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The Translation and Re-circulation of Ideas about Health Inequalities Within Policy

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Institutional Filters: The Translation and Re-Circulation of Ideas about Health Inequalities within Policy

Abstract

Taking health inequalities in the UK as a case study, this paper adopts a 'discursive institutionalist' approach to explore how the organisation of policymaking bodies shapes the relationship between research and policy. 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. This limits the extent to which research can inform policy. Yet, a lack of institutional memory within policymaking enables re-cycled ideas to appear innovative, creating an impression of meaningful, ongoing dialogue between research and policy.

Word count: 99

Keywords: Discursive institutionalism; evidence-based policy; health inequalities; ideas.

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Background

Despite a sustained political commitment to reducing the UK's health inequalities during a thirteen year period of office, by the time Labour lost the 2010 general election, mounting evidence indicated that health inequalities had widened (Marmot, 2010; National Audit Office, 2010). This has triggered much reflection within the health inequalities research community (e.g. Mackenbach, 2010, 2011) which, as a result of

Labour's simultaneous commitment to 'evidence-based policy' (Blunkett, 2000; Cabinet Office, 1999), had been positioned as a key source of potential solutions.

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). 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, Mackenbach (2011) suggests that policymakers did not have a democratic mandate to implement the kinds of redistributive policies supported by much of the available research. Whilst Mackenbach (2011) and Macintyre (2003) have both pointed out that the available evidence provided little guidance for policymakers on the effectiveness of potential interventions and did not, therefore, meet policyamkers' 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'.

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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).

This paper revisits the relationship between health inequalities research and policy in the UK, drawing on an empirical study involving 62 semi-structured interviews and an analysis of 59 policy statements. It 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, congniscent of the fact that, when asked about health inequalities *evidence*, policymakers usually responded by

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talking about *ideas* (albeit ideas that were linked to evidence), the paper focuses on the movement of research-informed *ideas* about health inequalities, rather than evidence (see Weiss, 1982; & Smith, 2007). 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). Empirically, the paper builds on the growing (though still limited) number of studies mapping the complex interaction between policy ideas and institutions (Béland, 2005). However, it is unusual in exploring these interactions for an issue in which radical policy change has not (yet) occurred.

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

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institutionalised, whilst limiting the influence, or changing the contours, of more challenging ideas. The findings also suggest that a lack of institutional memory within policy institutions enables similar ideas to be regularly re-cycled, creating the illusion that research is informing policy far more than it is.

Methods

The paper draws on data from a larger research project exploring how (if at all) research on health inequalities informed UK policy between 1997 and 2010 (Smith and Hellowell, 2012). In a post-devolution landscape, it seemed important not to focus *solely* on England. Hence, Scotland, which had taken an extremely similar stance to England on health inequalities, evidence-based policy and joined-up decision-making (Chief Scientist's Office, 2002; Scottish Executive Health Department, 2003), was chosen as a companion case study to England. This comparison was deemed potentially interesting for two reasons. First, health was one of the most significant areas to be devolved (Woods, 2004) and claims of significant post-devolution divergence had already emerged (e.g. Greer, 2004). Second, it had been suggested that the smaller nature of public health policymaking in Scotland might enhance the relationship between researchers and policymakers (e.g. Wimbush et al, 2005). However, the findings suggested that during the study period there were remarkably few differences in how institutional policy arrangements were shaping the influence of health inequalities research. These differences do not, therefore, form a core focus of this paper (for a comparative assessment, see Smith et al, 2009; Smith & Hellowell, 2012).

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The paper focuses primarily on an analysis of interviews with 62 individuals involved in the interplay between health inequalities research and policy in Scotland and England (see Table 1), although it also draws the overall research project was also informed by an analysis of 59 policy documents concerning health inequalities (Smith, 2008).

