

# Health inequalities in Scotland and England: the translation of ideas between research and policy

By Katherine Elizabeth Smith



*"Just how fresh are these insights?"*

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## Abstract

In the decade following the 1997 election of New Labour, both the UK government and the newly devolved Scottish Executive consistently pledged to reduce health inequalities. Concurrently, both governments emphasised the importance of employing research evidence in policymaking. In light of these commitments, this thesis set out to explore the relationship between the mass of research on health inequalities in the UK and the policy responses which emerged in Scotland and England during this period. To explore this relationship, documentary analysis of 42 major policy statements was undertaken and interviews were carried out with 61 relevant individuals. The findings provide very little evidence to support the notion that policies have been based on available *research* in either Scotland or England but they do suggest that research-based *ideas* have travelled into policy. Whilst this may seem a relatively simple distinction, it is also a crucial one to make, for once ideas become separated from the evidence on which they are based they become far more malleable entities, transforming as they move between actors and across boundaries. By focusing on these transformations, the thesis illustrates that the journeys of ideas about health inequalities have varied extensively: whilst some have demonstrated a remarkable degree of policy 'stickiness', others appear to have faltered or splintered along the way. To understand the variability of these journeys, the thesis explores what the data reveal about the development and circulation of ideas by considering the following: the way in which health inequalities have been constructed as a policy problem; the way in which ideas about health inequalities have been developed and marketed by researchers; the impact that policymaking institutions have on the circulation and translation of ideas; and the influence of actors' perceptions of wider political and societal contexts on their actions and interactions. Employing a Weberian theoretical framework, the thesis goes on to explain the differing journeys of research-based ideas by focusing on three very distinct ideational genres: (i) institutionalised ideas; (ii) charismatic (transformative) ideas; and (iii) vehicular (chameleon-like) ideas. Both the interview and documentary data suggest that, for health inequalities in the UK, some ideas have become so extensively institutionalised that the imaginative (intellectual) space from which charismatic ideas might have been expected to emerge has been increasingly squeezed. Hence, in the decade following 1997, the ideas which moved successfully from research into policy were either those which posed no challenge to institutionalised ideas or those with the metamorphic qualities of vehicular ideas. With this in mind, the thesis



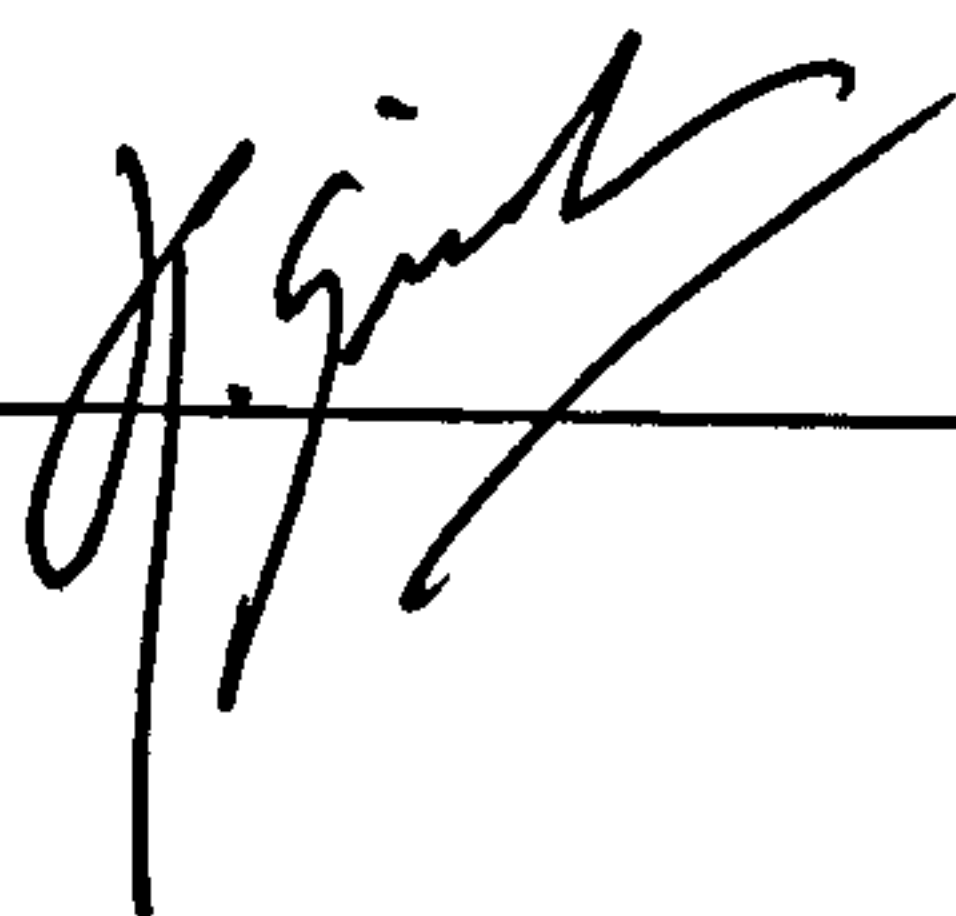
concludes that researchers ought to be *at least as* concerned with the influence of policy on research as the other way around. As a means of encouraging researchers and policymakers to address the multi-directional nature of the interplay between research and policy, the conclusion argues that it would be both more accurate and potentially more helpful to focus on 'ideas-based', rather than 'evidence-based', policy.



**Declaration of originality:**

I, Katherine Elizabeth Smith, declare that the work presented in this PhD thesis is my own and that it has not been submitted for any other degree or professional qualification:

Signed: \_\_\_\_\_

A handwritten signature in black ink, appearing to read 'K. Elizabeth Smith', is written over a horizontal line that extends across the page.



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## Acronyms and abbreviations:

ANT: Actor-network theory

BBC: British Broadcasting Corporation

BMC: British Medical Council

BMJ: British Medical Journal

CHD: Coronary heart disease

CMPS: Centre for Management of Policy Studies

DEFRA: Department for Environment, Food and Rural Affairs

DH: Department of Health

DWP: Department for Work and Pensions

ESRC: Economic and Social Research Council

HEA: Health Equity Audit

HIU: Health Inequalities Unit [part of the DH in England]

IBMs: International Business Machines (brand name for personal computers)

IMF: International Monetary Fund

KGB: *Komitet Gosudarstvennoy Bezopasnosti* (the former Soviet Union's security agency, secret police and intelligence agency, which operated from 1954 to 1991)

LHBs: Local Health Boards [local NHS bodies in Scotland]

MRC: Medical Research Council

NDPBs: Non-departmental Public Bodies

NGOs: Non-governmental organisations

NHS: National Health Service

ODPM: Office of the Deputy Prime Minister

OPCS: Office for Population and Census Surveys

PAF: Performance Assessment Framework

PCTs: Primary Care Trusts [local NHS bodies in England]

PSA: Public Service Agreement (agreements between the Treasury and other government departments in England)

TINA: 'There is no alternative'

UK: United Kingdom

WHO: World Health Organisation

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## ***Part I – Introduction to the thesis***

### **Prologue – the origin of the thesis**

#### **I. My interest in the topic**

The election of a New Labour government in 1997 heralded the promise of a new era for health inequalities in the UK. Not only was this government openly committed to reducing health inequalities (Department of Health, 1997, 1998, 1999a, 1999b), it was also promoting an ethos of 'evidence-based policy' (Cabinet Office, 1999a, 1999b). Additionally, the government had been elected on a manifesto which included a commitment to holding public referenda on devolving political power to Scotland and Wales. These three commitments underpinned the rationale for the research on which this thesis is based.

Like many research projects, the topic of investigation was at least partially informed by my biography which, in the interests of reflexivity (as discussed in Chapter Four), it seems important to outline. I had first become interested in patterns of health inequalities within the UK whilst studying for my undergraduate degree in Geography at the University of Edinburgh. As a student of UK politics from 1995-2000, I had also followed the election of New Labour closely (indeed, the year in which the Labour government was elected coincided with the first year that I was eligible to vote) and, consequently, I was well-aware of their commitment to employing 'evidence-based' approaches to policymaking. Additionally, being an English resident in Scotland, I had observed the process of political devolution in Scotland with interest and was aware that both health inequalities and knowledge transfer were also policy concerns north of the border. It is in this context that, after taking a post in a branch of the Scottish NHS which acted as an intermediary between the Scottish Executive and NHS staff, I was continually surprised by the extent to which academic work and academic researchers appeared to be regarded with disdain by many of those involved in the construction and implementation of Scottish health policies. It was these various experiences that led me to first develop an outline for a research proposal. The enthusiasm of my initial supervisory team, combined with a successful funding award for a cross-college studentship from the University of Edinburgh, subsequently facilitated the development of this thesis.



In summary, I wanted to find out if academic research on health inequalities had informed policy and, if it had, how and in what ways. Where a relationship could be observed, I wanted to know what had enabled research to influence policy. Similarly, where it seemed as if academic research had not informed policy, I wanted to understand why this was the case. The initial aim was therefore to explore the extent to which research relating to health inequalities had been employed in the policies designed to tackle the issue in the UK. Given the constraints on thesis-based research (especially in terms of resources) it was not possible to explore how health inequalities were being approached by each of the new governments in the post-devolution landscape but it did seem important not to focus *solely* on England. So, partly as a result of my own location in Scotland but also for a number of other reasons (which are explained in more detail later in this Prologue), Scotland and England were chosen as the two policy contexts upon which the research would centre.

The following section of this Prologue outlines the political backdrop to the interests of this thesis in more detail, as a means of explaining why the thesis focuses on the issues that it does. Chapter One then goes on to discuss some of the key ideas in the existing literature about the process of policymaking and the role that research might play in this. Although some studies of the relationship between research and policy relating to health inequalities already exist, most of these have focused their discussion on England, even though some specifically claim to be about the UK (e.g. Dowler & Spencer, 2007; Exworthy, Blane, & Marmot, 2003). Furthermore, of the work undertaken on this topic to date, there is often a presumption research should influence policy and very little reflection about whether this implies policy should (or does) also influence research. Finally, much of the recent work in this area focuses on only limited numbers of interviews/focus groups (e.g. Petticrew, Whitehead, *et al.*, 2004). In fact, there has been no detailed, qualitative exploration of the processes involved in the interface between health inequalities research and policy since Mel Bartley completed her PhD thesis on the debates surrounding the effects of unemployment on health in 1988.

## II. The political backdrop to the thesis

### *II (i) Health inequalities as a policy problem*

As a term, 'health inequalities' is a broad and accommodating one, which can be used to refer to differences in health outcomes between a variety of population groups (such as different socio-economic classes, the populations of different areas, or various ethnic communities, or genders). Within the UK, the term is most often used to refer to health differences between socio-economic groups or areas. In this context, there is usually an implicit moral dimension to the term. As Whitehead (2007, p473) describes, because health inequalities are perceived as 'socially produced' and 'potentially avoidable', they tend to be 'widely considered unacceptable in a civilised society'. Yet, both the frequency with which the term is used in the UK and the official recognition that there is an implicit moral dimension to such inequalities, are only relatively recent phenomenon. Under the Conservative governments of 1979-1997, health differences between social groups tended to be described with the far less emotive term, 'health variations'. This resulted in many of those with an interest in reducing health inequalities feeling that the issue was 'off' the policy agenda, at least between 1979 and 1990 when Thatcher was Prime Minister. Indeed, in a renowned foreword to the Black Report (which had been commissioned by the previous Labour government but which was published under the then new-to-office Conservative government), Patrick Jenkins, the then Secretary of State for Social Services, wholeheartedly dismissed the proposals to reduce health inequalities that were contained within it (Black, Morris, *et al.* 1980).

Seventeen-years after the publication of the Black Report, New Labour was keen to emphasise the Conservative government's failure to implement any of its (largely structural and socio-economic) recommendations, and criticised the Conservatives for choosing instead to place an, 'excessive emphasis on lifestyle issues,' which cast the responsibility for poor health back onto the individual (Department of Health 1997). Whilst the previous Labour government had also focused on personal lifestyle 'choices' (e.g. Health Departments of Great Britain and Northern Ireland 1976), New Labour promised, if elected, to follow-up the Black Report with an independent inquiry into health inequalities. This Inquiry was duly announced in July 1997 (Department of Health 1997), with a promise that the *evidence-based* conclusions would inform a new health strategy.



In broad terms many of the resulting Report's (Acheson 1998) 39 recommendations reflected the conclusions of the Black Report (Birch 1999): both highlighted the need to have a multifaceted approach to health inequalities and both advocated a reduction in income inequalities, with a particular focus on child poverty. The key difference was that the Acheson Report, as it became known, was released in a far more favourable political climate than its predecessor and might, therefore, have been expected to have more of a policy impact. However, Labour had also stipulated that the Inquiry's recommendations should recognise the government's fiscal commitments which, at that time, included a two-year agreement not to increase public spending. This restriction, Davey Smith and colleagues (Davey Smith, Morris, & Shaw 1998) claim, led to an under-representation of structural and socio-economic determinants in the emerging policy initiatives which were linked to the Acheson Report.

Whether or not this was the reason for a failure to effectively tackle health inequalities, research suggests that, measured geographically, health inequalities within the UK continued to increase between 1992-4 and 2001-3 (Shaw, Davey Smith & Dorling 2005). The *Health Inequalities Decennial Supplement*, which would normally have been expected in 2007, has not yet been updated since 1997 (Drever & Whitehead 1997), so there is a dearth of information with which to assess how patterns of health inequality stratified by socio-economic class have developed over the past ten years. However, official statistics relating to socio-economic class and *childhood* mortality in England indicate that this measure of class-related health inequality (which forms part of the English government's national health inequalities target) has also continued to widen (Health Inequalities Unit 2007). The latest *Status Report on Health Inequalities in England* confirms that the national targets for reducing health inequalities in England are unlikely to be met (Department of Health 2008). In Scotland the data currently available are even fewer but those that have been published suggest that the situation is similar (see Department of Health and Community Care 2007).

During this period (1997-2007), a number of academic analyses of official approaches to health inequalities within the UK have emerged. There are, for example, several reviews of research evidence on, and theories about, health inequalities in the UK (e.g. Bartley 2004; Gordon, Shaw, *et al.* 1999; Graham, 2007). There have also been a number of attempts to assess the extent to which recent policy initiatives relate to the available evidence and/or are

likely to reduce health inequalities (e.g. Asthana & Halliday 2006; Davey Smith *et al.* 1998; Dowler & Spencer 2007; Exworthy, Blane *et al.* 2003; Exworthy, Stuart, *et al.* 2003; Shaw, Dorling, Gordon & Davey Smith 1999), although it must be said that all of these focus rather more (if not solely) on England and not on the devolved nations. Many of these accounts, including the most recent (an edited collection by Dowler & Spencer 2007), express some level of disappointment with the English/UK government, often suggesting that policies started out with the right intentions but have not yet gone far enough. Others express some disappointment with the development of the evidence-base itself (e.g. Mackenbach 2003; Nutbeam 2003; Petticrew *et al.* 2004). There has, however, been very little (if any) analysis of how and why certain research ideas do appear to have influenced policy whilst others have not. As outlined below, it is this gap which the thesis seeks to address.

### *II (ii) The rise of 'evidence-based policy'*

The *Modernising Government* White Paper (Cabinet Office 1999a) was one of the first statements to officially highlight the new UK government's desire to improve the quality of policies through a process of *evidence-based* policymaking. Several further statements developed this commitment (e.g. Cabinet Office 1999b, 2000). As part of its concern for improving knowledge transfer and promoting evidence-based policy, the government appointed a number of 'specialist advisors' (some of whom were academics) and also began promoting the use of research in policy through newly created units such as the *Centre for Management of Policy Studies* (CMPS). Within this, the government appeared to be particularly enthusiastic about using *academic* research, an interest which was evident in a speech that David Blunkett (the then Education and Employment Secretary) addressed to the Economic and Social Research Council (ESRC) in February 2000. This claimed that academic researchers had an active role to play in helping government address a wide range of important social issues. Around the same time, but specifically in relation to public health, the UK's national drive towards evidence-based policy was further reinforced by international calls 'to adopt an evidence-based approach to health promotion policy and practice' (World Health Organisation 1998).



Following devolution in Scotland, the Scottish Executive<sup>1</sup> also took up the ethos of knowledge transfer, establishing a Research Policy and Practice Team to develop the role of social research in policy (see also Chief Scientist's Office 2002). Additionally, in April 2004, the Executive launched the *Scottish Academy for Health Policy and Management* as a means of improving the evidence-base of health policies in particular (Scottish Executive & NHS Scotland 2003). Within less than a year of its official launch, however, the notion of developing an Academy was quietly dropped from the Executive's agenda (for reasons which the interviewees questioned in this project seemed unclear about). Nevertheless, the Scottish Executive remained officially committed to the notion of employing more research in policy (see Clark & Kelly 2005), commitments evidenced by some of the work undertaken by NHS Education for Scotland (NHS Health Scotland 2007) and by the aims of the (largely Executively funded) *Glasgow Centre for Population Health* (Scottish Executive Health Department, 2004). In addition, the Scottish Executive began participating in the ESRC's knowledge transfer scheme (ESRC 2007).

The post-1997 commitments to evidence-based policy and knowledge transfer have resulted in renewed academic interest in the role of research in policy within the UK (e.g. Black 2001; Burrows & Bradshaw 2001; Davies, Nutley, & Smith 2000; Dobrow, Goel, & Upshur 2004; Hunter 2003a; Naughton, 2005; Packwood 2002; Pawson 2002a; Sanderson 2002; Solesbury, 2002; Young 2004; Young, Ashby *et al.* 2002). A major funding body (the ESRC) helped establish a *UK Centre for Evidence Based Policy and Practice* (now known as *EvidenceNetwork*) and a journal specifically dedicated to discussing the relationship between research evidence and policy was launched in January 2005 (see Young & Boaz, 2005).

Yet, whilst the idea of basing policies on the best available evidence seems innately attractive, it is not unproblematic (Davey Smith, Ebrahim, & Frankel 2001; Tenbensen 2004), particularly when the evidence in question is complex and contested (see Levitt 2003). For the issue of health inequalities, despite a mass of UK-based research, competing aetiological explanations remain. Consequently, unravelling recommendations on which to base policy decisions is far from an easy task. Indeed, even in the context of evidence-based medicine, it has been

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<sup>1</sup> The 'Scottish Executive' was the term used to refer to the Scottish Government during the period of study and, hence, is the term employed in this thesis. However, it should be noted that, following the election of a minority SNP government in 2007, it has since been re-named the 'Scottish Government.'



argued that the complexity of evidence may mean the idea of being able to base decisions on research is fundamentally flawed (see Goldenberg 2005). If this is true for evidence-based medicine, it is more so for 'evidence-based policy', where even the basic term 'evidence' can be interpreted in starkly contrasting ways by different actors (Davies *et al.* 2000; McQueen & Anderson 2003; Young *et al.* 2002). For example, some academics may consider that only the findings from *academic* research count as 'real' evidence, yet policymakers may interpret the concept far more liberally, including information from government studies, citizens juries and their own personal experiences (Booth 1988; Solesbury 2001).

Even within academic research, there are divisions between those who believe evidence-based policy requires experimental (usually quantifiable) data, such as those obtainable through randomised control trials (see Hadorn, Baker, *et al.* 1996), and those who assert it is essential for policymakers to take a more holistic view of evidence (e.g. Dixon-Woods, Fitzpatrick, & Roberts 2001; Graham & McDermott 2006; Pawson 2002a, 2002b; Young *et al.* 2002). Indeed, it is perhaps a telling sign that, so far, there has been significantly more guidance for assessing the validity and reliability of quantitative research for policy audiences than there has been for qualitative research (see Boaz & Ashby 2003; Dixon-Woods *et al.* 2001; Oakley 2002). In an attempt to redress this balance somewhat, the Cabinet Office published a framework for assessing qualitative research in 2003 (Spencer, Ritchie, *et al.*). Further techniques have been developed by members of the academic community who are committed to promoting the use of a broad range of research in policy (e.g. Dixon-Woods, Agarwal, *et al.* 2004; Popay, Rogers, & Williams 1998). However, key techniques for summarising research evidence, such as systematic reviewing and meta-analysis, frequently exclude data which do not match quality criteria defined for quantitative, experimental data (see Dixon-Woods *et al.* 2006). This is of particular importance for health inequalities because different types of research appear to have produced quite different ideas / 'policy messages' (an issue discussed further in Chapter Two).

As has already been hinted at, the concept of 'evidence-based policy' has encountered a variety of problems since the early days of the New Labour government and it is now widely accepted that research evidence can rarely offer clear-cut solutions to complex policy problems. Blunkett's (2000) appeal to the notion that, if based on evidence, policy can



somehow be freed from ideological influences has been rejected (see, for example, Packwood 2002). Indeed, within some quarters of policy, the term 'evidence-based policy' (which was never as officially popular north of the border) appears to have been replaced with the, less stringent, 'evidence-informed policy' (e.g. Department for International Development 2005). It is not only policymakers who seem wary; the aspiration to use more academic research in policy has sparked a variety of responses within academia and although some remain committed to the idea that policymakers ought to make better use of the available evidence (e.g. Nutley 2003), others claim that the idea academic research should feed directly into policy may prove dangerously restrictive for academics (e.g. Hammersley 2005). These debates are explored in more detail in Chapter One. The point for the moment is that, despite encountering various hurdles, *official* commitment to employing research evidence in policy has remained present throughout the period of study in both England (Cabinet Office 1999a, 1999b, 2000a, 2000b; Department of Health 2007; Mulgan & Lee 2001; Wanless 2004) and Scotland (Chief Scientist's Office 2002; Clark & Kelly 2005; Wimbush *et al.* 2005).

### *II (iii) Joined-up policymaking*

Another key policy approach of the New Labour government has been an emphasis on partnership-working and 'joined-up thinking'. This is also evident in the *Modernising Government* White Paper (Cabinet Office 1999a, p6), which promotes the idea of an inclusive and integrated government that will ensure that 'policy making is more joined-up and strategic'. Once again, this approach has been mirrored in Scotland. Indeed, one of the first policy documents to emerge from the post-devolution administration, entitled *Making it Work Together – A Programme for Government* (Scottish Executive 1999b), emphasises the importance of cross-sectoral policymaking and partnership working (see also Hogg 2000). It includes a chapter specifically focusing on health and health inequalities and states that the 'full range of the Scottish Executive's work' (Scottish Executive 1999b, p7) will contribute to the agenda to improve health and reduce health inequalities. Indeed, Keating and colleagues (Keating, Stevenson, *et al.*, 2003, p113) claim: 'Joined-up government appears to be more of a reality in Scotland than in Westminster, with White Papers and legislation keener to draw links between the immediate focus and other policy sectors'.

The idea that tackling health inequalities requires cross-departmental collaboration fits well with a great deal of the research on the topic, which suggests that a variety of approaches are



required (as discussed in Chapter Two). However, a variety of analyses of policymaking in both contexts suggest that 'joined-up working' has failed to take root (e.g. Downe & Martin 2006; Ling 2002; McAteer & Bennett 2005). These difficulties are returned to later in this thesis, particularly in Chapter Seven. For the moment, the point is that there has at least been official policy commitment throughout the last decade to ensuring that cross-cutting issues, such as health inequalities, can be met with cross-cutting responses (e.g. Department of Health 2002; Hogg 2000; Scottish Executive 1999).

#### *II (iv) The devolution of political power to Scotland*

Following a positive vote in the referendum on political devolution, the first Scottish elections were held in 1999 and the Scottish Executive (see footnote<sup>1</sup>) formed later that year. Although political devolution occurred at the same time in Wales (and soon after in Northern Ireland), arrangements for each country differed and Scotland, which had already enjoyed quite high levels of administrative devolution since the transfer of the Scottish Office's functions from London to Edinburgh in 1939, was given the greatest independence, being granted primary legislative powers for all areas except those specifically reserved in Schedule 5 of *The Scotland Act (1998)*<sup>2,3</sup>. From a fiscal perspective, however, the powers of *all* the devolved bodies remain limited; even though Scotland was granted 3% tax varying powers (unlike, the Welsh Assembly Government, which has no power to raise revenue through central taxation), these powers remain untested. Nevertheless, despite the limited nature of political devolution, it was welcomed by many as an opportunity to create distinctive and innovative policies (see Mooney, Scott, & Williams 2006). Health is one of the most significant policy areas in which the Scottish Parliament has been granted extensive responsibilities, making it one of the key areas of interest for analysts of the impact of devolution (e.g. Greer 2003a; Keating 2005).

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<sup>2</sup> Defence, foreign and home affairs, fiscal, economic and monetary policy, energy and transport policy, social security (including pensions and benefits), regulation of 'the professions' (including the medical professions), employment policy (including health and safety regulations) and equal opportunities legislation are the major policy areas which remain reserved to the UK.

<sup>3</sup> In contrast, the Government of Wales Act (1998) only afforded secondary legislative powers to the Welsh Assembly, consequently leaving it more dependent on decisions made in Westminster. Devolved powers were also granted to a Northern Ireland Assembly but the political situation here has been volatile and uncertain, with direct rule being re-imposed for over three months in 2000, twice in 2001, and again from 2002 until the spring of 2007.



Some broader analyses of post-devolution policies suggest that the dominance, until recently, of one political party (Labour) in all three polities<sup>4</sup> and the restricted nature of devolution arrangements have allowed for only limited policy divergence (e.g. Mooney *et al.* 2006). Health, however, is one area in which there appears to be some consensus that important policy distinctions have emerged, especially following the Scottish Executive's prominent early decisions to provide free personal care for the elderly and its more recent decision to ban smoking in public places (although the latter has now been taken up in both England and Wales). Indeed, Scott Greer's analyses (2001, 2003a, 2004, 2005) appear to dominate a current consensus that policymakers in the devolved governments within the UK have responded to their particular problems in ways that 'produce territorial policy divergence that matters' (Greer, 2005, p501). Greer's claim is that, whilst English health policies have focused on the introduction of markets to the NHS, Scottish health policies have concentrated on strengthening the role of medical professionals, and Welsh health policies have emphasised the importance of localism. This thesis is widely, and often uncritically, cited (e.g. Cairney 2006, 2007; Chaney & Drakeford 2004; Keating 2005; Poole & Mooney 2005) and has led to claims that we are now experiencing a natural policy 'experiment' in the health arena (e.g. Smith & Babbington 2006). However, as I argue in more detail with colleagues elsewhere (Smith *et al.* forthcoming - see Appendix VIII), existing analyses of the impact of devolution on health policies focus almost exclusively on NHS related policy. There is actually very little in the *public health* policy statements that have emerged from each polity to suggest that Scotland and England have, so far, taken significantly different approaches to the issue of health inequalities.

At the time I first began constructing my proposal for the research on which this thesis is based (2002-2004), however, the Scottish Executive was still very much in its infancy and the sense that a 'new' Scotland was emerging, or at least that a new approach to policymaking was taking root, seemed strong (see Curtice, McCrone *et al.* 2003; and Mooney & Scott 2005). Given the freshness of the new political arrangements, research on the impact of devolution was limited and, of the work that did exist (e.g. Greer 2001, 2003b; Keating 2003; Keating *et al.* 2003; Parry 2003; Woods 2003), there was a general acknowledgement that

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<sup>4</sup> This dominance is no longer the case in Scotland, where the Scottish National Party formed a minority government following the 2007 elections, although this is beyond the period under examination in this thesis.



any conclusions could be no more than preliminary. Combined with the particularly stark nature of Scotland's health inequalities (see Hanlon *et al.* 2005) and the political commitment to reducing these inequalities (discussed above), a study of the Scottish Executive's policy approach to health inequalities seemed timely.

With this in mind, I initially intended to focus solely on the relationship between research and policy for health inequalities in Scotland. However, upon studying the post-devolution policy statements, it soon became apparent that these documents were heavily rooted in pre-devolution documents (a point Parry 2003 makes in relation to post-devolution social policy in Scotland more generally). This was particularly true of the pre-devolution White Paper, *Towards a Healthier Scotland* (Secretary of State for Scotland 1999), which is referred to in many of the subsequent health policy statements. For example, *The Challenge* (Scottish Executive Health Department 2003a, p5) describes the pre-devolution White Paper as the 'foundation' on which it is based. Not only did this finding cause me to consider the need to include relevant pre-devolution documents but it also highlighted the importance of the links between the Scottish and English governments. *Towards a Healthier Scotland* (Secretary of State for Scotland 1999) was released in the same year as the English White Paper, *Saving Lives* (Secretary of State for Health 1999) and there is a great deal of overlap between the two statements (see Davidson, Hunt, & Kitzinger 2003). Furthermore, the Scottish White Paper draws directly on the UK-government commissioned *Independent Inquiry into Inequalities in Health* (Acheson 1998), revealing a key, shared source of ideas. All this led me to conclude that, if I wanted to understand the way in which research about health inequalities had influenced post-devolution Scottish policy (and vice versa), I would need to consider policy decisions taken in England as well as Scotland.

Coincidentally, it quickly became apparent that my initial proposal of undertaking in-depth research during a year-long placement at the Scottish Executive was unlikely to be feasible (see section 4.1 in Chapter Four for an explanation of this situation). This led to a decision to change my main research methods from participant observation to a combination of semi-structured interviews and documentary analysis. As both of these methods were less resource-intensive than my original proposal, I felt it opened up the potential to extend the scope of the study to include England as well as Scotland.



Examining more than one context simultaneously also has the appeal of potentially helping one to better understand the specificity of particular circumstances (Marmor, Freeman, & Okma 2005). So, whilst it was never the intention that this research project would focus on direct comparisons across the two contexts, I did feel that I might learn more about the peculiarities of each by looking at both. As Marmor and colleagues (2005, p331) point out, however, there are also some important potential pitfalls to avoid when undertaking any kind of comparative work, namely, 'unwarranted inferences, rhetorical distortion, and caricatures'. Fortunately, all of the potential difficulties Marmor and colleagues (2005) outline seemed avoidable as most appeared to stem either from inadequate knowledge of one of the contexts being compared, or a failure to appreciate significant differences between the contexts (or both). As I had lived in, and engaged with the politics of, both countries during the study period, I was hopeful I would be able to minimise the former; whilst the similarity of the political backdrop - the domination of the Labour party in government, the historical union between the two countries and the shared public values of each country (see Curtice *et al.* 2003) - provided me with some confidence that I would also be able to avoid the latter. Indeed, as Chapter Five outlines, it is the extent of overlap between the policy approaches to health inequalities in each country which perhaps invites the most explanation.

## ***Part I – Introduction to the thesis***

### **Chapter One: Theorising the relationship between academic research and policy**

#### **1.1 Introduction to the Chapter**

Having outlined the history behind this thesis in the Prologue, this chapter reviews existing ideas and theories about the processes of policymaking and the role that research might play in this. The aim is to begin to develop a theoretical framework to help facilitate the discussion presented in this thesis, which is guided by the following research question:

*To what extent did research concerning health inequalities in the UK influence policy responses to health inequalities in Scotland and England in the decade following the election of New Labour in 1997?*

A huge number of theories are potentially relevant to this question and section 1.2 attempts to organise the discussion by focusing on four sub-sections. The first of these provides a historical context to work concerning the relationship between research and policy<sup>5</sup>, looking back to some of the theories that were developed in the nineteen-seventies and eighties. The following three sub-sections are then divided into different ways of thinking about policy *change*, from theories which focus on policy *resistance* to change, through those which suggest *incremental* change is most likely, to those which explore the possibility of more *dramatic shifts*. Not all of the theories reviewed in these three sections directly concern the role of research in policy but each suggests that, if research *were* to influence policy, then rather different kinds of impact might be expected. Having reviewed these various theories, the chapter argues that, whilst accounts of policy inertia and incremental change are relatively convincing, the thesis should at least remain open to the possibility that research *might* also inform more dramatic policy shifts. With this in mind, section 1.3 focuses specifically on the potential insights offered by Max Weber's conceptual work around processes of

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<sup>5</sup> Given their centrality to this thesis, it seems important to provide clear definitions of what is meant by the terms 'research' and 'policy'. However, with the aim of allowing this chapter to draw on a large number of quite distinct theoretical accounts, this is left until Chapter Two (in relation to research) and Chapter Three (in relation to policy).



'institutionalisation' (informing policy inertia) and the rare but potential emergence of 'charismatic' challenges. Finally, section 1.4 explains how the thesis is structured and provides a brief overview of each of the subsequent chapters:

## 1.2 Existing theories of relevance to this thesis

A variety of methods could have been used to structure this section but I decided it would be most helpful to categorise the large number of relevant theories according to the extent to which they suggest it might be possible for academic research to contribute to policy *change*. This categorisation aims to foreground the opposition between change and stability as this is a tension which forms a central theme of the thesis. As mentioned in section 1.1, not all of the literature presented here specifically concerns the role of *research* in policy; some theories are about policymaking processes more generally but they have been included because what they claim about the development of policy is of direct relevance to the potential influence of research.

Before embarking on a presentation of relatively recent theoretical developments, it seems essential to first take stock of some of the key theories about the relationship between research and policy which were developed in the 1970s and 1980s. This body of work emerged following a period in which there had been a similarly high level of policy interest in increasing the utilisation of research. The first sub-section therefore reviews some key ideas about research and policy that were put forward during this era. Some of these are important because they directly inform more recent discussions and debates, whilst others are worth flagging up because they seem in danger of being unnecessarily forgotten. So, with the aim of avoiding what Miller (1980) terms 're-inventing the broken wheel', sub-section 1.2.1 outlines ideas about the role of research in policy that were already being discussed several decades ago.

Moving on to more recent debates, a great deal of the available literature suggests substantial policy change is extremely rare. Indeed, some of these theories overtly seek to explain why policy is unlikely to change. These ideas, which imply that research which does not 'fit' with dominant policy trajectories is highly unlikely to influence policy, are presented in sub-section 1.2.2. Other theories, presented in sub-section 1.2.3, suggest that policy directions do change

but that this process tends to be incremental and gradual. These theories imply that academic research may well contribute to policy change but only in subtle and limited ways, often over long periods. In contrast, the theories discussed in sub-section 1.2.4 evoke an image of policymaking as a series of 'punctured equilibriums'. In other words, they suggest that, whilst policy is often made in stable conditions in which the potential for change is limited, it is also possible for stark ruptures to occur as one way of thinking is challenged by another. From this perspective, academic research might *either* contribute to limited, incremental policy change (within a stable 'policy equilibrium') *or* it might contribute to one of the occasional but large-scale transformations.

### *1.2.1 Lessons from the past and concerns about the relationship between research and policy*

As already noted, the mid-nineteen-sixties was a period in which policymakers in both the UK and the USA became increasingly interested in utilising social research more effectively within policy. However, this interest was not sustained and, instead, a sense of disappointment seemed to beset both policymakers and researchers by the 1970s. From an academic perspective, this is evident in the body of work that emerged in this period which sought to explain the difficulties in employing social research in policy (e.g. Blume 1977; Bulmer 1982; Majchrzak 1984; Pahl 1977; Weiss 1977, 1979). A variety of theories and 'models' of the relationship were put forward during this period, some of which, such as the first two listed below, are often presented with the purpose of demonstrating what the relationship is *not*:

1. **A knowledge-driven model** in which research findings (i.e. knowledge) provide the necessary pressure for policy to develop in line with the new knowledge;
2. **A problem-solving model**, in which a policy problem is first recognised, prompting research with the aim of providing evidence on which to base policy solutions to the problem;
3. **A political model**, where research is used in a pre-determined manner to support policies which it has already been decided to implement for political reasons;
4. **A tactical model**, where research is used as a method of delaying the decision-making process, providing policymakers with some 'breathing space';



5. **An interactive model**, in which research is just one factor amongst many that have the ability to influence policy (other important ones include political ideology, external pressure and the personal experiences of policymakers).
6. **An enlightenment model**, in which research influences policy through indirect, diffuse processes over long periods, often contributing to a change in the way policy problems are framed, rather than addressing specific problems.
7. **A two-communities model**, which depicts policymakers and academics as contrasting communities with different (often conflicting) values, reward systems and languages. This makes it difficult for academic research to inform policy in any meaningful sense.

The way in which policy documents and politicians spoke about 'evidence-based policy' in the early years of the New Labour government evoked an image of a simple and linear relationship, reminiscent of the first two models described above, in which research would either *drive* policy change or *respond directly* to the policy concerns of the day. Yet, whilst there have been occasional examples of research feeding into policy in this manner, such simple models have long been discredited for failing to capture the intricacies of the actual relationship between research and policy (see Nutley & Davies 2000; Sutton 1999). All of the other models listed above developed as ways of explaining why policy was unlikely to be based on research in the simple and direct manner that the first two models imply.

The political model of the relationship between research and policy highlights the dominance of political ideology in shaping policy. From this perspective, research is only likely to play a role in policy if it is consistent with ruling ideological perspectives. In many ways, this model captures the way in which research on health inequalities was treated by the Thatcher-led governments of 1979-1990. However, it is important to acknowledge that this does not mean that the research undertaken in this period had *no* influence on policy because, whilst the policymakers in power ignored the research evidence, the research was employed by members of the political opposition as a means of supporting their critiques of the government. During this period, then, research into health inequalities influenced a range of *potential*

policymakers, many of whom who eventually entered into government in 1997. Disappointingly, some analysts seem to suggest that a political model of the relationship between research and policy has continued since the election of New Labour in 1997, with 'challenging' research still being ignored (e.g. Black 2001; Naughton 2005; Stevens 2007). Others, however, argue that such a model is overly cynical and, despite acknowledging the inherently political nature of policymaking, they claim that a political model is too simplistic (see Davies, Nutley & Smith 2000). The tactical model of the relationship, which suggests policymakers might encourage/fund research activity in particular areas with the aim of delaying awkward decisions, is similarly cynical and is therefore subject to the same kinds of critique.

In contrast, the interactive model, developed by Donnison (1972), paints an image of policymaking as a highly disordered and complex process in which policymakers seek information from a variety of sources, including practitioners, journalists and interest groups, as well as academic researchers. In this model, research ideas travel back and forth between a wide variety of groups, transforming as new connections and interactions occur, eventually developing into potential policy initiatives. Similarly, Cohen and colleagues' (Cohen, March & Olsen 1972) 'garbage can' model of policy decision-making suggests that a range of actors and interests feed into an interactive process in which the outcomes are difficult to predict. What these models share is a notion that the complexity and disorganization of policymaking mean that *chance* often plays a significant role in the outcomes (and therefore in the role that research might play in policy outcomes). Indeed, Cohen *et al* (1972) specifically describe decision-making within policy as a process of 'organised anarchy'.

Whilst such models might capture the *complexity* of policymaking, they have largely been overtaken by theories which retain their sense of intricacy but which allow more room for the conscious manipulation of outcomes by relevant actors. Theories like this, such as Kingdon's (1984, 1995) notions of 'agenda setting' and 'policy windows', are returned to in sub-section 1.2.4. For the moment, the point is that some key studies of the relationship between research and policy that were published in the 1970s demonstrate the importance of acknowledging the diversity of actors and interests involved in the construction of policy. Such theories warn against taking a blinkered approach to studying the relationship between



research and policy as they highlight the possible importance of external actors who may influence this relationship for particular issues.

The final two models listed above are also both drawn upon in contemporary work. Perhaps the one which is most frequently specifically referred to is Weiss' (1977, 1979) 'enlightenment model' (e.g. Pawson 2002c; Young, Ashby *et al.* 2002), which proposes that research influences policy through diffuse processes, resulting from the activities of various, overlapping networks. Such a model suggests that it is rarely the specific findings of a research project (or even a group of projects) which influence policy but rather the theoretical perspectives and concepts that develop out of research. This model makes no assumption that policymakers are on the look out for research evidence and, in an era in which policymakers have specifically claimed this will be a priority, Boaz and Haydon (2002) have criticised this model in this regard.

For other academics, the concepts outlined in Caplan's (1979) 'two communities' thesis appear to have been more enduring. This suggests that a 'cultural gap' exists between researchers and policymakers and that, as a consequence, research can only influence policy when efforts are made to bridge this gap. Whilst not necessarily referring to Caplan's work directly, various contemporary assessments of the limited use of research in health policy in Canada and the UK focus on the need to overcome such a 'gap' (e.g. Lavis, Robertson *et al.* 2003; Lomas 2000a; Wimbush *et al.* 2005). These authors tend to assume/claim that research would be more frequently employed by policymakers if only they could better access and understand the findings, and if researchers were more orientated towards tackling the kinds of issues that policymakers are interested in. From this perspective, efforts to bring researchers and policymakers closer together and/or to 'translate' information into appropriate terminology should result in its more effective 'use' within policy. However, such arguments fail to engage with some of the fundamental complexities in policymaking which other authors highlight, including the role of political ideologies and interests. So, whilst the notion that policymakers and researchers may fail to understand each other as a result of their differences remains plausible, it is important not to assume that merely facilitating such engagement will produce desirable results. Indeed, it may be the case that the cultural gap is so vast that the different communities aspire to entirely inconsistent outcomes, a conflict which

closer engagement is unlikely to resolve. Furthermore, it is possible that different actors *within* each 'community' may have quite different agendas (Kingdon 1995). Where this is the case, it might not be particularly helpful to conceive of 'researchers' and 'policymakers' as two distinct and relatively homogenous groups.

As the discussions above outline, much of the intellectual work which developed out of policy drives to use social science research in the mid-1960s focused specifically on exploring and explaining the complexities inherent in this relationship. The conclusions many of these analysts formed about the potential for research to play a greater role in policymaking were often pessimistic. Indeed, in 1979 Weiss concluded:

'There has been much glib rhetoric about the vast benefits that social science can offer if only policy makers paid attention. Perhaps it is time for social scientists to pay attention to the imperatives of policymaking systems and to consider soberly what they can do, not necessarily to increase the use of research, but to improve the contribution that research makes to the wisdom of social policy.' (Weiss, 1979p431)

Many of the more recent debates about official calls for 'evidence-based policy' suggest that some of the concepts, theories and conclusions developed in this era may have been forgotten. For example, Rein (1980) argues that the notion of research 'utilization' or 'use' is unhelpful because it suggests a one-way process in which research influences policy but is not informed by policy. By way of an alternative, Rein argues that it would be more helpful to think of the 'interplay' between research and policy. This choice of words is designed to highlight the interactive nature of the relationship between research and policy described by authors such as Weiss (1979) and Donnison (1972). Yet, whilst the terms 'use' and 'utilization' are now uncommon (at least within the UK), academics are still arguing that not enough attention has been given to the underlying point that Rein was trying to make, namely that there is a need to reflect on the, often subtle, influence of policy on research as well as the other way round (e.g. Hammersley 2003, 2005).

Rein also criticizes authors who focus solely on the use of *research*, ignoring the role of social *theory* and, in so doing, hints at the impossibility of research evidence ever serving to 'free' policy from ideology. Instead, Rein argues that the challenge in this genre of work is less about exploring the links between research and policy and more about "uncovering the latent



policies which organise the empirical research carried out by social science." (Rein 1980, p367). Yet, many of those who more recently argue in favour of notions of 'evidence-based policy', experimental research designs and systematic reviews of research findings, appear committed to the idea that research can somehow produce objective grounds for policy decisions. There is little acknowledgement that the very belief that 'evidence-based policy' should be aspired to is itself ideological (see Packwood 2002). Finally, Rein emphasizes some of the implicit and questionable assumptions underlying the notion that social research should inform policy, including a belief that such 'knowledge' is currently under-used in policy and that, if it were to be better employed, it would necessary lead to better policies. Rein (1980) claims that such assumptions were too often taken for granted by researchers in the 1970s, who concentrated on methods of increasing the use of research in policy. Once again, similar criticisms have been made in relation to the more recent push for evidence-based policy (see, for example, Packwood 2002).

In summary, it seems that whilst many of the theories and concepts developed in the 1970s and 1980s have informed more recent accounts of the relationship between research and policy, some of the significant criticisms raised within this body of work have not yet been adequately dealt with. Indeed, some of the tensions inherent in attempts to increase research utilization that Rein highlighted in 1980 appear alive and well. So, whilst some researchers have welcomed the government's decision to focus on social science as an important resource for shaping public policy (e.g. Massey 2000; McGrath 2004; Sanderson 2002), others have been far more cautious, criticising the government's 'positivist' conception of social science. For example, Parsons claims that the government's commitment to 'evidence-based policymaking' marks:

*'not so much a step forward as a step backwards: a return to the quest for a positivist yellow brick road leading to a promised policy dry ground - somewhere, over Charles Lindblom - where we can know 'what works' and from which government can exercise strategic guidance.'* (Parsons, 2002, p45)

Others, such as Cohen (2000) and Hammersley (2005), argue that the restrictions New Labour places on government-sponsored research limit the potential for academics to promote ideas that are out-of-line with government ideology. So, just as Rein's review did in 1980, some of these debates raise fundamental questions about whether it is reasonable, or even

desirable, to expect research to inform policy. Nevertheless, many commentators continue to believe that, although the relationship between researchers and policymakers is often uneasy, each has a great deal to contribute to the other (e.g. Stone 2001). The theoretical developments discussed in the remainder of section 1.2 outline the kinds of contributions that various commentators on this relationship and/or the development of policy suggest that each might make to the other.

### *1.2.2 Theories focusing on policy resistance to change*

As described in the introduction to this section, the theories discussed in this sub-section all suggest that policy is likely to be highly resistant to research which is in any way challenging to existing policy approaches. These theories can be thought of as falling into approximately two groups: (i) those which emphasise the role of politics in shaping policies; and (ii) those which focus on the way in which institutional and organisational processes act to limit policy change. The theories discussed here do not always engage with ideas about the role of *research* in policy but they do make some important claims about the constrained nature of policymaking.

The first group consists of theories which, in emphasising the role of politics in shaping policy outcomes (and, therefore, the interplay between research and policy), build on the ideas sketched out in the 'political' and 'tactical' models discussed in the previous sub-section. A number of quite divergent contributions fall into this category, from Foucauldian inspired interpretations of contemporary health policies (e.g. Armstrong 1995; Coveney 1998; Galvin 2002; Petersen 1996) to more neo-Marxist or socialist accounts of policymaking (Burnham 2006; Coburn 2004; Navarro *et al.* 2006; Navarro & Shi 2001). What these contributions share is the notion that an underlying political project is driving policy activity, whether that project is the production of self-regulating subjects (as some Foucauldian interpretations suggest) or the continuing dominance of ruling elites (as neo-Marxist or socialist accounts tend to posit). From the perspective of these analyses policymaking is, therefore, presented as a highly restrictive process; whilst those involved in the construction of policy are not necessarily consciously aware of the forces shaping their decisions, they will find it difficult to implement changes which challenge the overarching political framework within which they are situated. Such analyses suggest that the potential for research to play a creative role in



policymaking is extremely limited (see Wright, Parry, & Mathers 2007). Indeed, some argue that research is itself shaped by the 'powerful interests' that direct policy agendas (e.g. Navarro 2004).

Whilst neo-Marxist and Foucauldian interpretations of policy both tend to present far more complex accounts of policymaking than the simple 'political' and 'tactical' models of research discussed earlier, these theories are still criticised for over-emphasising the coherence of dominant interests and, consequently, denying the complexity and messiness of policy realities (see, for example, Larner 2000). Neo-Marxist accounts are also often accused of economic reductionism and of downplaying the agency of individuals and non-dominant groups (Cerny 2000; Jessop 2004). Nevertheless, over the past decade, a number of publications continue to place significant emphasis on the role of political ideologies in shaping policies relating to health inequalities (e.g. Bambra, Fox & Scott-Samuel 2005a; Carlisle 2001; Scott-Samuel 2004). Given that these accounts posit that political ideologies dominate policymaking outcomes, they suggest the outlook for achieving 'evidence-based policy' is bleak (Wright *et al.* 2007). However, some of these authors claim that if the influence of political ideology on policy were at least to be discussed more openly, then researchers would be better placed to challenge the underlying philosophies driving policy decisions (e.g. Bambra *et al.* 2005a; Bambra, Fox, & Scott-Samuel 2005b; Nash, Hudson, & Luttrell 2006).

The second group of theories which emphasise policy resistance to change are those which focus on the impact of institutions and organisational structures on policymaking. What these theories share with the previous group is a sense in which it is the wider structures in which actors are located that are key to explaining policy outcomes. Whilst political accounts tend to focus on power relations, these theories focus on organisational and decision-making structures. One term to describe this genre of work, which has become increasingly popular in the field of policy studies over the past two decades, is 'historical institutionalism' (e.g. Béland 2005; Immergut 1998; March & Olsen 1984). From this perspective, rather than constituting the collective result of individual preferences, policy decisions are considered to be significantly shaped by the historically constructed institutions and policy procedures within which they are embedded. As Immergut explains in the following quotation, individual agency

is still acknowledged but, it is argued, decisions can only be understood by considering the context within which actors are situated:

'This does not mean that institutions radically resocialise citizens in a revived version of social determinism or that norms dictate to actors what should be their behaviour. [...] Instead, institutions—be they the formal rules of political arenas, channels of communication, language codes, or the logics of strategic situations—act as filters that selectively favour particular interpretations either of the goals toward which political actors strive or of the best means to achieve these ends.' (Immergut, 1998, p20)

A related, though slightly different, concept is that of 'path dependency'. Associated largely with authors based in economics (e.g. Arthur 1989; David 1985), the defining feature of 'path dependency' theories is the notion that previous policy decisions limit the possibilities for future policy outcomes. So, whilst there may be a wide range of possible policy outcomes at an early stage in a 'path', decisions that are made during these early stages can effectively 'lock' in place the trajectory of future policy outcomes. David (1985) famously illustrates this point by describing how the dominance of the QWERTY format in typewriters and keyboards can be understood only by tracing the cumulative decisions of individuals and organisations back to the emergence of the first commercial typewriters. This same basic idea has been employed in relation to health care systems (e.g. Wilsford 2005) and other areas of social policy in the UK (e.g. Erhel & Zajdela 2004).

Theories which could be categorised as 'historical institutionalism' or 'path dependency' have often been welcomed for drawing attention to the importance of temporality in understanding policy processes and outcomes (e.g. McDonald 1996). However, they have also been charged with exhibiting a number of important deficiencies. In particular, this genre of work does little to explain how and why policy change does occur (Greener 2002; Hay 2002) or, therefore, what role research might play in these transformative moments. Those who have contributed to the development of this genre of work have emphasised that neither theories of 'path dependency' nor 'historical institutionalism' suggest that particular policy outcomes are *inevitable*. Rather, they merely suggest that it becomes increasingly difficult to change the overall direction of a policy trajectory as previous decisions become ever more deeply embedded in institutional structures and individuals' outlooks (e.g. Kay 2005).



To conclude this sub-section, whilst much of the work discussed here does not specifically deal with the role of research in policy, these theories do have important implications for this thesis because they suggest that research findings are most likely to influence policy when they 'fit' current policy trajectories. Such theories say very little about the potential for research to promote any significant change in these trajectories.

### 1.2.3 Theories focusing on incremental policy change

In contrast, there are a number of theories about the policymaking process, and/or the relationship between research and policy, which focus on the potential for *incremental* policy change. To some extent these theories build on Hecló's (1974) influential notion of policymaking as a process of 'collective puzzlement' and gradual 'social learning'. Four theoretical groupings are included in this category: (i) those which posit that research plays a role in gradual policy change through long-term processes of diffusion; (ii) those which suggest that, by building stronger links, there can be a continuous interplay between research and policy; (iii) those which promote the idea that policy outcomes are the cumulative result of the rational choices of individuals; and (iv) those which emphasise the role of 'policy networks' and 'epistemic communities' in developing and promoting particular ideas. Each of these is now discussed in turn.

The first genre builds on Weiss' (1977) 'enlightenment' model. This includes work, such as Radaelli's (1995) concept of 'knowledge creep', which suggests that the impact of research on policy should be thought about as a time-consuming process of gradually changing actors' perceptions and ways of thinking. As mentioned in 1.2.1, it is noticeable that recent assessments of the relationship between research and policy frequently still refer directly to Weiss' 'enlightenment model' (e.g. Hird 2005; Petticrew, Whitehead, *et al.* 2004; Walt 1994). Accounts which draw on this model tend to suggest, as Weiss herself directly claims (1977, 1979, 1982), that there is very little potential for research to have any immediate, direct impact on policy outcomes. So, whilst this body of work does not discount the possibility that research might contribute to what eventually become significant shifts in policy approaches, these shifts are usually perceived to be the outcome of the cumulative, incremental change.

The second genre of work which promotes the idea that research might contribute to incremental policy change relates to Caplan's (1979) model of policymakers and researchers as two distinct communities. Theories placed in this group are linked by their focus on the need to overcome the structural and social divides between research and policymakers. For example, Walt (1994), Saunders (2005) and Wimbush and colleagues (2005) all argue that a key barrier to the utilisation of research in policy is the lack of understanding and interaction between policymakers and academic researchers. Similarly, from a Canadian perspective, both Jonathon Lomas (2000a, 2000b) and John Lavis (2002, 2006) underline the importance of achieving shared understandings between researchers and policymakers, arguing that increased interaction between the two groups will improve the use of research in policy. All of these authors concentrate on the need to improve the mechanisms of communication between researchers and policymakers.

There are several crucial difficulties with this genre of work. The first, a point touched on earlier, is that it tends to construct both policymakers and researchers as relatively homogenous groups. This seems a questionable assumption when there have been so many accounts of the fractured and disjointed (even acrimonious) nature of relations within both academic research and policy (see Bartley 1992 and Gieryn 1983 on the former; and Kavanagh & Richards 2001 and Powell & Exworthy 2001 on the latter). A second problem is that these authors generally seem to assume that it is possible for research to respond directly to policymakers' questions and concerns, even though this assumption has been widely challenged, particularly within the field of health inequalities (e.g. Petticrew *et al.* 2004; Whitehead *et al.* 2004). The third major difficulty is that theories which focus on improving the communication and interaction between policymakers and researchers often fail to acknowledge the point that Rein (1980) made nearly three decades ago; that both policy and research agendas are shaped by particular theoretical, epistemological and political perspectives. Hence, policymakers and researchers might disagree not just on the implications of particular research findings but, more fundamentally, on the very issues which warrant research and the most appropriate methodologies with which to explore these issues (see Hammersley 2003).



Some of those who argue in favour of increased interactions between policymakers and researchers might reasonably claim that the second and third problems outlined above might not arise if policymakers and researchers worked more closely with each other. For example, in sketching out what they see as a desirable relationship, Wimbush and colleagues (2005) suggest that researchers should deliberately aim to focus on current policy concerns and work in ways which will respond to policymakers' key questions. Such a scenario might well result in the more frequent use of research in policy but it does not appear to allow for the possibility of research which challenges dominant policy approaches. Hence, the role of research in policy that these theories seem to advocate is inherently incremental. By increasing their interaction and communication with policymakers, researchers are expected to be able to respond more adequately to existing policy concerns, not to challenge these concerns. This is exactly the kind of prescriptive scenario which many academic researchers rallied against following various official statements (especially Blunkett, 2000) about the use of research in policy (e.g. Cohen 2000; Hammersley 2003, 2005; Hodgkinson 2000). In summary, whilst this body of work suggests a range of ways in which research could be more effectively used in policy, it does so in ways which appear only to allow for the influence of research which meets pre-defined agendas, thereby denying the possibility that research might also contribute to radical shifts in policy thinking.

The third genre of work located in this sub-section is known as 'rational choice theory.' This is a concept, developed by economists, which assumes that outcomes and events (including policy decisions and statements) can largely be understood as the cumulative effect of individual choices (see Hechter & Kanazawa 1997 for a more detailed overview). As the term itself implies, rational choice theorists propose that individuals will usually make *rational* decisions based on their own experiences and situation. Such theories do not deny that the values held by individuals and the contexts within which they are situated play a role in their decisions but, as models, they do deny the possibility of individuals making *irrational* decisions. Within this genre of work there is, therefore, an implicit assumption that it is possible to agree on a distinction between 'rational' and 'irrational' decisions, an assumption that many social scientists might challenge. Despite this, rational choice theory has become extremely popular in both economics and political science, possibly because it is one of the few theories which implies it is possible to predict outcomes (if the actors involved in a



potential outcome are identifiable and if their motivations can be understood). However, it has also come under substantial attack from various sources. Green and Shapiro (1994), for example, criticise the methodological foundations of many of the empirical studies which have been used to demonstrate the utility of rational choice theory and, therefore, question the evidence which advocates of the theory employ. Others criticise the assumption that individuals will always act in their own interests, on the basis both that individuals might act in the interests of others and that, in complex situations, they may not be capable of calculating what their optimum interests are (see Petersen 1994).

It is not necessarily obvious what rational choice theories have to say about the role of research in policy. However, I have decided to place rational choice theory in this sub-section because, if the fundamental basis of rational choice theory holds, it is most likely that individuals embedded and invested within a particular system will make decisions which do not significantly challenge the structure of that system. Such decisions might contribute to incremental policy change, through what individuals hope will be policy improvements. However, rational choice theories certainly do not seem to provide much scope for explaining how or why significant or sudden shifts in policy might occur because they do little to explain why individuals' preferences might change.

The fourth and final group of theories which support the notion that research is only likely to contribute to incremental policy change involves the concept of 'policy networks' (e.g. Marsh & Rhodes 1992; Marsh & Smith 2000) and 'epistemic communities' (a concept associated with Haas 1992). These theories concern the way in which knowledge about research and related ideas is circulated between a variety of actors, including publishers, journalists, lobbyists and other interested parties, as well as academics and policymakers. What links the various actors involved in a 'policy network' is a sense of a shared culture (McPherson & Raab 1988) or set of beliefs. Given the number of actors involved in a 'policy network' and the dialectical relationship between these actors, as well as the potential role of the broader context within which actors and networks are situated, 'policy networks' are not a theoretical tool which claims to be able to predict policy outcomes (see Marsh & Smith 2000). Rather, those who employ and develop the notion of 'policy networks' and 'epistemic communities' aim to capture the sense in which a range of key actors are engaged in an ongoing and iterative 'learning



process' (Marsh & Smith 2000). Members of such networks occupy privileged positions in relation to policy outcomes as they have the connections to be able to 'transport' new information and ideas between research and policy.

The term 'epistemic community' conjures up an image of a particularly tight policy network in which the role of 'recognized experts' is privileged. As Peter Haas outlines, whilst these experts may come from a variety of professional backgrounds, there are four key features which unite them:

'(1) a shared set of normative and principled beliefs, which provide a value-based rationale for the social action of community members; (2) shared causal beliefs, which are derived from their analysis of practices leading or contributing to a central set of problems in their domain and which then serve as the basis for elucidating the multiple linkages between possible policy actions and desired outcomes; (3) shared notions of validity - that is, intersubjective, internally defined criteria for weighing and validating knowledge in the domain of their expertise; and (4) a common policy enterprise - that is, a set of common practices associated with a set of problems to which their professional competence is directed, presumably out of the conviction that human welfare will be enhanced as a consequence.' (Haas 1992, p3)

The emphasis placed on the role that a sense of shared culture plays in defining and holding together such networks implies that 'epistemic communities' and 'policy networks' are not a means by which radically new ideas and alternative ways of thinking are likely to develop. By their very nature, success is dependent on a high degree of consensus amongst members. Hence, Marsh and Smith (2000, p6) reflect that the 'shared world view' of tight policy networks is likely to act as 'a structural constraint on the action of network members', serving to define 'the boundaries of acceptable policy'. Those who do not abide by the 'rules of the game' are likely to be excluded (Haas 1992 makes a similar point in relation to 'epistemic communities' - see p16). Indeed, to some extent the notion of policy networks overlaps with theories about 'historical institutionalism' and 'path dependency' as the structure and membership of policy networks is often perceived to be heavily influenced and organised by previous policy decisions and outcomes (Marsh & Smith 2000). What distinguishes accounts which employ the concept of 'policy networks' from theories which focus largely on the limitations to policy change is the fact networks are usually presented as fluid, constantly changing structures

which can be shaped by the agency of the actors within them as well as by external and temporal constraints.

Work in this area is diverse (Borzel 1998) and encompasses notions of a policymaking process in which *structure* is key (Marsh & Rhodes 1992) as well as theories which place significantly more emphasis on the agency of *actors* within networks (e.g. Dowding 1995). Indeed, the diversity of this body of work seems to be its major weakness. As a result of the proliferation of accounts employing different interpretations and accounts of 'policy networks', it is unclear what theoretical insights the concept can offer those studying the policy process (see Carlsson 2000). Indeed, Borzel (1998, p253) goes as far as claiming that it is unclear whether policy networks 'constitute a mere metaphor, a method, an analytical tool or a proper theory'. Nevertheless, or perhaps as a result of this diversity, the term 'policy network' has proved remarkably popular and, in contrast to theories which focus solely on researchers and policymakers, it serves to emphasise the diversity of actors who might be involved in the interplay between research and policy.

#### 1.2.4 Theories which conceive of policy development as a series of 'punctured equilibriums'

The third organisational category employed in this section focuses on theories which suggest that policy develops through a series of 'punctured equilibriums' (Baumgartner & Jones, 1993) or 'policy paradigms' (Hall 1990). This body of work directly challenges the idea that policies *only* develop through gradual, incremental change (and, therefore, that research is only able to contribute to this kind of low-level change). Whilst many of the theories discussed here acknowledge that there are periods in which policy change does occur incrementally (indeed, it is often suggested that this is the norm), they also suggest there are other moments during which significant shifts can occur. Such theories therefore open up a much greater possibility for the influence of research on policy.

The ideas categorised in this section can be conceived of as forming three sub-groups: (i) those which overtly develop the notion of policymaking as a series of 'punctuated equilibriums' or 'policy paradigms'; (ii) those which claim that opportunities for significant policy change occur momentarily and occasionally, when a variety of key factors converge in favour of change; and (iii) those which emphasise the persuasive power of *ideas* in promoting policy change.



Starting with theories which specifically claim that policy develops through a series of 'punctuated equilibriums', there are two bodies of work that are of particular importance. Firstly, in 1986, Peter Hall published *Governing the Economy*, in which he began to outline the idea that it might be helpful to think of the development of policy in terms of paradigmatic shifts. Hall further develops the concept of 'policy paradigms', which is based on Kuhn's (1962) theory of scientific revolutions, in subsequent publications (Hall 1990, 1993). It is a concept now widely referred to (e.g. Béland 2005; Blyth 1997; Capano 2003; Stone 2001). To the extent that it focuses on the role that *ideas* play in policymaking, Hall's work builds on Hecló's (1974) notion of policymaking as a process of 'social learning'. However, Hall places a greater emphasis on the role of actors outside official policymaking circles (particularly the media and politicians) and his notion of 'policy paradigms' is significantly different to Hecló's in that it suggests policy change can be sudden and significant as well as gradual and consensual.

At a simplistic level, Hall (1993) distinguishes between three different types of policy change: first order policy change, in which the settings of the policy instruments used to attain particular policy goals are changed (e.g. health inequalities targets might be altered); second order change, in which the basic techniques used to achieve particular goals are changed (e.g. different policy initiatives might be developed to help achieve the goal of reducing health inequalities); and third order change, in which a completely new way of thinking about a policy issue emerges, leading to changes in the policy goals, the discourse and epistemologies underlying those goals and the instruments and techniques used to achieve those goals (e.g. a complete shift from a medical model to a social model of health within policy). It is this third kind of change which Hall (1993) describes as a 'paradigm shift'.

Policy paradigms, therefore, constitute interpretive frameworks of ideas. As Hall (1993 p279) describes, 'Like a *Gestalt*, this framework is embedded in the very terminology through which policymakers communicate their work, and it is influential precisely because so much of it is taken for granted and unamenable to scrutiny as a whole.' The first and second order types of policy change he outlines can occur within a 'policy paradigm' or, in other words, within 'normal policymaking'. In contrast, securing a shift in an embedded policy paradigm is a rare



occurrence and, when it does happen, marks a 'periodic discontinuity' in policy. Hall argues that this kind of shift is unlikely to occur through gradual policy or research-based processes of learning because it tends to be more sociological and political in nature (although, following Kuhn, he claims that the emergence of perceived anomalies with an existing paradigm is likely to aid the chance that a new paradigm will succeed). A full paradigm shift is secured only when the new paradigm has become institutionalised (i.e. its supporters are in positions of authority and it is embedded in the organisational structures of policymaking institutions).

The separate notion that policy develops through a series of 'punctuated equilibriums' is descriptively similar to Hall's idea of 'policy paradigms'. Within policy studies, the term 'punctuated equilibrium' is most often associated with Baumgartner and Jones (1993), whose work suggests that the development of policy is similar to the biological model of evolutionary development. This implies that systems can quickly shift from one period of relative stability (in which only minimal, gradual change occurs) to another. Their ideas, which have subsequently been developed further with other colleagues (e.g. Jones, Baumgartner & MacLeod 2000; Jones, Baumgartner & True 1998) suggest 'punctuations' occur when persuasive ideas increasingly gain attention, subsequently becoming unstoppable. The potential for ideas to achieve this kind of influence depends on external (largely political) factors as well as on inherent qualities of the idea itself. Similarly to Hall (1990, 1993), therefore, the notion of 'punctuated equilibriums' implies that a number of different factors are required to converge in order for the kind of rare, large-scale policy change that marks a punctuation to occur.

The second group of theories in this sub-section explicitly develop the notion that the potential for significant policy change is often momentary, resulting from the convergence of a number of intertwined but essential factors. One frequently cited theorist whose work fits this description is Kingdon (1984, 1995), whose ideas about the policymaking process developed out of his observation that key policy actors (in the USA) were often unable to retrospectively explain why particular policy outcomes had occurred. This led Kingdon to focus on models which present the policymaking process as hugely complex, such as Cohen and colleagues' (1972) 'garbage can' model (referred to in sub-section 1.2.1). However, although Kingdon famously describes public policy as a 'primeval soup', his observations do not suggest that



randomness and serendipity are the sole determinants of policy outcomes. Instead, Kingdon argues that policy change occurs when a number of crucial factors come together. Like Hall, Kingdon distinguishes between low-level policy change (such as the uptake of new policy solutions to existing policy problems) and more significant policy change. Kingdon's analysis places greater emphasis than Hall's on the role of actors who promote various potential policy agendas and solutions. Nevertheless, he suggests that this agency is limited as the efforts of actors to move policy in particular directions can only be successful when other factors converge with the idea(s) being promoted by these actors. Kingdon describes these moments as 'policy windows' in which significant policy change is possible.

Mark Exworthy and colleagues employ Kingdon's (1995) theories in their analysis of health inequalities policy in the UK (e.g. Exworthy, Berney, & Powell 2002; Exworthy, Blane, & Marmot 2003). Their work suggests that, whilst progress has been made in relation to each of the 'policy', 'politics' and 'problem' streams that Kingdon identifies as essential to the opening up of a 'policy window', significant limitations also remain in each. As a consequence, policy outcomes relating to health inequalities (and, relatedly, the potential influence of research ideas on policy) have been significantly limited. In other words, these authors argue that, whilst there has been an official commitment to tackling health inequalities in the UK, perceived constraints on policy options (especially fiscal constraints), a lack of public interest in the issue and a lack of consensus about the potential policy solutions all serve to limit the 'window' of opportunity for significant policy development.

The notion of 'advocacy coalitions', developed by Sabatier and Jenkins (1993), similarly suggests that significant policy change occurs only when a range of key factors converge. This theory is more overtly political than many of the others discussed in this sub-section, being based on the claim that there are several *core* ideas relating to causation and values within policy, each of which arises out of a particular set of political and economic interests. Coalitions, or policy networks, form around these core ideas. Limited policy change occurs when these core ideas adapt in surface-level ways, which do not challenge the core values on which they are based. This kind of policy change (i.e. change which does not challenge the dominant 'core values') is more likely to be incremental than paradigmatic. However, Sabatier and Jenkins-Smith suggest that significant policy change can also occur. This becomes



possible when a particular coalition's ideas are perceived as successful. At these moments, some actors may switch coalitions (possibly for tactical reasons), thereby shifting the balance of power in relation to the 'core ideas' driving policy. These shifts constitute much more radical change and, given that research might be a source of new ideas for a coalition, it is plausible that research has the potential to play a role in both the low-level and the more radical policy shifts described within this framework.

The third and final theoretical development which evokes an image of policymaking as a series of 'punctuated equilibriums' places significant emphasis on the persuasive power of *ideas*. Over the past fifteen years or so, there has been increasing interest in the role that ideas play in promoting policy change. This trend has already been hinted at in the discussions above and it has been widely commented on elsewhere (e.g. Blyth, 1997; John, 2003). Numerous examples of policy analysis that emphasise the importance of ideas have emerged over the past decade or so (e.g. Béland, 2005; Campbell, 1998, 2002; Goldstein & Keohane, 1993; Howorth, 2004; Stevens, 2007). Indeed, several popular books focusing on the transformative power of ideas have also been published (e.g. Gladwell, 2000; Heath & Heath, 2007). However, as Blyth (1997) charges, there is a danger of ideas being employed as 'catch-all concepts' to help explain policy change without adequate reflection or discussion of what ideas are and what they do. It is important that theories which focus on the role of ideas undertake this work, otherwise they could fall subject to similar critiques to those lobbied at the simple, linear models of policy change (i.e. that when research/ideas are convincing enough, they will inevitably lead, eventually, to policy change). Given that this conception of the relationship between research and policy has been so widely discredited, it is essential for contemporary work to do rather more than redefine these conceptualisations.

One genre of work which has contributed a great deal to theories about the success (or otherwise) of particular ideas has emerged from science studies (e.g. Knorr-Cetina 1981; Latour 1987, 1988 [1984]; Latour & Woolgar 1986). This body of work focuses on trying to understand how, in the context of scientific activities, particular ideas are constructed and promoted. These theories directly contrast with the simple, linear models of the relationship between research and policy by emphasising the complex networks underlying knowledge-claims. From this perspective, the quality of research may have rather less relevance to its



potential influence than the way in which the ideas emanating from research are received, translated and promoted.

This genre of work is sometimes called the sociology of translation but is more commonly described as 'actor-network theory' (ANT). Its authors often focus on the mediums employed to construct and communicate ideas. Importantly, the term 'actor' relates to material objects, machines and concepts (or ideas) as well as to human actors, so it includes the tools used to communicate research-based ideas, such as texts, lecture theatres and projectors, as well as the human individuals involved. All of these actors are perceived to have agency and all are also treated as the effects of heterogeneous networks. According to Law (1992, p381 [emphasis in original]), 'the social is *nothing other than patterned networks of heterogeneous materials.*' So, whilst an individual or a government may each commonly be referred to as singular, discrete bodies, according to actor-network theorists, they are actually the *effect* of a diverse number of networks involving a range of actors. Networks, however, usually only become visible when they fail or when the interactions and actors involved are carefully uncovered through detailed anthropological work (for a more detailed explanation of actor-network theory see Latour, 2005 and; Law, 1992).

There have not yet been many attempts to take an actor-network approach to analysing policymaking (although Dugdale 1999 provides example). However, it is the fragile nature of heterogeneous networks (resulting from the number of the actors involved, the complexity of the interactions between these actors and the interactions between different networks) that causes me to argue that this is a genre of work which suggests policy has the potential to change dramatically and suddenly (as well as slowly and incrementally). For the idea that the networks underlying particular policy systems and ways of thinking might suddenly break down (as Law 1992 describes), implies that the potential for significant policy change is ever-present.

In her research exploring the unemployment and health debates of the nineteen-eighties, Mel Bartley (1988, 1994) extensively employs some of the theories developed by Latour and colleagues (e.g. Latour 1987, 1988 [1984]; Latour & Woolgar 1986). Whilst Bartley's thesis (1988) does not focus on the agency of non-human actors in the way that most actor-network



theorists do, it does highlight the need to understand interactions at the 'micro' level in order to understand outcomes at the 'macro' level. Bartley's (1988, 1994) conclusion is that (micro)political (or career) interests are crucial to understanding the interplay between research and policy, and that professional networks are the fundamental mechanism via which 'knowledge claims' (Knorr-Cetina 1981) travel. This suggests that the potential for research findings (or 'knowledge claims') to influence policy may be at least partially dependent on the factors driving researchers to undertake the work that they do.

In summary, the main theoretical contributions presented in this sub-section each suggest (whether directly or indirectly) that policymaking is an extremely complex process in which the interactions of a diverse number of actors determine policy outcomes. The important feature that distinguishes the theories presented in this sub-section from those discussed in previous sub-sections is that they all allow that, occasionally, it is possible for very significant policy change to occur. So, although not all of these theories refer directly to the relationship between research and policy, they open up the possibility that research (by contributing to new ideas) might play a role in promoting significant, as well as incremental, policy change.

Interestingly, although very different from one another, the two examples of research which specifically examine the relationship between research and policy relating to *health inequalities* in the UK - the work of Mel Bartley and of Mark Exworthy and colleagues - both fall within this category. In neither case do the authors claim that research on health inequalities has contributed to significant policy change, yet the theoretical frameworks each employs mean that they remained open to the possibility that such a shift *could* occur. This is important, because employing the theoretical ideas outlined in sub-section 1.2.2 and 1.2.3 would mean accepting from the outset that research has the potential to do no more than contribute to incremental policy change. Given that some of the research on health inequalities suggests quite radical policy change is required to effectively reduce health inequalities (as discussed in Chapter Two), taking such an approach to this thesis would involve making an assumption about the findings (and the reasons for this) at the outset. In contrast, by employing some of the ideas outlined in this final sub-section, it is possible to approach the thesis with a more open mind. Such an approach does not deny the contribution of some of the theories relating to policy resistance to change but it means that, where



significant policy change does *not* occur, despite the existence of ideas which challenge dominant policy approaches, we need to *explore* why this is so and not just assume that the situation could never have been otherwise.

The discussion in this sub-section therefore concludes that theories about policymaking which remain open to the possibility that significant changes in policy can occur provide the most appropriate starting point for this thesis. Criticisms of these theories are not discussed in much detail as, whilst they exist for each body of work, they do not generally discredit the idea that there is at least the *potential* for policy to change suddenly and significantly. Yet, there are weaknesses with the theories outlined in this sub-section. In particular, whilst these theories provide persuasive *descriptive* accounts of the potential for policy change (e.g. Baumgartner & Jones, 1993; Hall, 1990; Kingdon, 1984; Sabatier & Jenkins-Smith, 1993), or the construction and circulation of particular 'knowledge claims' (e.g. Knorr-Cetina, 1981; Latour & Woolgar, 1986), they say little about the *mechanisms* via which policy change, or resistance, operates.

It is in relation to this gap that it seems potentially helpful to introduce some of the concepts developed by one of the founders of social science, Max Weber. This is because Weber's analyses of institutions and charisma themselves provide an account of policy development that is not unlike Baumgartner and Jones' (1993) 'punctuated equilibriums' or Hall's (1986, 1993) 'policy paradigms'. Yet, Weber's work seems to offer rather more explanatory purchase in terms of the *mechanisms* via which forces for policy change (and resistance to it) operate. The following section therefore explores the similarities between Weber's work and some of the theories outlined in the previous section, before going on to consider what, if anything, Weber's theoretical contributions might add to the ideas outlined in this sub-section.

### 1.3 Some theoretical insights from Weber

In Weber's various texts, bureaucratic organisations are portrayed as mechanisms which, by continually reinstituting themselves, work to change the values and mentality of individuals (Eisenstadt 1968; Weber 1991, 1992 [1968]). Weber's analyses therefore overlap with some of the ideas discussed in sub-section 1.2.2 because his work suggests that, once particular ideas become institutionalised within policy structures, the actors involved in policymaking

become increasingly locked into particular ways of thinking. Indeed, Weber's work in relation to the development of policy is most frequently cited by historical institutionalists (e.g. Immergut 1998; Steinmo, Thelen & Longstreth 1992) to support theories about policy resistance to change. However, like Baumgartner and Jones (1993) and Hall (1986, 1993), Weber was also extremely interested in the potential for much more significant and large-scale policy change to occur:

'Central to Weber's interpretation of society was the distinction between the "extraordinary," or the explosively novel, and the recurrent processes through which institutions reproduce themselves, by virtue of the effective empirical validity of the traditional and legal rules or norms, and by the attachment of "significant" sectors of a society or its institutional sub-systems to the results of these norms or rules.' (Shils, 1965, p199)

As the above quotation implies, much of Weber's work focuses on the tension between processes of institutionalisation and the potential for dramatic change (a tension which forms the focus of Eisenstadt's 1968 edited collection of Weber's work). Weber often locates the source of the latter with the notion of 'charisma', a force that works in precisely the opposite manner to institutionalisation, by first changing people's values and mentality, which then produce new conditions (Samier 2005). Weber's ideas relating to policy development and political change would, therefore, seem to fit better with those discussed in sub-section 1.2.4 than with either of the previous two sections. Yet, Weber's work is not drawn on significantly by either Hall (1990, 1993) or by Baumgartner and Jones (1993, 2002). Given the lack of connectivity between Weber and the authors associated with the notion that policy develops as a series of 'punctuated equilibriums' (Baumgartner & Jones, 1993) or 'policy paradigms' (Hall 1990, 1993), it seems appropriate to consider whether either of Weber's relevant theoretical constructs, 'institutionalisation' and 'charisma', have anything to offer contemporary analyses of policy change (or stasis).

The concept of 'institutionalisation' has already been sketched out in sub-section 1.2.2. Indeed, as just stated, the body of work known as 'historical institutionalism' builds directly on Weber's work in this regard. However, this employment of Weber's ideas provides little insight into what he had to say about the mechanisms through which *policy change* might occur. Given that his work was undertaken so long ago, it cannot be expected to provide an unadulterated theoretical framework for understanding today's policy problems. However, the



concept of 'charisma' does seem to offer a fruitful opportunity for responding to Blyth's (1997) concern that there has not yet been enough analysis of what ideas are and what they do. For, whilst Weber suggests that the emergence of certain types of 'charisma' might be encouraged in particular circumstances, he also clearly states that it is not *dependent* on context (Dow 1969; Weber 1991 [1915]). So, unlike many of the theories outlined in sub-section 1.2.4, Weber's work focuses on describing the specific qualities that he believed were required for individuals to achieve 'revolutionary change', rather than the contexts in which this was likely to occur.

Some commentators have claimed that 'charisma' is one of the concepts in Weber's work that is most frequently explored (e.g. Schweitzer 1974). However, this is not necessarily equally so for each the different types of charismatic personality (religious, magical and political) that Weber outlines. So far, the concept has been employed rather more extensively in a theological context than in a political one:

'[W]hile today we have some very interesting interpretative studies on the concept of charisma as it appears in his sociology of world-religions, little is said about how it might be deployed to better grasp and reassess his political project, about what distinguishes it from the later but more visible version of charismatic domination and leadership, or about what constitutes its present political relevance. [...] While the transformative potentialities of charisma are ritualistically acknowledged in one way or another in almost every study of his thought, they are hardly recognized today in political theory as pertinent to contemporary debates regarding the relationship between legitimacy and legality, the extraordinary moments of radical founding and the legitimate foundations of normal politics.' (Kalyvas 2002, pp70-71)

If the concept of 'charisma' in relation to policy/political contexts has anything to offer this thesis, it is first necessary to sketch out how Weber employed the term. Firstly, although it is well known that Weber frequently attributes the quality of charisma to individuals, it is important to acknowledge that he also states that charisma is not necessarily a personalised trait. Indeed, as several analysts of 'charisma' have since pointed out (e.g. Fagen 1965; Sanders 1974; Spencer 1973), Weber's work emphasises that 'charisma' is dependent on the *interaction* between followers and a leader. It is not, therefore, a quality that can ever be *possessed* by individuals because it is *relational*. It is a concept which describes the ability of an individual to persuade others to follow their way of thinking and this ability depends on the

followers at least as much as any leader. This implies it is possible to think of charisma in a depersonalised sense, an interpretation which is supported in sections of *Economy and Society* (e.g. Weber 1992 [1968], pp1135-1141), in which Weber claims that charisma is transferable and specifically employs the term 'depersonalised charisma' (see also Shils 1965).

Having suggested that charisma is not a quality that can be possessed by individuals, we need to explore further what *it is*. According to Spencer (1973), the central feature of a 'charismatic leader' is his [*sic*] ability to convince others that his [*sic*] vision of the future will be borne out:

'[T]he revolutionary leader [...] generates charisma not by winning battles, settling strikes, ending depressions or feeding the poor, but by convincing his followers that *his vision of the future will come to pass*. His charismatic skills are therefore of an entirely different order. He need not be a great general or a great administrator — he relies upon the force of his will and the persuasive power of his arguments. He is constantly generating and sustaining a revolutionary reality for his followers by his writings and speeches, his 'iron will', his demonic energy and the power of his intelligence that envelops his followers in a world-to-be of his own creation. His charisma thus flows from *his mastery of the revolutionary dream* that he constantly vitalizes for those around him.' (Spencer 1973, p347) [Emphasis in original]

The central point that Spencer is making is that 'charisma' describes the abilities of an individual to persuade others that the future will develop in a particular manner. If actors are sufficiently persuaded of this vision, they will then make decisions and take action based on this belief (or understanding). From a social constructivist perspective (e.g. Law & Urry 2004), the followers in such a scenario consequently help to enact the vision to which they have subscribed to (i.e. by acting as if they believe the future will develop in a particular way, they begin to turn that vision into reality). If we understand 'charisma' in this sense, we can see that it might also be applied to ideas. In Spencer's (1973) explanation, arguments (or ideas) play a key role in 'charisma', but it remains associated with the individual who employs and articulates these ideas. An alternative interpretation might focus on an idea (or set of ideas) which is (are) employed and articulated by one or more actors. In this scenario, in the same way that Spencer describes the persuasion of others by an individual, it seems plausible that it



may be the qualities of an idea about the future which succeed in persuading others to believe that a particular vision will 'come to pass'.

Developing the notion of charisma in this sense has some important implications for how we might think about the role of ideas in policy. Firstly, it suggests, as do several other theoretical developments which were discussed in section 1.2 (particularly those labelled 'actor-network theory'), that ideas themselves have a degree of agency. This is not necessarily making a great leap from Weber's own writings, many of which reveal an underlying interest in the agency of ideas. Indeed, Berger (1963 p950) argues that Weber insists on 'the autonomy of... ideas' and that 'charisma' represents 'the sudden eruption into history of new forces... linked to... new ideas.' And, as Collins (2005 p310) outlines, after describing how a Russian revolt in 1905 brought together a diverse range of coalitions, Weber (1995 [1906], p150) states: 'This example is evidence of what the power of an 'idea' which unites the classes, and the cooperation of broad strata of the bourgeoisie can achieve'.

Secondly, for the analysis of the transformative capacities of ideas to be worthwhile, one must believe that it is possible to trace the trajectory of particular ideas on individuals, texts and institutions. For this to be plausible, it is necessary to believe that it is possible to identify certain 'core' features of ideas, despite their obvious mutability as different actors interpret and articulate them. If we accept both of the above conditions, 'charismatic ideas' begin to seem like a potentially useful mechanism for understanding policy change and the possible interplay between research and policy.

For the concept to significantly aid the analysis of this thesis, however, Weber's theory of 'charisma' needs to be unpacked further. This is not an easy task for, over the years, it has been charged both with vagueness (e.g. Sanders 1974) and incoherence (e.g. Adair-Toteff 2005; Schweitzer 1974; Spencer 1973). Yet, it is possible to pull out what seem to be the most essential features of the concept. First of all, it is important to emphasise that 'charisma', like many of Weber's concepts, is a theoretical (rather than a descriptive) construct, which means that Weber does not always claim that 'charisma' as he envisioned it would be found in its pure form in empirical contexts (Sanders 1974). This ought to be kept in mind when discussing the features that Weber most frequently attributes to 'charisma'.

As Adair-Toteff (2005) explains, Weber has a tendency to define concepts by first outlining what they are not. Hence, the concept of 'charisma' is frequently held up as the antithesis to 'institutionalisation'. In other words, 'charisma' is a force for innovation, which challenges ideas that have been institutionalised. Charismatic ideas then, as Weber (1968a) describes in relation to charismatic individuals, are those imbued with a creative, transformative power. They are revolutionary in their nature, providing a truly alternative way of thinking that challenges ideas that have become institutionalised. These institutionalised ideas may no longer even be recognised as 'ideas', having been elevated to the status of 'facts' as they became institutionalised. Consequently, charismatic ideas are likely to seem irrational to many (at least initially) because they challenge accepted ways of thinking. Indeed, Weber describes 'charismatic authority' as being 'specifically irrational in the sense of being foreign to all rules' (Weber 1992 [1968], p244). In other words, they are ideas which seek to influence perceptions of reality, replacing what is perceived to be the legitimate vision of the world with something quite different (see Kalyvas 2002). Their emergence depends on the ability of individuals to think outside the current boundaries of rationality and acceptability and, given the effects of institutionalisation on individuals that Weber famously describes, it is clear that he believed the potential for such ideas to develop within bureaucratic societies was slim:

'[W]here the bureaucratization of administration has been completely carried through, a form of power is established that is practically unshatterable. The individual bureaucrat cannot squirm out of the apparatus in which he is harnessed. In contrast to the honorific or avocational 'notable,' the professional bureaucrat is chained to his activity by his entire material and ideal existence. In the great majority of cases, he is only a single cog in an ever-moving mechanism which prescribes to him an essentially fixed route of march. The official is entrusted with specialised tasks and normally the mechanism cannot be put into motion or arrested by him, but only from the very top. The individual bureaucrat is thus forged to the community of all the functionaries who are integrated into the mechanism. They have a common interest in seeing that the mechanism continues its functions and that the societally exercised authority carries on.' (Weber 1968b, p75)

In addition, charisma is necessarily short-lived. The temporal nature of charisma arises from the fact that it must inevitably disappear for one of two reasons: either it will succeed in successfully replacing previously institutionalised ideas but, as a result, will then itself become institutionalised (and can, therefore, no longer be described as charismatic); or it will fail to



successfully challenge institutionalised ideas, eventually causing its followers to lose faith and, consequently, the charismatic qualities associated with the individual/idea vaporise. Hence, as Weber reflects (Weber 1968c, p54), 'in its pure form, charismatic authority may be said to exist only in the process of originating.'

Finally, it is important to be clear that Weber never suggested that 'charisma' was necessarily a positive force. Indeed, Weber specifically describes it as 'value-free' and often seems deeply concerned by the destructive, irresponsible potential of 'charisma'. Yet he also seems attracted by the potential for dramatic change (Dow 1969, 1978). In struggling with this tension, Weber attempted to outline some sort of compromise in a lecture he gave in one of the last years of his life, *Politics as a Vocation* (Weber 1991). In it, he proposed that politicians might exhibit the passion he associated with charismatic authority alongside a sense of proportion and an ethic of responsibility. As Dow outlines, such a compromise can be understood as an attempt by Weber to maintain a sense of hope about the future:

'Indeed, to speak seriously of a genuine path between the lifelessness of everyday convention and the dissolution of total charismatic release is to speak not primarily of history but rather of hope — the hope that passion in the service of an ethic of responsibility might yet rescue man [*sic*] from the immaturity and inhumanity of both unexamined routine and irresponsible release.' (Dow 1978, p91)

The kind of vision that Weber placed his hope in was therefore one in which responsible and reflective individuals might be able to exhibit the kind of political passion required for ethical forms of charisma to emerge. This is not dissimilar from the role that Said (1994) argues 'intellectuals' ought to play in society, something which is returned to and discussed in more detail in the final chapter of this thesis. The point of relevance to the moment, however, is the sense of optimism that Weber retained; the belief that opportunities for charismatic transformations might continue to emerge within society despite its increasing institutionalisation. Given that notions of 'institutionalism' remain alive and well in contemporary accounts of policy development (as discussed in section 1.2.2), it seems sensible to at least remain open to the possibility that Weber's predictions about the possible role of charismatic forces in promoting significant policy change might also be worth revisiting.

The aim is not to wrench Weber's analyses from the contexts upon which they were based and re-mould them to entirely different ones, nor to ignore the significant theoretical developments that have been made since Weber's time, but rather to develop two of the key concepts that Weber outlines, 'charisma' and 'institutionalisation', as heuristic devices which might aid the analysis of contemporary policy. The opposition between the relentless processes of institutionalisation and the persuasive challenges posed by charismatic ideas serves as a framework for this thesis to explore the tensions between ideas which are supported and encouraged by the institutional arrangements of policymaking bodies and ideas which seek to challenge those that have been institutionalised. In order to develop these theoretical discussions in more depth, it is necessary to first dedicate a significant amount of space to the empirical aspects of the thesis. The following section provides a brief overview of what each of the subsequent chapters contributes to the thesis, hopefully enabling readers to reflect in more detail on the potential utility of the Weberian framework outlined in this section.

#### **1.4 An overview of the thesis**

To contextualise the empirical study, Chapter Two first provides an overview of the key claims and theories that have been developed within the field of health inequalities research in the UK over the past forty years or so. Much like the theoretical literature discussed in this introductory chapter, this body of literature is far too vast to tackle systematically. So, once again, the aim is to provide an overview of the key ideas that have emerged. This approach might be thought of as an 'ideational cluster analysis' in that it groups and discusses health inequalities research according to its contribution to particular theoretical (or ideational) genres. The process of gathering and reviewing the material which contributes to this chapter has been ongoing over the past five years, commencing before the PhD started and being continually revisited as I encountered new information. Such information came from a variety of sources, including the various interviewees and the PhD supervisors, conferences and seminars I attended, journals and books that I read, and networks that I became a member of. Given that it is not the main aim of this thesis to provide an assessment of the research evidence on, or theories about, health inequalities (and taking into account the fact that there are a number of publications which already take on this task), I have tried to ensure that Chapter Two is concise rather than comprehensive. However, it does provide a clear sense of



the evidence-base that policymakers might potentially have drawn from during the study period.

A two-part, reflexive account of the methodological approach employed within the thesis is provided in the following two chapters (Three and Four). After considering a variety of qualitative methodologies to explore my research question, the approach that I eventually took involved the analysis of 42 key policy statements and interviews with 61 individuals who were involved in the interplay between research and policy during the study period (this included academic researchers, civil servants, relevant ministers, policy advisors, public health practitioners, research funders and some journalists).

Chapter Three focuses on explaining the approach taken to the analysis of the policy documents. A multifaceted approach was taken which aimed to: (i) trace evidence of health inequalities research within policy documents by locating references to the theories and ideas outlined in Chapter Two; (ii) uncover whether the construction of health inequalities as a particular kind of policy problem may have shaped the possible influence of research; and (iii) assess whether the language used and/or assumptions made within the policy documents reveal anything about the underlying 'discourses' or 'ideologies' that have guided policy approaches to health inequalities.

The insights of those involved in research and policy add much needed depth to the findings from this analysis. It is the approach taken to this part of the research which provides the focus for Chapter Four. Here, a descriptive account of the interviewing process is followed by a discussion of the theoretical rationale which underpinned this approach. Both Chapters Three and Four provide some reflexive insights into the experience of undertaking the research.

Chapter Five, the first of four empirical chapters, aims to demonstrate the ways in which health inequalities research appears to have influenced policy during the study period. To achieve this, the chapter draws largely on the data generated by a thematic and social constructivist analyses of policy statements and the interviews with individuals involved in the construction of policy. It opens by demonstrating that, whilst there is evidence that many of

the theories about health inequalities outlined in Chapter Two have travelled into policy, there is little support for the notion that policy has been *evidence-based*. Rather, the data suggest that (much like some of the theories discussed in section 1.2) it is the *ideas* to which research contributes that have moved into policy. Importantly, the Chapter reveals that these various ideas have not travelled equally – some have been far more influential than others. Furthermore, having been separated from the empirical data on which they are based, some of the ideas appear to have metamorphosed substantially during their journeys into policy. Overall, it seems evident that the ideas which have enjoyed the most success in terms of influencing policy responses to health inequalities are not necessarily those that are most supported by the research evidence. So, whilst the work on health inequalities that academic researchers have undertaken has clearly informed policy, it is also the case that policy is not based on this information alone.

The data presented in Chapter Five suggest that understanding how health inequalities have been constructed as a policy problem is an important part of understanding the differing journey types. These findings support Graham and Kelly's (2004) assertions that confused and shifting conceptualisations of health inequalities exist within policy (and research) which allow (or even encourage) the twin policy aims of improving overall population health and reducing health inequalities to become entangled. As a consequence, it is often unclear which of these two issues policy responses are aiming to address.

Chapters Six, Seven and Eight then go on to explore further explanations for the varying journeys outlined in Chapter Five. The analysis presented in these chapters also reveals some interesting insights as to why health inequalities are likely to have been constructed in the ways that they were. These chapters draw largely on the data from the interviews (although some data from the documentary analysis are referred to, where appropriate). They also draw explicitly on, and develop further, some of the theories concerning the policymaking process that are discussed in this introductory chapter.

The first of the three, Chapter Six, focuses on the ways in which academic research on health inequalities has been constructed and promoted within and beyond academia. It aims to uncover the extent to which academia provides a fertile (or restricted) context for the



development of potentially charismatic ideas. Chapter Seven then focuses on the aspects of the data which deal with the impact of policymaking institutions on decision-making processes and policy outcomes. Together, therefore, Chapters Six and Seven begin to address the Weberian inspired concepts of charismatic versus institutionalised ideas. Finding rather more evidence for the latter (in academia as well as policy), Chapter Eight goes on to explore what the data reveal about the political and social 'contexts' in which both research and policymaking activities take place. The concept of political and social 'contexts' recurs extensively in the data but trying to define quite what such 'contexts' signify, or constitute, is a difficult task. Chapter Eight approaches the issue by considering what the data reveal about interviewees' *perceptions* of the 'contexts' in which they have been situated. This involves both the examination of overt descriptions of these 'contexts' by interviewees and more subtle analyses of underlying discourses that are evident in both the interview transcripts and policy documents. It concludes by arguing that one way of conceptualising 'political context' is to see it as the successful and ongoing circulation of institutionalised ideas within the kinds of complex and large networks of actors that actor-network theorists focus on. This serves to actively limit the development of charismatic ideas.

In the conclusion to the thesis, Chapter Nine, argues that the Weberian inspired theoretical framework, which is sketched out in this chapter and developed further in Chapters Six to Eight, provides a useful device for understanding the research findings. In the first place, it emphasises the centrality of *ideas* to the interplay between research and policy. Secondly, it helps uncover the mechanisms via which *institutionalised* ideas operate; an influence which often remains undiscussed, possibly because their presence is obscured by the extent to which they have become institutionalised. Crucially, the findings suggest that the institutionalisation of ideas extends beyond policymaking bodies and into academia, thereby limiting a creative space from which charismatic ideas might emerge. Official commitment to 'evidence-based policy' appears only to have increased the influence of already institutionalised ideas. In other words, evidence tends only to be sought within the boundaries of institutionalised ideas. The conclusions of this thesis are, therefore, somewhat pessimistic about the interplay between research and policy; they suggest that researchers ought, perhaps, to be more concerned about the influence of policy on research than the other way around. However, the theoretical framework does allow the retention of some sense of

optimism about the future, for it implies that it is at least *possible* to challenge institutionalised ideas. In an attempt to open up this possibility, the conclusion argues that it might be both more truthful and more helpful to begin to talk about '*ideas-based*', rather than '*evidence-based*', policy.





## ***Part II: Literature Review***

### **Chapter Two: What are the key ideas to have emerged from research on health inequalities in the UK?**

#### **2.1 Introduction**

As most overviews of health inequalities research in Britain point out, studies concerned with varying patterns of mortality and life expectancy have a long history, dating back over three hundred years to the work of researchers such as William Petty (1623-87) (Macintyre 2003a). Historically, as now, health-related inequalities have been identifiable between both geographical areas and social groups (Davey Smith, Dorling *et al.* 2001). For example, in 1838-41 gentry and professional males residing in Bath had a life expectancy of 55, which was more than twice as long as the 25 years predicted for labourers living in the same area (Graham 2000). A similar gap in the life expectancy rates of contrasting occupational classes was visible in Liverpool during the same period but with significantly lower life expectancies for both groups than for the equivalent groups living in Bath (Graham 2000). Over the past three centuries, despite significant increases in overall life expectancy for all groups, the variations in life expectancy and mortality rates between various regions and social groups appear to have changed remarkably little in Britain. In fact, recent evidence suggests that the gap between the rich and poor in Britain may be widening, geographically as well as socially (Shaw, Dorling *et al.* 1998; Shaw, Davey Smith *et al.* 2005).

Throughout this period there have been sporadic calls for state intervention to tackle these health inequalities. For example, Edwin Chadwick used his report on *The Sanitary Condition of the Labouring Population of Great Britain 1842*, which demonstrated significant differences in life expectancy across England between both areas and occupational groups, to campaign for sanitary changes; work which significantly influenced the 1848 Public Health Act (see Golding 2006). In the twentieth century, the need to reduce variations in health across Britain contributed to the decision to establish a National Health Service (NHS) in 1948. Yet, despite the new service, by the 1970s it was becoming increasingly evident that free access to health care had not been enough to stem the widening inequalities in health and, in 1977, the then Secretary of State for Health and Social Services, David Ennals, faced fresh calls to do



something about the issue. Ennals decided to ask the Chief Scientist, Sir Douglas Black, to appoint a working group to investigate the matter further and make policy recommendations (see Berridge and Blume 2003 for a more detailed discussion of the circumstances which led to this inquiry).

The resulting report (Black, Morris *et al.* 1980) summarises the group's interpretation of the research evidence on inequalities in health that existed at that time. It argues that four distinctive explanations for health inequalities were identifiable within the research literature: (i) the notion that the inequalities were merely an artefact of the data; (ii) the idea that they resulted from social/natural selection (i.e. that poor health led to poor socio-economic circumstances and vice-versa); (iii) claims that material and economic factors explained the differential health patterns; and (iv) cultural/behavioural explanations which suggested that health outcomes varied as a result of different lifestyle choices and social norms. After rejecting the idea that artefact played a role, the authors accepted some of the claims made in all three of the other explanations but argued that materialist explanations were likely to play the largest role and, therefore, that policymakers ought to prioritise the reduction of differences in material and economic circumstances. The associated policy recommendations made by the authors were wholeheartedly rejected by the newly-elected Conservative government that had come to power between the commissioning and publication of the report. Nevertheless, it had a significant impact on the research community (internationally as well as in Britain) and a mass of research on health inequalities has since been published (again, see Berridge and Blume 2003).

Owing to the extent of research evidence that now exists on the topic of health inequalities, it is not possible to attempt any kind of comprehensive systematic review. In any case, attempts to provide in-depth overviews and assessments of the evidence on health inequalities already exist (e.g. Gordon, Shaw *et al.* 1999; Bartley 2004; Asthana and Halliday 2006). Instead, this chapter outlines prominent ideas and debates about health inequalities in Britain in a way which aims to draw out what the key implications or 'messages' for policy have been. This approach might be thought of as an 'ideational cluster analysis' in that it groups and discusses health inequalities research according to its contribution to particular theoretical (or ideational) genres. Given the time-period upon which this thesis is focusing, this chapter concentrates on



literature published in the latter quarter of the twentieth century and the early twenty-first century. Specifically, the theories put forward in the Black Report (Black, Morris et al. 1980) are used as a starting point in section 2.3 for considering the suggested causes of, and policy solutions to, health inequalities in Britain, before more recent explanations are outlined.

Taking the Black Report as a starting point is not unusual (see, for example, Shaw, Dorling *et al.* 1999), yet it is important to be clear, in light of Macintyre's (2002) comments on the issue, that this is in no way intended to suggest that the authors of the Black Report 'discovered' or 'identified' social inequalities in health in Britain. Indeed, as has already been articulated, research on social differences in mortality in Britain dates back to at least the seventeenth century. However, as the Black Report provides both a review of health inequalities research as it stood in the late nineteen-seventies *and* specific policy recommendations, it is a convenient point at which to start to consider the contemporary development of research-based ideas about health inequalities from a policy-orientated perspective. Obviously a great deal of research has been undertaken since the Black Report, so once the four approaches utilised within it have been outlined, consideration is given to how each approach has since developed since this time. Section 2.3 then outlines ideas that were not given much prominence in the Black Report but which have developed as key theories since this time. Although this section concentrates on research undertaken within the British context, international research which has engaged with and interacted with health inequalities research in Britain is also cited where relevant.

The final part of the chapter, section 2.4, summarises the extent to which consensus exists around the various ideas about, and explanations for, health inequalities in Britain and considers what the related policy 'messages' might be. To start with, however, it is first necessary to consider how health inequality in Britain is conceptualised as a problem, particularly in terms of the variables used to stratify health, and this is therefore the task undertaken in section 2.2. This is important because the various different interpretations of what is meant by the term 'health inequality' are in some ways linked to the contrasting aetiological accounts and ideas discussed in the following sections.





## 2.2 Conceptualising health inequalities in the UK

As outlined above, this section aims to provide a brief summary of the main ways in which health inequalities have been conceptualised in Britain, particularly in terms of the indicators used to stratify health. It is by no means a comprehensive account of how health inequalities are thought about but rather focuses on the ways in which health inequalities within Britain have tended to be conceptualised by researchers over the past thirty years or so.

