Ideas, Policy Learning and Policy Change:

The Determinants-of-Health Synthesis in Canada and the United Kingdom

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ABSTRACT

Over the past several decades, researchers have developed a vast body of knowledge about the social determinants of health. Drawing on scholarship about the role of ideas in policy-making, I developed a conceptual framework to identify institutional innovations or policy changes in Canada and the United Kingdom which may have come about, at least in part, because of the determinants-of-health synthesis and to determine the role that these ideas played in the politics associated with these developments. Elite interviews and reviews of primary and secondary sources suggested that the policy-relevant ideas embodied in the determinants-of-health synthesis played strategic, rather than instrumental, roles in any institutional innovation or policy change. The greater number of policy-making bodies in Canada’s federal governance structure and the different relationships between the governing party and the groups with whom these ideas were associated at the time they were introduced to the political arena may explain why the cases in which these ideas did play a role were all drawn from Canada. Discordance between these ideas and specialized bureaucratic structures suggests that institutional innovations may provide (in the short run) the most likely role for these ideas and (in the long run) the most influential role.
INTRODUCTION

Public policy can affect health, and this can be true of both those types of public policy for which health is considered an explicit objective and those types for which health is an unintended consequence. When thinking about health, national and subnational governments in advanced, democratic capitalist countries have largely concerned themselves with public policy for which health is considered an explicit objective, most notably with health policy and occupational health and safety policy. Over the past several decades researchers in many of these countries have developed a vast body of knowledge on the social determinants of health (Evans, Barer and Marmor, 1994; Amick, Chapman Walsh, Levine and Tarlov, 1995; Blane, Brunner and Wilkinson, 1996). These determinants include, for example, labour market experiences, income distribution, and social supports. Public policy can influence these determinants and, through them, health.

Evans and Stoddart (1990) assembled this knowledge, which I call the determinants-of-health synthesis, in a framework with three components: environments and endowments, individual responses, and outcomes. Environments refer to the social and physical environments within which we live and work and endowments refer to our genetic make-up. Labour market experiences like unemployment or high job strain, for example, represent one manifestation of our social environment. An individual's responses to such experiences can include both behavioural and biological elements, and these responses may be health-enhancing or health-damaging, inherited or acquired. Relevant behavioural responses can cover a range of actions, from some forms of consumption (eg. smoking, drinking, drug use) to help-seeking (eg. seeking social support, visiting a health-care provider, contacting a local politician) and some forms of avoidance (eg. repeatedly missing days of work). Biological responses include, for example, neuroendocrine and other physiological responses. These responses are the pathways through which aspects of our environments, and the public policies that modify these environments, can affect health.

Previous efforts to explore the links between the determinants-of-health synthesis and policy-making have framed the discussion negatively, as analyses focussed on barriers to action. Marmor, Barer and Evans (1994) adopted an interest group model and applied it only within the health policy community, that is within a policy subsystem that has limited if any influence on public policy beyond health policy. According to this formulation, the power of health-care providers explains why the determinants-of-health synthesis has played such a limited role. Lavis and Sullivan (forthcoming) adopted a new institutionalist (policy feedback) model. Poli-
cies designed to increase access to and quality of health care were argued to have long-run effects on government elites and interest groups that were not conducive to change in public policy beyond health policy. But establishing why the determinants-of-health synthesis has tended not to influence public policy is less instructive than determining whether the determinants-of-health synthesis has ever influenced public policy and if so, under what circumstances and in what ways.

I adopted a different approach to previous analyses, choosing to frame the discussion positively rather than negatively. First, drawing on scholarship about the role of ideas in policy-making, I developed a framework to identify institutional innovations or policy changes which may have come about, at least in part, because of the determinants-of-health synthesis and to determine the role that these ideas played in the politics associated with these developments. Second, I applied the framework in two countries, Canada and the United Kingdom, which share many important characteristics, including opportunities for access to these ideas. Finally, I drew from this preliminary effort several conclusions about the roles that the determinants-of-health synthesis has played in policy-making and the factors that make some roles more likely than others.

Ideas and Policy Change

Ideas can play many roles in policy-making and determining their precise role in a particular institutional innovation or policy change can be very difficult. At one extreme, ideas may provide a wholly new perspective through which individuals and groups choose their goals or the political strategies by which they hope to reach their goals. For example, ideas that constitute or emerge from the determinants-of-health synthesis could suggest (as a new goal) seeking to improve a population’s health status or (as a new political strategy) building a political coalition that unites health and social policy activists seeking to reduce income disparities within a population. At the other extreme, ideas may simply provide rhetorical camouflage for already chosen goals and political strategies. The idea that the determinants of health extend beyond medical care could be used, for example, as window-dressing for an established economic goal like deficit-reduction through reduced health-care spending. Most examples likely fall somewhere between epiphany and epiphenomenon. As such, a systematic approach is required to disentangle one potential role for ideas from another.

