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The Politics of Ideas: The complex interplay of health inequalities research and policy

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Abstract

Public health research is overtly orientated towards influencing policy and yet, despite official commitments to ‘evidence-based policy’, most analyses conclude the impact of public health research has been limited. Based on an analysis of post-1997 UK policy statements and interviews with 112 key actors, this article argues that the failure of ‘evidence-based’ policy to emerge relates to the fact it is ideas, not evidence, which travel between research and policy, and that these malleable entities are translated as they move between actors. By unpacking six factors that appear to have shaped the ‘interplay of ideas’ about health inequalities, the article draws attention to the ways in which policy influences research (as well as the other way round). The conclusion argues two distinct ‘idea types’ are evident within the data, each of which helps explain the difficulties in achieving ‘evidence-based’ policy responses to health inequalities: ‘institutionalised ideas’ and ‘chameleonic ideas’.

Introduction

Improving health outcomes and/or reducing health inequalities are the ultimate goals of most public health research but policymakers and practitioners are often the intermediate beneficiaries, or ‘target audience’ (Lavis, et al., 2004; Macintyre, et al., 2001). In some countries, such as Australia, Canada and the UK, this focus has been encouraged by official commitments to evidence-based policymaking (e.g. Rudd, 2008; Blunkett, 2000; Cabinet Office, 2000; Noseworthy and Watanabe, 1999). More recently, demonstrably achieving ‘impact’ on policy and practice has become an explicit performance measure for academic health researchers in the UK and Canada (Canadian Academy of Health Sciences, 2009; UK Higher Education Funding Bodies, 2011). Against this backdrop, it is perhaps unsurprising that a wealth of studies and commentaries consider the use of public health evidence in policy and practice (e.g. Lavis, et al., 2004; Macintyre, et al., 2001; Katikireddi, et al., 2011; Nutbeam and Boxall, 2008; Hunter, 2009; Petticrew, et al., 2004; Smith, 2007). Yet, despite official commitments to, and widespread disciplinary support for, ‘evidence-based’ public health policy, most studies continue to conclude that public health policies are not evidence-based (e.g. Macintyre, et al., 2001; Katikireddi, et al., 2011; Hunter, 2009; Smith, 2007; Bartley, 1994).

As Wehrens and colleagues note, this disjuncture is often conceptualised as a ‘knowledge to action gap’ and this, in turn, has stimulated efforts to build ‘bridges’ to overcome such ‘gaps’ (Wehrens, et al., 2011). From this perspective, the relationship between science and policy is conceived in a linear, uni-directional manner, with ‘science’ providing solutions for identifiable ‘policy problems’. This way of thinking pays little, if any, attention to the processes involved in undertaking research or constructing research outputs, tending to assume that ‘evidence’ is value-free, concrete and fixed (see Wehrens, et al., 2011). Such a view contrasts sharply with sociological studies of science, which emphasise the role that values, perceptions and (micro)politics all play in the construction of scientific evidence (e.g. Bartley, 1992; Knorr-Cetina, 1981; Latour and Woolgar, 1986). Moreover, a focus on ‘knowledge to action gaps’ does little to help illuminate some of the complexities involved in policymaking, or the diversity of relevant actors (Smith and Joyce, 2012). In contrast, popular theories of policy change consistently emphasise the complexity of policymaking and the important of networks, values, interests and politics (see Smith and Katikireddi, 2013). Indeed, from the perspective of much of the policy sciences

literature concerning policy change, the question becomes not, ‘why is public health policy not evidence-based?’ but ‘why would we ever assume it could (or should) be?’

Haas’ (1992) notion of ‘epistemic communities’ is unusual in paying attention to the potential policy contribution of both ‘knowledge based experts’, such as academics, *and* values and beliefs. Yet, although ‘knowledge-based experts’ are depicted as helping to shape the way policymakers think about particular issues, it is actors’ beliefs (particularly their causal beliefs) and values that are positioned as the fundamental basis around which ‘epistemic communities’ form. Further, because the success of ‘epistemic communities’ is framed as being dependent on a high degree of consensus amongst members (Haas 1992), it seems unlikely that evidence would be employed by an ‘epistemic community’ where it challenged the community’s norms. This inevitably limits the potential role of evidence in this framework, suggesting that it is most likely to be employed by actors where it supports their existing beliefs.

Others have argued that focusing on ideas offers a useful means of capturing the multiple dimensions of relationships between science and policy (e.g. Béland and Cox, 2011; Fafard, 2012; Weiss, 1982). Employing ‘ideas’, rather than ‘evidence’, as the primary unit of analysis is in some ways a simple distinction but it can be important in drawing attention to the potential malleability of evidence-informed messages as they move between actors and across contexts (e.g. Smith, 2007; Weiss, 1982; Stevens, 2007). This, in turn, highlights the importance of analysing how ideas are constructed and promoted and how politics, values and ethics can interact to shape the way in which ideas are subsequently translated and transformed (Sanderson 2006; Smith and Joyce 2012). However, the utility of focusing on ideas is dismissed by Haas (1992) on the basis that there has been insufficient work to assess how ideas are disseminated, how they evolve or why some ideas prevail over others (Haas, 1992). Meanwhile, Blyth (1997) cautions that existing definitions of ‘ideas’ are often so vague that they can be employed as ‘catch-all concepts’ that do little to advance current theoretical understandings.

Yet, three distinct ‘levels’ of idea are identifiable within many existing analyses focusing on the role of ideas within policy. First, ideas are often depicted as ideologies or overarching paradigms involving ‘organized principles and causal beliefs’ (Béland, 2005). At this level, ideas represent organising frameworks for understanding the world, or ‘road maps’ in Béland’s (2005) terms, which provide policymakers ‘with a relatively coherent set of assumptions about the functioning of

economic, political and social institutions’ (Béland, 2005: p.8). This way of thinking about ideas, which helps highlight the importance of values and causal beliefs, is similar to Hall’s (1990; 1993) concept of ‘policy paradigms’ and Jobert and Muller’s (1987) notion of ‘the *référential*’. Second, literature focusing on agenda-setting (e.g. Cobb and Elder, 1972; Edelman, 1988; Schattenschneider, 1960) highlights how ideas can operate as ‘policy frames’. From this perspective, ideas are positioned as tools that can be constructed and deployed by interested policy actors as ‘weapons of advocacy’ (Weiss, 1989: p.117), serving to define how policy problems are understood and who is involved (or not) in the policy process. Finally, ideas are often defined as simple policy proposals for responding to identifiable policy problems (see Béland, 2005; and Kingdon, 1995; 1984).

