for nearly a decade.

We might therefore ask: how far has the Wigan Deal internalized the ideological and political imperatives of austerity? And how 'transformative' were these ideas? Though work to counter feelings of disempowerment must surely be recognised, it risks bringing troubling, inward-facing exceptionalist politics to public health despite wider tides of retrenchment. But perhaps there is also something emerging which isn't entirely subsumed into, or at least ventriloquized by, the dominant neoliberal politics (Clarke 2010)? Consider the push towards emphasising happiness and hopefulness within Wigan. The back cover of the *Wigan Deal Road to Recovery* (Wigan Council 2021) assures 'things will get better' with another simply reading: 'Hope'. Whilst easy to be cynical, there is much to commend for work tackling social isolation by strengthening social ties in the face of decades of triumphant individualism eroding the kind of solidarities that helped make Wigan and its working class.

In fact, one of the more intriguing moves in Wigan has been to explore the possibilities of pulling 'community wealth building' into policy discussions over health and wellbeing which actively target reducing social and economic inequalities. Distinct from the 'Preston model' championed elsewhere in Lancashire (Brown & Jones 2021), we can nonetheless follow new place-based policies and political ideas around health and wellbeing gaining traction within local government—if not always the NHS—which are starting new conversations around public and common ownership, insourcing and the progressive possibilities of 'anchor institutions' (Centre for Local Economic Strategies & Democracy Collaborative 2019). Despite brutal cuts, the public sector remains one of the biggest employers across north west England. We can thus glimpse traces of socially useful policy experimentation in health and care emerging which focus on more inclusive local economies embracing the social value of organized labour, rather than positioning them as antagonistic to the responsibilising culture of the Deal (Goodwin 2023). As nascent strategies reimagining the connections between place, health and economy start to take hold, there may yet be some potential to help break from neoliberal hegemony.

Conclusions

Our point of departure in this paper has been to respond to recent enthusiasm for place-based approaches to health and care by challenging taken-for-granted understandings of place as straightforwardly local (cf. Naylor & Wellings 2019, Lent et al. 2022). Situating policymaking within ongoing struggles over places and their pasts, we followed geographer Doreen Massey by conceptualising places as open articulations of stretched out shifting social, economic and political relations meeting and condensing in particular combination. Looking out from Wigan, north west England – as a seemingly unlikely policy 'exemplar' – we emphasised how current place-based reforms risk being coopted by dominant economic logics and populist narratives of 'left behind' places. Despite genuine efforts to overcome the fragilities and fractures facing public services across local government and NHS, following decades of restructuring, hollowing out, and underfunding, we argued that place-based reforms are reproducing an austere spatial politics whereby localities and communities are required to resolve all kinds of different dilemmas and crises (Featherstone et al. 2012), including taking responsibility for their own health, wealth and wellbeing.

Thinking conjuncturally about the changing place of health calls attention to the multiple crises, contradictions and antagonisms conditioning public health. To foster interdisciplinary dialogue over the complexities of public health and competing policy narratives after the pandemic (this issue), we necessarily focused on but a few. But by foregrounding the spatialised narratives of loss, control and hope, we have sought to situate ongoing place-based reforms in health and social care within wider hegemonic struggles. It is not our intention to undermine meaningful efforts to break free from the logics of new public management which still haunt public services. Rather, by focusing on the spatial politics of articulation, we encourage those making and researching place-based policies – including those involved in Integrated Care Systems across England – to question the dominant ideologies and contradictory narratives finding place within our present troubles. By prompting a spatial sensitivity within decentred approaches to public health, our hope is to bring wider geographies into the frame to help *articulate*, to give voice to, other stories and counter-hegemonic practices. There must always be alternatives. And a rich and growing seam of critical geographical scholarship on public health moves in this direction (for instance, Arefin & Prouse 2024, Hirsch 2019, Sparke & Williams 2022, Temenos 2022). Orientating critical public health scholarship towards conjunctural analysis can help articulate new political possibilities and identify openings for making policy otherwise in these troubling times.

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Conflicts of interest

The authors have no conflicts of interest to report.

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