

**Impermeability, incorporation and  
transformation:**

**Ideation and health policy change**

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Policy change involves conflicts between interest groups and strains on institutions. It also involves ideation which supports specific actors and constrains policy solutions. Ideational explanations are increasingly contributing to the literature on policy change. They have much to offer an analysis of the policy process, through highlighting struggles over problem definition, the values that frame and shape policy discourses, and the “culture” of policy making.

An institutional approach concentrates on existing configurations of the state and its prior experience with related policies, which generate policy path dependencies. Interest group accounts of the health policy process concentrate instead on conflict among groups with different interests for claims on scarce resources. But the essence of policy making is the struggle over ideas, which are at the centre of all political conflict.

I do not intend to argue that ideation alone can explain policy change. It is ideas in combination with other structures and relationships that lead to policy choices and implementation (Poteete 2003). My purpose here is to examine the importance of ideas in shaping policy development through shaping the impact of institutional structures within which policymaking occurs, and assigning influence to interest groups. Focusing on ideas adds to an institutional approach an assessment of the effect of prevailing views on policy decisions (Smith 1995). And while interest group clashes are important, so are the ideas which undergird their power and are inextricably linked to them (Stone 1988).

Bacchi (1999) referred to Stone (1988) as setting the agenda for her own “What’s the problem (represented to be)?” approach. She argued that we need to ask how the definition of a policy problem also defines interested parties and allocates positions of power, and how a different definition would change power relations. Bacchi’s approach goes beyond an analysis of how and why some issues make it onto the political agenda and some do not, such as that provided by Bacharach and Baratz (1962) and Kingdon (1995). She focused instead on the discourse which sets limits on what can be said, in a similar way to Edelman (1977) who claimed that the naming of problems creates beliefs about what policy can change and what it cannot touch.

Clearly, ideas influence actors’ perceptions of their own interests. They play a role in coordinating expectations and help diffuse a certain conception of the world which justifies and legitimizes the social order (Braun and Busch 1999). New ideas must be viewed as relational, as their acceptance depends not only on the ideas themselves, but also on how they fit within existing ideas (Hall 1989). But it is also true that political actors cannot stand outside the processes they are engaged in. Competing social visions lie behind different representations of social problems and proposed solutions, and it is these competing visions that need to be discussed if we are to understand the policy process (Bacchi 1999).

The idea that ideas matter is hardly a new one. Edelman, Stone and Bacchi have all previously discussed problem definition and the struggle over ideas in the policy process. Baumgartner and Jones (1993) have examined how the images of problems affect policy development, and Schön and Rein (1994) stressed the importance of frames in identifying what counts. Other contributions such as Douglas and Wildavsky's (1982) have pointed to an underlying political "culture", while Forrester (1989) wrote about the shaping of the public discourse.

Ideas are clearly important in understanding public policy, and even a cursory examination of the health arena indicates that it is unlikely to be an exception to this rule. It is surprising then that so little of the literature on ideas and policy has addressed itself to how ideas govern health policy. This paper examines what ideation can contribute, over and above institutional and interest group approaches, to understanding policy change. The health sector is one where ideas are extraordinarily important. After constructing a typology of policy change, I use health policy as a case study for applying the typology. But first "ideation" is discussed in more detail.

## **Ideation**

Ideation means how we conceive of something. It is the formation of ideas or mental images, or the generation of images of ideas (Oxford English Dictionary). Ideation has multiple levels, as others have discussed. For example, Schön and Rein (1994) described three levels of frames in their work. Benson (1982) argued that a deep structure of interests and rules underlies the surface of policy formation, and Yee (1996) distinguished between ideation (ideas and beliefs) and policies (policy options). In this paper, ideation is viewed as a continuum running from "deep structure" to "surface level" ideas.

