Understanding Health Inequity and Related Policy Responses:
What Insights Can Political and Social Theories Offer?

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Introduction

Increasing policy attention is being given to social disparities in health in many contexts, with countries such as the United Kingdom and Norway having developed explicit policy commitments to reducing health inequity (Secretary of State for Health, 1998; 2004; 2010). Yet, despite vast amounts of empirical research and commitments to ‘evidence-based’ public health policy, we appear to be a long way from achieving greater health equity (Bambra et al., 2011). Various explanations for this apparent paradox have been put forward, including: (i) insufficient knowledge exists regarding what works in reducing health inequalities (Mackenbach, 2011; Garthwaite et al., under review); (ii) sufficient knowledge exists but there has been a failure to enact/implement policies to reduce health inequalities that reflect the available evidence (Bambr a et al, 2011; Garthwaite et al., under review); (iii) policymakers have been restricted in what they can do by the lack of a clear public mandate for the kinds of policies that available evidence suggests may be required to address health inequalities (Mackenbach, 2011); and (iv) the policies impacting on health inequalities were influenced more by other non-health interests, such as business interests involved with unhealthy products such as ultra-processed food and alcohol, than by the public health community (Smith et al, in process). These
contrasting explanations are not necessarily mutually incompatible and we argue that social and political theories can help explain the apparent paradox.

To date, the industrial level of empirical research that has been undertaken to explore health inequity has not yet been matched by comparable efforts to theorize: (a) the conditions under which health disparities become matters for policy attention; or (b) the characteristics of political institutions and processes, or the distributions of resources, that determine the success or failure of policy responses (Smith & Katikireddi, 2013). With the aim of beginning to address this gap, we focus on two theoretical perspectives which help explain the failure of efforts to reduce health disparities in the United Kingdom. First, we employ David Harvey’s Marxist interpretation of neoliberalism as a class project aimed at undoing postwar redistribution to explain the continued increase in health disparities in the United Kingdom, despite a commitment by the previous government to reducing them. Second, we use a Weberian framework to examine how the institutionalisation of particular ideas within policy in the UK (across devolved policymaking contexts) limits the ability of individual policymakers to address the social and structural factors driving health inequity, even when they are persuaded that ‘upstream’ policy responses are required. The second part of the paper helps explain how paradigmatic ideas (or ideologies) associated with neoliberalism, once embedded within policymaking institutions and discourses, operate at the micro-political level in self-perpetuating ways which may not always be apparent to the individual actors involved.

Neoliberalism and health: the UK experience

David Harvey’s identification of neoliberalism as a project directed at the restoration of class power, although ‘not necessarily … the restoration of economic power to the same people’ (Harvey, 2005, p. 31), demonstrates the value of an empirical, ¹ Marxist perspective in explaining the persistence of health inequalities. We draw here on two texts, Harvey’s 2005 (in German, 2006 in English) chapter on ‘Neo-liberalism and the restoration of class power’ and the longer version of its argument in his A Brief History of Neoliberalism (2005), which are not necessarily representative of the entire corpus of his work. Nor do they need to be, since our concern here is with explanatory power rather than attribution. Our concern here is with the United Kingdom; a context in which recent government-led policy efforts to reduce health inequalities have been described as ‘historically and internationally unique’ (Mackenbach, 2011).

Harvey identifies the rise to power of Margaret Thatcher’s Conservatives and Ronald Reagan’s Republicans (in the United States) as critical points in the history of neoliberalism. At the same time, neither our approach nor Harvey’s should be read as implying that neoliberalism has been confined to those jurisdictions. Harvey

¹ On the importance of this qualification see Lanchester (2012).
further emphasises the policies implemented after the coup that brought Pinochet to power in Chile in 1973 as ‘the first great experiment with neo-liberal state formation’ (2006, p. 12), and identifies neoliberalism as a global phenomenon closely tied to the lowering of trade and investment barriers and to the connection between the economic interests of capital and US foreign policy. Neoliberal economic restructuring, driven by debt crises and the conditionalities demanded by the International Monetary Fund and the World Bank as the price of maintaining access to global capital markets (Harvey, 2006, p. 32-33, 46-48), was unfolding in a more draconian way throughout much of the global South in parallel with the Reagan and Thatcher transformations, illustrating the global reach of neoliberalism from what might be thought of as its economic and geopolitical epicentres.