Table 1: A breakdown of interviewees' professional positions

Case Study A	
Interviewees' professional position	*Number of interviewees*
Academic researcher	30
Civil servant	10
Researcher in an independent/private research organisation	5
NHS based researcher / policy advisor	5
Journalist or media communications staff	5
Minister with responsibility for health inequalities	4
Research funder	3
Total	**62**

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The interviews were semi-structured and most took place in 2006-2007, although follow-up interviews were conducted with four key interviewees in 2011 as well as one additional interview (an academic who had previously been unable to participate). 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. A themed interview schedule was employed which focused questions around health inequalities research, policy and knowledge exchange. The interviews varied in length, lasting between 45-

150 minutes (most were around 60-80 minutes). All interviews were digitally recorded and transcribed verbatim, before being anonymised, then thematically coded in the qualitative data analysis programme*, Atlas.ti*, using a coding framework that was developed iteratively, via analysis and re-analysis of the transcripts. The research was conducted in line with University of Edinburgh's ethical guidelines.

An Ideational Approach to Understanding the Influence of Health Inequalities Research on Policy

Supporting claims of a dissonance between health inequalities policies and evidence (as discussed above), not a single interviewee said they believed that policy responses to health inequalities had been *based* on evidence. However, policy-based interviewees frequently discussed the influence of particular idea-sets on policy (e.g. 'psychosocial' ideas). The results indicate that all of the key ideas about health inequalities that academic interviewees felt were well-supported by evidence had travelled into policy. However, contrasting ideas had experienced remarkably different journeys. The following sub-sections briefly outline the four key journey types that were identifiable (a somewhat different, less developed account is in Smith, 2007).

(i) 'Successful journeys'

I categorised research-informed ideas about health inequalities as having experienced a 'successful' journey where they appeared to have travelled into policy relatively coherently, in a manner which reflected the underlying evidence-base, and where there

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was evidence they had influenced policy initiatives as well as discourse. Only one example of a 'successful journey' was detectable: the importance of the early years of life for explaining (and intervening in) health inequalities. The following extract is illustrative of a widely held view (across academic and policy interviews) that this idea-set had enjoyed a particularly successful journey into policy:

> Policy advisor (England): *'One of the most successful parts of policymaking as far as I'm concerned [is] the early years, children, childcare and Sure Start… 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 doing it across a range of initiatives, so that you have maternity leave policy as well as child care policy… Sure Start […] This was a very good example of joined-up government...'*

Furthermore, several policy-based interviewees referred directly to one of the leading health inequalities researchers associated with early years research, Professor David Barker (see Barker, 2007), whilst others mentioned specific studies (e.g. evaluations of Head Start in the USA). This suggests not only that ideas about early years provide an example of a 'successful journey' from research into policy but that research played an important role in facilitating this journey. It is worth noting, however, that some interviewees still felt this idea-set had been far less influential than it ought to have been.

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(ii) 'Partial journeys'

In contrast, I used the term 'partial journey' where research-informed ideas appeared to have influenced policy explanations of the *causes* of health inequalities but were far less evident in policy responses. The best example concerned ideas about material and socio-economic determinants of health inequalities. These ideas have long been supported by research (e.g. Black, 1980; Marmot, 2010) and nearly all of the policy documents acknowledged their role in contributing to health inequalities. Yet, as discussed elsewhere (Smith et al, 2009), specific responses to health inequalities often failed to reflect this emphasis. Furthermore, there appeared to have been a shift away from an initial focus on these ideas towards downstream, lifestyle-behavioural interventions by the time the interviews took place (2006-2007). This shift was identified by several individuals working in policy settings. For example:

> Policy advisor (England): *'I think there has been a shift. So [earlier policy documents] were clearly highlighting all the environmental issues… and the socio-economic issues that played into shaping people's health over their lifetime. And that's still there but […] I think it's much less prominent. So government policy documents now talk much more about people's personal responsibility… and, while it's true people can make choices… the dangers of that argument are it doesn't always recognise the constraints under which people are making those choices.'*

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Hence, the data suggest that, despite travelling into policy rhetoric, ideas about the importance of material and socio-economic determinants encountered obstacles which limited and challenged their influence. This meant not only that these ideas struggled to travel beyond policy discussions about the causes of health inequalities, to actually effect policy change, but that the influence of these ideas declined over time.