Determining the role that ideas play in a particular innovation or change can be approached, in part, by determining whether the related politics are more about learning or about conflict-resolution (Weatherford and Mayhew, 1995). Heclo (1974) argued that policy-making
should be viewed as a process of learning (e.g. about how to improve a population's health status or whether to have such a goal in the first place), typically on the part of state officials and other social actors intimately connected to the state. Such idea-oriented explanations arose largely as a reaction to the notion implicit in conflict-oriented theories - that governments are passive and policy-making is driven by social pressures. Pure conflict-oriented (i.e. interest-based) explanations provide no role for ideas. In these types of explanations -- whether based on pluralist, corporatist or Marxist theories -- debate (insofar as it exists) can be seen as part of a pre-determined strategy (e.g. reduced health-care spending) for achieving pre-determined goals (e.g. deficit reduction).

If some learning does take place, determining the role that ideas play can be further elaborated by determining who learned, what was learned, and what type of institutional innovation or policy change resulted (Bennett and Howlett, 1992). The people who learn can include experts (like economists on a presidential advisory council), state officials (like politicians or bureaucrats), and social actors (like interest groups or the public more generally). These people can learn about the different options for structuring decision-making organizations and processes, the different means to accepted ends, and even the different ends that policy can achieve. This learning can translate into institutional innovation or into policy changes that involve a change in means or even a change in ends.

Taken together, these two sets of questions -- learning or conflict resolution and who learns, what was learned, and what type of policy change resulted -- form the axes of a framework that can be used to examine systematically the role of ideas in policy-making (Table 1). The framework serves two main purposes. First, it can be used to identify institutional innovations and policy changes which may have come about because of the determinants-of-health synthesis. Second, it can be used to determine the role that these ideas played in the politics associated with these developments. The determinants-of-health synthesis may play different roles at different times, depending on the politics of a particular public policy. Thus the framework can be used both for case-finding and to situate these cases within a broader understanding of policy-making.

**Models of Politics**

Using this framework, six models of politics can be discerned (Hall, 1989; Weatherford and Mayhew, 1995), ranging from policy-making in a closed decision-making environment dominated by experts and the knowledge they bring to the table to policy-making in an environment with open conflict between opposing interests. The models at either end of this range, however,
lack intuitive plausibility: the expert-based model because it ignores interests and the interest-based model because it ignores ideas. On the spectrum between these two models sit four models of politics that allow a role for both ideas and interests: state-centred, coalition-centred, debate as dialogue, and debate as strategy.

The state-centred model posits that state officials learn about different options for structuring decision-making organizations and processes, and use what they learn to bring about organizational change. For example, bureaucrats in the national government may learn about the need for cross-sectoral organizations and processes to address the determinants of health -- determinants, like income distribution, which can be influenced by public policies that transcend ministerial or departmental lines of authority -- and convince their political masters of the need for an institutional innovation. This model involves "government learning" (Etheredge, 1981 and Etheredge & Short, 1983), a transplantation of "organizational learning" from its origins in the study of private firms to the study of public organizations (see also, Lindblom and Cohen, 1979 and Lynn, 1978).

The coalition-centred model broadens "who learns" beyond state officials to include social actors intimately connected to the state and changes "what was learned" from options for structuring decision-making organizations and processes to include either the means to accepted ends or even the different ends that policy can achieve. For example, an informal coalition of health-policy bureaucrats, public-health practitioners, and non-profit health-advocacy organizations may learn about the need to look beyond health policy in order to influence determinants of health like labour market experiences, and may learn to use health-related ideas to inform trade-offs in labour-market policy development. More dramatically, the same coalition may learn about the benefits of focusing on health as an important outcome of labour-market policy \textit{per se} and then work to bring about such a fundamental shift in the hierarchy of government goals.

Components of the coalition-centred model have been elaborated by different scholars. Some have focused on "who learns", with state officials and social actors typically seen as part of a domestic or transnational policy subsystem -- variously called an issue network (Heclo, 1978), policy network (Knoke, Pappi, Broadbent and Tsujinaka, 1996) or policy community (Walker, 1981; Brooks, 1994) -- or as a grouping within a policy subsystem, such as an advocacy coalition (Sabatier, 1987) or an epistemic community (Haas, 1992). Other scholars have focused on the type of learning. One formulation of the coalition-centred model, sometimes called "lesson-drawing" (Rose, 1988 and 1991), involves policy-oriented learning about different means to accepted ends, and this type of learning can be based on a group's own experiences (Sabatier,
1987, 1988 and 1993) or on others’ experiences (Rose, 1988 and 1991). A second formulation of the model, called "social learning" (Hall, 1989 and 1993), moves beyond the notion that changes in ends come about only with an externally-induced crisis that alters the distribution of political resources (Sabatier, 1987). Reinterpreting Kuhn (1962), Hall suggests that a change in ends -- a paradigm shift -- can occur if the accumulation of anomalies undermines the original normative and empirical assumptions underlying the hierarchy of goals.