The deep structure consists of the intellectual and normative framework which underpins any particular sector and grants power and legitimacy to those associated with it. Here, ideas are broad and enduring and so embedded that they can seem beyond challenge. The attributes of these ideas are fully understood by those within and outside a sector, even though they are rarely examined or debated, or even discussed. Hence, deep structure ideation circumscribes the terms within which policy proposals are discussed, allocates influence, and moulds how new policy proposals might succeed or fail in a particular policy sector.

The more visible "surface level" consists of policy options and their proponents. Kingdon's (1995) notion of proposals swirling around in the policy primeval soup, supported by actors who are waiting to attach them to a problem is situated at a similar level. At this more visible level, both problems and concrete policy proposals are plain to see, while problem definition is less so. Surface level ideas are particular proposals specific to particular policy problems, and they are constantly changing. Hence, the surface level refers to the familiar and relatively straightforward and

observable arena of worked out policies, and the contests that occur between actors pushing their own solutions forward.

At the deep end, ideation is very broad and enduring, while at the surface end it is more specific. While surface level ideas are easily observed, the deep structure is less so. A more detailed examination of the notion of deep structure follows.

Policy sectors have a foundational set of broad ideas and associated values underpinning them. This deep structure encompasses ideas that are more general rather than specific, and ideas that provide a kind of cultural bias – a selected view of the environment, which influences the choice of things that are worthy of attention. As Douglas and Wildavsky (1982) wrote, each set of shared values and supporting social institutions highlights certain things and downplays others. In other words, there is a cultural bias which organizes some things in and others out, and structures the various positions people take based on a cluster of values and beliefs. Analysis should highlight how the realm of what can be identified and worked with is circumscribed by the values and norms related to these fundamental ideas.

The deep structure, then, underpins the common space where people can argue about a particular policy. It corresponds to Hall's (1992) definition of a policy paradigm as an overarching set of ideas that specifies how problems are perceived, which goals might be attained and what techniques can be used to reach them. Individuals who hold conflicting policy positions still share understandings and a larger reality about the sector they are interested in (Baumgartner and Jones 1993; Schön and Rein 1994). So deep structure performs the function of making discourse possible, by constructing the basic categories recognizable to the participants (Douglas 1987).

Schön and Rein (1994) used three levels of frames to indicate underlying structures of beliefs and perceptions which exert a powerful influence on what is seen and how it is interpreted: "struggles over the naming and framing of a policy situation are symbolic contests over the social meaning of an issue domain, where meaning implies not only what is at issue but what is to be done." (Schön and Rein 1994: 29). Metacultural frames in their formulation are broadly shared beliefs, values and perspectives which are familiar to the members of a culture, even though they may be unaware of their role in organizing actions, thoughts and perceptions. This broadest level of ideas in their classification is congruent with the concept of deep structure used here.

So far, deep structure ideation has been discussed as a fundamental set of ideas, and associated beliefs, values and perspectives which determine problem recognition and definition, shapes the policy discourse, and constrains possible policy responses. But the deep structure of a policy arena relies on actors.

Actors (individuals and groups) draw on deep structure ideas to give meaning, sense and normative direction to their thinking and action at the surface level. Groups of actors are associated with particular ideas. Alternatively, we can conceive of ideas as shaping the policy preferences of those actors which propose them. The deep structure of a policy sector must be understood as consisting of both ideas and actors in order to have a dynamic concept that can be used to understand policy change. Ideation determines who can claim a place at the table, what they are allowed to discuss, and in what terms. It follows that deep structure ideas privilege certain actors and their preferred policy options, conferring influence and legitimacy on them.

Ideas about politics shape political alliances, and strategic considerations in building alliances shape the ideas espoused (Stone 1988). Schön and Rein (1994) made a similar point with their claim that frames and interests are logically independent concepts but interests are shaped by frames and frames may be used to promote interests. Contestants in a symbolic contest enter into it with their own interests in place and seek to promote these with others through argumentation (Majone 1989: 39). So, what we believe depends on the idea itself, who tells us, and how it is presented.