A similar kind of three-level division is evident in Sabatier and Jenkins-Smith’s (1999) advocacy-coalition framework (‘deep core’, ‘policy core’ and ‘secondary’ beliefs). Yet, whilst distinguishing between different ‘levels’ of ideas may be heuristically useful, as Béland (2005: p.2) notes, particular policy solutions are often embedded within policy paradigms and framed by policy actors in ways which aim to ‘increase their popular support, before and even after their enactment.’ This means that it is not always easy to disentangle the separate ‘levels’ of complex ideas when examining the relationship between research and policy.

Taking the relationship between health inequalities research and policy in the UK as a case study, this article argues that it may be more helpful to identify ideational characteristics that affect the ability of research-informed ideas to travel into, and survive within, policy. Employing the accounts of actors involved in health inequalities research and policy, the article first sets out the case for focusing on research-informed ideas, rather than evidence. In this sense, the article defines ‘ideas’ as ‘policy solutions’ for addressing health inequalities (although it quickly becomes clear that these ‘policy solutions’ are intertwined with higher-level ideas). It then identifies six factors that the data suggest have shaped the construction and translation of research-informed ideas about health inequalities within the UK. In so doing, the article highlights how institutions function to shape ideas, whilst simultaneously being themselves organised around overarching ideas, situating the article within the analytical approach Schmidt (2010) calls ‘discursive institutionalism’. The article concludes by arguing two distinct idea-types have functioned to limit the ability of

health inequalities research to influence policy: (i) institutionalised ideas; and (ii) chameleonic ideas.

Methods

The paper draws on data from a larger research project exploring how research on health inequalities informed British policies between 1997 and 2012 (Smith, 2013). Although political devolution in 1999 meant that different parts of Britain had opportunities to take contrasting approaches to both health inequalities and knowledge exchange, the research found very little evidence of significant differences across Britain. The focus of this paper is therefore on how the institutional arrangements across Britain shaped the influence of health inequalities research on policy (the limited differences are explored elsewhere – Smith et al, 2009; Smith and Hellowell, 2012). It is based on an analysis of interviews with 112 individuals involved in the interplay between health inequalities research and policy in Britain between 1997 and 2012 (see Table 1). This analysis was informed by a thematic review of health inequalities research and an analysis of 59 relevant policy documents (Smith, 2013).

Table 1: A breakdown of interviewees’ professional positions

<i>Interviewees’ primary professional position (many individuals also had experience of working in other sectors)</i>	<i>Number of interviewees 2005-2007</i>	<i>Number of interviewees 2011-2012</i>	<i>Total number of interviewees</i>
Academic researchers	30	20 (2*)	48
Individuals working in policy settings (largely civil servants)	10	15 (2*)	23
Researchers working in independent/private research organisation (including think tanks)	5	1	6
Public sector researchers / policy advisors	5	3	8
Journalists or media communications staff	5	0	5
Politicians (including ministers)	4	4	8
Research funders	3	4	7
Public health ‘knowledge brokers’	0	3	3
Senior staff in third sector / advocacy organisations	0	4	4
Total	62	54 (4*)	112
<i>(N*) Indicates the number of interviewees in 2011-2012 who had also been interviewed in 2005-2007.</i>			

The interviews were semi-structured and took place in two batches (the first in 2005-2007 and the second in 2011-2012). The second period of interviewing included conducting follow-up interviews with four key interviewees who had been interviewed in 2005-2007 (see Table 1). 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 (two interviews were joint interviews with two interviewees and four were conducted by telephone, all at the request of interviewees). 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). The research was conducted in line with University of Edinburgh's ethical guidelines. All interviews were digitally recorded and transcribed verbatim, before being 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. This iterative process helped identify both the importance of ideas (over evidence) and six key features of research and policy work that help explain why it can be so difficult to achieve research-informed policy decisions. Indeed, the findings support Rein's (1980) claim that the relationship between research and policy might be best understood as an 'interplay of ideas'.

Findings

Perhaps the most startling finding was that, despite all the official commitments to evidence-based policy, not a single interviewee said they believed that policies to reduce health inequalities had been based on research evidence. This challenges some recent assessments of English policy responses to health inequalities (e.g. Mackenbach, 2010; 2011) but is less surprising in the context of previous studies examining the use of public health research in policy (as outlined above). It would not, however, be accurate to suggest that policy debates and outputs concerning health inequalities were therefore *uninformed* by the available evidence. Rather, it was clear that most popular research-informed ideas about health inequalities, involving social determinants such as income, housing, employment and education, could be identified in policy settings (both in interviews with policymakers and in policy documents). However, virtually all of these ideas had only managed to influence policy in partial and limited ways. Indeed, the findings mirror Popay's assessment that there has been

a ‘seemingly irresistible ‘lifestyle drift’ that focuses researchers, policy makers and practitioners alike on individual behaviours’ (Popay, 2012: 59), despite the fact that major (government-commissioned) reviews of the available evidence have consistently highlighted the importance of ‘upstream’ social determinants (Marmot, 2010; Acheson, 1998; Black, et al., 1980).

It was not simply the case that research-informed ideas about ‘upstream’ determinants had failed to travel into policy debates. Rather, these ideas were easily identifiable within policy documents and interviews with individuals working in policy settings. However, they had not triggered the associated policy responses that might have been expected by researchers (see Bambra et al, 2011). Indeed, in some cases, research-informed ideas appeared to have transformed during their journey into policy, evolving into rather less politically challenging ideas. This presents two ‘puzzles’. First, why, despite official commitments to achieving both evidence-based policy and reductions in health inequalities, did there appear to be such a disjuncture between the available evidence on health inequalities and the proposed policy responses? Second, how and why had challenging research-informed ideas about health inequalities, concerning the social determinants of health, travelled into policy in ways which limited their likely impact?

This paper does not focus on assessing the extent to which evidence-informed ideas about health inequalities have (or have not) influenced policy, or exploring precisely how different ideas changed during their journey into policy, as this is the focus of other publications (Smith, 2007; 2010; 2013). Rather, this article aims to unpack the six key factors that the data suggest were most crucial in understanding these two puzzles. These six factors are organised into sub-sections which trace interviewees’ accounts of the construction and translation of research-informed ideas about health inequalities. The first sub-section focuses on researchers’ accounts of choosing to focus on particular issues within health inequalities research and the second considers how divisions within the health inequalities research community can limit the clarity of messages directed at policy communities. The third sub-section explores how the organisation of health inequalities within policy contexts works to shape the influence and construction of research-informed ideas about health inequalities. The fourth examines the micro(career) politics of providing policy advice and the fifth sheds light on interviewees’ perceptions of the broader social and political context in which they are all working. Finally, the sixth sub-section

demonstrates how limited institutional memory can function to create the appearance that research is informing policy more than it actually is.