### 2.2.1 Population versus individual data

As health inequalities are necessarily identified at population, or at least community, level, much of the research has an epidemiological basis (epidemiology being the, usually medical, science of populations and groups). Indeed, in merely accepting the existence of health inequalities, even the many projects in the field that are not themselves epidemiological are building on data concerning populations or groups. Importantly, many researchers argue that different kinds of determinants might explain patterns of health outcomes at population level from those which explain health experiences at an individual level. The late Geoffrey Rose made this case overtly in his influential article, *Sick individuals and sick populations* (Rose 1985), and later book, *The Strategy of Preventative Medicine* (Rose 1992), arguing that the determinants of the incidence of many diseases may be different to the determinants of individual causation. For example, whilst it is not always the case that salt restriction will help an *individual* patient with hypertension to evade negative health experiences such as stroke, epidemiological evidence suggests that the association between salt consumption and cardiovascular health problems mean that a small reduction in the consumption of salt across society would be likely to make a significant contribution to reducing the overall incidence of negative health outcomes related to cardiovascular problems. Following this line of thinking, Rose and others (e.g. Dahlgren and Whitehead 1991; Davey Smith, Chaturvedi *et al.*: 2000; Wilkinson 2005) argue that governments ought to pay rather more attention to *preventative* interventions at population and community levels and not focus solely on the *treatment* of individuals. This has brought epidemiological researchers into conflict with advocates of more traditional medical models of health, in which healthy individuals are perceived as the norm and intervention is only deemed appropriate (or even ethical) in response to ill-health (e.g. Charlton 1995). Such critics often charge theories drawn from population level data with falling foul of an 'ecological fallacy' (Pearce 2000). In other words, they emphasise that there



is a potential for reaching erroneous conclusions by assuming that interpretations of population-level data can be used to explain individual-level phenomena. In contrast, researchers concerned with population level data have argued that the inverse problem of 'atomistic fallacy' also warrants concern (i.e. they claim that it is not always appropriate to employ data drawn from individuals to develop theories about communities or populations). In recent years researchers have developed techniques and approaches which aim to respond to some of these critiques and respond to both the potential problems of 'ecological fallacy' and 'atomistic fallacy'. In particular, the progression of multi-level forms of modelling have allowed the simultaneous examination of the effects of group-level and individual-level factors (see Diez-Roux 2000).

### 2.2.2 Socio-economic status, 'social class' and health

Historically, studies of inequalities in health have tended to use measures of socio-economic position or 'class' to conceptualise the stratification of health within Britain, an approach which remains prominent today (e.g. Chaturvedi, Jarrett et al. 1998; Hart, Hole et al. 2001; Coleman, Rachet et al. 2004; Marmot 2004). Various measures of socio-economic status or 'social class' exist, most of which focus on occupational classifications (e.g. Office for National Statistics 2000) and/or indicators of income, wealth or educational attainment. As Grundy and Holt (2001) point out, the choice of indicator used is not often adequately reflected upon and the various measures of 'social class' described above are frequently used interchangeably in health inequalities research, possibly hampering efforts to understand the underlying mechanisms via which socio-economic position affects health. Scambler and Higgs (1999) argue that a further implication of this tendency is that 'class' is often 'explained away' by authors focusing on 'class-constitutive' or 'class-associated' factors (income, occupation, housing status, etc) rather than considering class as a 'phenomenon in its own right' (see also Mutaner and Lynch 1999). However, in a review of the ways in which health is stratified in the UK and the US, Nancy Krieger and colleagues (Krieger, Williams *et al.* 1997) argue that, as 'class' is not quantifiable, health researchers should indeed be focusing on the kind of class-associated factors listed above as a means of illuminating the various aetiological pathways via which differing positions in the class structure influence health.

Further criticisms of the ways in which 'social class' measures have been employed within health inequalities research relate to issues of ethnocentricity. For example, Davey Smith and



colleagues (Davey Smith, Charsley *et al.* 2000) and Karlsen and Nazroo (2000) both argue that as most measures of socioeconomic status are based on studies of majority white, male populations they are inappropriate for categorising minority ethnic populations. In a separate paper, Davey Smith and colleagues (Davey Smith, Chaturvedi *et al.* 2000) call for more detailed reflections on measuring socioeconomic position so that it is helpful in assessing the socioeconomic positions of the various minority ethnic groups in Britain, as well as the majority white population. Similar concerns have been raised about the (in)appropriateness of applying traditional, male-based measurements of social class to women and there has been particular concern about the, until recently, extremely common practice of categorising married women according to their husband's occupation (see Arber 1991).

Despite the difficulties in pinning down precisely what 'social class' is, or how we might measure such an amorphous concept, there is now a clear consensus that those positioned higher up the 'class' gradient in Britain experience better health and life expectancy than those further down for many health outcomes (Graham 2000; Bartley 2004; Marmot 2004). Within this understanding, however, there have been contrasting ways of conceptualising the 'class' difference. A great deal of research over the past twenty-five years has discussed the difference in terms of a 'health gap' between those at the top (such as wealthy professionals) and those at the bottom (such as unskilled labourers). However, the past two decades have seen increasing moves towards focusing discussions around a continuing gradient of health which affects the entire social spectrum. Championed largely by Professor Richard Wilkinson and Professor Sir Michael Marmot (e.g. 2004), the social gradient approach to health inequalities is not a new 'discovery' - the data used in the Black Report (Black, Morris *et al.* 1980) illustrate continuous improvements in health in each 'step up' the social class classifications - but it is a new and different way of thinking about the 'problem' of health inequalities which has important policy implications.

As Graham and Kelly (2004) highlight, the way in which health inequalities are constructed directly affects the perceived nature of the policy problem (where health inequalities are considered to be a policy problem). If health inequalities are thought about as an issue of health disadvantage facing the poorest in society, policy interventions are likely to focus on trying to improve the 'poor health of poor people'. Alternatively, if the problem is thought about



in terms of a 'health gap' between various groups (usually the most deprived compared to the least deprived, as discussed above), then policies are likely to aim to reduce this gap by trying to improve the health of the poorest groups at a faster rate than other groups. Both of these conceptualisations imply that targeted policy interventions might constitute an effective means of tackling the issue. However, if health inequalities are considered to be a continuous 'social gradient' affecting the whole of society, then policies must aim to alter population health in a way which reduces this gradient across the whole of society. From this perspective, interventions that are targeted only at sections of society placed at the lower end of the gradient no longer seem appropriate (or, at the very least, are far from sufficient).

### 2.2.3 Area and health

An alternative means of conceptualising health inequalities, and one which also has a long history in Britain, is to consider differences in health indicators between areas. For example, Shaw and colleagues' (Shaw, Dorling *et al.* 1998) review of regional inequalities in health over the forty-year period from 1951 demonstrates significant variation in mortality rates between various districts of Britain (with almost all causes of death being higher in Scotland and the North of England) and indicates that regional differences became more polarised over time.

The existence of differences in population health between various areas of Britain is widely acknowledged although, as with 'social class', there are important debates about how these differences are measured. Importantly, the choice of scale at which geographically bounded data are drawn from (e.g. postcode sector, electoral districts or nation-state level) will inevitably influence findings (although it should be noted that some authors (e.g. Reijneveld, Verheij *et al.* 2000) claim geographical classification has little influence on the size of health differences by area deprivation). Comparisons of large-scale areas may obscure significant variations in health within those areas, whilst, alternatively, a focus on health patterns within extremely small-scale areas may fail to capture variation between larger areas (see Wilkinson 2005, pp127-30). Yet, as Tunstall and colleagues point out (Tunstall, Shaw *et al.* 2004), the significance of scale is relatively under-theorised in the field of health research.

Regional comparisons often take a particular type of area boundary (e.g. parliamentary constituencies or the Census Electoral Districts) as the starting point for analysis in order to compare data on population health between the chosen areas and further debates have



arisen around the way in which area-level data have been used as a proxy for individual level characteristics. As Macintyre and colleagues (Macintyre, Ellaway *et al.* 2002) point out, researchers often employ area-level data as surrogates for missing individual-level data, particularly as a means of comparing health between different socioeconomic groups (data which can be difficult to obtain at individual level). In this case, data on population groups at a particular area level, such as parliamentary constituency, are used to calculate a level of 'deprivation' for the given area<sup>6</sup>. Health differences between areas are then frequently discussed in terms of socioeconomic differences between people (e.g. Shaw, Gordon *et al.* 2000; Benach, Yasui *et al.* 2001). This leads to two potential problems: Firstly, it can leave research open to the charge of 'ecological fallacy' (discussed earlier in the previous subsection) and, secondly, as Macintyre and colleagues (Macintyre, Maciver *et al.* 1993) outline, such approaches leave little room for considering the possibility of contextual, 'place' effects on health. The first issue has already been discussed but in relation to the second, a significant amount of research has been undertaken on the relationship between place and health since Macintyre and colleagues first highlighted the dearth of research in this area. Indeed, much of this has been pioneered by Macintyre and colleagues (e.g. Ellaway, Macintyre *et al.* 2001; Macintyre, Ellaway *et al.* 2002; Tunstall, Shaw *et al.* 2004). This body of work is discussed in more detail in section 2.4.4 as it involves considering causal accounts of health inequalities. The point, for the moment, is to emphasise the fact that health inequalities can be conceptualised geographically as well as socially.

#### 2.2.4 Gender and health

As interest in the relationship between social class and health increased, the nineteen-seventies also saw a growth in research considering health differences from a gendered perspective. One of the most widely cited studies of this era, Nathanson (1975), famously outlines the 'contradiction' that whilst women tend to live longer than men, they also experience higher levels of morbidity. Various theories have been put forward in an attempt to

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<sup>6</sup> Approaches to measuring and classifying regional deprivation vary, including, for example, the Carstairs Index (Carstairs & Morris 1989), the Townsend Index (Townsend, Phillimore, *et al.* 1988) and the Breadline Britain measure (Mack and Lansley 1985). Debates about the merits of the various measures exist (e.g. Morris, and Carstairs 1991) but the most frequently used indices in recent research are all based on a relative conception of poverty (i.e. they take into account that what constitutes poverty and deprivation changes over time as the wealth of the society in which people live alters). For pragmatic reasons, most measures are based on data that are captured by the national censuses, such as housing tenure and/or access to a car.



explain this apparent paradox, including the suggestion that women's reproductive role accounts for their higher rates of morbidity or, alternatively, that women are just more likely to *report* ill-health than men. Later research not only challenges these suggested 'explanations' (e.g. Arber and Cooper 1999; Macintyre, Ford *et al.* 1999) but also claims the general thesis that 'women live longer but experience more illness' is over-simplistic. For example, Macintyre and colleagues (Macintyre, Hunt *et al.* 1996) point out that, as gender differences vary significantly across the life course, it may be unhelpful to make broad and simplistic assertions about the differences between men and women's health experiences. Changes in women's position in British society since Nathanson's (1975) work was first published have presented further challenges to the orthodoxy that 'women live longer, but get sicker'. Indeed, recent research suggest gender differences in health are not as great as previously suggested (Arber and Cooper 1999).

As well as considering gender differences in health, there has also been research interest in relation to how health is stratified *amongst* women, particularly as most of the research on health inequalities in Britain in the 1970s and 1980s is based on variations in men's health (and research that was undertaken on 'social class' health differences amongst women usually relied on indicators which categorised married women according to their husband's class). In response, from the late nineteen-eighties onwards, feminist researchers began to explore whether the same kinds of socio-economic and 'social class' health differences were evident amongst women (e.g. Arber 1991; Bartley, Popay *et al.* 1992). On the whole, this body of research suggests socioeconomic or 'social class' inequalities in health are smaller for women than men but that their extent varies depending on which indicator(s) of 'social class' is/are employed (Sacker, Firth *et al.* 2000). As Arber and Cooper point out (1999, p62), a research focus on the nature and extent of health inequalities amongst women has largely eclipsed concern about gender differences in health, to the extent that it is now 'common-place to analyse men and women separately, examining gender differences in the magnitude of the relationships between socio-economic characteristics and ill-health'. There have been calls to bring the two strands of research (that which explores gender differences in health and that which considers health inequalities within each gender) together in order to enhance our understanding of the factors and processes affecting health (Arber and Cooper 1999).



### 2.2.5 Ethnicity and health

Whilst stratifying health in terms of ethnicity is becoming increasingly common in British health research (e.g. Davey Smith, Charsley *et al.* 2000; Davey Smith, Chaturvedi *et al.* 2000; Chandola 2001; Chaturvedi 2003; Nazroo 2006), this approach to conceptualising health inequalities has been far more common elsewhere. For example, health 'inequities' or 'disparities' (the more commonly used terms in North American health literature) between 'ethnic' or 'racial' groups frequently provide the main focus for considering health differences in the USA (e.g. Raphael 2000; Williams and Jackson 2005; Griffith, Moy *et al.* 2006). Furthermore, as Navarro (1990) points out, due to a lack of official data that can be used as indicators of 'class' in the USA, 'race-ethnicity' categories are sometimes used as a proxy for 'class' or socioeconomic status. In British health research in this area, this is never the case; rather, research on ethnicity and health has been somewhat of a speciality interest, albeit one which has significantly increased its prominence in recent years.

Generally the term 'ethnicity', as opposed 'race', is preferred in health research (Afshari and Bhopal 2002) and it is important to acknowledge the differences between the two terms. Although it has long been accepted that genetic differences within so-called 'racial' groups are greater than any between such groups (Lewontin 1972; Goodman 2000) and that 'racial' identities are not, therefore, biologically fixed but culturally constructed (Senior and Bhopal 1994), use of the term 'race' continues to imply a biological categorisation which can be externally imposed. 'Ethnicity', on the other hand, is more widely recognised as a cultural construct. Like 'social class', it is a complex concept which can be used to describe a wide variety of features. However, the process of categorisation differs from that of 'social class' or 'racial group' as it tends to rely on self-identified indicators that are thought to denote a sense of shared identity or social background. Such indicators variously include data on individuals' religion and/or spoken languages, their own or their parents' country of birth, or some other, less tangible feature which is thought to be indicative of a distinctive shared tradition that has passed between generations of a particular group (Senior and Bhopal 1994; Chaturvedi 2001). A frequent failure to adequately distinguish between the two concepts or, where using 'ethnicity' alone, to adequately define what is meant, has led to a number of critical commentaries over the past fifteen years. For example, Bhopal and Phillimore (1991) highlight the unhelpful way in which the term 'Asian' has been used in health research to lump



together people of a huge variety of religious and cultural backgrounds. As the authors point out, more than scientific clarity is at stake here:

'The prevailing British use of the term 'Asian' is not a self-description by the peoples of the Indian subcontinent, but a label imposed by a society which has historically defined 'otherness' primarily in terms of colour, and continues to do so. Of course, 'Asian' is not a colour term in the strict sense; but its saliency comes from its place within a set of categories used to define those who are not 'white', and are therefore 'other'. The benefit, more apparent than real, of such labels as 'Asian' is to permit relatively simple generalizations about complex populations. [...] Until more appropriate terminology is achieved, much research on ethnic minority groups will remain downright parochial, misleading and contradictory.' (Bhopal, Phillimore et al. 1991, pp244-245)

Their complaint is far from unique; a number of authors claim health research on 'ethnicity' has contributed to processes of racialisation (Sheldon and Parker 1992; Goodman 2000) or even relied on, and thereby implicitly promoted, racist assumptions (see Chaturvedi 2001). At the very least, much of the research undertaken in this area since the 1970s has been accused of overemphasising 'ethnic' differences (Davey Smith, Charsley *et al.* 2000; Karlsen and Nazroo 2000) and assuming that 'ethnic/race' variables represent true (and fixed) genetic or cultural differences between groups (Senior and Bhopal 1994; Karlsen and Nazroo 2000).

Despite all the criticisms, it is widely accepted that the majority of minority ethnic groups in Britain (or all, depending on how 'ethnicity' is categorised) experience poorer health outcomes for many measures than their 'white British' counterparts (Nazroo 1998)<sup>7</sup>. The explanations for these differences are discussed in more detail later in the chapter. For the moment, the important point is that there are serious concerns about the way in which the concepts of 'ethnicity' and 'race' are discussed and measured within health research. Some researchers believe the complexity of 'ethnicity' and of its relationship to socioeconomic position may, in the end, render it of limited use in studying health inequalities (e.g. Bradby 2003). However, others argue, despite the difficulties in defining and measuring a concept as complex as 'ethnicity', it is no more challenging than measuring 'socioeconomic position' or 'social class' and, furthermore, that understanding ethnic variations is crucial to determining the role of

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<sup>7</sup> This conclusion in itself can cause tensions; as Chaturvedi (2001) points out, research which emphasises high rates of disease in minority ethnic groups can imply that such disease rates (and therefore the ethnic groups in question) are a problem. Furthermore, recommendations for action may implicitly encourage assimilation of minority ethnic groups to the Western norm.



different exposures to disease risk, as well as providing important information for the targeting of public health interventions and resources (e.g. Chaturvedi 2001). These various concerns and debates are only likely to be resolved when greater reflection on measuring and constructing both 'ethnicity' and 'socioeconomic position' are developed and utilised in health research (Davey Smith, Chaturvedi *et al.* 2000).

### 2.2.6 Relative and absolute differences

Health inequalities can be thought of in terms of either 'absolute' or 'relative' differences between groups. This difference is important as, depending on which definition of health inequalities is employed, the same statistical trend could be used to demonstrate both that an absolute health inequality gap has increased and that the relative health inequality gap has decreased (and vice versa). The difference between relative and absolute inequality is illustrated in Figure 2.1, below, (taken from Department of Health 2005a). If group A follows the trajectory within shaded area in Figure 2.1a, then absolute inequality is narrowing but relative inequality is widening. Whereas if group A follows the trajectory within the shaded area in Figure 2.1b, then relative inequality is narrowing but absolute inequality is widening.

Figure 2.1: Relative and absolute differences in life expectancy (taken from Department of Health 2005a, p77):

Figure 2.1a: Trajectories for maintaining constant absolute and relative inequality between two groups, A and B, when reference group B trajectory is decreasing over time

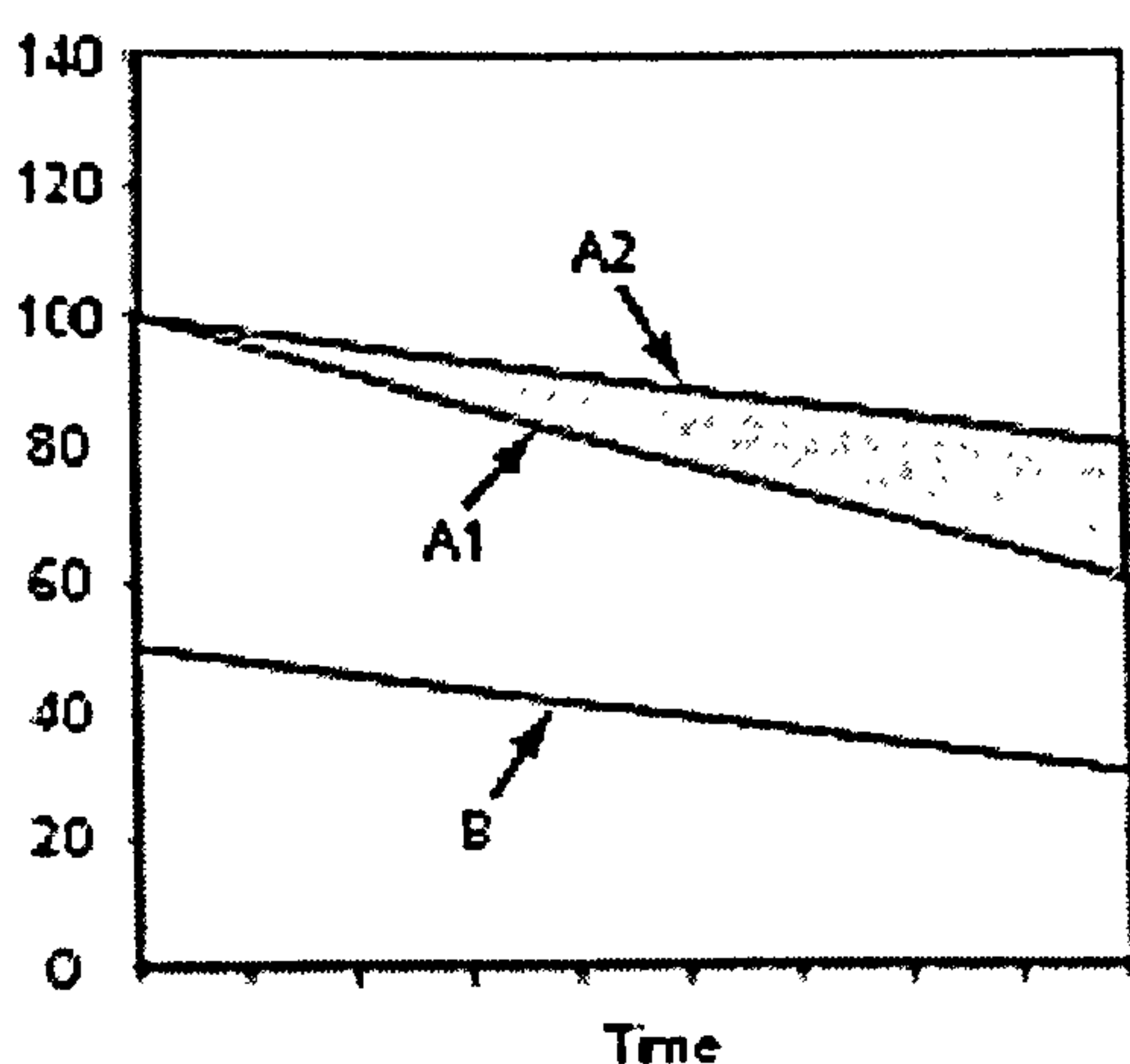
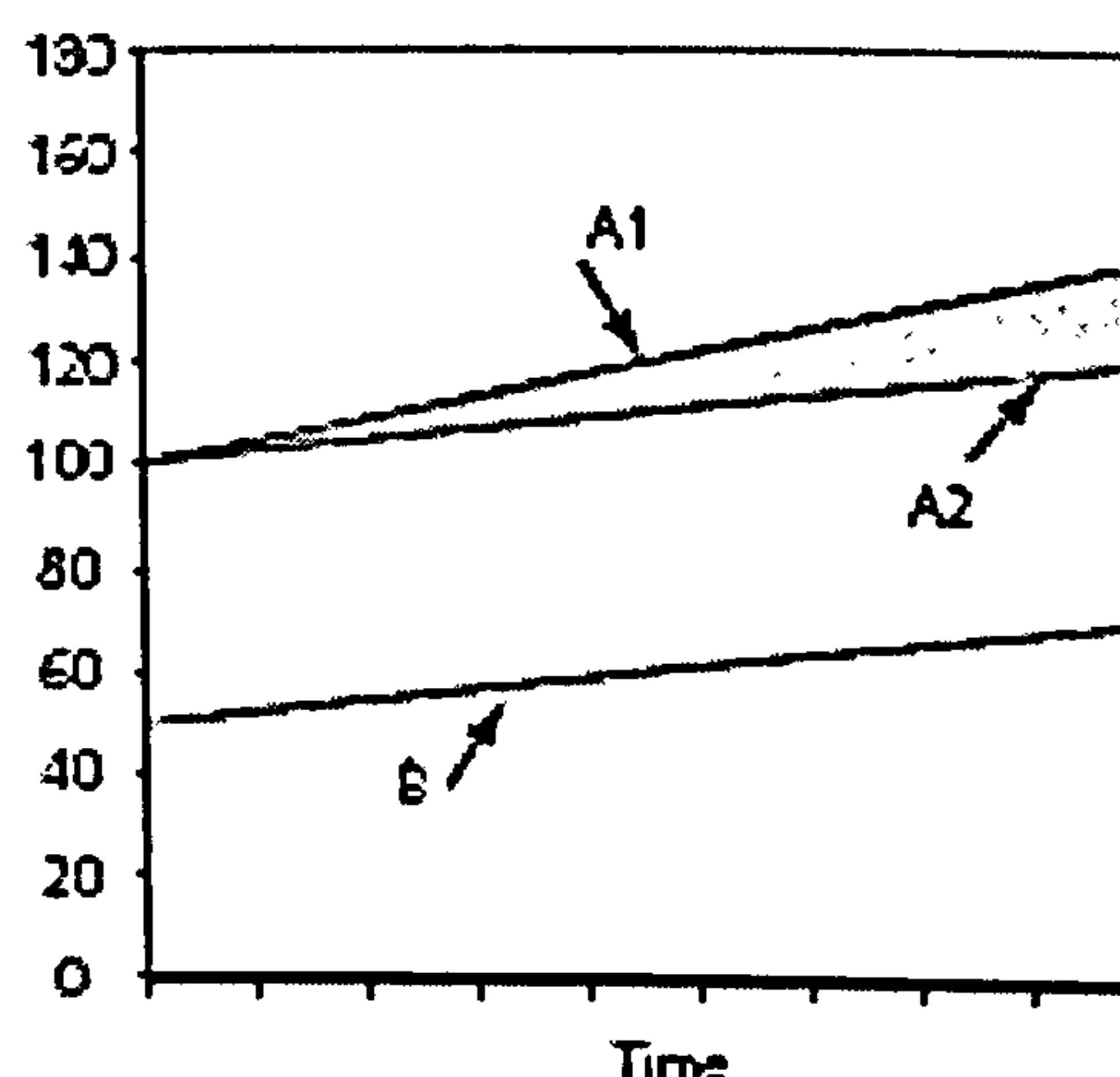


Figure 2.1b: Trajectories for maintaining constant absolute and relative inequality between two groups, A and B, when reference group B trajectory is increasing over time



**KEY:**

B = Trajectory of reference group B

A1 = Trajectory that group A must follow to maintain constant relative inequality with group B

A2 = Trajectory that group A must follow to maintain constant absolute inequality with group B

Relative and absolute differences are not discussed a great deal in the health inequalities research literature, which tends to focus on aetiological pathways. However, the policy commitment in England to specific national health inequalities targets for reducing health 'gaps' (discussed in Chapter Five) has led to debates about the benefits and drawbacks of using relative or absolute concepts of health inequalities (e.g. Low and Low 2005; Shaw, Davey Smith *et al.* 2005).

Overall, what this section demonstrates is that the term 'health inequalities' can be interpreted and employed in a number of different ways. Therefore, in using the term, it is important for both researchers and policymakers to elucidate what is meant more specifically, as this is likely to effect both the aetiological explanations of the 'inequality' and the policy implications for tackling it. However, this task is not always undertaken in either research or policy. Instead, there is often an assumption within research in the UK that it is health differences between socio-economic classes that are most important (although data relating to geographical areas is often used as a proxy for categorising groups of people, as discussed above). To some extent, as the following section reflects, this assumption is a legacy of the emphasis placed on these kinds of health inequalities within the Black Report. It is therefore this form of health inequalities that the literature discussed in section 2.3 relates to.

The purpose of section 2.3 is to identify the key ideas that have been developed by researchers to explain patterns of (socio-economic and geographical) health inequalities within the UK. As outlined in the introduction to the chapter, these ideas are grouped in 'ideational clusters' according to the broad policy messages to which they contribute. The issue of whether the research in question relates to relative or absolute health inequalities (or even to health gaps or gradients) is not a focus of this section for the simple reason that much of the available research does not itself reflect on such definitions. However, these issues are returned to in Chapter Five, which unpacks the ways in which health inequalities have been constructed and defined within Scottish and English policy statements in order to reflect on the way in which these constructions may have influenced policy understandings and interpretations of the research evidence.



## 2.3 Key explanations for patterns of health inequalities in the UK, from the Black Report onwards

The analyses of patterns of health in Britain undertaken by the authors of the Black Report (Black, Morris *et al.* 1980) are based on information from available data-sets such as the General Household Survey for 1977 and occupational mortality data from the Office for Population and Census Surveys (OPCS). In a variety of comparative analyses, these data are used to demonstrate an almost unvarying, inverse relationship between 'social class' (which is used as a proxy measure of wealth; the group claim they would have preferred to use some measure of wealth or income if such data had been available) and health. The data demonstrate that with each step down the social (occupational) class categorisations, mortality and morbidity rates increase. Although the phrase 'class based mortality gradient' is occasionally used to describe these findings, the Report frequently conceptualises health inequalities in terms of a 'gap' between opposite ends of the social class scale (see sub-2.2.2). Gender differences, variations between ethnic groups and regional health differences are all acknowledged at various points in the Report but, like much of the subsequent research, by far the majority of the discussion focuses on 'social class' differences and it is this form of health inequality for which four theoretical explanations are outlined in chapter six of the Black Report. Each of these explanations is described in this section in turn (2.3.1 – 2.3.6<sup>8</sup>), with consideration then being given as to how the ideas described have developed since 1980. Sub-sections 2.3.7 – 2.3.9 go on to identify three further approaches to health inequalities that have largely emerged since this time.

### 2.3.1 Artefact

The first explanation the Report considers is that the relationship between health and 'social class' could potentially be an artefact of the measurement process, being that there are difficulties with measuring both 'health' and 'social class'. In particular, the authors consider the suggestion that the apparent class-health relationship could be a result of upward social mobility, which has involved the healthier and younger members of the lower classes moving up the social class scale, leaving a residual older and/or less healthy population in at the bottom of the social class scale. The authors (Black, Morris *et al.* 1980) reject this explanation

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<sup>8</sup> For the purposes of this section, one of the theoretical explanations outlined in the Black Report (cultural and behavioural explanations) is divided into three more specific explanations. Consequently, six, rather than four, ideational clusters are drawn out from the Black Report within this chapter.



on the basis that the decline in the proportion of the population classified as social class V had not been as great as some commentators were suggesting and that, in fact, a significant proportion of younger men continued to form part of social class IV and V in the data employed in the report. Since this time, a variety of studies, but particularly those using data from the OPCS Longitudinal Study and the various British birth cohort studies, have been used to confirm that the inverse social class-health relationship is not due to any kind of statistical bias and cannot be wholly (or even largely) explained in terms of upwards social mobility (e.g. Fox, Goldblatt *et al.* 1985; Goldblatt 1990; Power, Matthews *et al.* 1997). A consensus therefore now exists that there is an inverse gradient linking health and 'social class', or wealth, which artefact cannot explain (Graham 2000). This claim is now rarely, if ever disputed. However, it remains important to remember that statistical relationships are not a precise reflection of reality and that the measurement process employed will affect the size and pattern of inequalities found (Vågerö and Illsley 1995). Indeed, as has already been noted, a variety of academics have criticised the way measurements of 'socio-economic position', 'social class' and 'ethnicity' have each been employed by health researchers.

### 2.3.2 *Natural/Social Selection*

Although the authors (Black, Morris *et al.* 1980) had already rejected the idea that upward social mobility could wholly account for the relationship between 'social class' and health illustrated in the Report (as discussed above), they go on to discuss the notion that natural or social selection might play a significant role in explaining the gradient separately. This idea suggests that the social gradient of health can be explained by viewing social class as the dependent variable and health as the explanatory factor, i.e. that the relationship results from poor health limiting people's access to financial and other resources and, as a result, shapes their 'social class'. The Social Darwinian notion of 'natural selection', which suggests that physically fitter people are more successful in life, seems rather outdated now and this idea was indeed rejected by the authors of the Black Report (Black, Morris *et al.* 1980). However, as Vågerö and Illsley (1995) point out, the Black Report fails to adequately distinguish between 'natural' and 'social' selection:

'[S]ocial selection [describes] a situation where health is associated with social mobility, either directly (and causally), or indirectly, in both instances without any assumptions that genes play any part in the process. Natural selection, in contrast, presupposes a genetic basis. Social selection could be direct and take the form of 'health



discrimination' (West 1991), or be indirect, as when some common social factor determines both health and social achievement.'

Whilst there has been virtually no support for the 'natural selection' thesis within the field of health inequalities for some time (with the possible exception of Himsforth 1984), recent developments in genetic research, particularly the human genome project, suggest health inequalities researchers will soon need to consider the implications of new types of genetic explanations for health inequalities. However it is, as yet, by no means clear what the implications of these new developments are likely to be (Davey Smith, Ebrahim *et al.* 2005; Mackenbach 2005). Relatedly, there is a growing body of work which claims intelligence (as measured by IQ) is a good predictor of health outcomes (Batty and Deary 2004; Gottfredson and Deary 2004; Batty, Deary *et al.* 2005; Batty, Der *et al.* 2006). Again, however, it is so far unclear what the implications of this research might be. For example, in the case of research supporting a link between health outcomes and intelligence, the implications are likely to vary depending on the significance placed on measures of IQ and the extent to which one believes IQ to be a measure of *inherent* capability or something which is affected by environmental and social context.

Aside from these new developments, there are various strands of research which support the idea that 'social selection' may influence patterns of health inequality (Vågerö and Illsley 1995). For example, a variety of studies indicate that social mobility is likely to play a role in health inequalities, albeit a small one (e.g. Blane, Davey Smith *et al.* 1993) or one that only operates in relation to those moving in and out of employment (e.g. Elstad and Krokstad 2003). There are also claims that 'indirect' contributors to social selection (i.e. factors, such as height, which seem to affect both health and social mobility) may play a significant role in explaining health inequalities (West 1991). Finally, recent qualitative research on the relationship between housing and health adds support to the notion that experiences of poor health can significantly affect social mobility (Easterlow, Smith *et al.* 2000; Smith, Easterlow *et al.* 2003). Research by these authors also reveals evidence of the existence of health discrimination in labour markets (Easterlow and Smith 2003). Taken together, these reports imply that fresh attention is being paid to the role of social mobility within health inequalities.

The policy implications of the research-based ideas discussed in this section obviously vary depending on the study but, in at the very least, much of the research suggests that social security and support for those experiencing poor health (in terms of housing, income and employment protection, etc) are likely to be important means of ameliorating the effects of poor health (Dahl 1996).

### 2.3.3 Materialist explanations

The third genre of explanations considered by the Black Report (Black, Morris *et al.* 1980) highlight the importance of material circumstance and/or the wider social and economic structures of society for health. As with some of the other four explanations put forward in the Black Report, the authors' definition of this theoretical account actually blurs an important distinction between two, slightly different explanations. In this case, the two explanations involve 'material' and 'structural' influences on health; approaches which are not always adequately distinguished from one another in subsequent research either.

In terms of materialist explanations, the Black Report highlights the importance of relative (as opposed to absolute) poverty: 'poverty is... a relative concept, and those who are unable to share the amenities or facilities provided within a rich society, or who are unable to fulfil the social and occupational obligations placed upon them by virtue of their limited resources, can properly be regarded as poor' (Black, Morris *et al.* 1980, p159). This is followed up by highlighting that: 'Personal wealth is still concentrated in the hands of small minority of the population', indicating that, in the authors' view, problems of poverty are directly linked to issues of wealth (see Sinfield 2001). The authors consider that, overall, the available research evidence in this area suggests a variety of factors affected by poverty, but particularly housing, employment, education and family size, all influence health, individually and/or in combination.

The various factors listed above are then situated within the wider socioeconomic context of capitalist society, which illustrates the authors' belief that structural factors are also important for explaining social inequalities in health. The claim made by the report's authors is that much of the variation in individuals' experiences of material factors can be explained in macro-structural terms: 'At what point one chooses to stop the analysis - i.e. what one accepts as an explanatory variable - is a matter of intellectual preference and of the task at hand.' (Black, Morris *et al.* 1980, p165). This structuralist position is significantly influenced by Marxist



theories of political-economy (indeed, although none of Marx's texts are specifically drawn upon, the Black Report does refer to Marx's basic, well-known theories about the economy).

The kind of materialist-structuralist perspective supported by the authors of the Black Report (Black, Morris et al. 1980) is evident in a great deal of the research on health inequalities that has been undertaken since (e.g. Whitehead 1987; Scott-Samuel and Blackburn 1988; Watt 1996; Wilkinson 1997; Gordon, Shaw *et al.* 1999; Shaw, Dorling et al. 1999; Mitchell, Dorling et al. 2000; Davey Smith, Dorling *et al.* 2001; Coburn 2004; Graham 2004; Wilkinson 2005; Navarro, Muntaner *et al.* 2006) and there now exists a significant consensus that social determinants of health, factors such as housing, education, employment and the social context within which people live, do affect health (Wilkinson and Marmot 1998; Graham 2004). In this sense, the materialist-structuralist explanation preferred by the Black Report's authors remains a favoured explanation for health inequalities in Britain, to the extent that some authors argue further research to establish this causal link is no longer necessary and that what we now require is an inter-disciplinary approach to illuminate the factors that influence socioeconomic position (Graham 2002). However, there have also been some important critiques of this explanation, one of the most common of which is that material-structuralist approaches fail to fully account for why inequalities in health persist within countries where the material standard of living has significantly increased, such as Britain. An alternative criticism has been that material-structural accounts do not allow much scope for the role of human agency or local contexts in influencing health. Whilst some researchers have attempted to adapt materialist explanations to account for these critiques (e.g. the neo-material perspective put forward by Lynch, Davey Smith *et al.* 2000), others have moved away from explicitly materialist explanations to focus on income inequality (see section 2.3.7).

Despite a significant amount of agreement around the factors which influence health, this split has led to a great deal of debate over the past decade concerning the aetiological pathways via which social determinants influence health. These debates are tied-up with slightly different ontological positions and conceptualisations of health inequalities: whilst some researchers have focused on the health gap between the least deprived and the most deprived and the importance of material wealth and poverty for health (e.g. Scott-Samuel and Blackburn 1988; Gordon, Shaw *et al.* 1999; Shaw, Dorling *et al.* 1999; Lynch, Davey Smith *et*

*al.* 2000; Mitchell, Dorling *et al.* 2000; Davey Smith, Dorling *et al.* 2001; Lynch, Harper *et al.* 2003; Coburn 2004), others have focused on the social gradient of health (see sub-section 2.2.2) and the importance of societal equality for health (e.g. Marmot, Shipley *et al.* 1984; Wilkinson 1997; Wilkinson and Marmot 1998; Subramanian and Kawachi 2003; Marmot 2004; Wilkinson 2005 - this research is discussed in more detail in section 2.3.7). Although these debates have, at times, become quite heated (see, for example, the exchange between Lynch, Harper *et al.* 2003; and Subramanian and Kawachi 2003) the policy implications of each position are not necessarily that different (a point which is discussed in more detail in section 2.4).

#### 2.3.4 Cultural/Behavioural explanations

Under the heading 'cultural/behavioural explanations, the Black Report (Black, Morris *et al.* 1980) refers both to lifestyle-behavioural issues and to the differential use of health services by different social groups. The authors explain the rationale for combining these two approaches lies with the way in which patterns of both lifestyle-behaviours and health service use have been attributed to 'cultural' characteristics:

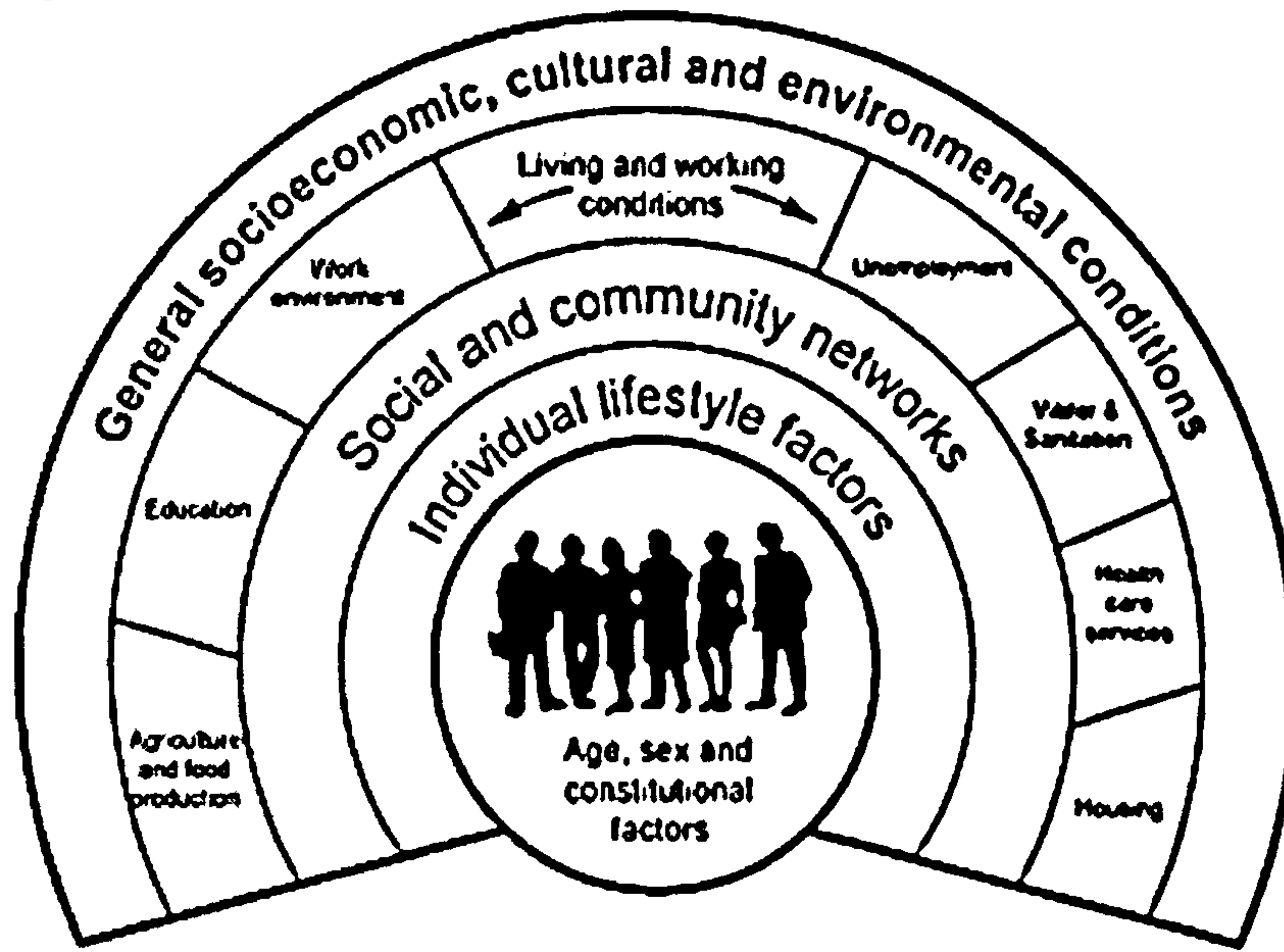
'What is implied [by 'cultural/behavioural explanations'] is that people unwittingly harm themselves or their children by the excessive consumption of harmful commodities, refined foods, tobacco, alcohol or by lack of exercise [...] or by their underutilisation of preventative health care, vaccination, antenatal surveillance or contraception. Some would argue that such systematic behaviour within certain social groups is a consequence only of lack of education, or of shiftlessness, foolishness or other individual traits. More theoretically developed as the basis for cultural/behavioural explanations is the 'culture of poverty' thesis — which has much in common with the idea of 'transmitted deprivation'.' (Black, Morris *et al.* 1980, p166)

Whilst the research data the authors present indicate that the lower classes exhibit both higher-rates of health-damaging lifestyle-behaviours and a tendency to underutilise preventative health services, the authors reject the 'culture of poverty' thesis (which they take to be based on ideas developed by the American anthropologist Oscar Lewis (1967)) in light of a range of criticisms put forward by British social scientists (Rutter and Madge 1976; Holman 1978; Townsend 1979). Instead, the authors (Black, Morris *et al.* 1980, p169) claim 'that what is often taken for cultural variation in cognition' involves a complexity of factors 'which are themselves a reflection of material security and advantage.' Therefore, whilst the



Black Report accepts that lifestyle-behaviours and use of health services play a role in health inequality patterns, it also suggests that these factors are themselves influenced by the wider material-structural environment within which people live. This position is now widely endorsed by many within the health inequalities field and is encapsulated in Dahlgren and Whitehead's famous 'rainbow model', which depicts various 'layers' of influence on individual health (reproduced as Figure 2.2, below):

Figure 2.2: Dahlgren and Whitehead's (1991) 'Rainbow model' of the determinants of health



The above diagram captures the wide variety of influences on health from individual characteristics, which cannot easily be altered, in the centre, through a range of factors which individuals have some control over, such as lifestyle, education and employment, but which all exist within, and are influenced by, the socioeconomic, cultural and environmental context.

In terms of research since the Black Report, very few articles suggest cultural factors are important for explaining health inequalities. One of the rare exceptions is a paper by Sweeting and West (1995) which argues that the notion of 'cultural' influences on health (and on health-relevant lifestyle-behaviours) has been too easily dismissed by the health inequalities research community. Sweeting and West (1995, p163) argue that the role of family in adolescence 'may have more direct effects on health than material factors and, through social mobility, may be indirectly linked to health inequalities in adulthood.' The authors argue that these 'family processes', which operate through other pathways as well as through lifestyle-

behaviours, are expressions of 'cultural influences', and conclude by suggesting that health inequalities researchers ought to revisit this explanation. In terms of other ways in which ideas included in the Black Report's 'cultural/behavioural explanations' have developed since 1980, it makes sense to deal with lifestyle-behavioural and health service-based explanations separately, so the following two sub-sections deal with each in turn.

### 2.3.5 Access to, use of and quality of health services

Although the Black Report only includes 'use of health services' in its 'cultural/behavioural explanation' of health inequalities, chapter four of the Report also discusses variations in both access to and use of health services by different groups and in the quality of care provided by NHS services. As research which explores the role of health services in explaining health inequalities tends to focus on all three of these issues (access to, utilisation of, and quality of care received from health services), this section will do the same.

Much of the literature in this area, including the Black Report discussion, draws directly on the work of Julian Tudor Hart who, in a widely cited article in the *Lancet* (Tudor Hart 1971), outlines his belief that an 'inverse care law' exists in Britain:

*'In areas with most sickness and death, general practitioners have more work, larger lists, less hospital support and inherit more clinically ineffective traditions of consultation than in the healthiest areas; and hospital doctors shoulder heavier case-loads with less staff and equipment, more obsolete buildings and suffer recurrent crises in the availability of beds and replacement staff. These trends can be summed up as the inverse care law: that the availability of good medical care tends to vary inversely with the need of the population served.'* (from p113 of Black, Morris *et al.* 1980)

The 'inverse care law' thesis suggests that, even though inequalities in access to health services are likely to make a far greater contribution to patterns of health inequalities in countries that do not provide a state-funded health service, it may still play a role in explaining health inequalities within countries that do provide a national health service. When Julian Tudor Hart was able to report, after twenty-five years of providing intensive health care services as a GP in a deprived area of Wales, that premature mortality appeared to be 28% lower in his village than in a neighbouring one with similar levels of deprivation (Tudor Hart, Thomas *et al.* 1991), support for the potential role of health services in reducing health



inequalities in Britain increased further (Watt 2002). Recent research that lends further support to this thesis includes Powell and Exworthy's (2003) analysis of NHS policies, which indicates that equal access to health care is still far from a reality in Britain, and Benzeval and Judge's (1996) study, which suggests that considerable inequalities remain in access to GP services in England.

Research exploring health service interventions in relation to specific health conditions, such as coronary heart disease (CHD), also sheds light on the potential role of health services in explaining health inequalities. For example, research based in Scotland (Pell, Pell *et al.* 2000) demonstrates a link between socioeconomic deprivation and waiting times for cardiac surgery. In seeking to explain this link, the authors (Pell, Pell *et al.* 2000) suggest deprived patients are less likely to be investigated or offered surgery once CHD has developed, despite the fact that this social group is more likely to develop CHD in the first place. Very similar findings were made by researchers studying the treatment of CHD in Rome, where a national health service is also available, (Ancona, Agabiti *et al.* 2000). Research such as this demonstrates that socioeconomic status may play an important role in accessing health services and, in turn (as CHD is a major cause of morbidity and mortality in Britain) to overall health inequalities.

However, these studies have been published against a backdrop in which claims made about the limited public health contribution of health services had become extremely popular: for example, McKeown's (1976) famous book emphasises the role of wider social and environmental determinants of health and criticises the notion that health services can effectively tackle public health issues. The book is cited in the Black Report and appears to have influenced the authors' conclusion that the role of health services is not likely to be a significant explanation for health inequality patterns. This belief has apparently continued to dominate the perceptions of many health inequalities researchers, most of whom (as discussed in section 2.3.3) agree that wider social determinants of health, largely beyond the control of the NHS, are more important for understanding patterns of health inequality in Britain than health services (e.g. Macintyre 2000).

In response to this consensus view, Bunker (2001, 2001) has recently assembled the case for the importance of clinical medicine, claiming that medical advances in the second half of the



twentieth century have significantly contributed to improved health and quality of life. Bunker's riposte to those who doubt the importance of health care for explaining patterns in health outcomes has been well-received by some, particularly those based in the medical profession (e.g. Watt 2002). Added to this, renewed interest in the role of health services in explaining health inequalities may well emerge as a result of recent increases in non-optional costs for patients using the NHS (e.g. prescription charges, which have recently been phased out in Wales but which remain in place in Scotland and England) and also as there are steady increases in the number of people opting for private health care.

Whether or not one subscribes to the idea that health services play a significant role in the production of health inequalities, the policy implication that it is important to ensure that access to, and quality of, care provided by NHS-commissioned bodies is equally available to everyone in the population is not one that is likely to be challenged. However, the disputes around this explanation do not provide much clarity in terms of suggesting a suitable division of investment between healthcare services and preventative interventions. Evidence that an inverse care law exists (Tudor Hart 1971; Tudor Hart, Thomas *et al.* 1991; Watt 2002) and that health services have provided major public health improvements in the past twenty-five years (Bunker 2001) provide support for increased investment in the NHS as a means of tackling health inequalities; whereas research which suggests 'upstream', social and structural determinants provide the key to explaining health inequalities (McKeown 1976; McKinlay 1979; McKinlay and Marceau 1999) suggests it is far more important to invest in interventions to tackle wider determinants than in healthcare services.

### 2.3.6 Lifestyle-behaviours

Although the authors of the Black Report (Black, Morris *et al.* 1980) clearly believe lifestyle-behaviours, such as diet, exercise, alcohol consumption and smoking, all contribute to health inequality patterns in Britain, they quickly reject this as a *sufficient* explanation for health inequalities on the basis that lifestyle-behaviours are significantly affected by the socio-economic contexts within which people live. For example, the Report concludes that people are more likely to be able to give up smoking if they have the resources to 'find compensatory means of fulfilling the needs which smoking satisfies' and that smoking should be seen as 'an epiphenomenon, a secondary symptom of deeper underlying features of economic society,' rather than a fundamental cause of ill-health (Black, Morris *et al.* 1980, p191).



The idea that social and economic context have an important influence on people's lifestyle-behaviours is present in a great deal of the research undertaken since. For example, Graham (1987) suggests that women in lower social classes smoke more because their lives are comparatively more stressful than women further up the social scale (see also Lynch, Kaplan *et al.* 1997a). It is from this perspective that some researchers claim attempts to place responsibility for health with individuals, through a focus on lifestyle-behaviours, constitutes nothing less than 'victim blaming' (Crawford 1977; Kelly and Charlton 1992; Stott, Kinnersley *et al.* 1994). Overall, despite a wealth of research linking various diseases, or poor health outcomes, to particular lifestyle-behaviours (e.g. Colditz 1990; James, Nelson *et al.* 1997; Cummings and Bingham 1998; Drake 2001), few researchers argue that interventions designed to improve lifestyle-behaviours offer a potential solution to health inequalities. Instead, many believe that programmes which aim to improve people's lifestyle-behaviours tend to bestow greater health benefits on wealthier groups than they do on deprived people and, therefore, may actually contribute to a widening health gap (Whitehead 1987).

The lack of support for lifestyle-behavioural interventions is further underpinned by a range of assessments that demonstrate interventions which have attempted to improve health and reduce inequality by promoting lifestyle changes have been remarkably unsuccessful. For example, a study looking at the social distribution of cardiovascular disease risk factors among men in England between 1984 and 1993 (a period in which there was a large-scale government effort to highlight the importance of lifestyle choices for health) found no link between changes in risk factors and the widening inequalities in cardiovascular mortality rates that had occurred during the same period (Bartley, Fitzpatrick *et al.* 2000). Similarly, evaluations of the Heartbeat Wales initiative found that, despite an unexpectedly rapid uptake of health promotion activity, there was no significant net effect on cardiovascular health when compared with control areas (Tudor-Smith, Nutbeam *et al.* 1998). An earlier assessment of the impact of the American Multiple Risk Factor Intervention Trial was equally negative (Multiple Risk Factor Intervention Trial Group 1982). However, a recent book edited by Robert Hornik (2002) presents evidence from several observational studies that have taken place in a range of different countries, which suggest that health promotion campaigns can lead to significant behavioural change (although it does not suggest that these changes will



necessarily result in reductions in health inequalities). In addition, a recent study (Bauld, Judge *et al.* 2007) of some NHS stop smoking services suggests that they have made a contribution to reducing health inequalities in England, albeit a relatively modest one. However, a study of the effects of smoking cessation programmes in New Zealand (Thompson, Pearce *et al.* 2007) claims the increasing stigmatisation of smoking, coupled with the spatial segregation of some disadvantaged communities, may be contributing to the production of 'smoking islands', in which tobacco use is reinforced rather than discouraged.

At a more theoretical level, the central concept that certain lifestyle-behaviours constitute health 'risks' has been criticised for transposing epidemiological associations derived from whole populations onto individual lives (Davison, Frankel *et al.* 2003). Indeed, although the evidence that smoking, excessive alcohol consumption and abuse of drugs all have negative health consequences is relatively strong, the evidence on the health effects of other lifestyle-behaviours, such as diet and physical exercise, is far less clear-cut (e.g. Gard and Wright 2005). Certainly within the field of health inequalities in Britain, research exists which claims to demonstrate the limited contribution of lifestyle-behaviours to explaining inequalities in adult health (e.g. Barker 1989) and data from Northern Italy (De Vogli, Gnesotto *et al.* 2005) suggest that conventional risk factors do not always show a social gradient even when a social gradient in overall life expectancy exists.

Alongside this, however, research also exists which suggests conventional 'risk factors' do explain the social gradient of health for particular diseases. For example, after examining data from the Whitehall cohort study and the London cohort of a WHO multinational study of vascular disease, Chaturvedi and colleagues (Chaturvedi, Jarrett *et al.* 1998) found most of the social gradient in cardiovascular disease could be explained by smoking and high blood pressure, leading them to conclude conventional risk factors provide the key to reducing the social gradient in health for cardiovascular disease. Additionally, Professor Sir Richard Peto (1993, 1994) has long argued that if conventional health risk factors are properly accounted for in epidemiological studies (i.e. that *all* known conventional risk factors are incorporated into studies, rather than focusing on one risk factor in particular), then these factors do largely explain patterns of health inequality. This does not, however, challenge claims that effective



interventions to tackle these issues need to consider the social, cultural and economic contexts within which individuals are situated.

Interestingly, two of the authors closely associated with neo-materialist theories of health inequality, John Lynch and George Davey Smith (see section 2.3.3), have recently argued that: 'Conventional risk factors explain the majority of absolute social inequality in CHD [coronary heart disease] because conventional risk factors explain the vast majority of CHD cases in the population' and therefore, that: 'If the concern is to reduce the overall population health burden of CHD and the disproportionate population health burden associated with the social inequalities in CHD, then reducing conventional risk factors will do the job.' (Lynch, Davey Smith *et al.* 2006, p436). At a glance, these statements seem to represent a shift away from the authors' previous concern with material and structural determinants. However, whilst Lynch, Davey Smith and colleagues (2006) overtly claim that reducing conventional risk factors will help tackle inequalities in CHD, they do not claim that these risk factors can be tackled through interventions which focus solely on lifestyle-behaviours and, furthermore, they make this claim only in relation to CHD and not other types of health inequality.

Overall, it is rather unclear what the policy implications for health inequalities of research around lifestyle-behaviours might be. There is a great deal of support for the idea that interventions focusing on reducing particular lifestyle-behaviours, particularly smoking, excessive alcohol consumption and drug use, will, if successful, result in overall population health improvement. Whether or not they are successful, and whether they reduce health inequalities, is likely to depend on how policies are implemented and the research evidence does not appear to provide clear guidance for policymakers wishing to know which type of approaches are likely to succeed (although the recent legislative changes on smoking in public places may shed further light on this). In relation to less well understood 'risk factors' such as diet and physical exercise, the evidence that successful interventions will necessarily lead to significant health improvement is more controversial (Gard and Wright 2005). Widespread belief amongst the research community that lifestyle-behavioural factors are influenced by wider social determinants suggest that to effectively tackle health inequalities, it may be more sensible to focus interventions on wider social determinants than on lifestyle-behaviours alone (Whitehead 1987). However, the lack of evidence to clarify which

determinants are most important, or how they might be effectively tackled, means the policy 'messages' on this front remain rather unclear (Macintyre 1997; Macintyre 2003b).

### 2.3.7 *The income inequalities hypothesis & psychosocial explanations*

This sub-section moves on to explore approaches to health inequalities in Britain that were not included in the Black Report's (Black, Morris *et al.* 1980) four key explanations. It is important to acknowledge that not all of these approaches are completely new; indeed many are present in some form in the Black Report and/or research that was published around the time of the Black Report, as we shall see, but were not put forward by the authors as potential explanations. As already briefly mentioned in section 2.3.3, criticisms of material-structural approaches have resulted in some researchers focusing on the importance of equality, rather than material wealth and poverty (Wilkinson 1997; Wilkinson and Marmot 1998; Kawachi, Kennedy *et al.* 1999; Marmot 2004; Marmot 2005; Wilkinson 2005; Pickett and Wilkinson 2007).

Pioneered by Richard Wilkinson, the 'income inequalities hypothesis' suggests that, beyond a certain basic level of wealth, health is more closely linked to how egalitarian a society is than to national economic performance or specific levels of poverty. This hypothesis has contributed to an increasing interest in 'psychosocial' explanations of health inequalities (Wilkinson 2004; Wilkinson 2005), a concept which shares much with the simultaneously emerging idea of 'social capital' (Putnam 2001). For both concepts, significant focus is placed on social interaction and support networks in determining health (and other beneficial) outcomes. Psychosocial accounts of health inequalities accept that social determinants influence health and suggest that much of this influence occurs through psychosocial pathways, which are also affected by the wider context of society. Simplistically, the idea is that the experience of being poor in developed countries is likely to be worse for individuals who live in a society where many people are significantly wealthier than they are, than it is for those who experience similar levels of poverty but who live in a more egalitarian society. Much of the research on psychosocial pathways focuses on the workplace and how a sense of control, security and esteem in the workplace influence health outcomes (e.g. Marmot, Bosma *et al.* 1997; De Vogli, Ferrie *et al.* 2008).



Psychosocial approaches to explaining health outcomes are not necessarily completely new. For example, in the late 1970s, Brenner (1973, 1976, 1977) published a series of articles and reports outlining the effect of recessions on mortality rates in the USA. His research suggested periods of significant economic stress lead to (delayed) increases in mortality rates, particularly in relation to cardiovascular and liver disease and suicide and homicide rates. Brenner posits that the effects of unemployment in economic recessions influence health through their impact on individual stress levels. Brenner's work is cited in the Black Report (Black, Morris *et al.* 1980, pp163-164) but is not thought to be particularly helpful by the authors, who dismiss the notion that 'stress' may provide an aetiological pathway through which the macro-economy influences individual health as 'somewhat ubiquitous'. However, since 1980, a great deal more research has been undertaken to develop ideas about psychosocial pathways.

Initially, there was a surge of interest in the effects of work-related psychosocial impacts on health in Sweden, with several studies reporting that work environments and arrangements (shift patterns, etc) appear to have an impact on rates of myocardial infarction (heart attack) (e.g. Theorell and Floderus-Myrhed 1977; Alfredsson, Karasek *et al.* 1982). Around this time, interest in the effects of employment and working conditions also increased in Britain and the first of the two Whitehall studies, one of the most famous investigations to invoke a psychosocial approach to health differences, began. This project explores varying levels of health outcomes for civil servants positioned at different levels within the Whitehall hierarchy, which demonstrates an inverse social gradient between health outcomes, such as CHD mortality rates, and employment status (Marmot, Shipley *et al.* 1984; Marmot, Bosma *et al.* 1997). A great deal of analysis has been undertaken on the data arising out of this project, much of which suggests, whilst differences in individual lifestyles and personal characteristics contribute to the gradient, they also leave a significant amount of the difference unexplained. As a means of explaining the remaining differences, the researchers involved, and particularly Marmot, have highlighted the importance of status and individual sense of control. For example, Marmot and colleagues (Marmot, Bosma *et al.* 1997) claim the results from the second Whitehall study demonstrate that sense of control at work is a major contributory factor in explaining CHD, and De Vogli and colleagues (De Vogli, Ferrie *et al.* 2008) use the data to show that perceptions of unfairness are associated with increased coronary events



and other negative health outcomes. This work has contributed to the development of psychosocial explanations of health inequalities. In addition, Eric Brunner and others (Brunner 1997; Davey Smith, Ben-Shlomo *et al.* 2005; Chandola, Britton *et al.* 2008) have tried to explore the biology of the relationship between stress and health by examining variations in a range of biological variables associated with stress, such as the hormone cortisol.

Some researchers now regard the psychosocial approach to health inequalities as an accepted theory (Bartley, Sacker *et al.* 2000), perhaps even a new paradigm (see Elstad 1998), but it has not gone un-criticised. MacLeod and Davey Smith (2003), for example, argue that verification of psychosocial links to health is limited and that evidence of the effectiveness of psychosocial interventions in reducing health inequalities is 'non-existent'. Instead, the authors suggest that 'psychosocial factors' may seem to explain health inequalities because they provide a better measure of socioeconomic circumstance than previously used measures. In particular, they criticise the use of self-reported health as an outcome measure for health, arguing that people who feel miserable may be inherently more likely to also feel 'sicker'. As well as making direct criticisms of this body of research, the authors are also concerned that psychosocial accounts of health inequalities may be (ab)used by policymakers to highlight the importance of unhealthy 'feelings', subsequently locating the responsibility for health at an individual level, rather than taking the more structural approach preferred by MacLeod and Davey Smith.

Despite the antagonistic nature of much of the debate between psychosocial and materialist researchers, as mentioned in section 2.3.3 (and, shortly, in more detail in 2.4), the policy implications of material-structural and psychosocial accounts of health inequalities are not necessarily different, particularly where a relative concept of poverty is invoked. Indeed, in many ways psychosocial theories about health inequalities appear to link structural and material explanations, for they imply that material factors contribute to health outcomes but that their effect on individuals is related to the context in which individuals are located. Recent publications suggest more agreement about these intertwined factors is beginning to emerge (e.g. Dorling, Mitchell *et al.* 2007). At a simplistic level, both suggest highly unequal societies, where extremes of poverty and wealth are accommodated, are likely to result in significant inequalities in health.



### 2.3.8 *The life course and the importance of early years in life*

One approach to understanding health inequalities which has held particular sway over the past fifteen years or so is the life course perspective. This is not, in itself, an aetiological explanation for health inequalities; rather, it is a perspective which suggests that it is essential for theories about the causes of health inequalities to consider the importance of timing and to think about the whole life course, rather than just particular points within it. Taking a life course perspective therefore involves considering the various risks that individuals are exposed to across their life courses, from foetal development through to old age. This is particularly important for chronic diseases, many of which are known to have long latency periods (Lynch and Davey Smith 2005).

In some ways it is surprising that a life course approach took so long to significantly influence health inequalities research. As with psychosocial theories, life course approaches to health inequalities were around, in some sense, well before 1980. For example, the Black Report itself (Black, Morris *et al.* 1980) employs the 'life cycle' to discuss health inequalities, comparing and contrasting health patterns at different times across the life course, particularly emphasising the importance of childhood. The Report also refers to Birch and Gussow's (1970) theory that cumulative hazards during foetal development and the early years of life have significant impacts on later health. In a recent overview of life course approaches to chronic disease, Lynch and Davey Smith (2005) suggest the history of life course thinking in epidemiology in Britain dates back even further, to research in the 1930s which demonstrated cohort patterns in mortality, indicating that the health of each successive generation is affected by significant events within the period through which they live (Kermack, McKendrick *et al.* 1934). Despite these examples, a tendency to focus on the age group within which premature death from chronic disease occurs (late-middle age) in epidemiological research meant life course perspectives on health inequalities research were largely absent between the 1960s to the end of the 1980s (Lynch, Davey Smith *et al.* 2006). Then, from the early 1990s onwards, studies highlighting the importance of foetal development for health outcome later in life (Barker 1989; Barker 1992) led to renewed discussions about the ways in which experiences at various stages of the life course influence health.

Initially, David Barker's hypothesis that health outcomes in later life are significantly influenced by experiences in the early stages of life, as far back as foetal development (Barker 1989, 1992; Barker, Eriksson *et al.* 2002), met with some resistance from those who felt this suggestion implied that health outcomes in later life were effectively pre-determined and largely unalterable. As the early research in this area had not been able to distinguish between influences on chronic disease stemming from early risk exposures and risk exposure which occurring later in life, it was suggested that Barker's research findings may result from the fact that those babies who experience heightened risk-exposures in their early years of life (leading to low birth weight, etc) are likely, through social circumstance, to also experience heightened risk exposures later in life (Ben-Shlomo & Davey Smith 1991). One outcome of the ensuing discussions has been a renewed interest in the importance of the life course. By the time Kuh and Ben-Shlomo's (1997) book, *A Life Course Approach to Chronic Disease Epidemiology*, was published, life course approaches were firmly on the health inequalities research agenda.

The evidence-base for this approach is multi-disciplinary, incorporating research on social inequality and social exclusion, and often invoking a range of the approaches to health inequalities discussed in this chapter. Indeed, the importance of the life course for health inequalities has not, so far, been subject to serious critique, possibly because it is able to sit alongside existing theories about health inequalities, rather than challenging them. Research invoking a life course perspective has expanded rapidly (e.g. Bartley, Blane *et al.* 1997; Davey Smith, Hart *et al.* 1997; Lynch, Kaplan *et al.* 1997a; Lynch, Kaplan *et al.* 1997b; Wadsworth 1997; Benzeval, Dilnot *et al.* 2000; Berney, Blane *et al.* 2000; Graham 2002), with two relatively recent overviews of theories about health inequalities both taking a life course approach (Davey Smith 2003; Asthana and Halliday 2006).

Within this body of work there have, however, been disagreements about whether all periods of the life course are equally important or whether specific periods are particularly critical. Those who focus on the accumulation of risk exposures across the life course (e.g. Davey Smith, Hart *et al.* 1997; Lynch, Kaplan *et al.* 1997a) claim it is the total amount of exposure to risk that is of most importance, whereas those who support the critical period model, claim there are particular periods of the life course, such as childhood, during which exposure to



certain risks is likely to be far more influential (e.g. Duncan, Yeung *et al.* 1998; Forsen, Eriksson *et al.* 2000).

Policy implications from both schools' point of view are that interventions which aim to change patterns of health inequality are likely to require a long-time to demonstrate effect, and that effective interventions require consideration of the whole life course, not just the period at which people are most at risk of premature mortality. Those who subscribe to the critical periods of life model would also suggest there are particular stages at which interventions are likely to be most effective, such as during pregnancy, childhood and various 'transition' stages (e.g. the move from education to employment). Although the researchers who favour an accumulative approach to life course would not necessarily support the notion of critical periods, their research does not suggest a policy focus on critical periods would necessarily be negative.

### 2.3.9 *The role of context or 'place'*

An issue which has been far more divisive amongst the health inequalities research community is the extent to which contextual effects contribute to health inequalities. Until recently the dominant approach to understanding regional variations in health was based on the study of individual characteristics (see 2.2.1) but, as mentioned earlier, over the past two decades, there has been an increasing interest in the importance of 'place' (see Gatrell 2002). The MRC's Social and Public Health Sciences Unit in Glasgow has led the way in research which considers the role that 'neighbourhood' might play in explaining health inequalities (Macintyre, Maciver *et al.* 1993; Ellaway, Macintyre *et al.* 2001; Macintyre, Ellaway *et al.* 2002). However, in direct contrast to this body of work, Sloggett and Joshi's (1998) analysis of data from the Longitudinal Study, and Andrew McCulloch's (2001, 2001) analysis of data from the British Household Panel Survey and the 1991 Census, both conclude that contextual contributions to patterns of health inequalities are small once individual factors have been adequately accounted for (see also Pickett and Pearl 2001).

Academics whose research favours the importance of people rather than places have criticised the use of research highlighting the importance of contextual effects to support area-based policies to tackle health inequalities, arguing that as health inequalities are a national problem, they require a national, people-based solution (e.g. Gordon 2000; Mitchell, Dorling *et*

*al.* 2000). Even academics who support the idea that context affects health do not necessarily agree that area-based policy initiatives are likely to provide an effective solution (Lupton 2003). Indeed, there is some consensus that area-based policies can only have limited (if any) success in reducing health inequalities because such policies 'miss' all the poor people who do not live in targeted areas (most poor people do not live in poor areas; and most of the people who live in these areas are not poor) (Mitchell, Dorling *et al.* 2000; McLoone 2001; Tunstall & Lupton 2003). In other words, responses to health inequalities which involve targeting people in poor areas rely on a conceptualisation of health inequalities as a 'health gap' or an issue of 'health disadvantage' and not as a 'social gradient'. Furthermore, as a recent report by the World Health Organisation's Commission on Social Determinants of Health (Commission on Social Determinants of Health 2007, p50) points out, 'this approach does not commit itself to bringing levels of health in the poorest groups closer to national averages. Even if a targeted programme is successful in generating absolute health gains among the disadvantaged, stronger progress among better-off groups may mean that health inequalities widen.'

Several academics have noted that contrasting 'contextual' and 'compositional' approaches is something of a false dichotomy, as it is impossible to separate people from contexts (Gatrell 2002) and many possible influences on health could be considered part of either or both categories (Macintyre, Hiscock *et al.* 2000). An increasing interest in 'social spaces' has blurred the context-composition division further (Smith and Easterlow 2005). Overall, researchers seem to agree that contextual factors do influence health inequalities, but that this influence is inter-linked with individual determinants and broader structures. As a result, a consensus is now emerging that, rather than there being 'an area effect', different contexts have different effects on different people. Recently, rather than solely focusing on trying to identify contextual factors with health damaging influences, work has begun to try to identify the factors that might contribute to individuals' resilience to health damaging contexts (e.g. Doran, Drever *et al.* 2006; Tunstall, Mitchell *et al.* 2007). However, the 'messages' for policy regarding this work are, as yet, unclear given the newness of research in this area. The following section now turns to the more general 'messages' for British policy that can be gleaned from the research on health inequalities.



## 2.4 What, if any, 'policy messages' emerge from the research-based debates?

The first point to highlight about the field of health inequalities research is, as section 2.2 illustrates, that the term 'health inequalities' is extremely slippery and can be interpreted in a number of different ways. To begin with, there are many different types of health inequality but the focus on socio-economic and geographical inequalities in health in this chapter reflects the dominance of these forms of health inequality within the UK research literature. Yet, other forms of health inequalities, particularly health differences between different ethnic groups and between men and women, are also clearly visible in the research literature and should not be forgotten. In addition, all of these different types of health inequality can be conceptualised in different ways: as issues of 'health disadvantage', 'health gaps' or as 'social gradients in health' (Graham & Kelly, 2004). These differences – both in terms of type and conceptualisation – are fundamental as the research literature provides different messages depending on the way in which health inequalities are defined. So, the first policy 'message' to flag up is that it is important to carefully define and reflect upon the nature of the perceived policy problem as this will affect the kinds of messages that the research literature provides in relation to potential policy responses and interventions. Without careful delineation, the fuzziness of the term 'health inequalities' has the potential to allow (or even promote) a sense of confusion.

Moving on to consider the messages that research on socio-economic and geographical differences in health provides for UK policymakers, it is important to acknowledge that the nine approaches to understanding health inequalities outlined in the previous section are by no means mutually exclusive and many researchers draw on a variety of theories to explain their findings. For example, Bartley and colleagues (Bartley, Sacker *et al.* 2000) use a combination of material-structural, lifestyle and psychosocial ideas to explain changes in women's health in recent years. The development of multilevel modelling over the past two decades is also allowing researchers to more easily consider the importance of a variety of variables at the same time, including both collective and individual characteristics. However, there clearly are competing ideas about health inequalities and this, in a way, is another of the 'messages' for policy that the research offers (albeit not a particularly helpful one). There are, however, some areas of consensus within these disagreements and it is these messages that this section tries to pull out, in order to highlight how the research suggests policymakers



might effectively contribute to reducing health inequalities in the UK. It should, of course, be acknowledged that health inequalities are not always perceived to be a policy problem by governments. Indeed, as the previous chapter outlines, they have not always been an accepted policy problem within the UK. However, given the official commitment to reducing health inequalities in Scotland and England during the period of interest to this thesis, this section focuses on the messages that the research seems to offer to policymakers who are already committed to tackling the issue.

Starting with explanations for health inequalities which are clearly contested, neither 'genetic' nor 'cultural' accounts of patterns of health currently have a great deal of support in the research community (see sections 2.3.2 and 2.3.4). However, interest in both positions appears to be increasing so, whilst there are no clear policy implications from these perspectives at the moment, this situation may change. In terms of the role that context might play in influencing health, the consensus seems to be that contextual effects have a small but significant role in explaining patterns of health inequality. This provides some support for policy interventions to improve the environments or neighbourhoods which exhibit poor health, but does not suggest that these types of interventions are likely to dramatically reduce health inequalities overall, as such interventions will inevitably 'miss' most of the population (including most poor people), as discussed in sub-section 2.3.9.

Explanations which appear to have a significant amount of support within the research community, but for which there are also important critiques, include the role that health services play (2.3.5) and Barker's hypothesis about the importance of foetal development for explaining patterns of inequality in adult health (discussed in 2.3.8). Whilst controversies about both of these approaches imply that policy implications are unclear, there is no research to suggest policy interventions to improve equity of access to, and care provided by, health services are likely to have any negative consequences for health inequalities, only that they may not significantly reduce these inequalities. The same is true of interventions that are likely to arise from an acceptance of Barker's hypothesis on foetal development; there is no research to suggest interventions to improve conditions for pregnant women are likely to have any significantly negative implications, only that this might not be the best way of tackling existing patterns of health inequalities.



Moving on to theories for which there appears to be a significant level of consensus, there is agreement, firstly, that a social gradient of health exists (see sections 2.2.2 and 2.3.7). Although this has been the case for some time, a great deal of health inequality research has continued to focus on 'health gaps' between the most and least deprived in society. However, there has recently been a shift towards focusing on the gradients which traverse the whole of society and the rationale underlying this shift is not significantly disputed (2.2.2). The message for policymakers here, then, is that tackling health inequalities comprehensively requires policies which focus on achieving societal, rather than targeted, changes. This is, however, probably easier to articulate than to put into action, especially given that many researchers have also yet to make this shift. Secondly, the importance of taking a life course perspective on health influences is also largely undisputed (2.3.8), which suggests a long-term policy perspective is required, rather than one which focuses interventions on those most immediately at risk of chronic disease. Thirdly, there is widespread support for the idea that lifestyle-behaviours influence health but that interventions focusing on trying to alter lifestyle-behaviours have, where they have had any effect at all (2.3.6), tended to widen health inequalities (although, as discussed, some recent evidence (Bauld, Judge *et al.* 2007) suggests that smoking cessation programmes may be an exception to this). The messages for policy to emerge from the consensus in this area are, however, less clear than for some other issues. The research does not provide enough evidence to conclude that it is impossible to reduce health inequalities through lifestyle-behavioural interventions but it does indicate that repeating previous approaches to trying to change lifestyle-behaviours is highly unlikely to reduce health inequalities (and may well widen them). The 'message' here relates to the fourth area of consensus, which is that wider determinants, such as employment, housing and education, all influence health inequalities. However, the routes through which this influence occurs remain unclear. Some researchers claim wider determinants are important because they directly influence health (2.3.3), whilst others claim wider determinants are crucial because of their links to lifestyle-behavioural patterns (2.3.6), and yet others suggest psychosocial pathways provide the main mechanism for their influence (2.3.7). The differences in these explanations have led to a great deal of discussion and debate within the field of health inequalities. Yet, in terms of policy implications, all of these approaches could be used to support the idea that it is essential to tackle variations in the social and economic



determinants of health if health inequalities are to be significantly reduced. Furthermore, as sub-section 2.3.7 mentions, recent publications suggest the differences between those promoting more material approaches and those focused on psychosocial pathways may now be lessening (Dorling, Mitchell *et al.* 2007).

Overall, therefore, by taking a step back from the various ideas and debates, it is possible to argue that there is less disagreement about the most effective ways of tackling health inequalities through policy than first appears. The majority of research-evidence seems to suggest that structural and material factors are an important cause of health inequalities. Many of the differences between the various approaches relate only to the precise nature of the causal pathways which link these determinants to health. So, whilst structural explanations focus on the direct influences of material and structural factors on health outcomes, psychosocial approaches can also be used to advocate for the need to make structural changes. Similarly, both sides of the 'context versus composition' debates have tended to focus on structural explanations – the difference here has been that compositional approaches tend to highlight nationally-based structures, whereas contextual research places the spotlight on local structures. Even the lifestyle-behavioural approach has been linked to structural factors through research which focuses on the capacity of individuals to 'choose' to adopt healthy lifestyles in the first place. So whilst Wagstaff *et al* (2001) use a conceptual framework which purports that health is determined by people's usage of health services and their lifestyle-behaviours, they acknowledge that these factors are in turn determined by underlying structural determinants, such as income and education.

The need for having some sort of structural dimension to health inequalities solutions is generally apparent in recent overviews of the field (e.g. Adams, Amos *et al.* 2002; Davey Smith 2003; Asthana and Halliday 2006). The fusion of the various approaches is summed up well by Dahlgren and Whitehead's (1991) famous 'Rainbow Model' (see Figure 2.2), which incorporates the various factors affecting health, placing individual biological factors at the centre and the wider societal factors at the outer edge. Lifestyles, social networks and living and working conditions are all placed in-between, indicating both that these factors are inter-linked and that they are all encompassed by broad *structural* factors.



Having highlighted the apparent consensus, it is necessary to acknowledge that there is an absence of experimental evidence to support claims that radical structural solutions (such as any large-scale redistribution of wealth) would be the most effective means of tackling health inequalities (although some international comparisons do support this claim, e.g. Navarro, Muntaner *et al.* 2006; Navarro 2007). This gap is important given the emphasis that some approaches to reviewing evidence for policy place on the experimental designs (e.g. Hadom, Baker *et al.* 1996); an emphasis which is returned to later in the thesis. For some researchers, the lacuna of research in this area is something that can and should be tackled so that a more transparent and informative evidence-base can be developed (e.g. Macintyre 2001; Macintyre, Chalmers *et al.* 2001). However, others argue that the kinds of evidence that are promoted by 'evidence-based' approaches to policy are destined to remain inevitably individualistic and medicalised:

'Despite occasional rhetorical interest in wider determinants of health, evidence based assessments are largely restricted to individualised interventions. The Cochrane Library is unlikely ever to contain systematic reviews or trials of the effects of redistributive national fiscal policies, or of economic investment leading to reductions in unemployment, on health.' (Davey Smith, Ebrahim *et al.* 2001, p185; see also Sonedda 2003).

From the perspective of Davey Smith and colleagues (Davey Smith, Ebrahim *et al.* 2001), policymakers ought to be less concerned about the nature of the evidence to support different claims and more concerned about the ethical and moral dimensions of policy decisions. Yet, even if policymakers decided they were fully convinced of the need to tackle structural and/or material determinants of health, the available research provides little guidance for policymakers as to *which* determinants warrant the most attention. Furthermore, as will be clear from the above overview, evidence of effective interventions is limited in health inequalities research; the accounts tend to focus on how to 'explain' the existence of health inequalities, rather than how health inequalities might best be reduced. So, whilst the majority of research on health inequalities suggests that structural and material factors are an important underlying cause of health inequalities, hardly any evidence exists to indicate what kind of interventions would be most effective in tackling these issues. This is problematic for a policy audience with limited available resources, where investing in one set of interventions is likely to involve not investing in alternative possibilities.

## ***Part III: Methodological approach***

### **Chapter Three: Analysing policy documents**

#### **3.1 Introduction to the Chapter**

In order to understand the relationship between research and policy for any issue it makes sense to analyse both 'policy' and 'research' relating to the issue. However, defining what counts as 'policy' is not necessarily straightforward. It is a term which may be understood in a variety of ways and at a range of levels, from broad ideological directions (e.g. 'capitalist policy'), to programmes of activity (e.g. 'housing policy'), to particular kinds of policy statement (e.g. specific White Papers). All of these conceptions of policy are relevant to this thesis but, for the purposes of this methodological chapter, it is the latter use of the term which is most pertinent as this chapter focuses specifically on the aspects of the research which are based on analysing national policy statements.

Written texts form an important part of social worlds in all literate societies and are often under-analysed compared to research that focuses on interactions with people (Atkinson & Coffey 2004). Public policy statements, of the kind analysed in this thesis, are a distinctive kind of text which frame the nature of public policy problems, shape the boundaries of possible responses and act as points of reference for a wide variety of actors to justify subsequent actions. As Iannantuono and Eyles (1997, p1620) point out, policy documents should not be viewed as a compilation or consensus of facts (even though the language employed within them may well suggest this is what they are) but as 'a soup of assumptions that recreate our picture of the world.' As a result of their (usually anonymous) authorship, policy documents are able to impose a particular kind of power through the words they use because they represent a dominant account of truth. What seems to be presented as fact within policy statements often represents policy decisions which, in turn, may be based on implicit assumptions. In order to understand policy documents more fully it is helpful to try to unravel the decisions and assumptions they encapsulate (Iannantuono & Eyles 1997). There are various different ways in which one might attempt this and, as this chapter demonstrates, I incorporated a range of techniques into my own approach. Before discussing this, however, it is important to outline the process involved in deciding *which* documents to analyse.



Since 1997, both the UK government and the Scottish Executive have published a large number of statements of direct relevance to health inequalities. Indeed, there are so many such documents, especially within England, that it was necessary to construct some clear boundaries for inclusion in order to produce a manageable list of documents to analyse. With this in mind, I decided generally not to include consultative documents (such as Green Papers) or advisory documents (such as the Acheson or Kerr reports) in the documentary analysis, even though I did read these kinds of documents and they therefore do inform the thesis. This decision was taken on the basis that my aim was to explore how health inequalities are framed and understood as a policy problem and how research has informed (or been informed by) this process. Whilst consultative and advisory documents are highly likely to contribute to eventual conceptions of health inequalities, they do not represent the *outcome* of policy decisions. Rather, they are a stage in the various processes which lead up to policy decisions being made (and a vehicle through which particular approaches and ideas, not all of which are subsequently incorporated, can be tried and tested). My expectation was that, where advisory and consultative documents had been influential in policy outcomes, their influence would be visible in subsequent policy statements. The only exceptions to this were the very first Green Papers on public health to be published under the New Labour government in each country (Secretary of State for Health 1998; and Secretary of State for Scotland 1998); these two documents were included on the basis that they provide the earliest textual insight into how the government was thinking about health inequalities near the beginning of the study period.

Secondly, as a general rule, only documents with a specific and significant focus on health inequalities were included. The only exceptions to this were some statements (in both contexts) which are concerned with policy changes relating to the NHS but which were included in the analysis because they contain important information about policy approaches to health inequalities (often relating to the various national targets which were gradually established - see Appendix X). As policy responsibility for health inequalities lies with the departments of health in both contexts, most of the statements that were included emerged from these departments. However, there were some more cross-cutting statements of relevance in both countries (Social Exclusion Unit 2001; ODPM 2004; Scottish Executive

1999a, 2004c; and the Labour and Liberal Democrat Parties 1999) and these were all included. A full list of the 42 statements (25 from England and 17 from Scotland) that were included in the analysis can be found in Appendix I, which also provides a brief outline of the stated aims of each document, hopefully helping readers to contextualise the data drawn on in this thesis by providing a little more information about why these particular statements were included.

Having outlined the rationale for including (and excluding) particular documents, the main focus of this chapter is to explain the approach taken to analysing these documents. In a wide-ranging review of methods of assessment of the utilisation of health research in policymaking, Hanney and colleagues (Hanney, Gonzalez-Block, *et al.* 2003) conclude that 'documentary analysis' of policies provides a crucial method. Additionally, health policy researchers are increasingly employing 'discourse analysis' as a tool to examine the content of policy messages and isolate the interests and values which appear to have informed policy (e.g. Davidson, Hunt, & Kitzinger 2003; Iannantuono & Eyles 1997).

At this point, it is important to clarify what it is meant (or, at least, what I mean) by some of the key terms listed above for, much like 'policy', the terms 'discourse analysis', 'documentary analysis' and 'policy analysis' have been widely deployed and variously applied by researchers. For the purposes of this thesis, I take 'policy analysis' to signify a broad approach to examining 'policy' (in its various conceptions – not just policy statements). My analysis of policy statements therefore forms a key part of the 'policy analysis' discussed in this thesis but it is not the only source of data; the data from the interviews are also relevant. Both methodological chapters therefore describe techniques which form part of the 'policy analysis' as both shed light on the construction and promotion of relevant policy claims and decisions. However, this chapter focuses specifically on what I shall call 'documentary analysis', by which I mean the analysis of written policy statements. I have purposely avoided the term 'discourse analysis' as a label for my methodological approach to analysing these documents as I am more comfortable employing 'discourse' in a broad, Foucauldian sense, as 'autonomous systems of rules that constitute objects, concepts, subjects and strategies,' and as the means by which different forces advance their interests and projects (Howarth 2000, pp48-49). This decision hopefully helps to avoid confusion with the way in which I employ



discussions of 'discourse' in later chapters (Chapter Eight in particular). There are two provisos to this decision. Firstly, whilst I am not describing my own approach to documentary analysis as 'discourse analysis', I do draw on the work of other authors who describe their methods in this way. Secondly, several aspects of the three-stage framework that I employed, described below, were included with the aim of uncovering underlying assumptions and 'discourses' (or the kinds of paradigmatic/institutionalised ideas discussed in Chapter One). However, as other aspects of the framework take a rather different approach, I did not feel it was appropriate to label the entire endeavour 'discourse analysis'.

### **3.2 Contextualising and describing my methodological approach to documentary analysis**

Exploring language is increasingly recognised as an important approach for researchers interested in social policy (e.g. Collins 2000; Hastings 1999). This interest forms part of a broader 'linguistic turn' in the social sciences, which has seen researchers across a wide variety of disciplines exploring and demonstrating the ways in which language is used (e.g. Blackledge 2002; Chomsky 1988; De Cillia, Reisigl & Wodak 1999; Stibbe 2001). This body of work has contributed to a growing consensus that language does far more than describe; it actively constructs social reality (see, for example, Law & Urry 2004) and as such, in Bourdieu's (1991) terms, constitutes an 'instrument of power'. This 'linguistic turn' within social sciences has seeded a wide range of approaches to analysing language and it would be impossible to do justice to this burgeoning body of work within this chapter. For the purposes of contextualising the work in this thesis, four key genres of analysis seem particularly important. These are: (i) social constructivist analysis; (ii) content or thematic analysis; (iii) linguistic forms of analysis, including conversational and semiotic analysis; and (iv) Foucauldian inspired discourse analysis (including what has become known as critical discourse analysis - see Fairclough, 2000). Many researchers employ (or develop) a particular one of these contrasting methodological approaches. However, I felt that that each offered something unique and constructive to the thesis and I therefore decided to incorporate elements of each.

After experimenting on some of the early policy statements with a range of different approaches, I decided that a thematic form of analysis was most helpful in tracing the possible

influence of the health inequalities research outlined in Chapter Two. This approach, however, reveals little (if anything) about why some research ideas might have been more influential than others. To achieve these kinds of insights, my initial analyses suggested both a social constructivist and a semiotic analysis could be fruitful. The former helps uncover the construction of health inequalities as a particular kind of policy problem is likely to have shaped the influence of research. Developed appropriately, the latter (semiotic analysis) allowed me to pick up on the Foucauldian 'discourses' referred to above. This multifaceted approach to analysing the documents required that every document be read at least three times so that I could focus on analysing each from the three different perspectives. These three stages are now explained in more detail, in the order in which I employed them, before the final sub-section reflects in more detail on the rationale for using this kind of multifaceted approach to the documentary analysis. The penultimate section moves on to reflect on the experience of actually undertaking the documentary analysis, before the final section explains how the documentary analysis supports, and is supported by, the interviews with relevant individuals that are discussed in Chapter Four.

### *3.2.1 Constructivist approach*

Social constructivism was once perceived as a radical position with 'shock value' but, as Hacking (1999, p35) claims, it often now seems rather tired. This is not because social constructivism has been abandoned but rather the opposite; as a broad concept, it has been largely absorbed by social scientists, at least in relation to social phenomenon<sup>9</sup>. So whilst the nineteen-eighties saw much debate about the extent to which social constructivism entailed the idea that everything is constructed<sup>10</sup> and, therefore, that everything can be understood as merely discourse or 'language games' (a view often attributed to Lyotard 1984 [1979]), over the past decade this furore has largely died down. This is perhaps because, as Hacking (1999) notes, it has generally been hard to find anyone who identifies as a 'universal constructivist' and, hence, the aspects of social constructivism which its opponents often find most abhorrent are, in actuality, rarely advocated. Meanwhile, the broad claim of social

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<sup>9</sup> As Hacking (1999) points out, the dividing line between those who see discoveries as 'facts' and those who claim such 'facts' are socially constructed remain more clearly demarcated with regards to the natural sciences.

<sup>10</sup> Such debates fuelled the infamous 'science wars' (see Ross, 1996) in which much mud-slinging occurred between those labelled (often by others) as 'social constructivists' and those who saw themselves as 'scientists'.



constructivism, that language plays a role in helping to construct social reality, is now widely accepted within social science research.

Nevertheless, in order to distance themselves from claims that everything is socially constructed, several movements occupying what might be viewed as 'compromise' positions emerged. One of these epistemological positions was known as 'critical realism', a movement that was strongly influenced by the work of academics such as Bhasker (1986) and Sayer (2000). At a simple level, critical realists overcome the difficulties many opponents to social constructivism originally articulated by clearly distinguishing between the 'real' (or 'natural') world and 'social reality'. The former, it is claimed (e.g. Fairclough 2005), exists independently of our knowledge about it and is a world which humans can never fully know; whilst the latter is dependent on human knowledge and is therefore inevitably socially constructed. As Fairclough (2005, p922) outlines, this means that, for critical realists, 'ontology must be distinguished from epistemology, and we must avoid the 'epistemic fallacy' of confusing the nature of reality with our knowledge of reality.' Thus, critical realists have been able to absorb a great many of social constructivist ideas without accepting 'judgemental relativism' or 'universal constructivism' as a consequence.

Persuaded by many of these ideas (although not completely convinced that they resolve debates about the extent to which natural scientific research is constructed – see<sup>9</sup>), I decided it was important to unpick how health inequalities are constructed as a policy problem, to examine how potential solutions are framed and to identify where responsibility for reducing health inequalities is located. In addition, given New Labour's initial commitment to evidence-based policy (as discussed in Chapter One), I felt it was also important to reflect on the ways in which the policy statements discuss and construct claims about the use of evidence and research in policymaking. I framed each of these issues as a question and listed these in a matrix style framework - see Table 3.1, over-page. The matrix was then employed as a tool with which to interrogate each policy document from a social constructivist perspective.

Table 3.1: A social constructivist matrix for analysing policy statements

Question	Examples
What are the specific aims of the policy document and who is it aimed at?	
What priority is given to tackling health inequalities within the document?	
How are health inequalities conceptualised as a policy problem (i.e. how are they defined and what are the suggested causes)?	
What, if any, targets for health inequalities are mentioned? If relevant, how do these targets relate to the conceptualisation of health inequalities discussed above?	
What potential solutions are presented to the problem of health inequalities and what, if any, guidance is provided on tackling health inequalities? Are solutions distinct from those relating to health improvement?	
Where is responsibility for health inequalities located? Does this differ from the location of responsibility for health improvement?	
Are there any specific references to evidence-based policy, knowledge transfer, etc within the document?	

In considering each of the issues outlined in Table 3.1, it was important to consider what the aims of each policy document were and who the intended readership was. These were therefore the first questions I tried to answer as I examined in each document. Whilst the aims were often clearly stated (although they did sometimes seem to change within individual documents), I found working out who the intended readership was rather more difficult. As Fairclough (1993, p79) outlines, 'producers within sophisticated organizations such as government departments produce texts in ways which anticipate their distribution, transformation, and consumption, and have multiple audiences built into them.' Fairclough (1993) goes on to suggest that the authors of such documents are likely to consider three types of policy consumer: those directly addressed, which Fairclough terms the 'addressees'; those not directly addressed but assumed to be part of the audience, whom Fairclough calls 'hearers'; and, finally, those who do not constitute part of the 'official' audience but who are perceived to be likely consumers, whom he describes as the 'overhearers'. For the kinds of documents I was analysing, the 'addressees' were often public sector workers (especially NHS and government staff), the 'hearers' would probably include the national media and/or other national government departments, and the 'overhearers' might include policy analysts, such as myself, as well as policy communities in other nations. However, it was not necessarily easy to identify statements directed towards either of the second groups, who, by their very nature, were not overtly addressed. Additionally, many of the documents I analysed are phrased in ways which suggest they are addressing extremely broad and rather vague



audiences such as 'the public', 'the private sector' or 'voluntary organisations'. Whether the authors really believed the documents would be consumed by such large audiences is unclear; it is perhaps more likely the policy statements were designed to act as points of reference for the authors and the addressees.

The other questions posed in Table 3.1 presented fewer difficulties as most were dealt with overtly in the policy statements (or, alternatively, were sometimes entirely absent). This is not to suggest that each statement told a consistent story about health inequalities, for this was most definitely not the case, but rather to emphasise the great deal of text within the documents that was relevant to many of these questions. The results of this stage of the analysis are discussed in Chapter Five.

### *3.2.2 Thematic content analysis*

The second stage of my approach to analysing the policy statements was designed to help me trace how particular research about health inequalities had influenced (or not) the policy statements. As Hacking (1999, p10) notes, the word 'idea' provides a very unsatisfactory, but nevertheless important, shorthand for items we accept to be socially constructed, items or classifications which can be 'proposed, criticized, entertained [and] rejected.' In the context of the second stage of the documentary analysis, I am employing the word 'idea' to signify a particular way of thinking about health inequalities which is based on my categorisation of the research literature that I employed in Chapter Two. As outlined in that chapter, this categorisation represents a list of the nine different explanatory accounts of health inequalities in the UK that had experienced some prominence amongst health inequalities researchers during the period from 1980 (the publication of the Black Report) to Spring 2007 (the end of the period of study for this thesis). Each of these explanatory accounts features aspects that conceptually distinguish it from other ways of thinking about health inequalities. It is these distinct ways of thinking about health inequalities that I am referring to when I use the term 'ideas about health inequalities'. Table 3.2, over-page, lists each of the nine key 'idea-groupings' that, in light of my reading of the research evidence (in Chapter Two) and the post-1997 policy commitments to employing research in policy (see Chapter One), I expected I might find in the policy statements. Further space was provided for any other ideas (i.e. other ways of thinking about health inequalities) that might be encountered in the policy statements.

It should be noted that the categorisation of some of the theories in this chapter differs slightly from the discussion in Chapter Two, even though all of the theories were touched on in that chapter. This is because Chapter Two presented the various different ideas in the way that they are often grouped together in the research literature. Consequently, 'social selection' (and social mobility), 'natural selection' and 'genetic' explanations for health inequalities were discussed in the same sub-section in Chapter Two, even though I suggested there were distinctive enough differences between each for them to warrant separation in thematic analysis. Similarly, the thematic analysis distinguished between 'material' and 'structural' explanations of health inequalities and between theories about the importance of early years and ideas concerning the full lifecourse, even though these were each discussed together in Chapter Two. The notion that health inequalities are no more than an artefact of the data was not included in the above table as this is an idea which was rejected by the research community well-before the start of the research period and which was visible neither in the relevant research nor in the policy statements.

*Table 3.2: A thematic matrix for tracing research theories about health inequalities in policy statements*

Health inequalities 'idea'	Evidence of this approach to health inequalities within policy document:
Cultural determinants	
Early years	
Health services	
Lifecourse	
Lifestyle-behaviours	
Neighbourhood / local context	
Psychosocial and income inequalities	
Socio-economic & material determinants	
Structural determinants	
Natural selection / genetics / intelligence	
Social selection / social mobility	
Other (Specify)	

It is rarely possible to be certain about the source of ideas within UK policy documents, given that such documents almost never cite references. With this in mind, it has to be acknowledged that it was often difficult to be sure about the extent to which theories discussed



in the policy statements, which seemed similar to ideas developed by researchers, were actually related to health inequalities research. For example, psychosocial approaches to health inequalities have been well developed (and much debated) within the health inequalities research community but these ideas overlap, or share aspects, with ideas about social capital. The concept of social capital is strongly associated with the work of Robert Putnam (2001) and is widely regarded as having had significant policy influence at both national and international levels (see Harriss 2002 for a critical overview). In this example, it is difficult to be sure whether the ideas expressed within some of the statements I analysed were emanating from ideas about social capital or from research which promotes psychosocial explanations of health inequalities, or both. This is a limitation which many policy analysts face and it is reflected on further in the analysis of the findings from this stage of the research (see Chapter Five). Fortunately, within this thesis, the interview data can also be drawn upon and these significantly help throw light on the possible sources of particular ideas.

Nevertheless, this does mean that, whilst Table 3.2 was helpful in focusing my attention on tracing what might potentially be examples of the influence of various research-based theories, it was quite a crude tool for definitively gauging the frequency with which different theories were drawn upon in these statements. Indeed, in many cases I had to guess whether a particular statement was likely to have been influenced by particular research-based idea about health inequalities. For consistency, I decided to be generous in my assessment of every statement (i.e. if I thought I had found any traces of a particular idea, no matter how small, I included it in my analysis). Whilst a long way from the kind of content analysis that this approach derives from (see Krippendorff 2004), completing Table 3.2 for each policy statement provided enough of a gauge to see which ideas were referred to frequently compared to those that were barely perceptible.

The main point of employing a thematic analysis in reading each policy statement, however, was not to track the frequency of occurrence of particular ideas but to examine the ways in which theories were developed, re-constituted and promoted within and between documents. For, as ideas are employed by new actors they are also translated and thereby transformed; in other words, 'what is supposedly the 'same' object can be translated into a number of alternative forms' (Prior 2004, p80). It is in trying to follow the different ways in which similar



ideas were presented and discussed between documents that Table 3.2 proved particularly fruitful and, as already highlighted, this aspect of the research is discussed in Chapter Five.

### 3.2.3 Semiotic discourse analysis

Drawing on Innantuono and Eyles' (1997) analysis of the Canadian Health policy document '*Achieving Health for All*,' an interpretative framework, based on semiotics, was used to further 'unpack' each policy statement in the third and final stage of the analysis. Semiotics refers to a system of analysing language which developed out of two separate bodies of work: the Swiss linguist Ferdinand de Saussure's (1966) system of 'semiology'; and the American Philosopher Charles Sanders Peirce's system of 'semiotics' (see Culler 1981). Whilst these two bodies of work differ in some respects, they both focus on the interpretation of 'signs'. Together, these two systems have influenced a wealth of researchers across the globe, including Roland Barthes and Umberto Eco, who have each used and developed semiotic analysis to uncover the ways in which meaning is generated in 'texts' (see Berger 1988 for an overview). Saussure (1966) argued that 'signifiers' (including words) do not have an essence in themselves and are only defined by a network of relations, so meaning can only be generated through the application of structured associations, or 'codes'. 'Codes' can be thought of as a collection of rules and understandings, which members of particular cultures are able to learn (in many ways this is similar to Bourdieu's (1991) explanation of '*linguistic habitus*'). Readers may use different 'codes' to interpret the meaning of texts from that employed by the author(s), resulting in conflicting interpretations of the 'true' meaning of the text. Semiotic analysis helps isolate and examine important 'signs' within a text and uncover the 'codes' used within it to provide meaning to the words.

Semiotic analysis can also reveal the paradigmatic structures of texts and go some way to uncovering the contributions of other texts and theorists. The latter is achieved by considering 'intertextuality' (a term developed by Kristeva (1986) in her analysis of Mikhail Bakhtin's work) and the use of other texts (consciously or unconsciously) within a text. As research may provide an important form of codified knowledge within policy documents (see Stone 2001), it seems appropriate to use semiotic analysis to try and unpack relevant signs and codes. It was this aspect of the semiotic analysis that I felt I would be able to draw out the presence of the kinds of Foucauldian 'discourses' that critical discourse analysts tend to focus on (see



Fairclough 1995; Jorgensen & Phillips 2002). These are related sets of ideas which, whilst often not overtly referred to in texts, are identifiable through their distinctive vocabularies, symbols, labels and assumptions – all aspects of the texts which the semiotic analysis focused on.

The approach taken to semiotic analysis of policy documents in this research project draws directly on Innantuono and Eyles' (1997) analytic strategy for examining the Canadian policy document, *Achieving Health for All* (Epp 1986). This strategy focuses on the context of language ('text' and 'intertext') to 'decode' policy statements, paying attention not only to the words within the document, but also to words 'hidden' or 'excluded' from the text, which may reveal 'non-stories' (Roe 1994, p1613) which run 'silently' but in counter to the story or argument in policy documents. Such silences are linked to assumptions made through 'tacit knowledge', which may, in turn, depend on (silent) references to particular theoretical paradigms (see Kuhn 1962).