A different approach to bringing together ideas and actors is provided by the concept of policy networks. Policy making is shaped by the arrangement of resources and the configuration of individuals and organizations which constitute the policy network, and these alliances strengthen and deteriorate over time (Marsh and Rhodes 1992). Paul Sabatier focuses instead on the binding together of coalitions on the basis of norms. This approach points to a deep core of fundamental normative axioms, which shapes individual beliefs and values and divides policy areas/subsystems into advocacy coalitions (Sabatier 1993). Interests are a result of the ideational perception of the social world by actors through their norms and values, and are based on belief systems (Sabatier and Jenkins Smith 1993). A related approach is Haas' (1992) epistemic communities, which consist of networks of expert actors who share ideologies.

Whether the link between ideas and actors is constructed as mutually defining ideas and alliances, the interlinking of frames and interests, networks of resource dependencies, advocacy coalitions, or epistemic communities, it is crucial in relation to public policy. Ideas are not merely rhetorical. they indicate competition between actors over plans for public policy. The definition of a policy area and its ongoing concern with certain problems is related to the establishment of boundaries by influential actors. Prevailing ideas provide signposts to which groups of actors will be important. Conversely, actors support ideas that legitimate their positions in the policy debate.

Explicit attention to actors indicates that while the deep structure has a characteristic stability, it does change over time. The boundaries which indicate who and what is

included or excluded are constantly being adjusted. As new ways of understanding old problems are accepted different actors begin to claim jurisdiction over issues that previously had not interested them (Baumgartner and Jones 1993). And in doing so, they contribute to the redefinition of the issues.

A different range of groups will be associated with divergent magnitudes of policy change. For adjustments of existing policy, agency officials responding to new information and programmatic experience are likely to dominate, but a paradigm shift is a much more inclusive and public affair (Hall 1993). Major policy changes, described by Hall as paradigm shifts and by Baumgartner and Jones (1993) as punctuated equilibria, introduce a process that may comprise an extremely wide range of participants. Change that occurs at the deep structure level is expected to be more major and involve more and different actors, compared to change at the surface level.

The literature cited up to this point is based on writing that specifically deals with public policy, plus some that is more focused on politics and culture. A summary of ideology by Freedon (2003) encapsulates much of what ideation is taken to mean here. Ideas and ideologies are political devices. They are crucial in ordering the social world, directing it towards certain activities and legitimating its practices. At the very least, ideologies exercise power by creating a framework within which decisions can be taken and make sense. They contain levels of meaning, and studying them involves identifying structures, contexts and motives that are not readily visible (Freedon 2003).

The deep structure of a policy sector consists of a normative framework of ideas, beliefs and values which determines policy problem definition in a broad and enduring manner, and assigns authority to individuals and groups of actors. Surface level ideas are more specific policy proposals, related to particular problems, and they change frequently. In between these two extremes is a continuum of ideation running from the broad and enduring to the narrow and volatile. At both ends of this continuum, ideas and actors are fundamentally interlinked and mutually defining. At the deep structure end, ideas and actors are characteristically stable, but they change as problems are redefined and new actors become involved. Ideas and actors are similarly linked at the surface level in the form of specific policies and their proponents.

## **Policy change**

Thinking about ideation as a continuum makes it clear that surface level policy making is often confined to changes which are meaningful in terms of compatibility with the underlying deep structure. I propose three main categories to describe different combinations of change at the surface and deep structure levels, remembering that these two represent the extreme ends of a continuum. Impermeability is the name given to the case where no change occurs to either the

deep structure or surface level ends of ideation. Incorporation is the case where change occurs at the surface level end, but the deep structure remains unchanged. Transformation is used to describe the case where change occurs at the deep structure end.

The three main types outlined below are each unique in terms of impact on the policy equilibrium – that is, the existing stable configuration of policies. A further distinction within the incorporation category is shown in this table, but these two sub-types have the same combination of changes at the two levels.