(i) *'Cycles of credit' and funding opportunities*

In health-related research it has long been acknowledged that sources of funding (particularly involving commercial interests) can influence research outputs (Bekelman, 2003; DeAngelis and Fontanarosa, 2008). Indeed, the growing awareness of the potential for funding sources to influence research outputs has stimulated a wealth of ethical guidance on declarations of funding and potential conflicts of interest (see Bates, et al., 2004). The findings from this research suggest that the ways in which research funding opportunities, and perceptions of those opportunities, have shaped public health research and its relationship with policy in the UK are complex, not least because policymaking bodies commonly represent both a potential source of research funding and a potential audience for research outputs. Indeed, as the following interviewee pointed out, funding opportunities can serve as a mechanism for drawing researchers' attention towards particular policy concerns:

Senior academic: '[X - civil servant], is still amazed that I don't know things like [policy] initiatives that are going on but then, can understand when I say, you know academics - we go on a need to know basis. [...]. If there's a call for research and there's some funding, well, we're learn about that, you know - in twenty-four hours we'll know about that!'

In other words, funding opportunities can operate as a means of encouraging the production of policy-informed public health research, something which public health researchers have themselves called for (e.g. Hunter, 2009). Such preferences are also evident in studies of policymakers (e.g. Petticrew et al, 2004) so it is perhaps unsurprising that several policy-based interviewees described actively working to achieve this kind of policy influence on public health research:

Senior policymaker (Scotland): 'One of the things that [we] have attempted to do - and, I think, quite successfully - is to... not just to give the money out but to... make sure that the money goes out in a structured way, which... plays into and

underpins... and provides answers for the research questions which we need for policymaking purposes.'

Senior civil servant (Scotland) [different to above]: *'[T]here is a kind of tension in discussions which go on nowadays between... researchers, who basically say, 'give us the money - I've got a great programme of research here... I can't tell you too much about it, 'cause the ideas are just beginning to... So, give me the money - you can trust me and... I'll produce something. Don't know what it is but, but something will happen.'* And on the other hand, people like me and [...] my colleagues in the MRC[Medical Research Council], who say, *'what did we buy for the money?'* And, *'Well, I know you're very interested in looking at... health inequalities but actually, I have a problem here - I am required to make policy in this area... at the moment, I have no hard facts at all... and I really would like some research done... and... by the way, I want it done within the next six months and I've got that amount of money available for it. So, I want you to give me the best answer you can within six months, given that amount of money.'* And... *that's the real world. [...]* *The critical thing is to try to get public health academics... having an effect on policy, but in turn having their activities shaped by policy aspirations. Not telling the academics what to do but saying, 'look, ministers are intent on going in this direction. Anyone want to follow and see what happens?'*

The above quotations draw attention to policymakers' desire for research evidence which not only provides clear policy 'solutions' but which also reflects the boundaries within which they are already working. In other words, they highlight the way in which the ideas currently shaping policy can be encouraged to inform research (as well as the other way round). The second quotation goes even further than this, suggesting that researchers ought to be able to provide funders with assurances about what they are 'buying' with research funding *in advance* of the research being conducted. This challenges traditional notions of the exploratory, experimental nature of scientific research and, whilst many academic interviewees expressed some sympathy for policymakers' desire for such assurances, the following interviewee was one of several who suggested that it could lead to researchers feeling they were being 'steered' towards producing particular 'policy messages':

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

This does not mean it is not possible for researchers who are awarded policy funding to (on the basis of their findings) present conclusions other than those they initially suggested they would. Indeed, several interviewees reported that they had done precisely this. However, the data also suggest that many health inequalities researchers were wary about presenting unfavourable messages to policy audiences for fear of losing credibility. Maintaining credibility with policy audiences seemed to matter a great deal to health inequalities researchers, partly because they were keen to influence such audiences but mainly because they were perceived to represent future sources of research funding. This was in a context in which researchers consistently described feeling under increasing pressure to secure research funding (see Smith, 2010).

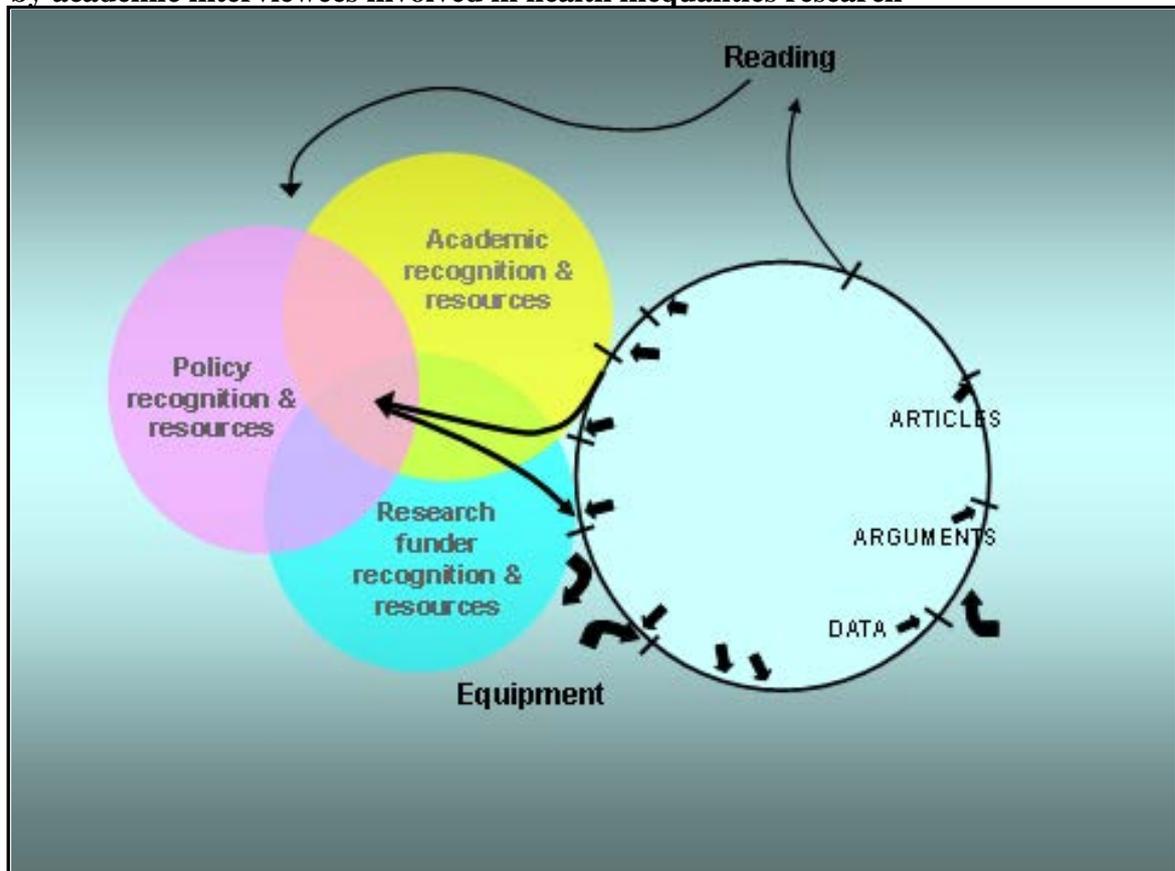
All this reflects Bartley's (1992) conclusion that micro-political, career interests are crucial to understanding the interplay between public health research and policy. Indeed, the strong emphasis placed on research funding within the interview data suggests, as Bartley (1992) found, that Latour and Woolgar's (1986) notion of 'cycles of credit' may be a useful way of conceptualising academic research activities. In this 'cycle', Latour and Woolgar (1986) suggest it is the credibility of a scientist's ideas, and their ability to communicate these ideas (e.g. via publishing), which improves their credibility as a scientist. This, in turn, influences their ability to secure future funding (or posts) in order to keep moving round the cycle. Latour and Woolgar (1986), however, focus only on how the scientists they were studying sought to develop and maintain credibility amongst their academic peers (the largest circle in Figure 1).