Since Innantuono and Eyles (1997) concluded that their analysis of the *Achieving Health for All* (Epp 1986) was successful at uncovering 'hidden' meanings, I had decided to employ a modified version of their framework in the documentary analysis I undertook for my MSc dissertation (see Smith 2004). However, during that process of analysis I had come to the conclusion that the semiotic framework was not highlighting some interesting aspects of the policies that I wanted to focus on and, furthermore, that it yielded massive amounts of data, which I was unable to discuss in full. It is the combination of these factors which led me to choose a rather different approach to the documentary analysis for the PhD thesis. My aim was to retain the parts of the semiotic framework which proved particularly useful at highlighting aspects of policy statements that I might otherwise not have noticed, whilst incorporating other techniques (as outlined in sections (i) and (ii) above) to ensure that those I had felt the semiotic framework failed to capture were included. Hence, the matrix I compiled for the third stage of the documentary analysis (see Table 3.3, over-page) is based on the aspects of the framework that I employed in my MSc dissertation research (Smith 2004) which I found most helpful.

Table 3.3: A semiotic matrix for analysing the policy statements

Sub-component	Explanation	Examples
i) affective symbolism	Symbolism within the text that affects the orientation and general emotion of communicating health inequalities, e.g. 'killer diseases'.	
ii) Mode of syntagms	Syntagms are new texts resulting from the combination of text elements, e.g. 'healthy public policy' or 'health-promoting schools'	
ii) assumptions	Assumptions made within the document which are not explained/supported (e.g. that economic development is the key priority of the population)	
i) surface versus underlying meaning	Comparing which words are denoted in the text with possible underlying meanings (drawing on knowledge of research and policy context)	
ii) Semiosis in meaning or evidence of contradiction	Changes throughout the text in meaning or conceptualisation of health and health inequalities.	

Semiotic analysis is not without its detractors. For example, Pierre Bourdieu (1991) is critical of this genre of analysis because he feels such an approach ignores the socio-historical conditions of the production and interpretation of texts and fails to do enough to reflect on the position of the analyst. Further to this, Bourdieu's (1991) approach to language emphasises the importance of considering who is vested with the authority to 'produce' particular texts and the implications that this has on the text itself. I have aimed to confront these critiques in the following ways: firstly, by ensuring that the socio-historical conditions in which these policy statements were produced is discussed (see Chapter One); secondly, by reflecting on my position as the analyst in the writing up process (see section 3.3, below, and section 4.4 in the following chapter); and finally, by supplementing the semiotic analysis with a range of other research methods (both those described elsewhere in this chapter and the semi-structured interviews).

#### 3.2.4 The combined, three-stage approach

A separate table was completed for each policy document that was analysed, so the analysis of each policy statement led to the production of three complete matrices. For each document, I completed Table 3.1 first, then Table 3.2 and finally Table 3.3. The documents were analysed in chronological order for each country (Scottish policies first, then English), in



order to help me draw out developments over time and between contexts. Once all of the statements had been analysed, it was possible to examine a series of matrices for each context and to reflect on whether my impressions gauged during the analysis process were supported by the data in the completed matrices. The matrices were particularly helpful in revealing consistencies, highlighting new developments and tracking the frequency with which particular issues came up. Without such a process, the extent of the data collected would have allowed for a range of quite different interpretations to be made quite convincingly as, between them, the statements incorporate a wide range of ideas and views over a significant period of time (ten years). I therefore felt it was important to have some way of assessing the frequency with which particular claims were made, or issues raised.

The data collected from the policy statements through the processes described above inform the thesis as a whole but the findings from the thematic analysis (Table 3.2) and the findings from the social constructivist perspective (Table 3.1) are drawn on extensively in Chapter Five and the semiotic analysis (Table 3.3) is particularly useful in Chapter Eight. By combining three quite different approaches to documentary analysis, it was possible to gather data which helped me to analyse two very different kinds of ideas: (i) the research-based theories about health inequalities that were discussed in Chapter Two; and (ii) the kinds of paradigmatic, or institutionalised, ideas or 'discourses' that were discussed in section 1.3 in Chapter One. The identification of this latter genre of ideas forms a central part of the overall conclusions to this thesis. More immediately, the data produced from the social constructivist analysis helps explain the role that the construction of health inequalities as a particular kind of policy problem appears to have played in shaping the research-policy interface for health inequalities.

### 3.3 Methodological Reflections

The discourse analysis was a time-consuming and lonely process, which involved four months of reading and dissecting the chosen policy documents, without the motivational interactions that the interviewing process provided. Fortunately, this process was broken up by the interviews; approximately one-third of the documentary analysis (which only included Scottish policy statements) was completed prior to the interviews and two-thirds afterwards. It had originally been my intention to complete all of the policy analysis prior to the interviews in



order to be as informed as possible about the policy statements before I asked interviewees about their own impressions of policy approaches to health inequalities. However, as the process of analysing the documents took far longer than I had anticipated (partly because I eventually decided to include rather more documents than I had initially planned but also because of the multifaceted approach I decided to take), I was only able to complete the analysis of the majority of the Scottish policy statements in advance of the interviews. Whilst this was not necessarily disastrous (and was probably beneficial for me personally, in terms of breaking up the monotony of policy analysis), I was conscious that I had more understanding of the Scottish policy context in the interviews than I did of the English policy context. Given the wariness that some of the civil servants seemed to feel towards me as a researcher, I feel my lack of knowledge of the English policy documents was particularly unhelpful in interviewing English civil servants, as section 3.4 in the following chapter discusses further.

Whilst not as enjoyable as interviewing, the process of analysing the policy statements was essential for understanding the ways in which health inequalities have been constructed as a policy problem and for tracking the varied influences of particular ideas. Fortunately, aside from some motivational difficulties, I experienced relatively few problems with the documentary analysis process. This is perhaps because I had already analysed four of the key Scottish policy statements for my MSc dissertation and so had been able to draw on my reflections of that process to further develop my analytical approach to examining the larger number of policy statements considered in this thesis.

Additionally, in order to help me reflect on my particular approach to documentary analysis, one of my research supervisors put me in touch with a fellow PhD student, Pauline Craig, who was analysing many of the same policy documents for a project focusing on mental health inequalities in Scotland. After a couple of meetings, in which we discussed our various thoughts about policy analysis and exchanged some methodological literature, Pauline and I each developed our own approach to the policy statements that we had chosen to analyse (our lists of documents to analyse overlapped but were not identical, given the slightly different foci of our projects). After we had completed our respective analysis, we decided it would be



helpful to each analyse a chapter of one of the policy documents we had both analysed<sup>11</sup> using the other person's framework, in order to help us each reflect on the extent to which our chosen approaches had shaped our results. This process was helpful in that it demonstrated that we were both focusing on similar aspects of the policy statements and generally making similar inferences. It led me to conclude that a simpler approach (as Pauline's was) than my detailed, three-stage framework would probably have led me to draw very similar conclusions. However, I believe employing the three different perspectives may have helped me to pick up on more nuanced and subtle aspects of the language in the policy statements. In particular, I feel some of the underlying assumptions and discourses, discussed in Chapter Five, might otherwise have been missed.

### 3.4 Linking the two methodological approaches

Before moving on to the second and final chapter of Part III, this section briefly explains how the two methodological approaches, documentary analysis and interviewing, inform and support each other. As Lindsay Prior (2004) describes, documents enter into human projects in a dual relation: firstly as a receptacle (of instructions, descriptive accounts, etcetera) and, secondly, as agents in their own right, agents which may be interpreted and employed differently by various actors (see also Latour 1987). Prior (2004, p88) criticises many other social scientists for failing to engage with the productive nature of documents or considering texts as agents which are 'open to manipulation by others' and which can act as allies for (or opponents to) subsequent actions. Viewing documents in this way is to accept that, whilst the content is obviously connected to the way in which a document functions, it is not the sole determinant of the way in which a document functions. Meanings of texts are situated and subjective; in other words, the same document may be interpreted and understood quite differently by different actors and their interpretations are likely to be significantly influenced by the context in which they engage with a document.

Whilst policy statements such as White Papers may often be presented, or referred to, as clear statements of intent, they are in fact more usually 'consensus documents' (Iannantuono & Eyles 1997, p1611) which try to take into account a range of views and ideas in order to

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<sup>11</sup> The text we eventually agreed to use for this purpose was section two of *Towards a Healthier Scotland* (Scottish Office, 1999).

appease diverse audiences (see Pahl 1977). So rather than aiming to limit subjective interpretations, the nature of policy statements may mean that they actively promote vagueness and confusion. This is perhaps why Fotaki (2007) argues that the implementation of policy should not be seen as something separate from the construction of policy statements but rather as a continuation of a policy-making process. Ideas and knowledge claims are harnessed to support particular policy decisions and actions at each stage of the process and the outcomes (including written texts) are never static. Whilst taking these observations into account, the aim of this thesis is to engage with the dialogue between research on health inequalities and *national* policy approaches to the issue and it was, therefore, beyond the scope of the project to consider how policies have been understood by local actors and performed in practice (although I have been involved in another project which is attempting to examine this process for health inequalities in the UK - see Blackman *et al.* 2006). However, it should be kept in mind that my interpretation of national policy statements is not necessarily shared by others; indeed such statements may be employed in quite contrasting ways by different actors according to each actor's purposes. This is one significant way in which the interviewing process contributed to the documentary analysis as it provided me with access to other actors' interpretations of the documents I was analysing (indeed, some tensions between these various interpretations emerge in Chapter Five).

Furthermore, if one wants to understand the work that policy statements do in constructing, promoting and circulating particular knowledge claims (see Freeman 2006), one must consider how such documents were produced, who produced them and how far the production process was socially organized (Bourdieu 1991; Prior 2004). Yet, as Fairclough (1993) points out:

'One can neither reconstruct the production process nor account for the interpretation process purely by reference to texts: they are respectively traces of and cues to these processes, and can be neither produced nor interpreted without members' resources.' (Fairclough, 1993, p72)

The documentary analysis described in this chapter should therefore be viewed as part of a combined approach, alongside the interviewing process, which has enabled me to reflect on these issues. The methods employed in examining the policy statements, i.e. the methods described in this chapter, were designed to unpack the ways in which the theories about



health inequalities promoted by various researchers have been received, translated and employed within policy statements and how these statements actively construct 'health inequalities' as a particular kind of policy problem. The insights of those involved in research and policy add much needed depth to the findings from this analysis (and vice versa), as the subsequent chapters hopefully demonstrate.

## ***Part III: Methodological approach***

### **Chapter Four: Semi-structured interviews**

#### **4.1 Introduction to the Chapter**

Interviewing, as a technique to gain insights into the worlds, beliefs, values and opinions of those you are interested in studying, is one of the most common methodological tools of social science (Kvale 1996). Thus, interviews with people involved in the policymaking and research processes relating to health inequalities was an obvious source of potential data for this thesis. However, it was not originally the intention that the project would rely on interview data to the extent that it eventually did. Initially, a more in-depth approach to the research was planned, which involved participant observation of policymakers in Scotland, as my aim was to gain experience of working within the context in which policy decisions were actively being made and policy documents constructed. It was intended that the findings from this approach would then be supplemented by a small number of interviews with key researchers and policymakers in Scotland. However, following a four-week period of an organised 'student placement' within the Office of the Chief Researcher at the Scottish Executive, which was designed to develop into a year-long engagement, substantial difficulties in the relationship between the relevant civil servants and myself and the research supervisors began to emerge.

Having had to agree not to use the information gathered in the initial placement directly in my thesis (or in any other publications), my supervisors and I sought assurances about the extent to which I would be able to use information gathered during the longer period of engagement prior to its commencement. After several meetings and conversations (not all of which I was party to), it became clear that the doors into the world of the Scottish Executive, which had at first seemed surprisingly open, were now quite firmly closed. The reasons for this change remain far from clear to me, especially as I had been given positive feedback from the civil servant I had had most contact with during the four-week placement. However, the experience provided some interesting insights into the wariness with which many civil servants treat researchers, a feature which was further evident in the interviews I eventually undertook. It also provided me with a useful grounding in the world of Scottish policymaking, albeit one which I am unable to discuss openly in the thesis.



The resulting situation was, on first reflection, rather daunting; not only was I unable to pursue the in-depth engagement I had originally planned, but I had been given the impression (by the civil servants involved in organising my four-week placement) that it would be difficult for me to interview any relevant individuals in the Scottish civil service without their support. Fortunately, my research supervisors, who had contacts elsewhere in the Executive, did not seem to think this would be the case and, having viewed the fractured and territorial basis of some relationships within the Scottish civil service, I was inclined to agree. It is within this context that I decided to approach the second stage of the research through a series of interviews with individuals involved in health inequalities research and policy. Given the less intense nature of this research (compared to participant observation), I felt it was now possible to extend the boundaries of the study to include England as well as Scotland, which I felt was important for the reasons noted in the Prologue (see section II). Having outlined the background to my decision to employ interviews as one strand of the research for this thesis, the following sections describe the approach taken to the interviews, review some of the methodological literature which informed my approach and reflect on some of the difficulties I encountered whilst undertaking this aspect of the research.

#### **4.2 A descriptive overview of the approach taken to interviewing**

A list of potential interviewees was constructed through reference to a wide variety of sources including the information collated during my MSc dissertation (Smith 2004), the four-week placement inside the Scottish Executive described above, discussions with relevant individuals (including my research supervisors), searches on the internet (especially of the Scottish Executive and Department of Health websites but also of policy think tanks, voluntary organisations and media outlets), as well as the vast available literature on health inequalities (both policy and research based). This list was supplemented with more names following some of the interviews (where time allowed, every interviewee was asked if they felt there were any key individuals that it would be useful for me to also consider interviewing). In the end, 93 people were contacted with a request for an interview. Potential interviewees were initially approached by a letter in the post, which, where necessary (and possible), was

followed up with an email. Of the 93 individuals who were contacted, 60<sup>12</sup> agreed to be interviewed; a relatively high response rate, which suggests that people involved in health inequalities work were generally keen to talk about the links between research and policy.

These individuals included civil servants, ministers and ex-ministers who had held posts relevant to health inequalities, professionals working in public health posts and relevant non-departmental bodies (NDPBs), researchers, research funders, television and newspaper journalists, and members of policy 'think tanks' and lobbying organisations. The latter three groups were not ones that I originally intended to interview but they each became increasingly visible as the research progressed. For groups in which a large number of people were approached (i.e. researchers and people closely involved in policymaking), I aimed to engage with a range of different perspectives. With this in mind, I constructed a matrix in which I situated research and policy based interviewees (see Appendix II), with the purpose of trying to ensure I had a spread of interviewees within each genre. So, for example, care was taken to include the perspectives of researchers whose work has focused on various types of health inequalities (stratified by gender, class, socioeconomic status, ethnicity, age and area) and who have been associated with a range of the key theoretical approaches (contextual, health services focused, the lifecourse and early years, lifestyle-behavioural, neo-materialist and psychosocial). In order to cover each of these areas, it was necessary to interview a greater number of academics than other types of interviewee (although, it should be noted, this necessity was compounded by a greater willingness amongst the academics who were contacted to be interviewed – in total, only five academics declined or failed to respond to my request). For the policy-based individuals, I contacted civil servants, ministers and ex-ministers based in a variety of different analytical divisions (including statistics, social research, economics, policy advice and media relations) and working for a range of relevant departments (including those focusing on health, community development, social exclusion, other equalities related issues and, in England, the Treasury). The interview process was divided into two batches to make it more manageable and this allowed me to re-check the matrices after the first batch of interviews had been conducted in order to focus the second round of interview requests on individuals involved in areas which had been underrepresented

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<sup>12</sup> As mentioned elsewhere, one of the interviewees requested that a colleague of his/hers also participate in the interview, which meant that there were 61 interviewees in total.



in the first batch. In the end, I was able to cover most of the areas I hoped to, with a few exceptions (I was unable to find a relevant statistician in the English civil service, an economist in the Scottish civil service, or any researchers based in health economics who were willing to be interviewed).

As I was interested in the period of research and policymaking from 1997 onwards, the inclusion criteria I used focused on interviewing people who had held positions of interest to this area during the period between 1997 and 2007. Most, but not all, of the interviewees were still in this position at the time of the interview. Table 4.1 summarises interviewees' occupational positions on the basis of the work which brought them to the attention of this project, rather than the positions they held at the time of being interviewed, as this is the position around which the questions I asked were focused.

*Table 4.1: A classification of the interviewees based on the occupation they held between 1997 and 2007 that was of most relevance to this research*

Occupation	Number of interviewees		
	Based in England	Based in Scotland	Total
Academic researchers	17*	8	25
Civil servants	4	7	11
Independent research organisations and think tanks	1	2	3
NHS based / NDPB policy advisors	1	5	6
Ministers / ex-ministers with portfolios of relevance to health inequalities	1	3	4
Media based interviewees	2	3	5
Other policy advisors	1	2	3
Research funders	4**	0	3
Total	31	30	61

\* One of these individuals, who was one of the first to be interviewed, was interviewed twice at my request as there were some issues I decided it would be good to explore further as the research progressed.

\*\* Three of these interviewees were based in research organisations that fund projects across the UK (two of whom worked for the same organisation and were interviewed jointly) and the other was based in an organisation that tends to focus on research projects based in England.

As Table 4.1 demonstrates, 25 academics and 36 non-academics were interviewed (although a few of the 'non-academics' had moved into academia at the time of the interview). All participants were UK-based, with 30 being based in Scotland and 31 in England. The interviews took place between Spring 2004 and Autumn 2006 (although the majority were conducted in Spring 2005 and Spring 2006). Categorising the interviewees for the purposes

of Table 4.1 was not an easy task for some of the interviewees as their posts were multi-faceted. For example, one of the civil servants in Scotland was directly involved with funding research, as were two of the Scotland-based individuals who are categorised as 'NHS based / NDPB policy advisors'. So, whilst Table 4.1 suggests no research funders based in Scotland were interviewed, this is not actually the case. However, I have chosen not to present detailed accounts of the various different roles of singular individuals as I felt it may have compromised their anonymity. Instead, where a specific experience or role of an individual is relevant to a particular quotation, this information is provided only in relation to that quotation and in a way which reveals as little as possible about their identity. All interviewees were contacted to check that they were satisfied that the way in which they are categorised in this thesis is accurate and that it maintains their anonymity.

As Table 4.1 also demonstrates, the majority of academics were based in England (17 compared to 8 in Scotland), whilst there were significantly more policy-related interviewees in Scotland. This reflects both the greater number of English based academic researchers working on health inequalities and the relative ease with which I found I was able to access policy-based individuals in Scotland compared to England (a point which has been raised more generally by authors such as Keating 2005).

Following my experience of undertaking interviews for the MSc, and of spending four weeks working with the Scottish civil service, I felt that being able to guarantee anonymity was likely to be an important factor in gaining access to many of the individuals I hoped to interview. On this basis, I opted for one-to-one, face-to-face interviews over other possibilities (such as telephone interviews or focus groups). There were only two exceptions to this. One involved an interview with a research funder who had another member of the staff in the room when I arrived and who requested that the other person should also participate in the interview. The other was an interview with a recently retired civil servant who lived in a remote area which I was unable to get to. By mutual agreement, this interview was therefore conducted over the telephone. For the face-to-face interviews, the majority took place in a private room (the remainder, at the preference of the interviewees, took place in less formal environments such as cafés). The University of Edinburgh's standard ethical guidance for interviewing was adhered to and all interviewees were asked to sign a consent form (see Appendix III) allowing



the interview to be recorded, transcribed and employed as data in this thesis and subsequent publications (on the basis that it would be anonymised before use).

A semi-structured approach to interviews was taken, using a thematic interview schedule which covered the following issues: health inequalities research of relevance to the UK; post-1997 policy development; the relationship between research and policy; and the relationship between researchers and policy-makers. The schedules were adapted slightly, depending on the interviewee (see Appendix IV for some generic examples) and, following the content of the conversations in some of the earlier interviews, I added some questions about the funding of research to later interviews. The interviews varied in length, lasting between 45-150 minutes (although most were around 60-70 minutes). All interviews were recorded and transcribed verbatim by myself. I opted for a fairly detailed level of transcription (including pauses, 'erms' and 'errs', laughing and coughing, etcetera) in order to help ensure that I did not later misinterpret what had been said and also to enable me to reflect on which questions seemed to provoke responses such as awkwardness amongst interviewees. However, I did not attempt to capture the level of detail that conversational analysts sometimes do (see ten Have 1998) as, given the extent of the data I collated, I did not think it would be possible to analyse the transcripts to this level of detail.

In the process of anonymisation, I removed some sections of text completely and for others I changed the colour of the font to blue. The blue sections contain information that I did not want to 'lose' (by deleting) but for which it was extremely difficult to adequately anonymise the text; these sections have not been quoted from directly and where this information is discussed I refer to it in ways which maintain anonymity. All of the interviewees were given a chance to view the transcript of their interview and, as agreed in the consent form, to comment on issues relating to anonymity and accuracy. In order to maintain anonymity, each transcript has only been seen by the researcher and the relevant interviewee. The supervisory team were included in some discussions about the identity of interviewees, where I felt this was necessary, although at no point were the supervisors given any indication of what specific interviewees said during the interviews. This was important as all three supervisors were personally known by a substantial number of the interviewees and at least four interviewees

asked for some assurance that the supervisor(s) they knew would not be provided with access to identifiable versions of the data they were providing.

The transcripts were then coded using the qualitative data analysis programme, *Atlas.ti*. I developed the coding framework as I went through the transcripts, one-at-a-time, rather than trying to impose a pre-developed framework on the data (i.e. the approach was 'bottom-up' rather than 'top-down'). The major downside of this was that as I added codes in later transcripts, I continually had to return to earlier transcripts and consider whether new codes might usefully apply to any previously coded sections. The eventual framework consisted of 115 of thematic codes, many of which were linked into 14 'families' which linked some of the more detailed codes together (see Appendix V).

I only employed *Atlas.ti* in quite a basic manner, approaching the coding framework as a tool to aid the writing-up process rather than exploring the more complex analytical possibilities the programme offers. I then used *Atlas.ti* to help me manage the interview data by producing lists of quotations under themed headings. As well as helping me to organise and search the data in this way, the coding framework played an important part in helping me reflect on the frequency with which particular issues are apparent in the interview data. I felt this was important as the extent of the data meant I sometimes felt, if I looked hard enough, I would be able to find the evidence to construct almost any argument I desired. It is on this basis that the analysis at times includes an indication of specifically how many times an issue was raised, or a viewpoint expressed. As with the discourse analysis data, it is important to be clear that the use of data in this manner is in no way intended to give the impression that quantitative analysis is being attempted, or that the findings might in any way be extrapolated beyond the contexts in which the research took place. Rather, given the decision not to publish the transcripts in full (in order to protect anonymity), this approach is intended to allow readers to gain some insight into the frequency with which the ideas I focus on are apparent within these data (see Easterlow & Smith 2003 for another example of this style of discussing qualitative data).



### 4.3 Reviewing the available methodological guidance on interviewing 'elites'

Having relatively little prior experience of interviewing professionals, I undertook a significant amount of preparatory reading around the issue. Much of the relevant methodological literature refers to professional participants as 'elites' (e.g. Desmond 2004; Hertz & Imber 1995; Hughes & Cormode 1998; Kezar 2003; McDowell 1998; Sabot 1999). Personally, I do not feel comfortable with this term for a variety of reasons, not least because the identification of 'elites' is rarely problematised, implying that those in powerful positions are clearly identifiable. Whereas, my own experience suggested that trying to identify precisely who shaped policy documents or made policy decisions was an extremely difficult process; as one of my interviewees said, it is virtually impossible to find anyone who self-identifies as a 'policymaker'. Indeed, as Atkinson and Coffey (2004 p70) point out, 'part of the facticity of many official and organizational documents is that they are not identifiably the work of an individual author'.

Getting beyond this anonymity can be difficult; a point the documentary analysis highlighted (see section 3.1 in Chapter Three) and the interviewing process confirmed. For example, I encountered several examples of individuals who claimed to have significantly shaped (or written) some of the policy statements I analysed but who seemed to disagree with key messages within them and I encountered two individuals who both claimed to have been the main author of the same policy statement. These findings make sense if we consider the consensual nature of policy documents (see Pahl 1977). This means, however, that it is extremely difficult (if not impossible) to identify who makes the key decisions that shape policy statements and on whose authority particular ideas, evidence and information are incorporated (or removed). Even in interviews with individuals who were at what might be considered the 'highest level' of policymaking - the ministers and ex-ministers - it was not at all clear how much power they were able to exercise in relation to controlling the content of policy statements released in their name (a point returned to in Chapters Seven and Eight). As Cochrane (1998) argues, 'one measure of power might be the extent to which policy can be influenced or determined without it being clear who has exerted it'.

My other major concern with a reliance on clearly defined dualisms in relation to power, such as 'elites' and 'non-elites', is that it paves the way for suggestions that there may be two



different sets of rules for researching each group. For example, Bradshaw (2001) and Desmond (2004) both claim that the approaches generally advocated by recent methodological literature may be inappropriate for interviewing 'elites'. The point of contention raised by those who suggest interviewing 'elites' requires a different approach from other types of interview is that, influenced by post-structural and feminist theoretical developments, much of the methodological literature published over the past few decades suggests that researchers ought to take a collaborative and empowering approach to research interviews. This genre of work, which Bradshaw (2001) refers to as the 'collaborative paradigm', emerged from criticisms of past claims to researcher objectivity; instead of advocating researcher neutrality, this more recent literature often calls on researchers to actively engage with, and reflect on, the subjective experience of the interview process (see, for example, England 1994; Oakley 1981; Tillmann-Healy 2003). This body of work tends to favour unstructured over structured interviewing techniques (so that the interview can become more of a conversation than a process of questioning) and often advocates methods for trying to minimise power differences in favour of the participants, such as allowing respondents to comment on, and have input in, the outcomes of research.

In summary, much of the recent guidance around, and discussions of, interviewing tends to favour collaborative, unstructured and reflexive approaches. These suggestions are often based on a presumption that those being interviewed are in some way 'vulnerable' or 'disempowered'. Very few of the texts in this genre provide any specific advice on interviewing professionals, perhaps because, as Ostrander (1995, p133) suggests, social scientists too rarely 'study up'. It is therefore not difficult to see why it is increasingly being suggested that existing guidance for interviewing is inadequate for interviewing people in positions of power and authority (Bradshaw 2001; Hertz & Imber 1995; Kezar 2003; Ostrander 1995). Indeed, several academics who have researched people in positions of power openly acknowledge that they treated the research participants quite differently from the 'best-practice' to which they would normally adhere (e.g. Routledge 2002; Spencer 1982). However, I do not think it necessarily follows that because there is a lack of guidance relating to interviewing elites, and a wealth of guidance advocating reflection and collaboration, that a collaborative, reflexive approach is incompatible with researching elites. Indeed one of the earliest publications on interviewing 'elites' (Dexter 1970) specifically advocates a collaborative approach for



interviewing professionals on the basis that it is helpful for investigators to let such interviewees 'teach' them about their experiences. I would not go as far as Dexter and claim that a collaborative approach to interviewing is *particularly* appropriate for interviewing people in professional positions but, as I began to reflect on the wide-range of research experiences that I read about and myself encountered, I became convinced that there is little evidence to support the idea that there are areas of concern which relate *specifically* to interviewing 'elites'. Instead, it seemed to me, that there exists an assortment of potential problems which *all* interviewers may encounter. What is missing from this literature are the links to wider conceptual and theoretical debates about post-structural conceptions of power (a point I expand on in Smith 2006 - see Appendix VI).

Bearing all this in mind, I have actively avoided using the term 'elite' to refer to any of the interviewees involved in this research, preferring instead to be more specific about the position/location of each interviewee. Furthermore, I decided to take the kind of collaborative and reflexive approach to my interviews that much of the recent literature referred to above advocates. However, to make sure that I would be able to cover the topics required within the limited time interviewees were able to provide for an interview, my 'semi-structured' approach was more structured than I would otherwise have liked. As already mentioned, generic versions of the interview schedule I employed are provided in Appendix IV, although it should be noted that minor adaptations were made for each interviewee. In line with the notion of a 'semi-structured' approach, the order of the questions was guided rather more by the conversation than the interview guide, and I also asked additional questions (and/or skipped others) where it seemed appropriate.

#### **4.4 Methodological reflections**

Following recent calls for researchers to reflect on the 'ups' and 'downs' of the research process in more detail (e.g. Cornwell 1988; Oakley 1981), this final section reflects on my experiences of the interviewing process (which I take to include the recording, transcribing, coding and utilisation of the data as well as the preliminary organisation of and the actual interview encounters themselves).

#### 4.4.1 Member-checking and anonymising the transcripts

Several researchers working in the so-called 'collaborative paradigm' referred to in the previous section place a great deal of importance on sharing their research results with participants (see Adler & Adler 1993; Bok 1982; Hunt 1993). Yet some researchers have argued that 'member-checking' (i.e. where researchers check their research findings with participants) is one aspect of the collaborative paradigm that may be inappropriate for research on 'elites' as such groups may be more likely to exercise their power by requesting changes to their own advantage. Indeed, Bradshaw (2001) claims that it is as a result of member-checking that he found himself being forced to agree to a 15 year embargo on his PhD thesis. Despite such warnings, however, I was persuaded by Herzog's (1995, p176) argument that, even in 'elite settings', the relationship between the researcher and the researched should not be one-sided and that, 'informants have an interest in the information they provide'. Furthermore, I agree with Al-Hindi Falconer and Kawabata (2002, p111) that, '[i]f feminist researchers really believe in sharing power and validating the knowledges of research participants, we must pursue their perspectives and invite their observations, no matter how uncomfortable for us these may be.' This may involve feeling out of control but, on the other hand, it does not necessarily require researchers to pass complete authority over research publications to their participants. The embargo Bradshaw (2001) faced arose from the fact that, in order to gain access to senior corporate managers, he felt compelled to agree to conditions which obliged him to accept *all changes* requested by them in relation to his own interpretation of his findings (or alternatively, as the eventual outcome became, to agree to an embargo not to make the findings publicly available). Had such a strict agreement not been a requirement of access, the perspectives of the participants on the findings could have added an interesting dimension to the project without necessarily requiring that Bradshaw refrain from publishing them.

With this in mind, I decided to 'member-check' the transcripts of interviews but not the pre-published analyses (although I have agreed to send all interviewees a summary of the findings, once the thesis is complete). I felt this meant I would be offering interviewees significant control over the interview data whilst maintaining my own authorship of the analysis and conclusions (which are, after all, based on more than the interview data alone). My approach included allowing any interviewees who requested to do so to read over the



interview schedule in advance (only three requested to do so) and offering all interviewees the opportunity to read and request changes to the final interview transcripts on the basis of either (a) anonymity or (b) accuracy. This involved sending all interviewees a copy of the transcript after I had attempted to anonymise it and highlighting that I was committed to making requested changes on the basis of (a) or (b). The only exceptions to this process related to a couple of interviewees who specifically requested just to be sent potential quotations that might be used in the thesis rather than the full transcripts. Although this left me open to possibly being unable to use interesting data, I felt this was a worthwhile risk for two reasons. Firstly, it allowed me to approach the interviews in a methodological manner with which I was ethically comfortable and which more than accorded with the ethical guidance I had consulted. Secondly, I hoped that it would increase the sense of security amongst potential interviewees and therefore, hopefully, their willingness to take part in the research. It is impossible to know how many people would have agreed to be interviewed had I taken a different approach but I did sense that the chance to 'member-check' the transcript was extremely important to a number of individuals, particularly the civil servants and some (female) academics. However, equally, several of the interviewees seemed to find my approach rather strange. For example:

Senior academic researcher: *'I'm surprised, actually, I mean I get the impression you've sort of had to prepare this, by people thinking there are important ethical implications, erm, and I would have been happy if you hadn't had any of that at all, and just said, 'would you like me to clear any quotes if I want to use quotes from this?''*

Interviewer: *'Right.'*

Senior academic researcher: *'You know, and then maybe I'd say, 'well yes, if you actually attribute a quote to me, I'd like to know what it is' but, otherwise, I wouldn't have been worried. [Section blanked for anonymity]. But you say it's all going to be anonymised, which seems, to me, odd.'*

Despite the fact several other interviewees (interestingly, mostly male academics and politicians) made similar comments, I remain largely happy with the approach I chose to take and think it likely that it did contribute to the unexpectedly high response rate (referred to above). Furthermore, there were fewer issues relating to losing potentially useful data than I



feared there might have been: Many of the interviewees did not request any changes at all (indeed I cannot be sure they even read the transcripts) and most of the 17 who did requested relatively minor changes relating to issues of anonymity, which I was happy to accommodate. However, three interviewees, all of whom were civil servants (two in Scotland and one in England), did request quite extensive changes to the transcripts. Many of their requests went beyond issues of anonymity or accuracy and seemed more to do with concern about how the information might be used to discuss or portray the civil service. All three made detailed requests for changes which included completely removing key passages and words from the transcript, even though none of the interviewees openly questioned the accuracy of the transcripts. In one case the changes included a detailed 'correction' of the grammar so that the verbatim transcription would read more like a written text. In another, the interviewee requested I remove the word 'market' (as in 'sell' or 'promote') from key sections of the transcript (presumably in anticipation that my analysis might discuss the dominance of free-market terminology within the conversation). Unfortunately, despite my qualms with making such changes, given the rather vague way in which I had worded my commitment to accepting interviewees' suggestions (see Appendix VII), I felt unable to refuse. In the end, despite my agreement to make all requested changes, one of the civil servants who was based in England re-contacted me at a later date to ask me not to use any direct quotations from the transcript of the interview with him/her, a request which I have complied with (although, in agreement with the interviewee, some aspects of this conversation are drawn on in a more general sense). Reflecting back on this process, my approach to 'member-checking' the data is one aspect of the interviewing which I would consider changing in any future interviews as, given this experience, I feel it might be helpful to be more specific about the kinds of changes one is committing to make by relating this more clearly solely to issues of anonymity and accuracy. Fortunately, in light of the extent of the data I collected overall, I do not feel this experience has significantly restricted the findings I am able to discuss in the thesis.

Furthermore, I do not think this experience necessarily lends weight to Bradshaw's (2001) claim that 'elites' might be more likely than other groups to try to make changes to findings in order to protect themselves (for example, none of the ministers - who might be seen as more 'elite' than some of the civil servants - asked me to make any changes to the transcripts). Indeed, it is interesting that all of the interviewees who requested extensive changes (or, in



one case, the use of no direct quotations at all) were based in the civil service. This suggests that some civil servants are particularly conscious of the ways in which they might be presented to, and discussed by, academic audiences, and that they perhaps feel less able to discuss their own opinions about the research and policy interface than other relevant actors. Indeed, some of the interviewees based in the civil service openly reflected that they were thinking about how they should respond to particular questions on behalf of their colleagues and the government, which underlines the fact that they did not always feel it was appropriate to present their *own* opinions about some issues. Chapter Seven returns to this issue when exploring the relationship between ministers and civil servants and between civil servants and the institutional frameworks within which they are situated.

Maintaining the anonymity of each interviewee was rather more of a minefield than 'member-checking' the transcripts. Firstly, I found that, for some participants, the matter had already been taken out of my control; on more than one occasion, interviewees told me that they already knew that I had interviewed X (usually a friend or colleague of their's) as they had both had a conversation about my research. In another situation, I found the electronic diary that many civil servants use meant that all civil servants with access to the diary system (which, I believe, included all those I interviewed in Scotland) could view their colleagues' appointments. As a result, if an interview with me was booked into an individual's diary in any obvious way, there was little I could do to ensure that their participation remained entirely anonymous. The extent to which the transcripts have been anonymised does, however, mean that it is unlikely individuals would be able to attribute quotations to particular people, even if they were aware of the identity of one or more person who had been interviewed.

The second problem I faced in relation to maintaining anonymity was that several awkward situations arose when I asked interviewees if there were any other individuals they felt it might be useful for me to interview. Often, and understandably enough, this question was met with queries about who was already on my 'list'. Most of the time, when I explained that I could not discuss this information in order to protect the anonymity of interviewees, the respondents did not pursue the matter any further (some, who were themselves particularly concerned about protecting their identity, even seemed relieved at my response). However, other interviewees pushed for further information anyway and one interviewee pointed out that it seemed rather

unfair that I expected him/her to share his/her experiences with me when I was not willing to do the same:

Senior academic researcher: [Pause]. *'Who else are you going to see?'*

Interviewer: *'Hmm, well, I'm not, because of that confidentiality form I can't really list them, but I've...'*

Senior academic researcher: [Laughs] *'Well that's silly!'*

Interviewer: [Laughs] *'But I started by...'*

Senior academic researcher: *'You mean you're, you're a PhD student and you can't tell me what other scientists, now that, that is about not, that is very interesting. Because, what's, hmm, it's about freedom of communication.'*

Interviewer: *'Yeah.'*

Senior academic researcher: *'I'll tell you who I'm going to see so what's so special about you?'*

Interviewer: *I know. It is a little, erm, yes, it is a little bit difficult...*

The fact the interviewee felt the need to point out I was a 'PhD student', whereas s/he and some of my other interviewees were 'scientists', is an example of the way in which some interviewees were keen to assert their relative authority in relation to me during the interview. There are plenty of other issues relating to power relations and these are explored in more detail next.

#### 4.4.2 Power relations

The intricacy of power relations in interviews is highlighted by Pile (1991, p464), who acknowledges that, 'the structures of power between the interviewer and the interviewed are complex and unstable,' and calls on geographers to reflect more seriously on the 'the (emotional, power) relationship between the interviewer and interviewed'. Pile's (1991) stance is supported by significant numbers of other human geographers who have called for a greater consideration of power relations in qualitative research (e.g. Baxter & Eyles 1997; Bondi 2003; England 1994; Rose 1997). Yet, aside from these (mostly feminist) examples, many geographers do not appear to have responded to Pile's (1991) request that we practice 'interpretative geography' and have instead continued to employ rather simplistic assumptions about power, as have many social scientists beyond geography. This is surprising



considering the extent to which the concept of power has been debated within the social sciences over the past century and the support which has grown for poststructural accounts of power (see, for example, Foucault 1978 [1976]; Lukes 1974). Indeed, Few (2002, p30) argues 'power' is currently 'one of the most contentious concepts in social science,' a claim supported by the existence of a wealth of literature outlining and debating extremely complex interpretations of 'power'.

It would not be possible to give an overview of the multitude of contributions to theorisations of power (e.g. Allen 2003; Lukes 1974; Morris 1984; Russell 1938) within the confines of this thesis. However, for the purposes of this chapter, it is important to at least highlight the distinction between two quite contrasting views of power. The first, which I shall call 'structural', suggests power is an inscribed capacity, something which is appropriated by particular individuals or organisations. From this perspective, power is configured across society so that particular individuals and organisations 'possess' power, which they can use to achieve certain outcomes, whilst others are 'powerless' (or, at least, far less powerful). In this scenario, power is always possessed but not always exercised and, as a result, power is perceived as 'always potential' (see Allen 1997, p60). It is this perception of power which much of the methodological literature on 'elites' employs. The alternative view, which I shall call 'poststructural', portrays power in a far more fluid manner, as something which is exercised but not appropriated. These poststructural re-theorisations of power have emerged out of the ideas developed by Henri Lefebvre and Michel Foucault, both of whose work has been used to critique structural ideas. From this viewpoint, power cannot be possessed and is rather, 'something which passes through the hands of the powerful no less than through the hands of the powerless,' (Allen 1997, p63). So, rather than being inscribed in particular individuals or organisations, power is seen as diffuse and mobile; it is continually circulating and allows more possibility for the role of individual agency.

Many of the articles that focus on interviewing 'elites,' rely on structural interpretations of power in at least two ways (though there are exceptions, especially in feminist geography, some of which have been referred to already). Firstly, as already discussed, authors who discuss 'elites' as an unproblematic category are assuming that it is possible to clearly identify 'powerful people' (i.e. it is relatively obvious which people in society possess the authority to

exercise power). Yet, as I have discussed, this was not supported by my own experiences of trying to identify key policy advisors and decision-makers. Secondly, there is often an assumption that the power associated with people through their professional positions will transfer directly onto the interview space (i.e. that it is transferable across contexts because it is inscribed in particular individuals). For example:

'These are, recall, very powerful and self-assured people, talking, moreover, to an obscure academic who poses, so far as they are concerned, absolutely no threat.' (Schoenberger, 1991 p217)

'...with elite interviewees the [interviewer–interviewee] relationship is inevitably asymmetrical regardless of the research strategies deployed.' (Desmond 2004, p265)

The above quotations leave little room for the possibility that individuals, whatever their professional position, may feel exposed or vulnerable in interviews, yet both Sabot (1999) and Puwar (1997) state that some of their 'elite' interviewees seemed to perceive them as a threat, indicating that 'elites' are not always as secure as Schoenberger (1991) and Desmond (2004) imply. This point is illustrated well by Shurmer-Smith's (1998) discussion of her participatory research with the Indian Administrative Service. Reflecting on this experience, Shurmer Smith explains that her initial assumptions about the universally privileged and powerful position of this group of people began to be challenged as she was drawn into individuals' life-worlds, in which she encountered a divided, insecure and rather vulnerable group of people. Whilst this account emerged both from a different context and from employing alternative research methods, the delicate and apparently precarious positions of people who might easily be labelled 'elite' resonated with my own experiences. In particular, I rarely felt that the interview space involved consistently asymmetrical power relations which favoured the interviewees. In fact, I was frequently surprised by the level of self-reflection, uncertainty and nervousness tangible in some of the most senior (in terms of their position within professional hierarchies) interviewees, as well as their willingness to share their thoughts with me (see also McDowell 1998). One interviewee in particular, a minister in the Scottish Parliament, stands out in this respect as s/he seemed to take each question I asked as an opportunity to reflect on what s/he could do better in relation to health inequalities and seemed keen to tap into what s/he continually referred to as my 'expertise' in this area.



At this point, it is appropriate to acknowledge the important contributions made by feminists, some of whose work has already been drawn upon, to opening up discussions about power relations in interviews. In particular, feminist researchers have often used reflections on positionality to 'unpack' power relations between the researcher and the researched, situating both within wider societal power structures; the idea being that by making one's position 'known' and 'visible', the specificity of research perspectives and claims to knowledge become clearer. In so doing, this body of feminist work aims to expose 'unseen, gendered power relations' (Rose 1997, p309). One researcher to reflect in detail on her interactions with 'elite' interviewees is McDowell (1998), who discusses the way that, after 'a quick assessment of a range of visual and verbal clues,' she presented herself in different ways to different interviewees:

*'In some interviews I seemed to fall into the classic male—female pattern, for example with an older charming but rather patriarchal figure I found myself to some extent 'playing dumb'; with an older and extremely fierce senior woman I was brusquely efficient, with other women I was 'sisterly' in the sense of the same age — same position, with some of the younger men I was superfast, well-informed, and definitely not to be patronized.'* (McDowell 1998, p2138)

McDowell's account responds well to feminist geographers' calls for researchers to be more reflexive about the research process and to pay closer attention to the shifting dynamics of positionality and power involved in interviewing. Reflexivity can, however, be a difficult process and, as Rose (1997) points out, it usually still relies on the idea that a 'wider power structure' exists and can be known and understood by the researcher; indeed, the notion of positionality relies on the idea that the researcher-self is 'a transparently knowable agent whose motivations can be fully known' (Rose 1997, p309). Yet, if we engage with the poststructural idea that people (including both the researcher and the interviewee) are multiply positioned and do not have one single identity (Fardon 1995; McDowell 1998; Parry 1998) it makes sense to accept Valentine's (2002, p121) observation that, 'as the interview develops, we are constantly (re)producing "ourselves" so that both researcher and interviewee may be multiply positioned during the course of an interview.' It is therefore unlikely to ever be possible to comprehend all of the subtleties of these interactions. However, this does not mean that we should discard attempts to reflect on positionality and power relations in research; Rose (1997), England (1994), McDowell (1998) and Bondi (2003) all demonstrate

that it is possible to think and write about these relations in a more open and discursive manner than has been generally undertaken and this is what I attempt to do in the remainder of this section.

As should be apparent from the literature discussed above, quite a number of reflections on power dynamics highlight gender as a characteristic of relevance to power relations and there were definitely some examples of its role in my own encounters. For example, one interviewee asked me to meet up with him after the interview on the grounds, I understood, that he would be willing to share more information with me in a non-recorded conversation. In fact when I met with the interviewee again, he seemed more interested in pursuing some kind of personal relationship, a situation with which I was quite uncomfortable (although I remain uncertain about the interviewee's precise intentions). Another interviewee displayed such unreconstructed views about conventional gender roles that I had difficulty engaging seriously in some aspects of the conversation; for example, having explicitly compared the role of women in society to that of female sheep (i.e. as beings whose main role in society is to bear offspring) he then asked me if, as a woman, I could explain why 'feminists' (a singular group, of which I was obviously part) might be un-convinced by the various theories that he was advocating. However, with a few exceptions such as these, I found the main issues regarding power relations that I encountered in these particular research interviews arose from hierarchical differences and contrasting ontological positions, as the following reflections hopefully make clear.

As already discussed, I was often surprised by the lack of confidence and apparent insecurity which some of the interviewees displayed in the interview and this was particularly the case for the Scottish minister I referred to above. However, whilst this interviewee seemed to regard me as an 'expert' in relation to the health inequalities research, there were, of course, other elements of our discussion (such as the process of constructing policy) in which the interviewee was far more knowledgeable than me. So I found the power dynamics shifted depending on the topic of conversation. This was the case for most of the other interviews. There were, however, a few interviewees who I felt deliberately attempted to exert their authority over me in ways more reflective of the methodological literature on 'elites', discussed earlier in section 4.3. In particular, four interviewees with quantitative backgrounds (three of



whom had also been trained medically) made quite disparaging comments about interview-based research. For example:

Minister: *'... what I detest are these qualitative reports where they've got quotes from people, you know – you must have seen them, they've got so and so said this, and so and so said that – I mean I just chuck them out – I'm not interested in what people say, I want to see some statistical analysis, correlation coefficients and all that. People say I'm extremely biased about that but it's only because it's the only way you can really prove something.'*

Academic researcher: *'There are some extremely good qualitative researchers but there are lots of crap ones, 'cause it's easy to call yourself one and interview people...'*

In both of the above cases, the interviewees' negative comments about qualitative research (or researchers) related specifically to the employment of interviewing as a technique, something which I felt was unlikely to be a coincidence and was more likely to represent a derogatory jibe at my own research methods. However, as the purpose of the interview was to find out about interviewees' perceptions and beliefs, this information was useful (particularly for the discussions concerning epistemological opinions and tensions presented in Chapter Six) and did not make me feel excessively uncomfortable, although there were some awkward silences following each of the above statements.

Another issue which came up several times in the interviews was the difficulty that some of the academic interviewees seemed to experience with finding themselves in the position of interviewee, rather than interviewer. Additionally some academics who were used to supervising PhD students seemed to have difficulty not taking on the role of a pseudo-supervisor during the interview. For example:

Academic researcher: *'It's strange because I'm usually the one asking the questions so I'm trying to get my head round being on the other side...'*

Senior academic researcher: *'I'm here as someone being interviewed, not as an academic.'* [Spoken as if interviewee is reminding him/herself of this situation.]  
 '[Laughs] I'm about to supervise a PhD student so I'm in that mode.'

In most cases where these kinds of issues arose, interviewees were quite self-reflexive about it, as the above statements illustrate. However, such statements still served to highlight the interviewees' seniority within academic hierarchies in relation to me and, as a result, often made me feel rather self-conscious about the extent to which my capabilities as a researcher might be being judged. Furthermore, when academic interviewees slipped into 'pseudo-supervisory mode' (as the above interviewee did immediately after reflecting on the fact s/he was 'here as someone being interviewed'), they often questioned me about aspects of my research in some detail, asking, for example, which policy documents I had analysed and what kinds of technique I had employed to do this, who else I had interviewed and why, what my initial findings were, etcetera. Whilst I usually felt these questions were posed in a manner which was aiming to be constructive, they also served to reverse our roles in the interview so that I was the one answering questions (and sometimes, it felt, defending choices I had made). As I have outlined earlier in this section, I do not believe it is necessarily the case that those asking questions are *always* in the more powerful position. However, in this particular context (especially in light of acknowledged academic hierarchies), when role reversal occurred I nearly always felt more vulnerable than I had when I was asking questions of the interviewee.

Having acknowledged this, I should also make it clear that I usually felt quite vulnerable in the role of the interviewer, especially during the first batch of interviews. Indeed, after I had undertaken the first few interviews, in which two interviewees had commented on my obvious nervousness, I was comforted to read Laurier and Parr's (2000, p99) reflections on their experiences of feeling nervous during interviews and to see them describe 'anxiety' as 'the classic interviewer's emotion'. In the process of my own research, I usually began feeling nervous and anxious *en route* to the interview and only calmed down if, and when, I felt the interview was progressing well and the digital recorder was working effectively. Although feeling nervous is not a particularly nice sensation, retrospectively (and having since undertaken interviews for which I felt less nervous) I feel it was a useful emotion in that it



helped to ensure my continual engagement with the conversation over what was often a lengthy period of time.

Interestingly, two of the interviews in which I ended up feeling least comfortable were with a couple of academic interviewees whom I had initially felt less nervous about interviewing because I had read so much of their work in advance and because I felt I shared a great many of their views. Retrospectively, I can see that my heightened casualness makes little sense as it is not as if either interviewee could have been aware that I held their work in such high regard and, indeed, my more relaxed attitude towards these interviewees may have suggested quite the opposite. Whether or not my approach to these interviews contributed to the comments each interviewee made about qualitative research is impossible to know but both made it clear that they did not hold qualitative research in high regard (as discussed above). In addition, both made what I felt were deliberate attempts to highlight that they had access to interesting information about the relationship between health inequalities research and policy (or between researchers and policy-makers) which they were unwilling to share with me. There is, of course, nothing wrong with being unwilling to share information *per se* and I certainly would not have wanted any interviewee to feel obliged to do so. However, I felt the fact that both of these particular interviewees seemed keen to let me know (or at least to give me the impression) that they knew of some interesting stories or ideas which were of relevance to my research project but which they would not discuss with me (for undisclosed reasons) formed part of a broader attempt to exert their authority over me. These attempts (whether intentional or not) were largely successful; when I listen back to each recording, there are a wealth of indications of my increasing nervousness and reticence as each interview progressed.

#### *4.4.3 Reflecting on interviewing technique (including the recording of interviews)*

In the early interviews, being extremely nervous, I relied on the interview schedule to boost my confidence as well as to jog my memory and often glanced down at it in-between questions. Additionally, I tended to read some questions word-for-word, precisely as I had written them on the schedule. It soon became apparent that this process was acting as an interruption to interviews which had developed into more casual conversations. Whilst most interviewees did not comment on this, I noticed that the dynamic of the early interviews often seemed to shift quite quickly from a rather uninhibited and consensual conversation to a realisation that the



conversation was for a particular purpose and was being recorded. Likewise, my (rather neurotic) attempts to constantly check the digital recorder was working effectively<sup>13</sup> also served as a reminder that every word would be later played back and transcribed. When, towards the end of the seventh interview, the interviewee laughed and said, *'It's funny when you get into the formal parts of it, every now and then, with your bit of paper,'* I resolved to minimise my use of an interview schedule in future interviews. Listening back to the interviews in chronological order, I am certain this was the right decision as the later interviews are audibly less tense.

#### 4.4.4 Problematic interview questions and avoidance tactics

Quite a few questions met with response that they were 'very broad' or 'big' and therefore difficult to answer. However, it was not consistently the same questions which led to these responses and I was, at times, unsure whether interviewees really found the question they were referring to difficult to answer or whether it was, instead, a question they felt uncomfortable answering for other reasons. In some cases, it seems fairly clear that interviewees were actively constructing boundaries around what they were prepared to talk about. For example:

Senior civil servant (Scotland): *'Erm, so, sorry, there's several - I'm trying to sort of think what not to say [laughing] you know - I mean in terms of just time [coughs].'*

The above quotation is indicative of a trend of question avoidance which was particularly evident amongst civil servants. For example, the civil servant based in England who requested that I not use direct quotations from the transcript paused before responding to a great deal of the questions and explained that some topics (such as variations in the interface between research and policy in different sections of the civil service and questions about joined-up government) were 'dangerous territory' which s/he found difficult to talk about. For me, this was a further example of the wariness with which civil servants often seemed to treat researchers (as touched on in section 4.4.1). Another technique of avoidance which two senior civil servants seemed to employ during the interviews was to speak at length on topics

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<sup>13</sup> I have not reflected in any more detail about the use of the digital recorder as, very fortunately, I experienced no mishaps with the recorder other than once having to delete a previous interview (which I had already downloaded but had not yet deleted) during a subsequent interview so that there was enough space on the memory stick to finish recording.



they were comfortable with, often going off on tangents, leaving me with only very limited time to bring the conversation back to my areas of interest. Looking back, I think I might have been better able to deal with these situations if I had completed all of the documentary analysis, and so provided myself with a more in-depth understanding of policy statements, prior to commencing the interviews. Indeed, two of the four English-based civil servants I interviewed questioned me about particular policy developments and arrangements and I felt my uncertainty in answering these questions helped both individuals to avoid questions they found awkward by suggesting certain questions made little sense or would require me to have some knowledge of particular developments (so rather than answering the questions, they described these developments). However, as I outline in Chapter Three, the way in which I scheduled my research made this impossible once the interviews had been arranged. Civil servants were also by no means the only interviewees to employ tactics of question avoidance. Indeed, for other types of interviewee, particular questions seemed to promote cautiousness, as Table 4.2, below, illustrates.

*Table 4.2: Academic interviewees' reluctance to talk about research funding*

<b>Illustrative examples of academics' reluctance to discuss research funding</b>
<p>Interviewer: [Towards the end of the interview] 'Erm... do you think there's any things that I, you're surprised I haven't asked you about or we haven't touch on?'</p> <p>Academic researcher: 'Err... [pause]. Yeah, there's some things but I'll only tell you, I'll tell you what they are if you don't ask me them [laughs].'</p> <p>Interviewer: 'Okay.'</p> <p>Academic researcher: '...if you keep them for future interviewees. Err, I think the issue of funding of health inequalities work is quite important. Have you talked to people about that?'</p>
<p>Interviewer: 'And do you think there's any disadvantage to direct funding from government departments?'</p> <p>Academic researcher: 'I'm not sure I'd want this to go on tape [laughs]. No, erm...'</p> <p>Interviewer: 'Well, obviously...'</p> <p>Academic researcher: 'Yeah?'</p> <p>Interviewer: '...it will be fully anonymised...'</p>
<p>Interviewer: 'I'm interested in - some of the people I've spoken to have said when they, erm... when they receive direct funding from government departments...'</p> <p>Academic researcher: 'Mmmm.'</p> <p>Interviewer: '...they don't - and this isn't everyone, just some people have said this - they...'</p> <p>Academic researcher: 'Hmmm.'</p> <p>Interviewer: '...there isn't any clear, erm, censoring or clear steers.. but there's a sense of perhaps of expectancy and a sense of loyalty because you're getting money from these people, so a feeling that you should phrase things in certain ways.'</p> <p>Academic researcher: 'Hmmm, yeah.'</p> <p>Interviewer: 'Do you think that might be true?'</p> <p>Academic researcher: 'Yes, I think that was what I was hinting at in my response.'</p>

As the quotations in Table 4.2 illustrate, academic interviewees seemed almost universally shy about discussing research funding. Each of the responses to the issue of funding is rather different but all point to a shared concern about discussing the impact of funding on research. In the first example (an early interview which led me to adapt my schedule to include questions about research funding), the interviewee clearly thinks the funding of research is important but only tells me this after having asked me to agree not to ask him/her his/her own thoughts on the issue. The second and third examples display elements that are shared across many of the interview transcripts; a vocal admission that the interviewee is not comfortable about discussing funding and/or short and hazy responses. This issue is discussed further in Chapter Six.





## ***Part IV: Tracing the presence of research-based ideas about health inequalities within policy***

### **Chapter Five: The contrasting journeys of competing ideas**

#### **5.1 Introduction to the Chapter**

Drawing largely on the data generated by the thematic and the social constructivist analyses of policy statements (see sections 3.2.1 and 3.2.2 in Chapter Three) and the interviews with individuals involved in the construction of policy, this chapter traces evidence of research about health inequalities within policy. In order to examine this issue, it is first necessary to be clear about the *types* of health inequality with which policy is concerned so this task is undertaken immediately after this introduction, in section 5.2. Originally, the intention of the subsequent sections of this chapter was to trace the extent to which research *evidence* concerning health inequalities was evident within policy. However, as section 5.3 demonstrates, it soon became clear that there are few data to suggest that evidence has played much of a role in policy. Instead, it is ideas which appear to have travelled into policy (Weiss 1982; Blyth 1997; Béland 2005; Stevens 2007). As a result, an ideational approach is taken to the rest of the analysis in this chapter, an approach which is explained in the first part of section 5.4.

Not surprisingly, it is clear from the data that not all ideas have journeyed into policy with equal success. The rest of section 5.4 focuses on exploring the traces of research-based ideas that are visible in the data. From this analysis, five distinct journey types are evident, each of which is discussed in turn: successful; re-contextualised; partial; fractured; and weak. In addition, at least two ideas evident in research reviewed in Chapter Two appear not to have journeyed from research into policy at all and are therefore classified as 'non-journeys'. There is also, perhaps unsurprisingly, evidence of ideas which are related to tackling health inequalities within policy but which appear to have emerged from sources other than health inequalities research. However, as the focus of this thesis is on the relationship between health inequalities research and policy, this chapter focuses on the journeys of research-based ideas rather than the influence of other kinds of ideas. This section also demonstrates how the way in which health inequalities have been conceptualised as a policy problem has



played an important role in the differential journeys of research-based ideas. Section 5.5 then briefly reflects on aspects of the data which suggest that there was a change in the level of policy interest in health inequalities towards the end of the study period, possibly due to emerging evidence that policy approaches to health inequalities appeared, so far, to have been relatively unsuccessful. Trying to understand the underlying reasons behind the construction of health inequalities as a particular kind of policy problem, the varying journeys of research-based ideas and the fluctuating levels of interest in the issue form the basis of much of the discussion in the remainder of the thesis. In preparation for this analysis, section 5.6 summarises the key findings presented in this chapter, highlighting the main points of interest for subsequent chapters.

It is important to highlight, at this point, that the analysis presented in this chapter is relevant to both the Scottish and English contexts. Some of the subtle differences between the two are mentioned but, on the whole, the similarity of the data meant that it made more sense for the narrative of the thesis to focus on developing and then explaining the typology of journey-types (rather than focusing on similarities and differences between the two contexts). Elsewhere, I have worked with colleagues to specifically explore the similarities and differences between policy approaches to health inequalities in England, Scotland and Wales (Smith, Hunter *et al.* forthcoming - see Appendix VIII).

## **5.2 What types of health inequalities have policy documents focused on?**

At various points in both the English and Scottish policy documents, most of the types of health inequality discussed in Chapter Two (section 2.2) are referred to, including health differences between socio-economic groups, between areas, between genders and between ethnic groups. However, much like the research literature discussed in Chapter Two, the form of health inequality on which policy most frequently focuses is that relating to socio-economic class or deprivation. For example, *Saving Lives* (Secretary of State for Health 1999, pt4.2) states: 'Health inequality runs throughout life, from before birth through into old age. It exists between social classes, different areas of the country, between men and women, and between people from different ethnic backgrounds. *But the story of health inequality is clear: the poorer you are, the more likely you are to be ill and to die younger*' [my emphasis] and *Partnership for Care* (Minister for Health and Community Care 2003, p7) highlights the health



'gap' between the richest and the poorest communities in Scotland as that which is 'unacceptable' and, therefore, the key focus of Scottish health policy.

Given the way in which the research on health inequalities in Britain has prioritised the stratification of health by socio-economic class and measures of deprivation over other possibilities, the policy priority given to these types of health inequality may seem unsurprising. It suggests that, in this respect at least, research has had a significant influence on policy. Indeed, it is worth noting that it is a focus which contrasts significantly with the foci of broader equalities agendas in both countries, which tend to focus on equalities relating to ethnicity, gender, disability, sexual orientation and religion, rather than socio-economic class or geographical location (e.g. Scottish Executive 2002, 2006, 2007; Cabinet Office 2007). This contrast underlines the fact that socio-economic differences in themselves do not tend to be viewed as problematic by policymakers (a point returned to late in this chapter and in subsequent chapters - see also Heath 2007).

Nevertheless, alternative forms of health inequality are not completely absent and there are references to health differences between ethnic groups and between men and women in the statements from both countries. Indeed, there is some indication within the data that policy interest in broadening conceptualisations of health inequalities beyond socio-economic status and deprivation increased during the study period. For example, in England, the data reveal a tangible increase in the emphasis placed on inequalities in health between different ethnic groups and in Scotland there is a noticeable interest in gender differences in life expectancy (most evident in a range of healthcare related interventions designed specifically to target men in deprived areas). Whether these moves to broaden conceptualisations of health inequalities result from recognition of a need to overcome the current contrast between policy approaches to health inequalities and the foci of the broader equalities agendas, or whether they represent the influence of research highlighting the important influence of a range of social positions on health (e.g. Davey Smith, Charsley *et al.* 2000; Chaturvedi 2001; Graham 2004; Stanistreet, Bambra *et al.* 2005), is unclear. The important point from the perspective of this thesis is that the data suggest that, during the study period, policy interest in health inequalities largely mirrored the majority of UK-based research evidence to the extent that the most significant concern has been with health differences between socio-economic groups.



A further parallel between policy conceptualisations of health inequalities and those evident in the research literature (as discussed in Chapter Two) is the way in which areas of deprivation are commonly used as a proxy measure for capturing socio-economic differences between groups of people. So although *The Social Justice Report* (Scottish Executive 1999a, p1), for example, is critical of past policies that focused on 'places instead of people,' the identification of the 'worst off' or 'most deprived' in the statements from both countries is frequently achieved through employing deprivation scores for the areas in which people live. Conceiving of health inequalities in this way has important implications for the types of intervention that might be considered most appropriate, as discussed later in this chapter.

### 5.3 Ideas, not evidence

Despite New Labour's initially strong rhetorical commitments to evidence-based policy, outlined in Chapter One (e.g. Cabinet Office 1999a, 1999b), there are very few indications of the presence of evidence within the data from the documentary analysis. Whilst this could be seen as a feature of the way in which such statements are written (i.e. usually without direct reference to non-policy sources), the interview data support this assessment. Indeed, *not a single interviewee* claimed that policies aimed at addressing health inequalities had been significantly based on research evidence. The data presented in Table 5.1, over-page, capture this belief and are illustrative of the broader trends in the data, demonstrating the high level of consensus about this matter, which was evident across interviews from different sectors and in both Scotland and England. The last interviewee quoted in Table 5.1 even expresses doubt about the policy influence of the government funded *Independent Inquiry into Inequalities in Health* (Acheson 1998), despite the fact that many policy statements claim it had significant influence on subsequent policy decisions (e.g. Department of Health 1999; Secretary of State for Scotland 1999). The data collected for this thesis are not sufficient enough to make broad claims about the specific role that this Report has played in subsequent policy decisions but they do make it clear that research evidence about health inequalities rarely appears to have informed policy responses in any direct sense.



Table 5.1: The lack of evidence-based health inequalities policy

Interviewee	Illustrative quotations
Senior academic researcher	'The research [on health inequalities] has had absolutely no, well, it's had very little impact on policies.'
Civil Servant (Scotland)	'The policy process does not rely on research evidence... it may be challenged, it may... but there's nothing that says, that makes the system stop, you know, there's not a button for evidence that you have to press for the policy process to continue.'
Civil Servant (England)	'My impression is that after about 2001, unfortunately the sheer pace and scale of action required of the Labour government meant that evidence again got pushed onto the back burner, which is a real shame - not just for health inequalities but also for other areas - just because government was producing more policies than it had time to master the evidence on.'
Minister (Scotland)	'I don't think there's very much evidence-based policy around yet.'
Minister (England)	'If I'm truthful, it [the Acheson Report] was... [pause] I think it had much more impact on other people than it ever did on me. It was, I mean most of it was sort of confirmation. We'd have done most of what we did whether Acheson had done his Report or not but we'd said that we would have a new Black Report and we did...'

Before jumping too hastily into a discussion about why UK policies to tackle health inequalities have not been based on the research evidence, it is important to take on-board the lessons already learned about the relationship between research and policy. As Weiss points out, it is ideas rather than specific research evidence which tend to influence policy:

'It is not usually a single finding or the recommendation derived from a single study that is adopted in executive or legislative action (although this occasionally happens). [...] Instead, what seems to happen is that generalizations and ideas from a number of studies come into currency indirectly – through articles in academic journals of opinion, stories in the media, the advice of consultants, lobbying by special interest groups, conversations with colleagues, attendance at conferences or training programmes, and other uncatalogued sources. Ideas from research are picked up in diverse ways and percolate through to officeholders in many officers who deal with the issues...' (Weiss 1982, p 622)

It is indeed the case that whilst policies relating to health inequalities were not perceived by interviewees to be evidence-based, nearly all of the interviewees suggested that key research-based ideas about health inequalities have travelled into policy. So although references to specific studies of, or researchers involved in, health inequalities were infrequent in the policy data (i.e. the analysis of policy statements and the interviews with individuals involved in policymaking), policy-based interviewees often discussed the influence of particular idea-sets



(such as 'psychosocial explanations of health inequalities' or ideas about the importance of the 'early years' of life). It is this more subtle kind of influence which the following interviewee suggests the Acheson Report eventually began to have on policy decisions in England:

Senior civil servant (England): *'What they [ministers] did [with the Acheson Report] was nothing much to start with, I think they had a think about it. [But...] as time went on they became more and more engrossed in the issue and so gradually Acheson became part of, if you like, the fabric of government and it was, it was almost a process of osmosis, really.'*

As the following interviewee explains, the complexity and enormity of the policy-making machinery can mean it is often unclear to Ministers where the ideas presented to them by civil servants have emerged from, or what evidence (if any) they are based on:

Minister (Scotland): *'I suppose my sense of it is that the research people feed into the civil service and then the civil service feed into ministers but... I suppose the ministers very rarely relate directly to the research people and that's part of the problem that I've articulated, that research is not routinely [...] it's like at a remove. And so it may be that some of the civil servants get this research and then draw their own conclusions from it and then give their advice but it's not, in that sense, explicit.'*

Although this may seem like rather a simple point, it is also an essential one because, as this chapter goes on to demonstrate, once detached from a specific evidence-base, ideas are more easily open to differing interpretations and uses by various actors (see Blyth 2001). The remainder of this chapter therefore takes an ideational approach (Finlayson 2004) to exploring the relationship between research and policy, tracing what appear to be footprints in policy of research-based *ideas* about health inequalities.

#### **5.4 Tracing the influence of health inequalities research in policy – an ideational approach**

As Chapter One discusses, academic interest in the role of ideas in policymaking has recently been increasing (Hall 1993; Blyth 1997; Campbell 2002; Béland 2005). Yet, this turn to ideas

has not gone uncriticised. Indeed, (Blyth 1997, p229) describes it as 'flawed' and 'theoretically degenerate' because it treats ideas, 'as desiderata, catch-all concepts to explain variance, rather than subjects in their own right' and does not explain 'what ideas are and what they do.' To avoid falling subject to such critiques it is therefore essential to be clear from the outset about what is meant by 'ideas' and an 'ideational approach'. In the thesis overall, several different genres of ideas are developed and discussed. Within this chapter, however, the focus is solely on the research-based ideas about health inequalities. That is, the ideas of concern here are those which were identified within the research literature (in Chapter Two) as advancing particular ways of thinking about the causes of health inequalities and which can be (and are) used to promote related responses.

This process perhaps sounds simpler than it is for ideas are not fixed entities, as Hall (1993, p290) reflects: 'Like subatomic particles, ideas do not leave much of a trail when they shift.' Without being witness to the moments at which ideas are translated between actors, it becomes difficult to know whether what appears to be a 'trace' of a particular idea actually is, or is merely another idea with some similar characteristics. Consequently, as discussed in Chapter Three (section 3.2.2), in undertaking the thematic analysis of the policy statements I was accommodating in my interpretations of the presence of particular ideas, noting all examples of ideas that seemed in any way recognisable in relation to the research-based ideas discussed in Chapter Two. Data from the interviews (particularly those with individuals who were involved in the construction of these documents) were then used to supplement this analysis. Nevertheless, when reading this section it should be borne in mind that, as I was not personally involved in, and did not observe, the construction of the policy statements, my analysis is inevitably retrospective and can, therefore, claim to be no more than an informed (but speculative) interpretation of the influence of research-based ideas on policy.

#### 5.4.1 *A typology of journeys*

The first point to note is that two of the ideas rejected in the Black Report and unsupported by subsequent research – the notion that health inequalities might be no more than an artefact of the data and the belief that health inequalities are *completely* 'natural' (or genetic) – are not evident in either the documentary or the interview data. This in itself seems likely to be at least partially a result of the ideas developed by researchers in and after the Black Report (Bartley, Blane *et al.* 1998; Berridge and Blume 2003). However, as this thesis is focusing on



a period in which policymakers had clearly accepted that health inequalities exist and are something that can (and should) be reduced, neither of these ideas is included in this analysis. Instead, the focus is on how research-based ideas travelled into policy once policymakers had decided that reducing health inequalities was a 'policy problem' that they wanted to tackle.

Virtually all the other well-known ideas about health inequalities that were discussed in Chapter Two feature somewhere in the data from the documentary analysis and the interviews with individuals involved in policy. However, not all had fared equally in terms of their influence. After analyzing the ways in which the various ideas about health inequalities were discussed within the policy statements and interview transcripts, I decided that the findings could helpfully be captured and explained by developing a typology of 'journeys' (an earlier version of this typology is explained in Smith 2007— please see Appendix IX). Six different types of journeys from research into policy were distinguishable, including those which did not appear to have travelled at all (i.e. 'non-journeys'). In addition, the data reveal traces of a number of ideas about health inequalities which do not appear to have come from the research evidence. Each journey type is now discussed in detail, with reference to the data. For reasons of brevity, only illustrative extracts from the data are employed to support this analysis so, in order to provide readers with some indication of the extent to which the idea is visible within the overall data, this information is accompanied by figures indicating the number of policy statements (of those analysed) in which similar examples can be found. Data from the social constructivist analysis of policy statements and from interviews with individuals who have been involved in constructing policy (or who have worked closely with policymakers) in the decade following 1997 are then used to reflect on some of the reasons behind these differing journeys. Sub-section 5.4.9 discusses the overall, resulting typology.

#### 5.4.2 'Successful journeys'

'Successful journeys' describe situations in which ideas appear to have travelled into policy coherently (i.e. with only limited transformation), in a way which has allowed them to significantly influence both policy rhetoric and subsequent actions. Ideas that are deemed to have travelled 'successfully' are therefore ones which are evident both in the way policy statements and policy-based interviewees describe the *causes of* existing patterns of health inequalities and in their articulations of appropriate policy *responses*. Perhaps unsurprisingly, given the widely held view that policy has not been evidence-based, only one example of a



'successful journey' was detectable: the importance of the early years of life for explaining (and intervening in) health inequalities. Whilst this idea is, for some people, perhaps better viewed as part of more general claims about the importance of the lifecourse, there has been particular interest within the research community about the effects early years (and even foetal) development on later life, as section 2.3.8 of Chapter Two outlines, and it is these ideas which are most visible within the policy data (the fate of ideas about the importance of the lifecourse more generally is discussed under 'fractured journeys' in section 5.4.5). Table 5.2, below, illustrates the ways in which ideas about the importance of early years have been employed within the policy statements concerning health inequalities in each country.

Table 5.2: Evidence of ideas about the importance of the early years of life within policy

Context	Illustrative extracts:
Scotland	<p><i>Towards a Healthier Scotland</i> (Secretary of State for Scotland 1999, pt49): 'The profound effects of early influences on lifelong health have been emphasised repeatedly in this White Paper and the recent Acheson Report. The future health of children is greatly influenced by their early years.'</p> <p><i>Improving Health in Scotland - The Challenge</i> (Scottish Executive Health Department 2003a, p17): 'There is clear evidence that health throughout life is powerfully influenced by experiences in early childhood, and indeed from the time of conception (when the health of the parents is important).'</p> <p><i>Partnership for Care</i> (Minister for Health and Community Care 2003 p13): 'The Executive will develop an integrated approach for Early Years, including an enhanced focus on health improvement.' [The document then lists a range of initiatives focusing on early years, including Sure Start in Scotland].</p>
England	<p><i>Tackling Health Inequalities: 2002 Cross Cutting Review</i> (Department of Health 2002, p1): 'Early investment programmes can produce significant long and short term benefits for children in terms of improved health, improved social and emotional development and improved educational attainment.'</p> <p><i>Choosing Health</i> (Secretary of State for Health 2004, p42): 'Addressing health inequalities among children and young people has to be a major priority for all local agencies in order to break the cycle of deprivation that has undermined so many strategies for improving health in the past.'</p> <p><i>Choosing Health</i> (Secretary of State for Health 2004, p44): The '<i>Child Health Promotion</i> programme set out in the <i>National Service Framework for Children, Young People and Maternity Services</i> [...] provides a joined-up system to ensure health and wellbeing for children and young people from birth to adulthood. The new programme moves on from a narrow focus on health screening and developmental reviews to a more broad-based programme of support to children and their families that will help address the wider determinants of health and reduce health inequalities.'</p>



As Table 5.2 illustrates, ideas about the importance of the early years of life have been used both to help explain patterns of health inequalities and to help justify decisions to target key policy interventions at mothers and young children. Importantly, the notion that health inequalities in later life may be at least partially explained by experiences in early life is not used in a fatalistic sense; there are no suggestions that patterns of health inequalities in later life cannot be altered by policy intervention and nor do the statements claim that policy attempts to reduce health inequalities can *only* have long-term effects. So whilst the idea that the early years of life are a crucial point in which to intervene in health inequalities has travelled successfully into policy, it is presented alongside other ideas which focus on different points of the lifecourse (as discussed in sub-section 5.4.5).

Overall, the analysis of all the key policy statements demonstrates that 11 of the English documents cite ideas about the importance of early years in relation both to understanding the causes of health inequalities and in justifying proposed solutions and a further 10 documents discuss the importance of having interventions which focus on early years (so only 5 of the 25 documents make no specific mention of early years). Amongst the 17 Scottish documents, 11 refer to ideas about early years in relation to causes of and solutions to health inequalities and 2 mention early years solely in relation to solutions to health inequalities (this leaves just 4 documents that make no specific mention of the importance of early years). All this suggests that the idea that experiences in the early years of life are important to understanding and responding to health inequalities in the UK has experienced a particularly successful journey from research into policy. This assessment is supported by the interview data. Indeed, the following interviewee claimed that it was one of the few ideas that s/he felt had successfully influenced related interventions in a variety of different government departments:

Policy advisor (England): *'One of the most successful parts of policymaking as far as I'm concerned, the early years, children, childcare and Sure Start and, err, not just necessarily in terms of what difference it's making (which I hope is substantial) but just in terms of how the government got its act together and operated and [...] made policy, recognising what needed to be done and stuff, and doing it across a range of initiatives, so that you have maternity leave policy as well as child care policy, you*

*know, parenting support through Sure Start. This was a very good example of joined-up government...'*

In addition, ideas about the importance of the early years of life were one of the few examples for which a specific researcher's name (Professor David Barker) and specific pieces of research (particularly the evaluations of Head Start in the USA) were mentioned by policy-based interviewees in both Scotland and England. This suggests not only that ideas about early years provide an example of a 'successful journey' from research into policy but that the research evidence itself played a key role in facilitating this journey. For example:

*Senior civil servant (England): 'There was a series of... we thought, quite powerful evidence and we commissioned a research review when we were carrying out this review of policy for early years... which, again, seemed to indicate that... sufficient was known about the importance of early influences on later outcomes to make it worthwhile to have a programme which focused on children in deprived areas and families of the children in deprived areas and had aspects of health, family support, early education, play, childcare and which reached out to the more difficult families'*

Yet, interestingly, an interviewee who is involved in work on early years firmly believed that his/her research had, to date, had no influence whatsoever on health policy in Britain. It is unlikely that this interviewee was completely unaware of the policy initiatives referred to in the policy statements examined in this research, at least those published by the English government, as s/he described actively trying to engage with policymakers. This interviewee was not the only one who felt that ideas about the early years of life had not been as influential as they should have been; seven policy-based interviewees overtly stated that they felt efforts to improve the early years of life remained far too limited. For example, the following interviewee described feeling frustrated at having been unable to implement more interventions to improve the early years of life during his/her time in relevant offices:

*Minister (Scotland): 'The evidence base is, and has been for decades, but by the year it grows, the evidence base is overwhelming that [we need] intervention in the early years, right? Even pre-birth, right? Even pre-conception, right? If you want to start*



*looking at... linkages with maternal health, through foetal health, through to birth and so on, you know, that's the area that, if you were really serious about turning around the health of a generation, and particularly in some of our poorer communities, then that's where you'd put much, much more focus. [...] And we're not doing enough of it - it's far too piecemeal.'*

The above quotation raises questions about who is able to exert the kind of influence required to effectively change policy approaches as it demonstrates that, even though a minister who held relevant positions during the research period had been persuaded by research-based ideas about the importance of the early years of life, s/he had felt unable to implement the kinds of interventions s/he felt were necessary. This is far from the only example in the data of a minister reflecting that they had been unable to implement the kinds of policy changes they would have liked whilst in office. This last point is an important issue and is returned in Chapters Seven and Eight. For the moment, the key point is that even ideas which appear to have successfully travelled from research into policy - in the sense that they are clearly evident in policy statements *and* in the interview data with policy-based individuals and are linked to specific interventions and not just to rhetoric - may still have a great deal further to travel if they are to influence policy responses in the ways that advocates of the idea hope.

#### 5.4.3 'Partial journeys'

The notion of a 'partial journey' signifies the movement of an idea which appears to have travelled into policy accounts of health inequalities but which appears to have experienced difficulty influencing corresponding policy interventions and initiatives. Only one example of a partial journey was evident in the data and this was the journey of ideas about material and socio-economic determinants of health inequalities. This idea is, as Chapter Two illustrates, widely supported within the research literature (even if the precise nature of the aetiological pathways through which their influence is exerted continues to be disputed) and the data from the thematic analysis consistently reveal traces of it within the policy statements, as Table 5.3 (over-page) illustrates. Indeed, nearly all of the policy documents which were analysed acknowledge the role of wider socio-economic and material inequalities in contributing to health inequalities.



Table 5.3: Illustrative examples of the presence of ideas concerning the importance of material and economic determinants of health inequalities

Context	Illustrative extracts
England	<p><i>Our Healthier Nation</i> (Secretary of State for Health 1998, pt3.28): 'The Government's main task under the national contracts for health is to tackle the root causes of ill health. Most of these are social, economic and environmental.' And: 'Inequalities in health have worsened in the past two decades. They are a consequence of the widening of social and economic inequalities.'</p> <p><i>Reducing Health Inequalities: An action report</i> (Department of Health 1999, p39): '[W]e are committed to tackling the underlying problems, such as poverty, neighbourhood deprivation and lack of educational and employment opportunity.'</p> <p><i>From Vision to Reality</i> (Department of Health 2001, p1): 'The worst health problems in the country will not be tackled without dealing with their fundamental causes – poverty, lack of education, poor housing, unemployment, discrimination and social exclusion.'</p> <p><i>Tackling Health Inequalities: 2002 Cross Cutting Review</i> (Department of Health 2002, p5): 'Education and employment have been identified as fundamental determinants of health inequalities...'</p>
Scotland	<p><i>Working Together for a Healthier Scotland</i> (Secretary of State for Scotland 1998, pt33): 'The [Black] report stated that there was no single or simple explanation [for social class gradient in health], but stressed the importance of material conditions of life. Further studies have confirmed the findings of the Black Report.'</p> <p><i>Towards a Healthier Scotland</i> (Secretary of State for Scotland 1999, pt126): 'This White Paper [...] is realistic, recognising that improvements in health and well-being depend heavily on socio-economic factors and the quality of the environment in which people live. This is why such emphasis has been laid on life circumstances in addition to more specific action on priority lifestyles and health topics.'</p> <p><i>Our National Health</i> (Scottish Executive 2000, p7): 'Poverty, poor housing, homelessness and the lack of educational and economic opportunity are the root causes of major inequalities in health in Scotland. We must fight the causes of illness as well as illness itself.'</p> <p><i>Closing the Opportunity Gap</i> (Scottish Executive 2004c, Target D): 'Poverty and social exclusion are known to have an adverse effect on health.'</p>

Crucially, however, it is noticeable that nearly all of the statements concerning the influence of material and socio-economic factors on health outcomes focus on the role of poverty and deprivation, rather than inequality, reflecting a broader policy concern with the lower end of the spectrum of wealth, as opposed to the full social gradient (see Hills 2004). For example,



although the first Green Paper on public health that the Labour government published in England, *Our Healthier Nation* (Secretary of State for Health 1998, pt1.12), accompanied these claims with the statement that, 'tackling inequalities generally is the best means of tackling health inequalities in particular,' the statements published since have made rather less of the need to tackle *inequalities* in material and social circumstances and have instead focused specifically on tackling poverty and deprivation (i.e. one end of the spectrum of inequality). Similarly, the ambitious statements relating to goals such as full employment evident in Scotland's first Social Justice report (Scottish Executive 1999a) are absent from subsequent documents, which focus rather more on the need to address extreme deprivation and poverty.

Focusing on trying to improve circumstances for disadvantaged communities corresponds with a conceptualisation of health inequalities as an issue of 'health disadvantage', or a 'health gap' resulting from the poor health of the most disadvantaged groups (see Graham and Kelly 2004 - discussed in more detail in Chapter Two). This has important implications for potential solutions to health inequalities as, conceived of in this way, policy interventions which aim to *improve* the health of the most deprived groups can logically be viewed as interventions which are addressing health inequalities, a view evident in the following extracts:

*Choosing Health* (Secretary of State for Health 2004, p11): 'In order to close the gap, we must ensure that the most marginalised and excluded groups and areas in society see faster improvements in health.'

*Improving Health in Scotland - The Challenge* (Scottish Executive Health Department 2003a, p4): '[The challenge is] to narrow the opportunity gap and improve the health of our most disadvantaged communities at a faster rate, thereby narrowing the health gap.'

In other words, the 'problem' is located with the people who tend to experience the poorest health, rather than with society as a whole, and targeted health improvement interventions then appear to be a logical response. In contrast, conceptualisations of health inequalities as social gradients which traverse society imply that targeted interventions are fundamentally flawed as a response because they only focus on small sections of the overall gradients. Indeed, where the English policy statements briefly refer to social gradients in health (Department of Health 2002, 2005a; Health Inequalities Unit 2005), there is some

acknowledgement that, posed in this way, health inequalities require substantially broader responses than a focus on deprived groups alone. Yet, even within these documents the main discussions remain dominated by conceptualisations of health inequalities as 'health gaps' caused by 'health disadvantage'. Meanwhile, notions of a social gradient in health remain absent from major English policy statements, such as White Papers, and were mentioned by only one of the policy-based interviewees in England. In Scotland, the concept of a social gradient of health is only evident in the 1998 Green Paper (Secretary of State for Scotland 1998) and was absent from most of the interviews with policy-based individuals. It is perhaps unsurprising, therefore, that policy responses to health inequalities largely focus on targeting groups with the poorest health.

So far, the analysis suggests that ideas about the importance of material and social circumstances for health inequalities have influenced both policy conceptualisations of the causes of health inequalities *and* policy responses, albeit within a framework that focuses on the circumstances of the most disadvantaged rather than society as a whole. However, it is also noticeable that all of the policy documents, with the exception of the initial two Green Papers and Scotland's first *Social Justice Report* (Secretary of State for Health 1998; Secretary of State for Scotland 1998; Scottish Executive 1999a), spend significantly less time discussing the role of interventions designed to change people's material and economic circumstances than they do discussing the need to change people's lifestyle-behaviours and strengthen the role of local public services (particularly the NHS) in tackling health inequalities. This trend is particularly noticeable in a table taken from an early Scottish policy statement, *Towards a Healthier Scotland* (Secretary of State for Scotland 1999), which is reproduced as Table 5.4, over-page. As this illustrates, whilst specific foci for action are provided for 'lifestyles' and 'health topics', the column for 'life circumstances' remains empty. By way of an explanation, the document says that, 'expert groups' are investigating 'the importance of setting targets', and that 'work is ongoing within The Scottish Office to determine, in consultation with relevant interests, appropriate measures of progress in key areas'. This may reflect a genuine desire to ensure that appropriate foci are chosen. However, it cannot be ignored that, whilst frequent references are made to tackling health inequalities by addressing material and economic circumstances in most of the policy statements analysed, very few of them specify precisely how this will be achieved.



Table 5.4: Reproduced from Chapter 2 of *Towards a Healthier Scotland* (Secretary of State for Scotland 1999):

Scotland's Health: National Priorities		
<i>Tackling Inequalities</i>		
Improved Life Circumstances*	<ul style="list-style-type: none"> <li>• Lifestyles</li> <li>• Less smoking, drug and alcohol misuse</li> <li>• A healthier diet</li> <li>• More physical activity</li> </ul>	<ul style="list-style-type: none"> <li>• Health Topics</li> <li>• Child health</li> <li>• Dental and oral health</li> <li>• Sexual health, including teenage pregnancies and sexually transmitted diseases</li> <li>• Coronary heart disease (and stroke)</li> <li>• Cancer</li> <li>• Mental health</li> <li>• Accidents and safety</li> </ul>
*Life circumstances include, for example, unemployment, poverty, poor housing, limited educational achievement, the general environment and all other forms of social exclusion.		

In addition, the policy data reveal two important shifts in relation to the emphasis placed on ideas about material and socio-economic determinants of health during the study period. On both occasions, the more recent statements place less emphasis on these ideas and more emphasis on lifestyle-behaviours and the role of the health services than the earlier documents. The first occurs between the publication of the initial, consultative Green Papers (Secretary of State for Health 1998; Secretary of State for Scotland 1998) and the subsequent publication of the White Papers (Secretary of State for Health 1999; Secretary of State for Scotland 1999), a change which has already been commented on in some detail by others (e.g. Davidson, Hunt et al. 2003). The second occurs around 2003-2004, when major public health statements were released in both countries (Scottish Executive Health Department 2003a; Secretary of State for Health 2004) which each place even more emphasis on the role of the health services and the need to change lifestyle behaviours than earlier documents. Whilst there has been little public comment about the Scottish statement, a number of critiques of the English *Choosing Health* White Paper (Secretary of State for Health 2004) raise concerns about the shift away from material and socio-economic determinants of health inequalities (e.g. Hunter 2005). More recently, in England, Tony Blair's 2006 lecture on public health has served to reinforce this shift. In it, Blair overtly repositions 'public health' as 'really' being about 'healthy living' and claims:



'Our public health problems are not, strictly speaking, public health questions at all. They are questions of individual lifestyle - obesity, smoking, alcohol abuse, diabetes, sexually transmitted disease' (Blair 2006 - part of the Our Nation's Future lecture series).

As the above quotation hints, the shift away from an initial interest in material and socio-economic determinants of health is associated with a shift in emphasis on where *responsibility* for health inequalities is located; a shift away from central government and towards individuals, as the extracts in Table 5.5, below, illustrate.

Table 5.5: The shift away from central government responsibility, towards individuals

Context	Illustrative extracts – England	Illustrative extracts - Scotland
Pre-2004 policies	<i>Saving Lives</i> (Secretary of State for Health 1999, pt4.9): 'While the roots of health inequality run deep, we refuse to accept such inequality as inevitable. Moreover, we fully accept the responsibility of Government to address such deep-seated problems. That is why we are committed to a wide-ranging programme of action, right across Government, to tackle them.'	<i>Towards a Healthier Scotland</i> (Secretary of State for Scotland 1999, chp6): 'A Public Health Strategy Group, led by the Minister for Health and drawn from all Scottish Office Departments, will ensure the integration of policies and initiatives with health implications within The Scottish Office, and encourage the use of Health Impact Assessment.'
2004+ policies	<i>Choosing Health</i> (Secretary of State for Health 2004, p6): 'People cannot be instructed to follow a healthy lifestyle in a democratic society. Health improvement depends upon people's motivation and their willingness to act on it. The Government will provide information and practical support to get people motivated and improve emotional wellbeing and access to services so that healthy choices are easier to make.' And: 'In our survey, 88% of respondents agreed that individuals are responsible for their own health. Health is a very personal issue.'	<i>Fair to All, Personal to Each</i> (Scottish Executive 2004a, p1): '[K]ey decisions affecting our health lie in our own hands. The Government can't make us eat more healthily or give up smoking. Each of us needs to take responsibility for our own health by choosing a healthier lifestyle and the Government can help by providing appropriate opportunities and ensuring services are accessible and available.'  <i>Delivering for Health</i> (Scottish Executive 2005, pvi): 'We are working to encourage people to take greater control over their own health.'

As the extracts in Table 5.5 demonstrate, statements in the policy documents published in the early years of the study period state that responsibility for health inequalities is cross-cutting and a key issue for most (if not all) central government departments. This articulation of responsibility fits with a belief that tackling material and socio-economic issues is essential to



reducing health inequalities. Yet, whilst the later policy documents do not dismiss the need to tackle these issues entirely, they place rather less emphasis on the role of central government in dealing with these issues. Instead, as Table 5.5 illustrates, they suggest that the role of central government is largely perceived to be one of providing information and leadership to encourage others to act. The 'others' who are expected to act include (as the extracts in Table 5.7 indicate) the public, who are expected to take action to improve their own health as far as possible. In addition, as the subsequent section discusses, a significant amount of responsibility is placed on local public bodies, particularly the NHS (Primary Care Trusts in England and Local Health Boards in Scotland).

The lessening of central government responsibility for health inequalities is perhaps most overt within aspects of the data which suggest that ideas specifically concerning the link between *economic* circumstances and health are declining in influence within policy. For example, in England, it is noticeable that in policy statements published up to (and including) 2003, all of the statements that were analysed make a clear reference to the notion that economic circumstances influence health. However, in the statements published from 2004 onwards, there is visibly less emphasis on ideas about economic influences on health: Although 10 out of the 12 documents analysed that were published in England during this period do refer to these ideas, only 3 make clear reference to solutions based on these ideas, and even in these documents (Secretary of State for Health 2004; Department of Health 2005a; Health Inequalities Unit 2005) such references are limited in scope compared to the content of some of the statements published before 2004 (e.g. Secretary of State for Health 1998, 1999; Department of Health 2003). In Scotland, the data do not suggest that there has been such a noticeable shift but it is nonetheless fair to say that *The Social Justice Report* (Scottish Executive 1999a) places far more emphasis on ideas about economic determinants of health inequalities than any of the subsequent policy statements. There was also a noticeable questioning of the role that economic circumstances might play in addressing health inequalities amongst interviewees involved in Scottish policy, which the quotations in Table 5.6, over-page, illustrate.



Table 5.6: Evidence from interviews with individuals involved in policy which suggests that ideas about economic influences on health are declining in influence in Scotland

Interviewee	Illustrative quotations
Policy advisor	<i>'I don't think that people's income is by any means the sole determinant of, of health inequalities...'</i>
Senior Civil Servant	<i>'Since... Gordon Brown became Chancellor every budget has moved money... has moved money from the wealthy to the poor... Hence the reason that Scotland and England have narrowed their economic position, a bit... but I still think that it's a long-term strategy of uncertain success, to be honest.'</i>
Civil servant	<i>'[A]ny clot worth his, err, with an inkling of sense knows that it's not simply about wealth or income. Poverty is much more. If people on very low incomes spend their money wisely, limited money wisely, or they don't have the commitments that others do, they'll enjoy good health.'</i>
NDPB Policy Advisor	<i>'[T]here is a question at the moment about the extent to which there are people in Scotland who still don't have a level of material income that would enable them to, you know, live more healthily, have better health. I don't absolutely subscribe to that view but [...] I would have to question whether reducing material inequalities would also inevitably reduce [other] factors [affecting health] too...'</i>
NDPB Policy Advisor [different to above]	<i>'I think at the moment, the current... received wisdom is that basically health inequalities, the most important thing is in relation to socio-economic disadvantage, that's the sort of thing that's generally trotted out, and that, you know, if we can overcome or diminish these socioeconomic disadvantages then health will improve as a consequence. Erm, and so this general idea has been used to inform a lot of current government policy [...]. That's, you know, been, I think, the sort of... the main idea. Err... I think, it's now emerging that... that that in itself doesn't necessarily lead to improved health, that there are other factors that are all tied in with that, which may be more difficult to address...'</i>

The first two interviewees quoted in Table 5.6 said no more than they felt income was not the sole determinant of health inequalities or that strategies to tackle health inequalities by addressing economic inequalities were 'uncertain'. However, the third and fourth interviewees quoted in the table query the link between individual economic circumstance and health more overtly. Both question the notion that there are individuals within Scotland who do not have the economic resources to be able to live as healthily as others. Their comments suggest the speakers believe that, although differences in economic circumstances may make it more difficult for some individuals to live as healthily as others, they do no more than this and, therefore, that if poorer individuals only tried hard enough, they would be able to achieve the same kind of health as those who are economically better off than them. Both of these statements are indicative of the 'moral underclass discourse' that Levitas (2004) identifies within New Labour policy. The various opinions expressed in Table 5.6 also make it clear that



several of the interviewees suggest there had been a relatively recent re-assessment of the importance of economic determinants of health inequalities within the policy community in Scotland. So, whilst the source of data supporting this point differ for each context (with the documentary analysis producing more evidence of a shift in England and the interview data throwing more light on this issue in Scotland), the conclusion for each context is consistent; the notion that policy ought to tackle inequalities in wealth or economic determinants in order to reduce health inequalities seems to be losing favour (and, indeed, might never have had as much support within policy communities as some of the earliest policy statements suggest).

The analysis therefore supports the interpretation that, despite travelling into policy, ideas about the importance of material and socio-economic determinants of health inequalities encountered obstacles which limited and challenged their influence. One of the main obstacles referred to by policy-based interviewees in both contexts was the location of departmental responsibility for health inequalities within health departments (an issue which is discussed further in Chapter Seven). Yet this, in itself, does not constitute a satisfactory explanation for the partial journey of ideas about material and economic circumstances as the location of responsibility for policy issues is itself a political decision. If, for example, the idea that material and economic determinants of health are crucial contributors to patterns of health inequality had journeyed into policy in a truly successful sense, then it may have been decided to locate some of the responsibility for reducing health inequalities with other departments. Interestingly, policy-based interviewees in both England and Scotland suggested that this possibility had been considered at various points within the period between 1997 and 2007 but that it had never been widely supported on the basis that key people felt that 'Health' remained the department which could contribute the *most* to reducing health inequalities.

Overall, the data imply that, in contrast to the successful journey described in the previous sub-section, the influence of ideas about the importance of material and economic circumstances has been far more limited. Despite the fact that these ideas are employed frequently in policy articulations about the *causes* of health inequalities, and despite what Chapter Two (and, indeed, many interviewees) suggest is a far better supporting evidence base, there are very few data which support claims that policy *responses* to health inequalities have been informed by this idea. Furthermore, the data reveal noticeable shifts away from the



emphasis on these ideas (particularly in relation to the role that economic circumstances play in health inequalities) within the study period, a shift which is accompanied by a lessening in role that policy statements suggest central government should play, which is balanced by a corresponding increase in the emphasis placed on the responsibility of individuals. For all of these reasons, the journey of these ideas has been categorised as 'partial', a term which captures the sense in which the journey of this set of ideas appears to have been blocked as it travelled into policy.

#### 5.4.4 *'Re-contextualised journeys'*

As may already be apparent from the discussion in the previous sub-section, ideas about the relationship of lifestyle-behaviours to health inequalities and ideas about the role of the health services in addressing health inequalities constitute, in many ways, the sets of ideas which the data suggest have enjoyed the most successful journeys into policy, being strongly evident in the policy statements of both countries. However, in both cases, the ways in which these ideas have been applied within policy differs substantially from the way the ideas are discussed by health inequalities researchers. Hence, each has been categorised as having undertaken a 're-contextualised', rather than a truly 'successful', journey into policy.

Starting with ideas about lifestyle-behaviours, Table 5.7, over-page, demonstrates that variations in a range of lifestyle behaviours (but particularly smoking) are articulated as key factors in explaining health inequalities in both countries. Furthermore, interventions designed to improve people's lifestyle behaviours (particularly interventions designed to reduce smoking, increase levels of exercise and improve diet) are put forward as key responses to health inequalities. Overall, 21 key policy statements in England (of the 25 analysed in total) and 13 key policy statements in Scotland (of the 17 analysed in total) mention lifestyle-behavioural ideas in relation to health inequalities. What is more, in-line with the shifts away from material and socio-economic determinants of health and from central government to individual responsibility for health (as discussed in the previous section), there is a noticeable increase in the emphasis placed on lifestyle-behavioural responses to health inequalities during the study period. However, the journey of these ideas between research and policy has not been categorised as 'successful' on the basis that, whilst the research supports the idea that there are links between lifestyle-behaviours and health inequalities, it does not support the idea that policy interventions which focus on specifically trying to address these



issues will be effective in reducing health inequalities (both because these determinants are influenced by other, underlying determinants – a point which many of the policy statements do acknowledge – and because previous attempts to change people's lifestyle-behaviours appear to have contributed to widening health inequalities).

Table 5.7 Illustrative examples of ideas about the links between lifestyle-behaviours and health inequalities in post-1997 policy statements

Context	Illustrative extracts
England	<p><i>Saving Lives</i> (Secretary of State for Health 1999, pt6.4): 'Several of the major risk factors which increase the chances of people developing coronary heart disease or having a stroke are now well established. The key lifestyle risk factors, shared by coronary heart disease and stroke, are smoking, poor nutrition, obesity, physical inactivity and high blood pressure. Excess alcohol intake is an important additional risk factor for stroke. Many of these risk factors are unevenly spread across society, with poorer people often exposed to the highest risks.'</p> <p><i>2002 Cross-cutting Review</i> (Department of Health 2002, p6): 'Smoking is the single most significant causal factor for the socio-economic differences in the incidence of cancer and heart disease. However, also important are physical activity and nutrition...'</p> <p><i>Choosing Health</i> (Secretary of State for Health 2004, p21) discusses the power of 'social marketing' as a tool for changing people's behaviours and also introduces some new initiatives designed to alter lifestyle behaviours amongst disadvantaged groups, such as community-based 'health trainers'.</p>
Scotland	<p><i>Towards a Healthier Scotland</i> (Secretary of State for Scotland 1999): 'Tobacco smoking is the most important preventable cause of ill-health and premature death in Scotland. It accounts for at least two-thirds of the excess deaths due to inequalities in health' (pt36); and 'The poor diet of deprived communities is a major reason why they experience such poor health.' (pts39-41) Goes on to suggest that the following will help reduce health inequalities: new laws to ban tobacco advertising, stop-smoking promotion campaigns and enhanced smoking cessation services, increased funding of the Diet Action Plan initiatives, appointment of a national dietary co-ordinator to give impetus to implementation of the Plan, funds to develop youth/school sport and the establishment of a Task Force to develop a National Physical Activity Strategy for Scotland, new drug prevention and treatment services, the three health demonstration projects; and a HEBS national media campaign to address the risk-factors thought to contribute to coronary heart disease and cancer. (All in Chapter 4).</p> <p><i>Delivering a Healthy Scotland</i> (Scottish Executive Health Department 2006, p24): 'Smoking remains the most important preventable cause of ill-health and premature death in Scotland. It is also strongly associated with health inequalities, with much higher proportions of people living in disadvantaged communities smoking than those in better off areas.'</p>



Despite the frequency with which lifestyle-behavioural approaches to tackle health inequalities were put forward within the policy statements, some of the policy statements (e.g. Secretary of State for Health 1999; Scottish Executive 2000) and many of the policy-based interviewees express awareness of (and some concern about) the limitations of such approaches. Indeed, whilst many of the interviewees said they thought the ban on smoking in public places was the most significant policy action taken to date in relation to health inequalities, they were far less certain about the potential impact of other (less universal) interventions and initiatives designed to alter people's lifestyle-behaviours. Many of the academic interviewees and several policy-based interviewees, particularly in Scotland, were openly critical of these kinds of approaches, as the quotations in Table 5.8 illustrate.

*Table 5.8: Concerns amongst Scottish interviewees (with connections to policy) about the limitations of lifestyle-behavioural responses to health inequalities*

<b>Illustrative quotations:</b>
Civil servant (Scotland): <i>'I think people have ignored the, the fact that, you know, evidence from, you know, large-scale risk factor interventions in... adults, evidence for the effectiveness of those kinds of interventions is very weak and [...] they've ignored the evidence from other multiple-risk factor intervention trials... that it's actually very hard to sustain any change in risk factors in adults... So the... policymakers remain focused on trying to tackle those kinds of problems whereas... if you look closely at the evidence, there may be a case for switching your investment into other areas.'</i>
Minister (Scotland): <i>'[T]hey [policymakers] still live with this idea that it's all about bananas [i.e. diet], which is complete rubbish.'</i>
NDPB (Scotland): <i>'Ministers and civil servants probably think that, err, they have greater confidence in the ability of what might be described as health promotion measures to make a difference, both with the population as a whole and tackling inequalities. Err... there still seems to be quite a sense that, say things like advertising campaigns in the media can improve people's health, you know, [if you] just get the message right. Whereas there isn't much evidence to, to support that...'</i>

It is worth noting that each of the interviewees quoted above suggested that it was individuals in roles other than the ones they themselves occupy who believed that lifestyle-behavioural approaches were an appropriate response. The first and second interviewees both use the term 'policymakers' in a way which suggests that they did not consider themselves part of this group, and the third interviewee, a policy advisor, claims the problem lies with 'ministers and civil servants'. The lack of clarity evident within the interview data about who really *makes*



policy and who influences policy outcomes is important and is returned to in Chapters Seven and Eight.