**Typology of policy change**

<i>Type</i>	<i>Change occurs at:</i>	<i>Change in policy equilibrium:</i>
Impermeability	Neither level	None
Incorporation Incorporation with modification	Surface level but not deep structure level	Minor and frequent
Transformation	Deep structure level	Major and rare

Impermeability refers to the case when policy proposals are ignored or regarded as unsuitable. A policy of this type makes no impact because it is too far removed from the existing configuration of ideas and actors that constitute the deep structure. When radically different policy options are proposed but there is no new understanding of the problem, the arena is impermeable and no policy equilibrium change occurs.

This type can be the most difficult to observe of those outlined here. When change does not occur we may be able to see a visible contest and the blocking of policy change. It is far more difficult to observe blockage caused by significant behind the scenes struggles (Bachrach and Baratz 1962) which remove other options from consideration, or the reshaping of views so that only options deemed acceptable are considered seriously (Lukes 1974). However, each of these belong in the impermeability category, where change does not occur at either end of the continuum from deep to surface, and the policy equilibrium does not change.

Incorporation occurs when policy options are able to be accommodated by the deep structure without causing major upheaval. Incorporated proposals are compatible with the deep structure for one of two reasons. The first case is where a new policy idea fits both ends of the ideation continuum. Such an idea will be new to the policy sector and may even appear to be threatening to the existing equilibrium. However, in this type new ideas are incorporated at the surface level without modification because they do not cause major problems for any of the strongly held ideas and

actors. The result is surface level but not deep structure change and a minor change in the policy equilibrium.

Incorporation with modification is where a new policy does not fit exactly, but is capable of being reworked to align with the limitations of an unchanged deep structure. For this type, new policy ideas can be incorporated once they have been modified to fit with the existing deep structure – hence the terminology. The result is again surface level but not deep structure change and a minor shift in the policy equilibrium.

Transformation refers to the case where ideation at the deep structure end of the continuum changes. This type results when new policies have become viable because the arena has changed significantly through a redefinition of ideas, and a new set of influential actors. The realm of possible change at the surface level moves as understandings of the problem shift and new actors are mobilised. When this occurs, the arena is transformed and a major impact on the policy equilibrium results. Transformation leads to enduring shifts, or movements to new points of equilibrium that will be recognisably different for some time. Hence transformation equates to major shifts in the policy equilibrium.

Causality is not easily observed or untangled. Policy making mainly evolves through gradual changes or incorporation of new policies at the surface level. But this results in significant lags, which in turn leads to major shifts and occasional periods of rapid change (March and Olsen 1989). Baumgartner and Jones (1993) argued that the monumental events that many take as critical points signify policy change but lag behind when the issue has already been redefined. When the deep structure shifts, this might only be recognised later because of surface level change. However, problems of causality do not undermine the categories outlined here, with their defining characteristics of change at different levels and impacts.

### **The deep structure of health**

To apply this typology of change to health policy, some crucial attributes of health need to be examined. What foundational ideas distinguish health policy and who are the key groups of actors associated with them? In other words, what does the deep structure of health consist of? Two enduring characteristics of this sector are the firm entrenchment of the biomedical model and the associated power of the medical profession. Without a comprehensive understanding of these it is difficult to understand how this policy sector is circumscribed, and what ideas are desirable or even thinkable.

The biomedical model - the idea that the body is a machine, and that health is about providing curative care to individuals once they become ill – is fundamental to much health policy. There was a paradigm shift to ‘scientific medicine’ in the late 19<sup>th</sup> Century, with the development of a new technology of medical work based on

developments in understanding and treatment of disease (Willis 1989). Pasteur's demonstration of the existence of germs in 1862 and Lister's application of that principle to surgery in 1867 (Porter 1999) marked the beginning of the rise of scientific medicine. Engel (1977) argued that the focus on disease which accompanies scientific medicine, leaves no room for the social, psychological and behavioural dimensions of illness.