In the context of peer-review (of publications and job and grant applications), maintaining credibility amongst academic peers seems intuitively important for academics and some academics did discuss this. Yet, in contrast to Latour and

Woolgar's (1986) study, the data suggest health inequalities researchers were working at least as hard to maintain 'credit' with research funders and policymakers.

Accordingly, the depiction of the 'cycle of credit' presented in Figure 1 has been adapted by adding three circles to the left of the main cycle of credit, highlighting the three groups with whom health inequalities research described trying to maintain credibility: other academics; policymakers and research funders. The overlapping nature of these three circles reflects the fact that all three groups were positioned as playing a role in decisions about resources (a point discussed in more detail below). Indeed, most academic interviewees described a difficult process of trying to maintain credibility amongst their peers, policy audiences *and* research funders.

Figure 1: Latour and Woolgar's (1986) 'cycle of credit', adapted to illustrate the multiple audiences amongst whom 'credibility' was perceived to be constructed by academic interviewees involved in health inequalities research



These efforts were most overtly described in relation to writing research proposals for funding as all three groups were commonly referred to as playing an important role in the assessment of grant applications, with academics and, increasingly, policymakers (i.e. potential 'beneficiaries') serving as reviewers. As

Knorr-Cetina observes, researchers tend to follow ‘the lead of ideas which hold the greatest promise of success,’ (Knorr-Cetina, 1981, p.60) rather than exposing themselves to unnecessary risks and uncertainties. Hence, academic interviewees often described the process of writing funding applications as being at least partially dependent on an applicants’ ability to assess the evolving funding landscape and frame applications accordingly. In total, there are sixteen accounts within the data in which academic researchers describe having ‘dressed’ ideas in ways which they believed would increase the chances of a research proposal’s success. In some cases, the data imply that the skill of ‘dressing’ applications was merely a matter of aesthetic, or linguistic, presentation. One interviewee, for example (who had been very successful at securing funding), described how s/he assessed, ‘What’s *in* right now? What’s sexy?’, before peppering proposals with the appropriate terminology. However, rather more bleakly, another interviewee claimed that ‘*researchers write applications in terms of what people want to hear rather than... what is... the most... important and valuable thing they can do.*’

Importantly, many of the interviewees suggested that policymakers and potential research funders were closely linked. Consequently, academics’ descriptions of policy and funding preferences were often conflated. In part, this is because direct policy funding of public health research (including health inequalities) was relatively generous across the UK during the research period. However, it is also important to note that several interviewees also suggested that the strategic priorities of UK Research Councils (which receive government funding) were informed by policy priorities. It is not the purpose of this article to explore the extent to which these perceptions were shared by staff at the Research Councils (although, in fact, the small number of interviews undertaken with staff at UK Research Councils did suggest they were increasingly trying to ensure their agendas were informed by policy needs). It is sufficient, for this article, to demonstrate that many health inequalities researchers seemed to *believe* that UK Research Councils were informed by government priorities because this belief in itself then functioned to shape the applications they submitted.

This is important because it helps explain the kinds of ideas that have been pursued by health inequalities researchers and why. Indeed, the data leave little doubt that, despite a belief amongst most interviewees that opportunities for funding health inequalities research had been plentiful during the study period, most interviewees

had still not felt able to focus on the issues they believed were most important (at least not to the extent they desired). Rather, a combination of responding to specific research calls with the crafting of proposals to reflect perceptions of funder preferences appeared to have actively focused health inequalities research away from ‘upstream’ determinants and towards evaluating ‘downstream’ interventions (e.g. initiatives aiming to change particular lifestyle-behaviours, such as smoking or drinking). For example:

Senior academic: ‘On the research [...] where I think there’s a gap is actually for the more kind of macro and theoretical discussions around health inequalities, and there’s almost kind of a lack of interest at least from a funding side I think, to think about what really causes health inequalities. And we still don’t actually know the exact answer to that [...] and the evaluations that you can do do tend to be more at the downstream end because that’s easier to fit within that kind of medical framework of analysis.’

In the above quotation, the interviewee suggests they have ended up undertaking research involving the evaluation of ‘downstream’ interventions because this fits with a medical framework of analysis, which the interviewee went on to say s/he felt funders preferred. In total, around half of the academic interviewees indicated that they believed the more useful research on health inequalities involved upstream, non-health determinants, but that funders had a preference for downstream research.

In addition, reflecting the circular nature of the ‘cycle of credit’, several researchers described feeling cautious about presenting policymakers with research-informed ideas which would be perceived as overtly challenging to, or critical of, existing policy trajectories. For example, one interviewee reflected that whilst s/he felt entirely comfortable emphasising the critical aspects of research findings to *academic* audiences, s/he presented *policy* audiences with less challenging accounts of these ideas which s/he felt would not ‘rock the boat’ as much.