The concerns about the possible impact of lifestyle-behavioural interventions that are expressed in both the documentary and interview data echo (and, indeed, sometimes refer directly to) research which, as discussed in Chapter Two, suggests that policies that aim to change lifestyle-behaviours alone are unlikely to be effective and may even widen health inequalities (e.g. MRFIT 1982; Tudor-Smith, Nutbeam *et al.* 1998). Yet, if it is the case that (at least some) individuals involved in the construction of post-1997 policies were wary about taking a lifestyle-behavioural approach, it seems strange that these ideas have been as influential as they have with regards to policy interventions. One of the interviewees quoted in Table 5.8 explained s/he felt the reason for the emphasis on lifestyle-behaviours in recent policies is that research had *previously* supported and promoted such ideas. According to this interviewee, lifestyle-behaviours represent an idea that successfully journeyed from research into policy some time ago and which have since remained influential within policy because they have not yet been effectively challenged by other ideas.

It would certainly seem that lifestyle-behavioural ideas journeyed into policy some time ago (see, for example, Health Departments of Great Britain and Northern Ireland 1976; Department of Health 1992; Scottish Office 1992) and the suggestion that these ideas have held sway since then, despite developments in the research evidence, makes sense if it is ideas rather than research which travel into policy. As Finlayson (2004, p 536) argues, '[in] politics, ideas and concepts are not social scientific in nature: they are political. Their function is not necessarily to be accurate or even adequate descriptions of the world,' but rather to act as a political tool, persuading others of the benefits in pursuing a particular course of action. If this theory is correct, changes in the research-base which support (or challenge) a particular idea will not automatically affect the position of an idea once it has travelled into policy. Indeed, ideas may become deemed, as several of the interviewees suggested in relation to the importance of smoking, 'self-evident' (i.e. no longer requiring research-evidence). Or, following Peter Hall (1990), once ideas become institutionally embedded, it may be extremely difficult for ideas that challenge them to have any influence. This 'embeddedness' appears to have contributed to an assumption that policies aimed specifically at addressing lifestyle-



behavioural risk factors will necessarily contribute to reductions in health inequalities simply because the relevant risk factor is more prevalent within groups experiencing health disadvantage. This is particularly evident in relation to aspects of the data which discuss smoking, as the extracts in Table 5.9 illustrate.

*Table 5.9: Evidence of an assumption that interventions to improve lifestyle-behaviours will contribute to reducing health inequalities*

<b>Illustrative extracts:</b>
Civil servant (Scotland): <i>'[In considering] the case for passive smoking, we knew from common sense, we knew that the prevalence of smoking was higher in disadvantaged communities so the health inequalities aspect played in there [in decision to focus policy on smoking cessation].'</i>
<i>Closing the Opportunity Gap</i> (Scottish Executive 2004c, Target D): 'The introduction of smoke free public places in March 2006 will almost certainly reduce the toll of preventable, premature deaths and ill health, and will be of particular benefit for those in deprived communities, who suffer most from the effects of smoking.'
<i>Saving Lives</i> (Secretary of State for Health 1999, pt1.28): '[S]moking more than any other identifiable factor contributes to the gap in healthy life expectancy between the most deprived and the most advantaged. [...] Tackling smoking achieves both our objectives - improved health for all, and especially better health for the worse off.'

In one interview with a Scottish civil servant, the interviewee went as far as to claim that, in the end, it is the 'lifestyle choices' themselves which kill people (this extract has not been included as the interviewee requested it be removed from the transcript – see Chapter Four). Without focusing overly on the specifics of this particular claim, it is clear from the data that there is a widespread belief within policy that, as health inequalities are evident in the distribution of major chronic diseases, policies which aim to reduce the prevalence of risk factors for these diseases (particularly smoking but also obesity and other risk factors) are automatically likely to reduce health inequalities. In the case of the smoking bans in public places, this assumption allowed the ban to be articulated by interviewees as a research-informed intervention for tackling health inequalities, even though the effects of national smoking bans on health inequalities are uncertain (see, for example, Thompson, Pearce *et al.* 2007). For other lifestyle-behaviours, the links to health outcomes remain less clear (see, for example, Gard and Wright 2005 on the moral ideologies underlying current concerns with diet and physical activity) but the policy statements (and some of the interview data) nevertheless claim that 'healthier lifestyle choices' provide a route to tackling health inequalities.



The logic employed in each instance relies on the presumption that interventions which aim to change lifestyle-behaviours will have at least as much impact (if not more) on groups exhibiting relatively poorer health outcomes as on groups exhibiting relatively better health outcomes, despite the fact that, as already discussed, a great deal of evidence suggests the reverse may be more likely. Indeed, some of the policy statements (and some of the policy based interviewees) overtly acknowledge these past failures. However, rather than concluding that such approaches may be unlikely to work in future, the conclusion often drawn within the data is that previous attempts to tackle health inequalities in this way only failed because they were not effectively (or appropriately) implemented. In line with this rationale, it is suggested that, if lifestyle-behavioural changes can be effectively targeted at the groups with poorest health outcomes then these measures *do* provide a means by which health inequalities can be addressed. For example:

*Tackling Health Inequalities: A programme for action* (Department of Health 2003, p6): 'Experience has shown that the potential to generate and share health gains across the population by preventive action — for example, by targeting smoking and sedentary lifestyles — has yet to be fully realised.'

Minister (England): 'A great deal of stuff to do with health inequality that's related to people's... sort of adjustable lifestyles, err... that is at least to some extent in their own hands, I think that a great deal of that publicity, over the years, has been talked of in terms, and promoted in images, and everything which are very, very middle-class and appeal to middle-class people and middle-class people take notice of them. And my view is that we needed to start changing it so that we had a Sun and Daily Mirror approach so that we might actually have more influence on people's lifestyles who were reading, the people who most needed some influence on their lifestyles were getting more influence...'

The notion that a new way of promoting lifestyle-behaviours is what is required, rather than a completely different approach to reducing health inequalities, is particularly evident in the recent policy interest 'social marketing' techniques, which feature in the post-2003 policy statements in both countries (Scottish Executive Health Department 2003a; Secretary of State for Health 2004). Advocates of social marketing claim the approach differs from previous

approaches to selling health promotion messages because it is based on detailed research with the intended audiences and is therefore capable of *targeting* messages more effectively than previous, one-size-fits-all approaches (Grier and Bryant 2005). Whether it actually will be effective in helping to reduce health inequalities or whether it is fair to claim that previous approaches to selling health promotion messages were not based on research are both questionable (Buchanan, Reddy *et al.* 1994). Yet the idea that 'social marketing' represents a new and substantially different approach to health promotion has evidently played a role in justifying an ongoing policy focus on lifestyle-behavioural approaches to tackling health inequalities.

The assumption that effective targeting will allow lifestyle-behavioural interventions to significantly contribute to reducing health inequalities appears to result, at least partially, from way in which health inequalities have been conceptualised, particularly within the national targets. As Appendix X illustrates, the English national targets concern the need to tackle 'health disadvantage' to reduce 'health gaps' and the Scottish national targets focus on reducing 'health disadvantage'. This has allowed research-based ideas about measures to improve health, such as interventions to improve lifestyle-behaviours, to be 're-contextualised' within policy as appropriate responses to health inequalities, so long as they are effectively focused on the groups towards which the national targets are orientated.

A deeper level of analysis reveals more general slippage (or lack of distinction) between the twin policy aims of reducing health inequalities and improving health, a further factor likely to have contributed to the re-contextualised journeys that have been identified. This overlap is particularly overt in the data from Scotland, where policy responsibility for health inequalities is largely located in a Health *Improvement* Directorate (as opposed to England's Health *Inequalities* Unit). Indeed, as the following two extracts demonstrate, the policy focus on 'health inequalities' in Scotland is often perceived as indistinct from 'health improvement':

Civil servant (Scotland): *'I would say that health improvement is very high on the agenda and health inequalities are an intrinsic part of that policy, rather than single them out as something separate.'*



*Improving Health in Scotland - The Challenge* (Scottish Executive Health Department 2003a, p11): '[A]ligned with the Executive's strategies for promoting social justice and closing the opportunity gap, there is a particular focus on tackling health inequalities as the 'overarching aim' of the health improvement agenda.'

In addition to the amalgamation of these two, distinct policy aims, the data from Scotland reveal a recurring concern about Scotland's reputation for poor health and its regular lowly performance in international league tables. This point is made in a wealth of policy statements (Secretary of State for Scotland 1997, 1999; Scottish Executive 2000; Scottish Executive and NHS Scotland 2001; Minister for Health and Community Care 2003; Scottish Executive Health Department 2003a) and was reflected upon by four of the policy-based interviewees. For example:

Civil servant (Scotland): *'There's this very strong perception that... our health in Scotland is a particular problem and it's worse than it is anywhere in Europe; it's a sort of national disgrace, you know, that this situation should obtain so people desperately want to do something about it.'*

Although the concern with international league tables is particularly overt in Scotland, similar comparisons are also made in some English documents (e.g. Department of Health 2004). So although, as Chapter One outlines, much was made of both governments' decision to focus on health inequalities as a policy problem, the data collated in this project raise some questions about the extent to which a policy focus on health inequalities has been overshadowed by a desire to improve overall population health (a point re-visited in section 5.5). Whilst, theoretically, it is possible to achieve overall population health improvement *and* a reduction in health inequalities simultaneously (by improving the health of everyone but achieving faster improvements for the population groups that are currently experiencing poorer health), as several of the research-based interviewees were keen to point out, recent trends in population health suggest that achieving overall health improvement is more likely to result in widening health inequalities (as those groups who start with better health tend to improve their health at a faster rate).

Adding yet another layer of confusion to this situation, the data analysed reveal a frequent blurring of factors thought to determine individual health (or, more often, ill-health) and factors

thought to contribute to societal inequalities in health. As others have pointed out (e.g. Graham and Kelly 2004; Regidor 2006), merging these two types of determinants into a 'catch-all' category adds fuzziness to an already complex set of relationships and allows wide-ranging health related interventions to be put forward as interventions which are perceived to be tackling health inequalities:

'The commitment to addressing underlying causes is often summed up in the phrase 'tackling the determinants of health and health inequalities.' Such phrases can create the impression that policies aimed at tackling the determinants of health are also and automatically tackling the determinants of health inequalities. What is obscured is that tackling the determinants of health inequalities is about tackling the *unequal distribution* of health determinants.' (Graham and Kelly 2004)

The confusion surrounding key concepts relating to health inequalities may well also have contributed to the second example of a 're-contextualised' journey, which involves the role of the health services in tackling health inequalities. As Chapter Two discusses, some research focuses on the role that unequal access to (or use of) health services plays in explaining inequalities in health outcomes. However, within the UK, this explanation is rarely put forward as a major *cause* of health inequalities and, rather, as a factor which may exacerbate existing inequalities. Many of the policy statements that were analysed reflect this conclusion. For example:

*The NHS Plan* (Department of Health 2000, p27): 'Health inequalities were compounded by a failure to match provision of services with health needs.'

*Designed to Care* (Secretary of State for Scotland 1997, pt4): 'We must [...] address the differences in the availability of health care which reinforce inequalities.'

In total, all 25 of the English policy statements that were analysed mention health services in relation to health inequalities and 13 of the 17 Scottish policy statements do. Lower use of health services by some minority ethnic communities, lower rates of childhood immunisation amongst disadvantaged communities and a tendency for men aged over 50 who are from disadvantaged communities to present any symptoms of chronic diseases to GPs at a relatively late stage are all flagged up as issues which contribute to patterns of health



inequalities and which, therefore, ought to be addressed (e.g. Scottish Executive Health Department 2003a; Health Inequalities Unit 2005). As both of the extracts on the previous page illustrate, although the suggestion that differences in individuals' ability to access health services may contribute to health inequalities is visible within the policy statements, it is not put forward as a central *cause* of health inequalities. Furthermore, the statements often acknowledged that differences in access to and quality of health services do not explain why people from disadvantaged communities tend to experience symptoms of chronic diseases at an earlier age than members of more affluent groups. This assessment is also true of the interview data. To this extent, this would therefore appear to be a relatively 'successful' journey of an idea between research and policy.

However, the documentary analysis of the policy statements also reveal that, during the study period, policy ideas about the role that the health services might play in *tackling* health inequalities significantly shifted. From 2004 onwards, the policy statements place an increasing emphasis on the extent to which NHS-based interventions are expected to play in reducing health inequalities, as the extracts in Table 5.10, over-page, demonstrate. In other words, health services are increasingly positioned as a key solution to the problem of health inequalities, even though no attempt is made to suggest that they play any more than a contributory role in explaining health inequalities, particularly with regards to meeting the relatively short-term national targets. This is particularly true of the English policy statements but is also evident in the Scottish data. In total, the belief that health services and clinical interventions can (and should) play a key role in meeting the national targets for reducing health inequalities in both countries is evident in at least six of the English policy statements and three of the Scottish statements, only one of which (*Towards a Healthier Scotland*, which was published in 1999) was published before 2004.

The palpable influence of the Wanless Reports in England (Wanless 2002, 2004) and the Kerr Report in Scotland (Kerr 2005) appears to have reinforced claims about the need for the NHS to play a greater role in preventing ill-health. In each of these high-profile reports, NHS involvement in the prevention of the early onset of chronic disease is presented as essential to the survival of the NHS. Yet, accepting that the prevention of ill-health makes financial sense for the NHS as an organisation, which has historically focused on treating those who are



already ill (Hunter 2003a), does not automatically mean that the NHS is the best organisation to undertake this task. Nevertheless, as the extracts in Table 5.10 illustrate, post-2003 policy statements suggest that the NHS can contribute significantly to tackling health inequalities, at least partially through 'anticipatory care' and 'secondary prevention' (which involves the use of clinical and pharmaceutical interventions for people at high risk of chronic diseases, such as the provision of statins for people at high risk of heart disease or angioplasty surgery for people experiencing angina).

*Table 5.10 Illustrative examples of the way in which policy statements from both countries suggest health services and clinical interventions can be used to tackle health inequalities*

Context	Illustrative extracts
England	<p><i>NHS Improvement Plan</i> (Department of Health 2004, p10): 'Having reduced waiting to the point where it is no longer the major issue for patients and the public, the NHS will be able to concentrate on transforming itself from a sickness service to a health service. Prevention of disease and tackling inequalities in health will assume a much greater priority in the NHS.'</p> <p><i>Delivering Choosing Health</i> (Department of Health 2005b, p19) identifies the following 'big wins' for tackling health inequalities: 'Improving access to primary care and secondary prevention and care, especially for disadvantaged groups by making services more accessible and responsive; reducing delays before patients' first visit to their GP; increasing uptake of screening; improving access to diagnostics and specialist referral, management of high blood pressure, cholesterol reduction and emergency care for treatment for heart attack, ensuring variations in prescribing (e.g. statins and cancer drugs) are explained and minimised; action focused on the big killers (cancer, CVD and respiratory disease, including action on smoking); identifying and treating those at high risk of disease, especially the over 50s.'</p>
Scotland	<p><i>Closing the Opportunity Gap</i> (Scottish Executive 2004c, target D): 'In order to narrow the health gap between the most and least deprived communities primary care services in Scotland 's most deprived areas will be strengthened. First trailed in <i>Delivery for Health, Prevention 2010</i> will identify people at particular risk of preventable ill health and provide access to services and treatments appropriate to their needs'; And: 'Pilot studies on unmet need are currently underway in 3 NHS boards with particularly high levels of deprivation - Greater Glasgow, Argyll and Clyde, and Tayside - to tackle the problem of unequal access to and uptake of NHS services by different socio-economic groups. The results of the pilots will provide evidence for Executive's drive to tackle health inequalities...'</p> <p><i>Delivering for Health</i> (Scottish Executive 2005, p25): 'We believe the most significant thing we can do to tackle health inequalities is to target and enhance primary care services in deprived areas. Strengthening primary care teams and promoting anticipatory care in disadvantaged areas will reduce health inequalities...'</p>



This shift seems to have been driven, at least in part, by the short-term nature of the national health inequality targets (see Blackman 2007). In addition, the location of responsibility for meeting these targets with NHS bodies (see Appendix X) is likely to be important. Indeed, there is a clear tension between statements within policy documents which outline an active role for central government departments in reducing health inequalities and statements which focus on local (especially NHS) responsibility for meeting the targets. For example, *Tackling Health Inequalities: 2002 Cross Cutting Review* (Department of Health 2002) clearly states that health inequalities should be seen as a cross-departmental priority and even says that there is a need to move away from the location of responsibility with the NHS:

*'Tackling the causes of health inequalities requires action at both national and local level, involving Government Departments, NHS organisations and Local Authorities. To date, health inequalities have been seen as primarily an issue for the NHS. However, addressing the underlying causes requires co-ordinated action, bringing together health services with a range of other interventions and programmes. The aim of the Review has been to set the strategic direction for action across Government, in local government and for local communities and services.'* (Department of Health 2002, p10).

Yet, later on the same page, it becomes clear that responsibility for achieving the national targets for reductions in health inequalities is still seen as a responsibility for the NHS and local government, rather than central government:

*'[This review aims to] ensure the PSA targets for health inequalities are made a clear priority for the NHS and local government and are integrated into their mainstream planning, performance management and funding structures.'* (Department of Health 2002, p10).

Whilst the acknowledgement in the first of the above two statements is never actively denied, the focus on producing guidance for the NHS (in association with local government and others) on how it can work to reduce health inequalities suggests the views in the latter statement hold more sway (see Marks, Brown *et al.* 2007). So, although many of the interviewees said they felt that the setting of targets for reducing health inequalities was essential to ensuring the issue remained a policy priority, it seems that the targets have (paradoxically) also played an important role in shifting the focus of policy attention away from

addressing underlying determinants of health inequalities and towards early clinical interventions amongst groups most at risk of premature mortality. Indeed, the data presented in Table 5.11, below, all reflect this.

*Table 5.11: The role played by the national targets to reduce health inequalities in encouraging a focus on health service based interventions*

Context	Illustrative extracts:
England	<p><i>Tackling Health Inequalities: What works</i> (Health Inequalities Unit 2005, p2): 'For 2010 [meeting the targets] is essentially a service-oriented agenda that needs PCTs to focus on tackling cancer, CVD and smoking in disadvantaged groups and areas, because these are the factors, along with respiratory disease, which are driving the lower life expectancy in the Spearhead Group and other disadvantaged areas. High quality and quantity of primary care in disadvantaged areas, reaching out if necessary to particular groups with low service use and high need, can be vital to driving down mortality rates. A focus on the over-50s would give the greatest short-term impact on life expectancy, and a focus on disadvantaged families, mothers and children would address the infant mortality gap across social groups.'</p> <p>Senior civil servant (England): 'If we think about our two-thousand-and-ten target, as opposed to sort of the long term, sustainable changes in health inequalities, in terms of the target, we probably need more health input than anything else, you know, we need some support from, you know, Environment, some support on Housing, some support on accidents, but probably, you know, Health is the biggest thing. And therefore we need to be able to have, as colleagues, a discussion about where does health inequalities sit in terms of NHS priorities? And the answer is, now, as from last month, health inequalities is in the top six, right? Which means that the NHS, SHA, and at PCT and at Trust level, have to take account of health inequalities and have to be able to explain what it is they've done to develop a plan, err, a timescale and, err, you know, err, activities, to demonstrate they're doing something and show what effect it's had.'</p>

Whether the national targets actually do act as an incentive for the NHS and local government to prioritise tackling health inequalities is a contentious issue (e.g. Hunter and Marks 2005). Indeed, in the most recent policy statements of both countries there is little indication that the stated policy hopes that the NHS will become more focused on *public health* issues have succeeded. Instead, what seems to be happening is that the agenda for meeting the health inequalities targets is becoming increasingly focused on NHS secondary prevention interventions.



In Scotland policy statements such as *Our National Health* (Scottish Executive 2000) and *Partnership for Care* (Minister for Health and Community Care 2003) emphasise the importance of cross-cutting government action and the need to ensure that health improvement does not continue to be seen solely as the responsibility of Directors of Public Health and the NHS. Yet, the Executive's initial decision to track indicators of health inequalities through the Performance Assessment Framework for the NHS (Scottish Executive Health Department 2003b) is just one of many examples which suggests it is NHS bodies that are expected to take responsibility for achieving reductions in health inequalities.

All of this suggests either that: (i) following the successful journey from research into policy of the idea that the health services could play a role in reducing health inequalities, policymakers began to focus increasingly on developing this role in a way which was not necessarily closely related to the research evidence (i.e. the idea continued to be transformed once it had travelled into policy); or (ii) that more recent research-based ideas about the potential for statin prescription (Heart Protection Study 2006) and NHS stop smoking services (Bauld, Judge *et al.* 2007) to reduce health inequalities have travelled into policy extremely quickly (even before some of the supporting research was published), whilst research challenging these ideas (e.g. Ravnskov, Rosch *et al.* 2006; Thompson, Pearce *et al.* 2007) has not.

The interview data suggest that each of these interpretations may have some relevance. Three of the policy-based interviewees in England and two in Scotland claimed they were aware of evidence that smoking cessation services could effectively help reduce health inequalities and one policy-based interviewee in England and two in Scotland mentioned evidence relating to the potential for statins to help reduce health inequalities (at least in relation to cardiovascular disease). This supports the notion that research-based ideas about these issues may have influenced policy. On the other hand, some of this evidence - especially that relating to NHS smoking cessation services (Bauld, Judge *et al.* 2007) - comes from evaluations of government interventions, which means that the idea was influential in policy *before* the research evidence emerged. This underlines the fact that the relationship between research and policy is far from uni-directional, a point that was touched on in Chapter One and which is returned to in later chapters. For the moment, whatever the reason behind the increasing policy emphasis on NHS and clinical interventions to tackle health inequalities,

it is clear that the idea that the health services can play a role in reducing health inequalities has travelled very successfully but in a way which allowed it to be applied in ways that are not extensively supported by research evidence. Hence, like ideas about lifestyle-behaviours, this idea appears to have been 're-contextualised' within policy.

#### 5.4.5 'Fractured journeys'

The fourth type of journey involves ideas that appear to have become fractured during their passage from research into policy. There are two clear examples of 'fractured journeys' in the data: ideas about the importance of the lifecourse in addressing health inequalities and ideas concerning psychosocial determinants. The latter is dealt with first and Table 5.12, over-page, provides some illustrative examples of the sorts of claims that are visible in the data from the documentary analysis which could conceivably have been influenced by research-based ideas about psychosocial determinants of health (and their relevance to health inequalities).

Tracing the influence of psychosocial ideas in the policy statements was a more complicated process than identifying many of the other ideas discussed within this chapter as the boundaries distinguishing psychosocial approaches to health inequalities from other ideas are particularly unclear. However, various phrases in the extracts in Table 5.12, over-page, are also employed by some of the key researchers who have advocated psychosocial accounts of health inequalities. For example, Professor Richard Wilkinson discusses the importance of community relations, societal trust and crime levels for health inequalities (Wilkinson 2005), and Professor Sir Michael Marmot's work on the Whitehall studies has been used to support the idea that 'job control' is an important determinant of the social gradients in health for cardiovascular disease (e.g. Marmot, Bosma *et al.* 1997).

Indeed, much like ideas about the importance of early years, the data provide some evidence not only that psychosocial *ideas* have travelled into policy but also that policymakers have drawn on the available *research evidence* for this issue (or, at the very least, that key individuals within policy are aware of this body of research). For example, it was notable that, very unusually, interviewees who mentioned psychosocial approaches to health inequalities often named specific academics, especially Richard Wilkinson but also occasionally Michael Marmot.



Table 5.12 Illustrative examples of the way in which policy statements from both countries employ psychosocial ideas about health inequalities

Context	Illustrative quotations
England	<p><i>Tackling Health Inequalities: 2002 cross-cutting review</i> (Department of Health 2002, p8): 'The social support networks, relationships, and levels of participation and trust in a community are important influences on the health of individuals in that community and on local capacity to address health problems.'</p> <p><i>Tackling Health Inequalities: A programme for action</i> (Department of Health 2003, p16) discusses: 'The corrosive effect of crime and fear of crime, combined with economic disadvantage and a poor physical environment has a major impact on the quality of peoples lives.'</p> <p><i>Choosing Health</i> (Secretary of State for Health 2004, p161): 'Evidence has shown that poor working arrangements, such as lack of job control or discretion, consistently high work demands and low social support, can lead to increased risk of coronary heart disease, musculoskeletal disorders, mental illness and sickness absence.'</p>
Scotland	<p><i>Our National Health</i> (Scottish Executive 2000, p16): 'The support of family, community, friends and loved ones is often as important as the services and support which professionals and statutory services can deliver.'</p> <p><i>Improving Health in Scotland - The Challenge</i> (Scottish Executive Health Department 2003a) discusses the need to 'Release the inner resources of individuals and communities by building social capital, and improve the infrastructure of communities to make rapid progress' (p8); and argues that: 'Improving the social environment – working towards a social environment which minimises crime and other threats while promoting trust and mutual support' (p11) will contribute to improving health.</p> <p>One of the <i>Closing the Opportunity Gap</i> (Scottish Executive 2004c, Target G) objectives involves improving the <i>confidence</i> of disadvantaged children and young people, 'in order to provide them with the greatest chance of avoiding poverty when they leave school' [My emphasis]</p>

The influence of psychosocial ideas within policy is perhaps unsurprising, particularly in the English context, given Michael Marmot's position as an official advisor to the government (as Chair of the Department of Health's Scientific Reference Group on tackling health inequalities). However, this journey has not been categorised as 'successful' because only particular aspects of psychosocial ideas appear to have travelled into policy. For example, whilst in England there were six (out of 25) policy documents in which the influence of psychosocial ideas was tangible to the extent that these documents made clear references to the importance of social support and a sense of being in control, only one of these five



documents makes any reference to the idea that material and social inequalities need to be addressed in order to reduce health inequalities (Secretary of State for Health 1998). Similarly, in Scotland, four policy statements make claims which seem closely linked to psychosocial ideas but only one suggests there is a need to address income inequalities. Yet, as Chapter Two describes, the key academic researchers associated with psychosocial theories about health inequalities, Wilkinson and Marmot, base many of their ideas about psychosocial pathways and determinants on the notion that other types of societal inequality (and, for Wilkinson, the key is clearly income inequality) explain health inequalities.

Within the interview data, only one of the policymakers who mentioned Wilkinson by name also referred to his income-inequality hypothesis (which, as outlined in Chapter Two, suggests that, beyond a certain level of wealth, it is the extent of inequalities in income, rather than the overall material wealth of a society, which explain health inequalities). In the following extract, one interviewee (a senior civil servant at the Scottish Executive) even appears to imply that Wilkinson's research supports the idea that the distribution of wealth does *not* explain health inequalities:

*'It [psychosocial ideas] explains the 'X' factor... which, for example, in Wilkinson's work... that if you simply redistribute the money, err, is this about wealth redistribution? Will that solve the problem? Well, it clearly didn't create the problem and... you always leave an 'X' factor there, there's some other thing unexplained... simply redistributing the wealth doesn't explain the anomalies; again, very well shown in international comparisons. [...] So there are inequalities [...] which are not explained by simply the redistribution of wealth. And the idea that there is an issue of social capital, as well as financial capital, I find intriguing, to the extent that I've actually flagged it up in [a report] this year, and I've said to the First Minister that we have to be aware of this idea...'*

Despite the specific association of the ideas being discussed with Wilkinson, the above quotation suggests that only the aspects of Wilkinson's ideas that relate to *social capital* have travelled into policy, whilst the notion that health inequalities are a result of *income inequalities* appears to have become lost somewhere along the way. The income inequalities hypothesis



for explaining health inequalities is disputed (e.g. Lynch, Davey Smith *et al.* 2000) but, as the work and ideas of those who have critiqued this hypothesis was not directly referred to by any of the policymakers who were interviewed, the existence of competing ideas does not appear to explain the fractured way in which Wilkinson's theories have travelled into policy.

The other fractured journey of a research-based idea that is visible within the data concerns the way in which ideas about the importance of the lifecourse have travelled into policy. As outlined in Chapter Two, ideas about the lifecourse are not really an alternative explanation of the causes of health inequalities but rather seek to shift the focus of attention from the periods of life in which inequalities in health outcomes are most overt (late middle-age to early old age) to either the whole of the lifecourse or to certain important transition points (including childhood and teenage years, the transition into adulthood and, later, into old age). As Table 5.13 demonstrates, the phrase 'life-course' is directly employed in one of the English policy statements and the related notions of the 'life-cycle' and 'transition points' are employed in one of the Scottish statements:

*Table 5.13 Illustrative examples of the way in which policy statements from both countries employ ideas about the importance of the lifecourse in relation to health inequalities*

Context	Extracts relating to lifecourse ideas about health inequalities
England	<i>Tackling Health Inequalities: 2002 cross-cutting review</i> (Department of Health 2002, p9): 'The Review used a life-course approach in its initial analysis of interventions needed to reduce health inequalities. This identified the early years of childhood and older age as life stages where action to tackle health inequalities is particularly important and likely to have a significant impact.'
Scotland	<p><i>Social Justice Report</i> (Scottish Executive 1999a, p10) employs a framework of the 'life cycle' to discuss its approach and places a particular emphasis on 'transition periods' such as teenage years, e.g.: 'A Scotland in which every young person has the opportunities, skills and support to make a successful transition to working life and active citizenship. The early teens are the next make or break period in a person's life.'</p> <p><i>Improving Health in Scotland - The Challenge</i> (Scottish Executive Health Department 2003a): 'The relative impact of these factors [on our health] varies at different times in our lives.' (p7) Highlights 'transitions' such as that 'from primary school through to the first years of secondary school and onto higher education or employment.' (p9) Claims: 'We know that, by supporting people at critical times in their lives and working to ensure groups of people believe that health improvement is within everyone's grasp, we can make a difference for ourselves, our families, those in our care or in our neighbourhoods.' (p16)</p>



Yet, although the examples in Table 5.13 leave little doubt that ideas about the lifecourse have travelled into policy in some sense, most of the policy statements analysed do not overtly refer to these ideas: Only three of the English documents and four of the Scottish documents make unmistakable references to the ideas relating to the importance of the lifecourse. Within most of the other documents there is a clear emphasis on the importance of early years (as discussed in section 5.4.2) which, whilst it could be argued represents the influence of ideas about the lifecourse, actually only represents the extension of policy foci from one particular point in the lifecourse to two points (early years as well as late middle-age). This is still some way from an emphasis the whole lifecourse or even on all of the key transition points identified in the research. Indeed, despite evidence that ideas about the lifecourse have travelled into policy, the more recent policy statements from both countries mark a noticeable return to a focus on late middle-age. For example:

*Tackling Health Inequalities: What works* (Health Inequalities Unit 2005, p3): 'A focus on the over-50s would give the greatest short-term impact on life expectancy, and a focus on disadvantaged families, mothers and children would address the infant mortality gap across social groups'

*Delivering a Healthy Scotland* (Scottish Executive Health Department 2006, p28): 'From October 2006, those aged 45-64 at risk of cardiovascular disease in some of our most deprived communities in Dundee, Edinburgh, Glasgow and North Lanarkshire, are being invited to attend for a *Keep well*/health check.'

So although ideas about the lifecourse have definitely travelled into policy in some sense, this journey appears to have occurred in a way which has only emphasised the importance of targeting 'at risk' groups (especially children, mothers and the over-50s). The more fundamental idea promoted by supporters of lifecourse theories, that the *whole* lifecourse needs to be considered in approaches to health inequalities, appears have been eclipsed during its journey into policy, suggesting this is also an example of a 'fractured journey', in which only parts of the idea have successfully managed the full journey into policy.

In this case, the way in which the targets for reducing health inequalities were set (see Appendix X) once again appears to have been important. For, as many of the policy statements acknowledge, interventions designed to tackle socio-economic and material determinants of health, and those which focus on the early years of life, are only likely to have



long-term effects on health outcomes. Hence, if the relatively short-term targets are to be achieved, there is an inevitable pressure to focus on interventions which are most likely to have short-term impacts on health outcomes (Blackman 2007). Clinical and lifestyle-behavioural based interventions amongst those most 'at-risk' of premature mortality in the short-term (i.e. those in late middle-age) are precisely the kinds of interventions which are likely to help meet the targets so it is easy to understand how ideas about the importance of focusing on the whole lifecourse became fractured in their journey into policy. However, the way in which health inequalities have been conceptualised and framed in terms of targets is rather less helpful in explaining the first of the two 'fractured' journeys, that of psychosocial ideas about health inequalities. To understand why this idea experienced a fractured journey, it is necessary to look at other aspects of the data, as subsequent chapters do.

#### 5.4.6 'Weak journeys'

Finally, there are two examples of ideas about health inequalities which were only faintly evident in the policy statements but which, nevertheless, were present. The movements of these ideas into policy have been categorised as 'weak journeys' on the basis that their influence is only just tangible. The first example of such a journey is the idea that social mobility explains, or contributes to, health inequalities (and/or that focusing on helping people to be upwardly mobile is an appropriate means of tackling health inequalities). As Chapter Two outlines, theories about social mobility focus on the ways in which experiences of health can influence other experiences and opportunities in life, to the extent that poor health can lead to a decline in socio-economic circumstances (if, for example, it leads to a person being unable to work). This idea was more evident in English policy statements than the Scottish documents, and occurs in both one of the earliest New Labour health policy statements and one of the most recent:

*Our Healthier Nation* (Secretary of State for Health 1998, pt1.14): 'Moreover, social exclusion can be both a *cause* and an *effect* of ill health. If people are too ill to work or to participate in everyday social life, isolated from the mainstream opportunities by illness or disability, then they can become socially excluded. If they are not in society's mainstream, they are more likely to damage their health by smoking or they may seek comfort in activities like illegal drug-taking and so damage their health.'

*Our Health, Our Care, Our Say* (Secretary of State for Health 2006, p28): 'Health conditions and disabilities, if not appropriately managed and supported, can lead to job loss and long-term benefit dependency, with all the associated consequences not just for individuals but for their families. Equally, good health and emotional well-being can assist people to enter work and maintain fitness for work.'

In Scotland, the notion that poor health can be a cause of social exclusion (as well as the other way round) was only clearly evident in relation to homelessness:

*Improving Health in Scotland - The Challenge* (Scottish Executive Health Department 2003a, p35): '[I]t is clear that health and homelessness are inextricably linked; ill health is both a cause and effect of homelessness.'

That said, Scottish policy statements such as *Closing the Opportunity Gap* (Scottish Executive 2004c, Target D) do emphasise that positive health experiences are likely to help children achieve their potential in education and adults to play 'a fuller role in the economic life of Scotland', which implies a belief that better health can lead to upwards social mobility. Yet, although this idea is occasionally visible, it could not be said that it occurs frequently in the policy statements of either country and it was mentioned by only one of the policy-based interviewees (a policy advisor in Scotland). Hence, it is only realistic to describe the influence of ideas about social mobility in policy as 'weak'.

The second example of an idea that fits the 'weak journey' description is that cultural factors play a role in explaining health inequalities (and/or that action is required which will help change the cultural values that are thought to contribute to poor health). This idea was not evident in any of the English policy statements analysed, with the exception of some references to 'binge-drinking'. However, it does appear more frequently in some Scottish policy statements. For example:

*Towards a Healthier Scotland* (Secretary of State for Scotland 1999, pt35): 'Fatalistic and defensive attitudes became embedded through the years. Many of Scotland's communities felt that their future and values were being eroded. We are determined to break down such negative attitudes and encourage the belief that good health is something well within the reach of everyone.'



Other Scottish policy statements discuss differences in the economic and health 'aspirations' of various groups, and suggest that part of a problem with poorer communities in Scotland is that they do not 'aspire' to better health or economic circumstances, or at least not to the same extent that wealthier communities do (e.g. Scottish Executive Health Department 2003a, 2006). Ideas about culture are also employed in relation to explaining patterns of excessive alcohol consumption and the poor 'Scottish' diet (e.g. Scottish Executive Health Department 2006) and such ideas were evident in the interviews with some policy-based individuals (or individuals with close policy connections). For example:

*NDPB: '[P]eople who are, you know, on the face of it, more disadvantaged economically, may also live in communities where there are various cultural norms which are quite well established, that might relate to people's diets, say, you know, the certain sort of foods that people tend to enjoy...'*

*Minister (Scotland): '[I]t's not even so much gaps in income, you know, one of the biggest issues these days, and again this is something I feel very profoundly from my own local experience, is the gaps of the poverty of aspiration, if you like, that exists in many, many places. I mean again if you take [blank – area of Scotland], I could take you into places where folk never come into the city centre, right? [...] Now I'm just giving you that as a really teeny-weeny example, right? I'm talking there about, obviously, about kind of cultural impoverishment...'*

Although the influence of cultural ideas about health inequalities seems weak in the sense that such ideas were not mentioned often in the policy statements, the above quotations suggest that some individuals involved in constructing or advising on Scottish policies clearly believed that culture is important in explaining health inequalities. Furthermore, to the extent that these ideas have travelled into policy in Scotland, they appear to have influenced both explanations about the causes of health inequalities and ideas about how health inequalities should be tackled. For example, *Towards a Healthier Scotland* (Secretary of State for Scotland 1999, Chp3) discusses the need to stimulate a 'pro health' culture in Scotland and the Minister quoted above explained that s/he believed that schemes which aim to introduce socially excluded youngsters to cultural arenas, such as art galleries, form an essential part of trying to

reduce differences in cultural 'aspirations' and that, in the long-term, this would help reduce health inequalities.

In England, despite a lack of evidence for the influence of ideas about cultural factors in the policy statements, there is some suggestion that 'low expectations' play a role in people from disadvantaged communities presenting with symptoms of chronic illness at a later stage (e.g. Health Inequalities Unit 2005). Additionally, one of the civil servants that was interviewed and an individual at a NDPB with close policy connections both mentioned cultural factors in explaining health inequalities and suggested there was a need to improve the 'expectations' of disadvantaged groups. This suggests that, although even weaker in influence than in Scotland, ideas about the role of cultural factors in health inequalities are not entirely absent from policy discussions south of the border.

#### *5.4.7 Non-journeys*

Finally, three ideas which were identified in Chapter Two as being supported by some researchers during (and immediately prior to) the study period were not at all evident in the policy statements or interviews with policy-based individuals. These ideas have been categorised as 'non-journeys' on the basis that there is no evidence that they travelled into policy. The first of these is the notion that health inequalities are a result of differential levels of intelligence amongst the population (which implies, if one believes IQ to be the measure of 'innate' intelligence that it was designed to be, that health inequalities may be to a large extent 'natural'). The second identifiable 'non-journey' concerns the idea that health inequalities are caused by macro-economic and ideological structures (such as capitalism). Thus, whilst there was no evidence of claims within the policy statements, or by policy-based individuals, that health inequalities are in any way biologically 'natural', or unchangeable, nor did there appear to be any appetite for some of the more radical ideas about the political and societal causes of (and solutions to) health inequalities, which some of the academic-based interviewees clearly favoured.

The third example of a 'non-journey' concerns ideas about the importance of place, or context, for health. As discussed in Chapter Two, there has, since the early nineties, been an increasing research interest in the role of 'place' (or contextual factors) in explaining differential patterns of health outcomes. If ideas about the importance of context had



influenced policy responses to health inequalities, it is conceivable that area-based policies focusing on issues like regeneration might be viewed as a logical policy response to health inequalities and there are indeed a wealth of suggestions within the statements that focusing interventions on particular areas will help reduce health inequalities. However, there are very few examples within the data from either country of specific references to the influence of context (or place) on health and the way in which area-based interventions are discussed within the data indicates that they are supported due to an assumption that targeting poor areas is a means of reducing the 'health disadvantage' and 'health gaps' affecting poor people, rather than because ideas about the importance of place have travelled into policy.

#### *5.4.8 The influence of ideas not evident in the research literature on health inequalities*

As mentioned in the introduction to this chapter, there was also evidence that some of the ideas which appeared to have influenced policy responses to health inequalities had come from sources other than the research literature on health inequalities. These largely concerned ideas about the way in which interventions to tackle health inequalities ought to be rolled out and implemented (as opposed to ideas about the causes of health inequalities). The most identifiable of such ideas were: (i) the emphasis placed on the need for local organisations to work in *partnership* to tackle health inequalities; and (ii) the necessity of public participation in interventions that are designed to tackle health inequalities. Amongst the 25 key English policy statements analysed, 14 mention public participation (or community engagement or empowerment) and all but one of the documents make some reference to partnership working. From the Scottish documents, 11 of the 17 documents analysed mention public participation in some form and all of the documents emphasise the need for partnership working. Much like the idea that targeting health improvement initiatives will provide an effective solution to health inequalities, both of these ideas appeal to 'common-sense' logic. Furthermore, they are both ideas which feature heavily in broader New Labour discourses (Fairclough 2000). It is worth noting that recent academic publications on partnership working and public participation (or 'community empowerment') have raised questions about the effectiveness and practicalities of each (e.g. Crawshaw, Bunton *et al.* 2003; Dowling, Powell *et al.* 2004; Bolam 2005). Hence, these are not ideas necessarily informed by research.

Finally, it is important to note that this section has only discussed the actors on whom the policy statements most often focus. In several of the documents a far wider range of players



are discussed, including the voluntary and business sectors. Whilst there is no room to analyse these discussions in detail, there are a couple of trends within these discussions which may be worth noting. One is the emergence of 'social enterprise' as a recognisably new sector, which somehow seems to straddle both commercial and social interests (the precise definition of social enterprises remains unclear - see Marks and Hunter 2007). The other is that there has been an increasing emphasis on corporate responsibility for health. For example, *Choosing Health* (Secretary of State for Health 2004, p93) states that 'Companies have the opportunity to improve the environment in which individuals make their healthy choices. They can achieve changes that individuals on their own cannot...' and the Scottish Executive makes similar points in *Healthy Working Lives* (Scottish Executive 2004b). These ideas are not discussed in more detail because they do not appear to constitute research-based ideas *about health inequalities*, which is what this chapter is concerned with. However, they are important in that they underline that research is far from the only source of ideas for policymakers concerned with deciding how to respond to health inequalities.

### 5.5 A decline in policy interest in health inequalities?

One of the key messages to emerge in this chapter is the importance of the way in which health inequalities are conceptualised and understood as this appears to have significantly influences subsequent responses. The data presented here suggest, as the following interview clearly articulates, that confusion about the term 'health inequalities' has played a significant part in the limitations of policy responses, allowing conflation between targeted strategies to improve health and strategies specifically designed to tackle health inequalities:

Senior academic researcher: *'I think, first of all, there's huge confusion about what the term health inequalities means, I mean just absolute, utter confusion. When you look, for example, around the United Kingdom at what people, yeah, at health improvement plans, at community plans, at, you know, whatever... At the local level, what people... claim is a strategy to reduce health inequalities is nothing of the sort, you know? They're isolated, trivial examples of helping this or that disadvantaged group without any clear sense of how that will impact on differences between social groups. I think at a more strategic level there's a lot of evidence that... health inequalities has just come too far down the pecking order...'*



On a positive note, the data provide evidence of some reflection on the importance of clarifying what is meant by the term 'health inequalities' and there was clearly some acknowledgement of the difference between 'health inequalities' and 'health improvement' amongst some of the policy-based interviewees. See, for example, the last two quotations in Table 5.14, below.

Table 5.14: Evidence that policy interest in health inequalities is declining

Context	Illustrative quotations
England	<p>Minister: <i>'I regret to say I think that this [health inequalities] has gone down the agenda, quite frankly. Err, and that there's been all this preposterous sort of management-consultant-led stuff about structural change [in the NHS], which has virtually no impact. I mean I don't know whether it does much good even to the organization and management of the NHS but it certainly doesn't have anything much to do with, err, with dealing with health inequalities. [...] I mean, when John Reid came up with his <u>preposterous</u>, err... smoking ban, I mean, nobody who really cared about... inequalities with health could possibly have come up with that preposterous idea. I mean it was, 'save the bourgeoisie, fuck the worker,' wasn't it? It was awful.'</i></p> <p>Senior civil servant: <i>'I would have to say that on the area of public health, under both Labour and Conservative, the rhetoric consistently ran ahead of the reality and one became a little bit disillusioned about it. Each time a new leadership would be announced, or new ministers appointed, announcements would be made but then one would consistently find that not much was actually being done. So [...] it was quite a frustrating area for policy analysts. And that was nearly as true, not quite as true, under Labour as it was under the Conservatives. [...] So these papers came out about the need to tackle health inequalities but then the resources were not there to follow them though because they were always diverted to waiting times and things like that.'</i></p>
Scotland	<p>Civil servant: <i>'What it [health inequalities] is linked to now, much more is... health improvement as a whole, which is a key priority for the Executive, the smoking bill, dieting, food - that's all very, very sexy. Inequalities less so, although it's part of the same mix. The concentration of health policy is on giving up smoking and diet and, at local government level as well, providing incentives for healthier lifestyles...'</i></p> <p>NDPB Policy advisor: <i>'I think it's important that people understand that to tackle health inequalities you need to do different things to the things you do to improve the health of the population... but whether, given what's happening with Scotland's health at the moment... going down a health inequalities policy route is the right response... I think has to be questioned, 'cause I think that things are changing so that some of the major issues are now whole population issues not health inequalities issues.'</i></p> <p>Civil servant [different to above]: <i>'I think increasingly it's part of the background rather than the foreground of health policy and, you know, in the foreground we have things like improving mental health and wellbeing, improving sexual health. And these have a health inequalities dimension but, you know, their main aim is not to reduce health inequalities, it's to improve sexual health outcomes or to improve mental wellbeing... I don't really think there have been that many major initiatives whose primary purpose is to tackle health inequalities... Yes, it, it's hard to think of any...'</i></p>



However, more worryingly, there is also some evidence that the difficulties encountered in effectively tackling health inequalities were beginning to contribute to a lessening of policy interest in the issue towards the end of the study period, and that confusion between the policy aims of reducing health inequalities and achieving health improvement were helping to facilitate this trend. Each of the quotations in Table 5.14 illustrates the perceived lessening in policy interest in health inequalities and the three statements from individuals in Scotland all relate this shift to an increasing policy focus on health improvement.

The first interviewee quoted in the table, who held a ministerial position of relevance to health inequalities in England during the study period, suggested the reduced policy interest in health inequalities was associated with a particular Secretary of State for Health. However, the second interviewee, a senior civil servant, attributed the change to more institutional difficulties in maintaining Department of Health policy interest in issues stretching beyond the immediate concerns of the NHS. The quotations from the Scottish context are slightly different in that none of them claimed such a clear shift in attention has occurred; rather, these interviewees seemed to suggest that interest in health inequalities had been discretely eclipsed by a focus on health improvement. Neither the first nor the second interviewee from Scotland appeared to feel that this was problematic; the first claiming the two issues were '*part of the same mix*' (underlying the conflation between the two issues) and the second interviewee explaining s/he felt that the situation was driven by the health situation facing Scotland (s/he went on to emphasise the importance of the coming 'obesity epidemic' which, s/he claimed, was an entirely distinct issue from health inequalities). The third interviewee's reflection that '*it's hard to think of any*' interventions designed specifically to tackle health inequalities in Scotland suggests that the limited policy focus on health inequalities is not necessarily the result of a recent decline in interest but, instead, the consequence of the longer-term tendency not to distinguish the two policy aims, at the expense of health inequalities.

These interviews, of course, took place at a particular point in time and it is important to reflect on the role that this may have played in interviewees' perceptions of the declining policy interest in health inequalities. In both Scotland and England, there was a sense amongst many of the policy-based interviewees (particularly in the interviews undertaken in 2006) that



no significant policy developments were likely to occur until after the elections had taken place in Scotland and the Prime Minister had changed in England. There was, therefore, some feeling that policy developments were 'on hold' and this may have exacerbated perceptions of the reduced interest in health inequalities. Furthermore, it is entirely possible that the change of government in Scotland and Prime Minister in England, which both occurred after the end of this study period, have allowed this situation to change (although the fact that the new Minister for Public Health in England, Dawn Primarolo, failed to mention health inequalities in her annual lecture on public health, does not bode well for the situation in England (Primarolo 2007)). Nevertheless, there are extensive examples within the data which suggest that in the last two or three years of the study period, health inequalities had slipped down the policy agenda in both countries, eclipsed by concerns with health improvement and, particularly in England, the NHS. As Chapter Six goes on to discuss, this appears not only to have affected health inequalities *policy* but also the level of interest in the issue amongst researchers.

## 5.6 Concluding discussion

Overall, the data in this chapter demonstrate that, although most of the ideas about health inequalities outlined in Chapter Two are visible in policy, these ideas have experienced quite differing levels of influence. A typology of five distinct journey types was developed to describe the varied movement of ideas from research into policy: 'successful'; 'partial'; 're-contextualised'; 'fractured'; and 'weak'. In addition, there appeared to be three 'non-journeys' (ideas which are supported by some research but which were not recognisable within policy during the study period) plus three ideas which were clearly identifiable in policy responses to health inequalities but which, based on the ideas outlined in Chapter Two, do not seem to have originated in (or been significantly promoted by) research. Table 5.15, over-page, summarises the way in which the various ideas identified in Chapter Two have been categorised according to this typology (please note that this table focused on research-based ideas about health inequalities and, hence, does not incorporate ideas discussed in subsection 5.4.8).

Table 5.15: The varying journeys of research-based ideas about health inequalities

Approach to health inequalities	Present in policy explanations of health inequalities?	Present in related policy interventions?	Journey type
<i>Focus on early years of life</i>	Yes	Yes	Successful
<i>Socio-economic &amp; material determinants</i>	Yes	To some extent	Partial (cause but not significant solution)
<i>Lifestyle-behaviours</i>	Yes	Yes	Re-contextualised
<i>Health service / clinical contributions</i>	To some extent	Yes	Re-contextualised
<i>Psychosocial and relative position (income inequalities, etc)</i>	Psychosocial pathways are mentioned but not income inequalities.	Addressing psychosocial determinants mentioned but not income inequalities.	Fractured
<i>The lifecourse</i>	Particular points in lifecourse are highlighted but others are not.	Particular points in lifecourse are highlighted but others are not.	Fractured (only particular points in the lifecourse are emphasised)
<i>Social selection / mobility</i>	Occasionally mentioned.	Occasionally mentioned.	Weak
<i>Cultural explanations</i>	Occasionally mentioned (more discernable in Scotland than England)	Occasionally mentioned (more discernable in Scotland than England)	Weak (more discernable in Scotland than England)
<i>Intelligence (IQ)</i>	No	No	Non-journey
<i>Structural / ideological explanations</i>	No	No	Non-journey
<i>Place / contextual effects</i>	Occasionally mentioned.	Area-based interventions identifiable but do not appear to be based on ideas about contextual effects	Non-journey

As highlighted earlier, it is important to acknowledge that, owing to the type of data on which it is based, this analysis is necessarily speculative, although the interview data provide important depth and insight into the analysis of the policy documents. To gain a better understanding of how research-based ideas have travelled into and informed policy, it would be necessary to conduct a far more in-depth observational or participatory study. Such methodologies have been successfully employed by researchers studying the development



and circulation of certain kinds of scientific knowledge claims (Knorr-Cetina 1981; Latour and Woolgar 1986; Latour 1987, 1999). However, it would be a far more ambitious (if not impossible) task to attempt to employ such a methodology to study a whole field of research, especially such a multi-faceted and cross-disciplinary field as health inequalities. What is more, the focus of this thesis is about more than the promotion of particular knowledge claims by researchers, so any in-depth study would have also required access to the world in which policymakers work and, as Chapter Four recounts, my initial attempts to undertake this kind of research were unsuccessful.

As Table 5.15 illustrates, only one set of ideas was categorised as having enjoyed a 'successful journey' from research into policy and this was not the group of ideas most widely supported within the research community. Furthermore, even the description of the movement of this set of ideas as a 'successful journey' needs to be accompanied by a proviso that a researcher associated with this body of work felt that these ideas had been remarkably unsuccessful in influencing policy. Hence, even though this idea was clearly identifiable within the data and, indeed, was attached to specific policy interventions, it may still have a lot further to travel to be successful in the ways that those promoting it believe it ought to be.

Ideas about the role of material and socio-economic factors in health inequalities were noticeably less successful in their influence. Whilst this set of ideas appeared to have travelled into policy rhetoric quite coherently, it seemed to have struggled to move much further within policy. Consequently, whilst such ideas were clearly evident within policy articulations of the causes of health inequalities, they appeared to have been far less influential with regards to policy interventions. Furthermore, where interventions were related to these kinds of ideas, they tended to be targeted only at the most disadvantaged groups. Here, it became clear that the way in which health inequalities have been conceptualised within policy is crucial to the kinds of responses that subsequently appear logical. Underlining the failure of this set of ideas to effectively influence policy, evidence was presented which suggests that ideas about the contribution of people's economic circumstances to health inequalities is declining in influence in both England and Scotland.

The third journey type, 're-contextualised' journeys, was developed to describe the movement of ideas which were applied within policy in ways which the research evidence did not really support. The first example of a 're-contextualised' journey concerned the role of lifestyle-behaviours in explaining and responding to health inequalities. This set of ideas appeared to have travelled into policy relatively coherently in relation to the potential for lifestyle-behavioural interventions to contribute to health improvement. However, the blurring of responses to 'health improvement' and 'health inequalities', and an assumption that targeted attempts to improve health will be effective in reducing health inequalities, enabled lifestyle-behavioural responses to be put forward as solutions to health inequalities, even though such an approach is not significantly supported by research. The importance of the way in which health inequalities have been conceptualised within policy, as a 'health gap' resulting from the 'health disadvantage' of people in poor areas, seems crucial to understanding the journey of this set of ideas as this conceptualisation seems to have facilitated the assumption that targeting interventions designed to improve health at areas with poor health is an adequate response to health inequalities. The second example of a 're-contextualised' journey was provided by ideas about the role of health services in tackling health inequalities. Whilst these ideas appeared to have initially made quite a successful journey into policy, a marked increase in the emphasis placed on the role of the NHS in tackling health inequalities (through, in particular, secondary prevention), which occurred from 2004 onwards, suggests that these ideas had begun to be applied within policy in ways which the overall research does not tend to support.

The fourth category of journey was termed 'fractured', which signifies that the traces of these ideas visible within the data suggest they have not travelled coherently. Instead, the ideas that follow this journey pattern appear to have been dismantled *en route* into policy. As a result, only parts of the idea appear to have influenced policy discussions of health inequalities, whilst other elements appear to have been lost, or discarded, along the way. The first example of this kind of journey discussed was psychosocial ideas about health inequalities. These ideas appeared to have influenced policy discussions in so far as there was a visible emphasis on ideas about the importance of social capital, yet there was very little evidence of the idea (advocated by the main proponents of psychosocial approaches to health inequalities, Wilkinson and Marmot) that social and economic inequalities are central to



understanding health inequalities. Similarly for the second example, only certain aspects of ideas about the lifecourse (namely the importance of early years) appeared to have had any significant influence on policy. In both cases, what are quite complex and demanding ideas appear to have been simplified in their journey into policy, being applied in ways which present far less of a challenge to policy responses.

Finally, 'weak' journeys describe the fate of ideas that, although evident in some policy statements and/or interview extracts, are mentioned only very occasionally and are, therefore, only just detectable. These, then, are ideas which have travelled into policy insubstantially and which do not appear to have significantly influenced policy understandings of either the causes of health inequalities or the potential policy responses. Yet, the small traces that are evident mean it would not be legitimate to claim that they have not journeyed into policy at all. Perhaps the most interesting point to highlight in relation to this category of journey is the evidence of a belief that the poor health of Scotland is in some way attributable to Scottish culture (or the cultures of disadvantaged groups within Scotland).

Overall, it seems evident that the research-based ideas which have enjoyed the most success in terms of influencing policy responses to health inequalities are not necessarily those that are most supported by the research evidence (or even, necessarily, by those involved in constructing policy). There are also some important shifts in emphasis during the ten year study period. In particular, there appears to have been an increasing confidence within the policy statements in the ability of interventions which focus on trying to change lifestyle-behaviours to effectively tackle health inequalities (although, interestingly, this shift is not reflected in most of the interviews with policy-based individuals). At the same time, there has been an increasing move away from interventions requiring policy attention on inequalities in material and economic circumstances (particularly the latter). Hence, as others have commented (Hunter 2005; Dorling, Shaw et al. 2007), there appears to be a disappointing return to previously dominant approaches to public health issues. Although the legislative ban on smoking in public places represents a very different approach to lifestyle-behavioural issues (albeit one that will not *necessarily* reduce health inequalities), policy approaches to addressing other lifestyle-behavioural problems (excessive alcohol consumption, poor diet, low exercise rates, illegal drug use, etcetera) do not appear to have developed significantly

since the previous government's major public health White Paper, *The Health of the Nation* (Department of Health 1992). Indeed, the policy message increasingly appears to be that, whilst inequalities in society may make it more difficult for some people to make 'healthy choices', it is still possible for them to do so *if only they try hard enough*. Hence, the responsibility for health inequalities is being increasingly shifted away from central government and onto individuals.

Around the same time as the shift towards an increasing emphasis on lifestyle-behaviours, the policy statements began to place much more pressure on the NHS to contribute to tackling health inequalities. Rather than merely ensuring that they do not exacerbate health inequalities through inequities in access to or quality of health service provision, as they were initially encouraged to do, NHS services have been increasingly expected to play a key role in meeting the health inequalities targets. The decision to locate responsibility for meeting the national health inequalities targets with local NHS bodies is likely to have exacerbated this shift. It suggests that the medical model of health that the early policy statements appeared to challenge regained influence towards the end of the study period.

Perhaps most worryingly for those concerned with health inequalities, the data presented in section 5.5 suggest that there was a more fundamental shift towards the end of the study period, with overall policy interest in health inequalities being eclipsed by other issues (especially health improvement and concerns about the NHS). As reflected in this section, it is difficult to assess whether the data which highlight this shift represent the start of a significant decline in policy interest in health inequalities or merely a temporary dip. With this in mind, the thesis focuses on trying to explain the interplay between research and policy during the study period, rather than focusing on the apparently lessening concern with health inequalities towards the end of the study period. After all, it remained the case that tackling health inequalities was, at least officially, consistently stated as a policy aim of both governments throughout the study period.

In part, the story told by this analysis is unsurprising for it will always be easier for policymakers to implement NHS based interventions, over which the health departments have an extensive amount of control, than to try to initiate cross-cutting responses. Similarly, it will



always be easier to emphasise the responsibility of individuals for making healthy lifestyle-choices than to tackle underlying determinants. Nevertheless, it seems disappointing that the influence of ideas in some of the earlier policy statements, and the comprehension of the research evidence by some of the policy-based individuals, have not been enough to effectively challenge the 'grip' of medical and individualised ideas about appropriate responses to health inequalities. The data presented in this chapter suggest the way in which health inequalities have been conceptualised as a 'health gap' resulting from the poor health of people in disadvantaged areas has helped facilitate this grip. The remainder of this thesis focuses on trying to unravel the deeper and more complex explanations for the findings presented in this chapter.

## ***Part V: Explaining the contrasting journeys of ideas from research into policy***

### **Chapter Six: Academic research - a restricted arena for the emergence of charismatic ideas?**

#### **6.1 Introduction**

This chapter focuses on the role of academic researchers as actors who develop, construct and market particular ideas about health inequalities and considers what light this throws on the differing journeys outlined in the previous chapter. The approach taken here echoes that of Mel Bartley (1988, 1992) in her research exploring the unemployment and health debates of the nineteen-eighties. Bartley's thesis (1988) draws heavily on theories put forward by Bruno Latour and colleagues (Latour, 1988 [1984]; Latour & Woolgar, 1986) to propose that the quality of research may have rather less relevance to its potential influence than the ways in which the ideas based on research are received, translated and promoted by actors. The analysis presented in section 6.2 supports this interpretation and, like Bartley, finds that Latour and Woolgar's (1986) notion of 'cycles of credit' serves as a useful way of conceptualising the activity of academic research. However, unlike Bartley's (1988, 1992) work, the findings presented here suggest: (i) that there are a number of important variations within perceptions of credibility amongst different groups of academics, in relation to political as well as epistemological positions; and (ii) that there are some tensions between the 'cycles of credit' in operation in academia and those perceived to be at work within policy and funding organisations. As a result, the maintenance of credibility as an academic researcher within the field of health inequalities often appears to be a something of a careful balancing act, particularly for researchers interested in influencing policy. Section 6.3 explores this situation in more detail by focusing on the qualities of individuals who, and ideas which, appear to have been able to maintain some degree of credibility amongst both research and policy audiences. Section 6.4 concludes by arguing that the analysis presented in this chapter suggests a range of factors appear to cumulatively operate to restrict the potential for ideas with charismatic qualities to emerge from academic arenas.



One point to note at the outset is that this chapter tends to assume that academic researchers working within the field of health inequalities research have actively tried to influence policy. Bearing in mind that some commentators have argued that academic research should not be designed to influence policy and, indeed, that to focus on policy audiences when undertaking research poses threats to academic integrity (Hammersley 2003, 2005), an explanation of this assumption is required: whilst three of the academic interviewees appeared sympathetic to this perspective (i.e. that academic researchers ought not to be orientated towards policy), virtually all of the academic interviewees involved in this research expressed some belief or desire that health inequalities research should inform policy, an ambition which is reflected in some recent publications within the field (e.g. Asthana & Halliday 2006; Graham, 2004; Macintyre 2007). For some, this desire was based on a personal or political commitment to the reduction of health inequalities (or inequalities in society more generally) whilst, for others, the aim appeared to relate to a more general belief that policy ought to be informed by research evidence. Health inequalities, therefore, would appear to be a field of research in which academics are broadly committed to some level of interplay between research and policy. It consequently seems reasonable for this chapter to focus on *how* this relationship functions from the perspective of academics.

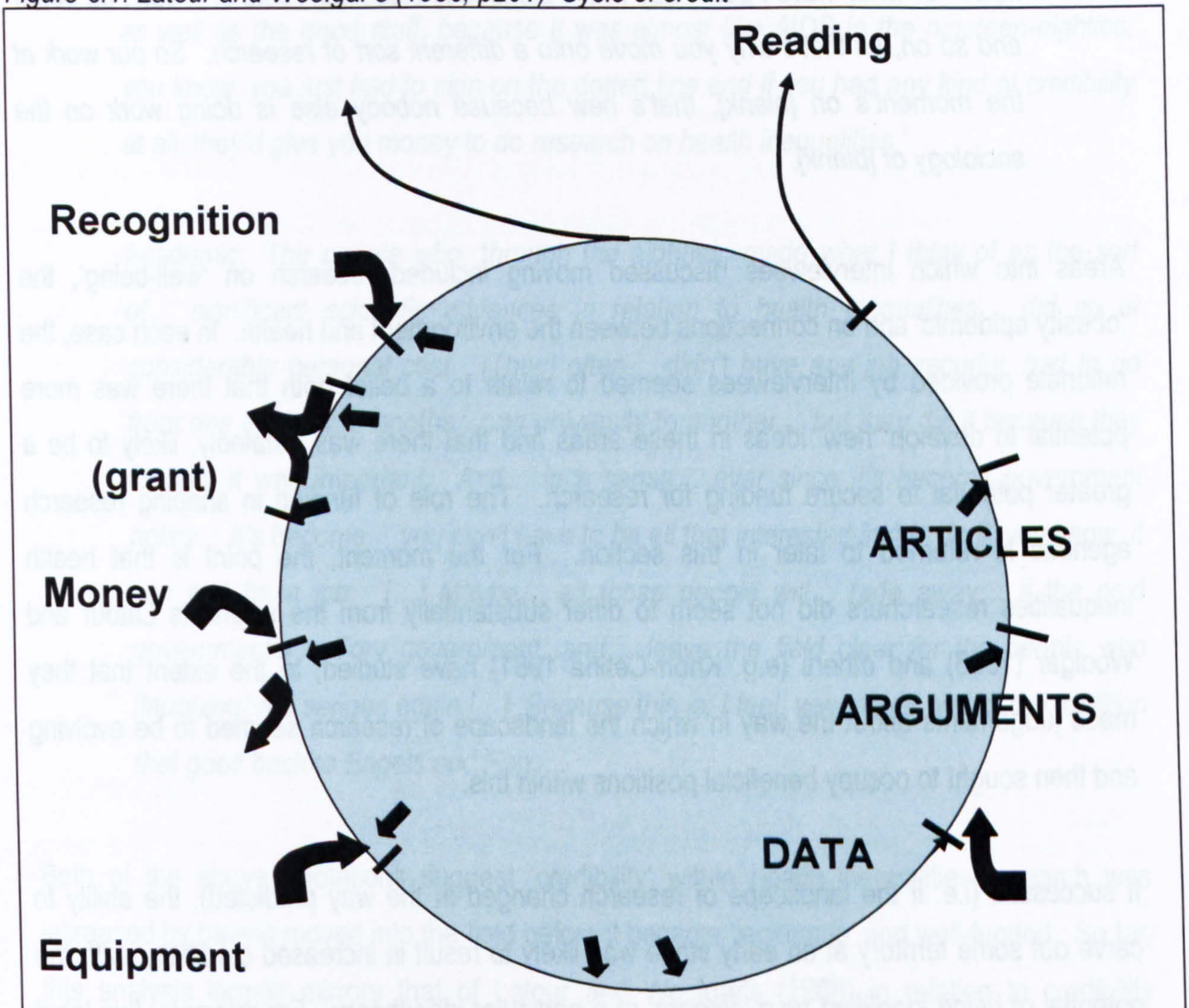
## 6.2 Conflicting cycles of credit?

This project differs considerably from that undertaken by Latour and Woolgar (1986). Indeed, their project developed out of quite different research questions and involved the detailed participant observation of a group of scientists all working in a specific biological laboratory in America. Nevertheless, the ways in which interviewees discussed notions of credibility within academic spheres closely resemble Latour and Woolgar's (1986) findings. Like Bartley (1988, 1992), I therefore found their concept of 'cycles of credit' provided a useful tool for reflecting on my findings. In this framework, 'credit' is perhaps better understood as 'credibility'; an attribute which persuades others to believe, and invest, in researchers and their ideas. Importantly, Latour and Woolgar (1986) suggest that in this cycle, scientists are rarely distinguishable from their ideas, so it is the credibility of a scientist's ideas, and their ability to communicate these ideas (e.g. by publishing them in reputable journals), which improves their own credibility as a scientist. The more credible a scientist is deemed by his/her peers, the better access s/he is likely to have to resources (such as funding), which, in turn, influences



the ability of the scientist to undertake more research and come up with further ideas. In this sense, the authors liken 'cycles of credit' to capital investment; there is no ultimate objective, rather the success of investments is measured by the extent to which they facilitate the conversion of credibility, allowing scientists to progress through the cycle. The diagram which Latour and Woolgar (*ibid.*) construct to help explain this cycle is re-produced, below, as Figure 6.1.

Figure 6.1: Latour and Woolgar's (1986, p201) 'Cycle of credit'



This section employs the concept of 'cycles of credit' to explore the factors which the interview data suggest inform the credibility of researchers and their ideas within the field of health inequalities research. As Latour and Woolgar (1986) found, a key part of researchers' decisions to pursue particular ideas appeared to relate to their sense that an idea was 'original' and would be deemed worthy of discussion by other academics in the field. The hope was that this would then lead to a 'return' on the investment by increasing the



'recognition' of the associated researcher(s) by others in the field. This aspect of the process of research was most noticeable within elements of the data in which some interviewees discussed their (relatively recent) decisions to move out of health inequalities research and into other fields of research. For example:

*Academic researcher: 'One of the reasons why I don't particularly do much on health inequalities any more [is] because I think, you know, what have I got to say which is new? Or what have I got to say which somebody else hasn't said or... can't do better and so on, so that's why you move onto a different sort of research. So our work at the moment's on [blank], that's new because nobody else is doing work on the sociology of [blank].'*

Areas into which interviewees discussed moving included research on 'well-being', the 'obesity epidemic' and on connections between the environment and health. In each case, the rationale provided by interviewees seemed to relate to a belief both that there was more potential to develop 'new' ideas in these areas and that there was, relatedly, likely to be a greater potential to secure funding for research. The role of funding in shaping research agendas is returned to later in this section. For the moment, the point is that health inequalities researchers did not seem to differ substantially from the scientists Latour and Woolgar (1986) and others (e.g. Knorr-Cetina 1981) have studied, to the extent that they made judgements about the way in which the landscape of research seemed to be evolving and then sought to occupy beneficial positions within this.

If successful (i.e. if the landscape of research changed in the way predicted), the ability to carve out some territory at an early stage was likely to result in increased credibility, with the potential of being identified as a 'pioneer' of a particular idea/theory. For example, this label was attached by interviewees to various researchers who had worked in health inequalities for substantial periods of time, including to Wilkinson in relation to the 'income inequalities hypothesis', to Marmot in relation to the 'social gradient' of health, and to Barker in relation to the role of foetal development and early childhood in explaining health inequalities. In contrast, five interviewees (all of whom had been involved in health inequalities research prior to the launch of the ESRC's *Health Variations* programme in 1995) suggested that

researchers who had moved into the health inequalities field later on, when the funding opportunities were greater, had not contributed as much as those who had already been occupying the field. For example:

*Academic: 'After nineteen-ninety-seven [...] all of a sudden the topic [health inequalities] was... almost to an extreme, actually, it became, almost, a bandwagon, so that you then got a lot of actually slightly less high quality research, I have to say, as well as the good stuff, because it was almost like AIDS in the nineteen-eighties, you know, you just had to sign on the dotted line and if you had any kind of credibility at all, they'd give you money to do research on health inequalities.'*

*Academic: 'The people who, through the eighties, made what I think of as the sort of... significant scientific advances in relation to health inequalities... did so at considerable personal cost. [They] often... didn't have any job security, had to go from one industry to another, one university to another... but they did it because they thought it was important. And... in a sense... ever since it's become government policy... it's become... you don't have to be all that interested in it to do it, you know, it can just be a job. [...] Maybe... all those people will... fade away... if the next government's a Tory government, and... leave the field clear for the people who [laughing] are serious again.[...] Because this is, I feel, very much part of the tradition that goes back to Engels and Farr...'*

Both of the above quotations suggest 'credibility' within health inequalities research was increased by having moved into the field before it became 'legitimate' and well-funded. So far, this analysis largely mirrors that of Latour and Woolgar's (1986) in relation to credibility amongst the scientists they studied. However, part of the rationale drawn upon by both of the above interviewees (and others) to distinguish between researchers who had been involved in health inequalities prior to 1995 and those who moved into the field later, involved perceptions about the political and ideological commitments of researchers. So, part of the reason researchers who had moved into the field only when funding opportunities were good were viewed with some suspicion by other researchers appeared to be because this was seen to signal a lack of *political* commitment to the importance of reducing health inequalities. This is



particularly evident in the quotation by the second interviewee on the previous page, who dismissed researchers for whom s/he felt studying health inequalities was 'just a job' and went on to suggest 'people who are serious' (about health inequalities) were people who shared his/her Marxist political outlook. Indeed, a clear distinction was made between different types of academics by some of the interviewees, which closely resembled Said's (1994) distinction between 'professional' academics, who treat research as a nine-to-five job, and 'amateur' academics, who are committed to asking challenging questions of those in power for ethical and political reasons.

This is an aspect of credibility that Latour and Woolgar (1986) do not touch on in their study and, indeed, Bartley (1988, 1992), claims that political (ideological) positions did not appear to be particularly relevant to individuals' positions in the debates about the links between and unemployment and health that took place in the nineteen-eighties. Yet, the data gathered for this project are littered with references to political and ideological positions. To begin with, nearly all of the academic interviewees were keen to spell out their personal political values during the interview, despite the fact that this was not something I specifically asked about. Nearly all identified themselves as Left-wing, socialist or Marxist, with a significant number of female interviewees and one male also identifying themselves as feminists.

The convergence of descriptive political identities suggests there is some level of political affinity within the health inequalities research community and, indeed, some of the data do evoke a sense that there are communities of researchers who feel they share some political or social values. One interviewee, for example, described feeling that s/he was part of a 'small network' of researchers who shared some fundamental values and that their work was '*an expression of some sort of concern with social justice.*' -However, the data also reveal a number of important political divisions within the field. The most fundamental of these relates to those academics (such as the two quoted on the previous page) who saw health inequalities research as a political, value-driven activity and those who felt it was essential to be 'realistic' about what was 'politically possible' and to concentrate on developing the evidence-base relating to 'feasible' policy interventions. The following interviewee, for example, criticised researchers associated with Bristol (which I took to mean George Davey Smith and Mary Shaw, who were both based at Bristol University when the interview took

place, and Danny Dorling, who was previously based there and still publishes with Davey Smith and Shaw) in precisely this manner:

*Academic: 'Some people make policy orientated contributions to the health inequalities literature that are pretty naïve really, like just saying, as people associated with Bristol might say, you know, 'you just willy-nilly deal with income inequality,' or whatever. Whereas... people like [Blank – professor], for example, who's always been much more interested in the policy process, I think, would take a view of health inequalities policy that was more informed by... the practical constraints on politicians in representative democracies.'*

The key political division described above has already been rehearsed in academic publications (see, for example, the debate between Davey Smith, Ebrahim, & Frankel, 2001; and Macintyre, Chalmers, *et al.* 2001) and it maps onto another visible difference in opinion within the data about the factors shaping academic credibility. On the one hand, academics who were critical of colleagues they perceived to be 'politically driven' sometimes suggested that the political outlook of these individuals served to diminish their 'objectivity' in research activities. For example:

*Academic: '[Blank - Professor] is a good researcher... very bright and very dedicated but the problem with [Blank], and I know [Blank] well, I've worked with him/her a number of times, [Blank] is a Marxist and s/he is hugely motivated by his/her political outlook... which can make it difficult because... I feel that [Blank's] scientific analysis is very often coloured by his/her materialist politics so I don't always agree with [Blank's] interpretation of the evidence.'*

On the other hand, the academics who saw health inequalities research as a 'political cause' were often extremely critical of researchers who they felt were too closely associated with policymakers, on the basis that this compromised their 'autonomy' as researchers:

*Academic: 'Let's problematise [Blank – academic] who, as you know, is a Professor at [Blank], and a well-known [researcher who has worked within the field of health*



*inequalities]... who supports the Blair line... and who has recently occupied [an advisory role within government]. And clearly when an academic becomes an official policy advisor, they rather lose their academic credibility, and also it perhaps calls into question the work that they've been doing... for a period before... they occupied that post. And it is in fact the case that quite a bit of the work that [Blank], in recent years, has been doing work about generating evidence to support... the market policies that Blair and his current Secretary of State in England, Patricia Hewitt, are pursuing.'*

Whilst 'objectivity' and 'autonomy' are different things, both signify some sort of claim to free or independent thinking. So, to some extent, the factors contributing to perceptions of credibility described in the two quotations above overlap. Nevertheless, it is clear that each interviewee thought about the issue in quite different terms. These two quotations were chosen for the way in which they particularly highlight what appeared to be a more widespread tension within the health inequalities research community; what served to increase credibility amongst researchers who were sympathetic to one of these viewpoints often seemed to actively damage credibility amongst researchers more sympathetic to the other.

The multifaceted nature of perceptions of credibility amongst health inequalities researchers is further underlined in the interviewees' comments about the validity of different methodological approaches to research. For, whilst there are some consistent trends within these accounts, there are also significant divisions. None of the interviewees suggested they subscribed entirely to Hadorn and colleagues' (Hadorn, Baker *et al.*, 1996) 'hierarchy of evidence' in which experimental, quantitative research is always prioritised over other types of data (with systematic reviews of randomised control trials representing a 'gold standard'). Indeed, most interviewees stressed that the appropriateness of the research methodology depended on the question/topic. However, there was a noticeable tendency to favour quantitative approaches amongst some researchers, particularly those with a medical background. In total, eight of the academic interviewees suggested quantitative methodologies produced more credible information than qualitative methodologies and two of these interviewees were quite openly hostile towards qualitative research, as Chapter Four has already discussed (see extracts on p124). On the other hand, however, many interviewees had themselves undertaken qualitative research and spoke very highly of particular qualitative studies and/or researchers.

Once again, therefore, perceptions of the credibility of health inequalities researchers and their work appeared to vary with the audience.

One characteristic that interviewees discussed more consistently in relation to credibility was the high status bestowed on medical expertise. This has been widely commented upon within the social sciences (e.g. Armstrong 1995; Finkelstein 1990; Gabe, Kelleher, & Williams 1994; Petersen & Bunton 1997) and it is perhaps unsurprising, therefore, that in a field of research which encompasses both social scientists and clinicians, there appears to be a division between those who are able to draw on claims to medical expertise and those who cannot. Not all of the interviewees felt the divide was problematic, but over half of the academic interviewees made some kind of reference to its existence and most of these comments suggest a background incorporating medical training was likely to aid the credibility of a researcher and his/her ideas. For example:

*Academic: 'The thing that's held back inequalities is there's one school of people whose points of reference are within... the psychosocial work and then there's another group of people, like me, who are medical and biological, and there hasn't been a whole lot of dialogue. [...] I mean I was a clinician [...] so I'm kosher with the medical people. [...] The kind of sort of freaky, left-wing people who do a load of health research antagonise doctors. They do it deliberately. So there's, there's a lot of that [laughs] going on. But, at the end of the day, we're the guys who look after the patients and... so I have a very clear view about the poor of being sick 'cause I've had to care for them and look after them. [...] I don't just write about it.'*

*Academic (who does not have a medical background): 'Even within the health inequalities group, those who are physicians have a much higher status and... they are somehow believed to be more credible sources of information. It's difficult to get the idea that... disease is caused by a social factor; they always try to find a gene or biochemical or a vitamin or... whatever.'*

It is interesting that neither of the above statements actually suggest that the research undertaken by researchers who are medically trained is necessarily any better in quality (that



it is more rigorous or valid, etcetera). Rather, they both focus on the higher *status* (and therefore credibility) accorded to researchers who have a medical training (and, therefore, to their ideas). Unlike opinions about methodological approach, perceptions about the role of medical status in credibility were relatively consistent; the data suggest that where medical training does have an influence, it is always positive (so none of the interviewees claimed medical expertise ever had a negative impact on a researcher's credibility). The consequence of these perceptions is that academics able to draw on claims to medical expertise appear to have an additional resource to draw on when promoting themselves and/or their ideas.

Both the variations in opinion about the credibility attached to different methodological approaches and the higher status accorded to medical expertise could be viewed as the outcome of ongoing 'boundary work' (Gieryn 1983, 1999). This concept describes the way in which boundaries are constructed by scientists to distinguish between what is considered 'scientific' and what is not. The purpose of boundary construction, according to Gieryn (1983, 1999), is to increase one's own credibility and thereby the ability to influence others and gain access to further resources. In the case of medical expertise, any boundary work that has been undertaken appears to have been relatively successful as, whilst non-medical research was not dismissed as 'non-scientific', there was widespread agreement that claims to medical expertise only ever served to increase researchers' credibility (and access to resources). In contrast, the boundaries constructed in relation to particular research methodologies seemed both more numerous and less concrete, with a number of interviewees actively contesting the opinions expressed by others.

Assessments of the credibility of researchers did not stop with the *process* of research. Many of the comments made about credibility concerned how particular researchers promoted their ideas to wider audiences and, yet again, there were differences in opinion about what made researchers more or less credible. A few researchers, most of whom had either appeared in media stories about health inequalities themselves or who had previously worked for advocacy organisations (such as charities), emphasised the importance of being able to get clear ideas and messages 'out there'. The ability to be able to promote what were often quite complex ideas in ways which appealed to non-academic audiences was described by many of these interviewees as a rare skill and they suggested that, where successful, such a skill

aided one's recognisability amongst peers and, therefore, one's credibility. However, other researchers were openly disparaging of their peers who appeared in the media. For example:

*Academic: 'A lot of them are media tarts and [just] like being on the telly [laughs] and, you know, like to see their names in the newspapers. [...] I suppose there are public intellectuals who will talk about any issue but not many of them are people who've actually done any fundamental work in this area.'*

*Academic: 'If you just become a complete sort of media whore, you know, [laughs] sort of just throwing out all these things, then people don't take you very seriously, so you've got to have a... you don't just want to be rent-a-quote ... you know, you... really want to have a good and important thing to say and you can back it up, and then people take you quite seriously.'*

The quotations above provide evidence of the kinds of sentiments which may lead to the credibility of an academic researcher who frequently appears in the media to decline. It is not always clear in the statements about this issue quite *why* a researcher's credibility should suffer from appearances in the media and it is possible that jealousy or, as one interviewee claimed, snobbery, play some role. The most tangible explanation, which was put forward by both of the interviewees quoted above, was that over-exposure in media outlets was likely to be damaging to researchers' reputations where they veered off the highly specialized areas in which they were regarded as academically credible, or 'expert', into discussions in which they were deemed less qualified to pass judgment (see Said 1994 for a critical account of the trend towards specialization within academia). The charge lobbed at such individuals was that they were somehow deemed less 'serious' researchers as a result, a claim reflected in Eden's (2005, p285) analysis of academics' relationship with the mass media, in which she argues that some academics may actively seek to 'denigrate' the research of their colleagues on the basis that 'their popularity or media-friendliness makes them somehow less academic'. Hence, the appropriateness (or not) with which academics are perceived to promote both themselves and the ideas they have constructed has the potential to affect how 'serious' their work is perceived to be.



This brings us full circle in the 'cycle of credit' to the point at which, having developed and promoted particular ideas, academics are required to search for sources of (further) funding to allow them to undertake new research projects and develop more ideas. In some ways, the search for funding would have provided a more obvious starting point to the discussion in this section. However, it has been left until now because it introduces the notion that credibility is required amongst non-academic, as well as academic, audiences. For, whilst academics play a significant role in assessing each other's potential access to resources (through, for example, peer review or the process of making academic appointments), they are far from the only actors involved in such decisions. Actors who provide the resources required for researchers to undertake research (such as the funding for specific projects, programmes or appointments) are central to this aspect of the 'cycle of credit'. Yet, this is a part of academic activity which is rarely discussed or reflected upon.

The ability to secure funding to undertake research (whether through employment in a research post or through obtaining a specific grant) plays a crucial role in shaping the career trajectories of researchers, as Latour and Woolgar (1986) and Knorr-Cetina (1981) both highlight in their respective studies of scientists. So it is perhaps to be expected that the interview data include repeated references to the processes of searching for and applying for funding. Indeed, many of the academic interviewees reported that the pressure to secure funding was virtually constant and consumed large parts of their time. Some of the academics who had been involved in the health inequalities research the longest (for twenty years or more) claimed that this pressure had substantially increased since they first entered academia. For example:

*Academic: 'When I was doing my research in the eighties [blanked for anonymity], I thought, you know, you do this, then you get a job a bit like the people who taught you who are lecturers and senior lecturers or whatever... and... unless you have a burning desire to run a department, you carry on doing your teaching and when the spirit takes you, you write things. Now that's... not remotely viable anymore. [...] Now you've got to go straight for the top - don't hang about, you finish your PhD, you get your first few papers, you get onto a research team as co-applicant, then you go for your own money, and after that you go for [bangs table] one after [bang] the other,*

*[bang] after the other, [bang] after the other... It's a bloody treadmill! And it doesn't matter whether you've got a university contract or not because university contracts are not worth the paper they're written on. So, basically, that's what you do. [...] You always have to have at least three or four applications in at any one time [sighs] because the average hit rate is about twenty percent... so that's just the way you do it. And you get to the stage where you no longer can remember what you were ever interested in because you're just making applications for the sake of it. Now once you've got the money, then you've got to produce something, so you just go through the motions. And you think, 'Jesus, it's amazing to think I once was interested in all this, you know, once...'*

The kinds of feelings expressed by the above interviewee may well have been informed by the increased pressures experienced further up the academic hierarchy (all of the individuals who claimed that the pressure to secure funding had increased substantially in their time in academia were professors at the time of the interviews) as well as to changes relating to academic research more generally. Nevertheless, it is interesting that in a period (from 1995 onwards) in which most of the interviewees reflected that funding opportunities for health inequalities research had been particularly good, so many felt the need to emphasise the centrality of acquiring funding to their activities. The data leave little doubt that, despite a sense that funding opportunities for researchers interested in health inequalities had been plentiful during the study period, researchers had still not always felt free to explore the issues in which they were most interested. Rather, a combination of calls for specific research proposals and researchers' own perceptions of funding opportunities appeared to have actively shaped research activity within the field of health inequalities. For example:

*Academic: 'There are kind of research opportunities. I mean I got into [blank – particular subject area] because there was [Blank – a research council funding] initiative in [that area], so they said, 'put in proposals'. I didn't know anything about [this subject area] but you stick a proposal and you do it. [...] So... I think there's a lot of serendipity sort of things going on. [...] You can put in grant applications for really good ideas and they don't come out so you don't do it, put grant applications for other things and they do. [...] Academics are entrepreneurial, they go where the*



*money is and so they apply for, you know, if somebody says, 'research project on X,' you know, 'cycling,' we'd all start doing sociology of cycling or something [laughs].'*

In the above quotation, the interviewee focuses on the way in which calls for research proposals shape research activity, a point which many interviewees touched upon. Not all research funding is connected to specific research calls, however, and some interviewees also described the process of judging what might be likely to succeed in applications for more open funding (from, for example, some of the UK research councils). Terms relating to chance, such as 'serendipity' (which the above interviewee uses) or 'luck,' occur frequently in these explanations. However, it is clear that researchers were not suggesting that they submitted applications blindly. Rather, as Knorr-Cetina (1981) describes:

*'When scientists follow the lead of an unrealised solution, they do not foolishly commit themselves to a journey of unknown destination and uncertain arrival time, in which the chances of getting anywhere are at all poor. Instead, they choose a known destination at which it seems likely they will arrive not only on time, but ahead of everyone else.'* (Knorr-Cetina 1981, pp59-60)

In this quotation, Knorr-Cetina is describing the decision-making processes of the scientists she studied with regards to the ideas they eventually chose to pursue through research, highlighting how these researchers followed 'the lead of ideas which hold the greatest promise of success,' (Knorr-Cetina 1981, p60) rather than exposing themselves to unnecessary risks and uncertainties. Although this particular quotation is not directly referring to the process of making funding applications (which Knorr-Cetina discusses elsewhere in the same chapter), it captures precisely the factors shaping funding applications that many of the academic interviewees in this research described. There are, for example, seven accounts within the data in which academic researchers describe having 'dressed' ideas in ways which they believed would increase the chances of a research proposal's success. One interviewee, for example, recounted having emphasised on a research application (which was successful) that, if funded, the results of the research may provide new information about tackling health inequalities relatively inexpensively, a possibility which s/he felt would appeal to a wide range of potential funders (especially policy-based funders). The following quotations provide two further examples of interviewees emphasising the extent to which funding applications are

shaped around researchers' perceptions of the ideas that potential sources of funding are likely to find attractive:

*Academic: 'You get questions, in a purely scientific sense, you get questions that you want to pursue. So what do you do? You hang it on, one way or another, you hang it as some issue that you think will get it funded.'*

*Academic: 'Researchers write applications in terms of what people want to hear rather than... what is... the most... important and valuable thing they can do.'*

The writing of funding applications was therefore described, at least partially, as a guessing game in which success depended on one's ability to assess what it was that potential sources of funding 'wanted to hear'. The first quotation above reflects aspects of the data which imply that the skill of 'dressing' applications appropriately may sometimes merely be a matter of aesthetic (or linguistic) presentation. One interviewee, for example, who had been very successful at securing funding within the field of health inequalities, described how s/he assessed, 'What's *in* right now? What's sexy?' when applying for funding, before peppering the proposal with the appropriate terminology. Such explanations seem to suggest that the 'framing' of research proposals does not necessarily substantially impact upon the actual research that is undertaken. Two other interviewees even described 'playing the funding system', either by: (i) applying for money to undertake one research project but then actually undertaking something rather different; or (ii) suggesting that a particular research project requires more resources (time and money) than it actually does and thereby creating some space to research issues in which they were interested but for which they had been unable to secure funding. The ability to manipulate research funding in this way, however, seemed rare. More commonly, the findings suggest health inequalities researchers have felt constrained in the work they do by their perceptions of the limitations of funding opportunities. In particular, the data repeatedly reveal a concern about the potential damage caused to researchers' credibility amongst potential funders by appearing to be 'too political' or 'radical'. For example:

*Academic: 'Politics is everywhere... and it's influencing research too. If you think about grants, for example, we are funded by grants and grants are funded by*



*institutions and these institutions decide which studies should be funded, based on certain assumptions. [...] Our job security, our status... can be threatened the moment we... try to address hot issues instead of... coincidental research questions that nobody cares about.'*

*Academic: 'By being a contract researcher, I have to be really careful what I get involved with in terms of politics - I can't afford to take chances.'*

This is particularly important given that, as already discussed, a substantial number of the academic interviewees suggested that their research on health inequalities was closely related to their political and ideological outlook. This suggests there is often a real tension between the ideas that researchers are interested in pursuing and those they feel *able* to pursue. It is worth noting that neither of the above interviewees were, at the time of the interviews, in tenured positions as some (although not all) of the interviewees suggested that a permanent academic positions afforded some level of protection (and, therefore, creative space) to individuals. Nevertheless, over half of the research-based interviewees said something to suggest that they carefully managed the image they projected to audiences who represented potential sources of future funding and many of these held tenured academic Chairs.

Crucially, interviewees suggested that the need to manage one's image with potential sources of funding in mind not only informed proposals for new research but also shaped the presentation research outputs. Given, as Figure 6.1 illustrates, the cyclical nature of the research process, this is perhaps not surprising. After all, the arguments and articles produced by academics directly feed into others' perceptions of them (and, hence, their credibility as researchers); a relationship which all interviewees seemed acutely aware of. Indeed, it was here that many interviewees suggested the most significant tension within health inequalities research lay, with researchers' concerns about their reputation amongst potential funders sometimes causing them to be less explicit in the claims they promoted than they might otherwise have been. The following interviewee, for example, reflected on his/her general perception that researchers within the field of health inequalities tended, as a result of their fear of losing credibility with funders, not to be explicit about what they believed the political implications of their research to be:

*Academic: 'An awful lot [of researchers] may feel inhibited from actually putting things as openly and assertively and sort of nakedly as I'm putting them and, I mean, it's only as I get nearer and nearer retirement that I'm increasingly explicit about... how I see things. [...] So that's one problem, I think, people not seeing, identifying the problem in that way and, to some extent, self-censorship.'*

Overall, accounts of self-censorship were far more frequent within the data than I had anticipated, particularly as the period on which the thesis focuses is one in which health inequalities researchers have frequently celebrated the opportunity to openly discuss health inequalities (Bartley, Blane, & Davey Smith, 1998; Berridge & Blume, 2003). Although the above quotation reflects numerous aspects of the data which suggest that the consideration of funding opportunities was a fairly consistent concern within the field of health inequalities, it was also clear that the sense of feeling constrained about what it was appropriate to say was most acute when researchers had received, or were receiving, funding from policy-based sources. For example, the following interviewee said s/he felt that research bids from policy-related sources were often highly suggestive about the kinds of conclusions that were desired:

*Academic: 'I think one of the difficulties is often when there are bids for research funding, it's almost if the findings or, you know, the messages that are required are stated from the start almost. [...] When one looks at research bids, it's, there are strong steers in terms of what they're looking for, what kinds of conclusions one's being steered towards, what kinds of policy messages they want...'*

It is, of course, nevertheless possible for researchers who are awarded such contracts to undertake the required research and present conclusions other than those they perceive the funders' desire (indeed, several interviewees reported that they had done precisely this). However, as we have seen, the data also suggest that most researchers are continually aware of the importance of maintaining credibility amongst research funders. It is for this reason that some researchers reflected they framed their findings in ways which presented less of a challenge to policy than they believed was warranted by the research. It is important to highlight that there are no instances within the data of interviewees suggesting that they (or



anyone else whom they knew) had misrepresented data or significantly altered findings. Nor were there any claims of having been put under direct pressure from research funders to do so. Rather, the pressures that researchers described experiencing, and sometimes submitting to, were far more subtle. One interviewee likened the situation to the process of gift-giving employed by the KGB (Soviet Union secret police), whereby the act of receiving a gift (or, in this case, funding) serves to instil a sense of loyalty and indebtedness in the receiver with the effect that they begin to feel obliged to act supportively. The subtlety of this process is captured in the following extract, taken from an interview with another researcher:

*Academic: 'When I was at [Blank – government funded organisation] I could have been much more... critical. Actually [...] it isn't simply that I feel the funding source wouldn't like me to say those things, I actually feel, would feel it would be a betrayal of the trust that the people who gave me the opportunity to spend my time doing that had in me... and I think, in a way, when I was working at [this organisation] and they are actually funded through [government department], I think... they would have looked at me and said, 'how can you not have read what is appropriate to say?' So I think the censoring is actually self-imposed. [...] It isn't that I think they would come the heavy on me, it's... there's an unwritten understanding that I won't rock the boat when I'm writing in that guise. So... at an academic event, I feel I'm me, you know, I can say, I can be much more pointed in the points I want to make... but... I think when I'm writing through a funding source, which is government... and I do out of, and maybe I shouldn't, I do out of a sense of loyalty to... the people who are trusting me not to say things that would make them feel uncomfortable... and cast into doubt the judgement that they had in saying I was the right person to do the job.'*

This extract illustrates how personal and professional relationships can become entangled in the process of research, with the consequence that feelings of loyalty towards individuals merge with a sense of loyalty towards the organisations within which those individuals are based (or associated with). In Latour and Woolgar's (1986) study of biologists, the concept of 'credibility' is largely discussed in relation to the scientists themselves, so the emphasis is on the importance of maintaining credibility amongst one's peers. However, the above extract is illustrative of a more general trend in the data collected for this thesis, in which interviewees

frequently distinguished between the images of themselves and their work that they projected to their peers and those which they constructed for policy and funding audiences. In the above extract, this distinction is particularly explicit; the speaker describes being in a certain 'guise' when working closely with policy-based individuals and only feeling able to be his/her 'real' self when interacting with academic audiences. Indeed, an ability to juggle more than one image of oneself appeared to be a crucial asset of researchers who succeeded in moving effectively between policy and research.

Other academic interviewees who had received direct funding from policy sources emphasised the pressures they felt to produce *policy-relevant* research. This is a related but slightly different kind of constraint to that discussed above. Whilst it is possible to produce work that is relevant to policy yet politically critical, the kind of relevance that these interviewees described did suggest that they felt a focus was required on addressing issues within the *existing* framework of policy approaches. For example:

*Academic: 'I mean my own research is funded through the Executive, as you know, so I've got a very... I feel a very strong sort of sense of being pulled in that direction, to do policy relevant research, ultimately because when research I'm involved in is reviewed [coughs], it's reviewed, I suppose, partly against... what policy relevance it has and what... specific relevance to Scottish Executive policy it has and... I assume that that's the case.'*

The fact that the above interviewee describes feeling s/he was being 'pulled' in a particular direction suggests s/he felt under pressure to work in ways which would be complementary to, rather than critical of, the Scottish Executive's existing approach to health inequalities. The desire for this kind of policy-relevant (or 'realistic') research was openly articulated by many of the policy-based interviewees in this research and has been commented upon elsewhere (e.g. Petticrew, Whitehead, *et al.* 2004) so it is perhaps unsurprising that those in receipt of policy funding reported experiencing this pressure. Nevertheless, it is an important finding for two reasons. Firstly, it provides yet further evidence that policy-funded research is unlikely to produce the kinds of 'charismatic' ideas outlined in Chapter One. Secondly, it underlines the conflict between the factors which interviewees perceived to shape credibility amongst policy



audiences compared to academic audiences. For, as discussed earlier in this section, interviewees based in academia frequently warned of the danger of losing credibility amongst one's academic peers by appearing to be too close to policy. Yet, those who had worked with (or received funding from) policymakers suggested that a researcher's credibility within policy was at least partially assessed by his/her willingness to engage in precisely such close relationships. Indeed, one interviewee, who was based in academia and who had close connections to individuals in policy, reflected that s/he felt from the policymakers' perspective, *'There's nothing quite as good as stuff that's got your label on it. You know, this is research that the Scottish Executive commissioned...'*

One of the demands that interviewees who had received funding from policy sources frequently claimed policymakers pushed was the production of clear, simple and actionable messages from research projects. On the whole, academic interviewees were sympathetic to policymakers' desire for this kind of clarity and a few suggested that researchers ought to be aiming for the production of this kind of knowledge in any case, regardless of the pressure from those outside academia. However, more frequently interviewees said they felt *academic* research was not concerned with producing this kind of information. For example:

*Academic: 'I think what they [policy makers] want and actually what they need is clear messages and that's the, the trouble is a lot of academia doesn't give very clear messages because there are a lot of nuances in research and, err... and academics make their living out of thinking about all the little tiny wrinkles and... complexities...'*

The differences between the kind of knowledge that academic endeavours tended to produce and those that policymakers' desired caused some interviewees to reflect on the importance of distinguishing between 'policy-orientated' and more 'autonomous' research; precisely the kind of distinction that Hammersley makes in the following extract:

*'The fundamental distinction I want to draw is between what I have referred to elsewhere as scientific versus practical research. This could equally have been formulated as academic versus practical research. [...] The basis for this distinction concerns the closeness of the relationship between research and policymaking or practice. And this has implications for the relative weight given to the two criteria that seem to be central in any assessment of*

research findings, and to how they are interpreted. Those criteria are validity and relevance.' (Hammersley 2005, p35).

From Hammersley's perspective, whilst 'practical' research may produce more 'relevant' information, it is also potentially less 'valid' and, therefore, less credible than what he terms 'scientific' or 'academic' research. Interviewees who drew this kind of distinction similarly implied that there was the potential for 'policy-relevant' research to be of lower in quality (and, therefore, credibility). For example:

*Academic: 'A lot of people would say... the integrity of research is best maintained by being independent to policy so... I adhere very strongly to the idea that the kind of basic research, fundamental research, is informed by, is driven by some sort of scientific agenda, which doesn't mean that it's kind of context indifferent... but that scientific questions have credibility in scientific terms [coughs]. I mean, namely, they are raising issues that require explanation. But I also think that there, there is this sort of middle tier of research or middle field of research, which I know people like to call applied research or strategic research or policy-informed research, and to me that's the place where there has to be a kind of mutual interchange between policy and research... for that field to flourish. [...] But I think... one of the difficulties at the moment is [...] the people in this middle territory are... their time is so absorbed now with policy agenda that it's very difficult for them to maintain their links with the scientific stream of work, which actually ensures the quality of what they do for policy.'*

All of this underlines the difficulties facing academic researchers who are attempting to maintain credibility amongst both policy and academic audiences. Often, it seems, through the very decision to undertake 'policy-relevant' (usually, though not always, policy-funded) research, a researcher's credibility as an academic may already be in decline. For even if the research that is undertaken might otherwise have been perceived to have high academic worth, boundary workers can *claim* that its worth is less on the basis of its practicality, 'to reinforce the expertise (and legitimacy) differential between the grey and the gold' (Eden 2005, p283).



To some extent, the fact that so many interviewees felt it was important to distinguish between the kinds of research seems to relate to interviewees' perceptions that there is more possibility of thinking in unconstrained ways within academic spaces. Indeed, most of the academic interviewees who discussed different sources of funding did suggest that there was more freedom to manage and manoeuvre research projects in directions of one's own choosing when those projects were funded by sources that were not directly linked to policy, such as the UK Research Councils (those most frequently mentioned being the ESRC and the MRC). However, even the Research Councils were not perceived to be *entirely* unconnected to policy and a number of interviewees pointed out that the research the Councils funded often correlated with policy interests. One example that several interviewees mentioned was the ESRC funding of the *Health Variations* project, which occurred shortly before New Labour came to power; the timing of which, one interviewee claimed, 'couldn't just be a coincidence' and was more likely to be the result of civil servants encouraging Research Councils to fund research that they believed might be of use to the next government. Another was the ESRC funding of the *Centre for Evidence-based Policy* (subsequently renamed *EvidenceNetwork*) and the ESRC's general emphasis on the importance of policy-relevant research, which has occurred alongside the UK government's interest in this relationship. For some interviewees, this was an unwelcome development. For example, one interviewee who described him/herself as 'very much a back room kind of person' with no desire to actively market their ideas to policy audiences, reported feeling compelled to do so due to requests from individuals at the ESRC, from whom s/he was receiving funding. This is important because it suggests that even researchers who are not orientated towards policy audiences through their own sense of the purpose of their work may feel compelled to consider the factors shaping the credibility of ideas within policy audiences.

It is not the purpose of this chapter to assess the extent to which funding decisions actually *are* related to policy preferences (although there are, in fact, plenty of data which show that the academic interviewees' perceptions of the preferences of potential funders significantly overlapped with what interviewees based in these organisations themselves claimed to be the case and some of these data are discussed in Chapters Seven and Eight). The point for this chapter is that *if*, as the data suggest, a significant number health inequalities researchers have acted on the basis that they *believe* research funding, including that from research

councils, is constrained or shaped by political and policy preferences, and if they then frame their applications and outputs accordingly, then research agendas are shaped by these beliefs, regardless of whether or not such decisions actually influence the funders of research. The effect is that applications to explore research ideas which are perceived to be politically challenging are likely to have been minimised. In other words, the scope for health inequalities researchers to explore ideas which represent 'charismatic' challenges to dominant ways of thinking appear to have been restricted by researchers' perceptions of the funding landscape.