We begin from the assumption that health inequalities are connected, not necessarily in a linear way, with the level and structure of economic inequality. Explaining the origins and persistence of those inequalities therefore demands engagement with what Diderichsen, Evans, & Whitehead (2001, p. 16) characterise as ‘those central engines in society that generate and distribute power, wealth and risks’. In the words of the World Health Organization’s Commission on Social Determinants of Health (2008), efforts to reduce health inequalities must ‘tackle the inequitable distribution of power, money, and resources’. In the UK context, on which we focus here, we presume a connection between the rapid rise in economic inequality that began at the start of the 1980s and the parallel rise in health inequalities (see, for example, Scott-Samuel et al., 2014). The health divide between rich and poor, based on comparisons of premature mortality in the deciles of local authority districts with the highest and lowest prevalence of poverty, was by 2007 – which is to say before the financial crisis and subsequent recession – wider than at any time since the Great Depression (Thomas, Dorling, & Smith, 2010). We do not further theorise the nature of that connection, beyond noting that it can operate both through material (deprivation) and psychosocial pathways (Bartley, 2004, p. 78-102), and that the biological mechanisms by which psychosocial pathways produce socioeconomic gradients in health – i.e., by which the quotidian manifestations of inequality get under your skin (Hunter & McEwen, 2013; McEwen, 2012) - are relatively well established. A political science of health inequalities therefore requires at least some inquiry into the ‘central engines’ that produce their economic substrate.

Harvey’s fundamental contribution is to reintroduce class analysis, in a Marxist sense, into political explanation. The significance of this reintroduction can be understood by contrasting Harvey’s view with the major academic report of the British Broadcasting Corporation’s ‘Great British Class Survey Experiment’ (Savage et al., 2013), which straight-facedly proclaimed that a model of social class defining seven classes based on employment position, completely ignoring ownership of capital and other assets, had ‘seen off’ a rival Marxist framework – without a single supporting citation, but with the observation that the non-Marxist ‘class schema
proved hugely influential in the overhaul of the official UK class schema’ (p. 221). The BBC experiment involved questionnaires designed ‘to develop detailed measures of economic, cultural and social capitals’ inspired by the work of Pierre Bourdieu on ‘social class as a multi-dimensional construct’ (p. 223) and in fact having as much to do with consumer preferences as with connections to the productive process. The fact that access to the opportunity consume is radically unequal, and growing more so, was conveniently elided, as were the reasons for that inequality. A further, and more surprising, contrast is with (Mudge, 2008)’s discussion of ‘What is neo-liberalism’, which proceeds without a single reference to class apart from a quotation that refers to ‘new class actors’. Although Mudge describes in some detail neoliberalism’s acolytes and the institutions that supported them, such as the Mont Pelerin society, the University of Chicago and the Catholic University of Chile, the material interests of their supporters and the class coalitions that were necessary for neoliberalism to achieve its current hegemony are simply ignored.

Harvey insists ‘that we identify a specific constellation of class forces assembled behind the turn to neo-liberal policies in the UK and the United States’ during the crucial transitional period at the end of the 1970s and start of the 1980s (Harvey, 2006, p. 13-14). The explanatory power of Harvey’s work is strengthened by his recognition of the central role of the state in transitions to neoliberalism, not only mobilising those class forces but also, to some extent, calling them into being. What Ward & England (2007) call ‘neoliberalisation’, in the UK as elsewhere, was and is in many respects a state-led transformation, albeit one that initially required the formation of cross-class elite alliances outside the formal structures of government. At the elite level, such alliances are exemplified by that between entrepreneurial Conservative Party outsider Margaret Thatcher and hereditary aristocrat Keith Joseph, who is widely identified as the key ideologue of the early stages of what came to be called Thatcherism. The most conspicuous and familiar examples of state-led neoliberalisation include the Thatcher government’s legislative attack on trade unions, financial deregulation, and the large-scale selling off of state-owned industries, but these are only part of the picture. Harvey points out that ‘opening up the UK to foreign competition and foreign investment’ (Harvey, 2005, p. 57; see also Stevenson, 1995) destroyed many traditional industries and, with them, the power of their unions. Whether or not those industries were economically viable in anything like their form at the time is questionable, as he himself concedes. Their destruction was nevertheless arguably an example of what Young (1991), far from a Marxist himself, refers to as the ‘tectonic’ character of Thatcher’s policies, exemplified for Young by selling off council houses to sitting tenants at a substantial discount. This was hardly an example of fiscal responsibility, a disjuncture that has continued to the
present\(^2\), but had the effect of expanding the ranks of homeowners who were perceived to be more likely to support Conservative policies.

Such initiatives can be viewed as central to what Harvey describes as the construction of consent. He argues that ‘[t]he Thatcher revolution was … prepared by the organization of a certain level of political consent particularly within the middle classes that bore her to electoral victory’ (2006, p. 16) and that ‘Thatcher forged consent through the cultivation of a middle class that relished the joys of home ownership, private property, individualism and the liberation of entrepreneurial opportunities’ (2005, p. 61). Thus, cross-class alliances were crucial at the mass (electoral) as well as the elite level, and the role of the middle class however defined (and Harvey does not define it) is crucial. Indeed, it can be argued that the selloff of council housing, combined with a prohibition on using the revenues for new construction, contributed to a changed electoral logic in which the political allegiances of a decisive plurality in the United Kingdom – which can be numerically quite small, given the arithmetic of a first-past-the-post electoral system - are now defined by trends in property prices. An evocative example on a smaller scale of the state-led nature of neoliberalisation under Thatcher involves the London Docklands Development Corporation (LDDC), created to bypass a local council whose ‘priorities were to preserve traditional land uses and activities employing the existing working-class population; LDDC, however, saw the future in terms of an international economy and was determined to attract jobs in activities serving this and to build homes for the predominantly middle-class people who would work in it’ (Buck, Gordon, Hall, Harloe, & Kleinman, 2002, p. 64; see also Smith, 1989). LDDC was to spend £3.9 billion (at 1998 sterling values) in the process (Deas & Ward, 1999, p. 122), a state subsidy that eventually made fortunes not only for property developers and their financiers but also for ‘middle-class people’, and continues to do so with a vengeance. Further, it can be argued that at the elite level the effect – if not the intent – of privatisation was to create a new, wealthy and powerful constituency of executives and major shareholders (domestic and foreign) in newly privatised industries such as water, gas, electricity and rail; they shared interests with their comparator groups in property development and of course financial services.