Overall, this section provides several important insights into the relationship between health inequalities research and policy. First, it highlights the crucial role that research funding can play in shaping the relationship between research and policy. Researchers try to assess what research funders are ‘looking for’ when

constructing applications and this then informs the way in which they pitch applications. Second, the circular nature of academic work, as outlined in Latour and Woolgar's (1986) 'cycle of credit', means researchers are aware not only of how research grant applications are read but also how their research outputs may shape their future credibility amongst academic peers, research funders and policy audiences. This means researchers' perceptions of dominant policy ideas can inform the messages they feel comfortable constructing and presenting to policy audiences.

In other words, this section unpacks some of the mechanisms via which policy ideas shape research (as well as the other way round). For some interviewees, the notion that health inequalities research was being informed by policy needs was positive and likely to increase its impact. However, others described feeling frustrated that they ended up investing more time exploring 'downstream' aspects of health inequalities (such as evaluating interventions intended to change people's lifestyle-behaviours) than they felt was justifiable on the basis of existing research evidence. This helps explain both the 'seemingly irresistible' nature of the 'lifestyle drift' (Popay, 2012) describes and the potential role of health inequalities researchers in facilitating the evolution of challenging research-informed ideas about health inequalities into less challenging policy ideas.

(ii) 'Boundary work' within health inequalities research

One of the most notable differences between the literature focusing on knowledge translation and sociological studies of science is the extent to which the latter often draws attention to divisions *within research communities*. Exploring these divisions within health inequalities seemed crucial to understanding the difficulties of trying to achieve evidence-informed policy. The data suggest clear divisions formed around interviewees' perceptions of the following three characteristics: (i) researchers' commitment to reducing health inequalities; (ii) researchers' ideological independence; and (iii) researchers' disciplinary training and/or methodological approach.

In relation to the first division, five interviewees suggested that researchers who had moved into the health inequalities field after the election of a Labour government in 1997 (i.e. once a government with a stated interest in health inequalities was in power) were somehow less credible. For example:

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

Senior academic: *'The people who, through the eighties, made what I think of as the sort of... significant scientific advances in relation to health inequalities... did so at considerable personal cost. [They] often... didn't have any job security, had to go from one industry to another, one university to another... but they did it because they thought it was important. And... in a sense... ever since it's become government policy... you don't have to be all that interested in it to do it... it can just be a job.'*

The above quotations suggest 'credit' within health inequalities research was increased by having moved into the field before it became 'legitimate' and well-funded. This was not so much because the researchers who moved into the field earlier were necessarily described as more 'original' (see Latour and Woolgar, 1986 on the potential importance of perceived originality). Rather, the rationale being articulated was that researchers who moved into the health inequalities sooner were both more committed to reducing health inequalities and more skilled as researchers. The second quotation, which dismisses researchers for whom studying health inequalities is 'just a job', resembles Said's (1994) distinction between 'professional' academics, who treat intellectual work as a nine-to-five job, and 'amateur' academics, who are committed to asking challenging questions of those in power for ethical and political reasons.

The second division concerned perceptions of the extent to which academic independence was compromised by researchers' political and/or policy connections. This division seemed particularly stark, despite the fact that nearly all academic interviewees identified themselves as left-of-centre. For the most part, interviewees who identified themselves (or who were perceived to be) Marxist (or at least fairly far to the left of the UK political spectrum) suggested academic independence was compromised by working closely with policymakers and they were often overtly

critical of colleagues who they deemed to be ‘too close’ to policymakers. In contrast, interviewees who identified themselves (or were perceived to be) more centre-left often suggested academic independence was compromised by strong ideological positions (such as being ‘a Marxist’) and not by working closely with policymakers (which many of them chose to do). In other words, both groups charged the other with being less academically ‘independent’ and, therefore, less credible in research terms. The following interviewee reflected on this contrasting approach to influencing policy within the health inequalities research community:

Senior academic: *‘The issue network of health inequalities has started to become a policy network. In other words, policymakers and civil servants are starting to set up groups and networks of similarly minded people that can talk about these issues and process them through government. [...] There’s been a transition. And some people have been quite facilitative of that, people like [Professor Y]. [...] Some people say that means... you’ve been co-opted into the system and you’re being blunted because you’re involved in it, you become a spokesman of that. [One policy document] has a foreword by [Professor Y] that follows on from the Minister and you think, ‘oh... they’re... nice and close,’ [laughs] if not only on the pages but... maybe in their views as well. So some people like to kind of maintain that dignified distance and... like to... have their sort of academic independence so.... [...] How do we get that evidence into practice or change policy? Well there are two different routes - you can work with the system or you can stand outside it.’*

The above interviewee was unusual within the data because, even though s/he seemed sympathetic to the view that getting ‘too close’ to policymakers could diminish an academic’s credibility amongst their peers, s/he later expressed a preference for working with policymakers. In most cases, interviewees who discussed this distinction were rather more dismissive of the alternative view. Whatever their beliefs about the desirability (or not) of having close connections with policymakers, nearly all interviewees at some point discussed the necessity (and difficulty) of trying to maintain credibility amongst research, policy and funding communities (the three overlapping circles in Figure 1). Indeed, it seemed that for many health inequalities researchers, providing policy advice entailed a careful balancing act.

It is important to note that this was not a division between academics preferring ‘mode 1’ (traditional) and ‘mode 2’ (applied) types of academic work, to use the terms coined by Gibbons and colleagues (1994). Rather, all academic interviewees articulated some level of commitment to using their research to achieve policy and practical changes, either because they were strongly committed to reducing health inequalities or because they believed those in receipt of public funding had a duty to engage with non-academics (or both). Yet, interviewees often held opposing views about the most effective way of achieving change (which, to some extent, appeared to overlap with perceptions about the extent of change required).

In several cases, the above division appeared to be intertwined with the third identifiable division which involved disciplinary differences. For example:

Senior academic: ‘The [...] sort of freaky, left-wing people who do a load of health research antagonise doctors - they do it deliberately. So there’s... a lot of that [laughs] going on. But, at the end of the day... we’re the guys who look after the patients... so, I have a very clear view about the poor of being sick ‘cause I’ve had to care for them and look after them.’

Senior academic: ‘There are people [in health inequalities research] who were, in the seventies, [...] very involved in far Leftwing... campaigns to try and change the world, change society. And there are a lot of people involved in health inequalities who’ve suffered bereavements, people dying on them, and it’s very personal... far more than you’d expect. [...] There’s definitely a driven, Leftwing group who, for personal reasons and political reasons, are fairly committed to changing things... and that’s quite strong in Britain. [...] If you’re trying to have a debate with somebody and you think it’s just an academic exercise and you’re debating with someone who actually cares about it, it’s uncomfortable. [...] A failed doctor decides that they don’t actually want to spend their life dealing with ill people so becomes an academic clinician... and enjoys the life and the money and so on, and pretending they’re useful, then comes up against people who actually think that things should be changed and... they don’t like it because it questions what they’re all about.’