The dialogue-based model broadens "who learns" even more, to include state officials, interest groups, and segments of the public, but retains "what was learned" as the means to accepted ends and the ends that policy can achieve. For example, these individuals and groups can learn, through debates in open fora and the media, about public policies that can influence the determinants of health and through them health, or about how health can be a goal of such public policies. Such debates can be seen as a dialogue between proponents of different ideas. Through debate goals are shaped, the relevance of different resources defined, and the legitimacy of different reasons or justifications conferred or denied. The outcome of the debate will determine whether policy change takes place.

The strategy-based model posits a more narrow role for ideas, one in which ideas are used by a limited range of actors (primarily politicians and bureaucrats) as a strategy to advance predetermined goals and the means to these ends (Weatherford and Mayhew, 1995). For example, politicians may learn that the determinants-of-health synthesis can be used as a rhetorical device to justify reductions in health-care spending - an end motivated by reasons other than a desire to reinvest health care dollars in public policy initiatives that could lead to larger health gains. Weatherford and Mayhew (1995) argue that a meaningful role for ideas in policy-making extends only as far as the dialogue-based model and does not include the strategy-based model. They believe that the strategy-based model -- where state officials alone learn and they learn only about politically-acceptable justifications for means and ends -- cannot be considered a meaningful role for ideas. Although strictly true, a role for ideas as rhetorical camouflage is still a role worth examining.

**Links to Models of Research Utilization**

Several models of social-science research utilization that have been described in the public policy literature (Weiss, 1979) provide additional perspective on how the role of ideas differs across these models of politics. One of these models of research utilization, the problem-solving model, helps explain the role of ideas in the coalition-centred model of politics. According to the problem-solving model, research such as that on the determinants of health helps to
solve a problem that already exists and about which a decision has to be made. Typically such research either antedates the policy problem or is purposefully commissioned when needed. State officials and other social actors intimately connected to the state may draw on specific published studies of the health consequences of unemployment in particular demographic groups, for example, to determine which groups to target with a new jobs strategy.

The enlightenment model of research utilization helps explain the role of ideas in the dialogue-based model of politics. Here research is taken to mean generalizations and orientations that science or social science research has engendered, not the findings of a single study nor even of a body of related studies. These ideas percolate through informed publics and come to shape the way people think about social issues or help them make sense of them. Decision-makers will rarely be able to cite the findings of a specific study that influenced their decisions but they have a sense that social science has given them a backdrop of ideas and orientations that has had important consequences. (Weiss, 1979) The determinants-of-health synthesis can be seen as an example of a set of generalizations and orientations about how to improve health.

At the other extreme, the political and tactical models of research utilization can be seen as examples of the strategy-based model of politics. According to the political model, research is used as ammunition for the side that finds its conclusions congenial and supportive; it is used to neutralize opponents, convince waverers, and bolster supporters. According to the tactical model, calls for new or more research are used as a argument to delay action by the side that finds the conclusions of current research uncongenial and unsupportive. Both models of research utilization suggest a strategic, not an instrumental, role for ideas.

From Theory to Application

For the purposes of this study, the key policy-relevant ideas that constitute or emerge from the determinants-of-health synthesis were taken to include the following:

1) the determinants of health extend beyond medical care, and include such factors as labour market experiences, income distribution, and social supports;
2) public policy for which health is an unintended consequence, not an explicit objective, can influence these factors and, through them, health;
3) substantial health gains might accrue from a shift in focus from health policy to public policy for which health is an unintended consequence; and
4) cross-sectoral organizations and processes are needed to bring about such a shift.

This formulation of these ideas is broad enough to encompass the range of research described by the models of research utilization.
The types of policy change relevant to this study follow from these ideas and from the conceptual framework and illustrative examples described in the last section. These policy changes include:

1) institutional innovation that involves the development of cross-sectoral organizations or processes to address the determinants of health;

2) change in means to improving health that involve public policy for which health is an unintended consequence and using health to inform trade-offs in these other areas; and

3) change in ends that involves focusing on health as a primary objective of public policy for which health was formerly considered an unintended consequence.

Because such developments may be indistinguishable in terms of practical consequences from developments that follow from ideas unrelated to the determinants of health, determining the role of ideas that constitute or emerge from the determinants-of-health synthesis requires more than simply identifying a relevant institutional innovation or change in means or ends. Accordingly, having identified institutional innovations or policy changes which may have come about, at least in part, because of the determinants-of-health synthesis, I studied the politics associated with a particular development and the role that these ideas played in these politics.