It now seems hard to credit, but a decade into the Thatcherite project it was possible to state: ‘Opinion is divided as to whether the election of the Thatcher government marked a major watershed in British politics (Gamble, 1989, p. 1). This should now be beyond question. Thatcher herself is quoted as having identified as her greatest achievement ‘Tony Blair and New Labour. We forced our opponents to change their minds’ (Burns, 2008). Harvey, like many other observers, emphasises the extent to which the New Labour government of Tony Blair that came to power in 1997 did not undo the transformations of the Thatcher era, and indeed continued the process of

\(^2\) The official historian of privatisation in the UK has noted that: ‘In 2006/07 the railways received taxpayer subsidies of more than £5 billion, or four times what BR [British Rail] had received prior to privatization’ (Parker, 2013, p. 313).
neoliberalisation in a number of areas, introducing, for example, university tuition fees for domestic students in England for the first time (2005, p. 61), which have now risen to £9,000 per year for many programmes. A striking parallel can be drawn with the Democratic (Clinton) administration’s 1996 adoption of policy measures championed by the far right that ended a decades-old guarantee of federal support for poor mothers under the Personal Responsibility and Work Opportunity Reconciliation Act.

We comment below on the ambiguity of Harvey’s explanation of this outcome and its implications for policies to reduce health inequalities. First, it is necessary to fast-forward to the financial crisis of 2008, the nature of policy responses, and the consequences for social determinants of health. The crisis, itself a consequence of wholesale financial deregulation not only in the UK but also, indeed especially, in the United States, was bound to have a destructive economic impact at least in the short term, as tax revenues declined whilst an estimated US $14 trillion in cash and credit guarantees were mobilised to avoid a collapse of financial institutions that would have led to a worldwide depression. In the UK, that impact has been compounded by income support reforms that will, on one set of calculations, take almost £19 billion per year out of the economy, mainly out of the poorest regions; the effects will be exacerbated by cuts to local authority budgets (Beatty & Fothergill, 2013; Special Interest Group, 2013). Even The Economist described the impact as brutal (Anon, 2013). A June, 2014 conference on poverty and social exclusion learned that the proportion of households living in deprived circumstances had more than doubled over the last 30 years: ‘Almost 18 million people cannot afford adequate housing conditions; 12 million people are too poor to engage in common social activities; one in three people cannot afford to heat their homes adequately in the winter and four million children and adults aren’t properly fed by today’s standards’ (Gordon, 2014). This has occurred against a background of dramatic increases in the incomes of those at the top of the economic scale, with several authors pointing out that macroeconomic policy responses to the financial crisis in the UK have, in fact, redistributed income upward (Green & Lavery, 2014; Wriglesworth Consultancy, 2014). Harvey’s analysis would suggest that this, like the fortunes built on Thatcher-era privatisations, may in fact be an intended, rather than an unintended, consequence. What is striking is the absence of challenges to the austerity prescription, with the Labour party – at least, its official spokespeople – conceding that, if elected, few changes would be made to the cuts announced by the Conservative-led coalition government, whilst silence reigns on most options for addressing the imperative of post-crisis deficit reduction on the revenue side,\(^3\) despite evident public concern with corporate corruption and tax avoidance (Sparkes, 2012).

This silence presents formidable challenges for efforts to reduce health inequalities, which, as noted earlier, have been singularly unsuccessful despite a post-1997

\(^3\) For critical voices from well outside the partisan apparatus see e.g. Monbiot (2014); Saez & Piketty (2013).
commitment to reducing these inequalities by New Labour⁴ and a wealth of policy activity (Smith et al, 2009; Smith and Hellowell, 2012). Mackenbach (2010, p. 1249) has reflected on this record by pointing out that ‘it is difficult to imagine a longer window of opportunity for tackling health inequalities’ and asking ‘If this did not work, what will?’ Mackenbach observes that ‘health inequalities are the result of the cumulative impact of decades of exposure to health risks, some of them intergenerational, of those who live in socioeconomically less advantaged circumstances.’ This means that reducing them ‘requires a massive re-allocation of societal resources’ (p. 1252); even given a serious political commitment, we would argue that 13 years might not be long enough. The core of Mackenbach’s argument, though, is that if the failure of the English strategy to reduce health inequalities under New Labour was due to the persistence and widening of economic inequalities – and he is more sceptical on this point than we would be - then ‘it is unlikely that a majority of the English electorate would have supported the substantial redistribution of income and wealth that would have been necessary’ (p. 1252) to alter that trend. He concluded flatly that ‘reducing health inequalities is currently beyond our means,’ even though we should continue to pursue the objective as a moral imperative (p. 1252), including by improving our efforts with regards to advocacy in this area.