All of the extracts presented in this section could be understood as examples of what Gieryn (1983) terms ‘boundary work’. This concept describes the way in which boundaries are constructed by scientists to distinguish between what is considered ‘scientific’ and what is not. The purpose of boundary construction, according to Gieryn (1983), is to increase one’s own credibility and thereby the ability to influence others and gain access to resources (or, in Latour and Woolgar’s (1986) terms, to move around the cycle of credit). Hence, whilst the first of the above two extracts implies medical experience provides health inequalities researchers with additional credibility, the second pejoratively frames medically qualified health inequalities researchers as ‘failed doctors’. Similarly, whilst the first extract dismisses ‘left-wing’ researchers as ‘freaky’ individuals who are deliberately antagonistic, the second provides an empathetic account of ‘left-wing’ researchers struggling to achieve social change for moral reasons, in difficult circumstances. In addition to the contrasting perspectives concerning the utility (or not) of medical training for health inequalities research, some division was evident between researchers who expressed a strong preference for quantitative (preferably experimental) research and those who articulated a need for more (and better) interdisciplinary research, incorporating qualitative elements.

The multiple boundaries and divisions discussed in this section highlight the potential complexity of relationships between science and policy. Understood as ‘boundary work’, these intersecting divisions help explain why, as one policy advisor reflected, health inequalities researchers can find it difficult to stop *‘fighting each other’* and work collaboratively to provide unambiguous policy messages. It supports claims made by many of the interviewees working in policy settings that the health inequalities research community has so far failed to provide clear policy guidance, despite the existence of three government-commissioned reviews of evidence which provide quite consistent advice (see Bambra et al, 2011). This further helps explain how and why research-informed ideas about health inequalities had been presented and interpreted in multiple ways.

(iii) The atomisation of policymaking

Having explored some of the factors shaping the construction and promotion of ideas about health inequalities within research, this section considers how the organisation of policymaking bodies influences the journeys of these research-

informed ideas. As historical institutionalists (e.g. Immergut, 1998) have long demonstrated, the division of bureaucratic organisations into small, specific units of policy activity usually makes it extremely difficult for policymakers to engage with cross-cutting ideas that stretch beyond their immediate areas of responsibility. Reflecting this, the interviewees' accounts consistently suggest that joined-up policymaking had been an illusive goal and that the location of responsibility for health inequalities with departments of health had consequently functioned to encourage the influence of ideas over which these departments had most control. In other words, the organisation of health inequalities policy actively served to encourage those ideas relating to health services and health promotion, whilst blocking ideas relating to broader policy areas. For example:

Policy advisor (Scotland): *'I think the big problem for the health inequalities agenda, or one of the big problems, is the fact that it's in the Health Department and it would much better if it was in a cross-cutting part of the Executive... because then it can relate to all the different departments, whereas at the moment it's seen to be an NHS agenda. [...] And... it's seen in **very different light** from an NHS perspective. And I'd say... it's much harder to influence from the health department than it would be from a... more central position in the [Scottish] Executive.'* [Interviewee's emphasis]

Moreover, it was clear that the organisation of civil servants within departments/directorates of health into sub-units and divisions with specific health responsibilities further atomised the channels via which research-informed ideas about health inequalities could travel:

Civil servant (Scotland): *'We have got divisions... which look after specific topics, so, for example [...] alcohol, smoking... So, you will have very specific interests, but on top of that there are... a small number of people who look at the strategy overall. And each one of those areas has an interest in the policy, in their own specific policy elements, but they also have a responsibility to see how that feeds... into health improvement as a whole.'*

Senior academic: *'I know in the Department of Health [in England], they tend to have... they'll have a team on tobacco and they'll have a team on obesity... a team on health improvement... a team on young people, you know, sort of topic and group focused, and then they've got someone who does health inequalities. And... I think that person finds it quite difficult to make the other teams realise that, actually, everything they do is about health inequalities.'*

Most interviewees (in research and policy) suggested that this atomisation meant that, even when research-based ideas had travelled successfully into a policy stream, there was little guarantee the idea would move beyond a particular vertical stream. This reflects existing observations that the organisational location of responsibility for reducing health inequalities has limited the influence of research-informed ideas about the wider determinants of health (Exworthy and Hunter, 2011).

Indeed, it is apparent from the interview data that policy atomisation not only functioned to block the influence of many cross-cutting, research-informed ideas but that it also impacted on the work that it was possible for *researchers* to undertake:

Senior academic: *'I think my biggest beef... is that... the department of health, in England or Scotland, hasn't paid sufficient attention to the health consequences of non-health policies. [...] So... I still think the research commissioning is very silo-based and although... they claim to have these cross-cutting social justice policies, there's not much evidence of cross-cutting research assessment. [...] I think it's relatively easy to persuade the Department of Health to evaluate a smoking ban or smoking cessation or... promote physical activity. But if you try and persuade the Department of Health to assess a housing policy or... It's not impossible but it's much harder.'*

Both the location of health inequalities within departments of health, and the sub-divisions within these departments (which largely centred on particular health problems, lifestyle-related risks, specific population groups and aspects of health services), are indicative of the institutionalisation of a medical model of health. In other words, as discursive institutionalists highlight (Schmidt, 2010), institutions are themselves shaped around particular (often paradigmatic) ideas. Once ideas have

been institutionalised, they can operate as policy filters, encouraging the influence of ideas which support this way of thinking whilst ‘blocking’ more challenging ones. The above quotation reveals the self-perpetuating qualities of ideas once they have been institutionalised, with the speaker explaining how the institutionalisation of a medical model of health actively works to encourage research within this frame, whilst preventing research informed by more social or material models of health.

All this helps explain why ideas concerning upstream, social determinants of health and health inequalities (which were not institutionalised within health departments) may have struggled to move much beyond policy rhetoric, whilst ideas complementing a medical model of health (such as those concerning ‘downstream’, lifestyle factors, which were institutionalised within health departments) were able to influence policy, despite having far more limited research-support.