(iii) 'Re-contextualised journeys'

Ideas about the role of lifestyle-behaviours and health services in addressing health inequalities constitute, in many ways, the ideas which the policy analysis suggested had enjoyed the most impact on policy in both countries (see Smith, 2008; & Smith et al, 2009). However, the ways in which these ideas have been applied within policy differs substantially from the ways they are most often discussed in health inequalities research. Hence, after initially categorising these ideas as examples of 'successful journeys' (in Smith, 2007), I ultimately decided these journeys should more accurately be understood as 're-contextualised'. For example, whilst research demonstrates clear links between health inequalities and damaging lifestyle-behaviours (e.g. Lynch et al, 1997), and between health inequalities and access to and/or use of health services (e.g. Watt, 2002), very little research suggests either represents a fundamental cause of health inequalities or a viable focus of solutions (see Graham, 2009; Whitehead, 2007). Yet, interventions designed to change lifestyle-behaviours and/or to improve the use of health services were frequently promoted as key policy responses to health inequalities,

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whilst the NHS was charged with responsibility for meeting national health inequalities targets (Smith et al, 2009). What is more, as the rhetoric shifted away from material and socio-economic determinants of health (see above), there was a corresponding increase in the emphasis placed on these avenues for addressing health inequalities (Smith et al, 2009).

What is particularly interesting about this shift is that several policy-based interviewees were openly critical of these kinds of approaches. For example:

> Civil servant (Scotland): *'I think people have ignored the fact that… evidence from… large-scale risk factor interventions in… adults, evidence for the effectiveness of those kinds of interventions is very weak […]. 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.'*

> Policy advisor (Scotland): '*There are some people… who say, well… we can't actually… do structural change or very effective societal intermediary change, therefore, at the very least, we should ensure that the health service corrects these inequalities. So we can… target primary care, we can change the funding patterns and we can at least ensure that the disease effects of wider inequalities don't manifest themselves as unfairly as they do. […] Others would say that's a*

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terrible betrayal of our understanding of how these problems arise […] and that would be a justified criticism.'

In light of the fact at least some individuals involved in the construction of post-1997 policies were wary about focusing on lifestyle-behaviours and health services as mechanisms for addressing health inequalities, it seems strange that these ideas were as influential as they appear to have been.

(iv) 'Fractured journeys'

The fourth journey type involved cases in which only elements of particular research-based ideas appeared to have travelled into policy. The best example involved 'psychosocial ideas' about health inequalities, including the importance of community relations, trust, social capital and crime levels (e.g. Wilkinson, 2005) as well as 'job control' and social status (e.g. Marmot, 2004). These ideas were frequently evident in policy documents (Smith, 2008) and in interviews with policy-based individuals. Moreover, several policy-based interviewees specifically linked these ideas to Wilkinson and/or Marmot. However, this journey has not been categorised as 'successful' because Wilkinson and Marmot base many of their ideas about psychosocial determinants on the premise that these mechanisms reflect underlying material and social inequalities (e.g. Marmot, 2004; Wilkinson, 2005). Yet, as the extract below illustrates, many of the policy-based interviewees who mentioned these ideas specifically challenged this link:

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Policy advisor (Scotland): *'There are all sorts of things about… position in society that is partly determined by material wealth but not solely… […] I think that some of the… issues about… how people are treated and… a chronic accumulation of stress [that] comes from not being understood, or not being valued, or not being treated well by society… is a very important determinant of health. […] I would have to question whether reducing material inequalities would also inevitably reduce those kinds of psychosocial factors too…'*

This suggests that, whilst aspects of psychosocial theories about health inequalities travelled into policy (e.g. elements emphasising the importance of social capital, confidence and perceptions of status and control), the link between these factors and actual societal or income inequalities was somehow lost (or dropped) along the way.