In one respect, Mackenbach’s reference to an electoral majority is a distraction, since governments frequently enact (and successor governments carry on with) policies that fail to command majority support. Like Harvey, however, he directs our attention to the construction of consent – or, in more neutral terminology, to the limits of permissible discourse about redistribution within the formal political process. On this point, Harvey could be clearer. He writes that ‘both Clinton and Blair found themselves in a situation where their room for manoeuvre was so limited that they could not help but sustain the process of restoration of class power even against their own better instincts (2005, p. 62-63), which implies that they had such instincts, but that the Thatcher-Reagan legacy ‘tangled subsequent politicians in a web of constraints from which they could not easily escape’ (2005, p. 63). Even if we accept this view, rather than the alternative one that Clinton and Blair were in fact actively seeking to push the neoliberal project further⁵, the nature of those constraints is not clear. Perhaps they are ideological, reflecting the pervasiveness and hegemony of neoliberal framings (cf. Rushton & Williams, 2012) – an interpretation suggested by Harvey’s reference to Gramsci at the start of the chapter on construction of consent in A Brief History of Neoliberalism. Another possibility is that the constraints arise out of the changed class structure to which state-led neoliberalisation has contributed. A variant of this latter, more explicitly materialist interpretation is advanced by Clark & Heath (2014), who posit the existence of a ‘constituency of the “squeezed but basically safe”’ (p. 213) and argue that ‘in hard

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⁴ It must be said that New Labour had considerable success in reducing child poverty before the crisis (Waldfogel, 2010), which one would not yet expect to have had an effect on mortality rates.

⁵ For whatever reasons; it may or may not be relevant that both men amassed substantial fortunes shortly after leaving office.
times the exposed are more desperate for help than ever, but the majority ... have come to calculate that it is better to throw their lot in with the haves, than to risk being saddled with tax rises to provide assistance to the have-nots’ (p. 202). This is a sobering observation, since alliances between plutocrats and the middle class can be stable and enduring. Too much can be made of the parallel, but Steve Stern begins his remarkable trilogy *The Memory Box of Pinochet’s Chile* with the observation that: ‘After eight years of democratic rule that included credible revelations of human rights violations by a blue-ribbon truth commission and by national media outlets, a substantial minority of Chileans – about two of five – continued to remember the military overthrow of the elected government of Salvador Allende in 1973 as a rescue mission (Stern, 2006, p. 9).

**Institutional Filters: A Weberian account of the translation and re-circulation of ideas about health inequalities within UK policy**

This section of our paper adopts a ‘discursive institutionalist’ approach to explore how the organisation of policymaking bodies shapes the relationship between research and policy. Inspired by Weber and the work of subsequent scholars who have employed Weber’s detailed accounts and theories concerning bureaucratisation, it demonstrates how policy ‘silos’ and hierarchies work as filters to research-based ideas, encouraging those ideas which support existing institutionalised ideas (or ‘policy paradigms’), whilst blocking or significantly transforming more challenging ideas. Despite official government commitments to implementing evidence-based policies (commitments that have been particularly strong in the UK – see, for example, Cabinet Office, 1999), this process limits the extent to which research can inform policy.

At a basic level, Labour’s recognition of the need for government intervention to reduce health inequalities reflected researchers’ claims that health inequalities are ‘socially produced’ (resulting from wider societal inequalities) and, therefore, ‘potentially avoidable’ (Whitehead, 2007). This marked a clear contrast with the previous Conservative government’s (1979-1997) disinterest in the issue (Berridge and Bloom, 2003) and helps explain the evident optimism amongst many health inequalities researchers during the early years of the New Labour UK government (Smith, 2013). Beyond this, however, it is unclear to what extent Labour’s policy responses to health inequalities were informed by evidence. Indeed, it has been claimed that dominant political ideologies and/or a lack of ‘joined-up’ thinking prevented much of the existing evidence from influencing policy (Blackman et al, 2009; Carlisle, 2001; Exworthy, Blane and Marmot, 2003; Exworthy and Hunter, 2011). Relatedly, as noted above, Mackenbach (2011) suggests that policymakers may not have felt they had the necessary democratic mandate to implement the kinds of redistributive policies supported by much of the available research (although, also as noted above, many policies are pursued without such a mandate). In addition, Mackenbach (2011) and Macintyre (2003) have both argued that the available evidence provided little guidance for policymakers on the effectiveness of
potential interventions and did not, therefore, meet policymakers’ needs (see Petticrew et al., 2004). In different ways, these accounts all suggest that the failure to reduce health inequalities was at least partially the result of a failure to achieve ‘evidence-based policy’.