**Country Selection**

I restricted my study to two countries, Canada and the United Kingdom, which shared a number of important characteristics over the last decade. First, both countries had roughly the same opportunities for access to ideas that constitute or emerge from the determinants-of-health synthesis in that they both had research programmes on the determinants of health that have matured or have been maturing over the last ten to fifteen years. The few publications available that mention national research traditions on the determinants of health lend support to the selection of these countries (Whitehead, 1995, p. 47-48; Gepkens and Gunning-Schepers, 1996). Second, both countries are at roughly the same level of economic development and, broadly speaking, face the same political and economic context for policy change. Third, both countries have roughly the same "capacities" to respond in that, unlike countries governed by social democratic or Christian democratic parties, they tend to limit the role of government to a residual role in social policy whenever possible (Esping-Anderson, 1990).

In both countries I focused on public policy at the national level, and in the case of Canada at the level of the constituent unit of the federation (i.e. the provinces) as well. I did so because most of the public policies that have unintended health consequences are enacted at these levels. For example, public policies that can influence the nature of people's labour market
experiences and the distribution of income are mostly, if not exclusively, made at the national or provincial level. Local government controls only a few relevant policy levers.

Methods

I used a combination of primary and secondary sources and elite interviews to identify potentially relevant cases of institutional innovation or policy change and to determine the role that these ideas played in the politics associated with these developments. Primary sources included records of presentations made to policy-makers, documents related to the determinants of health which were produced by both governments and non-governmental organizations, and (where relevant) transcripts of parliamentary debates. Secondary sources included academic studies of particular cases and an unpublished doctoral thesis. Interviews were conducted with key informants in both countries. These key informants included bureaucrats, representatives of funding agencies, researchers, and other social actors intimately connected to the government. Sampling was based initially on my knowledge of key informants in both countries and later on snowball sampling. The framework served as a guide to organize my search of primary and secondary sources and to prompt and categorize responses from key informants.

The interviews were conducted in two stages. To gather information on potentially relevant cases in Canada and the United Kingdom, I contacted key informants familiar with these ideas and asked them the following question: "Thinking specifically of Canada (or the United Kingdom), what institutional innovations or policy changes have come about, at least in part, because of the determinants-of-health synthesis [or this body of knowledge which may be known locally by another term, such as inequalities-in-health research]?” Because policy-makers may be more likely to contact researchers when they wish to use their research for strategic rather than instrumental purposes, the sample of key informants may be biased towards the detection of strategic rather than instrumental roles for the determinants-of-health synthesis.1 To determine the role that ideas played in the politics associated with these developments, I contacted key informants familiar with the innovation or change under and asked them the following question: "How, if at all, did ideas about the determinants-of-health affect the exploration of policy alternatives, the decision to adopt the institutional innovation or policy change, and the justifications used to support the decision."

1 I thank Jody Heymann for pointing out that, in her experience in the American Senate, policy staff frequently contacted researchers when they wanted to invoke their research for strategic purposes and hardly every contacted researchers when they used their research for more instrumental purposes like framing an issue, identifying policy alternatives, or choosing between policy alternatives.
Determinants-of-Health Synthesis and Policy Change in Canada and the United Kingdom

Although Canada and the United Kingdom have had similar opportunities for access to ideas that constitute or emerge from the determinants-of-health synthesis, these ideas came to attention under different circumstances. In Canada the first public expression of these ideas can be traced back to a federal government report -- widely known as the Lalonde Report (Lalonde, 1974) after the Minister of Health under whose direction it was produced -- which sought to broaden discussion of the determinants of health beyond medical care. The U.K. experience was quite different: the Black Report (reprinted in Townsend, Davidson and Whitehead, 1988) -- a report commissioned by a Labour Government but submitted to, initially suppressed by, and reluctantly released by an unsympathetic Conservative government -- was the first public expression of these ideas in that country.

These ideas have also been framed differently in the two countries. In Canada these ideas have come to be known by the neutral term "population health" and arguments in favour of focusing on the determinants of health have typically been presented (implicitly and explicitly) within an economic efficiency framework. As the argument goes, if the marginal health benefit from an investment in health care is less than the marginal health benefit from the same size investment in another policy domain, then reallocations between health care and this other policy domain could improve efficiency in the production of health (Evans and Stoddart, 1990; Lavis and Stoddart, 1994). As such, population health has been portrayed as a positive-sum game across the entire Canadian population whereby improvements in health can be achieved by reallocations across policy domains. In the United Kingdom these ideas have come to be known as "inequalities in health" and arguments in favour of focusing on the determinants of health have typically been presented within an equity framework. Improving health has been portrayed as a zero-sum game in the United Kingdom whereby improvements in health can be achieved by redistribution across sub-populations, a task presumably best accomplished by initiatives in policy domains other than health care.