The final tension between the factors perceived to shape the credibility of researchers in academia and the factors perceived to inform credibility in policy circles is epistemological. Whilst some interviewees said they felt that policymakers were often so focused on ideas (rather than evidence), the methodological approach to research became irrelevant, nine academic interviewees (five of whom had close connections to policy) felt that ideas based on quantitative research, or associated with medical researchers, were more persuasive. For example:

Academic (with policy links): *'In health inequalities... if the hard science can get pushed out [...] and our understanding get to a point where we can make convincing arguments... [...] They [policy advisors and some ministers] like to think that they're sort of cosmopolitan enough to pick up on a lot of different areas. If you can get it in their brain that we're getting hard evidence that... changing low income... can make a difference to brain functioning that changes the release of various stress hormones which changes your potential future life chances... and life expectancy then... woohoo, you know? [...] If you can get the medics, the academics, the... guys who are doing this stuff to be putting out hard - and I emphasis hard - scientific evidence of... The key advantage for health inequalities is you should be able to develop a hard science which says, 'how does it work?' [...] Ministers love that [hard scientific evidence], right? It stops the sense that they're sort of having their biases or prejudices are being sort of pandered to; this is hard, solid stuff. And so that kind of really helps.'*



The above quotation suggests that, despite the existence of a wealth of analyses which argue the notion that science is objective, value-free and resistant to researcher manipulation is something of a mirage (see Ross 1996), and despite recent surveys which point to a decline in public trust of science and scientists (e.g. Shaw 2002; Sturgis, Cooper *et al.*, 2004), a belief persisted that policy audiences still attributed a great deal of credibility to this kind of research (and, other aspects of the data suggest, to medical research). As Chapter One discusses, this belief was heightened in some sections of the academic community when David Blunkett (2000) addressed an audience convened by the ESRC with a speech that placed a great deal of emphasis on the need for large-scale, quantitative studies and it was notable that several interviewees referred to this speech.

In many ways, the tensions discussed in this section suggest that academic researchers agreed with the notion that they and policymakers constitute 'two distinct communities' (Caplan 1979), each of whom is guided by different interests and incentive structures. However, for a number of other reasons the findings do not suggest that theories of a 'gap' between the 'two communities' explain the differential journeys of ideas from research into policy that were described in Chapter Five. Firstly, the academic interviewees seemed highly aware of the different demands and desires of policy-based actors and many interviewees appeared to have shaped their research activities accordingly, suggesting there is rather more 'cross-cultural understanding' than some of the 'two communities' theorists imply. Secondly, whilst it is clear that academic researchers who wish to influence policy may have to carefully juggle some competing demands if they wish to build up and maintain high levels of credibility amongst both their peers and policy audiences, it is also clear that perceptions of the ways in which particular factors shape the credibility of researchers and their ideas are not homogenous. Thirdly, and perhaps as a consequence of the previous point, it is clear from what interviewees said that some academic researchers are able to maintain (at least some) credibility amongst both their academic colleagues and policy-based audiences (these individuals are discussed in more detail in the following section). Given the length of the discussion in this section, and its importance to the remainder of the chapter, a summary of the findings in this section is provided in Table 6.1, over-page.

Table 6.1: Academic interviewees' perceptions of how different audiences constructed 'credibility'

Factor affecting credibility	Perceptions of how other academics construct credibility	Perceptions of how research funders construct credibility	Perceptions of how policymakers construct credibility
<i>Originality of idea</i>	<i>Consistently important.</i>	<i>Consistently important.</i>	<i>Irrelevant (except in relation to funding).</i>
<i>Political (ideological) outlook of researchers</i>	Conflicting: credibility increases amongst researchers who share a political position but these positions ranged from self-identified Marxists to those who felt it was important to be 'realistic' and 'objective'.	Most interviewees did not discuss this but some suggested that links between policy and funding organisations meant it was important not to be perceived as 'too radical'.	Consistently perceived important not to be deemed 'too radical'.
<i>Links to policy (including funding but also immediate 'policy-relevance')</i>	Conflicting: a few interviewees suggested that being perceived as a 'policy advisor' increased credibility but most suggested links with policy decreased credibility as it raised questions about autonomy.	Some interviewees suggested funders were becoming increasingly interested in the policy-relevance of research.	Consistently perceived important to be able to work closely with policymakers and to produce 'policy-relevant' information.
<i>Methodological approach</i>	Conflicting: some interviewees suggested credibility depended on choosing the 'right methods for the right question'; others suggested quantitative (esp. experimental) approaches were more credible.	Not discussed.	Conflicting: some interviewees suggested methodology was irrelevant but others said quantitative data were more persuasive.
<i>Medical training</i>	Consistently perceived to increase credibility of researchers and their ideas.	Consistently perceived to increase opportunities for obtaining funding.	Consistently perceived to increase credibility of researchers and their ideas.
<i>Ability to promote ideas to non-academic audiences</i>	Conflicting: some interviewees suggested the resulting recognisability of appearing in mass media increased researchers' credibility but others suggested it decreased credibility because it suggested researchers were less than 'serious'.	Consistently perceived to be important.	Consistently perceived to be important



As Table 6.1 illustrates, for some issues it seems researchers are likely to have to choose between focusing on trying to maintain credibility with policy audiences or with their colleagues in the academic community. For example, by choosing to work very closely with policymakers (e.g. as a policy advisor), or appear frequently in the media, it seems unlikely that a researcher will not lose credibility in at least some sections of the academic community. However, there are also issues for which a researcher may be able to choose to operate differently for each audience, thereby possibly balancing credibility in both contexts. For example, a researcher may engage in complex research debates at a detailed level within media designed for policy audiences (e.g. in peer-reviewed journals and academic conferences) and may also try to present clearer and more policy-relevant messages to non-academic audiences. Finally, the data also suggest there are some factors, such as medical qualifications and quantitative methodological approaches, which appear to contribute positively to researchers' credibility in both policy *and* academic contexts.

Overall, the concept of 'cycles of credit', borrowed from Latour and Woolgar's (1986) analysis of research activities in a biological lab, has been extremely useful in facilitating a discussion of the data in a way which demonstrates the links between otherwise seemingly disparate aspects of research activity, from the writing of funding applications to the promotion of one's ideas in mass media outlets. However, unlike either Latour and Woolgar's (1986) or Bartley's (1988, 1992) studies, the findings presented in this section focus on the ways in which academic researchers perceived credibility to vary with a number of different potential audiences, namely: academic peers; research funders; and policymakers. These data suggest that far more attention ought to be given to the role of funding in shaping research activity, a point which a number of the interviewees themselves reflected upon. For example:

*Academic: 'I'd sort of got this fixed this view of thinking about the relationship between researchers and policymakers but actually the third leg of the stool is... funders and commissioners of research. [...] They often get left out of the picture and I think they, potentially, have quite a strong influence... they can have an influence on the sort of research that's done. They also have very strong... passions and commitments... about what sort of research ought to be done, so I think it's easy, when you're sitting on the research side, to think that you're deciding on the agenda and policymakers*

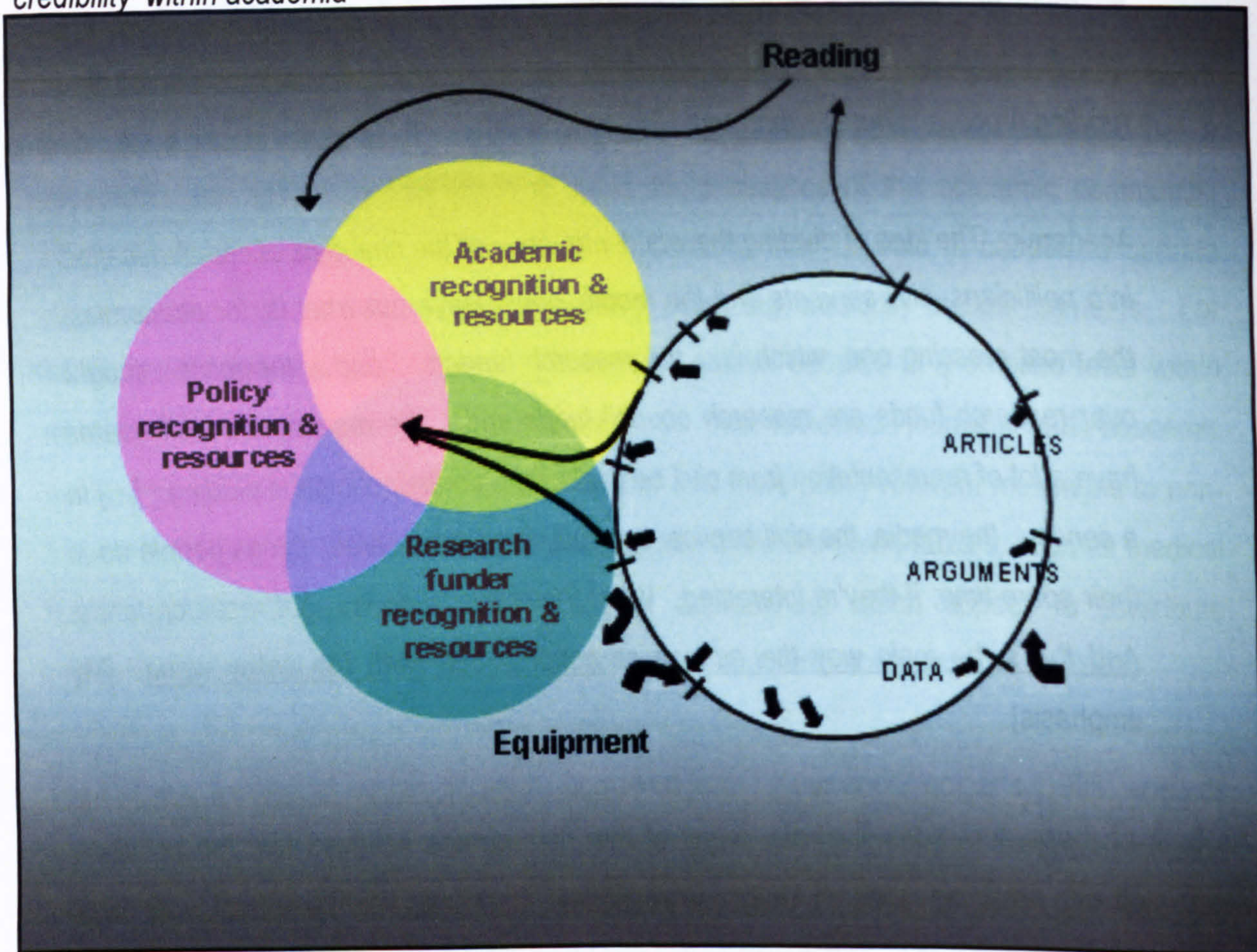
*decide what's done but actually... people on the funding side have got real... genuine interests and passions as well. [...] Most of the stuff that's written is about the transfer, back and forth, between research and policy but... the commissioning and funding process is hugely important.' [My emphasis]*

*Academic: 'The idea of dividing the world into, err... or the channels of communication into politicians, civil servants and the media, could leave out what is, for academics, the most pressing one, which is... the research funders... and... the most... fought over research funds, are research council funds and... the research council boards have a lot of representation from civil servants, who do their ministers bidding. [...] In a sense... the media, the civil service, the politicians, these are... things people do in their spare time, if they're interested. What they have to do is... get research funds. And that's the main way the academics communicate with the policy world.' [My emphasis]*

As both of these quotations illustrate, many of the interviewees believed that the activities associated with obtaining research funding were closely intertwined with the interplay of ideas between research and policy, both because the providers of funds were themselves perceived to be trying to influence research activity and because the exchange of funds between researchers and others was constructed as a mechanism of communication between academics and non-academics. This section has focused rather more on the former (the role of funding as a mechanism of communication is explored in more detail in the following chapter). In exploring this issue, the concept of 'credibility' helped demonstrate how and why researchers' activities were influenced by their perceptions of the preferences of policymakers and other sources of funding. Figure 6.2, over-page, is an adapted version of Latour and Woolgar's (1986) original diagram depicting the 'cycle of credit' (which was reproduced as Figure 6.1, earlier in this section) which tries to capture the findings discussed in this section.



Figure 6.2: The 'cycle of credit' adapted to illustrate the multiple audiences of relevance to 'credibility' within academia



In this adapted version of the 'cycle of credit', three overlapping circles are positioned at the point of the cycle in which academics' ideas move out of academia, via acts of communication (usually, but not only, written publications) which are intended to be read (or heard) by others. The texts (or other communications) constructed by academics include those which form part of the process of applying for research funding to undertake further research, as well as those which describe research-based ideas. It was through these acts of communication, which were usually perceived to involve at least some dialogue with non-academics, that interviewees appeared most aware of the varying ways in which credibility could be constructed. These three, overlapping circles represent the groups that are recurrently mentioned in the data: (i) academics; (ii) policymakers; and (iii) research funders. Importantly, academics and policymakers were perceived to be involved in decisions about the funding of potential research projects as well as research funders. Hence, all three groups were emphasised in relation to this point in the cycle; the moment at which researchers attempt to convert 'credibility' into the currency which will allow them to keep moving through the cycle.



The three circles overlap with each other in three senses. Firstly, there are connections between the three groups, both in terms of individuals and resources. For example, individuals in academia are often involved in the peer-reviewing of funding applications made to funding organisations. In addition, funding may be granted by a funding or policy institution to academic institutions (or between a policy and a funding institution). Secondly, as summarised in Table 6.1, it is clear that perceptions of the factors which shape credibility within each group were not always consistent and some factors appear to overlap between groups. For example, many of the academics did not believe quantitative research was necessarily any more credible than other types of research. However, most of these individuals also said that they believed some people in *both* academia and policy did attribute more credibility to such approaches.

The background to Figure 6.2 has been deliberately shaded to emphasise the cycle does not occur in a vacuum and that interviewees suggested broader social and political contexts informed the various perceptions of credibility. This is not discussed in this section, however, as it forms the basis of the discussion in Chapter Eight.

### 6.3 Moving between research and policy

In light of the discussion above, this section explores the factors which academic interviewees suggested enable and encourage individuals and ideas to move between research and policy. The first point to note here is that, despite the fact some of the most influential theories about the relationship between research and policy in recent years have focused on the notion of 'epistemic communities' (Haas, 1992) or policy networks (as discussed in Chapter One), very few data suggest these kinds of networks or communities exist for health inequalities. Instead, the data consistently suggest that the actors who are able to successfully introduce research-based ideas to policymakers are able to do so at least partially as a result of having established a reputation as *the* (individual) expert on a particular topic. For example:

Academic: *'New Labour has made a big thing of their use of special advisors... although I'm not quite sure that there are quite as many as there were. I think*



*possibly if... if they became less special or gave less advice, there might be more of a case for other researchers and policy people to collaborate more.'*

*Academic: 'I've been quite shocked, actually, that civil servants will say things like, 'oh, I talked to X about X,' you know, about, say, 'obesity to X.' And I'm thinking, 'of all the people in the world, I wouldn't have thought of talking to them.' [...] But they happen to be the person they know, and all doors, sort of all roads lead to that door.'*

The emphasis that interviewees placed on individual 'experts' fits Kingdon's (1995) description of 'policy entrepreneurs' or other theorists' notion of 'policy brokers' (Lavis, Posada, Haines, & Osei 2004; Lomas 2000a). Interestingly, from the perspective of some researchers (including the two quoted above), such individuals were often perceived to be barriers to, rather than enablers of, the movement of ideas from health inequalities research into policy. This is because these individuals were generally perceived to be promoting their own ideas, rather than serving as vehicles for a more general dialogue between research and policy.

The examples of individuals whom interviewees suggested occupied this role for health inequalities were extremely few (although, as some interviewees suggested, such individuals may serve as symbols for slightly broader groups). This was particularly true in the English context, where the name Professor Sir Michael Marmot (Director of the UCL International Institute for Society and Health) was mentioned in relation to this role far more than any other academic. In Scotland, two names dominated the data: Professor Phil Hanlon (Professor in Public Health at the University of Glasgow) and Professor Sally Macintyre (Director of the MRC's Social and Public Health Sciences Unit in Glasgow). In both contexts, a small number of other individual academics were mentioned less often (notably Professors Catherine Law and Hilary Graham in England and Professor Steve Platt in Scotland) but, even if one includes these names, the data suggest that academic researchers in health inequalities who are widely recognised within policy circles are low in number. Given the closed doors behind which policymaking takes place, these data do not provide enough evidence to conclude that the names mentioned represent the only health inequalities researchers who were widely held in high esteem by the policy community; there may well be other individuals who were not mentioned because they operate more covertly (indeed, one of the academic interviewees

directly claimed this was the case). What can be concluded, however, is that in both Scotland and England there were a clear (and extremely narrow) set of individuals who were identified by both policy-based and academic interviewees as people from whom civil servants and/or ministers sought advice.

Acknowledging that certain individuals are better positioned to promote ideas than others is not particularly helpful, unless we also understand the processes that allow particular individuals to occupy the privileged position of 'expert'. Here, the findings from the previous section, summarised in Table 6.1, are helpful as they suggest that perceptions that individuals (and their research) embody particular characteristics are likely to aid the maintenance of credibility amongst both academic and policy audiences. These characteristics are as follows: (i) perceived to have undertaken original research; (ii) not perceived to be 'too radical' (i.e. politically challenging); (iii) not perceived to be 'too close' to policymakers by academics yet perceived as someone who engages with policymakers by policy audiences; (iv) perceived to promote ideas based on quantitative data; (v) known to have experience of medical practice/clinical training; (vi) able to communicate research-based ideas to non-academic audiences yet not perceived (by academics) to be 'over-exposed'. Whilst none of the individuals identified in the previous paragraph were described in ways which suggested they exhibited *all* of these characteristics, the data do suggest that there was some correlation. The descriptions of Marmot, for example, suggest the only characteristic in the list above that he was not perceived to exhibit was a perception amongst academics that he was able to operate independently of policymakers (several interviewees said they felt his close relationship with policymakers had negatively impacted upon his credibility within academia). Likewise, the descriptions of Macintyre suggest there was only one characteristic that she was perceived not to match, that of being medically practice/clinical training<sup>14</sup>.

The key issue for this thesis is how these characteristics appear to impact on the movement of ideas between research and policy. Interestingly, despite accusations that individuals occupying these 'bridging' roles tended to promote the ideas with which they were associated,

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<sup>14</sup> The extent to which Hanlon matches these criteria is less clear as far few academics mentioned him. Indeed, the data suggest that (possibly in light of his non-academic background) he was perceived to be a 'policy advisor' *per se*, rather than an academic researcher who provided advice to policy (which was how Marmot and Macintyre were each described).



there are very few data to suggest that the ideas with which these researchers are associated have been particularly influential. This is evident in the analysis undertaken in Chapter Five and was reflected upon by some interviewees. For example, the concept of a social gradient in health is, as Chapter Two discusses, frequently associated with Marmot. Yet the data reveal that this conceptualisation of health inequalities appeared to have moved into policy in only a very limited sense and the importance of psychosocial determinants of health, with which Marmot is also associated, appeared to have undergone a 'fractured' rather than a 'successful' journey. In Macintyre's case, none of the work she was involved in relating to the role that context or neighbourhood plays in health was significantly evident in the Scottish policy statements. Hence, the perceptions that these individual 'experts' tended only to promote the ideas with which they were associated was not supported by this aspect of the data. Rather, the data suggest that to understand how such a situation has occurred, it is necessary to focus on the (usually un-stated) agreement, discussed above, that individuals working with policymakers will work within certain boundaries of policy 'acceptability'. Interviewees suggested this served to restrict the ideas that academics occupying the role of advisors to policymakers were able to promote, ruling out ideas which were not perceived to fit within these unwritten boundaries. This process is evident in the following extract, taken from an interview with an individual based in academia who identified him/her self as someone who provided advice to policymakers (and who was also identified by others as performing this role):

*Academic: 'I have almost come to the point where I think the challenge for public health is societal change... So, that sometimes brings me into conflict with our colleagues in [the civil service] because they rightly say, you know, their job is to implement the government's programme, not to change society. [...] And there is conflict there.'*

*Interviewer: 'Right, but you're able to work with them despite that?'*

*Academic: 'Oh yes, yes, yes, yeah. I mean we, we can put that a bit on the shelf and talk about more practical things.'*

The fact that this interviewee felt that s/he had to set aside ideas s/he supported which suggested there was a need for a substantial change in policy direction underlines the

bounded nature of the interactions between academic research and policy in the field of health inequalities. Similarly, a different interviewee described how, in attending a meeting with policymakers and other researchers to discuss a particular health-related issue, s/he experienced pressure from the other researchers who were present to avoid promoting research-based advice that was deemed 'too radical':

*Academic: 'I said, 'actually, if we're seriously going to avoid the repetition of the problems we've had with smoking, we have to learn from research, which would suggest that you have to think about the downstream determinants and particularly the distribution of those determinants'. And there were a couple of researchers who were in this group I was in who said, basically, 'we don't want to go there because that's too radical,' you know, 'lets come up with something that's more proximal because these distal determinants mean that you're opening up what will be read as some sort of socialist agenda.' And [...] of course I got quite agitated and I said, 'well actually, I'm not in the business, as a social scientist, of qualifying what needs to be said, to make it politically palatable.'*

All this suggests that, whilst it is possible for academics to build and maintain credibility amongst *both* policy and academic audiences, there are some crucial tensions in occupying such a position. The data discussed in this section suggest these tensions can rarely be completely avoided, even by the most proficient boundary crossers. So, rather than exhibiting the characteristics of the 'charismatic individuals' that Weber (1968, 1968c) describes, the academics who were described in the data as influential within policy contexts appeared to be more like the 'mediators' that Osborne (2004) describes. These are intellectual workers who act as 'enablers' or 'brokers of ideas', whose aim is to 'move things along'. This helps explain both the dearth of 'successful' journeys and the presence of 'partial' and 'fractured' journeys found in the analysis presented in Chapter Five. For Osborne's (2004) 'mediators' or 'brokers' are individuals who enable quite challenging ideas to travel into policy by marketing them in 'vehicular' ways, rather than trying to promote 'big ideas' or 'grand narratives'. 'Vehicular ideas' are summarised by McLennan as follows:



'Vehicular ideas emerge as ways of problem-solving and 'moving things on'. Anyone who wants to get from A to B, for whatever reason, can therefore usefully embrace certain sorts of ideas as 'vehicles' for doing so, whatever their other differences with fellow-travellers. There is an ineliminable vagueness and 'mobility' about these ideas because their significance can change with context, and they can be 'owned', and in the owning shifted in meaning, by different parts of the network.' (McLennan, 2004, p485)

In relation to the various journeys of ideas discussed in this paper, the concept of vehicular ideas can be used to help explain both the 'fractured journeys' of psychosocial and lifecourse theories, and the 'partial journey' of material-structural ideas. For example, in marketing Wilkinson's ideas to a policy audience, the emphasis could easily be placed on psychosocial pathways rather than income inequalities, with the consequence that the idea becomes less challenging to dominant policy boundaries. Equally, for those 'mediators' or 'entrepreneurs' committed to promoting material-structural accounts of health inequalities, ideas might be pitched in ways which avoid obvious conflicts with the direction of policy by, for example, focusing on the links between employment and health (given that increasing employment rates is already a policy priority for other reasons). The process of carefully judging how to frame particular ideas so they appear less radical than they might otherwise be is evident in the following extract:

*Academic: 'If you have poverty and adversity of that nature, nothing's gonna save you. Now, they [policy makers] are not gonna like hear that. [Pause] On the other hand, I have to say, I think probably some people have enough clout that we don't need to... be too tactful. But certainly when I was less experienced and I was putting in for money on [blanked] and health, we did produce papers which were - how can I put it? We weren't coming out and saying we were absolutely sure that [blank] causes ill-health and there's no element of selection. We actually found the perfect way through it, which was to say, 'well, if you look at a lifecourse perspective, you don't have to make that opposition.' Now that, I think that's probably true, actually, but, you know, we were doing it, I was doing it, I was pushing people towards it in order to be clever.'*

It is notable that the above interviewee was not, in his/her own words, particularly orientated towards influencing policy and yet, nevertheless, s/he felt it necessary not only to consider

how policymakers might interpret particular claims but to then avoid making such claims too overtly. In fact the data suggest, in contrast to Osborne's (2004) image of 'mediators' as individuals who, due to the work they want to do, deliberately promote 'vehicular' ideas, that the process of orientating ideas towards policy may not seem completely optional. Due to the centrality of obtaining funding for research described by the interviewees, combined with the perceived overlap in preferences of research funders and policymakers (as well as the potential for policy organisations themselves to provide funding), researchers may feel compelled to promote ideas with the flexibility and metamorphosing qualities of Osborne's 'vehicular' ideas. Indeed, the data suggest that this pressure is likely to escalate as academics reported being increasingly encouraged (both by funders and their own academic institutions) to market their ideas to audiences beyond academia (e.g. Economic and Social Research Centre 2004).

#### 6.4 Concluding summary

The findings discussed in this chapter paint a picture in which a variety of factors all serve to limit the likelihood that charismatically challenging ideas about health inequalities will emerge from the research community or, if they do, that they will be able to travel successfully into policy. The discussion presented in section 6.2 suggests Latour and Woolgar's (1986) concept of a 'cycle of credit' is crucial to understanding why many of the academics working in the field of health inequalities felt constrained in (or, at the very least, not entirely in control of) the trajectory of their research careers. For, as the interviewees were keen to highlight, the necessity of obtaining funding not only shapes the research that interviewees feel able to undertake but also plays an important role in determining the ways they chose to communicate their research-based ideas within and beyond academia. The circular nature of the 'cycle of credit' and the constant pressure to secure funding are both central to understanding why this occurs as it explains why academic interviewees believe it is necessary to consider policy preferences in the construction and promotion of their ideas.

In section 6.3, the characteristics of individuals and ideas who/which appear to have been able to move successfully from research into policy were examined in more detail. Here, Osborne's (2004) account of intellectual 'brokers' who promote 'vehicular' ideas seemed helpful. In contrast to Weber's (1968b, 1968c) notion of 'charismatic' individuals (or ideas –



see Section 1.3 in Chapter One), Osborne's (2004) work focuses on individuals whose ideas of choice are, rather than 'grand narratives', ideas with chameleon like qualities which allow them to be easily re-shaped, or subtly shifted in meaning, according to the audience. This concept helps explain why ideas about health inequalities which were perceived by academics to be too challenging for policy have been able to move into policy in partial or fractured ways. Unlike Osborne's assessment of 'mediators' or 'brokers' of ideas, however, the data discussed in this chapter suggest that academics do not necessarily feel empowered to decide whether or not to occupy such a role. Rather, the cyclical nature of research combined with an increasing pressure from research and funding organisations to 'disseminate' research findings meant that many of the interviewees appeared to feel they had little choice in trying to ensure that their work was of relevance to policy audiences.

In summary, this chapter suggests that a variety of factors cumulatively operate to limit the charismatic qualities of ideas emerging from the health inequalities research community. Some authors argue this is a desirable situation and that researchers ought to be further encouraged to undertake research which is 'consistent with national guidance and national/local priorities' and which is 'not a major challenge to existing policy or practice' (Wimbush *et al.* 2005, p403). A few of the academic interviewees who participated in this research expressed similar sentiments. However, it must be acknowledged that this is a situation which is likely to encourage an ongoing production of ideas which vary only mildly from existing policy approaches, rather than one from which imaginative, potentially 'charismatic', ideas about health inequalities might emerge. This is particularly important in policy settings which remain dominated by a medical model of health, as the following chapter explores.

## ***Part V: Explaining the contrasting journeys of ideas from research into policy***

### **Chapter Seven: The impact of policymaking institutions**

#### **7.1 Introduction**

Whilst the last chapter focused on the way in which ideas are packaged, promoted and circulated by academic actors, this chapter focuses on the role that interviewees suggested the structure of policymaking bodies plays in the circulation and translation of ideas. In taking this kind of structural approach, this chapter is located within a theoretical position which can loosely be termed 'historical institutionalism' and which has become increasingly popular within policy studies over the past two decades (e.g. Béland 2005; Hay & Wincott 1998; Immergut 1998; March & Olsen 1984, 1989). Whilst encompassing a variety of perspectives, what links these theories is a rejection of the idea that political decisions constitute the collective result of individual preferences. Instead, these theorists argue that political and policy decisions are significantly shaped by the historically constructed institutions and the political/policy procedures within which they are embedded. Individual agency is acknowledged but, it is argued, decisions can only be understood by considering the role of the context within which actors are situated (Immergut 1998).

The accounts explored in Chapters Six, Seven and Eight are not meant to entirely oppose each other, or even be completely distinct from one another. Indeed, it is clear in several sections of the previous chapter that the ways in which actors perceive the context within which they (or others) are operating significantly shapes their decisions and actions. Likewise, whilst this chapter focuses on the role of institutional structures in shaping the movement and translation of ideas about health inequalities, individual actors are necessarily ever-present as the data on which the chapter is based are the accounts of *individuals* working within these structures. Furthermore, both the institutional frameworks and the individuals whose activities are affected by these organisational bodies are situated within the wider social, political and economic structures that Chapter Eight discusses. Later on, in Chapter Nine, these various different accounts are woven together. For the moment, however, the split between the three



chapters that make up Part V of the thesis provides a useful way of structuring the analysis of the data.

Following this brief introduction, section 7.2 concentrates explores the ways in which the institutional organisation of policymaking divisions, and the lack of horizontal connectivity, may have contributed to the ways in which ideas have moved both *between* research and policy and *within* policy. Section 7.3 then explores interviewees' concerns about the poor links between the various hierarchical levels of policymaking, particularly between civil servants and ministers, and the impact of this on the movement of ideas about health inequalities. The penultimate part, section 7.4, specifically explores the lack of institutional memory that the data suggest exists within policymaking institutions and considers the implications of this in relation to the ongoing circulation of ideas. Finally, section 7.5 concludes the chapter by summarising the various ways in which accounts of the structural organisation of the policymaking institutions of relevance to this thesis appear to throw some light on the various journeys of research-based ideas that were outlined in Chapter Five.

## **7.2 Institutional filtering – how the organisation of policymaking shapes the journeys of ideas**

As outlined in the introduction to this chapter, historical institutionalists argue that the policymaking processes and institutions within which individuals operate significantly shape policy outcomes (e.g. Béland 2005; Hay & Wincott 1998; Immergut 1998; March & Olsen 1984, 1989). Informed by Weber's (1968 [1922]) emphasis on the role that the formal division of jurisdictional areas plays in shaping bureaucratic activity, this chapter explores how the division of responsibilities relating to health inequalities within policymaking institutions appears to contribute to shaping the journeys of research-based ideas. This influence occurs with regard both to the kinds of ideas that are encouraged (or blocked) by institutional arrangements and, subsequently, to the way in which ideas circulate within policymaking institutions.

In Weber's (1968b) analysis, the institutions within which civil servants operate are designed to detach their decision-making capacities as far as possible from their personal loyalties. Accordingly, responsibilities are divided within bureaucratic organisations in such a way that

individual civil servants are compelled to focus on small, specific areas of policy activity. This situation makes it extremely difficult for civil servants to engage with ideas beyond their immediate area of concern:

'The individual bureaucrat cannot squirm out of the apparatus in which he [*sic*] is harnessed. In contrast to the honorific or avocational 'notable,' the professional bureaucrat is chained to his activity by his entire material and ideal existence. In the great majority of cases, he is only a single cog in an ever-moving mechanism which prescribes to him an essentially fixed route of march. The official is entrusted with specialized tasks and normally the mechanism cannot be put into motion or arrested by him, but only from the very top. The individual bureaucrat is thus forged to the community of all the functionaries who are integrated into the mechanism.'  
(Weber 1968b, p75)

Weber was, of course, writing about an entirely different context, the bureaucratic development of Prussia and Germany, and at a much earlier time, during the early years of the twentieth century. However, a range of academics believe that his analysis of the role that institutions can play in shaping individual decisions and actions has relevance for contemporary analyses of policy institutions (e.g. Bensman 1987; du Gay 2000; Hay & Wincott 1998; Immergut 1998; March & Olsen 1984, 1989; Samier 2005) and the data from this study certainly suggest there is some merit in considering how the division of responsibilities that interviewees described act as filters on ideas by structuring the possible routes via which ideas might travel into policy. The most obvious starting place for exploring this issue is the location of policy responsibility for health inequalities within the departments of health and the consequences that this has for the circulation and translation of research-based ideas. As Chapter Five touched on, this decision seems to limit how it is possible for policymakers to think about responding to health inequalities.

As Chapter One outlines, the newly elected Labour government of 1997 openly accepted the problems caused by institutional divisions within policymaking bodies and, in response, they placed a significant emphasis on the need for 'joined-up government' (e.g. Cabinet Office 1999a, 1999b, 2000a, 2000b), as did Scotland's newly devolved policymaking body (Scottish Executive 1999a, 1999b). If such attempts had succeeded, the location of health inequalities within departments of health may not have had a significant impact on the movement of ideas about the issue. However, analyses of 'joined-up thinking' within UK policymaking has



consistently shown that it is extremely difficult to achieve (Clark 2002; Cope & Goodship 1999; Kavanagh & Richards 2001) and the findings in this thesis do little to challenge these claims. Instead, much like the comments about evidence-based policymaking, the interviewees' accounts unfailingly suggest that joined-up policymaking has been something of an illusive goal. The frustration many interviewees expressed about this situation is evident in the following interviewee's account of the failure of efforts to encourage the Department of Health in England to work with other departments:

*Policy advisor (England): 'It's a real, real fight to get Health to recognise that there are potential big gains to be made in other departments' patches [...] and that they may actually, in some cases, have to relinquish some control. [...] They [the Department of Health] treat health as purely about the health issues of the individual, not about the wider social issues that the individual may be having problems with, such as employment and... behaviour in society and social relations and... crime or what-have-you. They really don't sort of take on these sort of broader concerns, it's not a natural part of their thinking [...] So it's very hard to get... It still doesn't work well. [...] The nature of government at the top is that ministers have their patches and they look out for their patches, that's what they see as their responsibility but also where their careers and... development lie. Solving somebody else's problem is... it's not zero value but it's very much second order.'*

This quotation suggests that the barriers to enabling cross-departmental collaboration are two-fold. In the first place, it may be difficult for health departments to persuade other departments to take action to help achieve an objective for which they are charged with responsibility (and therefore likely to receive any subsequent rewards for achieving positive outcomes). Secondly, in order to maintain control over their own area of responsibility (and the associated budgets and rewards), individuals located within health departments may themselves have reservations about relying too heavily on the work of other departments. Both of these relate to the territoriality that Tony Blair famously highlighted in a major speech in 1999, in which he complained he had scars on his back from trying to get Whitehall departments, which were overly concerned with protecting departmental interests, to change (BBC, 2007). However, whereas Blair suggested that the difficulties in securing progress arose from the resistance to

change of the civil service, many of the interviewees for this project (including both the interviewee quoted above and below) focused on the way in which ministerial responsibility is divided up.

Other aspects of the data reveal further barriers to collaborative working within policymaking bodies, particularly the increased time and resources that effective collaborative working requires. For example:

*Civil servant (England): 'I don't think people sufficiently appreciated what... a sea-change it was and how much time and effort it would need. People thought that cross-government working, joined-up government as the phrase used to be, would mean that we could do things in half the time because we'd all be talking to one another - actually it takes at least twice the time because basically you're dealing with people who've been brought up on a particular culture and whose lines of accountability remain unchanged. You know, for all this talk about joined-up government, our primary... link is with our own home departments and if we don't satisfy our own ministers... and senior colleagues then however much good work we may be doing with other people... they may not be interested.'*

As has been acknowledged in analyses of partnership working for health issues at local levels (e.g. Matka, Barnes, & Sullivan 2002), rather than saving resources, 'joined-up working' usually requires further investment of time and resources. Given the bulging workloads and time-pressures that policy-based interviewees described, it is not surprising that many felt they did not have the resources to work more collaboratively.

Overall, whilst a small number of interviewees suggested the situation had improved over the past ten years, the majority claimed that policymaking remains dominated by departmental divisions and territorial claims to particular policy areas. Mirroring the findings of a recent civil service review of the Department of Health in England (Capability Reviews Team 2007), the data paint rather a damning picture of the limited connectivity within policymaking. Like this review, the interviews with policy-based individuals suggest that the Department of Health operates 'as a collection of silos focused on individual activities' (Capability Reviews Team



2007, p19) with the consequence that 'cross-boundary integration issues are not routinely thought through' (*ibid.*, p21). The data do not suggest the situation is any better in Scotland, a view hinted at in a publication from the Office of the Chief Researcher in Scotland (Milne 2005). This is perhaps unsurprising given that, according to Parry (2004), the Scottish civil service continues to mirror many of the organisational and procedural aspects of its English counterpart, even after devolution.

Rather than suggesting this was an issue still to be tackled, many of the policy-based interviewees (particularly the civil servants) were keen to point out that there were reasons for the vertical lines of responsibility that form the structure of policymaking institutions in England and Scotland. The quotation over-page is illustrative of this. Indeed, this speaker (like two others from Scotland and two from England) implies that joined-up working was no longer a clear policy objective by the time the interviews for this thesis took place:

Civil servant (Scotland): *'There was all this emphasis, a few years ago, on joined-up policy... Again... I mean it's very difficult to do. At the time, there was this sense that policy should not be made in silos but I think people lost sight of that fact that... policy's made in silos for a reason. There's only so much complexity you can tackle at once and... if you want to test your policy against... every kind of outcome it might... directly or indirectly effect, then I think... you going to be bogged down in... endless rounds of... assessment and implementation appraisal before you ever do anything. [...] I think you have to be realistic about... how far that you can sort of temper your policy decisions in relation to all these different... desired outcomes or... ultimate benefits... You know, joined-up policymaking, it's something that's nice in principle but... very difficult to do in practice if you really do want to keep moving forward.'*

Despite the lack of support for the notion that joined-up working was realistic (or even desirable) amongst some policy-based interviewees, it was clear that most of the researchers felt the limited connectivity between groups and departments caused a major constraint on policy responses to health inequalities. The following quotation reflects these concerns, with the speaker suggesting, as many interviewees did, that the location of responsibility for health

inequalities within departments of health has actively contributed to the policy focus on individualised health and the role of the NHS:

*Academic: 'Although, theoretically, policy for health would be made by lots of different government departments, in fact health policy comes out of the departments of health, usually... and the things that are under their direct control are the health services and things related to that. [...] And so, therefore, [when] they're under pressure to do something, their minister's got to deliver, they do the things they can do, which is... send some more health visitors out or things... So it comes down to an individual focus on it, rather than if health policy, say, was made in the Cabinet Office or... a Public Health Ministry [...] where they could have a more umbrella role. So I think, partly, it [the policy focus on individuals] is a function of the fact that they [policies] come through health departments and that's what health departments can do; they can't make other departments do things that might be in the wider determinants. [...] So it comes down to a... quite an individualistic approach when it comes out of a Health Department.'*

None of the interview transcripts contain interpretations which directly contradict that provided in the quotation above. Indeed, even the interviewees (mostly civil servants) who spent time emphasising the necessity and/or expediency of the vertical structures within policymaking accepted that these structures made responding to cross-cutting issues, like health inequalities, extremely difficult. Overall, there is a clear consensus within the interview data that individuals located across the sectors included in this research believed that, as cross-departmental working had proved so hard to achieve, the location of responsibility for health inequalities within the department of health in each context had worked to actively encourage the influence of ideas over which these departments had control. Such ideas concern the role of the NHS and attempts to improve health through initiatives to encourage individuals to improve their own lifestyles and behaviours through health promotion campaigns. So, as the analysis in Chapter Five suggests, both the 'successful' journey of ideas about the role of health services in tackling health inequalities and the 're-contextualised' journey of ideas about lifestyle-behaviours appear to have been actively aided by the way in which responsibility for health inequalities has been located within policymaking institutions. This point has been



widely made elsewhere (e.g. Hunter 2003b). What has perhaps been rather less explored is the way in which the structures of policymaking institutions can actively restrict the development of research. For example, one interviewee described consistently being unable to obtain funding to assess the impact of policy interventions that had emerged from departments other than health on health inequalities. Other researchers reflected that the gaps between different departments worked to prevent the circulation of research-based ideas already in existence. For example, two interviewees separately described being contacted by the Department for Work and Pensions (in England) with a request for advice on health inequalities research by individuals whom they felt appeared completely uninformed about any of the research-based ideas circulating within the Department of Health. Similarly, in Scotland, one academic interviewee described presenting very similar research-based ideas to a number of different policy audiences over a period of two years but, according to him/her, never once encountering someone within policy who had already heard about the ideas from previous presentations. Each of these vignettes highlights the difficulty that research-based ideas appeared to face in moving within policy contexts structured by institutional divisions.

The smaller size of the civil service in Scotland did mean, at least, that there appeared to be strong professional and personal connections between some interviewees working within different sectors of the civil service and between researchers and civil servants in a range of departments/divisions. In contrast, as the following quotation illustrates, some interviewees in England claimed that government departments were often so culturally distinct from each other that links into one department in no way necessarily facilitated links into policy more broadly:

*Academic: 'When I have worked with different government departments... they're quite different, culturally... so it's not as though you think, 'okay, I know how the English civil service works, I've done years of work with the DH, I'll just go to DEFRA now and talk to them about food, cause that's their thing,' err, cause they could, probably, operate quite differently. Certainly the... [lists three different departments interviewee has experience of working with and explains all are significantly different]. [Laughing] I don't think I want to commit myself to saying how different it was but*

*they're... just different and I suppose you get comfortable with one way of working. So I think it's quite practically difficult.'*

The above interviewee was unusual in that s/he had worked with a number of different policy departments and even s/he said s/he did not feel this qualified her/him to interact with policymakers in other departments. The extent of the differences between departmental cultures that this interviewee hinted at (and others commented on more directly) provides support for the observation made in the previous chapter (in sub-section 6.5.1) that ideas are more likely to move from research into policy through bi-lateral relationships between individuals than through 'policy networks' or 'epistemic communities'. Hence, a research-based idea may travel quite successfully into one vertical stream within policy without necessarily ever moving beyond this stream. This may help explain the 'partial journey' of ideas about material and socio-economic determinants of health inequalities that was described in Chapter Five, for whilst a successful journey of such ideas into vertical streams within health departments might result in their rhetorical visibility with departmental policy statements, it would not be enough to secure their translation into policy responses given that health departments are not responsible for these kind of determinants.

Divisions between departments are not the only hurdle facing complex and multi-faceted ideas; the data suggest that the institutional structuring of the departments of health in each context have further shaped the circulation of research-based ideas about health inequalities. As the quotations below demonstrate, policy-based interviewees in both contexts described a situation in which civil servants within the departments of health were divided into small units and groups, each of which was responsible for very specific aspects of their department's policy foci. Even though, in both accounts, individuals are mentioned whose job is to focus on health inequalities or health strategies more broadly, it is clear that most individuals within each departments are encouraged to have far more specific outlooks:

Civil servant (England): *'There's a Health Inequalities policy team but then there's lots of other policy teams... who work on physical activity, accidental injury, obesity, tobacco... and... [sighs] I guess the job of the inequalities policy team, as I perceive it, is trying to influence all their policy colleagues to take on their agenda.'*



Civil servant (Scotland): *'We have got divisions... which look after specific topics, so, for example [...] alcohol, smoking... So, you will have very specific interests, but on top of that there are... a small number of people who look at the strategy overall. And each one of those areas has an interest in the policy, in their own specific policy elements, but they also have a responsibility to see how that feeds into the, into health improvement as a whole.' [My emphasis]*

Overall, the data suggest that, in both England and Scotland, the number of people assigned to think specifically about health inequalities during the study period tended to be relatively small and that they were generally expected to impact on policy through exerting influence on the other divisions and groupings. These groupings changed several times in both contexts during the period of study but they have consistently featured divisions focusing on: aspects of the NHS; the prevention and better treatment of widespread (usually chronic) illnesses, such as cancer, coronary heart disease and stroke; the perceived risk factors for these diseases (e.g. alcohol consumption, obesity/diet, tobacco and drugs use, etcetera); plus a few divisions tasked with focusing on the health of particular social groups, considered vulnerable to ill-health (such as children, young mothers and older people). These divisions and groupings represent the institutionalisation of particular ideas and, as the examples provided illustrate, the data suggest that many of the ideas institutionalised within health departments relate to medical, rather than social, models of health. Noticeably absent from the data is any mention of civil service divisions charged with focusing on social, psychosocial or economic determinants of health, for example. This finding is unsurprising, given the extent of the literature highlighting the difficulty public health practitioners and campaigners have faced in challenging dominant, medicalised approaches to health policy and practice in the UK (see, for example Beaglehole, Bonita *et al.* 2004; Berridge, Christie, & Tansey 2004; Evans & Knight 2006; Hunter 2003a; Wills & Woodhead 2004) but it has important implications for this thesis. As one civil servant in Scotland reflected, even though s/he believed the whole health department was aware of the policy aim of reducing health inequalities, everyone ended up thinking about it as 'it applies to their own areas of interest'.

Such structural divisions not only affect how policy-based individuals think, they also shape the possible routes via which research-based ideas can travel into policy. This process is reflected in the following two extracts, in which the interviewees describe how the external links via which policymakers are likely to be exposed to new ideas are often based on very specific interests:

Civil servant (Scotland): *'People don't go traipsing through professional journals but you do have specialists within the Department as well. So, for example, on diet and physical activity, there is a Diet Co-ordinator, and there is a Physical Activity Co-ordinator, who are specialists in their own right... and in addition to that, you have specialists in terms of doctors and things like, many of whom do actually spend a bit of time with the journals.'*

Civil servant (England): *'The way the sort of work's carved up [here] is that, basically... there are people who are interested in the infant mortality side of things [and they] tend to have the engagement with the colleagues [elsewhere in government] and voluntary organisations who have an interest in children, and the people who are dealing with the life expectancy tend to have close links with colleagues who are focused on CHD, cancer, etcetera and, through them, form links out into the wider community, voluntary organisations and so forth.'*

For a complex issue like health inequalities, such relationships are likely to increase policymakers' exposure to ideas which fit within the institutional divisions in which they are based. The consequence is that policymakers' exposure to more complex and holistic ideas about health inequalities (such as those relating to the socio-economic and material determinants of health) is likely to be limited. Other aspects of the data suggest that even when more complex ideas are actively targeted at policymakers, the institutional organisation of policy acts as a filter which works to block the uptake of ideas which do not fit neatly within the singular channels of policy divisions. This process is visible in the following interviewee's account of the difficulties s/he had encountered in trying to promote ideas concerning policy responses to cannabis use in Scotland:



Academic: 'Amongst young people, their cannabis use and their tobacco is highly related. So if you want to help young people to deal with their smoking, you can't ignore their cannabis [use]. Now [this was discussed at a conference] and... some people were really quite heated about this - was that, yes, we want to, yes, some of us are seeing this as an issue, but how on earth do we move forward? Because... cannabis is in drugs, tobacco's in tobacco, alcohol's also a part of it, alcohol's up here [demonstrates with hands that alcohol is separate to both drugs and tobacco] and if you try to move forward on that? [...] I see that at Scottish Executive and... it's always a dilemma, isn't it? Because I know the money has to be parcelled up some way but... the danger is it then tends to then mean that you can only then focus in a narrow way on what... under what heading that is. So I think I find that a bit of a barrier... because people have to work to the funding stream that they're under and whilst, yes... I don't think it's that civil servants don't see the importance of that, but it just seems to... [sighs] I don't know, become difficult when it's sort of operationalised... Something seems to... [pause] ... just something seems to... block that. So I do think that's problem with working in a broader, [health] inequalities way.'

[Interviewee's emphasis]

As the above interviewee observes, these kinds of policy filters on ideas are particularly problematic for health inequalities as it is an issue that spans many different policy divisions. Indeed, if, as the above interviewee claims, even ideas which only require the collaboration between two specific policy streams (drug and tobacco use) encounter difficulty travelling into policy as a consequence of their failure to fit within one stream, the prospects for the successful movement into policy of some of the multi-faceted and complex ideas presented in Chapter Two seems bleak.

Additionally, the data suggest that once particular ideas are embedded within institutional arrangements, they actively shape future policy decisions. The clearest accounts of this process within the data relate to discussions about the various national health inequalities targets (see Appendix X). For example, in the following extract, the interviewee explains why the particular health targets set in Scotland were favoured over other possibilities. The interviewee describes how these targets were chosen to reflect existing departmental priorities

which, as we can see, relate to specific chronic diseases. Furthermore, the interviewee describes how advice was sought from the individuals at the top of each institutional division within the health department, further emphasising the way in which these structures actively shape policy outcomes:

Civil servant (Scotland): *'I think that they [health inequalities targets] were chosen after a round of discussions and I think, ultimately, they were chosen to highlight priority areas in the Health Department. So, you've got your cancer and your CHD, which are two of the big three killers, you've got something related to sexual health... by teenage pregnancies, mental health is associated by the suicide target, etcetera. [...] The Department states that the big three killers are still a priority, so cancer, coronary heart disease and stroke, so we chose two of them. And smoking, well that speaks for itself, that's a, that's always been identified as the, one of the key determinants of ill health in Scotland [...] The way in which the Department's structured is, you can quickly find who's top of the tree on smoking or alcohol or drugs or whatever, so... I mean... decisions like that [agreeing targets] would have gone through the most senior people who are responsible for those areas. [Coughs]. So I remember going round talking to each of the policy sections... who are responsible for those particular areas and discussing the trends, the evidence and the potential targets. [Pause] [...] So, there's a separate policy area on mental health, [...] you've got your Sexual Health Strategy, [...] [Blank] takes the lead on coronary heart disease and cancer and, you know, there's different teams on all these different areas, [...] the Department's made up from all these teams.'*

In describing how the health inequalities targets were chosen, this civil servant, who was personally involved in the process, explains that they were designed to mirror existing departmental priorities. The interviewee's sentence beginning, 'The Department states...' is particularly revealing as it highlights the way in which agency is sometimes attributed to institutional structures, rather than individuals. This underlines the power of the anonymity of decision-making within policy for once ideas become attributed to a 'department' rather than an individual (or group of individuals), they appear far less easy to challenge (see Freeman 2006 on the importance of policy documents in this respect). Indeed, in the above example, at



no point did the interviewee question whether or not these were the most helpful priorities and no indication was given that it was reasonable even to raise this question. Similarly, in explaining why it had been decided to retain the Health Inequalities Unit within the Department of Health in England, one civil servant explained a key factor had been the short time-frame of the national health inequalities targets and the resulting consensus that NHS based interventions (i.e. those with short-term impacts) were required to meet these deadlines. This interviewee never once appeared to consider that an acceptance that meeting the health inequalities targets was only possible through clinical interventions might indicate that the targets themselves ought to be reconsidered. Both of these examples illustrate that, once decisions have been made, or departmental priorities agreed, they are institutionalised and embedded in ways which render them extremely difficult to contest. Consequently, as supporters of 'path-dependency' models of policymaking argue (e.g. Goldstein & Keohane 1993; Mahoney 2000; Pierson 1993), in order to understand policy outcomes, it is necessary to understand the role that previous policy decisions play.

The data discussed in this section therefore support historical institutionalists' belief that institutions can significantly shape policy outcomes. The interviewees' accounts suggest that, in the context of the difficulties in achieving 'joined-up policymaking', the location of responsibility for health inequalities within health departments and the internal organisation of these departments have allowed the ideas institutionalised within health departments to act as filters for research-based ideas about health inequalities. Consequently, the policymaking institutions in both England and Scotland appear to be rather hostile environments for the complex and multifaceted ideas about health inequalities which much of the research evidence supports (as discussed in Chapter Two). Instead, these institutions seem more likely to encourage the movement of ideas which fit within particular policy divisions or professional groupings. This suggests that ideas which fit within the boundaries of ideas already embedded within institutional structures are far more likely to travel successfully into policy than ideas which do not. This finding supports Margaret Weir's (1992) notion of 'bounded innovation', a phrase which aims to reflect the way in which novel ideas are affected by the organisation of policymaking institutions. Based on a case study of unemployment policy in the USA, Weir demonstrates that the fragmentation of Congress made the adoption of an active, holistic employment policy virtually impossible. Like Weir (1992), the findings in

this section suggest that novel ideas are only likely to succeed if they are compatible with the institutional context into which they are introduced. This is particularly problematic in light of the fact that health inequalities have been presented by researchers as a quintessentially 'wicked issue' (see Blackman *et al.* 2006; Rittel & Webber 1973), involving complex systems (Blackman 2006; Hunter 2003b; Plsek & Greenhalgh 2001) and requiring 'whole system' perspectives.

### 7.3 The lack of vertical connectivity within policymaking institutions

In addition to a lack of horizontal connectivity within policymaking, the data suggest barriers also divide different levels of the policymaking hierarchy. In particular, several interviewees suggested there were often fairly stark divisions between the civil servants working on issues relating to health inequalities and the ministers responsible for the policy statements and interventions which eventually emerge. For example, even in Scotland, where interviewees generally suggested the smaller nature of the civil service and the Parliament meant that interaction between civil servants and ministers was more frequent, the following interviewees each described feeling at a distance from each other's colleagues:

Minister (Scotland): *'The research unit [the Office of the Chief Researcher]... tend to be like a civil service within the civil service. That's the other problem... that you don't see much of them... They're like the people in the shadows - you don't see them.'*

Civil servant (based in the Office of the Chief Researcher in Scotland): *'I feel that I'm at quite a distance from ministers. I don't have ministers breathing down my neck, you know... there's not much interaction.'*

Not only do the data suggest this lack of interaction acts as an obstacle to the circulation of ideas within policy simply as a result of limited communication, they also suggest it contributes to a sense of distrust between the two groups. Three of the four interviewees who held ministerial posts during the study period (one in England and two in Scotland) expressed some sense of distrust towards the civil servants who provided advice on, and suggestions about, potential policy responses to health inequalities. All four of these individuals also



explained that they had actively sought advice about health inequalities from individuals whom they knew and trusted beyond the civil service. For example, the following interviewee explained how, being unsure of the sources of the advice being provided by his/her advisors within the civil service, s/he turned to individuals whom s/he either already knew:

Minister (Scotland): *'If the civil servants have looked at all this evidence, they don't present it to you in terms of, 'this is what they do here and this is what they do there but we think this is best for Scotland,' if you know what I mean. It's not really presented in that kind of way, it's almost presented as... the final stage, 'this is what we recommend,' so there's almost a kind of mystery for ministers about how civil servants arrive at those particular conclusions. [...] I tended to operate with two sets of advice, which no doubt didn't always play to the civil service, because I had the civil service advice but I also had my advice outwith that. For example, I would invite some of [Blank's - academic] ideas and obviously I knew [Blank - policy advisor] and used to talk to him/her. So I would say I've been quite influenced by them but that was through a quite separate route from the civil service advice in the Department.'*

This aspect of the data is crucial because it suggests that even when civil servants do draw on the research evidence to construct suggestions for policy responses, these ideas may struggle to move beyond the civil service. Indeed, reflecting on the limited connectivity between the various hierarchical levels of policymaking in England, one policy advisor described attempts to get research-based ideas into policy through 'channels of government officials' as so unlikely to be effective that it constituted a 'death route'. This interviewee was one of eight who suggested that a far more successful mechanism for facilitating the influence of particular ideas within policy is for individual researchers to promote their ideas either directly to ministers or to those whom ministers turn to for advice. Yet again, this underlines the importance of the bi-lateral relationships described in the previous chapter. Importantly, the data presented in Chapter Six suggested that the factors most likely to enable researchers to develop credibility amongst these kinds of policy audiences include a willingness not to contest the dominant, institutionally embedded ideas that structure policymaking. Hence, the ideas travelling into policy via such routes are unlikely to constitute radical challenges to previous and existing policy approaches.

One of the civil servants based in England attributed initial tensions between civil servants and ministers in the early years of the New Labour government to the suspiciousness that the newly elected Labour ministers had about civil servants who had worked for so long under a Conservative administration. However, the broader data suggest that, whilst this may have exacerbated this situation, the issue is more of a long-term, systemic one. The problems around trust appear to be linked to the significant distance between the two groups. Often, as the following interviewee articulates, only very senior officials within the civil service have regular contact with ministers, so the majority of civil servants involved in undertaking research and/or interacting with researchers first have to convince the senior officials who advise ministers that particular ideas are worthy of consideration by the minister. If ideas do not get beyond this stage, the interviewee claimed, there would be little chance of it travelling very far up the vertical structures of policymaking:

Civil servant (England): *'The civil servants who would go out and do the research will quite often write it up for other civil servants. It's very rare that it would, except in very general terms, go into a submission to ministers. Most submissions to ministers are extremely short 'cause they've got a lot to do, so you wouldn't go into it, so it would be distilled into policy, if you like, before it actually gets to the Minister. [...] The ministers are really, you know, their diaries are chock-a-bloc, they've got large amounts of correspondence and policy submissions to look at and all the rest of it; the amount of time they have available for thinking about research or reading about research is very limited. So... the first battle is to get the senior officials, convince them that this would actually enable them to make better policy and that making better policy is, in that way, would be what Ministers want them to do. 'Cause in the end... they see themselves, very often, as just there to help ministers do what they want to do...'*

The above quotation suggest that the only way in which ideas are likely to move up through the vertical structures of policy is if the 'gatekeepers' to ministers, the most senior officials and policy advisors, believe an idea fits with the minister's agenda. This is important because it reveals that there are pressures towards politicization within the civil service, at least if we take the definition of politicization provided by du Gay (2000):



'Put simply, politicization can refer to a civil service that reacts over-favourably to political signals without the officials personally and necessarily having a commitment to a specific political party.' (du Gay 2000, p123)

The politicization of the British civil service in this sense has often been commented on. For example, reflecting on the situation in the early nineteen-eighties (under Thatcher's government), former civil servant, Lord Bancroft, argued that there was a 'subtle' and 'insidious' danger developing of a situation in which civil servants:

'seeing that advice which ministers want to hear falls with a joyous note on their ears, and advice which they need to hear falls on their ears with a rather dismal note, will tend to... make their advice what ministers want to hear rather than what they need to hear,' (quoted in Hennessey 1995, p130).

Precisely the kind of process Lord Bancroft warned of is visible in the following two quotations, where civil servants from both contexts reflect on the importance of understanding what ministers are 'looking for' when providing them with advice/ideas. As each interviewee explains, their judgements about this then shape the way in which they present ideas and information to ministers and/or their advisors:

Civil servant (England): *'If you've got a problem, [...] the first thing you do is to work back in the files and see what you said last time and then to ask one another what you think we should do and then to make a judgement about what ministers really want, what's feasible and what's politically this, that and the other.'* [My emphasis]

Civil servant (Scotland): *'Special advisors... are... advising the Minister. They're not civil servants, they're political appointees, and their role is to give political, partial advice: 'How is this gonna look best for you Minister? How does this fit with, you know, what do we want to do?' I've had... limited involvement with them but they're an important part of the system because... if you can develop relationships with them it may give you insights. It's hard to get access to them 'cause they're busy people but you probably can get better access to them than to the Minister and it may well be a useful way of understanding what the Minister's thinking, through them. Equally, if you're trying to say to the Minister, 'look at this important evidence,' you wouldn't want*

*the advisor going, 'what a load of old rubbish!' So it's important, from our perspective, for the advisor to say, 'it's credible and good.' So you know, it's, they've got an important part to play and we've got to think about how they'll respond.'*

The first of the two quotations above again underlines the way in which previous policy decisions shape subsequent ones. Of more relevance to the issue being considered here, however, the speaker reflects on the importance of civil servants being able to judge 'what ministers really want'. Similarly, the second interviewee quoted above describes how developing relationships with the individuals advising ministers can provide 'insights' into the direction in which policy is expected to develop. The importance this civil servant places on acquiring the endorsement of ministerial advisors suggests that ideas which are believed to challenge the preferences and outlook of such individuals are unlikely to be promoted by civil servants lower down the professional hierarchy. As du Gay (2000, p124) reflects, civil servants' attempts to provide ministers with the kinds of ideas and information they think they want to hear, 'flies directly in the face of the idea of the civil servant's duty outlined by Lord Armstrong,' which was to provide 'honest and impartial advice, without fear or favour... whether the advice accords with the minister's view or not.'

The importance of what is, essentially, a guessing game may well play a role in explaining the varying journeys of ideas about health inequalities into policy. The findings suggest that civil servants' and policy advisors' observations and interpretations of the policy (and political) preferences of ministers significantly influence the kinds of ideas that they present to senior officials and/or ministers. This means that ideas which do not 'fit' with these perceptions are likely either to be rejected by individuals before travelling very far up the vertical streams of policymaking, or to be re-presented in ways which make them more appealing to ministers. This process may, therefore, shed further light on why certain research-based ideas about health inequalities appear to have travelled into policy in partial and fractured ways, for it is plausible that they may have been re-framed in ways which those promoting the ideas within policy believed to be more in tune with the direction of policy.



#### 7.4 Limited structural links between research and policy

The data discussed in Chapter Six suggest that relationships between researchers and policymakers within the field of health inequalities are often bilateral, involving individual researchers rather than the 'epistemic communities' or 'policy networks' that some commentators have portrayed in other spheres of policy (see section 6.3 in the previous chapter and sub-section 1.2.3 in Chapter One). The previous section in this chapter supports this analysis as the findings suggest research-based ideas are more likely to travel into policy through individuals with direct connections to ministers or senior officials, than through broader connections between researchers and civil servants. This section further underlines the importance of bi-lateral, interpersonal relationships because it highlights, as many commentators have demonstrated (e.g. Caplan 1979; Lavis, Robertson, Woodside *et al.* 2003; Lavis, Ross *et al.* 2003; Lomas, 2000a), that there are few, if any, structural links between research and policy. Hence, many of the policy-based interviewees believed that a great deal of relevant research was probably never introduced to policymaking audiences. For example:

Policy advisor (England): *'There are probably a lot of academics out there who... who'd have something useful to contribute but... unless they're famous or... opportunist or something, policymakers would probably never find out about them and they would never have the chance to... have a say. There's no interface to make that easy, it's just about who you know and chance, really... [laughs].'*

Minister (Scotland): *'I get quite depressed sometimes [laughs], not in the area of health research per se but just generally, you know, and I think this applies across a whole host of different discipline... there's a capacity within academia in particular to... produce vast quantities of research which kind of sits over there [indicates to far left with hands], while the real world functions over there [indicates opposite direction with hands], and the two don't meet, you know? And that's, and that's not necessarily about the quality of the research, that's about the lack of connectivity, if you like, between the two communities, or between the individuals involved.'*

The comments in the data such as those above suggest there are extremely few structural mechanisms to encourage relationships between researchers and policymakers to develop.

This conclusion is also reflected in some official statements. For example, in England the lack of links between the Department of Health and the research community have recently been criticised in a departmental review that was undertaken by the civil service (Capability Reviews Team 2007). In Scotland, the short-lived Scottish Academy for Health Policy and Management was an attempt to improve the links between policymakers and researchers in the field of health and, as such, represented some recognition that existing arrangements (at least up until 2004) were deemed to be insufficient (see Clark & Kelly 2005). Considering the official emphasis placed on developing evidence-based, or evidence-informed, policy in both contexts (see sub-section (ii) of section II in the Prologue), it seems surprising that there appears to have been such little investment in developing structures to facilitate connections between research and policy. Indeed, it suggests that the popular rhetorical ideology of developing 'evidence-based policy' in the early years of the New Labour government was never fully thought through.

Nevertheless, the data indicate that many of the policy-based interviewees were keen to develop stronger and broader links with researchers. However, they also suggest that a range of factors have worked to prevent such connections from developing. In addition to a sense that policymakers were often unaware of whom to approach about particular issues within the research community (as is evident in the two quotations above), most of the policy-based interviewees reported being so busy that it was difficult to dedicate any time to developing relationships with researchers. Another barrier, as the quotation below illustrates, related to uncertainty about how to recompense researchers' for their time:

*Civil servant (Scotland): 'It can be quite difficult for us... if they [academics] are not going to [give us advice] for free, it can be quite difficult for us... to fund [their involvement]. It's very easy for us to commission a piece of research [...] but to kind of bring academics in a couple of days... the funding mechanisms for that are... more tricky. It is possible... we've tried to do that a bit... but there are limitations on that [...] you know, we can't just say [we're employing] lots of consultants, 'cause the Executive's got hammered in the past about its use of consultants - newspapers saying the Executive spends however much on consultants. And that term has got pejorative... meanings attached to it.'*



Given that many of the interviewees based in academia expressed similar uncertainty about how better to develop links between research and policy, and reported comparable frustrations about the pressures on their time and resources, it is perhaps unsurprising that the links between research and policy often appeared to depend on bi-lateral relationships between individual researchers and policymakers. In some cases (and this seemed particularly true of the interviewees who were ministers), these relationships seemed to have emerged from (often long-standing) personal or professional connections. Hence, ideas often seem to have moved from research into policy via communication between people who already knew each other well or who met through existing social networks. For example:

Civil servant (England): *'They [ministers and politicians] can go through their life without ever touching the sides, in terms of research, you know, and, and then, every now and then, quite by chance, they'll meet somebody at a dinner party, who'll say, 'oh, blah, blah, blah,' and they'll come back and say, 'oh, we should find out about that,' kind of thing. So that's the way it tends to work.'*

Although the above interviewee suggested such social connections represented the introduction of ideas to policy 'quite by chance', s/he was in fact describing a situation in which ideas are circulated between actors who are part of the same social networks and may, therefore, have more in common with one another than if two actors were to meet in a truly random sense. It is certainly questionable whether ideas which significantly challenge the current direction of policy would be likely to enter policy via this kind of route as there may well be a sense in which it is deemed impolite to overtly challenge the existing views of members of one's own social network.

The other key mechanism that interviewees suggested helped facilitate relationships between policymakers and researchers were those opened up by funding connections, as the following three quotations suggest (see also section 6.3 in the previous chapter):

Academic: *'It's a business to some extent, you know, so if someone has come to you to pay for a particular piece of research, they want the outcomes of it and also they*

*have to justify their investment in paying for that piece of research so... there's a channel and, apart from anything else, the channels are open all the time because there's continual feedback between... whoever the funder was or whoever commissioned the research and the research group. So, the channels stay open during the course of the project and you know that at the end... there is someone who wanted what you produced. And that's not the case, I think [...] if you are a researcher and you think up your own project for which you have got funding from whatever source.'*

*Civil servant (Scotland): 'If it's been commissioned directly from here, therefore people here are waiting for it, erm, whereas... university-based academics... will tend only to get their message into here if someone happens to read the journal. You know, you occasionally get sent a copy of a paper or something but it's very rare and most of the stuff I've come across, I happened to bump into myself.'*

*Policy advisor (Scotland): 'I think they [civil servants] are aware of how busy people [academics] are and I think at one level they actually feel a little more justified in calling... I mean it's quite time consuming, all of that stuff, you know, so if they're paying for the institution, they sometimes feel a bit more... justified, I think, in, you know, using someone.'*

This is important because, as sections 6.3 and 6.4 in the last chapter suggest, the characteristics of individuals who are able to maintain credibility amongst policymaking audiences include a willingness to work within current policy frames of reference. In both of the above forms of connection (relationships established either via existing social connections or through funding links), researchers may feel cautious about presenting ideas which challenge policymakers' existing approaches, either because they are receiving funding from those with whom they are communicating and hence feel under pressure to maintain policy 'credibility' (see sections 6.2 and 6.3 in the previous chapter) or because they feel some sense of personal loyalty towards them. Hence, the data suggest the possibility of charismatic ideas (i.e. those which significantly challenge current ways of thinking) being introduced to policy via bi-lateral relationships seems slim. It should be noted here that the data suggest there are



some other possible mechanisms for the movement of ideas between research and policy, such as via public media outlets. However these potential pathways are discussed in the following chapter as they concern the wider social and political context within which ideas circulate, rather than the way in which policymaking institutions impact upon the translation of ideas.

That there is a structural gap between research and policy and a desire for better mechanisms to link the two is supported by a broad body of existing literature in both the UK and North America (e.g. Lavis, Posada *et al.* 2004; Lavis, Robertson *et al.* 2003; Lomas 2000a; Nutley, Davies & Walter 2003; Wimbush *et al.* 2005). However, unlike some of these authors (see, for example, Petticrew, Whitehead, *et al.* 2004; and Wimbush *et al.* 2005), the conclusion drawn in this Chapter is not that more collaborative mechanisms are needed, whereby policymakers and researchers both actively contribute to research projects (i.e. that research is more 'policy-aware'). For this would only serve to further promote the flow of ideas into policy which fit within existing policy boundaries and, as far as health inequalities is concerned, these ideas already appear to be travelling into policy quite successfully (see Chapter Five). Rather, if there is to be a serious commitment to the notion that 'what matters is what works', mechanisms which encourage and facilitate the movement of *all* research ideas, not just those which work within existing policy approaches to particular issues, are required. This point is returned to in the conclusion of this thesis, Chapter Nine.

### 7.5 Limited institutional memory within policy

The penultimate section of this chapter highlights how various factors relating to the organisation of policymaking institutions, including the short time-frames within which policymakers are often required to work and a rapid level of staff turnover, work to contribute to an extremely limited institutional memory. The consequence of this is that the data reveal the same ideas can be constantly re-presented to policymakers with the illusion that, each time they return, they represent a new way of thinking. Hence, as the following interviewees believed, instead of learning from past policy initiatives, there was a feeling that the same ideas were constantly being 'reinvented' as new ones (a point raised in relation to other areas of social policy in a recent article in *The Guardian* - see Toynbee, 2007):

Academic: *'There are some areas where there's, it's either a rediscovery or, we keep reinventing the wheel, like area-based policies. So a lot of the Health Action Zones were very similar to the geographical areas that were the Community Development Programmes in the nineteen-seventies. So, you know, so we didn't quite learn from those.'*

Policy advisor (Scotland): *'I've been to lots of conferences where we throw up another few graphs showing inequalities, everyone agrees much more needs to be done about it [...] and it almost upsets me now to hear these presentations because they're the same presentations that people were making in the nineteen-eighties. Now in the nineteen-eighties that was a brave thing to do, you know, 'cause you could get passed over for promotion or, you know, given a hard time for that. It's not a brave thing to say anymore, it's just a boring orthodoxy to say now and... rather... we need to explore more imaginative ways of achieving it and that might be political ways as well as methodological ways.'*

The frustration that interviewees expressed at the difficulties in moving debates about health inequalities beyond a continual (re)circulation of remarkably similar ideas was not only targeted at those individuals working within policymaking institutions but also at researchers. For example, six interviewees based in academia claimed that the lack of institutional memory within policy actively enabled the funding of research projects for which evidence was already in existence. For example, four academic interviewees described undertaking research which had been specifically commissioned by policymakers only to find that, by the completion of the project, the policymakers who originally commissioned the research had moved on to other posts and were consequently no longer interested in the results yet nor were the individuals who took over their previous post. As a result, the research findings were barely acknowledged by policymakers, leaving the path open for the same kind of research, possibly even from the same researchers, to be commissioned by someone else at a later stage. Precisely such a situation was described by the following interviewee, who was about to embark on a research project that was not substantially different from one s/he and his/her team had undertaken two years ago:



Academic: *'What's really struck me [...] is we seem to do the same bits of work over and over again, you know? A demand will come for something and because... I don't keep copies of these things, I think, 'oh, I think we've done that before!' And then somebody else will dig out... So on Monday, we're doing a piece of work which I know we did two years ago... But... everybody's changed so nobody knows that that's what we did two years ago. [...] [And] in the DH they're now subcontracting a lot of their work... So... somebody, some agency will be given the job of coming up with something-or-other, and it's like reinventing the wheel - they'll have no knowledge of what the Department, or allied researchers, has already done. [...] So I think that fragmentation, which you've got with the normal process of civil servants moving round is becoming intensified because of this process of giving the work to outsiders, who don't even know what might have happened within the DH.'*

The data suggest, as the above interviewee articulates, that a major cause of this limited institutional memory is the frequency with which civil servants move post. This was something mentioned repeatedly in interviews but none of the interviewees seemed to feel this was a situation which could itself be addressed. Hence, other mechanisms for developing the memory capacity of policymaking institutions were put forward. One policy advisor in England suggested the solution was to 'tame academics' to ensure that they 'hold the body of knowledge' in a way that policymakers could more easily access. However, this suggestion does not acknowledge the significant pressure on researchers to obtain funding (as discussed in section 6.3 in the previous chapter), which may well dissuade them from pointing out that potentially funded research projects may be unnecessary (a point which was hinted at in several interviews). If stronger links between researchers and policymakers existed, such relationships might enable a shared institutional memory to develop. The downside of this, however, might be the bounded nature of the ideas being shared.

## 7.6 Concluding summary

This chapter suggests that the structure and organisation of policymaking institutions has a significant influence on the movement of ideas between research and policy. First of all, the organisational location of responsibility for health inequalities within health departments, and

the division of civil servants within these departments into groups that are charged with focusing on very specific issues, appears to have made it extremely difficult for policymakers to have been able to undertake the kind of complex, 'whole system' thinking that many authors argue is required for a multifaceted issue like health inequalities (e.g. Blackman 2006; Hunter 2003b; Plsek & Greenhalgh 2001). Furthermore, the foci of the various teams and groupings that were described by interviewees based within the health departments emphasise the extent to which a medical model of health (i.e. one that focuses on diseases, risk factors and individuals) has been institutionalised within the policymaking bodies in which policies to tackle health inequalities are made. All of this suggests that ideas which do not fit neatly within these various policy divisions (i.e. within a medical model of health) are likely to encounter difficulty moving successfully into policy. The 'filtering' effect on ideas caused by the organisation of policy institutions has been described by Weir (1992) as one which allows only 'bounded innovation' to occur (i.e. only innovation within the parameters of the institutional framework).

Secondly, the data in this chapter suggest that the impact of the institutional filtering process may be exacerbated by a lack of horizontal and vertical connectivity within policy, which makes it extremely difficult for ideas to circulate within policy. In addition to limiting the movement of ideas across different policy domains, the lack of horizontal connectivity further limits the potential for complex ideas to move into policy. Meanwhile, the data suggest that limited vertical connectivity may encourage civil servants to engage in second-guessing what ministers, or their advisors, are 'looking for'. In other words, the approach to research-based ideas taken by many of the policy-based interviewees seemed to be shaped by their perceptions of the policy direction that ministers had already decided upon. This process seems likely to further limit the possibility that charismatic ideas might travel into policy.

At the same time, interviewees who had held ministerial positions during the study period described being uncertain about the sources of advice that civil servants provided them with. As a result, these interviewees reported that they had turned to individuals whom they trusted *beyond* the civil service for advice about health inequalities. Both these accounts and the more widespread complaints within the data about the limited structural connections between research and policy appear to have contributed to a dependence on bi-lateral links between



researchers and policymakers. The data suggest that two situations commonly enable such links: (i) the funding of research by policymakers; and (ii) encounters between members of each group that are facilitated by existing social or professional networks. Neither of these situations appears likely to enable the movement of charismatic ideas from research into policy as both involve situations in which researchers seem liable to feel some sense of loyalty towards policymakers (an issue also touched upon in the previous chapter).

Finally, section 7.5 highlights aspects of the data which suggest that the frequent movement of civil servants within policy contexts results in an extremely limited institutional memory within policymaking organisations. The consequence of this appears to be that the same ideas can keep resonating between research and policy, leading to a situation in which the re-circulation of (non-charismatic) ideas creates the impression that there is an ongoing dialogue between researchers into policymakers even when this dialogue is, in fact, limited and repetitive. In Weir's (1992) terms, then, the data presented in this chapter very much describe a situation in which 'bounded innovation' dominates. The following chapter sheds further light on the palpable sense of constraint which the data suggest many interviewees believed existed, by exploring interviewees' perceptions of the role that wider political and social 'contexts' play in shaping the relationship between health inequalities research and policy.

## ***Part V: Explaining the contrasting journeys of ideas from research into policy***

### **Chapter Eight: Unravelling wider political and social 'contexts'**

#### **8.1 Introduction:**

So far, the chapters in Part V have considered the role that individual actors (particularly academics) and the institutions within which policies are made each play in explaining the varying journeys of research-based ideas that were described in Chapter Five. Each of these exploratory starting points appears to shed some light on the factors underlying the varying journeys. However, although 'politics' has been a recurrent theme, the thesis has not yet reflected in any detail on interviewees' perceptions of the influence that wider political and social contexts had on their activities. This chapter takes on this task by explicitly considering how interviewees understood and perceived the ideological, economic and societal 'contexts' within which they were operating; a process which sheds yet further light on the various journeys outlined in Chapter Five.

In the existing literature on the relationships between research and policy, briefly reviewed in Chapter One (see section 1.2), the role of political context has frequently been acknowledged (e.g. Elliot and Popay 2000; Exworthy, Blane *et al.* 2003) but, as John Wright and colleagues point out (Wright, Parry *et al.* 2007, p254), 'there has been little in the way of direct analysis of how context actually affects the use of evidence in policy'. This is not to say that academics have not discussed the links between policy and politics. Indeed, for many academics concerned with health inequalities, the importance of political context in shaping policy decisions is unquestionable (e.g. Mutaner and Lynch 1999; Navarro and Shi 2001; Coburn 2004; Navarro, Muntaner *et al.* 2006; Navarro 2007). Whilst differing to some extent in their analyses, these authors all believe that policymaking in many countries is made in the interests of dominant groups, rather than the majority of the population. Furthermore, many of these authors believe that, over the past fifty years or so, the social and economic policies implemented in developed countries, such as the UK, share some important features which,



often presented under the guise of an inescapable march of 'globalisation', have been developed in order to promote the interests of these dominant groups yet further (e.g. Navarro and Shi 2001; Coburn 2004; Navarro, Muntaner *et al.* 2006; Navarro 2007). For these authors, the findings described in Chapter Five of this thesis might seem unsurprising and they would probably suggest that the varying journeys could easily be explained by reference to political (and economic) contexts, the hegemony of particular ideologies and the underlying interests of dominant 'elites'. Indeed, several recent critiques of policy responses to health inequalities in the UK put forward these kinds of claims (e.g. Carlisle 2001; Scott-Samuel 2004).

Yet, there are also clear, and widely discussed, problems and gaps with these kinds of analyses. For example, in relation to the findings within this thesis, a simplistic political explanation would fail to explain why health inequalities moved onto the political agenda in the first place or why ideas which challenge what many of the interviewees believed to be the dominant political 'context' appear to have travelled into policy at all, albeit in partial or fractured ways. With regards to 'partial' journeys, it could be argued, as Edelman reflected over forty years ago, that 'it is not uncommon to give the rhetoric to the one side and the decision to the other' (Edelman 1964, p39). In other words, government may produce sympathetic rhetorical statements to alternative approaches to health inequalities without any intention of implementing the associated policy interventions. However, the fact that both governments have produced targets relating to reducing health inequalities, and published a profusion of policy statements on the topic, suggests there is rather more than unsubstantiated rhetoric underlying the political decision to focus on this issue.

A second weakness in some political explanations of policy outcomes is that, as already mentioned, the mechanisms via which political context exerts the effects ascribed to it usually remain under-explored. Such accounts often evoke an image of policy being consciously shaped by powerful and homogeneous interests without explaining where these interests come from and who (other than the rarely defined concept of 'governments' or 'elites') shape them. In particular, the role that individual actors and organisations might play in enacting (or resisting) political and economic ideologies is frequently neglected (Keck and Sikkink 1998; Campbell 2002; Lerner 2003). Not only would the employment of explanations which do not

focus on individuals' agency seem antithetical in a project which is *based* on the accounts of individuals but, as Latour (2005) reflects, it is also decidedly disempowering:

'If there is no way to inspect and decompose the contents of social forces, if they remain unexplained or overpowering, then there is not much that can be done. To insist that behind all the various issues there exists the overarching presence of the same system, the same empire, the same totality, has always struck me as an extreme case of masochism, a perverted way to look for sure defeat while enjoying the bittersweet feeling of superior political correctness.' (Latour 2005, p252)

To some extent articles by authors such as Galvin (2002), Petersen (1996) and Armstrong (1995), all of whom employ Foucauldian frameworks, provide examples of attempts to examine the inter-relationship between ideologies and individuals in more detail than the analyses that Latour is critiquing. Using a variety of data, each argues that 'neo-liberal' governments have deliberately emphasised the importance of avoiding 'risky behaviours' as a means of positioning individuals as responsible for their own health status. For example, making reference to Crawford's (1977) notion of 'victim-blaming', Galvin (2002, p119) argues that neo-liberal governments' decision to focus on health promotion and lifestyle-behaviours continually promotes a societal perception that individuals living with chronic diseases are to blame for their condition: 'for if we can *choose* to be healthy by acting in accordance with the lessons given to us by epidemiology and behavioural research, then surely we are culpable if we do become ill'. The underlying 'neo-liberal' political interest in such approaches is a desired (consequential) lessening of perceived governmental responsibility for ill-health. However, whilst this genre of work usefully reveals mechanisms via which people are encouraged to help enact the dominance of particular ideological paradigms, it makes little attempt to explore the processes through which the policies that these authors take apart have been (and continue to be) constructed.

In summary, the image of policymaking presented in many of these accounts tends to be one in which there is a unified consensus about particular political interests and objectives, which a variety of actors and institutions are all engaged in promoting (either in the overt interests of 'elites' or through the unconscious inculcation of particular ideologies). Yet, whilst the findings in this thesis suggest there are some similarities between interviewees' perceptions of the political and social 'contexts' in which they were situated, it could not be argued that the



transcripts evoke any sense of a clear, concrete political backdrop. Another weakness in this genre of work is that nearly all of the existing analyses of the relationship between research and policy which emphasise the overarching influence of political 'context' focus exclusively on the way in which this context shapes policy (e.g. Nash, Hudson *et al.* 2006; Wright, Parry *et al.* 2007). Far less attention is given to way in which *research*, and the interactions between researchers, policymakers and others, is influenced by this 'context'.

This chapter therefore takes a slightly different approach to exploring the role of political 'context' than most existing analyses and is, instead, informed by actor-network theorists such as John Law, Bruno Latour and Michel Callon. Like other post-structural theoretical contributions, actor-network theories emphasise the need not to start out by assuming what one wishes to explain. Instead, its proponents suggest researchers ought to focus on *interactions* between actors within and across networks (Law 1992). The phrase 'actor-network' is deliberately oxymoronic, aiming to confuse the frequently employed distinction between structure and agency. Importantly, as Chapter One explains, the term 'actor' relates to material objects, machines and concepts (or ideas) as well as to human actors. All 'actors' are perceived to have agency and all are also treated as the effects of heterogeneous networks. So, according to Law (1992, p381 [emphasis in original]), 'the social is *nothing other than patterned networks of heterogeneous materials.*' This includes macro-social concepts such as 'government' or 'political context'. The existence of such concepts is not, therefore, denied but they are understood as an *effect* of diverse but successful networks acting as a single block, rather than as Goliath-like actors in their own right:

*'//If a network acts as a single block, then it disappears, to be replaced by the action itself and the seemingly simple author of that action. At the same time, the way in which the effect is generated is also effaced: for the time being it is neither visible, nor relevant. So it is that something much simpler - a working television, a well-managed bank or a healthy body - comes, for a time, to mask the networks that produce it.'* (Law 1992, p385)

If we replace the 'working television' or 'healthy body' referred to in the above quotation with 'government' or 'neo-liberal economy', we begin to see how political context is understood by actor-network theorists. Networks, therefore, usually only become visible when they fail or, actor-network theorists argue, when the interactions involved in a network are carefully examined and uncovered (for a more detailed explanation of actor-network theory see Law

1992; and Latour 2005). Actor-network theorists are interested in how it is that some kinds of interactions, 'more or less succeed in stabilizing and reproducing themselves: how it is that they overcome resistance and seem to become 'macrosocial'; how is it that they seem to generate the effects such as power, fame, size, scope, or organization with which we are all familiar.' (Law 1992, p380). There is an assumption, then, that the 'macro' is actually no different from the 'micro', 'that Napoleons are no different in kind to small-time hustlers, and IBMs to wheel-stalls. And if they are larger, then we should be studying *how* this comes about - how, in other words, size, power, or organization are generated' (Law 1992, p380).

Following this introduction, section 8.2 begins this task by reflecting on the ways in which interviewees described how they viewed the political and social contexts within which they were situated. The common theme linking these accounts is a belief that such contexts were unfavourable to tackling health inequalities, both because there was believed to be a lack of public interest in the issue and because many interviewees perceived there to be overpowering and insurmountable ideologies working to minimise the influence of some of the research-based ideas about health inequalities that they supported. Here, it becomes clear that because actors' readings of political and social 'contexts' influence their actions and interactions, they are doing more than passively interpreting external 'contexts'. Rather, actors' perceptions of external realities play an active role in the construction and maintenance of these perceptions. Section 8.3 then attempts to uncover some of the *mechanisms* which appear to enable and reinforce actors' perceptions of a political and social 'context' which is largely hostile to the reduction of health inequalities. Unfortunately, given the size of the topic on which this thesis is focusing and the methodological approach that has been taken (i.e. not the kind usually advocated by actor-network theorists), there is a limit to the extent to which it is possible to fully unpick these networks. Nevertheless, sections 8.2 and 8.3 succeed in illustrating some of the factors which allow social and political 'contexts' to appear to function as singular, unchallengeable actors. Finally, section 8.4 concludes by reviewing the findings of this chapter and arguing that the analysis presented here adds further support to the idea that a variety of factors have operated to cumulatively reduce the likelihood that ideas about health inequalities with 'charismatic' qualities will emerge. This conclusion is explored further in Chapter Nine, which weaves together the findings of the three chapters which make up Part



V by exploring the findings in relation to Max Weber's notions of 'charismatic' and 'institutionalising' forces.

## 8.2 Interviewees' perceptions of social and political 'contexts'

As acknowledged above, it would certainly not be true to claim that all of the conversations with interviewees evoked precisely the same images of political and social 'contexts' but there was a consistently visible belief that, however these 'contexts' were perceived, they were not ones that were particularly favourable to the reduction of health inequalities. Indeed, as Table 8.1 briefly illustrates, the data contain numerous claims that there was a lack of media, NGO and think tank interest in health inequalities.

Table 8.1: The perceived lack of lack of public interest in health inequalities

Group or institution	Illustrative quotations
The media	<p>Academic: <i>'People get very bored with inequalities, the media gets very bored. [...] They even get bored of inequalities getting worse 'cause they've got used to that, it's like, 'we've had that story.' And you go, 'yeah but they're getting worse still,' you know? 'But weren't they the worst ever five years ago?' And you go, 'yes, but that was five years ago and they're now worse.' So coping with fatigue over... that is... quite difficult.'</i></p> <p>Documentary maker: <i>'There's no way that the BBC would make a programme which looked at [...] the Black Report or something, I mean on health inequalities, it just wouldn't make a programme about why the poor die younger than the rich... and go into the... I mean you might make a programme about that but... the analysis would be quite thin. You might compare a sort of poor housing estate with Hampstead or something and have some characters and... have few figures... but that would be it, you wouldn't have sort of Richard Wilkinson popping up and explaining his work. [...] You just can't get that sort of stuff on telly any more.'</i></p>
NGOs	<p>Policy advisor (England): <i>'I'm not aware of any charities that are really pushing the health inequalities stuff.'</i></p> <p>Academic: <i>'I'm probably missing a trick but I can't think of one or two major organisations that have [lobbied for action to reduce health inequalities]'</i></p>
Think tanks	<p>Academic: <i>'For some reason, the think tanks are not getting into it [health inequalities]. I don't know why not, actually. [...] We've... got DEMOS and IPPR and all the rest of it. Very interesting... organizations but none of them... I mean I've vaguely tried to get them interested in health inequality actually and [Blank], who does the PR for the [Blank – research group], was constantly bombarding them with things, and I think they used to come to the odd meeting but they never engaged with us. So, for whatever reason, they've decided it's not something to really get into.'</i></p>

In total, only one interviewee of the sixty who were interviewed said s/he felt health inequalities was an issue in which there was substantial media interest and only one (other) interviewee suggested that any 'think tanks' had taken up the issue. Similarly, most interviewees struggled to come up with examples of any charities or NGOs which they felt were actively campaigning about the issue. The only exceptions to this were that five interviewees said they felt children's charities (particularly the *Child Poverty Action Group* but also *Barnardo's*) were sometimes active in campaigning to reduce health inequalities amongst children and two interviewees mentioned the *Politics of Health Group* (a campaigning organisation which functioned largely as an email discussion group during the study period).

The perceived lack of interest in health inequalities amongst these various institutions and sectors was believed to be hugely problematic by many of the interviewees, both because it lessened the pressure on policymakers to follow-up rhetorical commitments to reducing health inequalities and because it limited the mechanisms (and potential audiences) for the circulation of research-based ideas about health inequalities. Such perceptions left many interviewees to conclude that the only actors really pushing to reduce health inequalities during the study period were academic researchers and a few sympathetic politicians and civil servants.

This context was held up in stark contrast to the memories that many interviewees described having of the situation prior to 1997. The picture painted of this period was often one in which the government's action of rejecting the findings of the Black report (Black, Morris *et al.* 1980) had served to ignite interest in the issue of health inequalities amongst a wide range of audiences, including the media, NGOs and public health practice communities. The stories told by interviewees about this era usually focused on the ways in which different actors had come together around the aim of ensuring that the reduction of health inequalities was a policy issue by the time that the New Labour government was elected. Many of these descriptions evoke a sense in which the period between 1979 and 1997 was marked by a sense of passion, excitement and relative unity within the health inequalities research community. In some senses, the period on which this thesis focuses was portrayed in almost precisely the opposite way; whilst all interviewees recognised, and seemed pleased, that the reduction of health inequalities had now become a clear policy aim, there was very little belief that there



was much of a 'campaign' around particular ideas about how to achieve this aim. In part, the lack of unity around a particular 'message' was seen to reflect the fractured nature of the research community (as discussed in Chapters Two and Six) but it was also believed to result from the loss of interest in health inequalities amongst some actors once the issue had been adopted as a 'policy problem'.

For the majority of interviewees, the perceived lack of interest in ideas about how to reduce health inequalities amongst individuals in the media, NGOs and think tanks was reflective of a broader lack of interest in the issue amongst the wider public. This was articulated in two, rather different ways. The first, as illustrated in the following quotation, was a sympathetic reflection that those most negatively affected by health inequalities were likely to be facing more immediate and pressing concerns than their relative life expectancy compared to others:

*Academic: 'I don't think it's an issue that you can kind of keep getting people going to the barricades on because it's actually, if you are in a tough social situation, it's hard enough without thinking, 'oh well, I'm only going to live to be seventy-two instead of seventy-five...'*

Sentiments very close to those expressed by the above interviewee were evident in interviews with four academic interviewees and two policy advisors (both of whom were based in Scotland). The second way in which a perceived lack of public interest was commented upon was much less sympathetic, evoking a sense of the 'moral underclass discourse' that Levitas (2004) identifies in New Labour policies. For example:

*Broadcast journalist: 'Certainly when it comes to health inequalities, [coughs] the people who are suffering from health inequalities are the people who consume the least news, you know... the deprived areas, they're the people who are watching the least news so, in a way, by doing that, they're influencing their own situation because... we would be trying to present a report which very few people would want to watch so... I mean certainly in terms of newspapers, if they know that that story isn't going to get people to buy their newspaper, they won't print the story, or they won't devote much time to it anyway.'*

The above quotation extends the notion of individual responsibility for health inequalities beyond the usual focus on lifestyle and behavioural 'choices' to the decisions people make about the programmes they watch and the newspapers they read, which adds another dimension to Crawford's (1977) analysis of 'victim blaming' discourses. Whilst this particular interviewee was the only one to specifically suggest that individuals' decisions about media consumption contributed to the paucity of public and political concern about health inequalities, five other interviewees expressed the view that public apathy about health inequalities contributed to (and was therefore partially responsible for) the lack of interest in the issue amongst other potential actors.

More specifically, in relation to the various research-based ideas about health inequalities, the perception which is perhaps most pertinent to this thesis is the widespread belief that interviewees expressed regarding political, media and public disdain for policies aimed at reducing *income* inequalities. This is illustrated by the quotations in Table 8.2, over-page. It is important to highlight that this perception was articulated relatively frequently within the data and only two of the 61 people interviewed openly claimed that there was some public appetite for more egalitarian policies (no interviewees claimed there was any media or political appetite for such policies). This is important in terms of the journeys described in Chapter Five as it suggests that of all the research-based ideas which were identifiable within policy, some of the ideas with particularly high levels of support amongst researchers - the need to tackle material deprivation and income inequalities - were also the ones which interviewees believed to be most *incompatible* with the dominant social and political 'context'. Indeed, a number of interviewees claimed these kinds of research-based ideas had effectively been 'blocked' by hostile political and social 'contexts'. For example:

Senior academic researcher: *'At one level you can think of... interventions that might operate within a kind of existing economic and political context, and those interventions that might challenge... an existing economic and political... context. So, there are, there are a whole range of potential interventions around redistribution of wealth that might, err, that might actually be really quite effective... in dealing with issues around nutrition and dealing with issues around housing as well as kind of*



*basic... income redistribution, transport and so on. But I think one of the things that... happens when those kind of obvious policy implications are pulled out of research is that... they're then placed within the context of a particular political economy and... they cannot be implemented within that context.'*

The above interviewee described his/her perception that the wider political and social 'context' had acted as a barrier to some research-based ideas about health inequalities particularly clearly but similar sentiments are also evident in the quotations in Table 8.2, below.

*Table 8.2: Perceptions of lack of public, political and media support for more egalitarian policies*

<b>Illustrative quotations:</b>
<p><i>Academic: 'I think... a government that isn't... keen to pursue issues around... income redistribution... you know, that's a reasonably popular thing to not do. Who wants to pay more taxes? And... if taxes go up for the richest, somehow or other everybody seems to feel they're being affected by it so, unless the government is prepared to tackle that at a media level, nobody's going to be unhappy with their decision... not to change taxation.'</i></p>
<p><i>Journalist: 'I mean if you look at the countries with the smallest wage differentials, then they're the countries with the lowest health inequalities so that's something that is clear. Are we ready for that in this country? I don't think so [...] I mean tax is usually the issue that we get, our elections get decided on and I can't imagine anybody going to the electorate and saying, 'well actually, we think that people who are earning above thirty-thousand pounds should be taxed and extra five percent... to help people at the lower levels and close these differentials and abolish health inequalities,' because I think the mentality in this country is, 'well, I don't want that,' you know, 'I'm okay; let these people look after themselves.' So I can't see that as being something that's going to be very popular.'</i></p>
<p><i>Academic: 'We're not willing to live in societies where there's equality in other domains, other than health. So we're not willing to live in societies where there's equality of wealth or equality of income [...] and... equality of housing or equality of access to other services. We're only willing to live in a society where we have, ostensibly, equality in health status and equality in children's education - those are about the only things where we're willing to accept equality. In virtually every other domain of life, we don't want equality; we actually worship inequality. So if we said... in the world at large, we should have equality in the amount of money you can spend on your holidays, people would never accept that. [...] It's a winner-take-all society we're creating, [...] that's the kind of place we're living in. If you can make a hundred million because of some good idea, good luck to you. And the fact that a head teacher has to look after a comprehensive school with fifteen hundred pupils in it and gets paid sixty thousand pounds a year and doesn't really have any prospects of increasing that, nobody seems to think that's an injustice, between that pay and the pay of a major footballer. To me, that's a massive injustice, and it's not till we get our values in society sorted out that... we can begin to make progress.'</i></p>

The opinions expressed above have been regularly put forward in academic literature (e.g. Levitas 2001; Carmel and Papadopoulos 2003) and so it is no surprise to find them so well represented in the data, especially within the transcripts of interviews with academics. Much like some of the theoretical accounts of policy that were discussed in the previous section, these data evoke a sense in which powerful and relatively homogenous forces are shaping the direction of policy. Yet, it is rarely, if ever, clear in the data who or what is perceived to be in control of the agenda. For example, the illustrative quotations in Table 8.2 refer to 'government', 'media' and 'society' as key actors but, although all three of these 'actors' are made up of a range of other actors, there is almost no reflection within the data on the heterogeneity and complexity underlying these terms. This process of simplification is particularly evident in the following two quotations, in which the interviewees suggest that even senior policymakers are actively constrained by 'the government', without reflecting on who or what 'the government' is:

*Academic: 'I recently had a rather unpleasant exchange with [senior person in the] Health Inequalities Unit at the Department of Health when I tried to get these views across, 'cause even though that person is a very estimable person, s/he is of course constrained by what the government will permit and... of course... the government will only permit its civil servants to go so far in doing anything that might challenge its fundamental tenets.'*

*Academic: 'I am not convinced, despite... some appealing commitments, committing statements, on the part of government... that even the Ministers feel that they have much authority in how... changes might be introduced. I think quite a few of them are... highly intelligent, they... know that inequalities in health is a very complex issue, but they, between the lines, they can read the unwillingness of the government to oblige... some of those in power to... change tack and to move in a different direction.'*

Both of these quotations highlight the disempowering consequence of leaving social forces, such as 'government', unexplained. For, just as Latour (2005) reflects, the failure to discuss



who or what the 'government' constitutes actively contributes to perceptions that it is a single, all-powerful entity. The consequence of this, as the above quotations suggest, is a belief that little, if anything, can be done to challenge the situation. In other words, at least some of the power associated with 'government' emerges from a relational process whereby actors are successfully persuaded that 'government' is a single, Goliath-like actor. Indeed, the only times in which the power of 'government' is significantly challenged within the interview data is by interviewees who suggested that 'governments' were controlled by even more powerful actors, such as global financial actors. For example:

*Academic: 'Governments right now... are influenced by multi-national corporations [...] and... it's the minority in affluence that are able to... press them and to make sure they implement certain policies. [...] These policies are... a sort of coherent package that is going to be implemented in virtually every country, with few exceptions. So... even a socialist government cannot address issues of poverty, of inequality effectively. [...] It is a very small percentage of people now who own the stock markets... and they can decide together to invest or disinvest in one economy so an economy's going to suffer very much if they decide they don't like their policies. So governments are actually responding to these interests. [...] I don't think England is under this threat but that's because it's playing the game according to the rules that these powerful groups want it to. So we have a socialist government that is implementing neo-liberal, market policies, privatising, liberalising and so on. So it's not actually a socialist government, it's not a Labour government... Labour is just the name. The reality is... it's promoting insecurity and it's not protecting the interests of poorer groups.'*

Like the above interviewee, many of the academic interviewees linked their perceptions of a restricted policy environment within the UK to the development to broader, global economic processes and the 'powerful reach' of large financial institutions such as multi-national corporations, the IMF and the World Bank. Yet, like references to the 'government', references to the 'global' processes via which the UK's political context was being shaped tended to be vague, often encompassing a range of different factors. For example, phrases employed by interviewees ranged from structural processes, such as 'globalisation', to

ideological positions such as 'capitalism' and 'neo-liberalism', and social trends such as 'hyper-consumerism'. The common thread linking the way in which these various phrases were used was a belief that international corporations and financial institutions were increasingly framing the boundaries of acceptable policy discussions at the level of the nation-state. These opinions are also evident in some academic literature surrounding policy and politics. For example, Jessop (1994) argues that processes of power displacement have resulted in the 'hollowing out' of the nation-state, with decision-making processes being transferred to a variety of supra-national, regional and local levels (see also Bell 1973; and Ohmae 1990, 1995). As the quotation above illustrates, the interviewees who referred to 'globalising' processes seemed rather fatalistic about the prospect for change; for the most part, they appeared to be able to see no realistic way (at least in the relatively near future) in which policies at the national level could ever seriously challenge global economic processes and financial interests. In this sense, many of the interviewees' accounts of processes of globalisation and the dominance of neo-liberalism betray an acceptance that 'there-is-no-alternative' (TINA) to neo-liberal, market policies (see Centeno 2001; Munck 2003). Yet, as various authors are keen to point out (Larner 2003; Tickell and Peck 2003; Peck 2004), policies everywhere are not necessarily converging around very specific similarities but, rather, share 'certain family resemblances' (Peck 2004) or historical legacies (Larner 2003). Indeed, it is worth reflecting on Larner's (2003) concerns that such terms can be used as receptacles for quite heterogeneous policies and activities, with the consequence that the complexities involved become eclipsed.

It is this process of the concealment of the complex heterogeneity underlying 'macro' concepts which seems essential to understanding the consistency with which many academic (and some other) interviewees' suggested that the dominant political and social 'contexts' were hostile to the reduction of health inequalities (or, at the very least, hostile to the implementation of policies they believed were likely to reduce health inequalities). Crucially, having been persuaded of the idea that 'governments' and/or of 'global financial organisations' represent powerful actors, the data suggest interviewees' actions help enact a situation which further reinforced the difficulty of challenging these hostile 'contexts'. As Chapter Six discusses, many of the interviewees involved in health inequalities research reflected that they pitched their ideas in ways which they felt would enhance (or at least not diminish) their



credibility amongst individuals working in relevant policy and funding contexts and their perceptions of these contexts were clearly informed by their interpretation of the wider social and political 'contexts' upon which this chapter is focusing. Shifting the focus on to individuals involved in the construction of policy, Chapter Seven provides evidence that policymakers involved in health inequalities tended to promote ideas which they believed were compatible with the existing direction of policy (or with what individuals further up the policymaking hierarchies were 'looking for'). The belief both that health inequalities are not an issue for which there is much political, public or media interest and that ideas associated with the need for a further redistribution of wealth are unpopular therefore appears to have shaped the ways in which research-based ideas about health inequalities have been constructed, circulated and translated between actors based in both research and policy contexts.