The entrenched position of this view of health is demonstrated by observing how health policy development and the expectations of consumers are bounded by prevailing conceptions of health and illness (Health Issues Centre 1988; Degeling and Anderson 1992). An unquestioned and widespread enactment of the values, meanings and practices associated with biomedicine structures the health agenda. This ensures that established practices, modes of service delivery, patterns of resource allocation and relationships of power are recreated.

Biomedicine has significant power in shaping societal beliefs about health problems and how they should be managed - in defining how we perceive of "health" and "illness", determining what constitutes sickness, who is sick and what treatment will be given them (Illich 1976; Starr 1982). With its primary focus on human biology or physiology, it is founded on a cultural framework of values, premises and problematics and enacted in a social division of labor (Hahn and Kleinman 1983).

This division of labour has pre-eminent practitioners – doctors – and others whose relations with them are controversial and always changing. In other words, the acceptance of biomedicine also justifies the authority of the medical profession. Medicine was fixed at the top of the health care hierarchy in 1880 when 'scientific medicine' became established, and so was able to exploit the technical developments which followed from germ theory and use the effectiveness of science as a means to advance itself as a profession (Willis 1989). As Freidson (1988) observed, the medical profession has enjoyed significant control in health care for more than a century through clinical autonomy, its authority in policy making and its dominance over other health occupations.

The deep structure of health is indicated not only by biomedicine and the associated authority of the medical profession, but also by the range of other interests which rely on a continuation of disease-focused and curative service policies (medical equipment manufacturers, pharmaceutical companies, and providers of care to people with acute and chronic illnesses). However, the group most closely examined in this paper is the medical profession, both because of the link between the medical professions' authority and biomedicine, and because it has been the target of much health policy attention over the last two decades.

In summary, deep structure ideation in health is based on biomedicine as the fundamental conception of health, and the medical profession as the dominant actor associated with this conception.

## **Biomedicine and alternative models of health**

In the biomedical conception, disease is an individual condition to be cured by individual action (Frankford 1994). However, the phenomenal progress of transplant surgery and biotechnology sits alongside persistent and worsening chronic and psychosomatic illnesses, highlighting the capacities of the powerful biomedical tradition and the unfulfilled requirements of large numbers of people around the world (Porter 1999). Socially based models of health locate disease within the wider environment, taking into account the effects of environment, class, ethnicity, and other factors. These models challenge biomedicine by emphasizing the importance of societal factors in determining health and illness and reducing the authority of the medical profession.

“New public health” is an alternative model which emphasizes the social structuring of health rather than individual behaviour.<sup>1</sup> Some definitions of the new public health include notions of individualism, for example: “an approach which brings together environmental change and personal preventative measures” (Ashton and Seymour 1988: 21). Other versions focus on community and societal structures, and see social cohesion as the ultimate goal in developing health (Lomas 1998). This position emphasizes the contrast with the implicit concerns of biomedicine, placing it further away from it in its view of health and illness. This more extreme definition is used here as device for emphasizing the contrast with biomedicine.

The new public health, then, casts professionals (some of whom will be medically trained) who focus on communities and societies rather than individuals, as more important actors than the medical profession. Many see the new public health as also linked to the notion that community participation is essential in promoting health (Baum 1998). Most recently, those proposing alternative models of health refer to the “social determinants of health” or focus on health inequalities or disparities in populations (e.g. Mechanic 2002; Marmot 1999; Acheson 1998).

Ideas about replacing biomedicine as the dominant model of health clearly operate at the deep structure end of the ideation continuum. However, policies which are more closely aligned with alternative models of health than with traditional biomedical concerns can also be observed at the surface level. For example, policy attention has been directed at health promotion rather than curative care, providing services in non-traditional service settings rather than in hospitals and clinics, and increasing consumer and community participation in health matters. In the examples used to

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<sup>1</sup> I use ‘new public health’ here as a more radical view than the ‘old public health’. The ‘old public health’ aimed to protect and promote the health of the population as a whole, and came to mean quarantine regulations, immunisation programs, clean water and safe food legislation (Fry and Baum 1992). The term ‘new public health’ was coined in the 1980s to differentiate it from these measures, and its institutionalisation in universities with epidemiology and biostatistics as the dominant disciplines, rather than social sciences (Martin and McQueen 1989).

illustrate my typology of change, a social determinants approach and community health programs are examined in more detail.