Policy Change in Canada and the United Kingdom

Primary and secondary sources and elite interviews suggested four potential institutional innovations or policy changes in Canada that may have come about, at least in part, because of the determinants-of-health synthesis, but no such developments in the United Kingdom. In Canada the list of potential cases included two institutional innovations to address the determinants of health, one change in means to improving health that involved public policy for which health is an unintended consequence, and one case of funding research to inform institutional innovations
or changes in means to improving health. In the United Kingdom no institutional innovations or changes in means were identified. Perhaps not surprisingly, given the magnitude of the required change in the hierarchy of government goals, neither Canada nor the United Kingdom provide any examples of a change in ends that involves focusing on health as a primary objective of public policy for which health was formerly considered an unintended consequence.

The first institutional innovation in Canada involved the development of a cross-sectoral advisory council, the Ontario Premier's Council on Health Strategy, by the Government of Ontario. The Council, established in December 1987, was charged with providing "leadership and guidance to the whole government in achieving the goal of health for every citizen in Ontario" (Premier's Council on Health Strategy, 1991a, p. 1). Unlike other advisory councils that have addressed the determinants of health -- like the federal Interdepartmental Reference Group on Population Health or the Federal/Provincial/Territorial Advisory Committee on Population Health -- this council was truly cross-sectoral in that it was chaired by the Premier and drew its members from the senior political and bureaucratic ranks of a number of different ministries. Given its structure, the Council could more easily focus on determinants of health that cut across traditional bureaucratic domains of expertise and authority. The Council produced a number of reports, including Nurturing Health (Premier's Council on Health Strategy, 1991b) which built a health-related case for government action in early childhood development and labour market adjustment. The Premier's Council served as a model for the development of similar structures in other provinces.

The second institutional innovation in Canada involved the pooling of health and social-service budgets and the allocation of decision-making authority over these budgets to regional boards by the Government of Prince Edward Island (PEI). The province's Health and Community Services Act, proclaimed in October 1993, charged regional boards with responsibility for providing a broad range of services including, for example, hospital care, employment development services, child and family services, and housing (Government of Prince Edward Island, 1993). This "single management structure" facilitated cross-sectoral reallocations and "provincial planning documents [encouraged the regions] to, as much as possible, broadly reallocate funds in line with recognized determinants of health" (Lomas and Rachlis, 1996). These reallocations could have taken the form of transferring funds from services for which the ratio of marginal health benefit to marginal cost might be quite low (like hospital care) to services from which the ratio of marginal health benefit to marginal cost might be quite high (like employment development services).
The United Kingdom has not developed any cross-sectoral organizations or processes to address the determinants of health. In fact, the first formal recognition by the U.K. Government of the Black Report's messages came fifteen years after the report's release. The Variations Sub-Group of the Chief Medical Officer's Health of the Nation Working Group -- a group drawing its members exclusively from the health-policy domain and the allied Office of Population Census and Surveys -- produced a report entitled *Variations in Health: What Can the Department of Health and the [National Health Service] Do?* (Department of Health, 1995). As the title suggests, the report adopted the politically more palatable label "health variations" instead of "health inequalities" and focused on what could be done through health policy alone, or even more narrowly through health services alone. The report did suggest that "the Department of Health should work actively in alliance with other government departments and other bodies to encourage social policies which promote health" (p. ii) and that the "[Medical Research Council], [Economic and Social Science Research Council] and the Department of Health should coordinate their programmes of research" (p. iii). Without either a formal cross-sectoral organizing structure or top-level representation in the Sub-Group from these other departments and granting councils, however, such admonishments about cross-sectoral processes were unlikely to bring about concrete action.

Primary and secondary sources and key informants suggested only one possible Canadian example of a change in means to improving health that involved public policy for which health is an unintended consequence: the development of the Ontario Training and Adjustment Board (OTAB). Proclaimed in September 1993, the Act that brought OTAB into existence sought to "coordinate and streamline Ontario's training and adjustment programs to make them more accessible to all Ontarions" (Office of the Provincial Auditor, 1996). Two years earlier the Premier's Council on Health Strategy (1991b) had cited evidence of the links between unemployment and health to make the case for government action in labour market adjustment. The Premier who chaired the Council in 1991 -- David Peterson -- was the same Premier who announced plans to develop OTAB (although he was no longer Premier at the time of the Act's proclamation).