This section now tries to uncover the processes through which individuals become 'acting subjects' (Larner 2003, p4) who contribute to enacting (as well as challenging) the dominance of the neo-liberal and globalising processes that they describe (see Law and Urry 2004). As the process via which academic researchers contribute to realising their perceptions of external 'contexts' was explored fairly extensively in Chapter Six, this section turns its attention to the data provided by policy-based interviewees. As might be expected, in light of the above discussion, policy-based interviewees often presented themselves as having no control over the political context within which they worked; rather it was something which they had to 'work with'. Yet, their comments suggest that they were constantly engaged in interpreting this shifting context, which they then re-presented to other actors, including academics. So although the interviewees consistently denied having any influence over the political and social contexts they described, the data suggest that they acted as interpreters and translators of it. For example, the following civil servant describes the importance of encouraging academics to work with the flow of the 'political tide':

Senior civil servant (Scotland): *'The critical thing is to try to get public health academics... having an effect on policy, but in turn having their activities shaped by policy aspirations. Not telling the academics what to do but saying, 'look, ministers are intent on going in this direction. Anyone want to follow and see what happens?' You know. So that's kind of how we do it. [...] I made a very deliberate decision that if*

*you were, if you're going to change things, you've got to work through the political process, you shouldn't work against the political process. Find the grain of the political, find what direction the political tide is running and try and surf with it. Erm... and I think that's how you get things done, to be honest, unless you kind of stumble on a, you know, an Armourlight rifle and a few hand grenades and you're prepared to have a revolution or whatever, you know? But that's not the way you do things in our society.'*

This quotation captures precisely the process via which this civil servant, as an individual who interacts with both ministers and researchers, positioned him/herself as a mediator of the political 'tide'; someone who encouraged researchers to work in ways which s/he perceived to be complementary to the existing direction of policy. The way in which the interviewee articulated this role suggests it was relatively passive, yet the acknowledgement that establishing the direction of this 'tide' is a process of exploration, rather than an interpretation of clear-cut directives, underlines that actors who work as 'interpreters' of the political 'context' actually play a translational role. That is, they enact *their* interpretations of political 'context' by trying to persuade others to act in line with their analyses. Importantly, as Chapter Seven discusses, the interpretation of the path that policy was moving in frequently appeared to be something of a guessing game, often undertaken by individuals who had very little interaction with the actors they perceived to be influencing its direction.

To help conceptualise this process, the notion of 'credibility' (as discussed in Chapter Six in relation to Latour and Woolgar's (1986) notion of 'cycles of credit'), seems, once again, to perform a useful role. When the interviewees involved in policymaking talked about the factors which shaped their assessment of what the political 'context' was, they (like the academics discussed in Chapter Six) frequently referred to the need to maintain credibility with a number of different audiences. In the immediacy, there were the other policymakers with whom they worked, particularly the ministers heading up departments or policy areas to which they were contributing (as Chapter Seven discusses). However, these interpretations were in turn shaped by perceptions of the importance political actors attached to maintaining credibility amongst other audiences, particularly the media and the voting public. For example:



Civil servant (England): *'I think perhaps the way that, if you like, the whole sort of social agenda has been underplayed, I think is in direct response to how it might be perceived in the media, you know, how News International might interpret it, or the Daily Mail, you know... People sort of think... politically, you might say, 'well that might undermine their credibility with... middle England,' which is... well, it's seen as being quite an important electoral... audience.'*

Like the above civil servant, most of the interviewees based in policy suggested that the media played an extremely important role in shaping the direction of policy and, whilst most of these interviewees (including the one above) said they felt it was politicians and ministers who placed too much emphasis on what was reported in the media, many also appeared to reinforce its importance by relaying it to others. For example, a civil servant in Scotland explained s/he felt that academic researchers ought to think *'a little bit more about the societal-political world we live in... and how it's driven by the media'* if they wanted their work to influence policy. Both this statement and the above quotation illustrate the circular nature of interpretations of credibility; interviewees involved in the construction of policy described a process in which they assessed what was likely to be deemed 'credible' by their colleagues (particularly ministers and their advisors) based on an interpretation of what they felt would be deemed 'credible' amongst the audiences towards whom those actors were orientated. Policy-based interviewees who interacted with academic researchers then appeared to relay these interpretations to academics, with the aim of encouraging a flow into policy of research-based ideas which were likely to be deemed 'credible'. Given, as Chapter Six argues, many of the academic researchers did suggest that they consciously shaped their ideas in ways that they believed would be deemed 'credible' by policymakers (or, at least, in ways which would not damage their credibility), we can begin to see how the way in which ideas are circulated contributes to the appearance of a relatively uniform and authoritative political and social 'context'.

The analysis presented here remains a long way off the kinds of detailed studies that actor-network theorists usually undertake (e.g. Callon 1986; Latour 1988 [1984]), a situation which is probably inevitable given that the methodological approach taken to this thesis was so

different from that advocated by actor-network theorists. Nevertheless, this section has begun to uncover some of the networks underlying the appearance of social and political 'context' as a singular actor. The fact that many of the interviewees referred to it as if it were a singular actor demonstrates the effectiveness with which these networks were operating, leaving many interviewees with the sense that there was no possibility of introducing ideas which challenged this 'context' (i.e. which would disrupt the underlying networks).

In relation to the various journeys of research-based ideas that was described in Chapter Five, the above analysis helps explain both the success of ideas which were not in conflict with perceptions of the wider social and political context (such as the focus on early years of life, the role of the health services and lifestyle-behaviours) and the more complex journeys of ideas which do appear to challenge this 'context' (such as ideas about socio-economic, material and psychosocial determinants).

Other aspects of the data shed further light on the 're-contextualised' journeys experienced by ideas relating to lifestyle behaviours and the health services in tackling health inequalities. The previous chapter has already illustrated the way in which a medical model of health appears to have been institutionalised within the organisation of the policymaking bodies concerned with health inequalities. The data of relevance to this chapter demonstrate that the status associated with medical expertise results from a similarly circular process to that described in relation to social and political 'context'. For example, in the following quotation, a Minister based in England explained that s/he felt it was essential for local public health leaders to be medically qualified solely because this imbued them with the *status* of being medical practitioners (and, therefore, the authority to influence others):

Minister (England): *'I think we should once again have Medical Officers of Health. Now quite a lot of people amongst the academics and such like would say, 'well, we need that post but we don't want it to be a Medical Officer of Health, it could be anybody of any discipline but with that status.'* My own view is, *that's all very well but really it's important because unless they're a doctor, they won't have the status.*' [My emphasis]



This interviewee reflected that his/her interpretation of the importance of medical status meant that s/he had then contributed to the construction of policies in ways which reinforced the value attached to medical qualifications within the field of public health (an issue which was the subject of much discussion within the public health community during the study period, e.g. Wills and Woodhead 2004). In other words, rather like the value attached to currency, the status attached to medical expertise survives because the value invested in and attached to it is accepted to be of value by a wide range of actors, each of whom helps facilitate the circulation of this idea. The circular and self-perpetuating nature of the value attached to medical credentials is particularly evident in the following extract, taken from an interview with a journalist who specialised in covering health-related stories:

*Journalist: 'The thing is you read the BMJ and The Lancet [i.e. influential medical journals] 'cause you know everybody else is reading the BMJ and The Lancet and the last thing that you want when you go in on a Friday morning is for your editor to say, 'well, why did you not get this story that's in every other paper?' So, you know, it's a bit of a herd mentality in journalism, you have to make sure that you're doing the same thing as other people.'*

The 'herd mentality' that the above interviewee referred to highlights the difficulty of challenging widely held perceptions. Furthermore, as the above interviewee recounts, s/he perceived there were likely to be some potentially negative consequences for her/his career if s/he began ignoring the status associated with medical ideas. Nevertheless, the ability to successfully translate medical qualifications into 'credibility' relies on others to accept the value associated with this 'currency' and, as economic analyses demonstrate, the values of particular currencies can suddenly decline when these networks breakdown (e.g. Gilbert 2005). Once again, therefore, whilst the data suggest that networks were operating in ways which made it difficult for actors to conceive that the situation might be otherwise, at least during the study period, the fact that underlying networks (rather than a single actor) are detectable suggests there is at least the *potential* for this situation to alter. The analysis presented in the following section helps uncover some of the mechanisms which help ensure that the potential for change remains extremely slim, at least in relation to perceptions of the political 'context'.

### 8.3 Underlying assumptions and discourses

In light of the discussion presented in the previous section, it is perhaps not surprising that one of the key trends from the semiotic analysis of the policy documents (see sub-section 3.2.3 in Chapter Three) is the presence of a recurrent assumption that national economic growth is an overarching policy aim to which the whole population subscribes and that it is a policy ambition which overshadows nearly all others. This is particularly evident in aspects of the data in which the underlying motivation for reducing health inequalities (or improving population health) is articulated as the need to ensure that as many people as possible are contributing to the expansion of the national economy. The extracts in Table 8.3, below, provide examples of this kind of rationale.

Table 8.3: Assumptions about the importance of national economic growth within policy

Context	Illustrative extracts
England	<p><i>Our Healthier Nation</i> (Secretary of State for Health 1998, pt1.16): 'To succeed in the modern world economy, the country's workforce must be healthy as well as highly skilled. The Confederation of British Industry has estimated that 187 million working days are lost each year because of sickness. That's a £12 billion social tax on business every year, damaging to competitiveness and a brake on prosperity.'</p> <p><i>Choosing Health</i> (Secretary of State for Health 2004, p83): 'Local authorities [...] are well placed to promote understanding within local communities of how good health and reducing inequalities can have a positive effect on the local economy, social and environmental fabric.'</p>
Scotland	<p><i>Closing the Opportunity Gap</i> (Scottish Executive 2004c, in Target D): 'Reducing health inequalities will have a positive effect on individual and community health, contributing, for example, to children reaching their potential in the education system, and adults playing a fuller role in the economic life of Scotland.'</p> <p><i>Healthy Working Lives</i> (Scottish Executive 2004b, p8): 'The health of working-age people [...] is of particular concern. [...] 2.2 million working days are lost every year through ill-health and we know that amongst men and women aged 15-74 we have one of the worst records in Europe for both overall mortality and specific conditions such as lung cancer, oesophageal cancer and ischaemic heart disease.'</p>

In each of the extracts in Table 8.3 there is an assumption that national economic growth provides a key incentive for reducing health inequalities (and/or improving population health) and there is a notable absence of references to ethical or other reasons that it might be desirable to reduce health inequalities. This kind of logic was also evident in four of the



interviews with policy-based individuals and the following quotation is the most overt example of this:

Senior civil servant (Scotland): *'The Communities Minister has a part to play, the Education Minister, the Justice Minister - they all have a part to play in health [...] So what I need to do [...] is show them [...] that by delivering the agenda they want to deliver - safer streets, better educated children - they're actually delivering the agenda that I want and, by doing that, the next link in the chain I make is that, by delivering a healthier Scotland, we're ultimately delivering a wealthier Scotland. [...] Classically, health spending is seen as a black hole, a necessary evil, something that governments and societies have to do, you know, as a kind of charitable... and it actually is money diverted from what they'd really like to do, which is invest it in powerful new machines and so on. Now, I don't think that argument holds up... because the basic unit of production is people [...] and the healthier humans are, the more productive they are. [...] So, my argument is, yes, I want better educated children because I know that they will be healthier children and I want them there because I want them to pay my pension, because this will create a wealthier economy, a more sustainable economy, one... that fits well with everybody else. So... I think this is a fascinating idea that needs to be... further unpacked and further explored and it, because it helps people who don't see themselves as part of the health debate to become part of it.'*

In the above extract, there is a clear assumption that it is somehow obvious and indisputable that securing economic wealth at the national level constitutes a key, motivating factor underlying every aspect of policymaking. The interviewee claims that the argument most likely to persuade both him/herself and his/her policymaking colleagues to tackle health inequalities is that there are *economic* advantages to doing so. It is noticeable that the interviewee at no point suggests there is a moral, ethical or human rights-based imperative to work towards the reduction in health inequalities. In other words, the extract suggests that the pursuit of national economic wealth operates as a 'meta-narrative' within policymaking (and, indeed, the data suggest, often beyond policy discourses to also shape broader public discourses).

Much like the notion of a political or social 'context', the concept of 'meta-narratives' (or 'grand narratives') has come under sustained attack from academics associated with postmodernism, such as Lyotard (1984 [1979]), for their 'totalizing' tendencies (i.e. their perceived ability to explain a huge variety of activities and outcomes with reference to single, often simple, explanations). By simplifying complex and heterogeneous situations, meta-narratives have also sometimes been criticised for legitimating dominant views. Positioning the pursuit of national economic wealth as a meta-narrative which explains the outcomes of *all* policy decisions would clearly be subject to these criticisms. The claim being made in this thesis is, therefore, not that a pursuit of national economic wealth *does* underlie all policy decisions but, rather, that some aspects of the policy statements suggest this is the case and some interviewees appeared to believe it to be. This is important within the context of this thesis as it may help explain some of the evident slippage between the twin policy aims of reducing health inequalities and improving overall population health (see sections 5.4 and 5.5 in Chapter Five). For, if the overarching goal is deemed (at least by some policymakers) to be about the need to ensure as many people as possible are in a position to contribute to the national economy, then addressing health inequalities is only likely to be of concern to the extent that it contributes to this goal. It must be acknowledged that the findings presented here relate only to particular aspects of some policy statements and a small number of interviews. However, on a more subtle level, the data reveal widespread acceptance of the importance of economic goals, as the following part of this section demonstrates.

The 'linguistic turn' in the social sciences has drawn researchers' attention to the importance of the language that actors employ. As Hall (1989, p384) explains, words, concepts and languages, 'define the terms of political debate and provide participants in the political arena with a discursive repertoire to be used there.' It was interesting, therefore, to note the way in which economic discourses appeared to have infiltrated the way some policy statements (especially those published from 2003 onwards) discussed responses to health inequalities. For example, both *Choosing Health* (Secretary of State for Health 2004) and *Improving Health in Scotland: The Challenge* (Scottish Executive Health Department 2003a) discuss the importance of 'marketing health' and of employing 'social marketing' techniques to encourage healthier lifestyle 'choices'. The Scottish document also discusses the perceived need to



create a 'healthy living brand'. All of this suggests that terminology more usually associated with economic discussions had not only entered dialogues about health inequalities but had begun to actively shape some of the policy responses.

The infiltration of economic terms was also evident in the interview data: as the quotations in Table 8.4 demonstrate, interviewees based in the media, academia and policy all employed economic terms such as 'marketing' and 'selling' to explain how ideas are circulated and translated between actors and across contexts.

*Table 8.4: The dominance of economic terminology in interviewees' accounts of the circulation of ideas*

**Illustrative quotations:**

Broadcast journalist: *'In terms of work, it [television] is not a particularly nice place to work. [...] It's all, 'where do you fit in the market?' It's not who you are as a person, it's... what do you provide for the market-driven economy? [...] Television is market driven. That's the way it goes, you know. I wish it wasn't, I wish it was a bit more like the nineteen-sixties, seventies and eighties, when there was a bigger scope for public service broadcasting, you know, and it was... the BBC was supposed to... inform, educate and entertain, but inform and educate was quite a big part, now it's just to entertain, even the news [laughs].'*

Civil servant (Scotland): *'If you don't have a team that's, well, it's marketing it [health inequalities]... It is marketing [...] Politicians need to be able to feel that they can make a difference and, therefore, you not only have to market it as being a problem, but you have to be able to market it as being something you can do something about.'*

Academic: *'What's happened in health inequality [...] is that actually the doing of the... the scientific advisor role is a market, and that market is monopolized by certain people, in the same way as any good capitalist will try to, not necessarily monopolise but just like Tesco, you know, you want to fill up as much of that as possible and you don't want other people on your territory.' [...] We're all competing with each other the whole time. Everybody competes with everybody else for these markets for expertise and that is always going to cause problems. [...] I mean you run yourself like a small business.'*

All of the interviewees quoted in Table 8.4 appear to position themselves as economic actors engaged in the marketing of ideas. It is clear that all three of these interviewees (and there are multiple other examples within the data) perceived themselves to be in competition with other sources of potential ideas. This has some important implications for the ways in which ideas are likely to have been constructed and promoted by individuals, possibly helping to explain some of the evident divisions within the research community. It also demonstrates that, economic discourses have been so successfully translated across a range of contexts

that they were employed even by interviewees who directly challenged the domination of economic ideals over others (as two of the interviewees quoted in Table 8.4 did, for example). In other words, some interviewees employed terminology derived from the very discourses which they positioned themselves as challenging. The fact that it appears logical to employ economic terms when trying to communicate ideas which are not directly related to economics (and it should be acknowledged that such logic is evident within the language I have myself used in this thesis) highlights the extent to which an orientation towards the importance of the economy has become embedded in the language that we use and, therefore, in the ways in which we think. To seriously challenge this way of thinking it may be necessary not only to critique underlying assumptions about the role of the economy in policy, as many of the interviewees did, or to try to uncover some of the underlying mechanisms which contribute to the success of this perspective, as this chapter attempts to do, but also to develop new terms and concepts which might help rupture its seemingly unquestionable dominance..

#### 8.4 Concluding summary

This chapter demonstrates the importance of understanding the role that actors' perceptions of wider social and political 'contexts' play in shaping the ways in which they frame, discuss, promote and translate various ideas. For the issue of health inequalities, the data suggest that there was widespread belief during the study period that this was not an issue which attracted a great deal of public or media interest. In addition, they suggest many interviewees believed that some of the ideas most widely supported by research evidence, namely material and socio-economic and psychosocial ideas (see Chapter Two), were also those most in conflict with the wider political and social 'contexts'. The nature of the research undertaken in this thesis mean that it is not possible to explore whether media and public interest in health inequalities was as low as interviewees perceived (although the five interviews with individuals based in the media did little to challenge this perception). What the analysis presented in this chapter does illustrate, however, is how actions and interactions are informed by, and therefore contribute to realising the dominance of, the perceived 'contexts' in which actors find themselves. The argument being put forward is not that there are no external forces or actors informing the 'contexts' that interviewees perceived (i.e. I do not want to claim that social and political 'contexts' are entirely imagined). Rather, given the virtually impossible task of trying to unravel the various contributors to the 'contexts' that actors perceived, this chapter aims



merely to: (i) demonstrate that such 'contexts' are more complicated and less concrete than some analysts (and some interviewees) suggest(ed); and (ii) that actors can play an important (albeit sometimes unconscious) role in maintaining their perceptions of external 'contexts'. The latter point is particularly well illustrated by the analysis presented in section 8.3, which highlights how the infiltration of economic terminology into the language of interviewees is one way in which actors may contribute to unconsciously reaffirming the dominance of particular ideologies in the 'contexts' that they described. This suggests that an orientation towards the importance of the national economy has become deeply institutionalised across a range of disciplinary and organisational contexts, which helps explain why so many interviewees referred to wider social and political 'contexts' in ways which suggested these contexts were relatively homogenous and powerful actors that operated to constrain potential policy responses to (and sometimes research concerning) health inequalities.

The decision to employ an actor-network theoretical approach to exploring these issues was undertaken with the aim of demonstrating that the 'macro-level' actors which many interviewees perceived to be blocking the movement of key research-based ideas about health inequalities are the result of the maintenance of smoothly operating networks. The successful circulation and translation of particular ideas, such as the notion there is no public support for more egalitarian economic policies or the idea that medical expertise is invested with more status than other kinds of expertise, within these networks enables them to be conceived of as singular, monolithic forces. Indeed, their operation appears to have been so successful that, even though the theoretical approach taken to this chapter is deliberately designed to be less disempowering than some analyses (such as some of those discussed in section 8.1, which evoke a sense of powerful, top-down forces being inflicted upon lower-level actors), the possibility of challenging these networks still seems extremely slim.

Returning to the Weberian theoretical framework which has been drawn upon throughout this thesis, the findings presented in this chapter have important consequences for the potential for charismatic ideas to emerge. For, as Chapter One (section 1.3) discusses, 'charisma' is a relational concept which is dependent on the ability of actors to convince others, and of others to be convinced, that an alternative vision of the future is not only possible but likely (Spencer 1973). It is only by being sufficiently persuaded of this that actors then begin to orientate their

actions and interactions around this alternative outlook, thereby helping to enact the alternative vision to which they have subscribed (Law and Urry 2004). The conclusions of this chapter suggest that the successful circulation of some (institutionalised) ideas within complex but efficiently operating networks made it extremely unlikely that charismatic ideas about health inequalities would emerge during the study period.





## ***Part VI: The Conclusion***

### **Chapter Nine: Ideas-based policy and the role of research**

#### **9.1 An overview of the thesis**

This thesis began by asking to what extent (if at all) academic research about health inequalities informed English and Scottish policies in the decade following Labour's UK electoral success in May 1997. Having explained the contextual reasons underlying my interest in this research question in the Prologue, Chapter One provides an overview of some of the relevant theoretical and empirical literature, sketching out three contrasting ways of thinking about the policymaking process: (i) as a process resistant to change; (ii) as a process which encourages only incremental change; and (iii) as a process which is normally resistant to significant change but which is marked by occasional and dramatic shifts in the direction of policy. Not wanting to foreclose the possibility that health inequalities research might have contributed to some significant policy shifts, Chapter One concludes that it is the theories presented in the latter group which provide the most appropriate theoretical starting point for the thesis. In addition, the discussion presented in this opening chapter highlights the increasing attention that academics have given to the role of *ideas* in policymaking (e.g. Béland 2005; Blyth 1997; Campbell 1998, 2002; Goldstein & Keohane 1993; Howorth 2004; John 2003; Stevens 2007). Finding that this role remains under-theorised (Blyth 1997), Chapter One begins to consider how two of Max Weber's key theoretical constructs, 'charisma' and the process of 'institutionalisation', might usefully be applied to the circulation of ideas within academic and policy circles. As the thesis progresses, the intertwined concepts of 'charismatic' and 'institutionalised' ideas begin to form a central theoretical framework which help unpack the interplay between health inequalities research and policy.

Following this introduction, Chapter Two provides a brief overview of health inequalities research in the UK. Owing to the vast amount of research that has been undertaken on this subject, it was impossible to systematically review all of this literature so Chapter Two approaches this task by undertaking an 'ideational cluster analysis' which focuses on grouping together the key (research-based) claims about health inequalities that have emerged over the past twenty-five years or so. After identifying nine quite distinct theories about health



inequalities, in a way which aims to draw out what the implications of each seem to be for policy, Chapter Two concludes by arguing that it is possible to identify at least some degree of consensus within the research literature. Namely, despite ongoing and sometimes extremely heated debates about the aetiological pathways between various determinants and health outcomes, many of the theories suggest that if health inequalities are to be meaningfully addressed it is necessary to reduce wider material, structural and social inequalities.

Chapters Three and Four then respectively outline the two-part qualitative methodology. This involved the documentary analysis of major policy statements and a series of semi-structured interviews with relevant actors. In total, 42 policy statements (25 from England and 17 from Scotland – see Appendix I) were analysed using a three-stage framework, which is presented and explained in Chapter Three. In light of the emphasis placed on theories and ideas in Chapters One and Two, a key aim of this framework was to aid the identification of particular ideas about health inequalities. The different approaches employed in this three-stage framework provided room for tracing two, rather different kinds of 'ideas': firstly, the framework focused on locating the presence of research-based ideas about health inequalities (i.e. the various theories which were outlined in Chapter Two); and secondly, it tried to uncover evidence of deeply institutionalised ideas, or underlying 'discourses'. Whilst the first of these tasks was relatively simple, the second required a much closer interrogation of the texts as it was necessary to identify 'ideas' that had been promoted to the status of 'facts'. Various aspects of the framework were therefore developed with the intention of trying to uncover some of the underlying assumptions within the policy statements. This was achieved through combining an analysis of the way in which health inequalities have been constructed and understood as a 'policy problem' with some semiotic analysis of the language employed in the texts. As Chapter Three explains, whilst the interpretations drawn from a textual analysis of this kind are inevitably subjective, I was encouraged that my analysis was justifiable through various exchanges between myself and another researcher, who took a different approach to some of the same texts but arrived at very similar conclusions.

Next, Chapter Four outlines the approach taken to the second part of the research methodology, the semi-structured interviews. In total, 61 interviews were undertaken. All of the participants were individuals deemed to be relevant to the interplay between health

inequalities research and policy during the period of study and many had been directly involved with the construction either of policy statements that were analysed in this study or the research-based ideas reviewed in Chapter Two. They included: academic, public and private sector researchers; civil servants; ministers; policy advisors; research funders; public health practitioners; and journalists. The first part of the chapter provides a descriptive account of the approach taken to the interviews, explaining the processes of recruitment, recording, transcription and analysis. The Chapter then goes on to review the growing methodological literature on interviewing 'elites', challenging the assumption, which is evident in much of this literature, that interviewing 'elites' is necessarily different to interviewing more vulnerable groups. Instead, it is argued that the, now extensively developed, rationale for employing a collaborative and reflexive approach to interviewing is entirely applicable to the research involved in this project (an argument I develop in more detail in Smith 2006 – see Appendix VI). Accordingly, this was the approach taken and, in line with this, the chapter ends by providing a reflexive account of the interviewing experience.

Chapter Five is the first of four empirical chapters in the thesis. It begins by demonstrating that, despite official commitments to evidence-based policy, there are extremely few examples within the data to support claims that *research evidence* has informed policy. Instead, drawing on theories about the role of ideas in policymaking, the chapter argues that it has been through the movement of research-based *ideas* that health inequalities research has influenced policy. This finding concurs with some of the theories discussed in Chapter One and is perhaps, therefore, not too surprising. Nevertheless, this finding marks a decisive moment in the thesis: It was as a result of the analysis that Chapter Five presents that the central research question around which the whole thesis is based shifted, becoming more concerned with the movement of ideas between research and policy than with the use of research evidence in policy.

Whilst the observation that ideas (or knowledge-claims) are central to understanding the relationship between research and policy is far from new (e.g. Bartley 1988, 1992; Knorr-Cetina 1981; Rein 1980), it is worth re-stating in the context of the discussions about 'evidence-based policy' that were taking place during the study period. As Chapter Five argues, the crucial point in making the distinction between the movement of research-based



ideas and of research evidence is that, once ideas become separated from the evidence on which they are based, they are far more malleable entities than phrases such as 'evidence' suggest. Indeed, as Latour (2005) insists, for ideas to move between actors and across boundaries, they *must* be translated so, unlike metaphorical batons in a relay race that can be passed from one actor to another, the movement of ideas is more comparable to a complex game of 'Telephone'<sup>15</sup>. Consequently, as becomes clear in Chapter Five, whilst many of the research-based ideas and theories about health inequalities (outlined in Chapter Two) are identifiable within policy contexts, they have also undergone varying degrees of transformation in their journeys into policy.

Six distinct journey types are identified in Chapter Five to describe the movements of research-based ideas about health inequalities into policy: (i) 'successful'; (ii) 're-contextualised'; (iii) 'partial'; (iv) 'fractured'; (v) 'weak'; and (vi) 'non-journeys'. 'Successful' journeys signify the movement of ideas which appear to have changed very little in their path from research into policy, and which are visible both in policy rhetoric and the proposed interventions that these statements outline. This is not to say that these ideas have not changed at all but only that their journey into policy does not appear to have resulted in their substantive transformation. Furthermore, these ideas are applied to policy interventions in ways which appear consistent with their theoretical construction within the research literature. Consequently, the ways in which these ideas are articulated in policy contexts is not dissimilar from the ways in which they have been described in the research literature. Only one example of a 'successful' journey for research-based ideas about health inequalities was identified, however, and this was the notion that it is important to intervene in the early years of life. Even for this supposedly successful journey, there was a lack of clarity within the data about the role that health inequalities research into the early years of life had played in securing the influence of a more general concern with the early years of life. The absence of other 'successful' journeys further reinforces the conclusion that there was little or no indication that policies had been evidence-based.

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<sup>15</sup> 'Telephone' is a game in which one person whispers a message to another, who then whispers it to another, who whispers it to another and so on. The conclusion of the game is marked by a comparison of the eventual message relayed to the final participant compared with the message that the first speaker constructed (the point of the game being the way in which messages are transformed as they are communicated between individuals).

The next journey type identified in Chapter Five is labelled 're-contextualised'. Like 'successful' journeys, 're-contextualised' journeys represent the movement of ideas from research into policy without substantive transformation. However, these ideas appear to have been applied in rather different ways within policy than the research-based discussions of the ideas support. Two examples of ideas which appeared to have experienced this kind of journey were found: (i) those relating to the links between lifestyle-behaviours and health inequalities; and (ii) those which focus on the role that the health services might play in tackling health inequalities. In both cases, the ways in which these ideas are applied within policy responses to health inequalities marks a significant departure from the ways in which they are usually constructed within research.

The third journey type identified in Chapter Five is termed 'partial'. Once again, this involves journeys of ideas that have not been substantively transformed during their journey into policy. However, rather than being 're-contextualised' the reason that the journeys of these ideas is not considered 'successful' is that they appear only to have exerted a significant influence on policy *rhetoric*, not on related policy *interventions*. In other words, the findings suggest that these ideas have only experienced a partial journey into policy, having failed to significantly influence policy actions. Ideas about socio-economic and material determinants of health inequalities (those which Chapter Two concludes are most widely supported by the research evidence) appear to have experienced this kind of journey.

It is in the fourth journey type that is outlined in Chapter Five, 'fractured' journeys, that the translation and transformation of ideas is most overt. In these journeys, it is apparent that accounts of the idea (or set of ideas) within policy contexts are substantively different from (at times even in conflict with) the accounts provided in research contexts. Consequently, whilst frequent references within policy statements to terms associated with an idea might suggest that it has 'successfully' travelled into policy, further analysis reveals that it has been radically transformed during its journey. As a result, the ways in which such ideas are understood and conceptualised within policy contexts is often significantly different to the ways in which they are articulated by researchers. The most illustrative example of this kind of journey within this project involves ideas about psychosocial determinants of health inequalities (although ideas about the 'lifecourse' also appear to have been fractured *en route* into policy).



The fifth journey type that Chapter Five describes is termed 'weak'. As the name suggests, 'weak' journeys reflect the movement into policy of research-based ideas in an extremely limited sense. These ideas are only just detectable within policy and, hence, appear to have exerted very little influence. The low number of examples of the presence of these ideas within policy means that it is not possible to reflect on the ways in which such ideas might have been transformed as there are not enough data to analyse. The two ideas that Chapter Five suggests have experienced such a journey relate to 'social mobility' and 'cultural explanations' of health inequalities. Finally, a sixth journey type, 'non-journeys', is put forward to describe those ideas which did not appear to have travelled into policy at all.

Chapter Five employs the data in ways which begin to account for factors underlying the six different journey-types that it identifies. Firstly, it argues that the way in which health inequalities have been constructed and understood as a policy problem seems likely to have constrained potential policy responses. Drawing on Graham and Kelly (2004), the chapter argues that an emphasis on 'health gaps', resulting from 'health disadvantage' (rather than on 'social gradients in health'), seems to have encouraged policy responses which focus on health improvement within disadvantaged groups or areas. This conceptualisation therefore seems to have contributed to a blurring of the twin policy aims of 'improving health' and 'reducing health inequalities'. Much as Kelly and Graham (2004) argue, the chapter suggests this haziness has been further exacerbated by a tendency (both amongst policy statements and policy-based interviewees) to refer to these distinct policy aims in conjunction with each other and to employ accommodating and vague terms such as the 'underlying determinants of health'. The way in which health inequalities have been constructed therefore appears to have played an active role in enabling research-based ideas relating to health improvement (particularly lifestyle-behavioural interventions) to have been 're-contextualised' within policy as logical responses to health inequalities. In addition, the chapter suggests that the short-term nature of the national targets for reducing health inequalities is linked to the increasing focus that began to be placed on the role of the health services in tackling health inequalities during the study period (through, for example, secondary prevention measures such as the prescription of statins). The analysis presented in Chapter Five is, therefore, more than a descriptive account of the interplay between research and policy; it begins to explain some of

the reasons behind some of the different journey types, particularly the 're-contextualised' journeys. It does not, however, do much to explain the other journey types and nor does it shed much light on why health inequalities might have been understood in the way that they were within policy.

This task is taken on in Chapters Six, Seven and Eight, which each take a different starting point to explaining the findings in Chapter Five. The first of these, Chapter Six, employs Latour and Woolgar's (1986) concept of 'cycles of credit' to reflect on what the data from interviews with academic researchers reveal about the ways in which research-based ideas have been constructed and promoted. The findings presented here suggest that many health inequalities researchers have felt unable to approach research as freely as they might have liked (or as is often assumed in literature concerning the relationship between research and policy). Rather, many reflected that they often pitched proposals for, and wrote-up accounts of, research based on their perceptions of what would, and what would not, be deemed credible amongst a number of key audiences. These audiences include other academics, the organisations which provide funding for research, policymakers and, less frequently, the media. In this chapter it therefore becomes clear that it is necessary to think about the relationship between research and policy as an 'interplay', in the way that Rein (1980) describes, rather than as a unidirectional movement of ideas. The influence that perceptions of policy preferences seem to have on research suggests that the potential for ideas, or individuals, to emerge from the research community with the kinds of radical, transformative and 'charismatic' qualities that were outlined in Chapter One is relatively slim.

Informed by Weber's (1968b), subsequently well-developed, observations about the effects of institutionalisation on individuals and society, Chapter Seven considers what the data reveal about the influence of organisational structures on policymakers who have been charged with responsibility for health inequalities policies. The findings presented here demonstrate that a risk-based, medical model of health has been institutionalised within the policymaking bodies responsible for health inequalities. This institutionalisation has shaped the potential routes into policy that research-based ideas about health inequalities have been able to take, resulting in a situation in which only 'bounded innovation' (that is ideational developments within the boundaries of the institutionalised ideas) is encouraged. As a result, ideas which



can easily be fitted within risk-based, medical models of health are likely to have been translated into policy far more easily than those which present (or require) alternative ways of thinking about health. The interview material suggests that this situation may have been exacerbated by a lack of any formal interface between research and policy, resulting in a dependence on bi-lateral relationships between individual researchers and policymakers who are operating from specific divisional locations. In this context, it is not surprising that holistic, cross-cutting ideas about health inequalities (such as those relating to socio-economic and psychosocial determinants) have encountered significant barriers in their journeys into policy.

In addition, Chapter Seven suggests that a lack of vertical and horizontal connectivity within policymaking institutions serves to limit the circulation of ideas within policy contexts. Furthermore, the chapter provides evidence that there is often a lack of institutional memory within policymaking organisations, which enables ideas that have previously been circulated to appear 'new'. The combination of a lack of policy connectivity and institutional memory mean that the translation of an idea between research and policy does not necessarily secure its translation into policy in any broad sense. Instead, the same research-based idea might travel into policy through various different routes, or recurrently over time, potentially being translated (and therefore understood) in a number of contrasting ways and without necessarily having any significant influence on policy outcomes. This explanation potentially helps account for the 'fractured' journey type described in Chapter Five.

Both Chapters Six and Seven touch on the way in which interviewees' perceptions of political and social 'contexts' appeared to inform their activities and interactions but neither of these chapters really explore this issue. This task is taken on in Chapter Eight, which establishes that many of the interviewees believed that the wider social and political 'contexts' in which they were situated were relatively hostile to the reduction of health inequalities. More specifically, a significant number of the interviewees said they believed that these 'contexts' acted to block some of the most widely supported research-based ideas about health inequalities, namely a belief that material and socio-economic deprivation, or inequalities in these factors, are the underlying cause of health inequalities. Rather than merely accepting these interviewees' descriptions at face value, the chapter tries to unpack the various different ways in which terms such as 'political context' and 'dominant ideologies' were used by

interviewees, with the aim of understanding how something as un-tangible and monolithic as political or social 'context' might usefully be understood within this thesis. Having employed Latour and Woolgar's (1986) work extensively in Chapter Six, Chapter Eight draws on other elements of the genre of work known as 'actor-network theory' (Latour 2005; Law 1992; Law & Hassard 1999) to argue that it is both helpful and potentially less disempowering to conceive of political and social 'contexts' as the outcomes of successfully operating networks that continually reproduce themselves, rather than as giant, insurmountable actors in their own right.

From this perspective, relevant data are employed in ways which focus on a circular process in which interviewees' perceptions of external 'contexts' inform their activities and interactions, which then contribute to the ongoing domination of particular ways of thinking, or 'contexts'. These data reveal two distinct ideas, or ways of thinking, which are likely to have shaped the journeys of research-based ideas about health inequalities into policy. One is a belief, or acceptance, that medical knowledge ought to be (or is) accorded a higher status than other types of knowledge. The other concerns the centrality of the economy to public policy. Each of these ideas appears to have been institutionalised well beyond the physical organisation of policymaking bodies, shaping research accounts of health inequalities as well as policy responses. Indeed, the extent to which economic discourses are evident within the language employed by interviewees from a wide range of professional backgrounds suggests that this way of thinking is so deeply embedded in society that it is almost impossible to avoid. Hence, even interviewees who actively sought to challenge the economic orientation of public policy sometimes employed language in ways which actively (albeit perhaps unconsciously) reinforced the hegemony of this way of thinking.

Between them, Chapters Six to Eight pull out a range of factors within the data which contribute to explaining the varying journeys into policy of research-based ideas about health inequalities that are described in Chapter Five. The remainder of this concluding chapter argues that all of these explanations can be understood by further developing the theoretical concepts of 'institutionalisation' and 'charisma' and examining the tensions between the two. To help facilitate this discussion, the following section focuses on describing in a little more detail how ideas are translated between actors and across boundaries. This is of crucial



importance to understanding the Weberian theoretical typology which is developed in the penultimate section of this chapter.

## 9.2 The translation of research-based ideas

As discussed, in contrast to the solidity evoked by terms such as 'facts', 'information' and 'evidence', this thesis focuses on 'ideas' as knowledge-claims which, as Latour and colleagues demonstrate (Latour 2005; Latour & Woolgar 1986), are malleable entities that alter as they move between actors and across boundaries. The work of Latour and others within the discipline known as 'science studies' has usefully unpacked the processes through which ideas are translated and transformed within various research contexts (particularly the biological and physical sciences). However, so far there have been very few studies of the interactions which allow ideas to move *between* research and policy contexts. Whilst this thesis is not based on the detailed anthropological work necessary to reveal the intricacies of interactions between actors in the way that researchers in science studies have managed to do, the data do expose a great deal of evidence to support the claim that ideas have been translated and transformed as they have moved between actors.

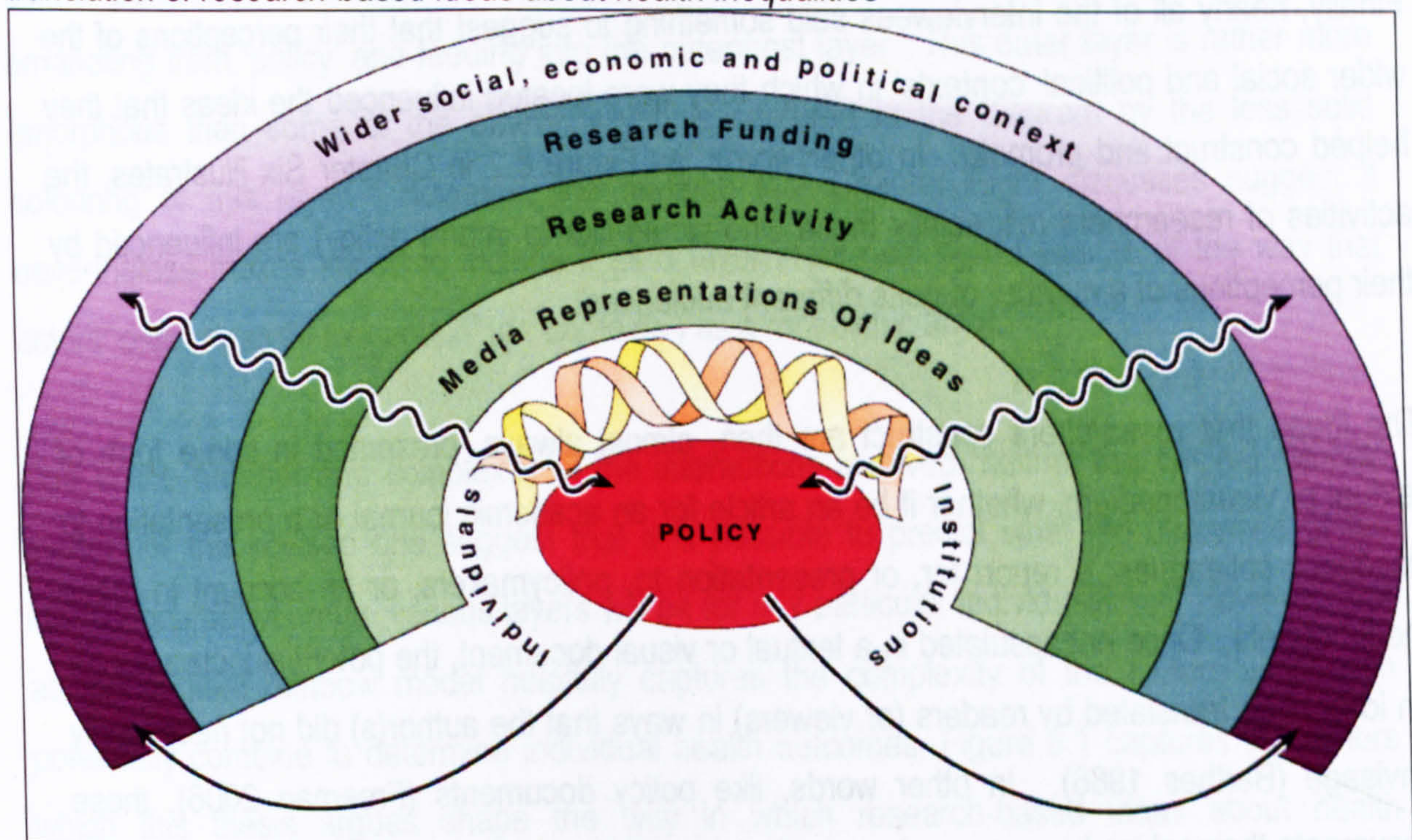
Importantly, these data suggest that it is in making the move across disciplinary and/or institutional boundaries that ideas are particularly likely to undergo significant transformations. For example, many of the interviewees offered accounts of what they felt individuals working in other contexts were 'looking for' and some reflected quite openly that they then tried to promote ideas to these audiences in ways which corresponded with these perceptions. For example, Chapter Six provides evidence of researchers who said they had packaged their ideas in particular ways for audiences beyond academia, and Chapter Seven demonstrates that civil servants and policy advisors often claimed to present ideas to ministers in ways which fitted their perceptions of the directions they felt ministers had already decided upon. In addition, Chapter Seven illustrates how the physical organisation of institutions can play a significant role in the way in which ideas are translated. All of this suggests that to understand the ways in which ideas about health inequalities have been transformed as they have moved between research and policy, it is important to think about: (i) the actors involved in constructing and promoting particular research-based ideas and the incentives and commitments which guide their activities; (ii) the media through which ideas are communicated; (iii) the actors involved in introducing ideas to, and circulating ideas within,



policy contexts; (iv) institutional contexts within which all actors are located; and (v) actors' perceptions of what it is that the actors whom they interact and communicate with are looking for and why (which appears to be informed by actors' perceptions of wider political and social 'contexts', as described in Chapter Eight).

Encapsulating this level of complexity within any kind of diagram is an almost impossible task, although the same could easily be said of the determinants of health, for which many visual models have been put forward. Indeed, the widely circulated 'rainbow model' of the determinants of health that was designed by Dahlgren and Whitehead (1991) is a particularly good example (see Figure 2.2 on p67). Given the explanatory purchase of diagrams, it seems worthwhile trying to capture this thesis' account of the factors affecting the ways in which ideas relating to health inequalities have been constructed, circulated and translated. So, inspired by Dahlgren and Whitehead's (1991) 'rainbow model' of the determinants of health, Figure 9.1 therefore attempts to do this.

Figure 9.1: A 'rainbow model' of the factors shaping the construction, circulation and translation of research-based ideas about health inequalities



(Inspired by Dahlgren & Whitehead 1991)

As with virtually all diagrams, one drawback to the above depiction is its inevitable sense of immobility and fixity, which contrasts sharply with the dynamism of what this thesis tries to



describe. The wiggly arrows are therefore included to help emphasise a sense of movement within and across the various layers. 'Policy' is placed at the centre of the rainbow to represent its centrality to this thesis, which began by asking how health inequalities research has informed policy and went on to explore the journeys of ideas about health inequalities from research into policy. As Chapter Three reflects, 'policy' can mean a number of different things, from broad ideological directions, through particular programmes of activity, to specific documents. In this diagram, the circle in which 'policy' is placed signifies all of these activities, although this thesis focuses most overtly on specific policy documents.

'Research activity' forms a middle layer of the rainbow, signifying that, as well as representing a source of new ideas that might travel into policy, research activity is itself shaped by other ideas that are circulating. As this thesis demonstrates, researchers in the field of health inequalities described having been influenced by their perceptions of what research funders are likely to fund (as well as their actual ability to secure funding). In addition, many of the interviewees who participated in this research suggested that they were, at least to some extent, orientated towards (or aware of) the perceived preferences of policy audiences. Finally, nearly all of the interviewees said something to suggest that their perceptions of the wider social and political 'contexts' in which they were located influenced the ideas that they helped construct and promote. In other words, as Figure 6.2 in Chapter Six illustrates, the activities of researchers (especially those who would like to inform policy) are influenced by their perceptions of a number of quite different audiences.

The ideas that researchers construct are then, almost always, presented in some form of textual or visual medium, whether it be an article for an academic journal or a presentation to academic colleagues, a report for, or presentation to, policymakers, or an account in mass media outlets. Once encapsulated in a textual or visual document, the potential increases for an idea to be translated by readers (or viewers) in ways that the author(s) did not necessarily envisage (Barthes 1986). In other words, like policy documents (Freeman 2006), these documents themselves have some degree of agency. Hence, a layer of the rainbow diagram specifically represents the various media through which ideas are articulated.

Moving down the rainbow, the next two layers, 'individuals' and 'institutions', are represented by a curved, double-helix, to illustrate the ways in which these actors/arenas interact with one another to shape the movement of ideas. So, in addition to being translated into and out of various media incarnations, ideas move between research and policy ideas through their translation between individuals and these individuals' actions and interactions are shaped by their institutional locations. As Chapter Seven illustrates, the lack of connectivity and institutional memory within policy institutions means that the translation of ideas between research-based and policy-based actors does not necessarily secure their full translation into policy. For this to occur, ideas must be translated into specific documents and, eventually, institutionalised within policy organisations. Truly successful ideas may become so embedded within the way that actors think and communicate, that they may become elevated to the status of a 'facts', at which point they may become rather less easy to identify as ideas, as Chapter Eight discusses.

As ideas become institutionalised, they feed into the wider political and social 'contexts' that actors perceive, a process represented in Figure 9.1 by the upturned, curved arrows emanating from 'policy' and feeding into the outermost layer. This outer layer is rather more amorphous than some of the others, which is captured in the diagram by the less solid colouring of this layer. However, the findings that Chapter Eight discusses suggest it nevertheless makes sense to include it as a layer in its own right because of the way that actors' often *referred* to 'context' (or 'contexts') as a monolithic actor.

Due to the number and complexity of the interactions involved, neither the original rainbow model nor this revised one suggest that it is possible to predict what the outcomes of the interactions between the various layers will be for any particular individual/idea. However, just as the original rainbow model helpfully captures the complexity of the factors which can potentially combine to determine individual health outcomes, Figure 9.1 captures the factors which this thesis argues shape the way in which research-based ideas about health inequalities are constructed and circulated. The model is particularly helpful in highlighting some of the boundaries across which ideas must be translated if they are to move between research and policy. As discussed above, it is in making the transition across boundaries, so



between the various layers of the rainbow, that ideas appear to be particularly vulnerable to significant transformation.

The model also reflects the way in which the interplay of ideas between research and policy is ongoing (rather than finite) and multi-directional (rather than uni-directional). For example, the construction of an idea (or set of ideas) about health inequalities is initially shaped by researchers' perceptions of what will be deemed credible amongst actors who are located in various different layers of the rainbow (whose activities and interactions are themselves shaped by their perceptions of the various layers). However, it is not possible to pinpoint any precise starting point to this process as it is informed by a huge variety of factors, including ideas which have already been institutionalised, research that has already been undertaken, what researchers believe will be deemed academically and politically 'acceptable' (or even 'desirable'), and the research funding that is made available and obtained (or not). In other words, the starting point for new research-based ideas lies with the ideas which are already being circulated and translated. Furthermore, when new ideas are constructed, they are continually transformed as they are translated across the various layers of the model. The fact that the wiggly arrows in Figure 9.1 are double-headed reflects the importance of understanding that ideas are translated from policy into research, as well as the other way round.

However, the diagram is far from perfect. For a start, it is less good at emphasising the interactions and translations which take place *within* each of the layers than it is at highlighting the importance of the boundaries across which ideas must be translated. Perhaps more importantly, the clearly defined depiction of each layer in this model belies the difficulty in circumscribing precisely what (or who) constitutes each layer (a point touched on in section 4.1, Chapter Four, in relation to the categorisation of interviewees). Finally, the model adds little, if anything, to understanding whether there is anything about the specific characteristics of ideas themselves which influence the ways in which they are translated between actors and across boundaries. It is this latter issue which the following section focuses on.

### 9.3 Three genres of ideas: A Weberian typology

So far, three key genres of ideas have been employed within the thesis: 'charismatic ideas', 'institutionalised ideas' and 'vehicular ideas'. In many ways, the two, Weberian inspired genres – 'charismatic' and 'institutionalised' ideas - are antithetical to each other. Institutionalised ideas are those which have been able to move so successfully across boundaries that they have become embedded within the organisation of institutions and the language with which actors communicate their ideas. These, then, are ideas which, through their continual and effective circulation within networks, are able to exhibit the characteristics of 'facts' or 'macro-level contexts'. It is important to emphasise that the term 'institutionalised' is an adjective which is attached to ideas that have undergone a *process* of institutionalisation. So, in contrast to the terms 'charismatic' or 'vehicular' ideas, 'institutionalised ideas' focus on the qualities of ideas *resulting* from their successful circulation, rather than the qualities of ideas which *enable* them to circulate. Once embedded, however, 'institutionalised ideas' move between actors and across boundaries in ways which work to maintain, reinforce and further embed their appearance as 'facts' or 'contexts'. This ongoing process affects the movement of ideas that have not yet been institutionalised by encouraging the translation of those ideas which complement (or at least do not overtly challenge) institutionalised ideas, whilst simultaneously working to 'block' ideas which do significantly challenge these ways of thinking. Accordingly, the findings in this thesis suggest that ideas about health inequalities which fit within the boundaries of ideas that have already been institutionalised (i.e. the primacy of the national economy and a medical model of health) have found it far easier to travel between actors and across boundaries (experiencing only minimal transformation in this process) than ideas which do not.

The concept of 'institutionalised ideas' shares a great deal with Foucauldian inspired discussions of 'discourse' (see section 3.1 in Chapter Three). Both terms are employed to explain how certain 'truths' or 'facts' are produced and maintained and both focus on the ways in which these 'truths' (ideas) work to shape the ways in which individuals think, communicate, act and interact. However, unlike the way in which many authors employ the term 'discourse', 'institutionalised ideas' are not presented as a means by which different forces are actively advancing particular interests or projects (Howarth 2000). This is not to say that the institutionalisation of particular ideas does not serve the interests of particular actors – it is



highly likely that they do – but this process does not necessarily rely upon the existence of an underlying political project. So, whilst authors who employ 'discourse' as an analytical tool are usually concerned with uncovering the nature of the underlying interests that are driving the promotion or maintenance of particular 'truths', employing the concept of 'institutionalised ideas' shifts the spotlight to focus on the *mechanisms* through which these ideas are able to operate as 'truths' or 'facts'. For example, both Chapters Six and Eight focus on the circular processes through which actors' perceptions of other actors' preferences, or of macro-level 'contexts', influence their own actions and interactions in ways which often help enact, or reinforce, the situations that they describe.

Crucially, both terms capture the sense in which particular ideas can become so deeply embedded in the way in which society is organised, and the language that actors employ to communicate, that it becomes extremely difficult to find a space in which it is possible to critically assess or challenge the assumptions on which they are based. Whilst proponents of Foucauldian inspired 'discourse analysis' suggest that critically analysing the ways in which particular 'discourses' operate begins to open up the possibility of thinking in alternative ways, the Weberian/Latourian framework developed within this thesis focuses on the possibility of the emergence of ideas that have the capacity to challenge those that have been institutionalised. These ideas, as Chapter One outlined, have been labelled 'charismatic ideas'.

By their very nature, 'charismatic ideas' constitute a truly alternative way of thinking which offer the potential of disrupting the networks which allow 'institutionalised ideas' to dominate, thereby transforming the ways in which policy and society are organised. Consequently, charismatic ideas are likely to seem irrational to many (at least initially) because they challenge accepted ways of thinking. They are ideas which seek to challenge perceptions of reality, replacing what is perceived to be the legitimate vision of the world with something quite different (see Kalyvas 2002). Indeed, as section 1.3 in Chapter One recounts, Weber describes 'charismatic authority' as being 'specifically irrational in the sense of being foreign to all rules' (Weber 1992 [1968], p244). In the context of Figure 9.1, outlined in the previous section, 'charismatic ideas' would be those with the capacity to transform actors' perceptions of the contexts within which they are operating, thereby transforming how they operate, in-line

with the new idea. It should perhaps be noted at this point, as Chapter One discusses, that Weber more usually applied the notion of 'charisma' to *individuals*, whereas (informed by the data) this thesis places the focus on *ideas*. These two foci are entirely complementary, however. Indeed, where 'charisma' is easily identifiable, we might expect to find a 'charismatic alliance' of individuals *and* ideas with charismatic qualities.

Employing the typology of journeys that Chapter Five outlines, we would expect 'charismatic ideas' (or ideas promoted by charismatic individuals) to have experienced a 'successful' journey into policy, despite challenging dominant policy approaches/assumptions. As this thesis demonstrates, however, the only example of a 'successful' journey of a research-based idea about health inequalities into policy during the study period appeared to be the importance of focusing on the early years of life and this idea does not really warrant the label 'charismatic', being relatively unchallenging to existing ways of thinking (as it is neither in conflict with a medical model of health, nor, necessarily, with the economic orientation of public policy). This is not to say, however, that 'charismatic ideas' are completely absent from this thesis. Indeed, the story of how health inequalities came to be seen as a 'policy problem' in the first place could itself be understood as an example of the influence of a 'charismatic idea' or, alternatively, as an idea that successfully journeyed into policy as the result of the combined efforts of charismatic individuals (Berridge & Blume 2003). However, as would be expected, having metamorphosed into an institutionalised idea that is embodied within official documents, targets and institutional structures, the notion that health inequalities constitute a 'policy problem' no longer appears charismatic. Nevertheless, it is important to acknowledge that this situation represents the successful journey of a significantly challenging idea from research into policy.

In some senses, it is not surprising that no examples of 'charismatic ideas' about health inequalities were identifiable within the study period for, whilst ideas that have become institutionalised necessarily exist (although they may not be easily identifiable), Weber's analysis of charisma suggests it is a quality which emerges infrequently, if at all. However, the moment at which the period of study for this thesis began did seem to hold some potential for the emergence of 'charismatic ideas' about health inequalities. For one thing, the official commitment to reducing health inequalities in Scotland and England appeared to relax



previous constraints on researchers who were interested in the area, opening up new possibilities for funding and enabling researchers to feel less wary about the career consequences of working in this area. In addition, the political drive to achieve 'evidence-based policy' held the promise of encouraging a dialogue between researchers and policymakers. Yet, despite this, no evidence was found of ideas which were able to effectively challenge already 'institutionalised ideas'.

This is not to say that ideas which appeared to pose a *challenge* to institutionalised ideas had not emerged or, indeed, been able to move from research into policy. Indeed, Chapter Five demonstrates that most of the ideas about health inequalities that are presented in Chapter Two are evident within policy to some extent. However, the processes of translation that these ideas had undergone appeared to have resulted either in: (i) their being partially 'blocked' by the institutionalised ideas which they sought to challenge; or, more commonly, (ii) their translation into policy in ways which allowed them to fit within the boundaries of the institutionalised ideas. Whilst these ideas therefore cannot be described as unsuccessful – they have, after all, moved from research into policy – they fit neither within the genre of 'institutionalised' nor 'charismatic' ideas. The characteristics of these ideas which appear to have enabled them to move successfully between actors and across boundaries is their elasticity and transformability. It is these qualities that are captured by the third genre of ideas referred to in this thesis; the chameleon-like ideas that, as Chapter Six outlines, Osborne (2004) has termed 'vehicular'. The key qualities of this genre of ideas, as McLennan (2004, p485) describes, is their 'ineliminable vagueness and 'mobility'', which allows them to transform with relative ease as they move between actors and across contexts. In other words, they are ideas which are able to move successfully through the various layers of Figure 9.1 because they are *transformable* rather than *transforming*. The best example of this genre of idea seemed to be psychosocial ideas about health inequalities, which appeared to have been able to travel into policy only once their more challenging facets (the importance of relative inequalities) had been cast aside in favour of an emphasis on aspects relating to 'social capital', community relations and individuals' sense of self-confidence and control.

This three-genre typology of ideas helps explain why the various research-based ideas about health inequalities that are outlined in Chapter Two experienced the different journey types

that Chapter Five outlines. Importantly, by focusing on the qualities of ideas that enable them to move between actors and contexts, this typology responds to Blyth's (1997) call for the need to more adequately reflect on what ideas are and what they do. In addition, this theoretical approach aims to tread a careful balance between the emphases placed on the agency of actors and their ideas, and the contexts in which both are situated. Hence, it relies neither on the presence of over-arching political and economic structures nor on all-powerful individuals.

In summary, the application of this three-genre typology suggests that research-based ideas about health inequalities have been able to move into policy either because they already fit within the boundaries of institutionalised ideas (in which case they may even have been 're-contextualised', i.e. applied within policy in ways which the research does not necessarily support) or because they have been translated in ways which limit any challenges to the institutionalised ideas that they may have posed. Hence, the ideas which have moved successfully from research into policy have either been those which pose no challenge to institutionalised ideas (such as a focus on the early years of life, a concern with lifestyle-behaviours, or an emphasis on the role of health services in tackling health inequalities) or those with the metamorphic qualities of vehicular ideas (such as psychosocial theories about health inequalities). As discussed above, ideas about health inequalities which have the qualities outlined in the remaining genre, 'charismatic ideas', appear disappointingly absent from the data.

The descriptive account of policymaking implied by this framework fits with those theories that evoke an image of policy development as a series of 'punctuated equilibriums' (see subsection 1.2.4 in Chapter One). However, this framework aims to contribute to discussions about the mechanisms which drive this kind of development, rather than merely describing the aesthetic features of policy development. Importantly, and unlike some of the other theoretical ideas that were outlined in Chapter One, this Weberian framework always remains open to the possibility that significant policy change can and might occur. This means that, where change does not occur, it becomes necessary not only to focus on the ways in which institutionalised ideas have operated but also to examine the failure of charismatic ideas to emerge. Consequently, for a situation such as the one outlined within this thesis – where there



appeared to be a political moment in which the *potential* for a significant, research-inspired policy change was high but in which charismatic ideas still failed to emerge – the framework focuses attention on the factors which have shaped (and constrained) the development and promotion of research-based ideas. The following section specifically addresses this issue.

#### 9.4 The squeeze on imaginative spaces

Given that the emergence of charismatic ideas depends on the ability of individuals to think outside the current boundaries of rationality and acceptability (see Kalyvas 2002) and, in light of the effects of institutionalisation on individuals that Weber (1968b) famously describes, it is clear that he believed the potential for such ideas to develop within bureaucratic societies would be increasingly slim (see section 1.3 in Chapter One). That said, many of Weber's essays suggest that he did not believe the emergence of charisma was *dependent* on an amenable context (see, for example, Weber 1991 [1915]). Indeed, as Dow argues:

“[O]ne may conclude that the charismatic phenomenon is not bound necessarily to any particular historical period. As we have argued, there is no likely time or place for the form of transcendent change contained in any charismatic movement. All times are against such change, and it is precisely the fact that charisma is not a necessary development from any set of present circumstances that makes it a truly revolutionary departure. That we, of necessity, lack a clear vision of the forms that such departures might take in the future, is not to be construed as a limiting factor on such possibilities. [...] [However,] we do not accept a completely asocial or ahistorical perspective. The occurrence of a specific charismatic episode is indeterminate as to time and place-and yet the frequency of charismatic events may be greater under some circumstances than others.” (Dow 1969, p311)

This suggests that, whilst unlikely, charismatic ideas still have the potential to emerge in even the most bureaucratic and institutionalised societies. What is more, as discussed in the previous section, at face value, the study period seemed to be one which offered the potential for research activities and discussions about health inequalities to be far more open than they had been (see sub-section (i) in section II of the Prologue). Hence, one might have expected the prospects for charismatic ideas about health inequalities to have been somewhat greater than in the previous eighteen years of Conservative rule. With this in mind, it is necessary to reflect on what the findings of this thesis indicate about factors that may have actively

contributed to minimising the potential for charismatic ideas to emerge from the research community.

Of course, it must be acknowledged that researchers are far from the only potential source of charismatic ideas. Nevertheless, the combination of researchers' role in ensuring health inequalities moved onto the policy agenda with New Labour's policy emphasis on evidence-informed policy suggests that researchers were one of the main sources of potentially charismatic ideas about health inequalities during the study period. What is more, in his own time, Weber (1995 [1906], 1995 [1917]) saw the 'intelligensia' as a uniquely free-thinking section of society and a potential source of radical and innovative ideas. This notion has been echoed many times since then including, notably, by Edward Said who, in his 1993 Reith Lectures, described 'intellectuals' in the following terms:

'There is no question in my mind that the intellectual belongs on the same side with the weak and unrepresented. Robin Hood, some are likely to say. Yet it's not that simple a role, and therefore cannot be so easily dismissed as just so much romantic idealism. At bottom, the intellectual in my sense of the word, is neither a pacifier nor a consensus-builder, but someone whose whole being is staked on a critical sense, a sense of being unwilling to accept easy formulas, or ready-made clichés, or the smooth, ever-so-accommodating confirmations of what the powerful or conventional have to say, and what they do. Not just passively unwilling, but actively unwilling to say so in public.' (Said 1994, p17)

The 'intelligensia' or 'intellectuals' are not interchangeable with 'researchers' and, indeed, whilst it is clear that there is a significant research population within the UK, some have questioned whether or not there has ever been such an intellectual culture (see, for example, Osborne, 1998 on intellectuals in England, whom he describes as 'notoriously supine' on p159). Furthermore, Weber's reflections on, and prophecies about, the ways Western societies were developing often evoked a sense in which increasing institutionalism would limit the abilities of individuals to think outside the current boundaries of rationality. In his Reith Lectures, Said's claims that academia was experiencing an increasing tendency towards 'professionalisation' suggests that Weber's concerns had been well-founded:

'By professionalism I mean thinking of your work as an intellectual as something you do for a living, between the hours of nine and five within one eye on the clock, and another cocked at what is considered to be proper,



professional behaviour – not rocking the boat, not straying outside the accepted paradigms or limits, making yourself marketable and above all presentable, hence uncontroversial and political and ‘objective.’ (Said 1994, p55)

Said went on to focus on a number pressures within academia which he felt were contributing to this trend, including a growing tendency towards specialisation, which he felt was limiting academics’ capacities to think in cross-cutting and imaginative ways (resonating Weber’s concerns about the effects of bureaucratisation). In addition, Said warned that to be considered an ‘expert’ required being ‘certified by the proper authorities’. As a result, Said (1994, p59) reflected on the, ‘inevitable drift towards power and authority’ within academia; ‘towards the requirements and prerogatives of power, and towards being directly employed by it.’ These concerns, raised just four years before the start of the period on which this thesis has focused, suggest that academia had already begun moving in a direction in which the space for creative and radical thinking was being squeezed<sup>16</sup>.

The interview data gathered for this thesis suggest that this squeeze has continued, at least for health inequalities in Scotland and England, with the imaginative (intellectual) space from which charismatic ideas might have been expected to emerge appearing to have been severely limited during the study period. Crucially, the ‘emergent mood’ about the future, which, as Collins (2005) outlines, Weber believed to be an essential part of the materialization of charisma, does not appear to have been in existence. As Chapter Eight demonstrates, none of the interviewees seemed to believe that health inequalities were likely to be effectively tackled in the near future. This was partially reflected in the widespread belief, expressed by interviewees, that much of the media and most of the public were largely apathetic about the issue. Hence, health inequalities were frequently presented as an issue through which it was unlikely to be possible to convince others of any necessity for radical change. The necessary belief that an alternative future will (or at least could) come to pass was, consequently, missing.

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<sup>16</sup> I should note, however, that I found absolutely no evidence of academics’ ‘clock watching’ in a nine-to-five sense – in fact, quite the opposite.

In its place, there appeared to be a fairly widespread glumness amongst researchers and, as Chapter Eight highlights, it was noticeable that a significant number of the research-based interviewees suggested that they were now turning their attention either to other locations (e.g. other countries or international policy institutions) or to other issues (notably the links between health and environmental issues but also genetics). There are, of course, many reasons why researchers might look to new topics and locations, including the credibility associated with ideas that are perceived to be 'new' and perceptions about the availability of funding (see Chapter Six). However, the data suggest that some researchers were exploring new fields, particularly ideas relating to climate change, because they believed that such areas may offer more charismatic opportunities for the kinds of ideas about reducing health inequalities that they supported / believed in.

The situation described in this thesis raises some important questions about the impact of calls for 'evidence-based policy' on the production of research-based ideas. Indeed, the data suggest that the promotion of the idea that policy ought to be better informed by research may well have contributed to the imaginative squeeze, much as Hammersley (2003, 2005) and others (e.g. Cohen 2000) feared. For the flip-side of this approach to policy has been a pressure on researchers to become more attuned to, and informed by, 'policy needs' and 'policy realities'. This is most overtly demonstrated in Chapter Six, where interview extracts demonstrate the importance that researchers placed on policy and funding audiences when they were considering both how to construct and promote ideas based on their previous research activities and which new ideas to pursue.

According to many of the interviewees who participated in this project, the space in which discussions about health inequalities research ideas take place changed significantly before and after the mid-nineteen-nineties. Prior to this, work in this area was known to be politically 'difficult' and the area was not seen as one in which funding opportunities were likely to be particularly high. Therefore, those researchers who chose to engage with this area of research were already pushing the boundaries of what they felt was considered politically 'acceptable'. As a consequence, the limitations on research into health inequalities during this period were widely recognised and, indeed, have since been reflected upon (e.g. Bartley, Blane, & Davey Smith 1998; Berridge & Blume 2003). In contrast, any limitations on thinking



about and discussing health inequalities since this time have been largely un-discussed (at least publicly). Yet, the findings in this thesis suggest that the pressure on researchers to focus on exploring issues in ways that are likely to be applicable to current 'policy realities' could be perceived as a pressure to produce 'policy-informed evidence' (or, more accurately, policy-informed, research-based ideas). Such a phrase foregrounds the extent to which 'institutionalised ideas' work to shape and inform the research from which new ideas emerge. This suggests, as Said argued over a decade ago, that, as academics, we ought to be rather more concerned with the limitations on imaginative, intellectual spaces in the Western world:

'[I]n spending a lot of time worrying about the restrictions on thought and intellectual freedom under totalitarian systems of government we have not been as fastidious in considering the threats to the individual intellectual of a system that rewards intellectual conformity, as well as willing participation in goals that have been set not by science but by the government; accordingly, research and accreditation are controlled in order to get and keep a larger share of the market. [...] In other words, the space for individual and subjective intellectual representation, for asking questions and challenging the wisdom of a war or an immense social program that awards contracts and endows prizes, has shrunk dramatically from what it was a hundred years ago when Stephen Dedalus could say that as an intellectual his duty was not to serve any power or authority at all.' (Said 1994, p61)

The concerns Said raised in the above passage do not yet appear to have been addressed. Instead, the promotion of the need for 'evidence-based policy' during the past decade may, if anything, have further contributed to some of the trends Said was reflecting upon. This is not to say that the notion of 'evidence-based policy' is itself innately restrictive but rather that the way in which the concept has been promoted and employed needs to be further explored and unpacked. Given that the pressure on academics to 'disseminate' their work to policy-relevant audiences still appears to be increasing, the findings in this thesis suggest that further discussion about, and reflection upon, the desirability of different kinds of academic (intellectual) spaces is much needed.

### **9.5 Creating some space for charismatic ideas: the case for 'ideas-based policy'**

The conclusions of this thesis are, overall, quite pessimistic about the potential for research on health inequalities to play an influential, transformative role in policymaking within the UK. They suggest that official commitment to reducing health inequalities in Scotland and England,

and to increasing the use of research in policy, probably have helped the flow of ideas about health inequalities between research and policy. However, this flow has not been unidirectional and, crucially, 'institutionalised ideas' appear to have constrained the ideas that have emerged from research. So, whilst official commitment to 'evidence-based policy' may have helped increase the frequency with which ideas about health inequalities move from research into policy, the ideas that have been effectively translated and circulated are either those which fit within the boundaries of already 'institutionalised ideas', or those with the metamorphic qualities of 'vehicular ideas'.

On a more positive note, the Weberian/Latourian theoretical framework which has been developed to help conceptualise the findings suggests that this situation is neither inevitable nor unchangeable. For one thing, thinking about political and social 'contexts', or deeply institutionalised ideas, from an actor-network theoretical perspective denies the existence of large, monolithic actors and deliberately emphasises the role that networks of 'smaller' actors play in helping to facilitate the apparition of gargantuan actors. In addition, given that Weber's observations about the processes of institutionalisation have proved so central to this thesis, it seems sensible to remain open to the possibility that the kinds of charismatic forces which Weber also identifies at least have the *potential* to emerge. However, if academic research is to provide any space for ideas with these kinds of qualities to be developed, the findings suggest some changes are required.

Many of the changes that the interviewees themselves suggested they would like to see in relation to the organisation of academia have been widely reported and discussed, including the process of the Research Assessment Exercise and the varying balances between teaching and research. The potential for change in these areas is not, however, the focus of this thesis. What the conclusions of this thesis do suggest is that it would be both more honest and possibly more helpful for conversations concerning 'evidence-based policy' to be replaced with discussions about 'ideas-based policy'. Not only does the phrase 'ideas-based policy' help focus attention on the centrality of ideas to understanding the relationship between research and policy but it also places a spotlight on the characteristics and qualities of different ideas. This should help highlight the influence of 'institutionalised ideas' on the emergence and circulation of other ideas; an influence which appears to have been effectively



masked behind the notion of 'evidence-based policy' during the study period. The purpose of such a shift would be to enable conversations to take place outside the boundaries of 'institutionalised ideas'. In other words, a focus on 'ideas-based policy' might help facilitate more imaginative research spaces to develop, spaces from which charismatic ideas may be more likely to emerge.

In making this case, it is necessary to acknowledge that charismatic ideas will not necessarily bring research and policy relating to health inequalities any closer together. After all, as Weber continually stresses, charisma is a value-neutral term which cannot always be expected to act as a positive or ethical force (see Dow 1969, 1978 and the discussion of this issue in section 1.3, Chapter One). What a shift to the notion of 'ideas-based policy' might achieve, however, is an increase in the attention given to struggles between conflicting ideas and values. So, rather than the kinds of conversations which 'evidence-based policy' appears to have encouraged, in which certain ideas are treated as unchangeable facts (and, consequently, others as impossible dreams), 'ideas-based policy' opens up the opportunity for more radical and imaginative dialogue.

As a final point, given both the focus of this thesis on research and the fact that it is in itself the output of research, it is important to emphasise that the case being made for a shift to 'ideas-based policy' does not imply that research is in any way an unnecessary activity that could be replaced by abstract philosophical debates about the merits and deficiencies of particular ideas. Rather, as Weber (1968d) argues in *Science as a Vocation*, the role of science in society is not to tell us what we should do or how we should live, but to make more meaningful choices possible.

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## Appendix I: Policy documents included analysis

### England

Title	Date	Description/notes
1. <i>Our Healthier Nation - A Contract for Health</i>	February 1998	Green Paper setting out the Government's proposals to improve people's living conditions and health (consultative document leading to Saving Lives White Paper). Proposes a 'contract for health' between the Government, local organisations and individuals. Sets four health improvement targets (but none relating to health inequalities).
2. <i>The NHS performance assessment framework</i>	01/03/1999	This document sets out the NHS Performance Assessment Framework [PAF], revised following the consultation and road test over the Spring and Summer of 1998, for implementation from April 1999. The PAF formed part of the government's attempt to make information about the quality and performance of health care services available to the public, with the aim of improving performance. This version of PAF only mentions health inequalities three times but it does claim that PAF will help efforts to reduce health inequalities.
3. <i>Reducing Health inequalities: an action report</i>	June 1999	An official response to the publication of the Acheson's <i>Independent Inquiry into Inequalities in Health</i> , which was commissioned by the government and published in November 1998. This policy statement claims to detail the 'breadth' of the government's response to the <i>Independent Inquiry</i> , although many of the initiatives listed within it were announced prior to the publication of the <i>Independent Inquiry</i> .
4. <i>Saving lives: Our Healthier Nation</i>	05/07/1999	The White Paper, which followed <i>Our Healthier Nation - A Contract for Health</i> . Sets out the Government's action plan for improving health and reducing health inequalities. It sets four key targets for health improvement but none for health inequalities. Of the 11 chapters, the first is an introductory overview, two focus on chronic diseases (cancer and CHD/stroke) and two others on 'accidents' and 'mental health', one focuses on individuals and one on communities, then two focus on public health and 'wider action', and the last two focus on how to implement initiatives (through partnership working, monitoring, etc).
5. <i>The NHS Plan: a plan for investment, a plan for reform</i>	01/07/2000	The NHS Plan plans for changes to the health service in England. Chapter 13 focuses specifically on improving health and reducing health inequalities. This chapter includes a commitment to producing national targets for the reduction of health inequalities in 2001.
6. <i>A New Commitment to Neighbourhood</i>	January 2001	A report from the Social Exclusion Unit (Cabinet Office), outlining strategy for the



<p><i>Renewal: A National Strategy Action Plan</i></p>		<p>Government's vision for 'narrowing the gap between deprived neighbourhoods and the rest of the country'. Aims to ensure 'that within 10 to 20 years, no-one should be seriously disadvantaged by where they live.' Refers to health inequalities quite extensively, although usually locates responsibility for this issue largely with the Department of Health.</p>
<p>7. <i>Shifting the balance of power within the NHS: Securing delivery</i></p>	<p>27/07/2001</p>	<p>This statement focuses on changes to the NHS but is the first official document to include the national targets for reducing health inequalities, which were announced by the Secretary of State in February 2001.</p>
<p>8. <i>From vision to reality</i></p>	<p>23/08/2001</p>	<p>Sets out how the government sees its progress in relation to its commitment to reducing health inequalities. Focuses on the role of the NHS and public health, on tackling the 'big killers', working in partnership and improving the evidence-base of policies.</p>
<p>9. <i>Shifting the Balance of Power: The Next Steps</i></p>	<p>04/01/2002</p>	<p>This document largely focuses on changes to the NHS but it was included in the analysis on the basis that it mentions health inequalities eleven times, largely in relation to the role that the NHS can/should play in reducing health inequalities.</p>
<p>10. <i>Health inequalities – National targets on infant mortality and life expectancy – Technical briefing</i></p>	<p>05/03/2002</p>	<p>As mentioned above, two national health inequalities targets were announced in February 2001, one relating to infant mortality and the other to life expectancy. This document assesses the progress made towards these targets and explains what the latest data show.</p>
<p>11. <i>Tackling health inequalities through local public service agreements</i></p>	<p>02/10/2002</p>	<p>A Department of Health document which contains guidance for Local Authorities. Encourages those authorities within, or near, the bottom fifth for life expectancy to adopt a Local Public Service Agreement target on health inequalities.</p>
<p>12. <i>Improvement, expansion and reform – the next 3 years: priorities and planning framework 2003-2006</i></p>	<p>02/10/2002</p>	<p>Focuses on advising local health and social service organisations what they ought to do over the next three years in order to achieve various government aims, including the reduction of health inequalities. It identifies national priorities and targets (including for health inequalities) which organisations are required to build into their local plans.</p>
<p>13. <i>Tackling health inequalities – 2002 cross-cutting review</i></p>	<p>19/11/02</p>	<p>A 'cross-cutting' review was set up, with help from the Treasury, to establish how a wide range of government departments could contribute to the policy aim of reducing health inequalities. Claims to set out 'a long term strategy to reduce health inequalities'. Notable for the number of government departments that signed up to it (as well as the DH and the Treasury, the ODPM, DWP, Department for Transport, Department for Education and Skills, the Home Office, Department for the Environment, Food and Rural Affairs, Department for Culture, Media and Sport and the Department for Trade and Industry all</p>



			signed up to this statement, as well as several NDPBs.
14. <i>Tackling Health Inequalities: A Programme for Action</i>	July 2003		Reviews progress against, and sets out what the government intends to do (and is requiring/encouraging other organisations to do) in order to help meet, the 2010 national health inequalities targets. Includes section focusing on performance management of local organisations.
15. <i>Health equity audit: a self-assessment tool</i>	15/01/2004		Emphasises that PCTs need to use HEA tool if the 2010 target on inequalities is to be met. States that PCTs will be performance managed on this.
16. <i>Local Area Agreements: a prospectus</i>	July 2004		ODPM document which sets out a new initiative called 'Local Area Agreements' (to be implemented through Local Strategic Partnerships) which is designed to improve relationships between central and local government and between local authorities and their partners. As part of this, the document encourages local authorities to work with other sectors to help reduce health inequalities.
17. <i>Choosing Health: Making healthy choices easier</i>	16/11/2004		The second White Paper on public health (concerned largely with improving population health and reducing health inequalities) to be released during the study period, this document sets out the key principles for 'supporting the public to make healthier and more informed choices in regards to their health.'
18. <i>Tackling health inequalities: the spearhead group of Local Authorities and Primary Care Trusts</i>	19/11/2004		This document outlines the Public Service Agreement targets on Health Inequalities. It also sets out the Spearhead Group Local Authority Districts and Primary Care Trusts, which underpin the geographically based Health Inequalities aspects of the targets on Life Expectancy, Cancer and Heart Disease, Stroke and related diseases.
19. <i>Tackling health inequalities: what works?</i>	01/02/2005		The aim of this document is to provide (non-mandatory) advice and guidance to NHS planners and commissioners (especially those in the Spearhead Group of areas) about what they can do to help reduce health inequalities and meet the national targets. It focuses on the NHS activity which the government expected would help attain the national health inequalities targets.
20. <i>Delivering choosing health: making healthier choices easier</i>	09/03/2005		A delivery plan relating to the <i>Choosing Health</i> White Paper, referred to above, which also outlines all of the relevant Public Service Agreements and local targets, with the aim of bringing all the relevant targets/commitments together in one document. It outlines the priorities for delivery at national, regional and local levels and states what will be done, by whom and when.
21. <i>Tackling health inequalities: Status</i>	11/08/2005		A status report which reviews developments and data relating to progress since the



<p><i>report on the Programme for Action</i></p>		<p>publication of the <i>Programme for Action</i> in 2003. It considers progress against the Public Service Agreement target, the national headline indicators and against government commitments. Finding progress limited (albeit within a very short time), the report highlights the 'challenging nature of the health inequalities PSA target for 2010.'</p>
<p>22. <i>Health Inequalities - Rising to the Challenge</i></p>	27/10/2005	<p>Published by the Municipal Journal on behalf of the Department of Health's HIU in partnership with the ODPM and the Local Government Association. Designed to highlight what is being done to tackle health inequalities and to promote successful local initiatives</p>
<p>23. <i>Our health, our care, our say: a new direction for community services</i></p>	30/01/2006	<p>A White Paper which sets a new direction for 'the whole health and social care system' (follows on from the Green Paper, <i>Independence, Well-being and Choice</i>). Aims to give people a bigger 'say' in how local services are run. Includes a sub-section which specifically focuses on health inequalities (under a section focusing on 'Better Access to General Practise').</p>
<p>24. <i>Health Challenge England – next steps for Choosing Health</i></p>	10/10/2006	<p>Aims to provide policymakers 'across the public, business, voluntary and community sectors' with advice about what they can do to help reduce health inequalities and implement the vision set out in the 2004 White Paper <i>Choosing Health</i>. Sets out what it refers to as the Department of Health's 'new approach to public health, which aims to ensure that all sectors of society can contribute to the nation's health.'</p>
<p>25. <i>Our health, our care, our say: Making it happen</i></p>	18/10/2006	<p>Provides an update on progress of the implementation of the 2006 White Paper and sets out 'a road map' to further implementation. Designed to provide a resource for relevant local bodies.</p>

## Scotland:

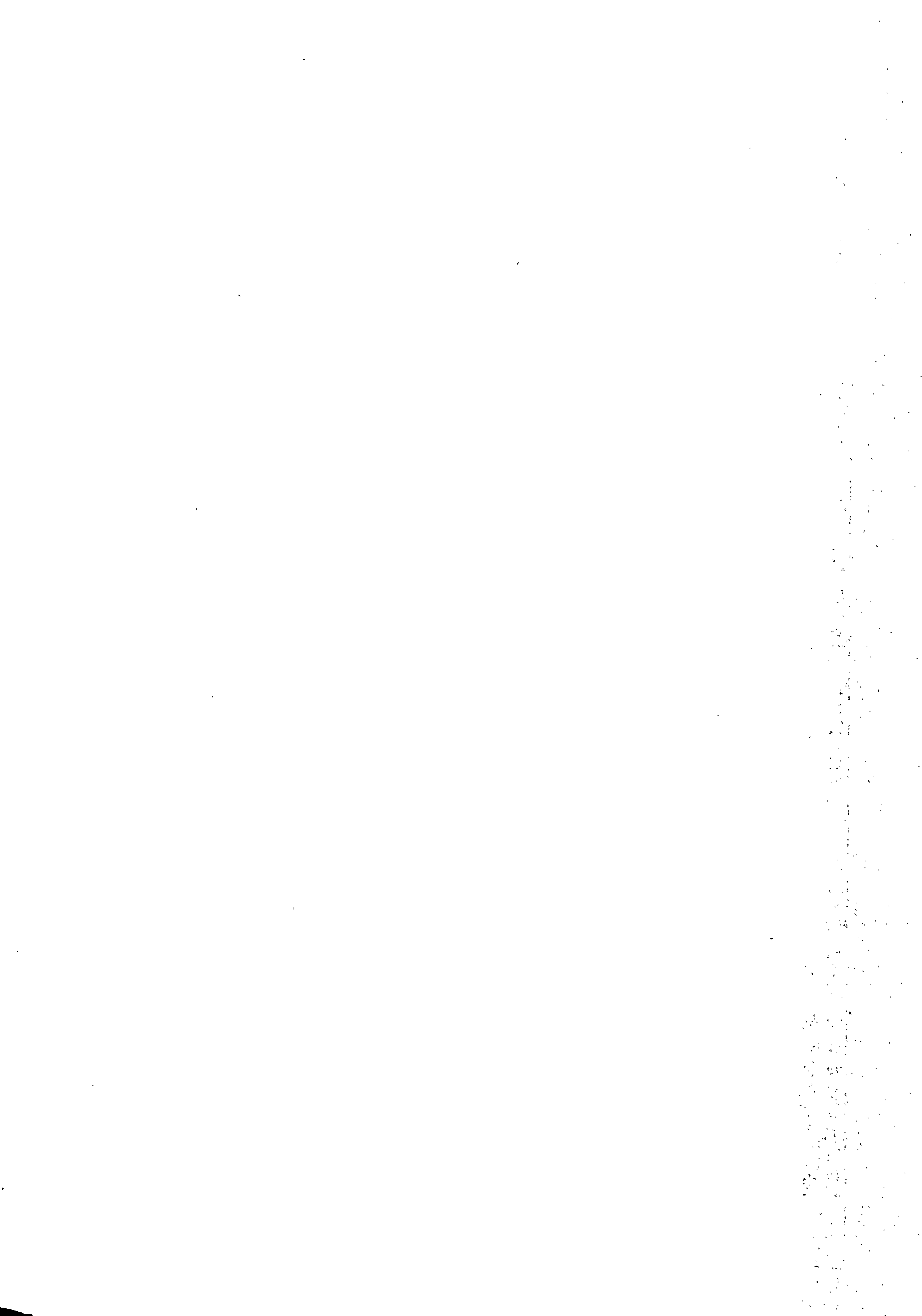
Title	Date	Description/notes
1. <i>Designed to Care Renewing the National Health Service in Scotland</i>	8/12/1997	First post-1997 White Paper focusing on NHS Scotland, which it claims will focus on the specific needs of Scotland. States that the aim is to achieve an NHS which is focused on improving health and reducing health inequalities.
2. <i>Working Together for a Healthier Scotland - A Consultation Document</i>	February 1998	A Green Paper focusing on public health in Scotland (the first post-1997 major policy statement on public health in Scotland). Includes a commitment to having targets that are relevant to the overall aims of improving population health and reducing health inequalities but, unlike the English Green Paper, does not specify any potential targets.
3. <i>Towards a Healthier Scotland</i>	February 1999	The White Paper which followed the above Green Paper. Although published prior to devolution, this statement remains the only post-1997 White Paper focusing largely on public health issues and it appears to have significantly informed the post-devolution approach to health inequalities.
4. <i>Partnership Agreement</i>	May 1999	The first Partnership Agreement (a result of the fact the first, newly elected Scottish government formed from a collation of the Labour and Liberal Democrat parties). Includes a section specifically focusing on the new government's commitments to health policy, which includes improving health and reducing health inequalities in Scotland.
5. <i>The Social Justice Report... a Scotland where EVERYONE matters</i>	22/11/1999	The first major post-devolution policy statement of relevance to health inequalities in Scotland, this document was jointly published by the First Minister and the Minister for Communities. Although its focus concerns social justice in a broad sense, it lists 'reducing health inequalities as a 'long-term target' (although this is not quantified).
6. <i>Our National Health. A plan for action, a plan for change</i>	December 2000	This document provides a clear statement of national priorities for the NHS and health policy more generally. Emphasises that it aims to focus on facilitating the implementation of the numerous initiatives that it outlines. Reducing health inequalities is described as a 'core aim' and lists proposed (and already implemented) actions associated with this aim.
7. <i>National Health Demonstration Projects</i>	27/03/2001	Document outlining Scotland's 'National Health Demonstration Projects', which initially consisted of the following four projects: <i>Starting Well</i> (focusing on trying to improve conditions for, and the wellbeing of, deprived children in Glasgow); <i>Healthy Respect</i> (focusing on trying to reduce sexually transmitted diseases among young people in Lothian); <i>Have a Heart Paisley</i> (focusing on trying to reduce coronary Heart Disease in Paisley); and <i>Cancer Challenge</i> (focusing on improving and



			increasing rates of screening for cancer in Tayside, Grampian and Fife Health Boards). All four initiatives were designed to act as pilots, which would be evaluated, to help guide future policy action on improving health and reducing health inequalities. [NB Cancer Challenge was fairly quickly dropped as an area-based demonstration project, becoming part of a national approach to cancer screening].
8. <i>Our National Health: Delivering Change</i>	14/12/2001		A progress report on attempts to deliver the commitments outlined in <i>Our National Health</i> . Includes a section specifically focusing on 'Improving Health', which also deals with progress relating to the aim of reducing health inequalities.
9. <i>Performance Assessment Framework</i>	04/10/2001		Sets out the approach to Performance Assessment of the NHS in Scotland. Despite sharing its name with the approach in England, the approach in Scotland was significantly more collaborative and less top-down than the approach outlined in England. Includes the need for Local Health Boards to monitor local trends in relation to health inequalities.
10. <i>Partnership for Care Scotland's Health White Paper</i>	27/02/2003		A White Paper which builds on the <i>Our National Health</i> . Largely focused on the NHS but also claims to set out 'a new approach to improve health in Scotland and to reduce health inequalities.'
11. <i>Improving Health in Scotland - The Challenge</i>	17/03/2003		This statement was published to accompany <i>Partnership for Care</i> and the focus is on public health issues, particularly improving health and reducing health inequalities. The most significant statement relating to health inequalities published in the post-devolution part of the study period.
12. <i>Closing the Opportunity Gap</i>	12/07/2004		A cross-government initiative focusing on improving social justice and reducing poverty. The Initiative was associated with a website (rather than a specific policy publication) and sets out specific targets, including some for health inequalities.
13. <i>Healthy Working Lives a plan for action</i>	26/08/2004		Policy developed to take forward the Workplace strand of the <i>Health Improvement: The Challenge</i> .
14. <i>Fair to All, Personal to Each - The next steps for NHSScotland</i>	15/12/2004 [Modified June 2005]		The Scottish Executive's plan for tackling NHS waiting times. Does not say that much about health inequalities (or health improvement) but does emphasise the NHS' role with respect to both of these aims.
15. <i>Delivering for Health</i>	02/11/2005		Focuses on future plans for the NHS in Scotland. Includes a sub-section specifically focusing on reducing health inequalities which sets out what the NHS should to help reduce health inequalities and meet the national targets which were announced in 2004.
16. <i>National Programme for Improving</i>	08/11/2005		Working paper relating to mental health and inequalities in Scotland, jointly published by the

<p><i>Mental Health and Well-Being: Addressing Mental Health Inequalities in Scotland - equal minds</i></p>		<p>Deputy Minister for Health and Social Care and the Minister for Communities, and based on a conference that was held in October 2003. Marks the particular focus on mental health taken by the Scottish Executive (relative to the English government).</p>
<p><i>17. Tackling Health Inequalities – An NHS Response</i></p>	<p>April 2006</p>	<p>Another document focusing on the role that the NHS is expected to play in tackling health inequalities and achieving the national targets.</p>





## Appendix II: Matrices constructed to help guide the selection of potential interviewees

### Potential interviewees categorised as 'researchers':

Main focus w/in HIs research / Policy links	Economic / Class	Psychosocial	Health Policy	Lifestyles / Health Promotion	Health service	Early Years	Gender	Ethnicity	Medical / epidemiology	Mixed / other
Academic researchers with some experience of policy involvement	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Academic researcher with no apparent involvement in policy	✓		✓	✓						✓
Non-academic researchers (NDPBs, think tanks & charities)	✓		✓	✓	✓	✓				✓

### Potential interviewees categorised as 'policymakers':

Location / Position	Politician	Civil Servant
England	✓	✓
Scotland	✓	✓

### Potential interviewees categorised as 'research funders':

Location / Position	Based in a relevant research council	Based in government departments	Based in NDPBs
England		✓	✓
Scotland		✓	✓
UK	✓		

### Potential interviewees categorised as 'journalists':

Location / Position	Freelance journalist	Broadsheet newspaper	Tabloid Newspaper	Broadcast media (TV & Radio)
Scotland	✓			✓
UK				✓



**Brief explanation of the matrices:**

These matrices were constructed as the research progressed and were designed to help me decide who to approach in both batches of interviews (but particularly the second batch). The aim was to try to include enough interviewees to be able to tick every cell of these matrices. However, due to the fact that some potential interviewees either did not reply or said that they did not want to participate, I was only able to 'tick off' those cells on the previous page which display a tick.

### Appendix III: Consent form, which all interviewees were required to sign

Working title of Project: *'An exploration of the relationship between research and policy for health inequalities in Britain'*

Katherine Smith is undertaking research for submission as a PhD at the University of Edinburgh. This involves new research into the relationship between research and policy within the field of health inequalities. One element of this work involves individual interviews asking people to discuss their own experiences of, and opinions about, the relationship between research and policy.

The University understands that you are willing to be interviewed by Katherine. It is important to the University that only people who want to do so participate in this study. We make sure of this by asking you to sign this form to confirm that you have freely agreed to be interviewed. You should also be aware that you do not need to answer any particular question and that you may stop the interview at any time.

The interview will be digitally-recorded and you will be given a chance to review and amend the transcript in due course. Any personal details will be anonymised and I will not intentionally reveal your identity to anyone outside the research/supervision team. Whilst interviewees' identities will be revealed within the supervision team, the data will be anonymised before they are discussed with the team.

The contents of the interviews – including yours – will be analysed and written up during the course of the research. The findings may be included in unpublished theses submitted for higher degrees, and later lodged in the University Library. They may also be used in published works, such as academic journal articles or scholarly texts. This written work may include quotations from some of the interviews, including yours. Neither your own name nor any of your other personal details that would identify you will ever be associated with these quotations. We would be grateful if you could confirm, by signing this form, that you are happy for us to use the recorded interview or extracts from it in this way.

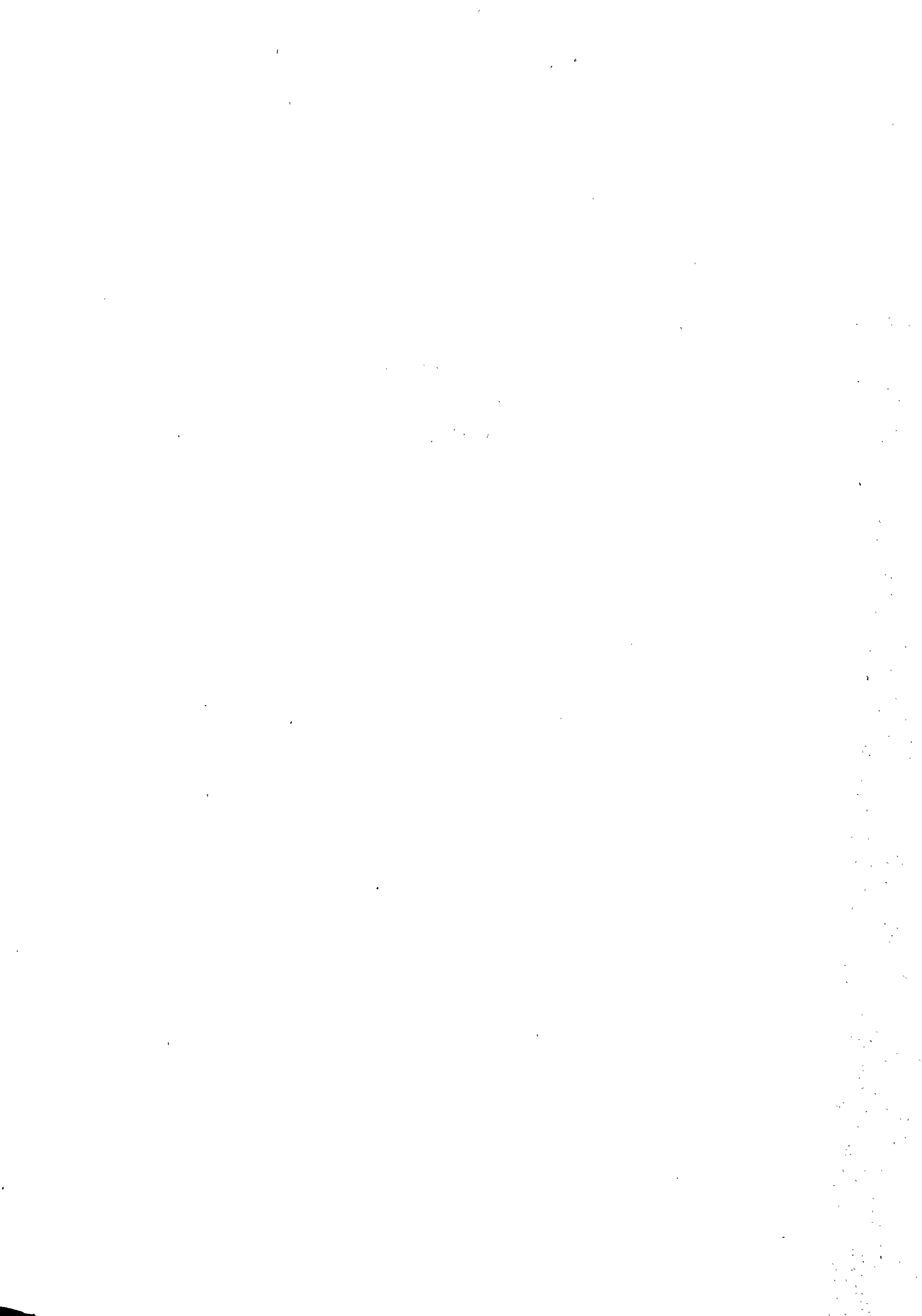
I confirm I have freely agreed to be interviewed for this project and that the recorded interview or extracts from it may be used as described above.

Signed: .....

Print Name: .....

Date: .....





## **Appendix IV: Generic examples of the interview schedules constructed for different types of interviewee**

*Title: 'An exploration of the relationship between research and policy for health inequalities in Britain'*

**Generic opening script – used in all interviews:**

Thank you for agreeing to give this interview.

I'd like to begin by saying a little bit about the research project and then I'll explain a bit more about this interview.

As you know, the project focuses on the relationship between health inequalities research and policy in Britain, and is funded by the University of Edinburgh. It is informed by a one year MSc research project and a 4-week placement in the Office of the Chief Researcher at the Scottish Executive. The research will involve a series of interviews, together with the analysis of official policy documents and press media coverage of health inequalities in Britain.

I am hoping that interviews with a range of researchers, policymakers and others involved in health inequalities debates will provide some insights into the relationship between research and policy. In today's interview, I am hoping to find out a bit more about the processes through which research ideas about health inequalities in Scotland / England might influence the policy agenda. I am particularly interested in why some ideas seem to be successfully transferred onto the policy agenda whilst others do not.

If it is OK with you, I would like to digitally-record this interview. After the interview, I will transcribe the interview in full and send you a copy of the transcript for approval. If, at this stage, you feel you would like any of aspects of the interview not to be included in my research, or if you feel I have misunderstood anything that you said, you will have the opportunity to suggest changes to the transcript. I will treat our conversation as confidential and will hold the transcript securely.

Your participation is, of course, entirely voluntary so if at any point you want to terminate the interview, or turn off the recorder, that is fine. The interview should not last much more than an hour.

Have you had time to look over the consent form I sent you before hand? Are you happy to sign this? [Ensure form is signed]. Do you have any questions about the project or anything else before we start?



## I) Interview guide for researchers:

### Section 1 – Interviewee's involvement in HI research and policy:

1A) Could we start with you telling me a bit about your own particular interests in the field of health inequalities?

- What are the practical implications of this for those working to reduce health inequalities?

1B) Do you think these kind of ideas have been picked up by policymakers at all?

- If so: Why do you think they were picked up?
  - Where / how did policymakers find out about these ideas?
  - Have they been used in ways that you anticipated / hoped?
- If not: Why do you think they haven't been picked up?

1C) As you know, I have chosen to use health inequalities as the focus of this research but, before we discuss this further, I want to ask whether you think this is the biggest issue for public health at the moment or whether there are other, more pressing issues?

- If they think health inequalities are a big issue: Why? Do you think policymakers and politicians agree?
- If they think other issues are more important: Which issues and why? How do you think current policymakers perceive health inequalities in relation to other public health issues?

1D) Where do you, as a researcher, tend to find out about new ideas / research relating to health inequalities?

### Section 2 – Interviewee's beliefs about policy relating to health inequalities:

2A) Where do you believe responsibility lies for reducing health inequalities?

2B) What's the most useful thing that the current government or the Scottish Executive has done in relation to Health inequalities?

- Do you think policymakers involved in Health inequalities have a good awareness of the research evidence?
- Do you think there are significant differences between the SE's and the NL government's approach to Health inequalities?

2C) Do you think there have been any important missed opportunities since 1997, where a different approach to Health inequalities might have had a significant impact?

### Section 3 – Research-policy links:

3A) I'd now like to move on to discussing the relationship between research and policy, and I'd like to start by asking you what you believe the role of academic research *should* be and whether it should have a close relationship with policy?

3B) In terms of the available research relating to health inequalities, to what extent do you believe this kind of information is informing policy?

- Do you think most policymakers have a good awareness of the available research?
- Are there any specific research ideas which you believe are particularly influential for health inequalities policy at the moment?

3C) What are the difficulties in using the available research to inform policy?

- Do you think the cross-departmental nature of health inequalities leads to any difficulties in formulating policy initiatives designed to tackle these inequalities?

3D) How would you describe the relationship between academic researchers and policymakers involved in health inequalities?

3E) There now seems to be some agreement (both in academia and in policy) that social circumstances are important determinants of health inequalities, yet it doesn't seem as if there are many specific policy initiatives focusing on this area. Why do you think this might be?

3F) One of my key interests is the way in which lifestyle-behavioural ideas seem to have dominated the policy agenda for so long - Why do you think this approach to health inequalities has been so enduring?

- Can you think of any ideas powerful or practical enough to dislodge lifestyle-behavioural approaches from the policy agenda?

3G) What do you believe is most likely to facilitate the transfer of research onto the policy agenda?