The Translation and Re-Circulation of Ideas about Health Inequalities within Policy

This section sheds light on the four contrasting journey types outlined above by exploring the interactions between research-informed ideas about health inequalities and the policy institutions charged with responsibility for reducing health inequalities. It demonstrates that the influence of research-based ideas in policy has been informed by the organisation of policymaking institutions, whilst also highlighting that organisational divisions can themselves be understood as the successful institutionalisation of particular ideas.

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(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 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 a rather illusive 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.'*

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> 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, in both Scotland and England

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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).

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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

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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*

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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,

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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:

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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

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process was the best means of selecting targets for a cross-cutting issue like health inequalities.

These examples illustrates 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*

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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.'*

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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

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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, p123)

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 <u>make a judgement about what ministers really want</u>, what's feasible and what's politically this, that and the other.'* [My emphasis]

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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.'* [My emphasis]

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).

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(iii) Limited institutional memory within policy

Finally, the short time-frames within which policymakers were often required to work, combined with a rapid level of staff turnover, functioned to limit the institutional memory within policy bodies. The data reveal that one consequence of this was that similar ideas were being constantly re-presented to policymakers with the illusion that, each time they returned, they represented a new way of thinking. Hence, as the following interviewee believed, instead of learning from past policy initiatives, there was a feeling that the same ideas were continually being 'reinvented':

> 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.'*

The frustration that interviewees expressed about the difficulties in moving debates about health inequalities beyond a continual (re)circulation of similar ideas was not only targeted at individuals working within policy but also at researchers. Indeed, six interviewees based in academia claimed that the lack of institutional memory within policy enabled the funding of research projects for which sufficient evidence existed, whilst four academic interviewees described undertaking research which had been specifically commissioned by policymakers only to find that, on completion of the

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project, the policymakers who originally commissioned the research had moved posts and were no longer interested in the results, leaving the path open for similar research, possibly even by the same researchers, to be commissioned by someone else at a later stage. Precisely such a situation was described by the following interviewee:

> Academic: *'What's really struck me […] is <u>we seem to do the same bits of work over and over again</u>. 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 [it] 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.'*

This fragmentation and re-circulation of ideas may help explain 're-contextualised' and 'fractured' journeys. For it suggests that research-informed ideas are being regularly re-defined and re-presented to perpetually shifting policy landscapes, a process which may facilitate the ongoing transformation of research-informed ideas.

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 something which could be changed. Hence, other mechanisms for developing the memory capacity of policymaking institutions were put forward. One

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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 fails to acknowledge the significant pressure on researchers to obtain funding which may well dissuade them from pointing out that potentially fundable research projects may be unnecessary (see Fuller, 2005).

In light of this, it seems more likely that designated 'research brokers' may be required (Sin, 2008). Indeed, organisations to undertake a research brokerage role for public health were established in England and Scotland towards the end of the study period: the Scottish Collaboration for Public Health Research and Policy (SCPHRP) was set up in 2008, jointly funded by the Medical Research Council and the Chief Scientist's Office of the Scottish Government (SCPHRP, 2012); whilst the UK Centre for Translational Research in Public Health (a collaboration between universities and other partners in North-East England) was one of five public health centres funded for five years by the UK research councils and others (Gray, 2008). Both have a remit to improve the use of public health research in policy and practice and to support the development of policy relevant research. Further research is required to explore what, if any, impact these organisations are having on the links between health inequalities research and policy.

Conclusion

The first part of this paper illustrated why it may make more sense to think of ideas, rather than evidence, as the unit of analysis when exploring the relationship between

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research and policy. It 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. The second part shed light on these varying journeys by examining the interaction of research-informed ideas about health inequalities with policymaking institutions.