Finally, Health Canada, Canada's national health department, provides the sole example of funding research to inform the development of cross-sectoral organizations and processes to address the determinants of health or to inform a change in means to improving health that involves public policy for which health is an unintended consequence. The department has directly funded research through two main initiatives. First, the National Forum on Health -- co-chaired by the Prime Minister and the federal Minister of Health -- commissioned a series of 26 papers
on the social determinants of health and success stories in addressing them (National Forum on Health, 1996). Second, to support one of its core business lines, Health Canada directed the National Health Research and Development Program to designate the social determinants of health as a priority area for research funding. These two initiatives potentially directed attention away from conducting research to inform the financing and delivery of medical care and towards providing research to inform institutional innovations or changes in means to improving health. (The Economic and Social Science Council in the United Kingdom also funded research on the determinants of health but this decision was taken independently of the government.)

A Role for Ideas?

To distinguish between institutional innovations or policy changes that followed from the determinants-of-health synthesis and those developments that followed from unrelated ideas or more purely conflictual policy-making, I applied two criteria to determine the plausibility of a role for the determinants-of-health synthesis in the politics related to these developments and I used the framework to determine what role, if any, the ideas played in these politics. The two criteria included the following:
1) explicit reference was made to ideas related to the determinants-of-health synthesis in primary sources produced at the time of innovation or change; and
2) post-hoc assessments by key informants familiar with the particular innovation or change concurred that ideas related to the determinants-of-health synthesis played some role in the politics associated with the development.

If these criteria were met, I sought to match the politics associated with the innovation or change with one of the models of politics (described earlier) by asking whether the related politics were more about learning or about conflict-resolution and, if some learning did take place, who learned and what was learned.

In the case of the Ontario Training and Adjustment Board, neither plausibility criterion was met. Reports produced and debates conducted around the time of the policy change suggest that the development followed from unrelated ideas. The first recommendation to develop OTAB came in a report produced by the Premier's Council on the Economy (1990, p. 139-142), entitled *People and Skills in the New Global Economy*. The report makes reference to the social and health effects of job loss (p. 169-170) but as an afterthought to the recommendation to establish OTAB (p. 139), not as an explicit justification for OTAB. Moreover, no mention of the health consequences of unemployment or other labour market experiences was made in the parliamentary debates associated with the readings of the Act (Legislative Assembly of Ontario, 1993) or in a political analysis of the origins of OTAB (Wolfe, 1997). The health-related arguments made
by the Premier's Council on Health Strategy (1991b) appear not to have carried over to the labour-market policy domain. Post-hoc assessments by key informants concurred: ideas related to the determinants-of-health synthesis played no important role in the politics associated with the development of OTAB. As such, the decision to facilitate the adjustment of unemployed workers appears to have preceded, not followed, an understanding of the links between unemployment and health and the potentially health-improving effects of improved labour market adjustment.

The development of the Premier's Council on Health Strategy met one, but not both, of the plausibility criteria. As required by the first criterion, explicit reference was made to ideas related to the determinants-of-health synthesis in the report that called for the creation of the Council:

"Without a strategy which involves government broadly and at the highest level, it is unlikely that policies of diverse ministries which affect health will receive adequate attention or that the difficult decisions on changing priorities in health care will have the political commitment needed for implementation." (Ontario Health Review Panel, 1987, p. iii, emphasis added)

Post-hoc assessments by key informants (Signal, 1994), however, suggested that these ideas did not play an important role in the politics associated with the decision to move forward with the establishment of the Council (although these ideas may have played a role in the willingness of some Review Panel members to recommend the establishment of the Council and in the willingness of some Premier's Council members to devote time and energy to the Council once it was established). Instead, the political momentum for institutional innovation and a model for this innovation came from elsewhere.

The political momentum for the establishment of the Premier's Council can be traced to a bitter doctor's strike and the model for its structure can be traced to the already-existing Premier's Council on the Economy. The doctor's strike took place in June and July 1986 and the Ontario Health Review Panel, which recommended the development of the Premier's Council on Health Strategy (Ontario Health Review Panel, 1987), was convened by the Premier in November 1996 to honour his promise to examine the health-care system. The Review Panel and later the Premier's Council thus served the important function of getting policy-makers and doctors back to the discussion table, as well as opening up the range of topics beyond politically-contentious issues related to the financing and delivery of health care. Signal (1994) interviewed key informants familiar with the origins of the Council and concluded that the Premier, pleased with the operation of the Premier's Council on the Economy, had fed the idea of a Premiers Council on
Health Strategy to the Review Panel, not vice versa. Thus, while some Review Panel members and Premier's Council members may have been attracted by the Council's cross-sectoral advisory capacity and explicit focus on the determinants of health, the decision to move forward with the establishment of the Council originated with the Premier and was predicated on conflict-resolution, not informed by ideas related to the determinants of health.