#### Section 4 – Concluding questions:

4) We're almost at the end of the interview and I'd like the chance to ask you whether you feel that there's anything important that we haven't yet touched on, or whether there's anything else you'd like to add to what you've said already?

- Are there any papers/documents you think I ought to read?
- Is there anyone you think I ought to contact in relation to this research?

We have now reached the end of the main body of the interview. Thank you very much for taking the time to answer these questions. Before I go I would like to ask you a few final questions which are designed to help me reflect on the research process and improve future next stages, as well as establish what type of feedback, if any, you would like me to provide you with at a later date:

- ◆ Would you like to comment on the way this interview has been conducted?
- ◆ Are you happy for me to transcribe the recording and send you a full copy of the transcript for your approval?
- ◆ Would you like to receive feedback about the outcome of the research?
  - If yes, how? **NB Check I have appropriate contact details.**
- ◆ OK, that covers everything I wanted to ask you today. Do you have any questions about the research project that you would like to ask me?

***Thank you once again for your input. You should have my contact details from my emails / letter - If you think of any questions you would like to ask, or if you think of anything you would like to add to what you've said today, I would be delighted to hear from you.***



## II) Interview guide for policymakers:

### Section 1 – The policymaking process:

1A) Could we start with you telling me a bit about your role in the policymaking process?

1B) Now, as you know, I have chosen to use health inequalities as the focus of this research but, before we discuss this further, I want to ask whether you think this is the biggest issue for public health at the moment or whether there are other, more pressing issues?

- If they think health inequalities are a big issue: Why do you think health inequalities is such a major issue on the policy agenda in Scotland / England?
- If they think other issues are more important: Which issues and why?

1C) Once an issue like health inequalities has been acknowledged as a policy 'problem' that requires action, what happens next?

- What kind of information is sought and who is responsible for compiling this?

1D) In terms of official policy documents relating to health inequalities at the national level, who would decide that a new policy is needed?

- What would you expect the driving factors behind the desire for a new policy to be?
- Who directs the content of official documents and who would be involved in the writing process?
- What role would evidence play in informing the direction of a new policy document?

1E) Do you think the cross-departmental nature of health inequalities leads to any difficulties in formulating policy initiatives designed to tackle these inequalities?

1F) Having discussed some of the factors that are likely to get an issue onto the policy agenda, can you tell me which factors are likely to lead to an issue maintaining high-level policy interest?

- If they haven't already mentioned the media / pressure groups, ask: What role do people working outside the research and policymaking communities play in the policymaking process?

### Section 2: The role of health inequalities research in the policy process:

2A) If it is decided that more evidence is required in relation to health inequalities, are there particular experts from whom advice is sought?

- Do you know who might be contacted specifically in relation to health inequalities by the Scottish Executive / Whitehall?
- Through what processes do particular individuals become known as 'experts'?

2B) What is the role of academic research in the policymaking process for health inequalities?

- How / where do policymakers find out about academic research and ideas?
- What factors are likely to lead to research being picked up and used in policymaking?

- How does the role of academic research differ from other kinds of research and information used by policymakers?

2C) What do you believe the role of academic research should be in relation to policy?

2D) In terms of the available research relating to health inequalities, to what extent do you believe this kind of information is informing policy?

- Do you think most policymakers have a good awareness of the available research?
- Are there any specific research ideas which you believe are particularly influential for health inequalities at the moment?

2E) What are the difficulties in using the available research to inform policy?

2F) There now seems to be some agreement (both in academia and in policy) that social circumstances are important determinants of health inequalities, yet it doesn't seem as if there are many specific policy initiatives focusing on this area. Why do you think this might be?

2G) One of my key interests is the way in which lifestyle-behavioural ideas seem to have dominated the policy agenda for so long - Why do you think this approach to Health inequalities has been so enduring?

- Can you think of any ideas powerful or practical enough to dislodge lifestyle-behavioural approaches from the policy agenda?

2H) What do you believe is most likely to facilitate the transfer of research to policy?

### Section 3 – Concluding questions:

3) We're almost at the end of the interview and I'd like the chance to ask you whether you feel that there's anything important that we haven't yet touched on, or whether there's anything else you'd like to add to what you've said already?

- Are there any papers/documents you think I ought to read?
- Is there anyone you think I ought to contact in relation to this research?

We have now reached the end of the main body of the interview. Thank you very much for taking the time to answer these questions. Before I go I would like to ask you a few final questions which are designed to help me reflect on the research process and improve future next stages, as well as establish what type of feedback, if any, you would like me to provide you with at a later date:

- ◆ Would you like to comment on the way this interview has been conducted?
- ◆ Are you happy for me to transcribe the recording and send you a full copy of the transcript for your approval?
- ◆ Would you like to receive feedback about the outcome of the research?
  - If yes, how? **NB Check I have appropriate contact details.**
- ◆ OK, that covers everything I wanted to ask you today. Do you have any questions about the research project that you would like to ask me?

*Thank you once again for your input. You should have my contact details from my emails and letter to you. If you think of any questions you would like to ask, or if you think of anything you would like to add to what you've said today, I would be delighted to hear from you.*



### III) Interview guide for research funders:

1) I have chosen to use health inequalities as the focus of this research but, before we discuss this further, I want to ask whether you think this is the biggest issue for public health at the moment or whether there are other, more pressing issues?

2) When making decisions about whether to fund research relating to health inequalities (or other public health issues), what are likely to be the key issues/factors [this organisation] takes into consideration?

- To what extent does the research topic influence decisions (and how are research topics assessed)?
- To what extent does the political/policy context influence decisions?
- To what extent do the people involved in the research effect decisions?
- To what extent is the methodology likely to effect decisions?

3) I'd now like to move on to discussing the relationship between research and policy, and I'd like to start by asking you what you believe the role of academic research *should* be and whether it should have a close relationship with policy?

4) In terms of the available research relating to health inequalities, to what extent do you believe this kind of information is informing policy?

- Do you think most policymakers have a good awareness of the available research?
- Do you think mot academics have a good awareness of the policy context?
- Are there any specific research ideas which you believe are particularly influential for health inequalities policy at the moment?

5) What do you believe to be the difficulties in using the available research to inform policy on health inequalities?

6) How would you describe the relationship between academic researchers and policymakers involved in health inequalities?

7) What do you believe is most likely to facilitate the transfer of research onto the policy agenda?

8) We're almost at the end of the interview and I'd like the chance to ask you whether you feel that there's anything important that we haven't yet touched on, or whether there's anything else you'd like to add to what you've said already?

- Are there any papers/documents you think I ought to read?
- Is there anyone you think I ought to contact in relation to this research?

We have now reached the end of the main body of the interview. Thank you very much for taking the time to answer these questions. Before I go I would like to ask you a few final questions which are designed to help me reflect on the research process and improve future next stages, as well as establish what type of feedback, if any, you would like me to provide you with at a later date:

- ◆ Would you like to comment on the way this interview has been conducted?

- ◆ Are you happy for me to transcribe the recording and send you a full copy of the transcript for your approval?
- ◆ Would you like to receive feedback about the outcome of the research?
  - If yes, how? **NB Check I have appropriate contact details.**
- ◆ OK, that covers everything I wanted to ask you today. Do you have any questions about the research project that you would like to ask me?

***Thank you once again for your input. You should have my contact details from my emails / letter - If you think of any questions you would like to ask, or if you think of anything you would like to add to what you've said today, I would be delighted to hear from you.***



## IV) Interview guide for journalists / interviews working in the mass media:

Topics to discuss:

1. Could you explain to me a bit about the process which would lead to a particular social documentary being made and what influences the choice of topic?
  - Who tends to come up with the initial idea?
  - What happens next?
  - Who decides whether or no the idea is workable?
  - Where does funding come from?
  - Who influences the editing process?
  - Who decides whether (and when) the documentary will be aired?
  - How long does this process tend to take
2. What's likely to make an issue a popular topic for documentary makers?
3. To what extent do you think the current political context effects the kinds of documentaries being produced?
  - How would you describe the current relationship between the political context of the UK and documentary making here?
4. To what extent do you feel funding sources effect the kinds of documentaries being produced?
5. Are there any other major influences/constraints on documentary making around social issues?
6. To what extent have you worked with academic researchers?
  - What are the benefits of involving academic researchers in documentary making?
  - How would the people involved in making the documentary know who to contact in the academic world?
  - Are there any difficulties in working with academic researchers in this way?
7. To what extent have you worked with policymakers or politicians?
  - What are the benefits of involving policymakers / politicians in documentary making?
  - How would the people involved in making the documentary know who to contact in the policymaking / political world?
  - Are there any difficulties in working with policymakers / politicians in this way?
8. Do you think the coverage of social issues by documentaries in recent years has been adequate in the UK?
9. Do you have any frustrations with the way documentary making operates in the UK, in terms of the topics covered?

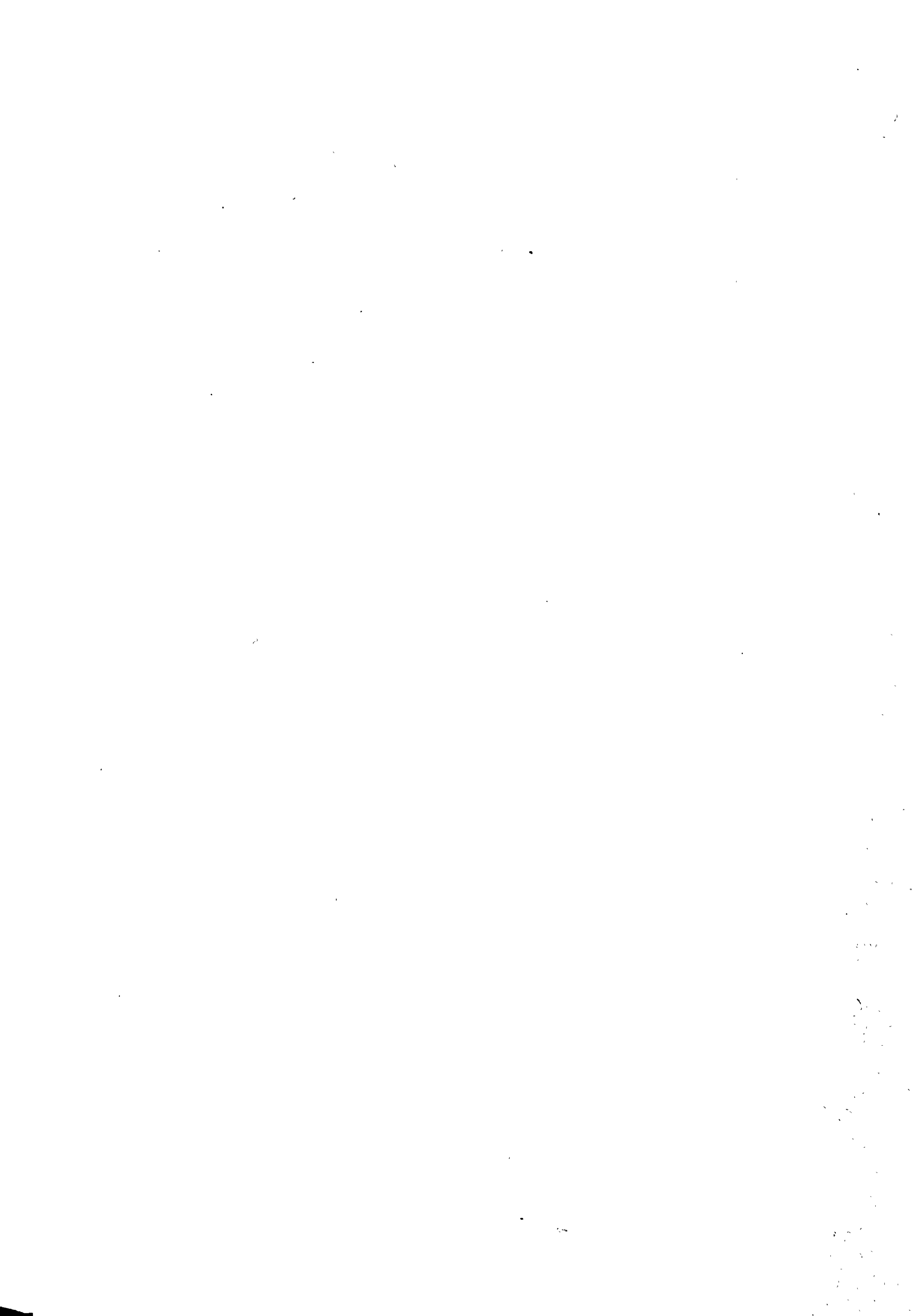
10. We're almost at the end of the interview, so I just wanted to ask you whether you think there's anything we haven't discussed that's of relevance to my research?

We have now reached the end of the main body of the interview. Thank you very much for taking the time to answer these questions. Before I go I would like to ask you a few final questions which are designed to help me reflect on the research process and improve future next stages, as well as establish what type of feedback, if any, you would like me to provide you with at a later date:

- ◆ Would you like to comment on the way this interview has been conducted?
- ◆ Are you happy for me to transcribe the recording and send you a full copy of the transcript for your approval?
- ◆ Would you like to receive feedback about the outcome of the research?
  - If yes, how? ***NB Check I have appropriate contact details.***
- ◆ OK, that covers everything I wanted to ask you today. Do you have any questions about the research project that you would like to ask me?

***Thank you once again for your input. You should have my contact details from my emails / letter - If you think of any questions you would like to ask, or if you think of anything you would like to add to what you've said today, I would be delighted to hear from you.***





**Appendix V (a): List of codes developed through analysis in  
*Atlas.ti***

1. Acheson Report
2. Anonymity - related issues
3. Area-based / targeted (solutions)
4. Area/social/ethnic/gender HIs
5. Big ideas / initiatives
6. Busy - lack of time
7. Chance/timing
8. Childhood/early years (causes)
9. Childhood/early years (solutions)
10. Civil servant - Ministerial links
11. Common sense / intrinsic / obvious
12. Communicating ideas
13. Community-based action
14. Complexity
15. Constraints on what interviewee feels they can say
16. Contextual/place effects
17. Corporations
18. Credibility
19. Cross-Departmental collaboration
20. Cross-Dept tensions / lack of JUG
21. Cross-governmental issues - other
22. Cultural (causes of HIs)
23. Devolution
24. EBM
25. Environmental issues / sustainable dev
26. Evaluating interventions
27. Experts / charismatic individuals
28. Feedback on interview questions
29. Feeling cynical/trying to be positive
30. Fiscal constraints
31. Funding of research (& impact on how it's used)
32. Genetics/breeding/intelligence
33. Health improvement Vs HIs
34. Health Service (solutions)
35. Health Services (causes of HIs)
36. HIs moving onto/off political/research agendas
37. HIs, DHs & the NHS
38. Ideas from abroad
39. Income inequalities & HIs



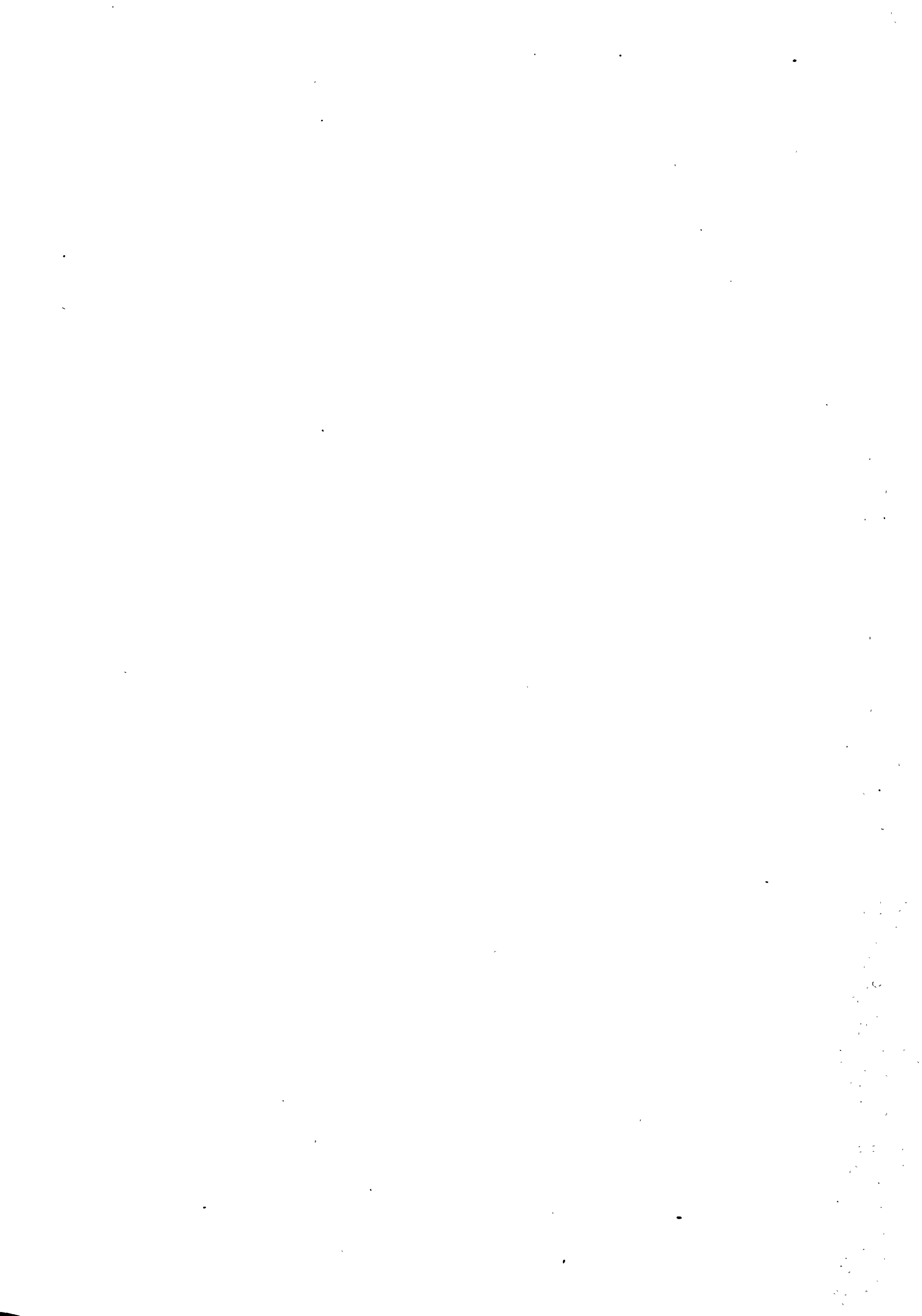
40. Incremental change
41. Individual agency
42. Institutionalism
43. International comparisons (HIs)
44. International comparisons (res-pol)
45. International pressures/constraints
46. Interviewee questioning me
47. Killer diseases
48. Lack of certainty in knowledge
49. Lack of clarity/usefulness in avail research
50. Lack of EBP / research-influenced policy
51. Lifecourse
52. Lifestyle-behaviours (cause of HIs)
53. Lifestyle-behaviours (solutions)
54. Lobbying
55. Location
56. Material-structural (cause of HIs)
57. Material-structural (solutions)
58. Medical/non-med divide / the professions
59. Methodological issues
60. Miscellaneous quotations of interest
61. Multi-factorial (causes of HIs)
62. Multi-factorial (solutions to HIs)
63. National (Scott/UK) responsibility
64. NDPBs/Independent Research Organisations
65. Networks
66. Official reports/policy docs
67. partnership working
68. Personal accounts of the history of HIs
69. Personal/political values & beliefs
70. Policy process- PM/FM/Treasury
71. Policy process - Civil service
72. Policy process - Ministerial
73. Policy process – MPs & MSPs
74. Policy process - mysterious/complex
75. Policy process - obtaining info
76. Policy process - policy docs
77. Policy process - role of research(ers)
78. Policy/political understanding of HIs
79. Political action (missed opportunities / lack of action)
80. Political action taken
81. Political context
82. Political responsibility/pressure
83. Prevention/cure (or up/down stream)
84. Psychosocial (causes)

85. Psychosocial (solutions)
86. Public Health workforce
87. Pure Vs applied research
88. Regulating / targeting (solutions)
89. Relative Vs absolute poverty
90. Research-policy tensions / misunderstandings
91. Research collaboration
92. Research tensions / factions
93. resilience
94. Responsibility for addressing HIs
95. Scot-Eng comparisons (HIs)
96. Scot - Eng comparisons (res-pol)
97. Scotland - national pride
98. Self-reflection
99. Selling ideas
100. Size of country & communication
101. Social determinants of health
102. Social gradient, health gap, etc
103. Social mobility
104. Surveillance
105. Targets & target setting
106. The media
107. The public
108. Think Tanks
109. Time cycle
110. Too much / not enough research?
111. Translators/ middle ground
112. Trust / respect
113. Two communities
114. Victim blaming
115. Voluntary groups / charities

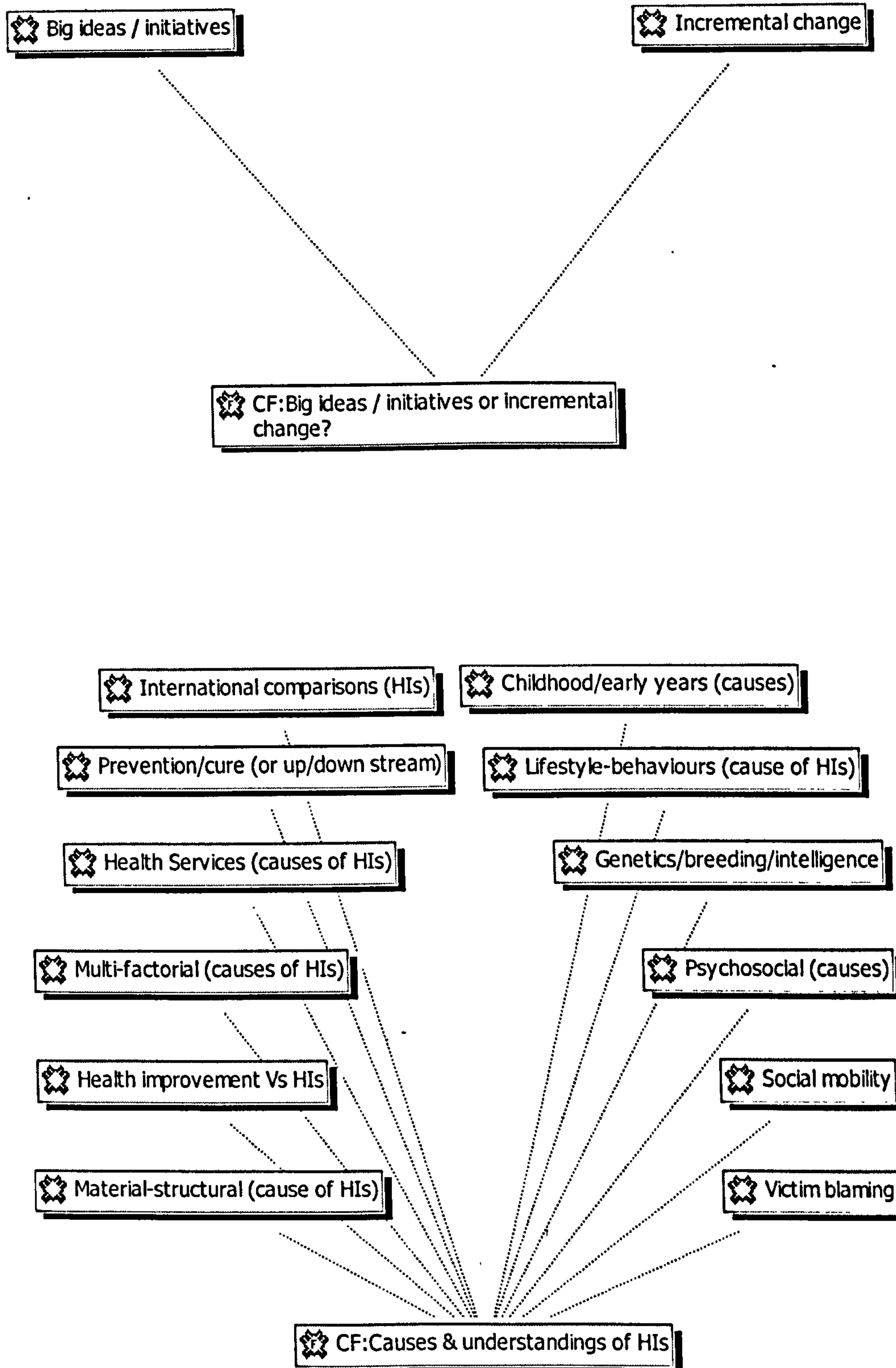
**Key:**

- DHs: Departments of health (Scotland and England)  
EBM: Evidence-based medicine  
EBP: Evidence-based policy  
FM: First Minister (of Scotland)  
HIs: health inequalities  
JUG: Joined-up government  
MPs: Members of Parliament  
MSPs: Members of the Scottish Parliament  
NDPBs: Non-departmental public bodies  
NHS: National health service  
PM: Prime Minister (of the UK)  
Res-pol: the relationship between research and policy

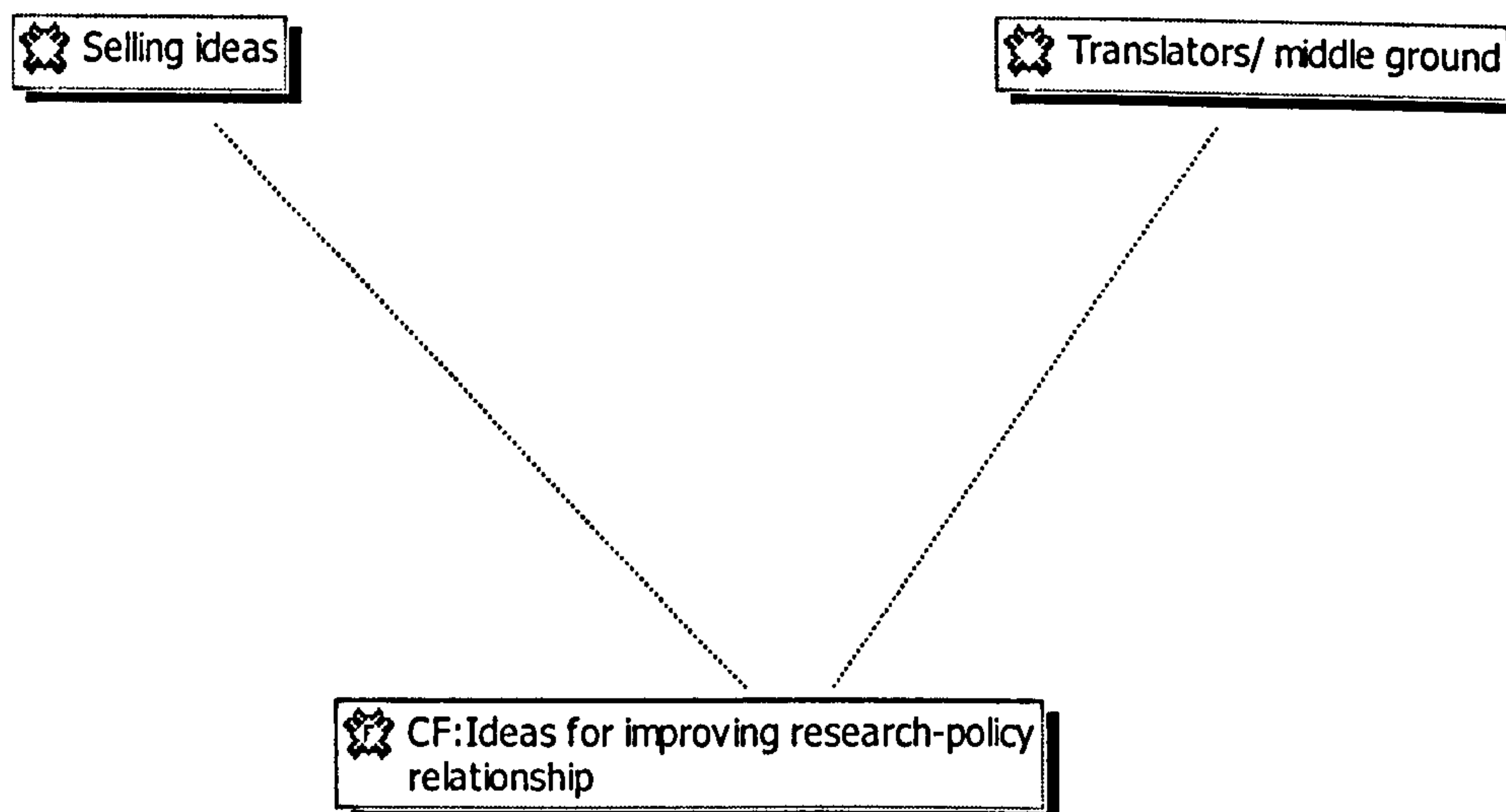
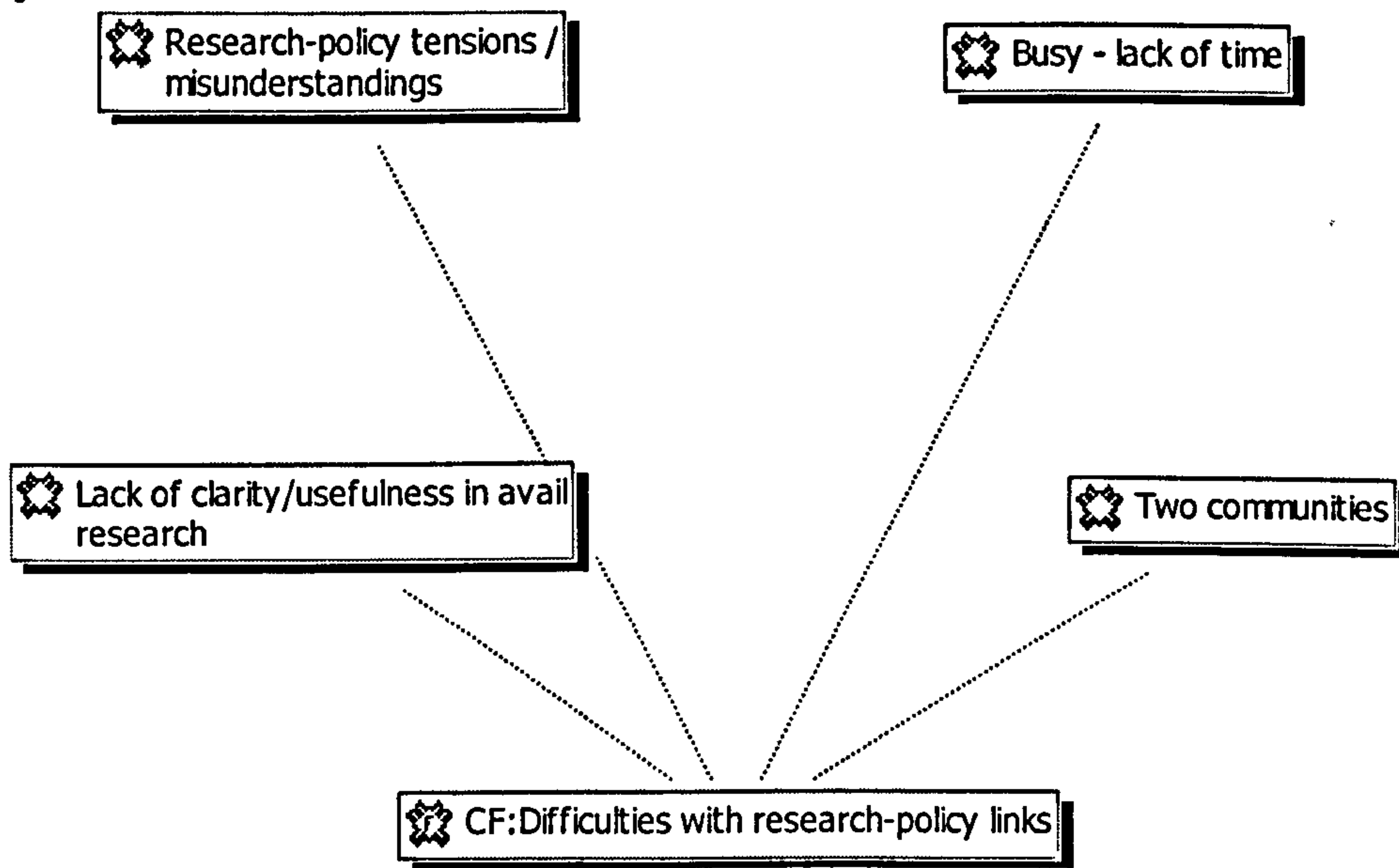


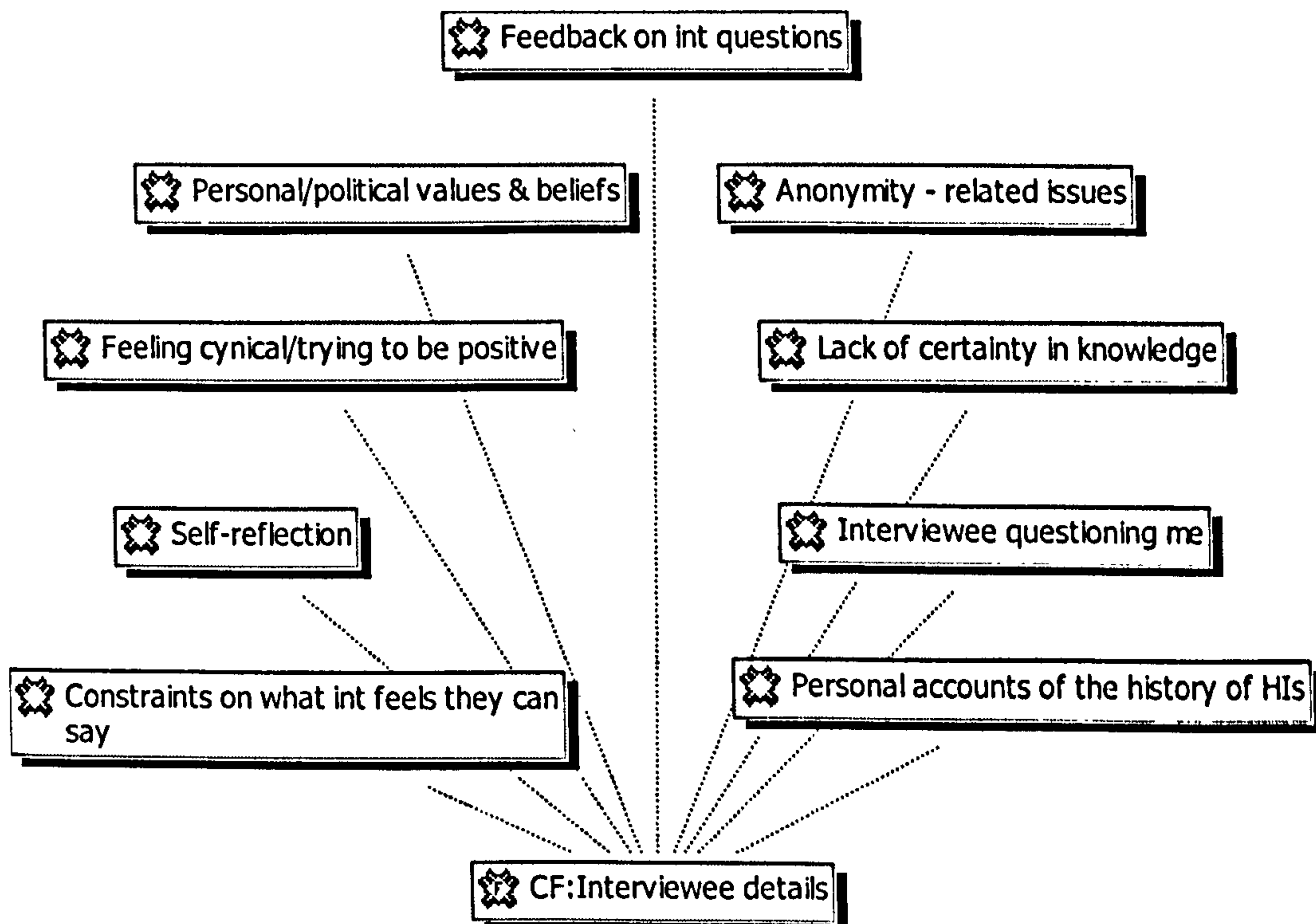
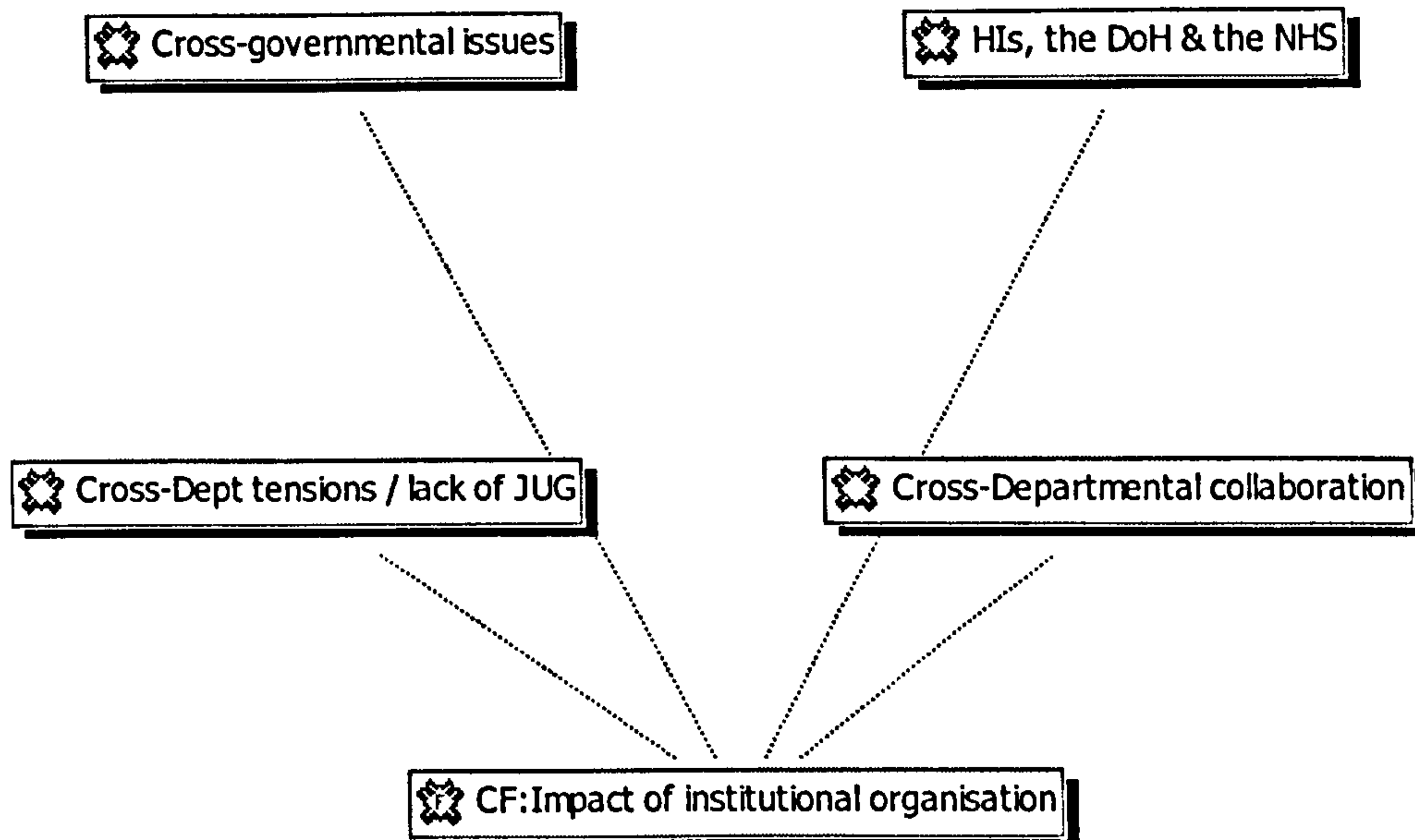


### Appendix V (b): List of 'family' networks used to link some codes, developed through analysis in *Atlas.ti*

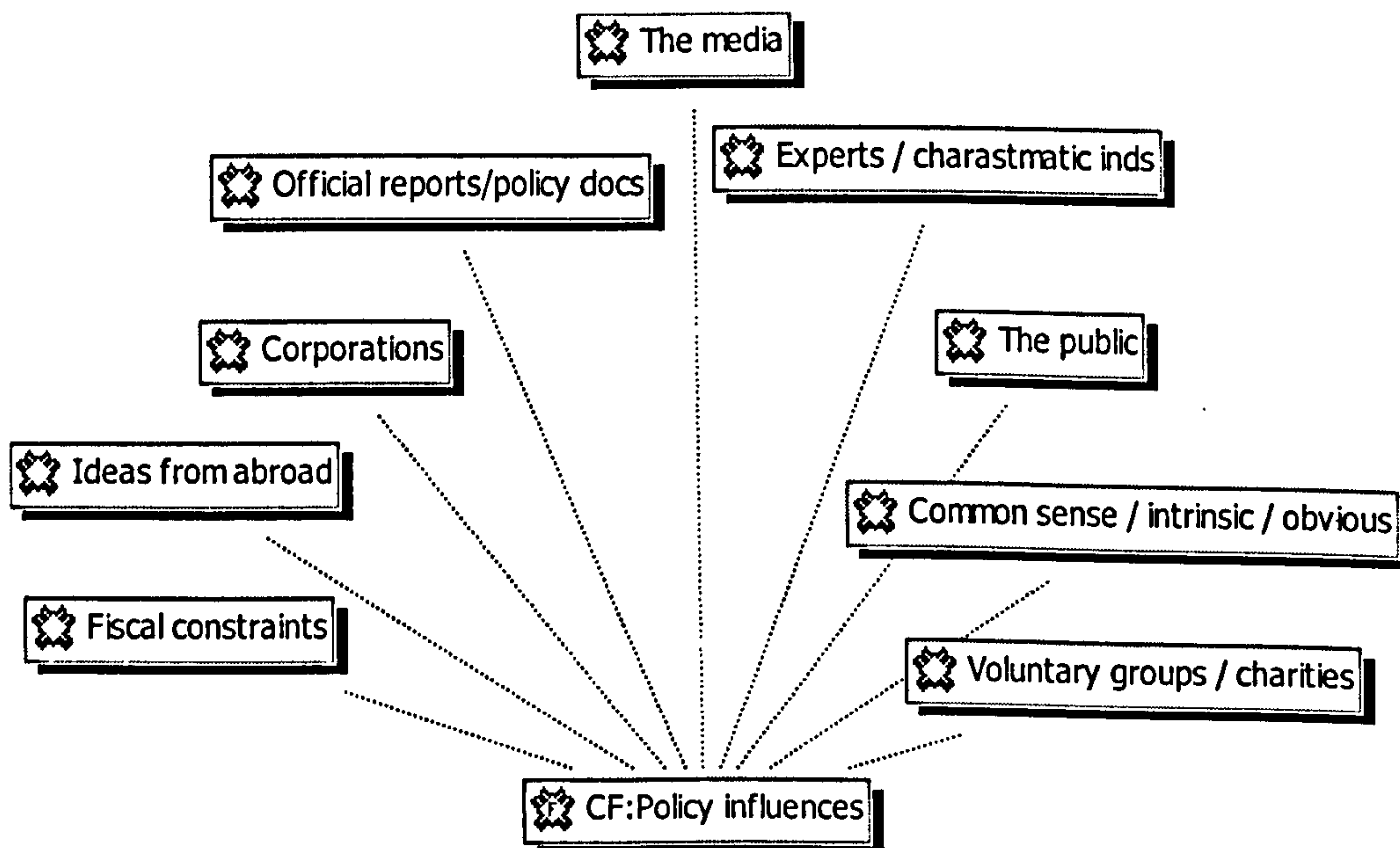
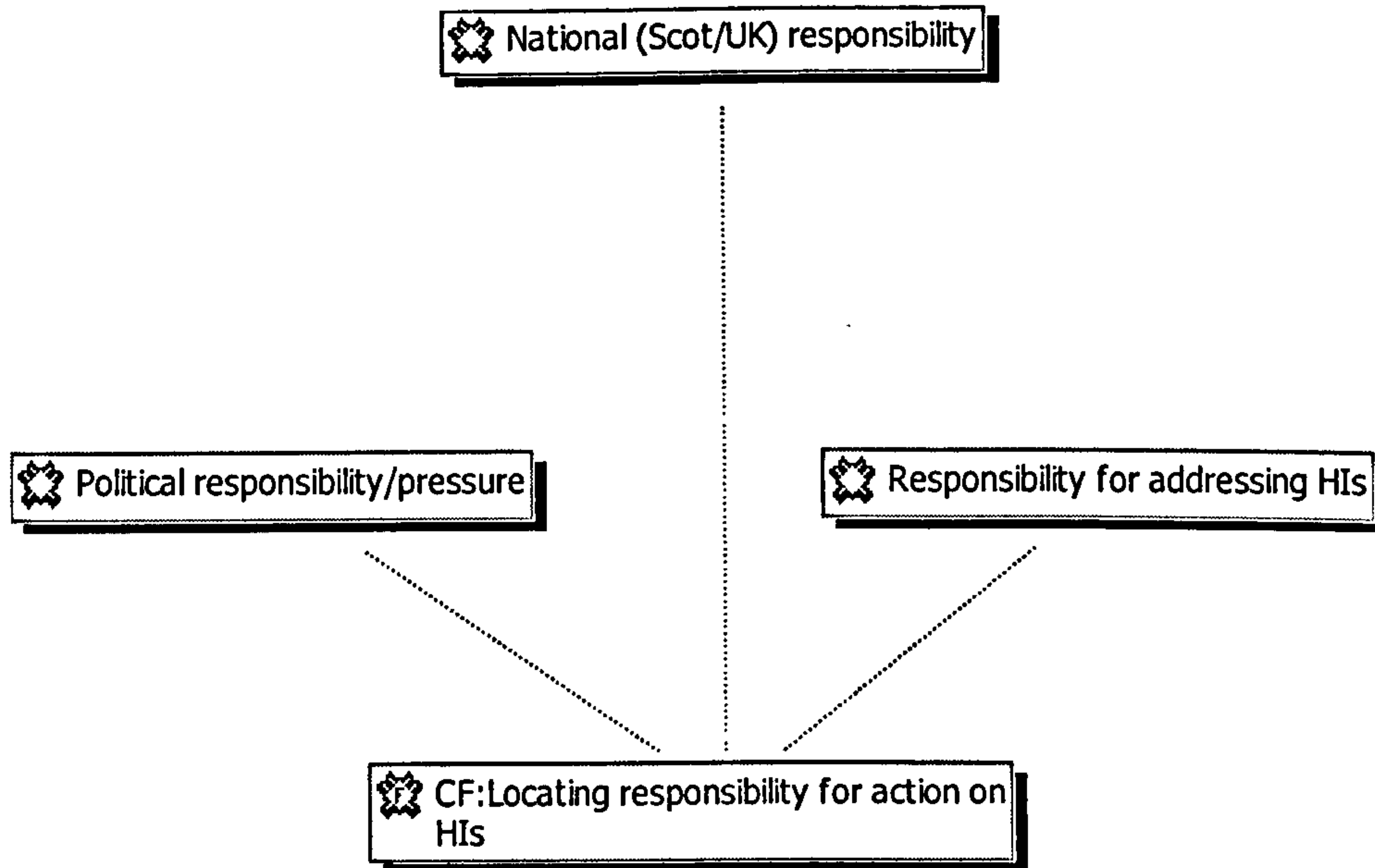


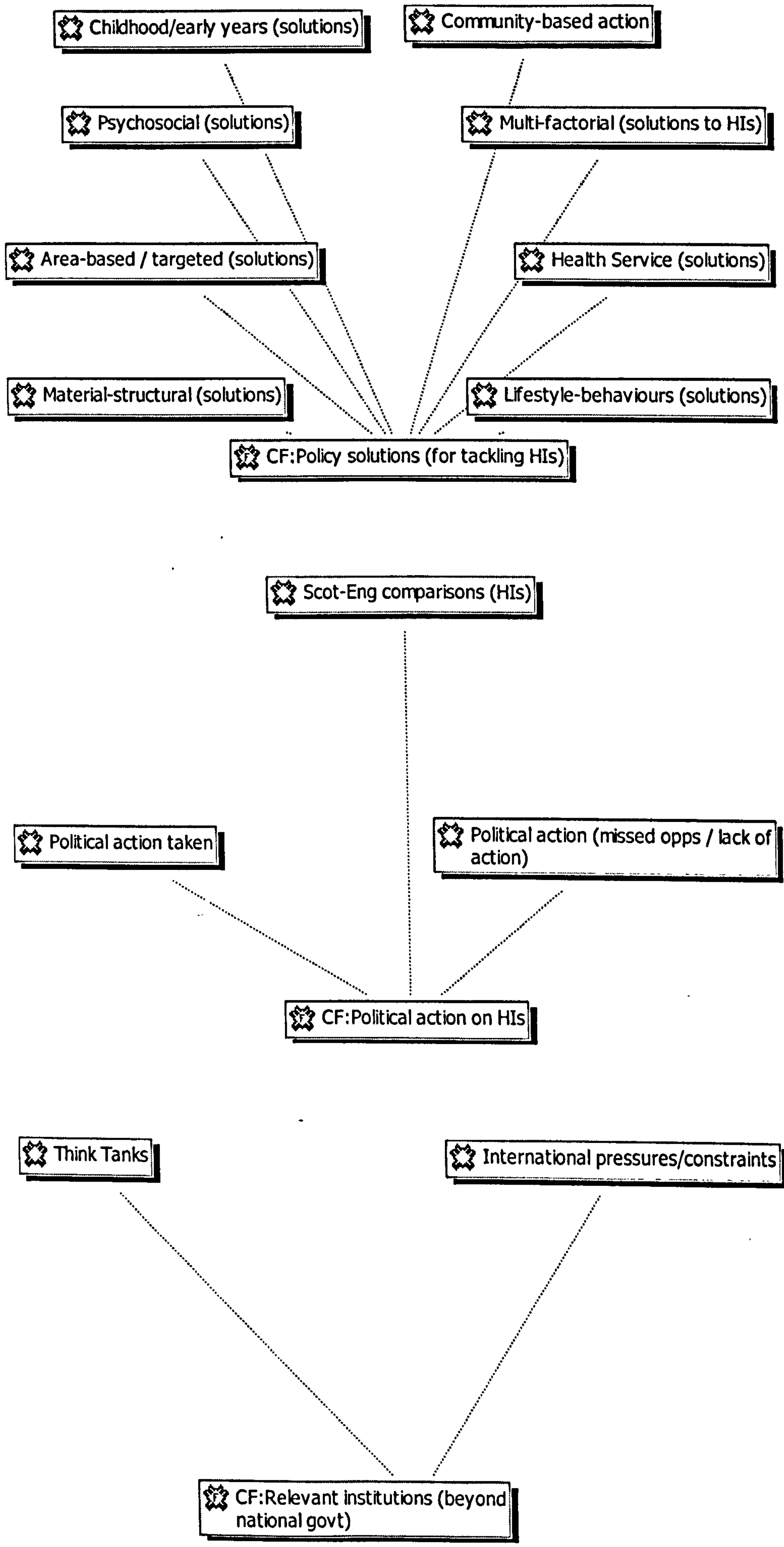




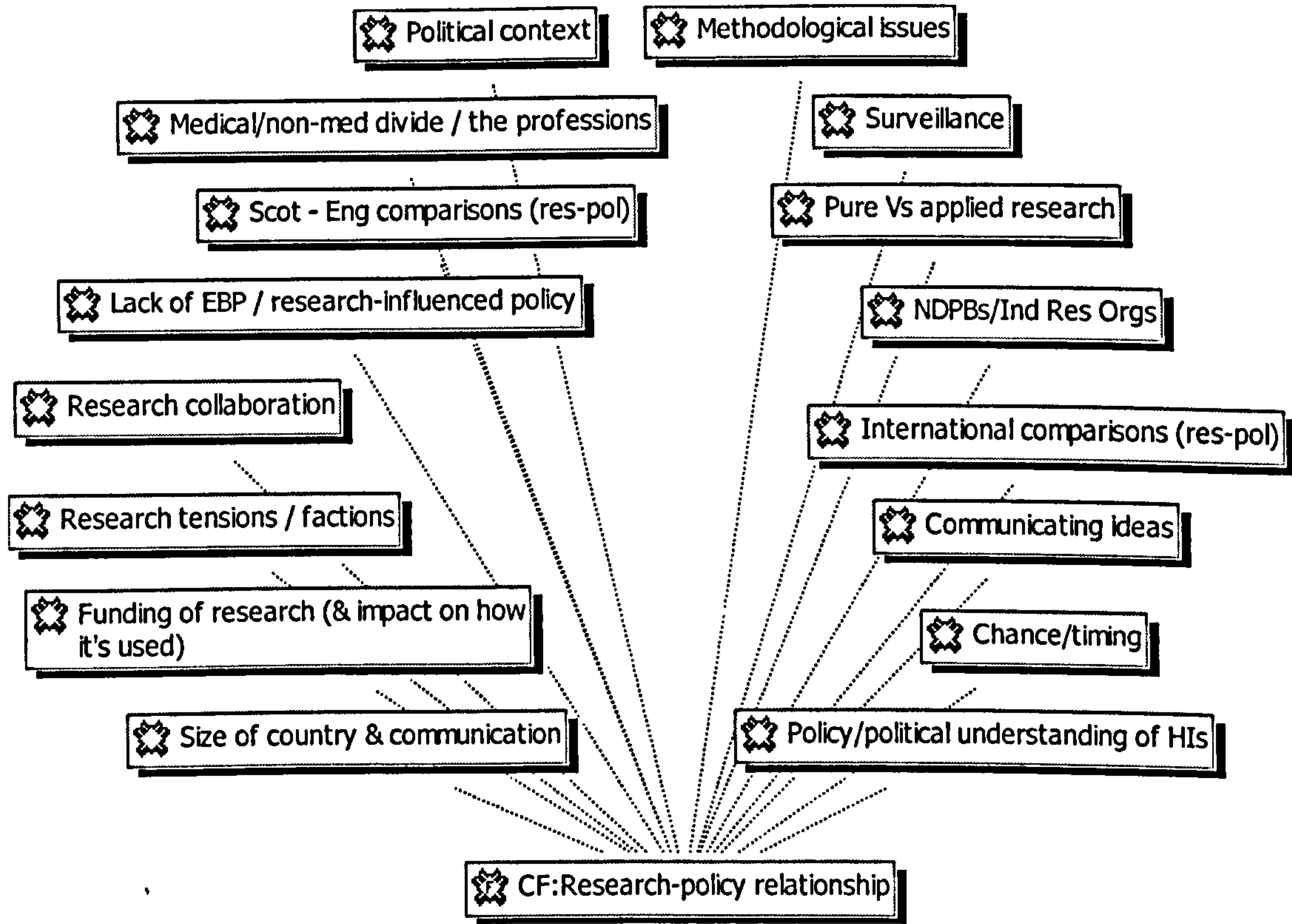












**Appendix VI: Solo-authored article (published in *Geoforum*\* in 2006) relating to the methodology which informed my approach to the interviews for this PhD.**

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# Problematizing power relations in ‘elite’ interviews

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## Abstract

Methodological debates about interviewing ‘elites’ have recently received significant attention within human geography. Many of the contributors to this debate have suggested that there is something intrinsically different about interviewing ‘up’, which geography’s methodological literature needs to make space to consider. This paper argues that, in fact, the distinction between ‘elite’ interviewees and other types of interviewees is based on inadequate and widely critiqued conceptions of power. If, instead, geographers employ a poststructural understanding of power, we may be able to achieve a more sophisticated analysis of power relations within the interview space.  
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*Keywords:* Elites; Interview; Power; Poststructural; Complexity

## 1. Introduction

Human geography is an expansive subject and, consequently, it can sometimes be difficult to sustain an interest in areas of research which do not seem to relate to one’s own. Yet, this paper emerged out of discussions with a human geography colleague who was about to embark on a very different research project from my own and is a good example of the benefits of discussions within geography.

We had been asked to facilitate a seminar discussing the use of interviews as a methodology. I was about to undertake a project involving interviews with policymakers and academics, whilst my colleague was in the early stages of a research project which involved interviewing people living in a relatively deprived area of Glasgow. It seemed obvious to us that the seminar would involve some discussion of the differences between these two types of interviews: those for which the interviewees were in a relatively powerful position; and those for which the inter-

viewees were relatively disempowered. So it came as a surprise to us that many of the issues we ended up discussing were remarkably similar. When I thought about it further, it was actually more surprising that we had ever thought we could so easily distinguish our research participants into two clear categories: those ‘possessing power’ as opposed to those who we viewed as ‘disempowered’. Yet, it seems that this distinction continues to be used by some human geographers in methodological texts.

In a recent article, Desmond (2004) joins a growing number of qualitative researchers who claim that there is a gap in the methodological literature relating to researching people in positions of power and authority (e.g. Bradshaw, 2001; Hertz and Imber, 1995; Ostrander, 1995; Kezar, 2003; Puwar, 1997; Parry, 1998; Hughes and Cormode, 1998). This is perhaps because, as Ostrander (1995, p. 133) suggests, ‘social scientists too rarely “study up”’. It is frequently argued that this gap is important because guidance based on researching ‘non-elite’ groups may be inappropriate for researching ‘elites’:

*‘Working in an elite field poses major difficulties which stem from the challenges of researching up, which are quite different to those encountered in studying down.’  
(Desmond, 2004, p. 262)*

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*'While some of the concerns are the same in both cases, interviewing elites does raise different sorts of issues than for researchers studying less powerful groups.'*  
(England, 2002, p. 200)

The difficulties that authors have suggested relate specifically to 'researching up' incorporate issues at every stage of the research process, from the initial planning stages through to dissemination of the results. It has been variously argued that 'elite' groups are more difficult to penetrate than other groups (e.g. Cochrane, 1998; Desmond, 2004; England, 2002; McDowell, 1998; Parry, 1998; Sabot, 1999), that they are better equipped to protect themselves and are better positioned to manipulate research results and dissemination (Sabot, 1999; Bradshaw, 2001). As a result of these perceived differences, several researchers have argued that empowering and collaborative approaches to research, which are so often advocated in contemporary human geography, may not be appropriate for studying these groups (e.g. Bradshaw, 2001). Indeed, several academics who have researched people in positions of power have openly acknowledged that they treated the research participants quite differently from the ethical 'best-practice' that they would normally adhere to (e.g. Spencer, 1982; Routledge, 2002). This situation raises some difficult questions for an academic community that has largely acknowledged the hybrid and multifaceted nature of power.

This paper will examine concepts of power in relation to qualitative interviews and will argue that the identification of individuals as 'elite' often relies on structural notions of power which have been usefully critiqued elsewhere in geography. Furthermore, claims highlighting the differences between 'elite' and 'non-elite' interviews may conceal both the differences within groups of participants and the extent to which research experiences vary with context. Some recurring claims about the specificity of 'elite interviews' are considered in detail, with the aim of demonstrating that most of these concerns resonate beyond 'elite' interview spaces and can be better understood if a poststructural notion of power is applied to the whole interview process. I argue that there is indeed a need to address some important gaps in the literature around effective and ethical interviewing but that there is no unambiguous link between this current disparity and researching 'elites' in particular. Rather, there is a need to overcome the current schism between conceptions of power within some of geography's methodological literature and the more complex ideas discussed in theoretical texts. The paper goes on to argue that, by employing more sophisticated accounts of power, it may be possible to usefully re-conceptualise the power dynamics involved in the process of interviewing.

The paper begins by discussing the ways in which power, particularly in relation to interviews, is conceptualised in geographical literature, and reflects on the difficulties in defining and identifying 'elites'. The next section specifically

considers three of the main ways in which it is claimed that 'elite' interviews may differ from other types of interview: gaining access to research participants; using collaborative approaches to the research; and the use of ethical guidance/codes of conduct. The penultimate section draws on the poststructural conceptualisations of power discussed earlier in the paper, together with some key methodological texts by feminist geographers, to illustrate the important role of reflexivity in trying to unpack the complex and shifting dynamics between researchers and their participants. The aim, informed by my own experiences of interviewing policymakers and senior academics, is to suggest ways in which power relations connected to the process of interviewing might usefully be further reflected on. Finally, I attempt to draw my arguments together into some preliminary conclusions, which I hope add a further dimension to some of the existing debates which have emerged from feminist geographers' methodological work and will perhaps stimulate further debate amongst geographers interested in using qualitative research interviews as a methodology.

## 2. Conceptualising power in research interviews

The intricacy of power relations in interviews is highlighted by Pile (1991, p. 464), who acknowledges that, 'the structures of power between the interviewer and the interviewed are complex and unstable,' and calls on geographers to reflect more seriously on the 'the (emotional, power) relationship between the interviewer and interviewed' (see also England, 1994). Pile's stance is supported by significant numbers of other human geographers who have called for a greater consideration of power relations in qualitative research (e.g. England, 1994; Baxter and Eyles, 1997; Rose, 1997; Bondi, 2003). Yet, aside from these (mostly feminist) examples, many methodological papers within human geography do not appear to have responded to Pile's (1991) request that we practice 'interpretative geography' and have instead continued to employ rather simplistic assumptions about power. This is despite the fact that Few (2001, p. 30) argues 'power' is currently 'one of the most contentious concepts in social science,' a claim supported by the existence of a wealth of literature outlining and debating extremely complex interpretations of 'power'.

It would not be possible to give an overview of the multitude of contributions to theorisations of power (e.g. Allen, 2003; Lukes, 1974; Morris, 1984; Russell, 1938) within the confines of this article. So, for the purposes of this paper, I draw on two important variations in the conceptualisation of power. The first view, which I shall call 'structural', views power as an inscribed capacity, something which is appropriated by particular individuals or organisations. From this perspective, power is configured across society so that particular individuals and organisations 'possess' power, which they can use to achieve certain outcomes, whilst others are 'powerless' (or, at least, far less



powerful). Power is always possessed but not always exercised and, as a result, power is perceived as 'always potential' (see Allen, 1997, p. 60). Marxist geography tends to be based on these ideas, viewing power as something which is located in particular institutions and sections of society (e.g. capitalist organisations and the 'ruling classes'). The alternative view, which I shall call 'poststructural', portrays power in a far more fluid manner, as something which is exercised but not appropriated. These poststructural re-theorisations of power have emerged out of the ideas of Henri Lefebvre and Michel Foucault and have been used to critique structural ideas. From this viewpoint, power cannot be possessed and is rather, 'something which passes through the hands of the powerful no less than through the hands of the powerless,' (Allen, 1997, p. 63). Rather than being inscribed in particular individuals or organisations, power is seen as far more diffuse and mobile; it is continually circulating and allows more possibility for the role of individual agency. More recently, Allen (2003) has critiqued both these approaches, arguing instead that power is an *effect* rather than any substantive 'thing' and that power is visible only in its various (but different) modalities: seduction, coercion, manipulation, dominance and authority.

Allen's (2003) ideas will be returned to later on in this paper. For the moment I want to make the point that whilst poststructural interpretations of power have been highly visible in recent theoretical geography (see, for example, Philo, 1992; Driver, 1997; Sharp et al., 2000), they appear to have made less of an impact on more practical avenues of the discipline. A number of the articles that focus on interviewing 'elites,' rely on structural interpretations of power in at least two ways (there are exceptions, especially in feminist geography, and these will be discussed later). Firstly, authors who discuss 'elites' as an unproblematic category of people, are assuming that it is possible to clearly identify 'powerful people' (i.e. it is relatively obvious which people in society possess the authority to exercise power). Secondly, they tend to assume that the power associated with people through their professional positions will transfer directly onto the interview space (i.e. that it is transferable across contexts because it is inscribed in particular individuals). This section will draw on examples of research experiences to demonstrate that both these assumptions are questionable. Examples of feminist research are then used to illustrate that some geographers have already begun to problematise power relations in interviews. However, using Rose's (1997) analysis of the limits of reflexivity and positionality, I suggest that many of these attempts have not yet gone far enough in acknowledging the complexity of power relations. In particular, these reflections often focus on the interview space, without revealing much about the role of power in the research process as a whole.

Along with many others (e.g. Hughes and Cormode, 1998; Nader, 1972) I agree that it is just as important to study those who influence important decisions as it is to

research the lives of those affected by these decisions. However, I am uncertain about how easy it is to identify the people who influence 'important decisions'. The factors that researchers have used to signify 'elite' varies greatly from context to context; whilst Parry's (1998) research on 'gene-hunters' focuses on people with an elite form of *knowledge*, McDowell (1998) and England (2002) both focus on professionals working in prestigious *financial institutions*, and Sabot (1999) and Cochrane (1998) use 'elite' to signify people holding positions of *political authority*. Oinas (1999, p. 352) suggests, 'an elite status can be regarded as stemming from the control of resources' but, with such diversity between the kinds of resources 'elites' are perceived to control, I am not sure how useful the category is. Furthermore, I do not believe that it is possible to clearly segregate people into dualistic categories of 'elite' and 'non-elite' (or 'powerful' and 'vulnerable'); no-one is removed from the effects of power in societies and all those involved in making or influencing important decisions are also effected by the decisions of others. Consequently, I am wary about the use of the term 'elite' as it appears in much of the methodological literature (e.g. Desmond, 2004; Hertz and Imber, 1995; Schoenberger, 1991). I am not alone in experiencing such unease. In fact, as far back as 1964, Reisman was already expressing discomfort with employing the term:

*"I am not happy with the term 'elite' with its connotations of superiority. Yet I have found no other term that is shorthand for the point I want to make, namely that people in important or exposed positions may require VIP interviewing treatment on the topics which relate to their importance or exposure."* (Reisman, 1964, p. 528 n. 16, quoted in Dexter, 1970, p. 5)

Yet, as Cochrane (1998, p. 2127) points out, the tendency for researchers to take the definition of 'elites' for granted has persisted, 'even if they might claim a more sophisticated understanding in principle.' The idea that 'elites' can be neatly defined and treated as consistently powerful is a view which relies on the rather simplistic idea that there is a dichotomy between 'powerful elites' and 'powerless others'. The use of dualistic categories (e.g. male/female, black/white, etc.) has been contested by some feminist geographers (see Valentine, 2002) and there is no reason why dualisms of power should escape such critiques. Such an outlook ignores the proposition that power exists in a variety of modalities (Allen, 2003), that these modalities of power can be negotiated and are neither constant nor inscribed and, consequently, that 'elites' may change over time (even during the course of one research project). That the identification of 'elites' is so rarely problematised is surprising considering the extent to which poststructural notions of power have informed recent geographical texts (as discussed earlier). Yet, Woods (1998, p. 2101) is one of the few academics writing on the subject of researching 'elites' to argue that the term ought to be carefully re-examined in light of poststructural critiques:



*'...the re-emergence of the term 'elite' in social science literature has often been superficial and atheoretical. Compared with other terms of social categorisation – class, race, ethnicity, gender and community – 'elite' remains remarkably unproblematised, employed largely as a short-hand term for those actors who are in some way perceived to be more powerful or more privileged than some unidentified group, but without any substantive conceptual depth.'*

In light of this apparent under-theorisation, it is perhaps unsurprising that several authors who have employed the term 'elite' have attempted to re-define it to suit the specific purposes of their research (e.g. McDowell (1998) suggests 'professional elite', Parry (1998) suggests 'hybrid elite'). These attempts at re-defining what 'elite' signifies suggests some researchers already acknowledge the subjectivity involved in identifying who is and who is not 'elite'. However, the term is still frequently used to refer to people in 'positions of power'. Woods (1998, p. 2105) argues that a more productive approach to re-conceptualising 'elites' would imagine society as a 'web of social relations', implying that there is no 'natural order' to society and rather that it is 'constructed through social interaction.' This appears to be consistent with Allen's (2003, p. 8) conception of power as, 'only ever mediated as a relational effect of social interaction'. This is not to say that the concept of 'elites' is redundant, rather that the view of 'elites' as 'power holders' should be replaced by a more flexible interpretation, which defines 'elites' as individuals who appear to routinely exercise power, 'without significant challenge to the legitimacy of their authority' (Woods, 1998, p. 2106).

Authority is one of the modalities which Allen (2003) describes as a form of power and he seems to suggest that it is perhaps more easily identifiable than power itself, so Woods' definition of 'elites' is potentially useful. However, whilst it may be possible to identify people who hold positions of authority in a variety of contexts (e.g. senior managers, religious leaders, cabinet ministers, etc.), I would argue that it may be far less easy to be certain that these individuals are routinely exercising power 'without significant challenge to the legitimacy of their authority.' As Shurmer-Smith's (1998) reflections on her research with 'elites' employed in the Indian Administrative Service demonstrates (discussed in more detail later in this paper), those who may first appear to the researcher to be in positions of authority (by virtue of their professional position) may in reality not exert as much influence as first perceived. There might also be other, perhaps more obscure, 'elites' who exert influence through personal networks (Woods, 1998). As Cochrane (1998) argues, 'one measure of power might be the extent to which policy can be influenced or determined without it being clear who has exerted it'. Indeed, as Parry (1998) explains, those exercising power in a particular field may be a disparate, informal or even invisible network of people, dispersed across a variety of locations and professions.

If we acknowledge these claims, the difficulties involved in the process of identifying exactly who is exerting influence in a particular context are clear. The more obscure kinds of 'elite' described by Woods, Cochrane and Parry may not necessarily be visible to the researcher, particularly in the early stages of a research project, which is when the process of identifying potential participants is often undertaken. Consequently, whilst I am not entirely opposed to the use of the term 'elite,' in identifying the participants in my own research (civil servants, ministers and academic researchers) I have chosen not to use 'elite' as a label (although I have drawn heavily on literature which does, so it is not entirely absent as a notion). Instead, I refer to the specific genre within which the interviewees do most of their work (as outlined above). I am not necessarily advocating this style of 'labelling' as an alternative to the use of the term 'elite,' it is merely how I felt most comfortable in describing the interviewees in this particular research project, where the context of participants' authority varied significantly between interviewees. However, I do believe geographers wishing to employ the term should reflect on their definition of 'elite' and the uncertainties involved in really knowing who is exerting what kinds of power.

Aside from the problem with defining 'elites,' there are complexities involved in considering how the authoritative position of interviewees may effect the power relations within the interview. Some of the literature appears to presume that the power and authority available to 'elites' in their professional life will translate directly onto the interviewer-interviewee relationship, ignoring both the Foucauldian observation that power cannot be appropriated and Allen's (2003) argument that different modalities of power should not be confused:

*'These are, recall, very powerful and self-assured people, talking, moreover, to an obscure academic who poses, so far as they are concerned, absolutely no threat.'* (Schoenberger, 1992, p. 217)

*'...with elite interviewees the [interviewer-interviewee] relationship is inevitably asymmetrical regardless of the research strategies deployed.'* (Desmond, 2004, p. 265)

The above quotations leave little room for the possibility that individuals, whatever their professional position, may feel exposed or vulnerable in interviews, yet both Sabot (1999) and Puwar (1997) state that some of their 'elite' interviewees seemed to perceive them as a threat, indicating that 'elites' are not always as secure as Schoenberger (1992) implies. In my own research with policymakers and academics (who were all further up the academic hierarchy than me), I rarely felt that the interview space involved consistently asymmetrical power relations which favoured the interviewees. In fact, I have frequently been surprised by the level of self-reflection, uncertainty and nervousness tangible in some of the most senior (in terms



of their position within professional hierarchies) interviewees, as well as their willingness to share their thoughts with me (see also McDowell, 1998). Interestingly, the few occasions where I have felt that an interviewee has specifically attempted to demonstrate their relative authority compared to me have been in interviews with some of the relatively less 'senior' participants (involving things such as getting secretaries or personal assistants to fetch me from reception rather than meeting me themselves, or challenging me about my own opinions during the interview).

At this point, it is appropriate to acknowledge the important contributions made by feminist geographers, some of whose work has already been drawn upon, in opening up discussions about power relations in interviews. In particular, feminist researchers have often used reflections on positionality to 'unpack' power relations between the researcher and the researched, situating both within wider societal power structures; the idea being that by making one's position 'known' and 'visible', the specificity of research perspectives and claims to knowledge become clearer. In doing so, feminist work aims to expose 'unseen, gendered power relations' (Rose, 1997, p. 309). These ideas seem to suggest that reflexivity might be a powerful tool for re-considering the power dynamics within the research interview. One researcher to reflect in detail on her interactions with 'elite' interviewees is McDowell (1998, p. 2138), who discusses the way that, after 'a quick assessment of a range of visual and verbal clues,' she presented herself in different ways to different interviewees:

*'In some interviews I seemed to fall into the classic male-female pattern, for example with an older charming but rather patriarchal figure I found myself to some extent 'playing dumb'; with an older and extremely fierce senior woman I was brusquely efficient, with other women I was 'sisterly' in the sense of the same age - same position, with some of the younger men I was superfast, well-informed, and definitely not to be patronized.'*

McDowell's account responds well to feminist geographers' calls for researchers to be more reflexive about the research process and to pay closer attention to the shifting dynamics of positionality and power involved in interviewing. Reflexivity can, however, be a difficult process and, as Rose (1997) points out, it often still relies on the idea that a 'wider power structure' exists and can be known and understood by the researcher. The notion of positionality relies on the idea that the researcher-self is 'a transparently knowable agent whose motivations can be fully known' (Rose, 1997, p. 309). Despite agreement that the characteristics of those involved in an interview are likely to have an effect on the conversation that entails, there is also a consensus that it is difficult to know exactly what this effect is (see Bondi, 2003, 2005; Rose, 1997; McDowell, 1992b, 1998; Schoenberger, 1992). If we accept the poststructural

idea that people (including both the researcher and the interviewee) are multiply positioned and do not have one single identity (Fardon, 1995; Parry, 1998; McDowell, 1998), it seems understandable that power dynamics are liable to shift within interviews:

*'In other words, as the interview develops, we are constantly (re)producing "ourselves" so that both researcher and interviewee may be multiply positioned during the course of an interview.'* (Valentine, 2002, p. 121)

It may not ever be possible to comprehend some of the subtleties of these interactions but this does not mean that we should discard attempts to reflect on positionality and power relations in research. Whilst it may not be possible to ever fully understand the nature of the power relations or shifting positionalities within an interview, Rose (1997), England (1994), McDowell (1998) and Bondi (2003) all demonstrate that it is possible to think and write about these relations in a more open and discursive manner than has been generally undertaken. The commitment to the usefulness of reflexivity, despite an awareness of its limitations, is summed up well by Valentine (2002, pp. 125–126) in the quotation below:

*'We cannot ever really know what is going on in any given research encounter and therefore how the knowledge we take from it is being produced, nor how the information we use might have been different if our performances had been different.'*

*'This is not to suggest, however, that as researchers we should forget the notion of being reflexive altogether. But rather than attempting the impossible quest of trying to identify a transparent knowable self, our focus should instead be looking at the tensions, conflicts and unexpected occurrences which emerge in the research process, [...] By exploring these moments we might begin to decenter [sic] our research assumptions, and question the certainties that slip into the way we produce knowledge.'*

Although the notion of reflexivity has been successfully employed by a variety of feminist geographers as a means of providing sophisticated analyses of interactions within the interview space (England, 1994; McDowell, 1998; Rose, 1997), I believe there needs to be more reflexivity about the interview process as a whole. McDowell's (1998) article is rare in its reflections on the interview process from start to finish and she herself describes being continually surprised at 'how 'substantive' texts remain so different and separate from 'methodological' texts,' (McDowell, 1998, p. 2140). In the following section, I attempt to disrupt the idea that there is something inherently 'different' about interviewing 'elites' by considering three of the most frequently cited 'difficulties,' which relate to the process of interviewing as a whole rather than solely focusing on the research encounter.



### 3. Perceived particularities about interviewing 'elites'

This section looks in more detail at some of the key issues that a variety of authors claim to have found problematic specifically in interviews with 'elites'. For each issue, examples will be used to demonstrate that the problems outlined are not unique to interviewing 'elites' but are instead issues which all qualitative researchers may encounter. The aim is to demonstrate that Cormode and Hughes (1999, p. 299) are not necessarily correct to claim that, '[r]esearching 'the powerful' presents very different methodological and ethical challenges from studying 'down'. It is not my intention to suggest that significant differences between various types of interview do not exist, rather that differences are context-specific and cannot be generalised by labelling interviewees 'elites' (or not). For each case considered in this section, I try to show that employing the more complex and fluid understandings of power offered by poststructuralism allows for a more sophisticated analysis of the situation.

#### 3.1. Gaining access

It is generally accepted that trying to gain access to research groups is a problematic aspect of many social research projects. Several authors (e.g. Cochrane, 1998; England, 2002; Sabot, 1999) have suggested that it may be particularly difficult to access 'elite' groups as they are more accustomed to negotiating terms and conditions, or even preventing access, than other groups. Hertz and Imber (1995) go so far as to suggest that the establishment of barriers to keep other members of society out is part of what defines a community as an 'elite.' Leaving aside, for the moment, my suggestions that even the process of labelling particular individuals as 'elite' is problematic, I want to argue that there are other difficulties with Thomas' (1995) observation:

*'Penetrating the social life of a neighbourhood can be difficult, but usually does not take as concentrated a form as it does in a large company. You cannot just walk into an office suite and expect to strike up a conversation or hang out and observe the scene – the courtesies a letter carrier or a drugstore clerk might extend to a stranger in the neighbourhood are generally not extended by executive secretaries to intruders who obviously 'don't belong.'* (Thomas, 1995, p. 5)

In fact, some researchers of far more marginal groups may face even larger obstacles in accessing their research group than researchers interested in large companies. An example of the potential extent of these difficulties is provided by Bourgois' (1995) research, which involved accessing a Puerto Rican neighbourhood that was involved in illegal drug dealing. Not only did Bourgois find that his position as a white, professional researcher meant he clearly did 'not belong', but he also lived with the constant fear that, once gained, access could be denied at any point. On several

occasions, a research participant became so wary of Bourgois' research that he was informed it was not only his research, but also his life, which was at risk of being brought to an abrupt halt. It is difficult to conceive of circumstances in which gaining and maintaining access to any research group could be much more problematic for a researcher than this, which leads me to suggest that whilst gaining access to powerful groups may indeed be extremely difficult, this is no more true of 'elites' than it is for some other groups. Whilst this example illustrates this point in a rather extreme manner, there are plenty of other accounts of the difficulties involved in 'accessing' particular research participants. For example, Taylor (2004) provides a detailed account of the problems she experienced in trying to identify and contact working-class lesbians. Taylor found the previously acknowledged difficulties in researching lesbian lives (John and Patrick, 1999) was heightened by her desire to focus on (self-identifying) 'working-class' lesbians, who did not appear participate in the lesbian groups she made contact with, or hang out at the gay and lesbian commercial venues (such as cafes and restaurants) that she placed posters in.

Techniques of negotiating access may vary considerably between research contexts but the likelihood of experiencing difficulties in gaining entry to a field does not necessarily correlate with the perceived 'elite' identity of a group. Taylor's (2004) research experience illustrates that marginalized groups may be just as difficult to locate and identify as 'elites' and Bourgois' (1995) research demonstrates that individuals who may be thought of, from a structural perspective, as lacking power (the research participants largely consisted of an immigrant population living in a relatively deprived neighbourhood) may in fact be able to exert a different kind of power over the researcher. Taking a post-structural approach allows far more room for the kind of agency apparent in Bourgois' research participants and challenges claims that particular groups have significantly more (or less) capacity to prevent researchers from accessing the individuals involved.

#### 3.2. Collaborative approaches to research

Classically, the geographical researcher is presumed to be in control of the interview space (Pile, 1991). It is this presumption which has led some human geographers to attempt to disrupt the widely accepted 'powerful/powerless' dichotomy of the researcher-participant relationship through the adoption critical and reflexive methodologies. Examples of such approaches include action-research (e.g. Edwards and Talbot, 1994), member-checking (e.g. Lincoln and Guba, 1985) and contract negotiation (e.g. Baxter and Eyles, 1997), all of which incorporate an attempt to involve the people being researched in the research process. Interestingly, writing at a time before feminist critiques had made such an impact on the social sciences, Dexter (1970) was already arguing that a collaborative approach should be taken to interviewing 'elites'.



When Dexter was writing, the majority of guidance on interviewing technique suggested that the interviewer should maintain a polite and objective distance from the interviewee, by adopting 'business-like nature' (Moser, 1958). Dexter argues that a more collaborative approach is required when interviewing 'elites' precisely because they may be more knowledgeable (and powerful) in their field than the interviewer. In recent times, however, it seems the situation has entirely reversed, and researchers have begun to argue that the powerful position of some interviewees means that the 'new paradigm' of collaborative, interpretive approaches may not be appropriate for 'elite' interviews (e.g. Sabot, 1999; McDowell, 1992a).

One aspect of the collaborative research paradigm is the importance placed on disseminating research results (see Adler and Adler, 1993; Bok, 1982). Hunt (1993) has criticised many researchers for over-researching marginalised, deprived communities and failing to use the knowledge acquired to actively try to improve their situation. Drawing on her own experience of research on a housing project in Glasgow, Hunt (1993) argues that, in many contexts, researchers have a 'moral obligation' to ensure that the participants are aware of and, if possible, involved in the dissemination of the research results. Yet some researchers have argued that member-checking (i.e. where researchers check their interpretation of the research findings with the participants) is not appropriate for research on 'elites', who may try to exercise their power by requesting changes to the research write-up. It is, Bradshaw (2001) claims, as a result of member-checking that he found himself being forced to agree to a 15 year embargo on his Ph.D. thesis. However, Bradshaw (2001) accepts that he would not have gained access to senior managers at the two corporations he was interested in researching had he not agreed to conditions which *obliged* him to accept the changes requested by them. It was this agreement which resulted in the embargo on Bradshaw's thesis, rather than the decision to share his findings with the participants. Had such a strict agreement not been a requirement of access, the perspectives of the participants on the findings could have added an interesting dimension to the project without necessarily requiring an embargo. I agree with Al-Hindi Falconer and Kawabata (2002, p. 111) that, '[i]f feminist researchers really believe in sharing power and validating the knowledges of research participants, we must pursue their perspectives and invite their observations, no matter how uncomfortable for us these may be.' This may involve feeling out of control but it does not mean that researchers must pass complete control of the eventual content of research write-ups to participants.

Whilst Bradshaw's account is particularly persuasive at highlighting the potential dangers of giving people in authoritative positions too much control over the research process, Herzog (1995, p. 176) argues that, even in elite settings, the relationship cannot be one-sided and that, 'informants have an interest in the information they provide'.

Although Bradshaw (2001) found that the 'interest' expressed by his research participants was actually a means of the senior staff at the companies he was researching ensuring that the research presented them in a 'good light', Herzog (1995) found that interacting with the research participants allowed the participants to use her findings as a 'mirror', enabling the participants to learn and change as a result of the experience.

In an attempt to relate feminist, narrative methodologies with 'elite' interviewing techniques, Adrianna Kezar (2003) also argues that it is possible (and useful) to attempt to empower 'elite' respondents and that this need not result in negative outcomes for the research. Part of Kezar's argument rests on a separation between power within the interview space and the wider power structures that (she believes) are woven into society; Kezar suggests that by using 'empowering' interview techniques, it is possible to aid participants to transform their views and work towards breaking down societal hierarchies. Whilst she admits that this is dependent on a willingness to change on the part of the interviewee, Kezar argues that this should not prevent the interviewer from trying to relate as deeply as possible to the interviewee, allowing perspectives to be altered on both sides (Kezar, 2003, p. 412). Dexter's (1970) book, and Kezar's (2003) and Herzog's (1995) articles suggest that a collaborative approach can be entirely suitable for interviewing 'elites'. It would therefore seem that the problem is not that 'elite' interviews do not fit guidance which advocates a collaborative and empowering approach to interviewing. Instead, what is missing from much of the available interview guidance is a consideration of the complexity of power relations within the process of interviewing as a whole, combined with a full acknowledgement of the impossibility of knowing the outcomes of particular approaches in advance.

### 3.3. *Ethics and codes of conduct*

Attempts to cordon-off 'elite' research as demanding a different type of ethical framework from other kinds of research are problematic for a variety of reasons, not least because this is dependent on the researcher's ability to define who does and who does not exercise power. Yet, although Bradshaw (2001) is careful to point out that, as researchers, 'we cannot work with two codes, one for researching up and one for researching down,' (Bradshaw, 2001, p. 204) some researchers admit to doing exactly this. In a study of a US Military Academy at West Point, USA, Spencer (1982) actively deceived and betrayed several of the research participants, arguing that where researchers face 'conditions of hostility and mutual suspicion' when researching 'elites,' '[t]he usual reciprocal alliances between researcher and the researched do not exist,' (Spencer, 1982, p. 28). Effectively, despite acknowledging that his position went against the American Sociological Association's Code of Ethics, Spencer concludes that:



*'I believe it is legitimate, under certain conditions, when dealing with powerful bureaucracies, to mask one's true purpose of seeking facts rather than the perpetuation of myths, in order to obtain the information essential to sustain a free society. . . . Social scientists must establish their legitimacy to conduct research at the level of bureaucratic elites, and not simply conduct research which serves these elites. If legitimacy cannot be established, then conflict methods should continue to be utilised.'* (Spencer, 1982, pp. 29–30)

Admittedly, this example is drawn from a period before reflective and collaborative research techniques were so widespread. However, in an interesting twist, Routledge (2002) has drawn on the 'new paradigm' of collaborative and empowering research methodologies to justify his decision to masquerade as a tour operator in order to obtain information from various authorities involved in the tourist industry in Goa, India. Routledge and Spencer's positions are similar in so far as they argue that their political beliefs justified the deception of people and groups in powerful positions. Whilst these two examples may seem extreme, in a far more banal way a similar argument is made within a great deal of research involving 'elite' groups. Drawing on his own experience of interviewing the 'Political Elite', Lilleker (2003, p. 209) unselfconsciously suggests couching controversial topics in broad terms, whilst trying to 'flatter' the respondent by emphasising their influential role in the matter. Cochrane (1998, p. 2124) quotes Richards (1996) describing how it is important to create the 'right impression' when interviewing 'elites' by dressing appropriately and 'establishing a rapport' through research into the interviewees' backgrounds. Puwar (1997) advocates similar ideas when she explains how she went about establishing 'rapport' in her interviews with women MPs. These examples all suggest that the researchers felt the 'powerful' position of their research participants warranted some level of manipulation, a suggestion which resembles much of the interviewing guidance that existed before the 'new paradigm' of reflexive and collaborative research emerged (see Oakley, 1981).

The danger in the belief that research on 'elites' does not require the same level of ethical conduct as other types of research is apparent in Shurmer-Smith's (1998) research experience. At the start of her research, Shurmer-Smith (1998, p. 2165) contemplated the view that the hierarchical societal position of the group she was researching rendered the usual ethical concerns of qualitative research less problematic (see also Parry, 1998, p. 2159):

*'Studying elites such as the IAS [Indian Administrative Service] seems, on the surface, to be a way out of the moral impasse of aiming to do 'good' research with real people, without having to worry about doing violence to them. One identifies a category of people who seem to have an unfair advantage: any theft of their souls is no more than a featherweight in the scales of life-chances. When one exposes the beliefs and practices, doubts and*

*foibles of an elite, it even seems one does some little service for their subalterns. Surely one need not exercise one's conscience about revealing the lives of people who live so publicly and so well in such a poor country, people daily exposed in the press and local gossip as obstructive bureaucrats and corrupt operators?'*

However, Shurmer-Smith (1998) goes on to explain that, once drawn into the life-world of the IAS workers and their families, she began to uncover a divided, insecure and rather vulnerable group of people with a range of political and personal agendas. Again, this example points towards the potential usefulness of employing poststructural conceptualisations of power. If we accept that power is dynamic, complex and difficult to interpret it becomes harder to argue that it may be justifiable to be guided by different codes of ethics when researching particular groups of people.

#### 4. Rethinking power within the interview space

As we have seen, poststructural conceptualisations of power call into question the notion that it is possible to identify interviewees as 'elite' or not, suggesting that Woods (1998) is right to highlight the relative under-theorisation of the term. Making room for discussions around the ways interviewees are constructed as 'elite', and reflecting further on what this means, may provide some helpful insights. As the above section outlines, Shurmer-Smith (1998) found herself usefully reflecting on the vulnerabilities and complexities evident amongst her 'elite' participants. Questioning assumptions about the modalities of power available to the 'elites' may also provide constructive avenues for researchers.

Poststructural conceptions of power disrupt the idea that the power associated with particular individuals in one context is easily transferred into other spaces. Almost all of the arguments which favour the idea that interviewing 'up' is a significantly different experience from other kinds of interviewing presume that the power the researcher perceives in the interviewee (as a result of his or her professional position) will be transferred in some way onto the interview space. Several examples already referred to in this paper (e.g. Shurmer-Smith, 1998; Sabot, 1999) suggest that it is not always the case that 'elites' exert the power associated with their professional position in the research space. Perhaps we need to make room to consider the possibility of 'vulnerable elites'.

As well as arguing that 'elites' may be more vulnerable in interviews than many researchers suggest, we also need to resist other assumptions about the location of power during interviews. Although, in terms of authorship, the researcher (where this is also the author) *does* exert significant levels of power in relation to the voices of the researched (see McDowell, 1998, p. 2144), this does not necessarily mean that the researcher is always in a position of power within the research encounter. Davidson's (2001)



reflections on the ways in which the women she researched (participants of self-help groups for women who had experienced agoraphobia) asserted their authority and control in ways she had not previously considered, such as through humour, provides a useful account of the ways in which the anticipated power of the researcher may be challenged. Whilst one can understand Pile's (1991, p. 467) suggestion that, 'the author must relinquish the claim to represent other people,' the process of the interview involves at least 'two consenting adults' (Parry, 1998, p. 2161) and it seems better to understand the power relations in this space as negotiable and not necessarily one-way. As Few (2001, p. 30) asserts, resistance is 'just as much a mode of power as 'domination'' and power should not be viewed in a uni-directional sense, 'even in the most unequal of power relations.' If we employ poststructural ideas about power, we should accept that power relations within interviews are unpredictable and variable.

Returning to the story with which this paper began, when my colleague and I later discussed our research experiences (after we had undertaken our respective interviews) it was interesting that my experiences 'in the field' seemed to have been significantly easier than hers. I had been able to identify and locate potential research participants relatively easily (through government and university websites), I was fortunate enough to have had an extremely good response rate and, as I mention earlier in this paper, I rarely felt disempowered within the interviews (and never in any serious way). In contrast, my colleague experienced significant difficulties with locating the types of interviewees she was searching for and, once located, she found potential participants were often resistant to discussing the topics she wished to ask them about. Furthermore, she sometimes felt uneasy and threatened in the research environment she was working in (a relatively deprived and somewhat notorious area of Glasgow), in ways which I never did. We were not, therefore, 'wrong' in our original desire to focus on anticipated *differences* between the experience of interviewing in these two, contrasting research contexts. However, I believe the differences we did experience could not have been anticipated and it was beneficial for both of us to consider similar difficulties in advance. That my research experience turned out to be so much easier and less stressful than hers was unexpected and was, I believe, in large part due to the good nature of the particular research participants I contacted. I do not wish to dispute England's (2002, p. 208) claim that, 'it's very important not to put too much weight on luck and chance, or lack thereof. Negotiating and (hopefully) gaining access requires lots of careful preparation.' But I cannot help feeling that, in this example, my colleague's and my differing research experiences were significantly influenced by contextual factors beyond our control and which we could not predict. Our shared reflections (pre and post research) certainly challenged both of our initial assumptions about whom was more likely to feel disempowered, vulnerable or threatened within the interviewing process. For me, this experience not only highlighted the

usefulness of discussions with colleagues working in areas rather different from my own, it also demonstrated that the theoretical musings available in human geography's vast literature can have very practical applications.

Poststructural notions of power do limit the idea that we can ever fully reflect on either our own position (as researchers) or that of our interviewees. However, as Rose (1997) outlines, accepting the limits of reflexivity does not necessarily need to be a negative development. Once we accept that power exists in a variety of modalities and that it is not possible to ever fully understand the exchanges of power taking place in social interactions, we can draw on poststructural theories to frame our discussions and understandings of power in relation to the whole interview process. In practical terms, for interviews with so-called 'elites', this might involve far more discursive accounts of the modalities of power associated with the interviewees' professional positions, together with some acknowledgement that the extent to which interviewees are able to exert power in their respective positions can never be fully comprehended. Added to this, I believe it is important not to over-state the likelihood that 'elite' interviewees will attempt to exercise the kinds of power available to them in their professional capacities within the space of the interview (i.e. power within a particular profession should not be assumed to be automatically projected onto the relationship between the interviewer and interviewee). Within the interview space, reflections on dynamics of power might benefit from considering the different modalities of power that Allen (2003) identifies. Overall, I suggest that researchers might benefit from applying more complex interpretations of power to the whole process of interviewing, from the preparatory stages right through to dissemination.

## 5. Drawing some reflexive conclusions

Classic approaches to the interviewer–interviewee relationship tend to portray the researcher as the one in the position of relative power (Pile, 1991). Some researchers interested in interviewing people they term 'elite' have used this idea to argue that one of the factors which makes interviewing 'up' so different from other types of interview is the likelihood that this anticipated dynamic of power is disrupted when the interviewee is a 'powerful individual'. This claim relies on a structural perspective of power in two ways: Firstly, it requires that structures of power exist and people's position within these structures are tangible to researchers even before the interviews commence; secondly, there is an assumption that power can be appropriated by individuals and transferred across contexts (from their position in a professional hierarchy, for example, into the space of the interview). From a poststructural perspective, the idea that it is possible to clearly define and identify particular individuals as 'elite' is problematic. This is not to suggest that people or organisations able to exert significant power do not exist, or should not be researched. Rather, this paper argues that researchers ought to reflect



more carefully on assumptions about where power lies and should consider that the power relations social scientists sometimes employ in relation to society at large do not necessarily translate directly into the interview space.

Whilst feminist geographers have usefully problematised power relations within the interview space, we have seen that calls for researchers to reflect on their own positionality still rely on the notion that it is possible to know and understand wider power structures (Rose, 1997). If, instead, we employ a poststructural theorisation of power to the whole research process, the potential exists to gain a more sophisticated understanding of power relations involved in interviewing (whether or not the participants are considered 'elite').

Drawing on a wide-range of interview and qualitative research experiences, this paper suggests that there is little evidence to support the idea that any areas of concern relate *specifically* to interviewing 'elites'. Instead, there seems to be an assortment of potential problems which *all* interviewers *may* encounter. This does not therefore mean that all interviewing is 'fundamentally flawed' but, as Oakley (1981, p. 51) states in her critique of the 'mythology of "hygienic" research', it does seem appropriate that the majority of interview guidance at least admits 'the goal of perfection is actually unobtainable.' Whilst it may not be possible to provide clear and prescriptive methods for approaching interviews (Hughes and Cormode, 1998; Rose, 1997) researchers can and, I suggest, should reflect on the power relations involved in the process of interviewing more deeply (Few, 2001). These reflections should be made available to readers (Cornwell, 1988; Oakley, 1981; Baxter and Eyles, 1997; Pile, 1991) and, as McDowell (1998) has argued, future methodological texts could usefully forge stronger links with wider conceptual and theoretical debates in the social science community.

### Acknowledgements

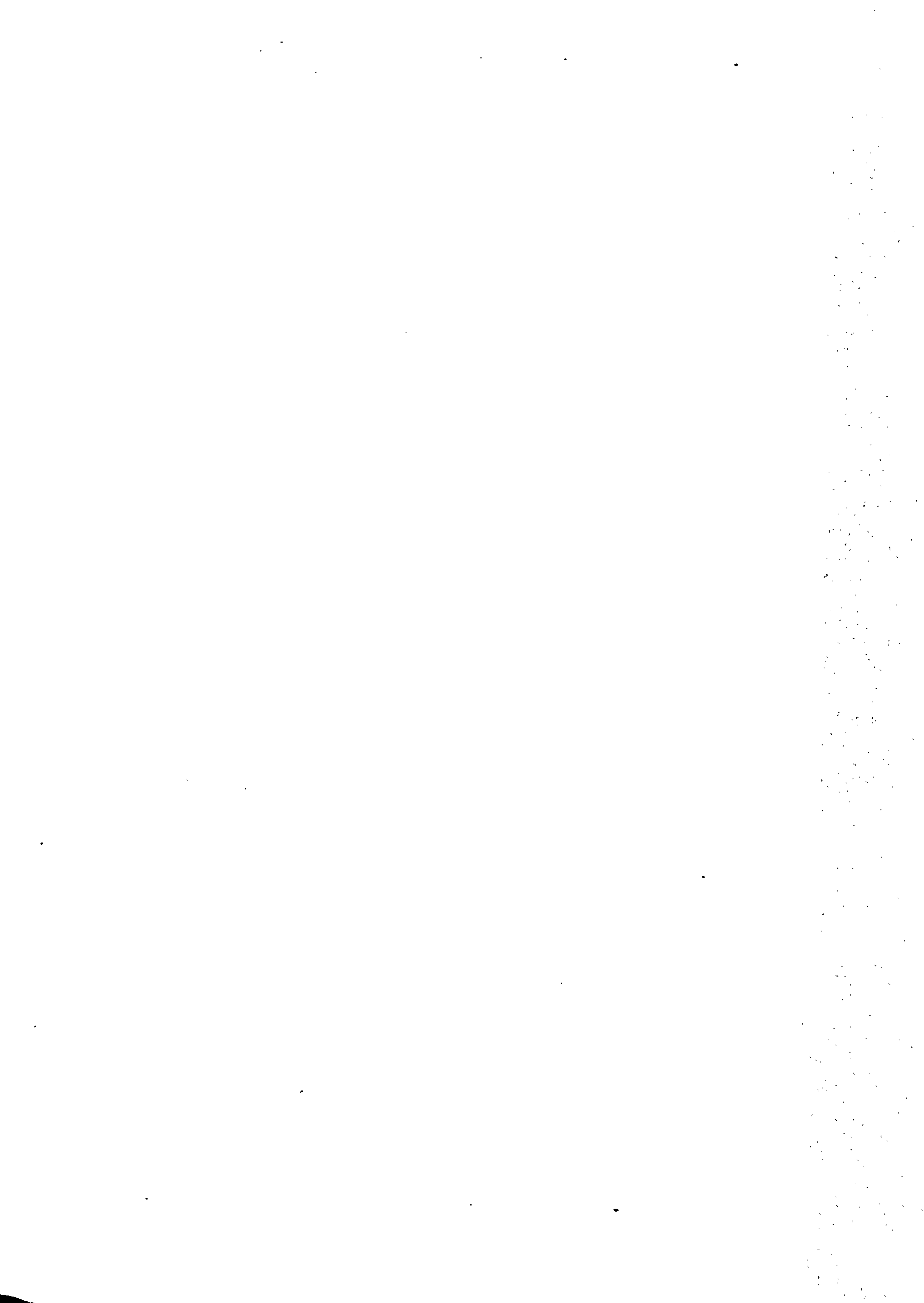
Thanks are due, in particular, to Professor Liz Bondi for her insightful comments on several drafts of this article. I would also like to thank Professor Susan J. Smith and Dr. Richard Mitchell for comments on an early draft of this paper, and my supervisory team as a whole for their collective (and much appreciated) support for me and my research. Susan Motherwell deserves significant acknowledgement for her input into the discussions from which this paper emerged. Finally, I am extremely appreciative of the supportive and constructive comments provided by Editor of *Geoforum*, Professor Andrew Leyshon, and three anonymous referees.

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## Appendix VII (a): Letter of invitation to potential interviewees to participate in research

«Title» «FirstName» «LastName»  
 «JobTitle»  
 «Organisation»  
 «Address»

DATE

Dear «Title» «LastName»,

### RE: An exploration of the relationship between research and policy for health inequalities in Britain

I am currently working on a research project (for submission as a PhD thesis) that investigates the relationship between research and policy in the field of health inequalities in Britain (with a particular focus on Scotland). The research will involve in-depth analysis of major public health policy documents, published since 1997, as well as a series of interviews with key figures working at the research-policy interface for health inequalities. It is partly informed by a one-year MSc research project (completed in September 2004), as well as a temporary placement at the Scottish Executive in September and October 2004. In case you would like a bit more information, I have enclosed a more detailed explanation of the research project.

Due to your involvement in the field of health inequalities, I am writing to establish whether you might be willing to be interviewed for this project. I am aware that you are probably extremely busy but I would be particularly grateful for your input due to your experience of <<Insert personalised section relevant to each addressee>>. The interview should take approximately one hour and I am happy to travel to a location of your choice.

I would like to take this opportunity to assure you that I am committed to ensuring that any information provided during interviews will be meticulously anonymised. If you do agree to be interviewed, I will provide you with a copy of the full transcript as soon as possible after the interview and if there is anything which you feel ought to be changed in order to clarify what was said during the interview, or to protect your anonymity, I will undertake changes as recommended by you before using any of the material in my research.

I will email you in the near future in order to establish whether you are interested in being interviewed for this research. If you would like to discuss the nature of this research project in more detail before you make a decision, I will be very happy to do so at this stage.