### **Medical autonomy and authority**

To understand ideation and health policy, it is important to separate out the notions of autonomy and authority. Harrison and Ahmad (2000) argued that there are different levels of work freedoms for the medical profession. In their formulation, the macro level is where biomedicine operates, while autonomy is under challenge at the micro level. I distinguish between the authority of the medical profession and the professional autonomy of doctors. I also make a further distinction between three interlinked aspects of authority – political authority in policy making, social authority in the granting of expertise and the division of labour, and cultural authority in the social construction of health and illness (Lewis 2002).

A decline in medical authority was widely acknowledged by the 1980s associated with a loss of faith in science. The critiques of sociologists in particular contributed to this, by painting the medical profession as self serving and not always to be trusted to act in the public interest (e.g. Freidson 1988; Willis 1989) and even detrimental to health (Illich 1975). One medical historian subsequently argued that once medicine based on science proved effective: "...the physician no longer had to be thanked and could be disparaged as a figure of authority a tool of patriarchy or a stooge of the state" (Porter 1999: 717).

A significant challenge to the medical profession over the last 20 years has resulted from concerns about containing the costs of health care (Wilsford 1995; Ham 1997). Many attempts have been launched to control the medical profession in different countries (Freddi and Bjorkman 1989; Harrison and Pollitt 1994). The challenging interests of governments, insurers and health care provider organizations aim to increase rationality and efficiency in service provision (Alford 1975). In doing so, many of the policies introduced have attempted to reduce medical autonomy.

Ideas about generating efficiencies through better management and planning, and more monitoring and evaluation have become widespread. Associated policy changes include greater control over the allocation of resources and an emphasis on outputs, more stringent requirements for performance measurement, and greater oversight of the work of health professionals by managers. Managed care in the US has been used to overcome physician autonomy over clinical matters in attempts to control health care costs (Belkin 1998), and has led to an increased administrative burden falling on physicians, including having to seek prior approval before following their own judgment (Luft 1999). Such changes strike at the core of professional autonomy.

External scrutiny and evaluation of professional work has been used in efforts to increase professional accountability, as have financial incentives, techniques for

managing clinical activity and patient-focused approaches for improving the quality of care. In the examples used to highlight the typology's categories, policies that increase the scrutiny and evaluation of clinical work (reducing autonomy) are examined.

### **Impermeability, incorporation and transformation**

Concrete examples of health policy, seen through an ideational lens, are now used to illustrate the categories of the typology and demonstrate its usefulness. Each example draws on the ideas outlined in the previous section. A brief description is followed by an *a priori* classification of the example into one of the categories, based on an assessment of the level of ideation at which the policy is working, the likely change at both ends of the ideation continuum, and the expected impact on the policy equilibrium. Particular policies which have been in place long enough to assess their impacts are then used to show how this typology is strongly suggestive of which category of change will result. The four types and the examples used are shown below. I do not claim that this is an exhaustive list of policies. My aim is to demonstrate that the typology points to the convergence (or lack of) policy ideas with the deep structure, and that examining this helps to explain the likely impact.

#### **Typology of change with examples of health policy ideas**

<i>Type</i>	<i>Example</i>
Impermeability	Social determinants of health 1970s-2000
Incorporation	Clinical oversight and evaluation 1980s onwards
Incorporation with modification	Community health 1970s onwards
Transformation	Social determinants of health Post 2000 (hypothetical)

#### *Impermeability*

This first type is best illustrated by examining attempts to emphasize the social determinants of health rather than medical factors. A social determinants approach represents a deep structure idea that does not sit easily with the foundational biomedical model of health and the authoritative position of the medical profession which is buttressed by this model. It presents a fundamentally different conceptualisation of health as a product of society, and undermines the authority of the medical profession and the existing health care system. The sector could be expected to be impervious to such alternative conceptions of health. So, it is postulated that the

social determinants approach would not impact at either end of the ideation continuum, resulting in the case of impermeability and no change in the policy equilibrium.