The decision to pool health and social-service budgets in Prince Edward Island and to allocate decision-making authority over these budgets to regional boards met the two plausibility criteria and the politics associated with the decision match with the "debate as strategy" model of politics. Explicit reference was made to ideas related to the determinants-of-health synthesis in the reports that called for this institutional innovation. The P.E.I. Task Force on Health argued that "important gains in health are achieved through public policy changes in sectors other than health" (P.E.I. Task Force on Health, 1992, p. 4) and, reiterating a suggestion of the Role Panel which preceded it, recommended that "different management structures be developed to manage health as an entire system" (P.E.I. Task Force on Health, 1991, p. 1). These ideas were not, however, the sole ideas in play at the time: a review of health-related reform documents (and interviews with policy-makers) conducted by Lomas and Rachlis (1996) suggested that other objectives included more primary and community-based care, improved effectiveness and efficiency, needs-based planning, increased personal responsibility, and community empowerment. Unfortunately no transcripts of parliamentary debates are available from this period so these debates could not be reviewed to determine which objectives were given particular weight by politicians.

Post-hoc assessments by key informants familiar with the move towards a single management structure concurred that ideas related to the determinants of health played some role in the politics associated with the development, particularly by attracting the support of some parts of the health-policy community for a large-scale restructuring effort. Within both Cabinet and the Cabinet Committee on Government Reform, the political momentum for innovation was motivated primarily by a push for less government. During the same period the government was also simplifying the administrative structures of other sectors, like education. Some key informants argued that the innovation was also motivated by the opportunity it provided for obfuscation during a period of fiscal restraint. Taking money out of a large pot leaves the politically difficult decision about what to cut to others; taking money out of small pots means the politically difficult decision can more easily be traced to a particular political actor. By arguing that the new structure facilitated cross-sectoral reallocations in line with the determinants of health, however, politicians and bureaucrats were able to garner support for what might otherwise have been a
unanimously unpopular decision. Thus, unlike the case of the Premier's Council on Health Strategy, an institutional innovation for which the necessary political support at the time of the decision came from elsewhere, P.E.I.'s single management structure garnered the support of segments of the health policy community in part because politicians and bureaucrats invoked ideas related to the determinants of health to justify it.

The politics associated with this development in P.E.I. match with the "debate as strategy" model of politics. The related politics were partly about learning on the part of politicians and bureaucrats, not just about conflict resolution. But what they learned was not so much that a single management structure would facilitate cross-sectoral reallocations in line with ideas about the determinants of health. Rather, politicians and bureaucrats learned that making such an argument attracted support amongst some members of the health-policy community for initiatives that they might not otherwise have supported. Invoking ideas related to the determinants-of-health synthesis can therefore be seen as a strategy for advancing predetermined goals (less government) and the means to these ends (a single management structure). This role for ideas conforms to Weiss's (1979) political model of research utilization in that an idea related to the determinants of health was used by the side that found it supportive of its position, but the idea did not play a role in the development of the position.

Health Canada's targeted funding of policy-relevant research related to the determinants of health clearly meets the plausibility criteria for these ideas to have played a role in the politics associated with the decision and these politics, like those with the P.E.I. institutional innovation, match with the "debate as strategy" model of politics (and with the tactical model of research utilization). The politics related to Health Canada's funding decision were partly about politicians and bureaucrats learning that actions linked to the determinants of health legitimated the federal government's role in the health-policy domain. The constitutional division of authority over health policy gives control over health-care financing and delivery to the provinces. The federal government's role in this electorally popular policy domain is restricted to fiscal transfers and the enforcement of the Canada Health Act (Government of Canada, 1984). With deficit reduction steadily diminishing the size of its fiscal transfers to the provinces, the federal government has used rhetoric about the determinants of health to maintain the appearance of activity on health-related issues (see, for example, the National Forum on Health, 1997). Yet there are no cases in which the federal government has brought about an institutional innovation or policy change for reasons related to the determinants-of-health synthesis. According to Weiss's (1979) models of research utilization, the funding of research on the social determinants of health can thus be seen as a tactical manoeuvre on the part of the federal government to delay more meaningful action.
Conclusion

Developing and applying a framework about the role of ideas in policy change, and more specifically about the role of the determinants-of-health synthesis in policy change, provides insight into the ways in which ideas can play into the politics associated with a particular policy. Researchers often take as a given that their work, and the broader ideas to which their work contributes, should influence policy. Cases like the Ontario Training and Adjustment Board or the Premier's Council on Health Strategy are sometimes taken incorrectly to support the presumption that it does. Other cases, like P.E.I.'s institutional innovation or Health Canada's research-funding decisions, suggest that ideas can play a role in policy-making, although the role may be strategic, rather than instrumental.