(iv) The ‘market’ of policy advice

The data suggest that micro-political (career) interests are as important within policy as research and that this helps explain why research-informed ideas may experience ongoing transformation as they move around policy contexts. Crucially, most policy-based interviewees suggested that, in addition to the horizontal policy divisions described in the previous section, there were important vertical divisions, particularly between ministers and civil servants. For example, five of the civil servants interviewed and three (of the four) interviewees who had held ministerial posts during the study period claimed these relationships were often strained and that ministers did not always trust the advice civil servants presented them with. Moreover, it was clear that civil servants were just one of several potential sources of information for ministers, who often sought advice from political advisors and from individuals outside policy with whom they had personal and/or professional connections. This meant that, as several interviewees put it, providing advice to ministers (and other senior policymakers) involved competitively marketing ideas:

Civil servant (Scotland): *‘It’s marketing it [health inequalities]... It is marketing [...] Politicians need to be able to feel that they can make a difference and, therefore, you not only have to market it as being a problem, but you have to be able to market it as being something **you** can do something about.’* [Interviewee’s emphasis]

It is as a result of this ‘market’, that the following senior academic described finding feeling that they were perceived by some civil servants as unwelcome competition within a ‘market’ of health inequalities advice:

Senior academic: *‘Government departments are market places... Giving policy to government is a market and the research outfits within government departments are fighting for their territory, they’re fighting to preserve their reason for existence and so they’re not going to let anyone else in on that territory. [...] I actually had a person who came to see me, from [government department] about [a particular research project] and I thought, ‘oh, that’s good, they want to consult us and, you know, we can engage them.’ Not a bit of it! And the same thing from [a non-departmental public body], people came to see me and it turns out they’re afraid that we’ll be on **their territory!** [...] And it’s actually seen as, if we gain the ear of the policymakers, we’re actually competing for territory with research groups [within government].’*
[Interviewee’s emphasis]

All this suggests that civil servants do not always enjoy a particularly privileged position within the ‘marketplace of policy advice’. In such a context, civil servants have to think carefully about which ideas they pitch to senior colleagues and how they frame these ideas. Interviewees working in ‘in-between’ spaces (such as external policy advisors and knowledge brokers) frequently discussed this tendency. For example:

Policy advisor (Scotland): *‘[Civil servants] are very persuadable to different positions and they are always very, very mindful of what they perceive the Minister will like and they tailor the advice they give the Ministers to what they think is possible rather than speaking from the evidence that they might have been informed on.’*

The analysis presented in this section highlights how the career pressures facing civil servants may lead them to deliberately re-present research-informed ideas to ensure a better ‘fit’ with what they believed ministers were looking for, even when

they have a very good understanding of the associated evidence (several of the interviews with civil servants reflected precisely this situation). This helps explain how research-informed ideas can travel into policy contexts and be well understood by civil servants, perhaps even well-regarded, without necessarily having much influence on ministerial decisions, or even on the advice civil servants give ministers. Once again, the data in this section reveal why ideas tend to be translated as they move between actors, changing as the travel from one actor and context to another.

(v) Perceptions of the wider social and political context

In order to better understand why research-informed ideas about health inequalities were translated in ways which led to an emphasis on ‘downstream’ interventions and gradual side-lining of ‘upstream’ determinants, it is necessary to consider interviewees’ perceptions of the social and political context in which they were operating. Most interviewees’ perceptions were informed by a belief that there was a dearth of interest in health inequalities and a general disdain for policies aimed at reducing other kinds of inequalities. For example:

Journalist: ‘I mean if you look at the countries with the smallest wage differentials, then they’re the countries with the lowest health inequalities so... that is clear. Are we ready for that in this country? I don’t think so.’

Senior academic: ‘We’re not willing to live in societies where there’s equality in other domains, other than health. So we’re not willing to live in societies where there’s equality of wealth or equality of income [...] and... equality of housing or equality of access to other services. [...] In virtually every other domain of life, we don’t want equality; we actually worship inequality.’

Overall, only eight of the 112 interviewees claimed there was any public appetite for more egalitarian policies and no-one claimed there was much media or political appetite for such policies. Moreover, as two senior civil servants in Wales explained, they (and their ministers) did not experience much lobbying in relation to health inequalities (in contrast, for example, to the lobbying that they experienced around tobacco and alcohol, from both public health and commercial actors). This is important as it suggests that interviewees perceived key research-informed ideas

about health inequalities to be facing a hostile context in which they were unlikely to receive significant support; sentiments summed up by the following interviewee:

Senior academic: *'At one level you can think of... interventions that might operate within a kind of existing economic and political context, and those interventions that might challenge... an existing economic and political... context. So... there are a whole range of potential interventions around redistribution of wealth that might... actually be really quite effective... in dealing with issues around nutrition and dealing with issues around housing as well as kind of basic... income redistribution, transport and so on. But I think one of the things that... happens when those kind of obvious policy implications are pulled out of research is that... they're then placed within the context of a particular political economy and... they **cannot** be implemented within that context.'* [Interviewee's emphasis]

Believing that the 'political context' was unfavourable to many research-informed ideas about health inequalities, interviewees working in research *and* policy described pitching ideas to policy colleagues in ways which they felt would enhance (or at least not diminish) their survival. In this context, interviewees described both setting aside more challenging ideas in favour of providing 'more practical advice' and framing ideas in ways which made them appear less challenging (as discussed earlier). This further explains how research-informed ideas about health inequalities were able to travel into policy without stimulating the kinds of changes they had been associated with in research debates.

(vi) A lack of institutional memory and the re-cycling of ideas

Finally, the data reveal that the short-term nature of many policy posts, combined with the lack of a structural interface between research and policy, had enabled a situation in which very similar ideas could be continually re-considered. Hence, several academic interviewees described feeling that researchers were '*reinventing the wheel*' and being asked by policymakers to do '*the same bits of work over and over again.*' This gave the impression that research was influencing policy to a much greater extent than it actually was.

Although it was clear that the academic interviewees who described this situation were frustrated by it, it was also clear that the pressure to obtain funding often dissuaded them from actively seeking to redress this problem (see Fuller, 2005):

Senior academic: 'In a way... it suits people like me to have this phase of going round and round in circles because those circles produce demand for research, which means people like me can get funded, so our kind of every-day coping strategy is just to think, 'oh well, we won't complain while we're ahead. We won't... look a gift horse in the mouth.' Although... it's frustrating in some ways, in other ways it's kind of... not too bad a situation.'

From the point of view of understanding how research-informed ideas about health inequalities move into policy, this sheds further light on the potential for similar research-informed ideas to be understood in a myriad of different ways within policy. On the one hand, the suggestion that different policy actors may encounter (and perhaps encourage) research-informed ideas with little or no sense that similar ideas have been explored before, presents the depressing possibility that virtually identical ideas are regularly re-cycled between research and policy with little, if any, change. More positively, however, this situation also grants researchers and research-informed ideas multiple opportunities to influence policy. As policy actors and contexts change, this may mean that research-informed ideas which have been previously unsuccessful in influencing policy are re-discovered.