The conclusion that policies to reduce health inequalities were not ‘evidence-based’ mirrors claims by scholars studying Labour’s responses to other policy concerns during the same period (e.g. Naughton, 2005; Stevens, 2011). Part of the problem was perhaps Labour’s initial articulation of ‘evidence-based policy’, which implied the relationship between research and policy could be simple and linear, with research either driving policy change or responding directly to the policy concerns of the day (e.g. Blunkett, 2000; Cabinet Office, 1999). Subsequent public health policies have often been evaluated on this basis (e.g. Katikireddi et al, 2011). Yet, such aspirations appear blind to: (i) the wealth of popular theories of policymaking that highlight the multitude of other factors shaping policy decisions (e.g. Hall, 1990; Kingdon, 1995[1984], Sabatier and Jenkins-Smith, 1999); and (ii) earlier, empirical studies of the relationship between research and policy, which consistently demonstrate that policymakers are unlikely to utilize research in a direct sense (e.g. Pahl, 1977; Weiss, 1982).

Drawing on an empirical study involving 62 semi-structured interviews (with researchers, civil servants, ministers and others involved in policy debates about health inequalities) and an analysis of 59 policy statements, this section of our paper highlights how theories concerning the policymaking process can enhance our understanding of the complex relationship between health inequalities research and policy, helping to explain the dissonance between the available evidence and the chosen policy responses. It differs from most existing accounts of this relationship in two key respects. First, cognisant of the fact that, when asked about health inequalities evidence, policymakers usually responded by talking about ideas (albeit ideas that were linked to evidence), our focus here is on the movement of research-informed ideas about health inequalities, rather than evidence (see Weiss, 1982; & Smith, 2007; 2013). This distinction may seem simple but it is also important because, once detached from a specific evidence-base, ideas can be extremely malleable, open to differing interpretations and uses (Blyth, 2002). Second, the paper highlights the relatively un-explored role of policymaking institutions in shaping the relationship between health inequalities research and policy.

In drawing on a combination of ideational and institutionalist theories, the paper is situated within the emerging analytical framework that Schmidt (2010, 2011) terms ‘discursive institutionalism’. Like its more established, closely related predecessor, ‘historical institutionalism’ (Immergut, 1998), ‘discursive institutionalism’ recognises that ideas are shaped by institutions (Schmidt, 2011). However, it is also overtly constructivist, viewing ‘ideas as constitutive of institutions’ (Schmidt, 2011: p53). The paper demonstrates that policymaking institutions have operated as filters for ideas about health inequalities, encouraging (even exacerbating) the influence of
ideas fitting with overarching ideas, or ‘policy paradigms’ (Hall, 1990), that have been institutionalised, whilst limiting the influence, or changing the contours, of more challenging ideas.

**An ideational approach to understanding research-policy relations**

In the study on which this section of the paper is based, it was certainly the case that interviewees did not perceive health inequalities policies to be evidence-based (indeed, not a single interviewee claimed policies had been based on evidence) and yet most interviewees did claim that key (research-based) ideas about health inequalities had travelled into policy (Smith, 2007; 2013). For example, although references to specific studies were uncommon, policy-based interviewees frequently discussed the influence of particular idea-sets (e.g. ‘psychosocial’ accounts of health inequalities). As Table 1 summarises, after analyzing the ways in which various ideas about health inequalities were discussed by interviewees and in policy documents, four journey types were distinguishable: (i) successful journeys - research-based ideas which appear to have travelled into policy relatively coherently and influentially; (ii) re-contextualised journeys - research-based ideas which appear to have been employed within policies in ways not necessarily supported by the research evidence; (iii) partial journeys - research-based ideas which appear to have influenced policy explanations of the causes of health inequalities but not policy responses; and (iv) fractured journeys – in which only certain elements of research-based ideas appear to have made it into policy. The following section sheds light on these contrasting journeys by exploring the interactions between research-based ideas and policy institutions.