Answers to two sets of questions -- learning or conflict resolution and who learns, what was learned, and what type of policy change resulted -- can be used to identify more precisely what role, if any, ideas play in policy-making. In both the P.E.I. and Health Canada cases, the politics related to the initiatives resemble the "debate as strategy" model of politics, with politicians and bureaucrats using the determinants-of-health synthesis as a strategy to advance predetermined goals and the means to these ends. The ideas were used in different ways, however, with ideas serving a political purpose for politicians and bureaucrats in P.E.I. (in that arguments that invoked the determinants-of-health synthesis attracted support from some members of the health-policy community for health-care reform) and a tactical purpose for politicians and bureaucrats in Health Canada (in that funding research on the determinants-of-health helped to delay more meaningful action on these determinants).

A framework about the role of ideas in policy change can be used within both the health-policy and the broader public-policy fields. Many applications of the models of politics that constitute the framework have been within the economic-policy field. Health-policy analysts have only recently begun to draw on this literature in a systematic way (see, for example: Peterson, 1997; Wilensky, 1997; Klein, 1997; and Brown, 1998). Insights from the use of the framework can provide more nuance to analyses of health-care and health policy-making and give some additional perspective to health-policy researchers who conduct policy-relevant research.

The particular application of the framework to the role of the determinants-of-health synthesis in policy change may give pause to policy-makers and researchers working in this field. Health-policy making is not like clinical decision-making, a domain in which it is taken as a given that research should influence decisions. Ideas constitute only a part of the puzzle in health-policy making so it should come as no surprise that the determinants-of-health synthesis
has not yet had much instrumental effect. The application of the framework does, however, highlight the importance to researchers of considering the range of audiences for their research (state officials, social actors intimately connected to the state, and a broader group of social actors) and the range of uses for their research (establishing decision-making organizations and processes and choosing between different means and ends). Such considerations can suggest new approaches to research transfer, like the development of audience-specific briefing notes which specify the implications of the research for each of organizations and processes, means, and ends separately.

Taking a step back, two factors may explain why the cases in which these ideas related to the determinants-of-health synthesis did play a role were all drawn from Canada. First, because of its federal governance structure, Canada has a greater number of policy-making bodies than the United Kingdom, and more policy-making bodies mean more opportunities for institutional innovation or policy change. One federal, ten provincial, and two territorial governments in Canada were exposed to ideas related to the determinants-of-health synthesis but only one government, the national government, was exposed to these ideas in the United Kingdom. Second, as alluded to previously, the governing party and the groups with whom these ideas were associated at the time they were introduced to the political arena had very different relationships in Canada and the United Kingdom. An efficiency-based argument put forward by independent researchers resonated more with generally centrist political parties in Canada than an equity-based argument put forward by a Labour government-sponsored working group resonated with a newly elected Conservative government in the United Kingdom. Recent announcements in the United Kingdom, such as the one establishing eleven "health action zones" (Dean, 1998), suggest that the climate for the determinants-of-health synthesis has improved with the election of a Labour government.

Discordance between ideas related to the determinants of health and specialized bureaucratic structures suggests that support for institutional innovations may provide (in the short run) the most likely role for these ideas and (in the long run) the most influential role. Whereas the determinants-of-health synthesis embodies a call for an integration rather than a separation of policy domains, existing bureaucratic structures tend to be highly specialized. This discordance may explain why the only non-tactical use of these ideas, P.E.I.'s decision to move towards a single-management structure, involved an institutional innovation. Such an innovation can be seen almost as a precondition for policy change because it makes possible a cross-sectoral perspective, which in turn makes possible a health-related policy change in another sector. Accordingly, institutional innovations may provide the most influential role for these ideas because they increase the likelihood that other developments will be considered.
This study represents a first effort to identify institutional innovations or policy changes which may have come about, at least in part, because of the determinants-of-health synthesis and to determine the role that these ideas played in the politics associated with these developments. With only two countries, a relatively short time frame during which policy-makers had access to these ideas, and a sampling technique that may have been biased towards the detection of strategic rather than instrumental roles for the determinants-of-health synthesis, generalizations from the study are necessarily limited. I hope to go some way toward addressing this concern in a follow-up study that adds at least two more cases, Sweden and the Netherlands, and adopts a different sampling technique. The more stubborn challenge, determining the role that ideas play in policy-making, regardless of the number of countries or the time frame studied, remains just that - a stubborn challenge. Like Heclo, I "deal in that difficult but perhaps rewarding middle zone - between the large questions with no determinate answers and the small questions of tiresome and often insignificant conclusiveness. As usual, the challenge is to find a balance between being irrefutable and being worth refuting." (Heclo, 1974)
REFERENCES


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Table 1

Framework (adapted from Weatherford & Mayhew (1995), Weiss (1979), Hall (1989), and Bennett & Howlett (1992))
Ideas, Policy Learning and Policy Change: The Determinants-of-Health Synthesis in Canada and the United Kingdom

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