Yours sincerely,

Katherine Smith  
*PhD Research Student*  
*The University of Edinburgh*  
 Email: [K.E.Smith-2@sms.ed.ac.uk](mailto:K.E.Smith-2@sms.ed.ac.uk)  
 Telephone: 0131 6502528



## **Appendix VII (b): Information sheet about research project, enclosed with letters of invitation to potential interviewees**

**An exploration of the relationship between research and policy for health inequalities in Britain, with a particular focus on the Scottish context**

### **Summary of the intended research project:**

A key area of recent British social policy is that of public health, and there is a particular commitment to reducing health inequalities. A wealth of research exists on the causes and manifestations of health inequalities in Britain, yet many researchers feel that attempts to translate academic research into effective policy have been limited. It is not clear why this should be the case, particularly in light of the fact that the UK government has been actively encouraging a strong relationship between research and policy. For example, the 'Modernising Government' White Paper (March, 1999) highlights concerns about the need to improve the quality of policymaking and emphasises the British government's desire for 'evidence-based policy'. The Scottish Executive has also emphasised the need to increase 'knowledge transfer', particularly within the field of health, recently launching the Scottish Academy for Health Policy and Management (SE and NHS Scotland, 2003) as a means of bringing together health research, policy and practice. Using health inequalities in Scotland and England as the focus, this research aims to explore how research on a complex social issue has been transferred (or not) onto the policy agenda, in the hope that the findings can help inform a stronger research-policy relationship. Discourse analysis will be used to 'unpack' key social policy documents in order to examine which research ideas about health inequalities appear to have 'travelled' into the documents. Supplementing this, a series of qualitative interviews with researchers, policymakers and others working in the field will be used to shed light on mechanisms which facilitate the transfer of health inequalities research into policy. The project should be of relevance to anyone interested in better understanding the communication links between researchers and policymakers, as well as to all those with a desire to reduce inequalities in health.

### **Preliminary Research Questions:**

- 1) *How are health inequalities in Britain accounted for in key policy documents released since New Labour came to power in 1997?*
- 2) *How are Scottish health inequalities accounted for in key policy documents released since the establishment of the new Scottish Parliament, in 1999?*
- 3) *What evidence is used to support the British Government's and the Scottish Executive's approaches to health inequalities within these documents and how do approaches vary between England and Scotland?*
- 4) *How (by what mechanisms and pathways) does health inequalities research 'travel into' policy?*
- 5) *Do existing academic models provide an adequate conceptual framework for understanding the research-policy relationship?*

### **The need to explore the research-policy relationship**

Whilst much research exists on manifestations and causes of health inequalities, less is known about how policies to tackle health inequalities are formulated and implemented (Exworthy *et al*, 2000). Ever since the publication of the Black Report was limited to 260



copies by Thatcher's government in 1980, many academics researching health inequalities have expressed frustration at what they often view as a reluctance to act on their evidence due to the financial implications. On the other hand, Shaw and Matthews (1998; p368) have claimed that, at least as far as geography is concerned, the problem is a "failure among academic geographers to communicate the value of their work effectively to a wider audience." This research will explore both sides of this argument, by focusing on the research evidence available in relation to health inequalities, and by accounting for the extent to which it has been used (or not) to inform policies in England and Scotland.

**Acknowledgements:**

*This research is supervised by Professor Liz Bondi (Head of the Institute of Geography and Co-Director of the School of Health in Social Science, University of Edinburgh), Professor Susan Smith (Department of Geography, University of Durham) and Dr Richard Mitchell (Associate Director of the Research Unit in Health and Behaviour Change, University of Edinburgh). I am funded, as a PhD Research Student, by a University of Edinburgh Cross-College Studentship.*

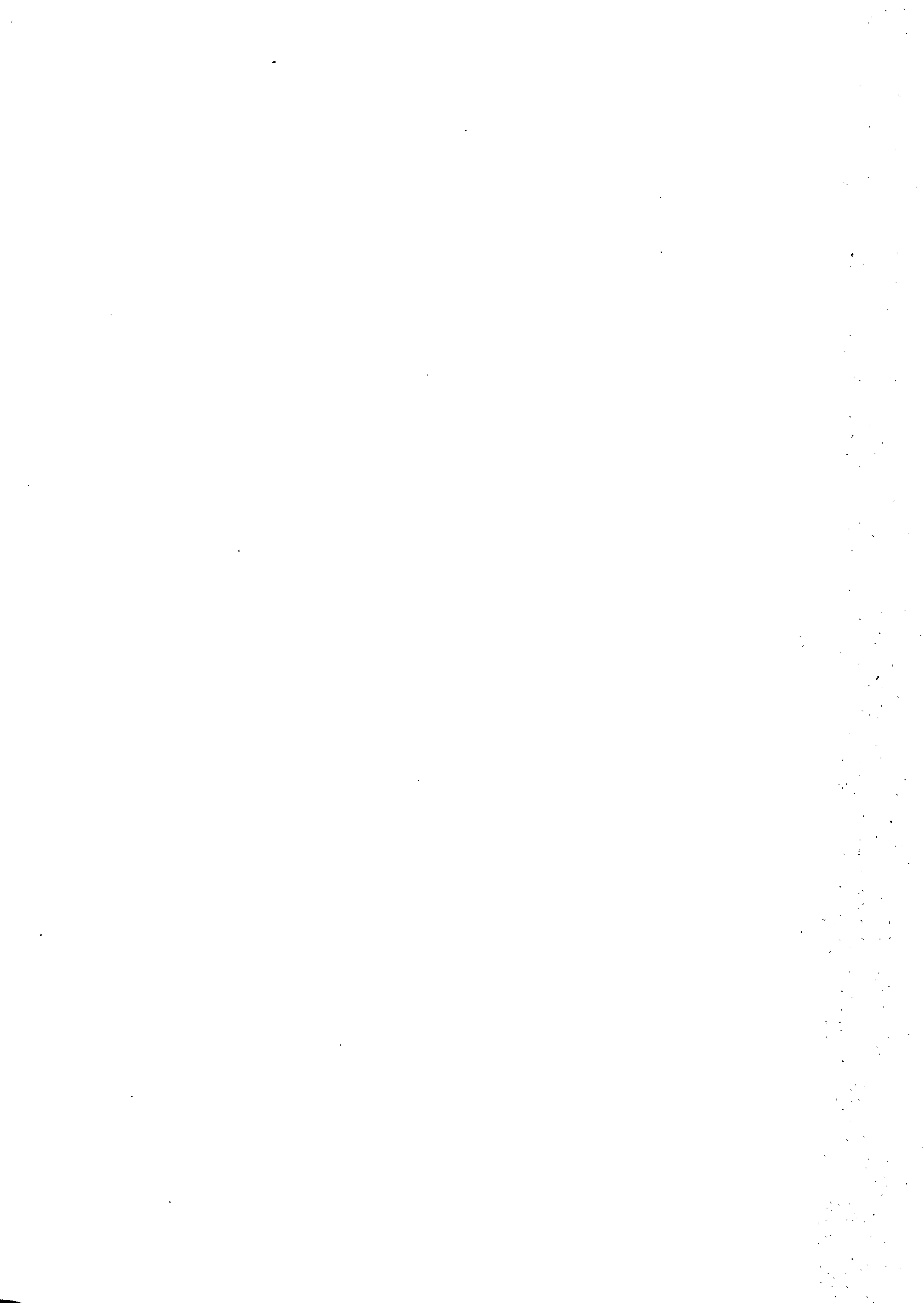
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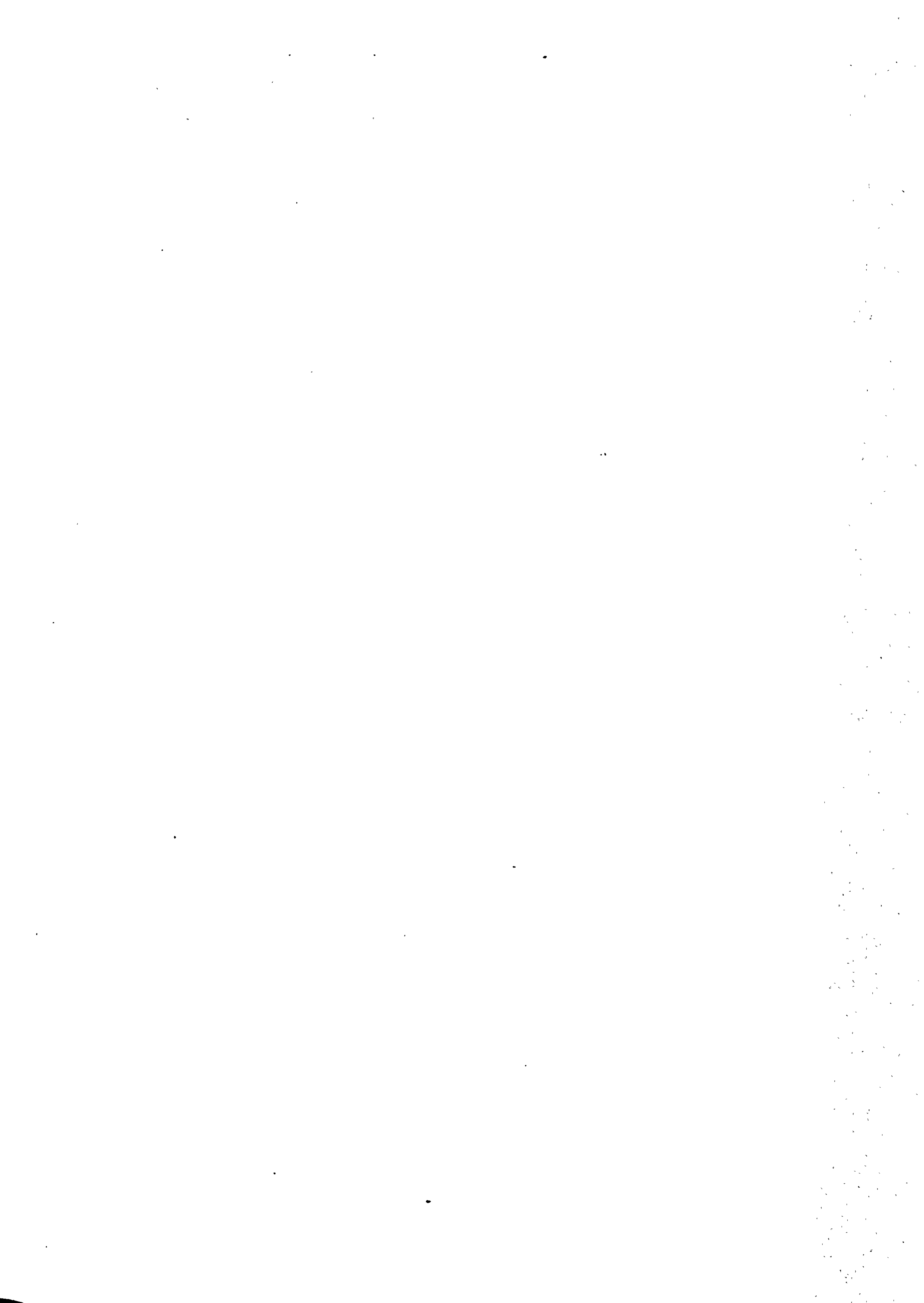
Shaw, J. and Matthews, J. (1998) '*Communicating Academic Geography – the Continuing Challenge*' pp367-372 in *Area* Vol:30(4)





**Appendix VIII: Co-authored article relating to some of the analysis presented in Chapter Five of this thesis, which is forthcoming in *Critical Social Policy*\***

*\* Permission to reproduce this article as an appendix to hard copies of this thesis has been obtained from all other authors and from the publisher, SAGE publications.*





## Divergence or Convergence? Health Inequalities and Policy in a Devolved Britain

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### **Abstract:**

Since the advent of political devolution in the UK, it has been widely reported that markedly different health policies have emerged. However, most of these analyses are based on a comparison of healthcare policies and, as such, only tell part of a complex and evolving story. This paper considers official responses to a shared *public health* policy aim, the reduction of health inequalities, through an examination of national policy statements produced in England, Scotland and Wales respectively since 1997. The analysis suggests that the relatively consistent manner in which the 'policy problem' of health inequalities has been framed combined with the dominance of a medical model of health have constrained policy responses. Our findings differ from existing analyses, raising some important questions about the actuality of, and scope for, policy divergence since devolution.

**Key words:** Health inequalities; devolution; policy divergence; critical discourse analysis; Britain.

### **Introduction:**

Although the political devolution of power to a Scottish Executive<sup>i</sup> and a Welsh Assembly Government in 1999 was limited, it was still welcomed by many as a process which opened up 'the potential for the development of radically different social policies' (Mooney et al, 2006:

483)<sup>ii,iii</sup>. Indeed, commenting on the discussions which led up to devolution in Scotland, Parry (1997: 34) claims that 'The ability to take distinctive action on social policy has been one of the main justifications for a Scottish Assembly or Parliament.' Similarly for Wales, Mooney and Williams (2006: 610) claim it was the 'potential of [devolved] social policymaking to produce a more socially cohesive society' which persuaded the electorate to vote in favour (albeit narrowly) of a Welsh Assembly. Furthermore, a perception that both Wales and Scotland faced distinct social problems which required context-specific responses formed a significant part of the rationale for political devolution (see, for example, Dewar, 1999; National Assembly for Wales, 2001). However, the extent to which Wales and Scotland have developed into the 'policy laboratories' some expected (e.g. ESRC Devolution & Constitutional Change Programme, 2003) remains the subject of much debate (Mooney & Scott, 2005; Silburn, 2004; Stewart, 2004).

The dominance, until recently, of one political party (Labour) in all three polities<sup>iv</sup>, the restricted nature of devolution arrangements (e.g. Cairney, 2004; Mooney et al., 2006), processes of 'path dependency' or historical institutionalism (see Fawcett, 2003) and a global, 'neoliberal onslaught' (Mooney et al., 2006) have all been cited as factors which have operated to constrain the possibility of significant policy divergence. However, health policy, one of the most significant policy areas in which the devolved governments have been granted extensive responsibilities, is one area in which there appears to be some consensus that important policy distinctions have emerged. For example, some of the most widely reported policy divergences to date relate to health, such as the Scottish Executive's prominent early decisions to provide free personal care for the elderly and to ban smoking in public places and, and the Welsh Assembly Government's decision to phase out prescription charges. Indeed, Scott Greer's analyses (2001, 2003, 2004, 2005) appear to dominate a current consensus that policymakers concerned with health issues in the devolved governments have responded to 'their particular problems and debates in ways that vary territorially and produce territorial policy divergence that matters' (Greer, 2005: 501).

Put simply, Greer's claim is that whilst English health policies have focused on the introduction of markets to the NHS, Scottish health policies have concentrated on strengthening the role of medical professionals, and Welsh health policies have emphasised the importance of



localism. This thesis is widely, and often uncritically, cited (e.g. Cairney, 2006, 2007; Chaney & Drakeford, 2004; Keating, 2005; Poole & Mooney, 2005) and has led to claims that we are now experiencing a natural policy experiment in the health arena (e.g. Smith & Babbington, 2006). Amid such enthusiastic claims, there has been only limited acknowledgement that some not insignificant differences between the three countries existed long before political devolution (see, for example, the pre-devolution analysis of diversity in the field of community care by Hunter & Wistow, 1987). Perhaps more remarkably, there has been little reflection on the way in which analyses purporting to consider divergences in 'health policy' focus almost entirely on healthcare policies. For example, only one of Greer's analyses specifically considers how each government has approached *public health* policy issues and, as this was published only two years after devolution, the findings provide only a snapshot of post-devolution policies in their infancy (Greer, 2001). Furthermore, although Greer (2001) finds some similarities between approaches to public health in Scotland and England, he does not suggest that public health policy is any less divergent than healthcare policy, and seems to include this part of the analysis in his general conclusion that 'distinct logics' are governing each polity's approach to 'health policy'.

This gap in the literature is *particularly surprising* when public health has formed a key concern of all three governments. Indeed, as has been widely reported, the election of a Labour government in 1997 marked a key moment for many in the public health community as it represented the first time in 18 years that a government had made an explicit commitment to reducing health inequalities (see Berridge & Blume, 2003). Since then, the issue has been consistently highlighted as a policy priority in all three mainland British countries (e.g. Department of Health, 2000; Health Improvement Strategy Division, 2002; Public Health Strategy Division, 2002). Health inequalities are a particularly interesting social issue to explore from the perspective of devolution as they represent a cross-cutting and complex problem to which solutions remain unclear and contested. In other words, health inequalities constitute a 'wicked issue' of the sort one might expect different policymaking contexts to approach experimentally (Blackman et al., 2006).

This paper attempts to redress the service-orientated bias of current analyses of the impact of devolution on 'health policies' by focusing specifically on policy responses to health



inequalities. By this term we mean the preventable variations in individuals' health status which are associated with differences in their social (or geographical) position<sup>v</sup>. In exploring the ways in which policy statements from each country frame and discuss this issue, the findings presented in this paper contrast significantly with most existing analyses of post-devolution health policy, revealing a surprising degree of convergence across the three countries as well as some continuity with the past (Parry, 2003). It is argued that the similar ways in which health inequalities have been conceptualised and framed as a policy problem in the three policy contexts, combined with the dominance of a medical model of health, are likely to have played an important role in constraining policy responses. This paper forms part of a larger ESRC-funded project looking at the impact of varying performance assessment arrangements on making progress with tackling health inequalities across Britain (see Blackman et al., 2006).

### **Methodology:**

Written texts form an important part of social worlds in all literate societies and are often under-analysed compared to research that focuses on interactions with people (Atkinson & Coffey, 2004). Public policy statements are a distinctive kind of text which frame the nature of public policy problems, shape the boundaries of possible responses and act as points of reference for a wide variety of actors to justify subsequent actions (see Freeman, 2006). As a result of their authorship, policy documents are able to impose a particular kind of power through the words they use. What seems to be presented as fact within policy statements, often represents policy decisions (or non-decisions) which, in turn, may be based on implicit assumptions (Iannantuono & Eyles, 1997: 1620). Analysing these texts in order to uncover what these assumptions are and how they are likely to shape the way in which other actors conceive of and respond to particular policy problems therefore provides a key method of understanding policy processes. Unsurprisingly, then, Hanney and colleagues (Hanney et al, 2003) conclude that the analysis of policy documents is a crucial method of understanding policy responses to health problems.

This 'linguistic turn' within social sciences has stimulated a wide range of approaches to exploring language and several alternative approaches to analysing the policy texts were initially piloted on some of the key documents included in the analysis. The eventual



approach chosen combined elements of *Critical Discourse Analysis* techniques, pioneered by academics such as Fairclough (2000), with a focus on exploring how health inequalities have been constructed as a 'policy problem' (see Gamble & Stone, 2006). On this basis, a framework of key questions was compiled to aid the analysis of each document. This framework focuses on three sets of questions: (i) the first explore how health inequalities are constructed as a 'policy problem'; (ii) the second focus on how the texts present the causes of, and solutions to, health inequalities and the assumptions which underlie these claims; (iii) and the third aims to uncover where responsibility for taking action to tackle health inequalities (and achieve results) lies and on what assumptions these allocations are made. Both the framework for analysis and the inclusion criteria for policy statements were approved by the authors of this paper who, between them, have a range of disciplinary backgrounds and are dispersed across England, Scotland and Wales.

Given that health inequalities only moved back onto the official policy agenda in 1997, with the arrival of a Labour government, this year was taken as the starting point for the analysis and May 2007 was chosen as the end point on the basis that it was in this month that new governments were formed in Wales and Scotland and, shortly afterwards, that a new Prime Minister took office in England. It is important to state at the outset that as this paper is based solely on the discourse analysis of national policy statements and it does not aim to capture the views of local or national actors, which may well tell a different story. Nor can it explore how the differing structures of the NHS and local government in each country impact on the way in which policies are implemented. However, both these issues are being explored in the broader ESRC project (Blackman et al., 2006).

Owing to the volume of official publications relating to health inequalities in each country (especially in England), it was necessary to establish clear inclusion criteria for the study. It was decided to include only national policy statements of significant relevance to health inequalities, notably White Papers and national guidance on how other organisations/individuals should tackle health inequalities. It did not include advisory documents, such as the Acheson (1998), Wanless (2002, 2003, 2004), Beecham (2006), or Kerr (2005) reports. Nor, for England and Scotland, did it include consultative documents. This decision was made on the basis that where aspects of consultative or advisory



documents had been taken up by policymakers, they should be visible in subsequent policy statements. The inclusion criteria had to be adjusted somewhat for Wales in light of the fact that Wales has not had primary legislative making powers. As a result, key consultative documents were included for Wales, especially those, such as *Well Being in Wales*, which are referred to in later documents as having set the national agenda (Public Health Strategy Division, 2002). Based on these criteria, 75 statements were included in the analysis (33 from England, 24 from Scotland, and 18 from Wales). Given the extent of the data arising from this analysis, this paper does not attempt to provide a detailed account of the selected policy statements but rather summarises aspects of the overall findings which, firstly, illustrate the extent of policy similarities with regards to the issue of health inequalities and, secondly, provide insights into the reasons underlying this convergence.

### **Health inequalities in post-1997 English, Scottish and Welsh health policy statements**

#### *(i) The construction of health inequalities as a 'policy problem'*

The policy statements from all three countries employ the term 'health inequalities' to refer to a variety of forms of health stratification, including health differences between men and women and between ethnic groups. However, although there are some minor but noticeable differences between the emphases of each country in this respect<sup>vi</sup>, policy conceptualisations generally echo the UK research literature by most frequently focusing on health differences between social classes and geographical areas<sup>vii</sup>.

Moving beyond *types* of health inequality, the issue can be further conceptualised in the following three ways (see Graham and Kelly, 2004): (i) as a problem of 'health disadvantage', resulting from the poor health of poor people (or people in poor areas); (ii) as a 'health gap', in which the issue requiring attention is the health difference between poor groups and others ('others' possibly representing the wealthiest groups or, perhaps, the national average); or (iii) as a 'social gradient in health', involving a health slope which cuts across the whole of society. These three conceptualisations are not entirely incompatible. However, as Graham and Kelly demonstrate (2004), the way in which the problem of health inequalities is conceived within policy has important consequences for the kinds of solutions which consequently appear most logical. A crucial difference is that the first and second conceptualisations locate the 'problem' of health inequalities largely at the poorer end of the spectrum (i.e. with lower social classes or



with people living in deprived areas). Such conceptualisations are therefore likely to encourage policy interventions which are targeted specifically at these groups. Notions of social gradients in health, on the other hand, challenge the logic of focusing only on people at one end of a spectrum by framing the problem as one which cuts across the whole of society and therefore requires a societal (and not just a targeted) response. A societal response would need to address the full range of inequality in incomes and wealth, and their manifestation as a health gradient, rather than the position of the poorest (either in absolute or *relative terms*).

Similarly to Graham and Kelly's (2004) analysis of the English policy, the analysis on which this paper is based found rather more evidence of the first two conceptualisations of health inequalities than of a 'social gradient in health'. Table 1 provides some illustrative extracts from policy statements of each country which demonstrate the way in which health inequalities have been described as an issue of 'health disadvantage' and 'health gaps'. There are no examples of references to social gradients in health because none were found in either the Welsh or Scottish policy statements and, although a few references to social gradients in health were found in some English policy statements (e.g. Department of Health, 2003 and Health Inequalities Unit, 2005), these remained far outnumbered by discussions focusing on 'health gaps' and 'health disadvantage'.

#### TABLE 1 TO BE INSERTED HERE

The key point about the way in which health inequalities has been conceptualised as a policy problem in each country is that, even where 'health gaps' are referred to, the focus remains on the need to improve the poor health of poor people. This conceptualisation is evident in the targets (or, in the case of Wales, aspirations) which were eventually set out in relation to health inequalities in each country.

In 2001, England became the first of the three countries to introduce specific, national targets for reducing health inequalities. Initially there were two separate targets focusing on a reduction in the infant mortality 'gap' between manual groups and the rest of the population and a reduction in the 'gap' between the fifth of areas with the lowest life expectancy at birth



and the population as a whole, both of which were to be achieved by 2010 (see Department of Health, 2001a, 2001b). However, following several amendments<sup>viii</sup>, these targets were combined into a single Public Service Agreement focusing on area-based differences (HM Treasury, 2004). The way in which these targets have been constructed underlines the conceptualisation of health inequalities as an area-based 'health gap'. The national policy focus, therefore, has been on improving the health outcomes of these areas (such as the Spearhead areas) at a faster rate than the national average.

Although the Scottish Executive had not officially introduced any national health inequality targets when the English ones were announced, the performance assessment framework for the NHS introduced in Scotland in 2001 did include a commitment to tracking indicators of inequality. This form of monitoring health inequalities relied on a conceptualisation of the issue as a 'health gap' but, in contrast to England (which focused on the differences between the most deprived areas and the national average), the gap to be measured was the more ambitious one of that between the most deprived and the most affluent areas. Following a report from an expert group (Measuring Inequalities in Health Working Group, 2003), Scotland later introduced national targets for reducing health inequalities. However, despite a previous commitment to setting targets around the narrowing of a 'health gap' (Scottish Executive Health Department, 2003), the targets that were eventually introduced were, in fact, health improvement targets with a specific focus on the most deprived areas of Scotland (Scottish Executive, 2004). Until 2006 'health gaps' continued to be monitored as part of the performance assessment framework but the recent introduction of a new performance management system, referred to as HEAT (Health, Efficiency, Access and Treatment targets), has effectively removed any commitment to measuring 'health gaps' in Scotland and reinforced a conceptualisation of health inequalities as a problem of 'health disadvantage'.

Much of the language in the statements that were analysed suggests Welsh policymakers have, to date, been less concerned with targets than their colleagues in England and Scotland. However, Wales also decided to establish an expert group to advise on measuring health inequalities (Expert Group on Indicators of Health Inequality, 2001). This group recommended that 'health gaps' between areas should be officially monitored (a recommendation that has not yet been followed up) but advised against setting specific



targets for reducing health inequalities on the basis that it would allow the government to take a longer-term (but more effective) approach to the issue by focusing on wider, social determinants. Between 2003 and 2004, several new 'health gain' (health improvement) targets were announced and these include what are referred to as 'health inequalities targets'. However, these 'targets' are essentially statements of aspiration. The Welsh Assembly Government has, therefore, continued to avoid specific, quantified targets for health inequalities (against which the success or failure of its policies in this area might be measured).

The contrasting decisions that each government made about health inequalities targets to some extent support Greer's (2001) claims that different 'logics' are governing each country's approach to health policy. The fact that England was the first to set specific national health inequality targets may reflect its much-discussed 'target-culture' (see Blackman et al., 2006). Whilst the decision in Wales initially not to set targets for health inequalities, and even its more recent decision to outline only aspirational 'targets', suggests there is notably less of a belief amongst Welsh policymakers that quantifiable targets are an effective way of promoting desirable change. Scotland's decision to outline health inequality targets suggests the logic at work here may not be so different from that in England (even if, as discussed, the Scottish targets are not dependent on the reduction of a 'health gap'). From this perspective, it is the Welsh Assembly Government that has most noticeably diverged from the other two countries, supporting Greer's (2003) and Chaney and Drakeford's (2004) claims that, despite more limited policymaking powers, the approach to health policy has been more long-term and, perhaps, more radical in Wales. However, whether the contrasting approaches taken to targets mean that the broader approach to health inequalities also differs, and whether the lack of specific targets has enabled Wales to take a longer-term strategy, remains questionable, as the next sections discuss. Crucially, in all three countries, health inequalities have consistently been conceptualised as a policy problem relating to the poor health of poor people (or people in poor areas).

*(ii) How the policies portray the causes of, and solutions to, health inequalities*

In explaining the existence of health inequalities, the initial policy statements of each country place a significant amount of emphasis on wider determinants of health such as social

exclusion, poor housing and inequalities in educational and employment opportunities, as well as on differential patterns of lifestyle behaviour:

*From Vision to Reality* (Department of Health, 2001a): 'The worst health problems in the country will not be tackled without dealing with their fundamental causes – poverty, lack of education, poor housing, unemployment, discrimination and social exclusion.'

*Our National Health* (Scottish Executive, 2000): 'Poverty, poor housing, homelessness and the lack of educational and economic opportunity are the root causes of major inequalities in health in Scotland. We must fight the causes of illness as well as illness itself.'

*Well Being in Wales* (Public Health Strategy Division, 2002): 'The mix of social, economic, environmental and cultural factors that affect individuals' lives determines their health and well being. We can only improve well being in the long term by addressing these factors.'

The above three quotations are illustrative of the emphasis placed on broader determinants of health in the policy statements from each country published prior to 2003. However, despite such rhetorical commitments to tackling 'wider determinants', explanations as to *how* such determinants are to be tackled are limited, often consisting of no more than referencing existing or forthcoming initiatives from non-health departments (with little indication that the initiatives were designed to reduce health inequalities). The best example of this is in the Scottish White Paper, *Towards a Healthier Scotland* (Secretary of State for Scotland, 1999), which provides a table outlining the 'three-level' approach to tackling health inequalities, incorporating 'life circumstances', 'lifestyles' and 'health topics'. However, as Table 2 illustrates, whilst specific foci for action are provided in the columns for the latter two foci, the column for 'life circumstances' is left completely empty.

TABLE 2 TO BE INSERTED HERE



In explaining the empty first column, the document says that 'expert groups' are investigating how to set targets relating to life circumstances and that the consultation process is ongoing. This may reflect a genuine desire to ensure that appropriate foci are chosen, although it is unclear why the factors listed as a footnote to the table could not have been included in the first column. Overall, it cannot be ignored that, whilst frequent references are made to tackling the 'wider determinants' of health inequalities throughout many of the policy statements, few attempts are made to specify how this will be achieved.

Additionally, it is noticeable that in all three contexts the emphasis placed on policy interventions designed to tackle the wider determinants of health (at least those mentioned within health policies) has lessened over time. This shift is accompanied by a noticeable increase in the emphasis placed on the role of lifestyle behaviours (especially smoking) in explaining and responding to health inequalities. Within Scottish and English statements, this change is reflected in a shift in the focus of phrases such as 'determinants of health and health inequalities'. Prior to 2003, these types of phrase are frequently employed to describe social and economic determinants, such as poverty and deprivation, as well as various lifestyle behaviours, such as smoking and diet. However, in the documents published from 2003 onwards, such phrases increasingly emphasise the latter rather than the former. For example, *Delivering Choosing Health* (Department of Health, 2005) specifically states that one of its key objectives is to: 'Tackle the *underlying* determinants of ill health and health inequalities' [our emphasis], a phrase which is often employed in the academic literature to refer to the social and economic contexts within which people are situated. However, the way in which the document claims this objective will be achieved relates solely to tackling three lifestyle-behavioural issues (reducing adult smoking, childhood obesity and under-18 conception rates). In other words, as Graham and Kelly (2004) point out, all-encompassing phrases such as 'wider (or underlying) determinants of health' can facilitate confusion between the policy aim of tackling the determinants of health inequalities and that of merely improving determinants of health. This is important because improving the latter could, potentially, lead to widening health inequalities (as seems to have been the case within the UK over the past twenty years).

The way in which health inequalities have been conceptualised as a policy problem relating to the poor health of poor people may well underlie this confusion as it appears to have resulted in an assumption (evident across statements from all three countries) that policy interventions designed to improve health will, if targeted correctly, reduce health inequalities. This assumption is apparent in the following quotations:

*Choosing Health* (Secretary of State for Health, 2004): 'In order to close the gap, we must ensure that the most marginalised and excluded groups and areas in society see faster improvements in health.'

*The Challenge* (Scottish Executive Health Department, 2003): '[The challenge is] to narrow the opportunity gap and improve the health of our most disadvantaged communities at a faster rate, thereby narrowing the health gap.'

*Improving Health in Wales* (Health Service Strategy Team (WAG), 2001): 'Imagination and courage are needed to tackle and overcome the health and social inequalities that are related to each other. [...] We are committed to providing additional funding that is targeted at groups with the greatest health and social need...'

Each of the above quotations implies that a policy focus on improving the health of poorer groups will necessarily reduce health inequalities. Further evidence of the apparent policy belief that approaches designed to *improve* population health can also be employed to help reduce health *inequalities* is provided in claims that targets for health improvement (reducing rates of major chronic diseases and/or rates of contributory lifestyle behaviours), which have been set in all three countries (Secretary of State for Health, 1998; Secretary of State for Scotland, 1999; The Welsh Office, 1997), were expected to contribute to the aim of reducing health inequalities.

In Wales, whilst there is less evidence of a rhetorical shift in the meanings attached to terms like 'wider determinants of health', or of confusion between interventions designed to tackle health inequalities and those designed to promote health improvement, there is a clear policy shift away from tackling wider determinants of health and reducing health inequalities and



towards a focus on health improvement (a shift associated with the high-profile replacement of Health Minister, Jane Hutt, in January 2005). Despite Greer's (2003) and others' (e.g. Chaney & Drakeford, 2004) optimistic claims that the medical model of individualised health may be being abandoned in Wales, the publication of the on-line statement, *Health Challenge Wales* (Welsh Assembly Government, 2004), marks a return to a focus on individuals and their lifestyle behaviours. Unlike the Scottish and English documents published around this time, *Health Challenge Wales* makes no direct claims that its approach will aid the reduction of health inequalities. Instead, it seems to mark a complete overshadowing of the health inequalities agenda.

Overall, whilst a nuanced account of the documents could potentially highlight differences in the ways in which health policy statements in all three countries have promoted the need to tackle lifestyle behavioural determinants *vis-à-vis* wider determinants, the 'bigger picture' reveals some striking similarities and a common direction of travel. All three governments were initially keen to discuss the need to tackle wider determinants of health in order to effectively address health inequalities but, following something of a watershed in 2003-2004, there seems to be a shift in concern away from wider determinants and towards lifestyle behaviours (especially smoking). It is a change of direction that seems to conflict with statements in the early policy documents which point out that previous policy attempts to try to change lifestyle behaviours may have contributed to widening health inequalities. This finding suggests that a medical model of health has remained remarkably persistent within health policy, despite evidence of initial attempts to shift the focus to a more complex, social model.

Further evidence of the dominance of a medical model of health is provided by the noticeable increase in emphasis placed on the role of health services in tackling health inequalities, which again occurs in Scotland and England in 2003-2004. Initially, whilst the policy statements from all three countries suggest that unequal access to, use and quality of health services are likely to compound health inequalities (for example, references to Julian Tudor Hart's (1971) 'inverse care law' are evident), health services appear to have little place in either explanations for or strategies to tackle health inequalities. Furthermore, the statements from each country acknowledge that differences in the use and quality of health services do not explain why poorer groups tend to experience symptoms of chronic diseases at an earlier



age than more affluent groups. Over time, however, as the illustrative quotations in Table 3 demonstrate, the contribution that the health services are expected to make to reducing health inequalities expands significantly in the Scottish and English documents over the period of study. The first quotations in each of the two rows in Table 3 illustrate the supportive role that health services are encouraged to play in earlier documents, whilst the second quotations in each row demonstrate the far more central role outlined for the health services in more recent policy statements.

#### TABLE 3 TO BE INSERTED HERE

This post-2003 emphasis on 'anticipatory care' and 'secondary prevention'<sup>ix</sup> in Scotland and England seems likely to have been driven, at least in part, by the short-term nature of the national health inequality targets (see Blackman, 2007). This might not be expected in Wales, with its longer-term and more aspirational perspective. Yet, once again, a generally similar shift in emphasis is visible at around the same time. Whilst the Welsh documents do not place as much emphasis as the other two countries on secondary prevention as a means of tackling health inequalities, there is a similar shift in the focus of health policy. For example, the current health strategy, *Designed for Life* (Minister for Health and Social Care, 2005), makes it clear that there is to be a change in emphasis towards clinical priorities, especially the reduction of waiting times for treatment. This occurred in the wake of a media and political storm about rising waiting lists in the Welsh NHS, including adverse comparisons with England (see Drakeford, 2006). This means that, despite quite different reasons for doing so, Wales has mirrored England and Scotland in placing an increased emphasis on clinical priorities in health policy since 2003.

#### (iii) *The location of responsibility for health inequalities (including for targets):*

It would be too simplistic to claim that there are clear shifts in the location of responsibility in each policy context between 1997 and 2007 as the findings suggest a more fluctuating and complex picture. However, once again, the analysis does reveal some striking cross-country similarities. Most of the pre-2003 policy statements are rather vague about how health inequalities will be tackled and who should take responsibility but they do clearly suggest that health inequality is a cross-cutting issue affecting a range of government departments.



Although these documents acknowledge that success can only be achieved by working in partnership with local public bodies, the private and voluntary sectors and the public, they often suggest that the role of central government will be significant. In contrast, the messages in the post-2003 documents seem more focused on underlining the limited role central government can play and on maximising the responsibility of local NHS and local government bodies and of individuals.

Primary responsibility for reducing health inequalities (including, for Scotland and England, meeting the relevant targets) is placed with local NHS bodies in all three countries (these are Primary Care Trusts in England and Health Boards in Scotland and Wales), although partnership with other agencies, especially local government, is emphasised. Guidance on precisely how the NHS is expected to achieve these reductions is initially hazy and revolves around suggestions that it needs to change from being a 'national illness service' to a 'national health service'. The lack of discussion about how this shift is expected to take place is problematic when, as Hunter (2003: 111) points out, 'All available evidence suggests that the NHS, essentially a 'sickness' service, will never take the wider public health seriously.' However, following the publication of the Wanless Reports in England (Wanless, 2002, 2004) and Wales (Wanless, 2003) and the Kerr Report in Scotland (Kerr, 2005), all of which emphasise the need for the NHS to play a greater role in preventing ill-health, the level of responsibility for reducing health inequalities that is located with health services increases.

In addition, the growing emphasis on lifestyle-behaviours from 2003 onwards (as discussed in the previous section) is accompanied by a greater emphasis on individual responsibility for health. For example:

*Choosing Health* (Secretary of State for Health, 2004): 'In our survey, 88% of respondents agreed that individuals are responsible for their own health. Health is a very personal issue. People do not want to be told how to live their lives or for Government to make decisions for them.'

*Delivering for Health* (Scottish Executive, 2005): 'We are working to encourage people to take greater control over their own health.'

*Health Challenge Wales* (Welsh Assembly Government, 2004): 'Health Challenge Wales asks every individual to consider what they are doing, and what more they could do, to improve their health and the health of their family.'

With this shift towards individual responsibility comes an increasingly obvious tension between statements in the policy texts that acknowledge some of the key factors influencing health are beyond individuals' control and statements which repeatedly underline the importance of individual decision-making. In England, and to a lesser extent in Scotland, individual responsibility is often couched in terms of 'choice'. Where material, structural and social determinants are referred to in post-2003 statements, it tends to be local (rather than central) government with whom responsibility for delivery is placed. Yet the guidance provided for local government is, like that for the NHS, often vague and revolves around suggestions that local government bodies should act as 'public health organisations', focusing on the likely impact that each of their activities will have on local population health.

### Concluding discussion

In contrast to existing claims about the divergent direction of post-devolution health policy in England, Scotland and Wales, the findings in this paper suggest that, at least for the issue of health inequalities, the approaches taken by the three governments have been remarkably similar, with a marked cross-country shift in policy direction occurring from 2003 onwards. In particular, despite some differences in relation to the establishment of targets for health inequalities, the 'policy problem' of health inequalities has been framed in a relatively consistent manner - as a problem of a 'health gap' relating to the 'health disadvantage' of deprived communities. As Graham and Kelly (2004) underline, the framing of the problem in this way invites responses which focus on trying to improve the health of the poorest people (or people in the poorest areas) as quickly as possible, rather than tackling the broader, societal responses advocated by many researchers in the field (e.g. Graham, 2006 and Dorling et al, 2007). This suggests that the possibilities for policy divergence were restricted from the start by a concern not to open up debates about income and wealth inequalities, a concern which may reflect the limited fiscal powers of the devolved governments (especially the Welsh Assembly Government) as well as Labour's 1997 election manifesto pledge not to



increase public spending above the rate projected by the Conservative government for at least two years.

The findings also suggest that, despite a great deal of emphasis on social determinants of health in the policy statements which initially emerged from each country, a medical model of health was never entirely absent and, since 2003-2004, it is this approach to health (and health inequalities) which has dominated official statements. Hence, both the Scottish and English documents place much of the responsibility for reducing health inequalities (and meeting the related targets) with the NHS. This implies (as some of the most recent statements explicitly state) that policymakers in Scotland and England perceive the major policy tools with which to tackle health inequalities to be those relating to health service treatments and secondary prevention measures (particularly smoking cessation and pharmacological interventions). Whilst the Welsh statements are less prone to locate responsibility for health inequalities with NHS bodies, the initial focus on a social model of health was also challenged in 2004, when the focus of policy statements began to shift towards clinical priorities such as the reduction of waiting times (see Drakeford, 2006). Further evidence of the dominance of a medical model of health is provided by the increasing emphasis (especially from 2003 onwards) in statements from all three polities on the importance of individual responsibility for adopting 'healthy' lifestyle behaviours. Interventions to tackle health inequalities which focus on people who are considered 'at risk' of ill-health, either by trying to change their lifestyle behaviours or by employing health service and pharmacological interventions, fail to address the factors which cause the differential patterning of those who are considered more 'at risk' of ill-health in the first place. However, such interventions are likely to remain politically popular because (as some of the statements implicitly acknowledge) they have the potential to produce the kinds of short-term gains which rapidly moving political cycles demand.

At a rhetorical level, there is plenty of evidence that, as Greer (2003) and Chaney and Drakeford (2004) claim, the Welsh Assembly Government initially attempted to take a more radical approach to public health by placing an even greater emphasis on the wider determinants of health than either England or Scotland. However, as Drakeford (2006) argues, this commitment appears to have faltered in the face of media and political pressure



to focus on clinical issues such as waiting times. As a consequence, the initial indications of divergence within the field of health policy that are highlighted by analysts such as Scott Greer (2001) now seem outdated. Whilst it may remain the case that different logics are promoting the emergence of rather different health service structures, there is less evidence of contrasting approaches to public health issues such as health inequalities.

What is apparent from our analysis is that, while much of the language and the detail of policy-making convey an impression of difference, it is the similarities that invite explanation. As already discussed, two important considerations are the limited nature of devolution arrangements within the UK (especially for Wales) and the dominance, until recently, of one political party in all three contexts. At an institutional level, Parry's (2003, 2004) account of post-devolution Scotland may shed further light on our findings. He argues that the frameworks for post-devolution policies, including health, were largely set in the pre-devolution documents published between 1997 and 1999. Furthermore, Parry (2004) claims that the Scottish civil service has tended to mimic the institutional traditions of Whitehall - a situation which may also have occurred in Wales (see Laffin, 2007). This suggests that institutional factors may also have played a role in promoting policy convergence. Yet, the fact that Scotland was able to introduce free care for the elderly and ban smoking in public places, and that Wales was able to phase out prescription charges, all demonstrate that policy divergence is possible, so questions remain about the reasons for the lack of policy divergence in relation to health inequalities.

The apparent convergence of policy approaches to health inequalities may be the result of 'policy transfer' between the three polities (although it is impossible to make a judgement about this based on the analysis of policy statements alone). Alternatively, to understand policy approaches to a 'wicked issue' such as this, it may be necessary to reflect on wider cultural and societal trends, such as rising individualism and its relation to happiness (see Layard, 2005) or the pressures of economic globalisation and the influence of neoliberal ideologies in reducing the role of the state (Mooney et al, 2006). Each of these explanations underlines the need for further research to explore the processes involved in post-devolution policymaking.



Political devolution is, of course, a process rather than an event and it will take more than ten years to be able to assess its eventual impact on social policy. Indeed, as the arrangements for devolution continue to evolve and new political parties assume power (as has happened in Scotland following the parliamentary election in May 2007<sup>v</sup>), we will be better able to reflect on the extent to which it has been the specific political and policy contexts of the past decade which have constrained policy divergence or whether other, more deep-seated forces are at play, either within Britain or emanating from perceptions of, and responses to, wider societal or global pressures.

In the meantime, the findings discussed in this paper raise important questions about the extent to which divergence has been possible at the local (sub-national) level, a point which the findings from the wider project will address (Blackman *et al.*, 2006). These are not, however, questions which can be answered through the analysis of national policy statements. The aim of this paper has been more modest, namely, to explore how health inequalities have been constructed as a policy problem in England, Scotland and Wales and, in so doing, to challenge existing claims about the extent of health policy divergence between the three polities over the past decade.

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## Tables to be inserted into text

Table 1: Policy conceptualisations of health inequalities in the three countries

Policy context	Illustrative examples of conceptualisations of 'health disadvantage'	Illustrative examples of conceptualisations of 'health gaps'
England	<i>Programme for Action</i> (Department of Health, 2003): 'To reduce health inequalities and achieve the targets will require us to improve the health of the poorest 30–40 per cent of the population where the greatest burden of disease exists.'	<i>Our Healthier Nation</i> (Secretary of State for Health, 1998): 'No one should doubt the seriousness of our approach. In particular, our determination to narrow the health gap between the worst off in society and the better off...'
Scotland	<i>Towards a Healthier Scotland</i> (Secretary of State for Scotland, 1999): '[This document] is about health for all, but children and groups disadvantaged by poor health have a special place.'	<i>Partnership for Care</i> (Minister for Health and Community Care, 2003): '[There is] an unacceptable health gap between the richest and the poorest communities.'
Wales	<i>Promoting Health and Well Being</i> (Minister for Health and Social Services, 2001): 'Addressing inequalities in health by targeting action on hard to reach and disadvantaged groups within the population will be a major consideration in the roll-out of the programme and its component parts.'	<i>Better Health – Better Wales</i> (Secretary of State for Wales, 1998): 'Despite the considerable reduction in premature mortality across the whole population, the gap between those with the best health and those with the worst is widening.'

Table 2: Reproduced from *Towards a Healthier Scotland* (Secretary of State for Scotland, 1999: Chapter Two)

Scotland's Health: National Priorities		
Tackling Inequalities		
Improved Life Circumstances*	Lifestyles	Health Topics
	<ul style="list-style-type: none"> <li>• Less smoking, drug and alcohol misuse</li> <li>• A healthier diet</li> <li>• More physical activity</li> </ul>	<ul style="list-style-type: none"> <li>• Child health</li> <li>• Dental and oral health</li> <li>• Sexual health, including teenage pregnancies and sexually transmitted diseases</li> <li>• Coronary heart disease (and stroke)</li> <li>• Cancer</li> <li>• Mental health</li> <li>• Accidents and safety</li> </ul>

\*Life circumstances include, for example, unemployment, poverty, poor housing, limited educational achievement, the general environment and all other forms of social exclusion.



Table 3: Role of health care services in tackling health inequalities: examples from England and Scotland

Policy context	Illustrative examples:
England	<p><i>A First Class Service</i> (Department of Health, 1998): 'Improving the quality and consistency of NHS services is an important part of improving the overall health of the population and tackling inequalities in both health and access to care.'</p> <p><i>Delivering Choosing Health</i> (Department of Health, 2005) identifies the following 'big wins' for tackling health inequalities: 'Improving access to primary and secondary care, especially for disadvantaged groups by making services more accessible and responsive; reducing delays before patients' first visit to their GP; increasing uptake of screening; improving access to diagnostics and specialist referral, management of high blood pressure, cholesterol reduction and emergency care for treatment for heart attack, ensuring variations in prescribing (e.g. statins and cancer drugs) are explained and minimised; action focused on the big killers (cancer, CVD and respiratory disease, including action on smoking); identifying and treating those at high risk of disease, especially the over 50s.'</p>
Scotland	<p><i>Our National Health: Delivering Change</i> (Scottish Executive Health Department, 2001): 'Personal Medical Service pilots are being used to improve access to primary care services, reduce inequalities and address recruitment and retention problems, particularly in remote, rural and deprived areas.'</p> <p><i>Delivering for Health</i> (Scottish Executive, 2005): 'We believe the most significant thing we can do to tackle health inequalities is to target and enhance primary care services in deprived areas. Strengthening primary care teams and promoting anticipatory care in disadvantaged areas will reduce health inequalities...'</p>

<sup>i</sup> Since their election to government in 2007, the Scottish National Party have renamed the 'Scottish Executive' the 'Scottish Government'. However, the title 'Scottish Executive' has been retained for the purposes of this paper, given that this was the title in use during the period of study.

<sup>ii</sup> The Government of Wales Act (2006) somewhat extended the powers devolved to Wales. However, for the period in which this paper is interested, the Welsh Assembly Government has only been able to legislate where it was empowered to do so by a complex and vast array of Westminster laws.

<sup>iii</sup> Devolved powers were also granted to a Northern Ireland Assembly but as the political situation here has been so volatile and uncertain (with direct rule being re-imposed for over three months in 2000, twice in 2001, and again from 2002 until the spring of 2007), developments in relation to health policy have been significantly restricted. Consequently, we decided not to include it in this comparative study.

<sup>iv</sup> This dominance is no longer the case in Scotland, where the Scottish National Party formed a minority government following the 2007 elections, and has been weakened in Wales by the forced coalition of Labour with Plaid Cymru.

<sup>v</sup> The meaning of the term varies widely and is one of the issues that the overall project explores.

<sup>vi</sup> For example, whilst the English documents pay a little more attention to health differences between ethnic groups, gender health differences and inequalities in mental health are most discernible in the Scottish documents, and the Welsh discussions more frequently highlight the issues facing traveller communities and the differences between language groups. Additionally, discussions of health inequalities in Scottish policy statements are often linked to notions of social justice, whilst in Wales the emphasis has been more around the concept of wellbeing.

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<sup>vii</sup> Whilst this policy emphasis may seem unsurprising, it is worth noting that it is a focus which contrasts significantly with the broader equalities strategies of the three countries, which tend to focus on ethnicity, gender, sexuality and religion, and pay almost no attention to differences between social classes.

<sup>viii</sup> The wording of the life expectancy target was later revised (Department of Health, 2002), following the replacement of local Health Authorities with much larger Strategic Health Authorities, to focus on 'Local Authorities' (rather than 'Health Authorities') so as to retain the focus on local areas.

<sup>ix</sup> This involves clinical and pharmaceutical interventions such as the prescription of statins to people at high risk of heart disease or angioplasty surgery for people experiencing angina.

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**Appendix IX: Solo-authored article (published in *Social Science and Medicine*\* in 2007) relating to the analysis presented in Chapters Five and Six of this PhD.**

*\* Permission to reproduce this article as an appendix to hard copies of this thesis has been obtained from the publisher, Elsevier.*



## Health inequalities in Scotland and England: the contrasting journeys of ideas from research into policy

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### Abstract

Both the UK's Labour Government and Scotland's devolved Labour–Liberal Democrat coalition Executive have committed themselves to reducing health inequalities. Furthermore, both institutions have emphasised the importance of using evidence to inform policy responses. In light of such political commitments, a significant amount of work has been undertaken in the field of health inequalities in order to: (i) review the available research evidence; (ii) assess the extent to which policies have been based on this research evidence; and (iii) evaluate the success (or failure) of policies to tackle health inequalities. Yet so far only limited attention has been given to exploring how key actors involved in research-policy dialogues understand the processes involved. In an attempt to address this gap, this article draws on data from semi-structured interviews with 58 key actors in the field of health inequalities research and policymaking in the UK to argue that it is ideas, rather than research evidence, which have travelled from research into policy. The descriptions of the varying journeys of these ideas fit three types—successful, partial and fractured—each of which is outlined with reference to one example. The paper then employs existing theories about research-policy relations and the movement of ideas in an attempt to illuminate and better understand the contrasting journeys. In the concluding discussion, it is argued that the third approach, which focuses on the entrepreneurial processes involved in the marketing of ideas, is most helpful in understanding the research findings, but that this needs to be discussed in relation to the political context within which negotiations take place.

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*Keywords:* UK; Research-policy relations; Ideas; Health inequalities; Entrepreneurial processes

### Introduction

The election of a New Labour government in 1997 heralded the promise of a new era for health inequalities in the UK. Not only was the government openly committed to reducing health inequalities (Department of Health, 1997, 1998, 1999a, 1999b), it was also promoting an ethos of evidence-

based policy (Cabinet Office, 1999a, 1999b). Following devolution of key social policy responsibilities to Scotland in 1999, the first Scottish Executive (as the devolved government is known) was elected. Over the past decade, New Labour has dominated both the UK Government (with a consistent overall majority) and, since 1999, the devolved Scottish Executive (through coalition with the Liberal Democrats). Perhaps unsurprisingly, therefore, the Scottish Executive has taken a similar line on many social policy issues, including committing itself to

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the reduction of health inequalities (Scottish Executive, 2000, 2003) and to the promotion of knowledge transfer (Clark & Kelly, 2005). As the two political contexts are so closely linked (and several relevant areas, including most fiscal and social security policies, remain reserved with the English-based government), it would be difficult to study policies relating to health inequalities in Scotland without also considering the situation in England. The discussion in this paper employs interview data from Scotland and England to consider issues which appear to be relevant to research-policy relations for health inequalities in both political contexts (any differences between the two contexts will be explored in a separate paper in due course).

The political enthusiasm for evidence-based policy has re-ignited prominent debates from the nineteen-seventies and eighties about how social scientists and policymakers inform each other's work (e.g. Booth, 1988; Weiss, 1977c, 1979). After the mid-nineteen-sixties, during which significant emphasis had been placed on the use of social research in government, there followed a sense of disappointment with research-policy relations (see Weiss, 1977a). From this emerged a body of work which sought to highlight the non-linear, complex and often muddled processes involved in making policy (e.g. Cohen, March, & Olsen, 1972; Kingdon, 1995 [1st Ed. 1984]). Several models of research-policy relations were outlined in this period (see Davies, Nutley, & Smith, 2000; Weiss, 1977a), the most enduring of which is Carol Weiss' (1977b) 'enlightenment model', which suggests that social research is unlikely to have any direct, measurable impact on policy but may still influence policy in diffuse, indirect ways over long time periods.

New Labour's recent commitments to *evidence-based* policy have resulted in renewed interest in research-policy relations within the UK (e.g. Naughton, 2005; Sanderson, 2002; Solesbury, 2002). A major funding body, the Economic and Social Research Council, helped establish a UK Centre for Evidence Based Policy and Practice (now known as EvidenceNetwork) and a journal specifically dedicated to discussing the issue has been launched; *Evidence and Policy, a Journal of Research, Debate and Practice*. Specifically in relation to the issue of health inequalities, interest in research-policy relations has resulted in several reviews of the available research evidence and theories (e.g. Asthana & Halliday, 2006; Bartley, 2004; Gordon, Shaw, Dorling, & Davey Smith,

1999) as well as a number of attempts to assess the extent to which recent policy initiatives relate to the available evidence and/or are likely to reduce health inequalities (e.g. Asthana & Halliday, 2006; Davey Smith, Morris, & Shaw, 1998; Exworthy, Blane, & Marmot, 2003; Exworthy, Stuart, Blane, & Marmot, 2003; Shaw, Dorling, Gordon, & Davey Smith, 1999). Yet there have been relatively few attempts to research *the processes* involved in the construction of policies relating to health inequalities, or to explore the opinions of the *key actors* involved in research-policy relations.

The available research which is of direct relevance to the topic of this paper can, approximately, be thought of as providing three rather different perspectives on research-policy relations. The first of these constructs researchers and policymakers as two distinct communities (Caplan, 1979) and focuses on exploring the interactions between the two groups. In Canada, Jonathon Lomas (e.g. 2000a, 2000b) and John Lavis (e.g. John Lavis, 2002, 2006; Lavis, Posada, Haines, & Osei, 2004) both underline the importance of achieving shared understandings between researchers and policymakers, arguing that increased interaction between the two groups is essential for improving links between research and policy. A recent exploration of research-policy relations for health inequalities in the UK (Petticrew, Whitehead, Macintyre, Graham, & Egan, 2004; Whitehead et al., 2004) has similarly focused on the distinction between the two communities; exploring the issue through holding separate workshops with 'senior civil servants' and 'research leaders'.

The second body of work focuses on the processes involved in the construction of policies and emphasises the role of politics in shaping research-policy relations. The work of Mark Exworthy and colleagues is a particularly good example of this approach within the field of health inequalities (e.g. Exworthy, Berney, & Powell, 2002; Exworthy, Blane et al., 2003). In conceptualizing how policies are formulated, Exworthy and colleagues (Exworthy, Blane et al., 2003) draw on John Kingdon's (1995 [1st Ed. 1984]) 'policy windows' model, suggesting that issues get taken up and implemented in the policy world when a 'window' is opened by the coupling of three key streams: 'problem', 'policy' and 'politics'. Exworthy et al.'s (*ibid.*) work suggests that the criteria for the 'policy' and 'problem' streams has not yet been met for health inequalities in the UK, which limits policy outcomes and, relatedly, the influence research is likely to have on policy.



The third approach focuses on the construction and marketing of particular ideas. This was the approach taken by Mel Bartley (1988, 1994) in her research exploring the unemployment and health debates of the nineteen-eighties. Bartley's thesis (1988) draws on the theories of Bruno Latour (e.g. 1988 [1984]; Latour & Woolgar, 1986) to propose that political (career) interests are crucial to understanding research-policy relations, and that professional networks are the fundamental mechanism via which 'knowledge claims' (Knorr-Cetina, 1981) travel. Latour's (1988 [1984], 2005) work suggests the quality of research may have rather less relevance to the potential of its influence than the ways in which the ideas emanating from research are received, translated and promoted by others.

Each of the above three perspectives is drawn on in the discussion later in this paper. Prior to this, the paper briefly outlines the rationale for choosing interviews as the main source of data before explaining the decision to focus on the influence of *ideas* about health inequalities, rather than research *evidence*. Next, the three differing journey-types of ideas about health inequalities evident in the interview data are summarised, each of which is outlined with reference to one example. It is at this point that the paper returns to the theories discussed in this introduction, in an attempt to better understand the differing journey types. Whilst the conclusions of the paper largely support Bartley's (1988, 1994) assertions that the entrepreneurial processes involved in the marketing of ideas are crucial to understanding research-policy relations, it is argued that these negotiations can only be understood if discussed in relation to the *political context* within which they take place.

## Methodology

One-to-one (face-to-face) interviews were selected over other qualitative methods because they seemed

to provide scope to gain insights into the perspectives of a range of individuals involved in the construction of policy (Kvale, 1996) whilst maintaining anonymity to a far greater extent than observational or group research approaches would have allowed. Preparatory research involved the analysis of relevant policy documents and research evidence, some exploratory communications with academic researchers and civil servants involved in the field of health inequalities and a four-week period of observation working with social researchers at the Scottish Executive. The information collated from these stages was used to draw up a list of 85 potential interviewees, all of whom were approached, initially by letter, and then, where necessary (and possible) by a follow-up email. Of the 85 individuals who were contacted, 58 agreed to be interviewed; a relatively high response rate which indicates that people involved in health inequalities work were keen to talk about research-policy relations.

It is not possible to categorise the individuals precisely as many had moved between, or were actively involved in, more than one disciplinary context. However, Table 1 summarises the main positions of the interviewees at the time the research took place. As Table 1 demonstrates, 29 academics and 29 non-academics were interviewed. Amongst the academics, care was taken to include the perspectives of researchers who have focused on various types of health inequalities (stratified by gender, class or socioeconomic status, ethnicity, age and area) and who are associated with a range of the key theoretical approaches (contextual, health services focused, the lifecourse and early years, lifestyle-behavioural, neo-materialist and psychosocial). The non-academics interviewees traversed a range of sectors that were identified, through the initial stages of the research, as having a significant influence on health inequalities related policy. All participants were UK-based, with 29 each being

Table 1

Professional position at the time of the interview (between spring 2004 and 2006)	Number of interviewees in this position
Academic researchers	29
Civil servants	10
Independent research organisations (including think tanks)	5
NHS based researchers/policy advisors	5
Media-communications related employees	5
Ministers/ex-ministers with portfolios of relevance to health inequalities	4



based in Scotland and England at the time of the interviews. As mentioned earlier, the material provided by English and Scottish interviewees was not *substantially* different and any variations that were evident will be explored elsewhere.

The interviewees share characteristics with those individuals identified as 'elite' in much of the methodological literature (Desmond, 2004; Lilleker, 2003) but are not referred to as 'elites' within this article in order to avoid the implicit suggestion, which is explicit in some literature (Desmond, 2004), that interviewing individuals who occupy positions of power necessarily requires a different approach to other types of interviewing. Rather, influenced by feminist methodological approaches (e.g. Maynard & Purvis, 1994), a collaborative, non-hierarchical relationship between the interviewee and researcher was sought (Oakley, 1981), although it was also acknowledged that power relations in interviews are complex and that this aim was likely to remain an aspiration rather than a reality (England, 1994). A more detailed discussion of the methodological literature which influenced the approach taken to this research is available elsewhere (Smith, 2006).

The majority of interviews took place in a private room where, for the duration of the interview, only the interviewee and the researcher were present (the remainder, at the preference of the interviewees, took place in less formal environments such as cafés). A semi-structured approach to interviews was taken, using a themed interview schedule which focused questions around health inequalities research, policy (post-1997) and research-policy relations. The interviews varied in length, lasting between 45–150 min (although most were around 60–70 min). All interviews were recorded and transcribed verbatim by the researcher. The transcripts were anonymised in conjunction with the interviewees, before being coded to aid analysis. The full transcripts were seen only by the researcher and the interviewees, in order to protect anonymity within what is a relatively small community.

#### The disjuncture between research and policy

Despite New Labour's strong rhetorical commitments to evidence-based policy (Cabinet Office, 1999a, 1999b), not a single interviewee claimed that policies aimed at addressing health inequalities had been (or even should necessarily be) significantly based on research evidence, as the following quotations demonstrate:

Senior academic researcher: "The research [on health inequalities] has had absolutely no, well, it's had very little impact on policies,"

Civil Servant: "The policy process does not rely on research evidence... it may be challenged, it may... but there's nothing that says, that makes the system stop, you know, there's not a button for evidence that you have to press for the policy process to continue."

However, before jumping too hastily into a discussion about why UK policies to tackle health inequalities have not been based on the research *evidence*, it is important to take on-board the lessons already learned about research-policy relations. As Carol Weiss points out, it is *ideas* rather than specific *research evidence* which tend to influence policy:

It is not usually a single finding or the recommendation derived from a single study that is adopted in executive or legislative action (although this occasionally happens). [...] Instead, what seems to happen is that generalizations and ideas from a number of studies come into currency indirectly—through articles in academic journals of opinion, stories in the media, the advice of consultants, lobbying by special interest groups, conversations with colleagues, attendance at conferences or training programmes, and other uncatalogued sources. Ideas from research are picked up in diverse ways and percolate through to officeholders in many offices who deal with the issues (Weiss, 1982, p. 622; see also Kingdon, 1995 [1st Ed. 1984])

It is indeed the case that whilst policies relating to health inequalities were not perceived by interviewees to be *evidence-based*, nearly all the interviewees suggested that key academic *ideas* about health inequalities have travelled into policy: whilst references to specific studies of, or researchers involved in, health inequalities were rare, interviewees often discussed the influence of particular idea-sets (such as 'psychosocial explanations of health inequalities'). Although this may seem like rather a simple point, it is essential because, as this paper goes on to demonstrate, once detached from specific research findings, ideas are more easily open to differing interpretations and uses by various actors (see Blyth, 2001). The remainder of this paper takes an ideational approach (Finlayson,



2004) by concentrating on the interviewees' perceptions of the various journeys of *ideas* about health inequalities.

### The contrasting journeys of ideas about health inequalities

Virtually all the well-known theories about health inequalities feature somewhere in the interview data, including psychosocial, material-structural, lifestyle-behavioural and lifecourse approaches. After analysing the ways in which the various ideas about health inequalities were discussed, it was evident that three different types of journey between research and policy were described: successful; partial; and fractured. Due to spatial constraints the following section illustrates each journey type with reference to just one example.

#### *Successful journeys*

The majority of interviewees suggested that lifestyle-behavioural ideas about health inequalities had enjoyed more success in policy than any other idea, journeying into both policy rhetoric and actions some time ago and retaining influence ever since:

Senior academic researcher (who had recently worked in policy): "... they [policymakers] still live with this idea that it's all about bananas, which is complete rubbish. I mean it's not exactly the policymakers fault because, you know, I mean what the civil service do with most policies is turn to the academic community, which is the correct way to do it, it's just that... academics' ideas for a while—it was the in vogue thing—that it was all about lifestyles, and that holds sway for the moment..."

As the above extract suggests, the idea that policies which aim to change lifestyle-behaviours will reduce health inequalities is not currently supported by much available research evidence (see MRFIT, 1982; Tudor-Smith, Nutbeam, Moore, & Catford, 1998). However, the suggestion that this approach has retained influence in policy makes sense if it is ideas rather than research which travel into policy. As Finlayson (2004, p. 536) argues, '[in] politics, ideas and concepts are not social scientific in nature: they are political. Their function is not necessarily to be accurate or even adequate descriptions of the world,' but rather to act as a political

tool, persuading others of the benefits in pursuing a particular course of action. If this theory is correct, changes in the research-base which support (or challenge) a particular idea will not automatically affect the position of an idea once it has travelled into policy. Indeed, ideas may become deemed, as several of the interviewees suggested in relation to the importance of smoking, 'self-evident' (i.e. no longer requiring research-evidence). Or, following Peter Hall (1993), once ideas become institutionally embedded it may be extremely difficult for ideas that challenge the dominant 'policy paradigm' to have influence. So, whilst the majority of interviewees thought the policy focus on lifestyle-behaviours underlined the lack of evidence-based policy, their comments suggest that this is an example of the successful journey of an idea from research into policy.

#### *Partial journeys*

In contrast, the descriptions of the influence of material-structural ideas about health inequalities suggest their journey has been far less successful. The publication of the Black Report (Townsend & Davidson), which had been commissioned by a Labour government but published under (and largely dismissed by) the new Conservative government in 1980, was often cited as the point at which material-structural ideas came to the attention of policymakers (see Berridge & Blume, 2003). However, it was not until the mid-nineties that most interviewees felt these ideas travelled much further into policy and, even then, the majority of interviewees felt the ideas had travelled no further than policy rhetoric:

NHS researcher: "the... sort of social circumstances causation—I think it's picked up in the rhetoric but not so much in the policies. Well, certainly when the health department puts it into policy because... they mention it always but then, when you go into the policy it's all about lifestyles and they say very little about actually changing circumstances..."

So, in contrast to the successful journeys of ideas about lifestyle-behaviours, the journeys of material-structural theories about health inequalities were generally articulated as limited, despite, many interviewees felt, far better supporting research evidence.



### Fractured journeys

The third type of journey involves ideas that appear to have become fractured during their journey from research into policy and the example used to illustrate this is psychosocial approaches to health inequalities. On one level, psychosocial ideas appeared to be an example of *research evidence* travelling into policy; it was notable that, very unusually, interviewees who mentioned psychosocial approaches to health inequalities often named specific academics, notably Professor Richard Wilkinson. However, the majority of policymakers who mentioned Wilkinson's research focused almost wholly on the links between psychosocial theories and ideas about social capital. Only one of the policymakers who mentioned Wilkinson by name also referred to his income-inequality hypothesis (which suggests that, beyond a certain level of wealth, it is the extent of inequalities in income, rather than the overall material wealth of a society, which explain health inequalities (Wilkinson, 1997, 2005)). In the following extract, one interviewee (a senior civil servant at the Scottish Executive) appears to imply that Wilkinson's research supports the idea that the distribution of wealth does *not* explain health inequalities:

"It [psychosocial ideas] explains the 'X' factor... which, for example, in Wilkinson's work... that if you simply redistribute the money, err, is this about wealth redistribution? Will that solve the problem? Well, it clearly didn't create the problem and... you always leave an 'X' factor there, there's some other thing unexplained... simply redistributing the wealth doesn't explain the anomalies; again, very well shown in international comparisons. [...] So there are inequalities [...] which are not explained by simply the redistribution of wealth. And the idea that there is an issue of social capital, as well as financial capital, I find intriguing, to the extent that I've actually flagged it up in [a report] this year, and I've said to the First Minister that we have to be aware of this idea..."

Despite the specific association of the ideas being discussed with Wilkinson, the above quotations suggest that only the aspects of Wilkinson's ideas that relate to *social capital* have travelled into policy, whilst the notion that health inequalities are a result of *income inequalities* appears to have become lost somewhere along the way. The income

inequalities hypothesis for explaining health inequalities is disputed (e.g. Lynch, Davey Smith, Kaplan, & House, 2000) but, as the work and ideas of those who have critiqued this hypothesis was not directly referred to by any of the policymakers who were interviewed, the existence of competing ideas does not appear to explain the fractured way in which Wilkinson's theories have travelled into policy.

### Understanding the differing journeys of ideas from research into policy

To try to shed some light on these contrasting journeys, the paper now discusses the findings in relation to the three perspectives on research-policy relations and the influence of ideas outlined in the introduction.

#### *Two communities?*

The notion that difficulties in interacting and communicating occur between policymakers and academic researchers occurs frequently in the literature on research-policy relations (e.g. Booth, 1988; Lavis, 2006; Lomas, 2000a) and was clearly present in the interview data:

Senior academic researcher: "There are basic issues of how research is done and why it's done that way that aren't widely understood, in the same way that there are aspects of the policy culture, policy environment, that researchers don't understand. I think there is still this... you know, there are different cultures and I think that's a problem".

This suggests that Caplan's (1979) 'two communities' theory, still referred to in much of the more recent literature (e.g. Oh & Rich, 1996), is of relevance. From this perspective, a 'cultural gap' exists between researchers and policymakers; involving different 'languages' and ontological perspectives. Based upon this understanding, the differences between the 'two communities' are substantive rather than dialogical. Consequently, the research-policy divide cannot necessarily be resolved by simply addressing communication difficulties or career incentives.

However, several aspects of the data contradict this understanding. Firstly, as we have seen, the interviewees believed that many significant academic ideas about health inequalities *have* travelled



into policy, albeit with varying degrees of success. Secondly, whilst Caplan's (1979) model evokes an image of two distinct communities, the data in this research suggests that many different communities, including the NHS, the media and the wider public, are involved in research-policy relations. Thirdly, as many of the interviewees had experience of working across a range of professions and several were formally employed in more than one 'community' at the time of the interview, the suggestion that there is something innately distinct about each community to the extent that it limits interaction seems questionable.

#### *Political context and policy 'windows'*

Whilst the interviewees' comments provide limited support for either a 'political model' (where research is used in a pre-determined manner to support policies that it has already been decided to implement for political reasons) or a 'tactical model' (where research is used as a method of delaying the decision-making process) (see Davies et al., 2000 for more details), virtually all the interviewees suggested politics, economics and ideology played a crucial role in shaping research-policy relations, e.g.:

NHS Researcher: "I think that you would have to say that's [political ideology] the strongest drive—'cause it's like, that's like the veto, at the top of it all, and if the Minister at the end, or the Cabinet, say, I don't want to go down that particular track, it doesn't matter *what* the evidence is."

Ministers/ex-minister: "Policy should, *and must*, always be based on judgement, on values, *and some of it on instinct*, otherwise what is the democratic process about, what's the political process about?"

Whilst the suggestion that 'political context' (frequently described by interviewees as 'neo-liberal') may 'block', or act as a 'veto' to, particular ideas (such as material-structural perspectives), it does not explain why New Labour made commitments to reduce health inequalities in the first place or why funding opportunities for research on health inequalities suddenly opened up in the mid-nineties (a point made by many of the interviewees), and nor does it explain why material-structural ideas travelled into policy at all, even if only in a rhetorical sense. The 'policy windows' model introduced by Kingdon (1995 [1st Ed. 1984]) and utilised by

Exworthy and colleagues (Exworthy, Blane et al., 2003) provides more scope for understanding the complex relationship between policy problems, policy responses and politics. This model demonstrates how ideas from research might be used to construct a policy 'problem' (such as health inequalities) without necessarily influencing subsequent policy actions as, in order to influence policy actions, it is necessary for the other two streams, 'policy' and 'politics', to be coupled with the 'problem' stream. The interviewees' frequent references to a 'neoliberal' political context were usually made in ways which suggested the ruling political ideology presents difficulties for certain ideas about health inequalities, suggesting the 'politics' stream is currently dis-joined from the 'problem' stream. Furthermore, both Exworthy and colleagues (Exworthy, Blane et al., 2003) and several of the interviewees suggest the lack of evidence about the effectiveness of policies means that the criteria for the 'policy' stream have not yet been met either:

Senior civil servant: "The big problem in public health was that the evidence on which to base policy just wasn't there. There was enormous enthusiasm amongst policymakers and researchers for... for a policy drive towards tackling health inequalities but it quickly turned out that... obviously the evidence for effective interventions to actually tackle inequalities simply wasn't there."

The 'policy windows' model is helpful in highlighting the role of politics in research-policy relations and is particularly good at accounting for why certain ideas might get picked up rhetorically, yet fail to influence policy outcomes (i.e. 'partial journeys'). However, by focusing very much of construction of policies, rather than the marketing of ideas, this perspective provides only limited scope for understanding the third journey type, 'fractured journeys'.

#### *Entrepreneurial processes and the marketing of ideas*

Many authors with an interest in the relationship between research and policy (several of whom have already been cited in this paper) emphasise the important role that 'policy entrepreneurs' (Kingdon, 1995 [1st Ed. 1984]) and 'brokers' (e.g. Lavis et al., 2004; Lomas, 2000a) play in promoting particular research ideas. So it is perhaps unsurprising that the transcripts contain multiple references



to the importance of influential individuals and expertise:

Senior academic researcher: “I think they’re [policymakers] influenced by notions of expertise—if certain people say something it must be true...”

Senior academic researcher: “I think policy contacts are incredibly important. [...] I’m quite shocked really at the number of times somebody, a civil servant, has said to me, ‘Oh, I talked to X,’ and X is one person, but if you and I were to sit down and think who is the right person to talk to? Maybe we wouldn’t have come up with X... So I am constantly reminded of the importance of the influential person.”

Acknowledging that certain individuals are better positioned to promote ideas than others is not particularly helpful, however, unless we also understand the processes that allow particular individuals to occupy the privileged position of ‘expert’. It is here that Mel Bartley’s (1988, 1994) insights into the complex entrepreneurial processes involved in the promotion of particular ‘knowledge-claims’ (Knorr-Cetina, 1981) are particularly relevant. In her case study of the relationship between research and policy, ‘Unemployment & health 1975–1987,’ Bartley (1988) employs Latour and Woolgar’s (1986) notion of ‘cycles of credit’. In this framework, ‘credibility’ is a circular process; scientists are not distinguishable from their ideas, so it is the credibility of a scientist’s *ideas* which improves their credibility *as a scientist*, and the more ‘credible’ a scientist is deemed by other actors in the field, the better access s/he is likely to have to resources (such as funding), which in turn influences the ability of the scientist to undertake research and come up with ideas that are deemed ‘credible’. In this sense, the authors liken ‘cycles of credit’ to capital investment; there is no ultimate objective, rather the success of investments is measured by the extent to which they facilitate the conversion of credibility, allowing scientists to progress through the cycle.

This project differs considerably from that undertaken by Latour and Woolgar (1986): instead of looking at the *construction* of scientific knowledge by studying a particular group of scientists, the research undertaken for this article involved talking to a range of individuals from a variety of disciplinary backgrounds to explore the *movement* of ideas between research and policy. Yet, the ways in which interviewees discussed notions of cred-

ibility within academic spheres closely resembles Latour and Woolgar’s ‘cycles of credit’. The credibility of individual academic researchers is not clearly distinguishable from the credibility of their ideas, and is closely related to their previous qualifications and positions, as well as being linked to funding; to obtain funding potential research projects had to be based on credible ideas and, in turn, the credibility of ideas emerging from research were affected by the credibility of the funding source used to support the research. The credibility of researchers’ ideas was also articulated as being dependent on a perception by other actors in the field that the ideas were ‘new’. For example:

Senior academic researcher: “that’s one of the reasons why I don’t particularly do much on health inequalities any more because I think, you know, what have I got to say which is new? [...] So that’s why you move onto a different sort of research. So our work at the moment’s on [blanked], that’s new because nobody else is doing work on that”

However, in order to be deemed ‘credible’ amongst policymakers, the data suggest other factors are involved. Interviewees suggested researchers needed to ensure their ideas had clear, implementable policy messages and that they, as researchers, were visible in circles beyond academia:

Senior civil servant: “Politicians need to be able to feel that they are, can make a difference. And therefore you not only have to market it as being a problem but you have to be able to market it as being something you can do something about.”

Senior civil servant: “I’ll tell you the phrase I absolutely cringe at—how many times do you see a research paper or assessment where the final sentence is, ‘but further research is required’? It’s just job-generation!”

Civil servant (social researcher): “There are academics who are very good but who don’t like doing media work, or just don’t do the media work, and who are therefore less well known, certainly less well-known to Ministers and so on. They don’t have that public expert kind of role or recognition so their credibility then is a bit, you know...”

In summary, to be perceived as credible amongst policymakers, interviewees suggested that researchers



need to be able to communicate clear, policy-relevant messages, provide solutions to identifiable problems (rather than solely identifying problems), avoid too much hesitancy in conclusions, and gain (visible) credibility from actors beyond academia. Within academic circles, factors that seemed particularly important to 'credibility' involved perceptions of academic integrity (which was often articulated in relation to sources of funding) and involvement in 'new' research agendas and ideas. So, investing in academic credibility seems to require a rather different approach to investing in credibility amongst policymakers. Indeed, for some issues, such as media coverage, what may constitute an increase in credibility within policy spheres may result in decreases in credibility amongst academics:

Senior academic researcher: "I think the media's very important, as long as you use it carefully, you know, you don't want to put out too many things [...] You know, if you just become a complete sort of media whore [laughs], sort of just throwing out all these things, then people don't take you very seriously,"

Negotiating levels of credibility may, therefore, be particularly complex for academic researchers attempting to influence policy; in order to enjoy a successful academic career, maintaining credibility amongst academics and funders is essential and yet, to successfully influence policy, a different kind of credibility is required. Academics acting as 'policy entrepreneurs' or 'experts' are therefore required to negotiate their level of credibility with a variety of actors in different spheres.

An equally important consideration for those marketing particular ideas to policymakers is that not all ideas are equally 'sellable'. For example, attempts to reduce smoking and interventions focusing on children were both deemed to be 'self-evidently' good ideas that did not, therefore, require much 'selling'. In contrast, ideas that challenged the perceived 'neoliberal' policy paradigm were thought to be the most difficult to market to policy. Yet, an over-reliance on the notion that political context acts as a 'veto' to certain research ideas does not, as we have seen, explain how ideas which do not appear to fit in with the political context have still been able to influence policy rhetoric. One way of better understanding the variety of journeys evident in this research might be to employ Tom Osborne's (2004) notion of 'vehicular ideas'. In this interpretation, the people whom this section has so far

referred to as 'entrepreneurs' are better conceived of as 'mediators', intellectual workers who act as 'enablers' or 'brokers of ideas', with the aim of 'moving things along'. Rather than trying to market 'big ideas' or 'grand narratives', the ideas of choice for mediators are 'vehicular'; a notion summarised by McLennan (2004, p. 485) as follows:

Vehicular ideas emerge as ways of problem-solving and 'moving things on'. Anyone who wants to get from A to B, for whatever reason, can therefore usefully embrace certain sorts of ideas as 'vehicles' for doing so, whatever their other differences with fellow-travellers. There is an ineliminable vagueness and 'mobility' about these ideas because their significance can change with context, and they can be 'owned', and in the owning shifted in meaning, by different parts of the network.

In relation to the various journeys of ideas discussed in this paper, the concept of vehicular ideas can be used to explain both the 'fractured journey' of psychosocial theories and the 'partial journey' of material-structural ideas. In marketing Wilkinson's ideas to a policy audience, for example, the emphasis could be placed on psychosocial pathways rather than income inequalities. For those 'mediators' or 'entrepreneurs' wishing to promote material-structural theories about health inequalities, ideas might be pitched to avoid obvious conflict with government ideology. This kind of process is evident in the following extract from the interview data:

Senior academic researcher: "If you have poverty and adversity of that nature, nothing's gonna save you. Now, they're [policymakers and funders] not gonna like hear that. On the other hand, I have to say, I think some probably have enough clout that we don't need to be too tactful. But certainly when I was less experienced and I was putting in for money on [blanked], we did produce papers which were—how can I put it? We weren't coming out and saying we were absolutely sure that [material-structural factor] causes ill-health and there's no element of selection. We actually found the perfect way through it, which was to say, 'well, if you look at a lifecourse perspective, you don't have to make that opposition.' Now that, I think that's probably true, actually, but, you know, we were



doing it, I was doing it, I was pushing people towards it in order to be clever.”

Whilst Osborne (2004) seems to suggest that ‘mediators,’ due to the work they want to do, deliberately promote ‘vehicular’ ideas, the comments made by interviewees in this research suggest that the process may be less optional than this. The interviewee quoted above described him/herself as ‘very much a back room kind of person’, who had no desire to actively market their ideas but who felt compelled to do so due to the requirement of funding bodies such as the ESRC. This suggests academics may not necessarily be able to choose whether or not to adopt the role of ‘mediator’ and, consequently, where their ideas appear to conflict with the interests of the policy ‘user group’, they may feel compelled to promote ideas with the flexibility and metamorphosing qualities of Osborne’s ‘vehicular’ ideas.

### Concluding discussion

Of the three frameworks employed to discuss the research findings, the ‘two communities’ model appears to offer the least potential for explaining the various journeys of ideas about health inequalities from research into policy. The second framework, which suggests the disjuncture between ‘problem’, ‘policy’ and ‘politics’ streams act as a barrier to the journeys of ideas from research into policy, can be used to explain why certain ideas are able to travel into policy rhetoric and yet do not appear to influence subsequent policy action (‘partial journeys’). However, this approach does not throw much light on the ‘fractured journey,’ which was illustrated with reference to psychosocial theories. It is the third and final framework, focusing on the entrepreneurial processes involved in the marketing of ideas, which provides the most scope for understanding the research findings.

Echoing Mel Bartley’s (1988, 1994) research, this framework suggests it is the complex entrepreneurial processes whereby certain ideas are promoted in particular ways, by particular people, which explains the differing journeys of ideas about health inequalities from research into policy. Within this framework, some individuals have more capacity to act as entrepreneurs than others and, again drawing on Bartley (1988, 1994), Latour and Woolgar’s (1986) notion of ‘cycles of credit’ was employed to explore this issue further. The interviewees’ com-

ments suggest that contrasting perceptions of ‘credibility’ exist in different spheres and, of most concern to this paper, the factors influencing an individual’s credibility in policy circles are likely to be different to, and may potentially conflict with, the factors influencing credibility in academic circles (a finding not evident in Bartley’s (1988, 1994) research). This suggests that negotiating an identity as a ‘credible’ researcher with ‘credible’ ideas may be particularly difficult for academics wishing to influence policy whilst simultaneously pursuing an academic career.

The most significant difference between the findings of this research project and Mel Bartley’s (1988, 1994) work relates to the importance of *political context*. Whilst Bartley acknowledges that political context *may* have played a role in the scientific controversy surrounding the unemployment and health debate, she found, ‘political interests were very seldom quoted by the scientists themselves,’ (1994, p. 181) and, in light of this, consciously leaves a detailed exploration of the role of political context, ‘for future researchers to consider’. Although it was not the specific aim of this research to address this potential gap, the importance of political context was a reoccurring theme in many of the interviews. Furthermore, political context appeared to be closely connected to the entrepreneurial processes which both Bartley (1988, 1994) and this article employ to describe the findings. Interviewees suggested the ‘sellability’ of ideas was shaped by the wider political framework; if an idea is thought to overtly conflict with ruling political ideology, marketing to a policy audience may require a shift in meaning of the idea or, at the very least, a more flexible construction of the idea. In this sense, the interviewees’ accounts reflected Tom Osborne’s (2004) notion of ‘vehicular ideas’. Paradoxically, then, although the interviewees’ suggested ‘clear messages’ were necessary for ideas to be deemed ‘credible’ within policy circles, academics who choose (or feel compelled) to market their ideas to a policy audience may deliberately employ vagueness and flexibility as tools which enable them to promote certain ideas without overtly challenging the political context and thereby losing credibility within policy (and, potentially, funding) spheres. Thus, notions of ‘entrepreneurial individuals,’ ‘sellable ideas’ and ‘credibility’ are closely intertwined and can only be understood with reference to each other and the political context within which negotiations take place.



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## Appendix X: A brief overview of the national targets relating to health inequalities in England and Scotland

### (i) Targets in England

The newly elected Labour government of 1997 soon made it clear that they believed targets would act as a key motivator for change across a range of public policy issues, including health. Initially, the Department of Health focused on setting targets for service-related and health improvement issues, such as reducing waiting times and cutting levels of widespread chronic diseases. For example, *Our Healthier Nation* (Secretary of State for Health, 1998) outlined targets for reducing rates of the most common chronic diseases, serious accidents and suicide by 2010. Although these could not be described as health inequalities targets (using any of the three ways of thinking about the issue outlined in sections 2.2 and 5.4 of this thesis), both *Our Healthier Nation* (Secretary of State for Health 1998) and *Saving Lives* (Secretary of State for Health 1999) claim that efforts to meet these targets will facilitate the aim of reducing the 'health gap'. The suggestion that achieving targets for improving population health will necessarily contribute to reducing health inequalities underlines the confusion between the two issues (a point discussed in section 5.4 of this thesis).

The first targets which might feasibly be described as inequalities targets appeared in *Public Services for the Future: Modernisation, Reform, Accountability* (Chief Secretary to the Treasury, 1998) and were known as 'floor targets'. The aim of 'floor targets' was to shift the focus of service providers on to the areas in which they were performing worst. However, it was not until the publication of *The NHS Plan* (Department of Health 2000) and the Public Service Agreements 2001-2004 (HM Treasury) in 2000 that there was a clear commitment to setting national targets for health inequalities. Prior this, it was suggested that targets for reducing health inequalities would just be set locally (e.g. Secretary of State for Health 1999).

The then Secretary of State for Health, Alan Milburn, first outlined two national targets for health inequalities in February 2001 and these targets were re-stated later that year in *From vision to reality* (Department of Health 2001) as follows:

- 'Starting with children under one year, by 2010 we will reduce by at least 10 per cent the gap in infant mortality between manual groups and the population as a whole.'
- 'Starting with Health Authorities, by 2010 we will reduce by at least 10% the gap between the fifth of areas with the lowest life expectancy at birth and the population as a whole.'

In the following year the two targets were slightly amended (see<sup>1</sup>). They were then altered further and combined into one target in the *Spending Review 2004 Public Service Agreements 2005-2008* (HM Treasury 2004), which states that the single PSA target is: 'Starting with Local Authorities, by 2010 to reduce by at least 10% the gap between the fifth of areas with the

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<sup>1</sup> The two targets were combined into one PSA target in *Spending Review 2002 Public Service Agreement* (HM Treasury 2002) and the wording of the life expectancy target was later revised, in *Technical Note for the Spending Review 2002 Public Service Agreement* (Department of Health 2002), following the replacement of local Health Authorities with much larger Strategic Health Authorities; the revised wording replaces the reference to Health Authorities with Local Authorities so as to retain the focus on local areas.



worst health and deprivation indicators and the population as a whole.' This target remains in place and the indicators on which it is based include measures of life expectancy and infant mortality (in-line with the focus of the two original targets). Additional health and deprivation indicators have also been added to take account of the following more disease-specific health inequality targets, which were introduced in 2004 (HM Treasury):

'Substantially reduce mortality rates by 2010:

- from heart disease and stroke and related diseases by at least 40% in people under 75, with a 40% reduction in the inequalities gap between the fifth of areas with the worst health and deprivation indicators and the population as a whole;
- from cancer by at least 20% in people under 75, with a reduction in the inequalities gap of at least 6% between the fifth of areas with the worst health and deprivation indicators and the population as a whole'

Additionally, *Improvement, Expansion and Reform: The Next 3 Years – Priorities and Planning Framework 2003 – 2006* (Department of Health, 2002) introduces an area-based inequalities element to a target for reducing teenage conception rates. This document also suggests that efforts to meet other public health targets, such as targets for reducing rates of cancer, heart disease and smoking during pregnancy, should be targeted at the most deprived groups and areas.

The way in which national health inequalities targets have been constructed in England supports the idea that English policy documents have tended to conceptualise health inequalities as a health 'gap' between the best and worst performing areas. Initially, the infant mortality target was designed to focus on the gap between social groups (manual groups compared to the population as a whole) but when this target was combined with the life expectancy target to become a single PSA target (see above), it too became area-based. The government's decision to focus targets on reducing differences between the worst performing areas and the rest of the population is epitomised by the *Neighbourhood Renewal programme* and, more recently, by the introduction of the notion of 'Spearhead areas', which is the name given to the fifth of areas with the worst health and deprivation indicators (Department of Health, 2004). To help achieve the national health inequality targets, the PCTs and local authorities within these areas are charged with achieving additional mandatory local targets.

As mentioned above, local targets for health inequalities have consistently been encouraged by the New Labour government. However, in the statements that refer to local targets, it is not always clear whether what is being called for are targets which aim to *improve* health in poorly performing areas, thereby contributing to the aim of reducing the health gap *between* these areas and others, or targets which aim to reduce health inequalities *within* local areas. At the end of the study period, for Spearhead areas, targets and activities which were expected to contribute to achieving the national health inequalities target were mandatory; whereas for areas in receipt of Neighbourhood Renewal Funding only targets and activities which will contribute to achieving the national circulatory diseases inequality target, plus the adoption of targets for reducing within-area health inequalities, were mandatory; and for areas that fell into neither category, there was only a requirement to have local targets for narrowing within-area



health inequalities. So depending on the way in which a local area is categorised<sup>2</sup>, and the funding it receives, the mandatory local targets could be ones which will encourage the fastest possible health improvement for that area (which may have the consequence of increasing within-area inequalities), or a reduction of within-area inequalities (with no particular concern as to how this impacts on national inequalities), or a combination. It is therefore not consistently clear how local and national health inequalities targets are expected to interact with each other.

Finally, returning to health inequalities targets at the national level, there is some haziness in England around whether the targets concern relative or absolute gaps (see sub-section 2.2.6). The *Spending Review 2004: Public Service Agreements* (HM Treasury, 2004) at one point states: 'The target is to narrow the absolute gap between the national average rate and the average rate for the Local Authority areas identified as having the 'worst health and deprivation indicators' in the baseline years (1995-97)'; but later says, 'The aim is to reduce the relative gap by at least 10% by 2010' [my emphases]. An earlier progress note on achieving the targets states that the targets are relative (Department of Health, 2002), a point which has been encouragingly commentated on in the *BMJ* by Low and Low (2005).

Before moving on to the situation in Scotland, it ought to be acknowledged that various policy documents make it clear that the government expects a range of other national targets to contribute to reductions in health inequalities, including targets which focus on more material and environmental factors, such as the Neighbourhood Renewal targets to narrow the 'gap' in employment rates, education, crime, housing and liveability as well as health (Social Exclusion Unit 2001), other PSA targets for government departments beyond the Department of Health (some of which are shared between departments), such as the Department of Transport's target to reduce the number of people killed in road accidents and the number of children killed and seriously injured in road accidents (for which there is a steep social gradient), the Department for Education and Skills target to narrow the gap in the educational attainment of disadvantaged children compared to the population as a whole and the widely shared target of improving access to healthy affordable food (Department of Health 2002). Additionally, the UK's stated aim of halving child poverty by 2010 and eradicating it by 2020 is mentioned in several policy statements as a key target that is expected to help efforts in reducing health inequalities (e.g. Secretary of State for Health 2004).

## **(ii) Targets in Scotland**

Similarly to the English government, the Scottish Executive initially set targets for reducing chronic diseases and health-damaging lifestyle-behaviours but not for reducing health inequalities. Likewise, Scottish policy statements also suggest that these targets, whilst not health inequalities targets in themselves, will help achieve the desired reduction health inequalities. Differing from the English government, however, the Scottish Executive immediately committed itself to monitoring inequality trends for many of the health targets it had set. For example, *Towards a Healthier Scotland* (Secretary of State for Scotland 1999) sets 'headline targets' for reducing coronary heart disease, cancer, smoking, excessive alcohol consumption, unwanted teenage pregnancies and improving dental health (to be

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<sup>2</sup> As many of the areas receiving Neighbourhood Renewal Funding are also part of the Spearhead groups, many areas may fall into both of the first two categories.



achieved by 2010) and also commits to regularly measuring the inequalities gap for each of these targets 'to assess progress in reducing the disparity in health status between different socio-economic groups.' Additionally, *Our National Health* (Scottish Executive 2000) commits to developing further health indicators within the *Social Justice framework* of targets and milestones 'to track progress in tackling health inequalities'. This was followed-up with the creation of a working group to examine the measurement of health inequalities in Scotland, which reported in November 2003 (The Measuring Inequalities in Health Working Group).

Although the Scottish Executive had still not introduced any national health inequalities targets in 2001, when the English targets were announced, the introduction of performance assessment to Scotland in this year did include a commitment to using the framework to track indicators of inequality (in contrast to performance assessment in England, which had been introduced earlier but initially focused almost solely on clinical performance). The Performance Assessment Framework (PAF) (Scottish Executive Health Department 2001) states that indicators of inequalities were under development and PAF Mark3 2003/04 (Scottish Executive Health Department 2003) introduces an inequalities aspect to a range of indicators which were to be assessed as part of the Framework:

- percentage of pregnant women who smoke at the time of their first antenatal visit;
- percentage of 5 year olds with dental cavities;
- percentage of 16-64 year olds who are current smokers;
- age standardised mortality rate from Coronary Heart Disease in people under 75;
- life expectancy at birth.

For each of these indicators, part of the performance assessment process included a comparison of the percentages for the 20 per cent of the population living in the most deprived postcode sectors against the percentages for the 20 per cent living in the most affluent postcode sectors (as determined by the Carstairs score within each NHS Board) (Scottish Executive Health Department 2003). Similarly to England, this form of monitoring health inequalities relied on a conceptualisation of the issue as a 'health gap' but unlike England, the gap being focused on was that between the most deprived and the most *affluent* areas (rather than between the most deprived and the national *average*), making it slightly more ambitious.

In 2003, the publication of *Improving Health in Scotland: The Challenge* (Scottish Executive Health Department 2003) includes the first clear commitment to producing national targets and indicators for health inequalities. In line with PAF, this policy statement states: 'Inequalities will be measured as the ratio between the 20 per cent living in the most deprived postcode sectors and the 20 per cent living in the most affluent postcode sectors as determined by the Carstairs deprivation index'. However, when national health inequalities targets were eventually introduced in Scotland, in *Building a Better Scotland Spending Proposals 2005-2008* (Scottish Executive 2004), they were not based on reducing the gap between the most and least affluent areas (or groups of people), or even between the most deprived areas and the national average. Rather, what were put forward as health inequalities targets were actually health improvement targets with a specific focus on the most deprived areas:

'Objective 1: Working across Scottish Executive Departments and with other delivery partners to improve the health of everyone in Scotland and reduce the health gap between people living in the most affluent and most deprived communities.'



- Target 1: Reduce the mortality rates for those aged under 75, between 1995 and 2010 by health improvement action to tackle diet, physical activity, smoking and alcohol consumption and by action to ensure early detection and improved access to treatment and care: cancer - 20%; coronary heart disease - 60%; stroke - 50%.'
- Target 2: Reduce health inequalities by increasing the rate of improvement across a range of indicators for the most deprived communities by 15%, by 2008. (The range of indicators has been selected from the 23 recommended indicators of health inequality. For adults - coronary heart disease, cancer, adults smoking, smoking during pregnancy, and for young people - teenage pregnancy and suicides in young people.)' (Scottish Executive 2004)

An element of target 2 (above) was incorporated into the targets for the Executive's cross-cutting Executive initiative, *Closing the Opportunity Gap*, which was launched in the same year (Scottish Executive 2004). The *Closing the Opportunity Gap* health inequalities target is stated as being: 'To reduce health inequalities by increasing the rate of improvement for under 75 Coronary Heart Disease mortality and under 75 cancer mortality (1995-2003) for the most deprived communities by 15% by 2008' (Scottish Executive 2004). Both policy statements claim these targets represent health inequalities targets, yet all of the targets are theoretically achievable without any necessary reduction in a 'health gap' (the chosen indicators may be improved by 15% for the most deprived communities but if they also improve at the same, or a greater, rate for the rest of the population, then the 'health gap' will not be reduced and may even increase). A later document, *Delivering for Health* (2005), describes the Scottish health inequalities targets as aiming 'to reduce premature mortality by 15% above the national rate, for people in the most disadvantaged communities', which seems to describe a target that does specifically aim to reduce a health gap between the most deprived communities and the national average (like the English targets) as it depends on faster health improvement amongst deprived groups than the national average. However, there is no evidence of targets which depend on this aim in any of the documents. Rather, the health inequalities targets in Scotland could more fairly be described as 'health improvement targets for the most deprived communities', signifying a conceptualisation of health inequalities as an issue of 'health disadvantage'. Indeed, the annex to *Delivering a Healthy Scotland Meeting the Challenge* (Minister for Health and Community Care, 2006) demonstrates that whilst all but one of the six indicators for the 'health inequality targets' are on track to meet the 2008 figures, the inequalities 'gap' has actually widened for three indicators (i.e. because of the focus on health improvement amongst deprived groups, Scotland is meeting aspects of its 'health inequalities' target even though the 'gap' between the most deprived groups and others is widening).

As already outlined, this conceptualisation differs from that enshrined in the original PAF (Scottish Executive Health Department 2003) which focuses on the health gap between the most and the least deprived areas. However, in 2006 the original PAF was replaced with a new performance management system involving Local Delivery Plans, which are based on a core set of key Ministerial targets, referred to as HEAT (Health, Efficiency, Access and Treatment targets). This new performance assessment system<sup>3</sup> combines the various targets that had been previously outlined in PAF into a single 'key target' to: 'Reduce health inequalities by increasing the rate of improvement for the most deprived communities by 15%

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<sup>3</sup> The new performance management system is structured around the hierarchy of 4 Key Ministerial objectives (the HEAT targets), which incorporate 28 Key targets, 32 Key performance measures and 20 Supporting measures.



across a range of indicators including; CHD, cancer, adult smoking, smoking during pregnancy, teenage pregnancy and suicides in young people: target date 2008'. The new performance management system therefore brings the performance management health inequalities target into line with the national health inequalities targets outlined elsewhere; as a target relating to the health improvement of the most deprived groups.

Beneath the national level, as in England, there appears to be some confusion about whether local areas are expected to focus on achieving national aspirations to reduce health inequalities or on reducing within-area health inequalities. To date, substantially less information has been published in Scotland than in England to guide local bodies aiming (or being encouraged) to achieve reductions in health inequalities (which may reflect the lack of a national target with this aim) so the published policy statements reveal little about this intersection.

In summary, Scotland did not introduce national 'health inequalities targets' until 2004 and, when it did, the targets demanded significant health improvement in deprived areas rather than any reduction in health gaps or gradients. However, the new PAF system introduced in 2001, did require a comparison of health indicators between the most and least deprived areas and, as such, constituted a similar approach to the English national targets (but with a focus on the gap between the most and least deprived areas, rather than between the most deprived areas and the national average). In 2006, however, PAF was replaced with a new performance management system which introduced targets reflecting the national 'health inequalities targets' that were introduced in 2004 (Scottish Executive 2004). At the end of the study period, therefore, all of the Scottish Executive's targets and monitoring systems for health inequalities (including those forming part of its performance management system) only required certain levels of health improvement in the most disadvantaged areas and did not depend on the achievement of a reduction in 'health gaps' (between areas or people). As such, Scotland's health inequalities targets signified a conceptualisation of health inequalities as an issue of 'health disadvantage'. Nevertheless, although there was now no longer a specific target for reducing health differences between areas or groups, this did remain a stated policy aim of the Scottish Executive.

Beyond specific health inequalities targets, the Scottish Executive, like the English government, claimed a range of other targets that it had committed itself to would be likely to contribute to reducing health inequalities. In particular, several statements emphasise the Executive's commitment to the UK target to end child poverty by 2020. More broadly, the Social Justice Report (Scottish Executive 1999) makes commitments (and sets milestones) relating to social determinants. Although they do not specifically focus on health inequalities and are not actual 'targets', they do focus on issues which some of the material-structural and psychosocial schools of research (discussed in Chapter Two) would suggest are key causal determinants of health inequalities. The more recent cross-cutting, social justice policy, *Closing the Opportunity Gap* (Scottish Executive 2004) introduces specific targets for some of these issues (including, for example, targets to reduce worklessness and to improve educational opportunities and community regeneration).

### **(iii) Responsibility for meeting health inequalities targets in England and Scotland**



In England, the NHS bodies initially charged with the most responsibility for health inequalities were Health Authorities. However, following NHS restructuring and the replacement of Health Authorities with much larger Strategic Health Authorities, this responsibility was shifted to the smaller, recently created PCTs (Primary Care Trusts). And although responsibility remained with PCTs until the end of the study period, NHS restructuring had led to the merger of a great deal of PCTs into significantly larger organisations, changing the scale of organisation at which responsibility for health inequalities was located yet again. In Scotland, where there has so far been far less restructuring of the NHS, similar levels of responsibility to those attributed to Health Authorities/PCTs in England have been placed with LHBs (Local Health Boards). In both countries, therefore, it is local NHS bodies which have largely been charged with achieving national health inequalities targets (a requirement enforced through the differing systems of performance management). However, local government participation in achieving this aim has been strongly encouraged by both the Scottish and English central governments. Furthermore, partnerships between local NHS bodies and Local Authorities (at times, extending to bodies in the voluntary sector and beyond) have been actively encouraged as an essential means of reducing health inequalities (a point picked up in Chapter Five).

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