<table>
<thead>
<tr>
<th>Approach to health inequalities</th>
<th>Significantly supported by research evidence?</th>
<th>Present in policy explanations of health inequalities?</th>
<th>Present in the described policy responses?</th>
<th>Journey type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Importance of early years</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Successful</td>
</tr>
<tr>
<td>Socio-economic &amp; material determinants</td>
<td>Yes (although pathways of influence and importance of contrasting determinants remains disputed)</td>
<td>Yes</td>
<td>To some extent</td>
<td>Partial (presented as cause but not a significant solution within policy).</td>
</tr>
<tr>
<td>Lifestyle-behavioural determinants</td>
<td>Research suggests lifestyle-behaviours are closely linked to</td>
<td>Yes</td>
<td>Yes</td>
<td>Re-contextualised (idea is employed differently within)</td>
</tr>
<tr>
<td>(the role of alcohol, smoking, diet, exercise, etc)</td>
<td>health inequalities but that there are also important underlying factors which influence lifestyle-behaviours. Evidence also indicates that interventions focusing solely on lifestyle-behaviours may increase health inequalities.</td>
<td>policy compared to research as there is a far greater emphasis on the possible role of lifestyle-behavioural interventions for reducing health inequalities).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health service / clinical contributions to health inequalities</td>
<td>Research suggests inequalities in health services in the UK are likely to exacerbate health inequalities but does not suggest they are a fundamental cause of health inequalities.</td>
<td>To some extent</td>
<td>Yes</td>
<td>Re-contextualised (idea is employed differently within policy compared to research, with far more emphasis being placed on the potential for health services to significantly reduce health inequalities)</td>
</tr>
<tr>
<td>Psychosocial determinants and the importance of relative social positions (income inequalities, etc)</td>
<td>Although contested until recently, there is now an emerging consensus that relative inequalities are important and that psychosocial pathways play a role in the way in which social and material inequalities influence health inequalities.</td>
<td>Psychosocial pathways are mentioned but income inequalities are not</td>
<td>Addressing psychosocial determinants is mentioned but addressing income inequalities is not.</td>
<td>Fractured (aspects of ideas about psychosocial pathways have travelled into policy but the focus on relative inequalities has not).</td>
</tr>
<tr>
<td>The importance of the whole lifecourse (as opposed to specific points in the lifecourse)</td>
<td>Yes (this approach merely suggests it is important to consider the whole lifecourse and is therefore complementary to other explanations).</td>
<td>Particular points in lifecourse (namely early years and motherhood) are highlighted but others are not.</td>
<td>Particular points in lifecourse (namely early years and motherhood) are highlighted but others are not.</td>
<td>Fractured (only particular points in the lifecourse are emphasised).</td>
</tr>
</tbody>
</table>
A ‘discursive institutionalist’ account of the translation and circulation of research-based ideas about health inequalities within policy

The contrasting journeys of different research-based ideas about health inequalities summarised in Table 1 support claims (e.g. Capability Reviews Team, 2007) that the relationship between evidence and health policy in the UK remains a long way from the desired relationship, at least as it was expressed in the White Paper *Modernising Government* (Cabinet Office, 1999a). To this extent, the findings support calls for investing in structures and new ways of working that are likely to cultivate stronger connections between research and policy (e.g. Lavis, Robertson et al, 2003; Lomas, 2000; Nutley, Davies & Walter, 2003; Wimbush et al, 2005). However, unlike most existing studies of the relationship between research and policy, the findings also indicate that the organisation of policymaking bodies significantly shape the ways in which research-based ideas can move into (and around) policy environments. The following sub-sections outline three distinct processes through which this ‘filtering’ process occurs. In line with institutionalist accounts, it demonstrates that the influence of research-based ideas is informed by more than the beliefs and preferences of the individuals working within policymaking organisations (although it should be noted that the views of some policy-based interviewees reflected the dominance of the particular policy paradigms evident in institutional arrangements).

(i) Institutional filtering

Informed by Weber’s (1968a) analysis of the way in which formal policy divisions shape bureaucratic activity, this section explores how the division of policy responsibilities relating to health inequalities shaped the influence of available research-based ideas. In Weber’s (1968b) assessment, 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, making it extremely difficult for them to engage with ideas beyond their immediate area of responsibility. Weber was, of course, writing in a very different time but this aspect of his analysis remains influential in contemporary analyses (e.g. du Gay, 2000; Immergut, 1998) and the data from this study suggest there is merit in considering how the division of responsibilities within policy institutions structures the routes via which ideas can travel. For, mirroring the findings of other studies (Capability Reviews Team, 2007; Exworthy and Hunter, 2011), the interviewees’ accounts unfailingly suggest that joined-up policymaking has been an elusive goal:

Civil servant (England): ‘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.’
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.’

Moreover, there was a consensus within the interview data that, as ‘joined-up government’ had proved so hard to achieve, the location of responsibility for health inequalities within the departments of health functioned to actively encourage the influence of ideas over which these departments had most control:

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. […] 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… 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 […] and do things about the wider determinants.’

The location of responsibility for health inequalities with departments of health, and the apparent failure of efforts to join-up policymaking, potentially helps explain both of the ‘re-contextualised’ journeys described above. As the above interviewee reflects, the policy levers over which UK departments of health have most control are health services and health promotion activities. The influence of ideas concerning the role that health services and efforts to change lifestyle-behaviours might play in reducing health inequalities are therefore likely to have been actively aided by the location of policy responsibility for health inequalities.

This paper is not the first to highlight the extent to which the decision to make departments of health responsible for health inequalities, and the failure to achieve joined-up decision-making, has constrained policy responses to health inequalities (see Exworthy and Hunter, 2011). However, what has not yet been considered in much detail is how these policy divisions can actively shape the research that is undertaken. For example, one (academic) interviewee described consistently trying but failing to obtain funding to assess the impact of policy interventions that had emerged from departments other than health on health inequalities, whilst finding it relatively easy to obtain funding to study the impact of ‘health policy’ interventions on health inequalities. This is just one example of the way in which the ideas embedded within policy can inform research evidence (as well as the other way round); a direction of influence that may be reinforced by calls for academics to ensure their work is ‘policy relevant’ (Smith, 2012).