Concluding Discussion

Taking health inequalities in the UK as a case study, this article began by arguing that it is ideas, rather than evidence, that form the appropriate unit of analysis for studying the relationship between research and public policy. This claim reflects both the growing interest in the role that ideas play within policy change (Béland and Cox, 2011; Schmidt, 2010; Blyth, 1997), and aspects of the science studies literature (e.g. Knorr-Cetina, 1981; Latour and Woolgar, 1986). The distinction is important both because it draws attention both to the potential malleability of research-informed ideas as they move between actors and because it creates space for exploring interactions between research evidence, values, ethics and politics.

The article argues that an ideational approach which carefully traces and unpacks the construction and translation of research-informed ideas helps explain two ‘puzzles’ concerning the relationship between evidence and policy that have been widely commented upon within health inequalities debates. The first puzzle involves the persistent influence of research-informed ideas concerning ‘downstream’ determinants (e.g. smoking, diet and alcohol) in health inequalities debates, despite a lack of support for these ideas amongst most health inequalities researchers and many of the individuals involved in constructing policy responses to health inequalities (Bambra et al, 2011; Popay, 2012). This article explains this ‘puzzle’ via the decision to locate the policy responsibility for health inequalities with departments of health (see sub-section (iii)). This decision (which was taken across the UK) reflects the institutionalised of a medical model of health which assumes that the most important determinants of health inequalities lie within the health sector. As the article demonstrates, the organisational divisions within departments of health then worked to perpetuate this way of thinking about health, encouraging the influence of ideas that ‘fitted’ this model. To this extent, the findings reflect Schmidt’s (2010) notion of ‘discursive institutionalism’, demonstrating how ideas shape the formation of institutions which, in turn, work to shape the formation of related ideas.

Crucially, however, the article goes beyond existing discussions of ‘discursive institutionalism’ to demonstrate how the influence of ‘institutionalised ideas’ can extend to shape the ideas that are constructed and promoted by academic researchers (see sub-section (i)). In part, this occurred because policy bodies represented important sources of funding for health inequalities research in the UK and were directly commissioning research to aid this way of approaching health inequalities. However, health inequalities researchers also described trying to develop ideas that they felt would be welcomed by policy audiences (to increase their chances of securing future funding and influencing policy debates). Researchers’ perceptions of both the institutionalisation of a medical model of health (see sub-sections (i) and (iii)) and a more broadly hostile environment, with limited public interest in health or related social and economic inequalities (see sub-section (v)), informed decisions not to work to promote some research-informed ideas to policy audiences. This represents an additional (rather more subtle) means via which ideas institutionalised within policy were shaping the ideas being constructed in research (i.e. policy was influencing research as well as the other way round).

The second ‘puzzle’ this article addresses is why the kinds of research-informed ideas about health inequalities more widely supported by academic interviewees (concerning ‘upstream’, material determinants) were identifiable within policy settings, even though they had not stimulated the kinds of changes that might have been expected. This ‘puzzle’ is not so easily explained by a discursive institutionalist framework. Whilst the institutionalisation of a medical model of health, combined with researchers’ perception of low public interest in inequalities, helps explain the failure of these kinds of ideas to stimulate policy change, it does not explain how or why these ideas were nonetheless easily identifiable in policy debates. To understand this, the article suggests it is necessary to understand the accounts of researchers, policy advisors and civil servants, all of whom described reframing ideas about health inequalities in ways which they felt would increase their chances of survival in policy contexts and which would aid, or at least not directly threaten, their own credibility and career trajectories (see sub-sections (i) and (iv)). This involved emphasising aspects of ideas that complemented (or at least did not overtly challenge) existing policy directions, whilst omitting (or downplaying) more challenging aspects. In other words, interviewees described deliberately imbuing more challenging research-informed ideas about health inequalities (notably those situated in a social model of health) with malleable qualities, particularly when promoting them to senior policy audiences. These mercurial qualities enabled such ideas to become (or appear) more compatible with ‘institutionalised ideas’, enhancing the chances that they would be given serious consideration in policy contexts. These ideas might be understood as ‘chameleonic’ in nature due to their ability to easily change in appearance, in ways which reflect their changing environment.

In addition, the data suggest that multiple divisions within the health inequalities research community and a lack of institutional memory within policy (see sub-sections (ii) and (vi)) have created opportunities for similar ideas to be interpreted in multiple ways by different actors. This further helps explain the potential for ideas to evolve in different contexts and enter policy debates in contrasting at different points in time. All of this serves to highlight the complexity and the political nature of the relationship between science and public policy and the potential for ideas to be translated as they move.

In theoretical terms, this article suggests it may be helpful for scholars concerned with the relationship between research and policy to consider how the

characteristics of research-informed ideas can work to enable, or disrupt, their potential journeys into policy. Whilst thinking about different ‘levels’ of ideas can (as the introduction outlines) be useful, the findings highlight how difficult it can be to delineate ideas as policy solutions from ideas as policy frames, as the two are often interlinked. These ideas are then situated within broader, overarching ideas or ‘paradigms’ (see Béland, 2005).

Reflecting the claims of ‘discursive institutionalism’, the case study presented in this article suggests that ideas which fit within the parameters of ‘institutionalised ideas’ are most likely to travel easily from research into policy (even if they are not widely supported in research or policy). Moreover, the findings suggest researchers are encouraged (via funding opportunities) to produce research-informed ideas that reflect ‘institutionalised ideas’, highlighting the self-perpetuating nature of ideas once institutionalised. In addition, the article identifies a new idea type: ‘chameleonic ideas’, which exhibit malleable features that enable them to travel into policy, even if they challenge aspects of ‘institutionalised ideas’. However, these same malleable qualities also work to limit the likely policy impact of these ideas as they adapt to, rather than challenge, overarching ‘institutionalised ideas’.

It is argued both idea types may have broader application for scholars of the relationship between science and policy. However, it is also important to acknowledge that these two idea-types alone offer only limited explanatory potential for neither helps explain why significant policy change does sometimes occur. The aim of this article was not to set out a comprehensive typology of ideational characteristics but rather to demonstrate that identifying the characteristics of ideas may can be a fruitful line of analysis that can complement ideational approaches focusing on distinct ‘levels’ of ideas. It is hoped that future research can help further unpack and develop the characteristics of ‘institutionalised’ and ‘chameleonic’ ideas as well as identifying additional idea-types (see Smith, 2013), including those that contribute to rather more significant policy change than has been evident for health inequalities.

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