The results indicate that the location of responsibility for health inequalities within health departments, and the organisational divisions within these departments, has significantly shaped the relationship between health inequalities research and policy. Crucially, such divisions have made it extremely difficult for policymakers to undertake the kind of complex, 'whole system' thinking that many commentators argue is required for a multifaceted issue like health inequalities (Exworthy and Hunter, 2011). This institutional 'filtering' process 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). This was certainly apparent for health inequalities as policy divisions largely reflected the institutionalisation of a medical model of health (i.e. an approach to health which focuses on diseases, risk factors and individuals), as opposed to the social model of health that forms the basis of many research-informed ideas about health inequalities (see Graham, 2009). All of this suggests that ideas which do not fit neatly within these various policy divisions (i.e. within a medical health paradigm) are likely to encounter difficulties moving into policy, whilst ideas linking to existing

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channels are likely to be actively encouraged and may end up having rather more influence within policy than the evidence suggests they warrant.

The problems caused by the location of responsibility for a cross-cutting issue like health inequalities with health departments have been widely recognised (Exworthy & Hunter, 2011) and a range of potential solutions are currently being experimented with. For example, Scotland has recently replaced government departments with 'directorates', with the intention of facilitating collaboration (see Parry, 2012). The impact of this organisational change remains to be assessed but these efforts may, as many interviewees suggested, be aided by the relatively small nature of policymaking in Scotland. An alternative response, evident in both England and Scotland, has been the introduction into decision-making processes of 'health impact assessments' (HIA), which are designed to encourage policymakers across government to think about potential health impacts (Kemm, 2001). An even more radical response is represented by the concept of 'Health in All Policies' (HiAP), which involves a commitment to thinking about health issues across policy divisions and which was promoted by the Finnish EU Presidency in 2006 (Puska & Ståhl, 2010). However, the success of either HIAs or HiAP in effectively countering strong institutional policy divisions has yet to be demonstrated and early analyses suggest the implementation of both has been problematic (Koivusalo, 2010; Salay & Lincoln, 2008).

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The data also indicate that institutional filtering processes may be further exacerbated by a lack of vertical connectivity within policy, which prevents ideas from circulating freely between different policy levels. Indeed, the interview data suggest that limited vertical connectivity may encourage civil servants to engage in second-guessing what ministers, or their advisors, are 'looking for'; a process which seems likely to further limit the influence of challenging or innovative ideas. This aspect of the findings suggests health inequalities academics perhaps ought to do more to develop connections with ministers and their advisors as well as with civil servants.

The final section highlights how the frequent movement of civil servants within policy contexts limits institutional memory within policymaking organisations (see also Institute for Government, 2011). One consequence of this appears to be that the same ideas can keep resonating between research and policy, leading to a situation in which similar ideas re-circulate. This potentially aids the re-presentation and transformation of research-informed ideas as they move into policy. It also creates the impression that there is an ongoing dialogue between researchers into policymakers even when this dialogue is, in reality, limited and repetitive. It is here that recent investments in organisations focusing on performing public health translation may (if they continue) be particularly useful, for it is plausible that such organisations might aid the 'institutional memory' of public health policymaking.

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In exploring the crucial role that the organization of policy bodies plays in shaping the journeys of research-based ideas about health inequalities into and within policy, this paper addresses an important gap. It brings together studies concerned with the relationship between research and policy and ideational and institutionalist theories about the policy process, suggesting that the former could be substantially enhanced by the latter. Specifically, the findings support the emergence of 'discursive institutionalism' as an analytical framework and suggest that such a framework is relevant to exploring unsuccessful (as well as successful) efforts to achieve significant policy change. Whilst this paper focuses on the case study of health inequalities, which may be an a-typical policy problem, it seems plausible that aspects of the findings may have relevance for other complex and cross-cutting policy concerns, such as drugs policy (Stevens, 2011) and climate change (Urwin and Jordan, 2008).

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