Other researchers reflected that the gaps between different departments worked to prevent the circulation of research-based ideas once they had moved into policy contexts. For example, three academic interviewees (two in England, one in Scotland) separately described being surprised to find that policymakers working in
departments other than health appeared to have almost no awareness of what health policymakers were doing about health inequalities. This highlights the difficulty that research-based ideas face in moving around policy contexts structured by institutional divisions. 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. Whilst such ideas may have experienced a successful journey into health departments, accounting for their rhetorical visibility with health policy statements and interviews with individuals working in health departments, this would not be enough to secure their translation into policy action to address these determinants, given the lack of joined-up working and the fact that health departments are largely not responsible for the relevant policy levers (see Stevens, 2011).

The data also suggest that the institutional structures within departments shaped the journeys of research-based ideas about health inequalities. Indeed, the data reflect claims that the Department of Health (in England) operates ‘as a collection of silos focused on individual activities’ (Capability Reviews Team, 2007: 19). Policy-based interviewees in Scotland and England both described a situation in which civil servants within health departments were divided into small sub-groups, each of which was responsible for very specific policy foci. These groupings changed during the period of study but consistently featured divisions focusing on: aspects of the NHS; the prevention and better treatment of chronic illnesses (e.g. cancer, coronary heart disease and stroke); the perceived risk factors for these diseases (e.g. alcohol consumption, obesity, smoking and drugs use); and the health of particular social groups considered vulnerable to ill-health (such as children, mothers and older people). Such divisions represent the institutionalisation of medical, rather than social, models of health (see Hunter, 2003). The consequence of this, as one civil servant in Scotland reflected, was that even though the whole health department was aware of the policy aim of reducing health inequalities, everyone thought about it as ‘it applies to their own areas of interest’.

These divisions shaped the possible routes via which research-based ideas could travel into policy, meaning that policymakers’ exposure to cross-cutting ideas about health inequalities (such as those relating to social determinants of health) was probably more limited than their exposure to ideas relating to their specific areas of responsibility. This is evident in the following two extracts:

Civil servant (England): ‘The way the sort of work’s carved up 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 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 [coronary heart disease], cancer, etcetera and, through them, form links out into the wider community, voluntary organisations and so forth.’
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 Coordinator, 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.’

Both of the above quotations suggest that health policymakers are far more likely to encounter research-informed ideas where those ideas map onto their own specialist area of responsibility. This potentially helps explain both the ‘successful journey’ experienced by ideas concerning ‘early years’ and the ‘re-contextualised journeys’ made by ideas about lifestyle-behaviours and health services, as all three idea-sets had an obvious and identifiable policy audience. In other words, these ideas were able to move into policy through existing institutional routes which were unavailable to some of the other research-informed ideas.

Other aspects of the data suggest that, even when more complex ideas were actively targeted at policymakers, the institutional organisation of policy acted as a filter, blocking or re-shaping ideas which did not fit within the organisational channels of policy divisions. This process is visible in the following interviewee’s account:

Academic: ‘If you want to help young people to deal with their smoking, you can’t ignore their cannabis [use]. Now… how on earth do we move forward? Because… cannabis is in Drugs [policy], tobacco’s in Tobacco [policy], alcohol’s also a part of it, alcohol’s somewhere else [within policy] and if you try to move forward on that… I know the money has to be parcelled up some way but the danger is you can only then focus in a narrow way… under each [policy] heading. […] I don’t think it’s that civil servants don’t see the importance of [interactions between different issues] but it just seems to… become difficult when it’s… operationalised … Something seems to… block that. So I do think that’s problem with working in a broader, inequalities way.’ [Interviewee’s emphasis]

These kinds of descriptions, which are evident across the interview data, highlight how historical policy decisions concerning the prioritisation of particular issues (often embodied through the creation of particular units or posts) continue to shape subsequent ways of thinking. The following extract, in which an interviewee explains how national health inequalities targets were chosen, provides a particularly good example of how departmental priorities can, once selected, be self-perpetuating:

Civil servant (Scotland): ‘I think that [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. […] 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 always been identified as… 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 would have gone through the
most senior people who are responsible for those areas. 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.’

In describing how the health inequalities targets were chosen, this interviewee
explains that they were designed to mirror existing departmental priorities. The
sentence beginning, ‘The Department states…’ is particularly revealing as it
highlights the way in which agency is sometimes attributed to institutions (and,
implicitly, existing institutional structures), rather than individuals. This underlines
the power of the anonymity of policy decision-making, for once ideas are attributed to
a ‘department’, rather than individuals, they appear far less easy to challenge (see
Freeman, 2006). Indeed, in the above example, at no point did the interviewee
question whether this process was the best means of selecting targets for a cross-
cutting issue like health inequalities.

These examples illustrate that, once policy decisions have been made, they often
become embedded within the organisation of policy in ways which not only render
them extremely difficult to contest but are also potentially self-reinforcing. This
supports one of the central tenets of discursive institutionalism, namely that it is
necessary to consider how particular ideas have been historically institutionalised
and embedded within policymaking organisations and how this then shapes
subsequent debates and decisions.

(ii) The lack of vertical connectivity within policymaking institutions

The data also indicate that important divisions exist between different levels of the
policymaking hierarchy. In particular, interviewees suggested there were often fairly
stark divisions between civil servants and ministers (a finding reflected in a 2011
Institute for Government report). This was apparent even in Scotland, where
interviewees generally suggested the smaller nature of the policy community meant
that interaction between civil servants and ministers was greater:

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 (Scotland): ‘I feel that I’m at quite a distance from ministers, […]
there’s not much interaction.’

The data suggest that this lack of interaction served as an obstacle to the circulation
of research-based ideas within policy and contributed to a sense of distrust between
civil servants and ministers. Indeed, 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, health inequalities. For example:
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.’

Like the above interviewee, all four interviewees who had held Ministerial positions within the study period explained that they had actively sought advice about health inequalities from external advisors they knew, on the basis that they often trusted this advice more than that provided by civil servants. This aspect of the data is crucial because it suggests that even when civil servants do draw on research evidence to inform the policy responses they recommend, 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 policy influence of particular ideas was for individual researchers to promote their ideas directly to ministers or their external advisors (others suggested both routes were necessary). Yet, most of the academic interviewees described having much stronger links with civil servants that with ministers or their advisors.

Another hurdle facing research-based ideas that move into policy via traditional civil service routes is the extent to which these ideas can change as they move up policy hierarchies. The opportunities for this to occur are significant, partly because only very senior officials and special advisors tend to have regular contact with ministers. Hence, the majority of civil servants involved in undertaking research and/or interacting with researchers first have to convince these ‘gatekeepers’ that particular ideas are worthy of being put forward to ministers. Interviewees suggested that this was only likely to happen when these senior individuals could be persuaded that an idea fitted with (their perception of) the minister’s existing 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, p. 123)

This kind of subtle politicization is visible in the following two quotations, where civil servants from England and Scotland reflect on the importance of understanding what ministers are ‘looking for’. As the second interviewee explains, these judgements informed the way they were likely to present ideas and information:
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. [...] Their role is to give political, partial advice: ‘How is this gonna look best for you Minister? How does this fit with… what 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... they’ve got an important part to play and we’ve got to think about how they'll respond’ [authors’ emphases].

Both of the above quotations suggest that ideas which are believed to challenge the policy preferences of ministers are unlikely to be promoted by civil servants lower down the professional hierarchy, or at least not in a form that makes the ideas appear challenging. This process may 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 were re-framed or adapted in ways which those promoting the ideas within policy believed to be more in tune with the direction of policy (see Stevens, 2011).

Concluding discussion

The first part of this paper illustrated how and why a materialist analytical perspective based in Marxist conceptions of class and identifying the current neoliberal drift in public policy as a class project can contribute to understanding recent patterns in health inequalities in the United Kingdom and the public policies that have influenced these tendencies. The second part of our paper argues that it may make more sense to think of ideas, rather than evidence, as the unit of analysis when exploring the relationship between research and policy. Table 1 briefly outlined four distinct journey types experienced by research-informed ideas about health inequalities as they moved into policy and highlighted the potential for ideas to transform as they travel. This part of the paper then went on to explain these varying journeys by examining the interaction of research-informed ideas about health inequalities with policymaking institutions. Specifically, the findings suggest that ‘discursive institutionalism’ is a useful analytical framework for understanding the variable success of research-informed ideas travelling into policy.

Many creative tensions between theoretical perspectives exist as subtexts within the paper, of which we highlight only three here because of their methodological
significance. The first is the basic, long-standing issue of whether and how ‘ideas’ can be understood in isolation from the material interests of those articulating and promoting them (or not) and the institutional and political contexts in which they are being discussed. The second is the extent to which policy actors’ perceptions of what other (particularly more senior) policy actors are seeking can shape how they interpret, present and re-present ideas in policy debates, leading to an ongoing process of ideational translation. This process, in turn, needs to be understood as part of a larger political-economic context and situated with reference to the forces that shape that context – including, after Harvey, changing constellations of class forces that may reflect both global influences and path dependencies arising from previous state actions. A third question, that to some degree integrates the first two, is that of scale and time. At what scale, and over what time period, is it most appropriate to attempt to explain the outcome of policies that aim to reduce health inequalities, and for that matter the failure to adopt policies with that objective, or to incorporate health inequality concerns into public policy more generally? This last question, in particular, transcends the difference in perspectives between (for example) the two authors of this paper, and underscores the value of our longer-term project of bringing the resources of social and political theory to bear on the policy question of why and how to reduce health inequalities.

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