Since the 1970s the idea that social structures are as important as, or more important than, medical factors in determining health, has been growing in importance. In Canada, ideas about the non medical determinants of health have been commonly discussed since the 1970s (Lavis 2002). In Britain, the Black report (Black 1980) linked health with income and inequality two decades ago. There was also a good deal of rhetoric about changing to a new model of health since the World Health Organization's *Ottawa Charter* (1986) which emphasized social structures rather than individual lifestyle. These reports led to calls for the need for policy makers to reassess how health is defined and for resources to be shifted from medical care to other kinds of health care and to other sectors such as education and transport.

However, while there has been a rapidly increasing volume of research documenting the impact of social determinants on health, these ideas have had virtually no impact on policy. The lack of impact of the Black report in the UK was observed on the release of the Acheson report nearly two decades later (Acheson 1998) which covers the same territory (Black, Morris, Smith and Townsend 1999). It is not clear whether change will occur in line with the more recent Acheson report recommendations (Marmot 1999). This is returned to in the discussion of transformation.

In general, calls for multi-agency, multi-sectoral, cooperation and coordination have been little realized in the UK and Germany (Freeman 1995), governments in the US do not see health as interlinked with taxation, monetary policy and employment (Levine 1994), and targets to reduce unemployment or redistribute wealth remain largely absent from policy making in the UK (Klein 1996). In Canada there has been a largely rhetorical impact on health policy, and trivial impacts on (crucial) financial policy advisers, few of whom are convinced that non medical determinants of health are important (Lavis 2002).

At the end of the twentieth century, the focus of health policy had not shifted to a view of health being determined by social and economic factors. Biomedicine has continued to exert a strong influence on the structure of health services and the attention given to individuals by biomedicine had generally outweighed concerns over social systems (Lomas 1998). The deep structure of health frames ideas directed at improving health through building societal structures as irrelevant, unachievable or ludicrous policy options. During this period, these ideas had insignificant impacts on ideation, and no impact on the policy equilibrium.

### *Incorporation*

The quest for greater control over health care costs since the 1970s has resulted in the introduction of policies which have challenged medical autonomy through audits and evaluation. What could we expect the impact of these ideas to be? Performance

measurement and standardization and greater managerial control exemplify the challenge to medical autonomy. However, biomedicine and health services research share positivist epistemic and methodological premises (Frankford 1994) and a core assumption that the individual is the appropriate unit of measurement, analysis and modification (Lomas 1998). So while ideas about increasing clinical oversight are not sympathetic to maintaining clinical autonomy, they are congruent with prevailing deep structure ideas about health. They challenge the idea of medical autonomy but also fit the individualistic and curative foci of the deep structure. Such ideas should impact at the surface level in reducing clinical autonomy, resulting in incorporation and minor change in the policy equilibrium.

Outside scrutiny of clinician's work through greater management and evaluation has been growing in the US since the early small area studies of Wennberg (1984). Managed care organizations have tried to make doctors more directly accountable for the cost of treatments they provide, and to restrict the autonomy of individual doctors by greater scrutiny of the appropriateness of care provided (Robinson and Steiner 1997). The examination of clinical practice required by managed care plans rests on evidence of effective care and the apparent failure of doctors to treat on this basis. The establishment of Cochrane systematic reviews in 1992 (Chalmers, Dickersin and Chalmers 1992) indicates that an emphasis on effectiveness for medical decision making (or evidence based medicine) has also grown in the UK and elsewhere

The clinical oversight undertaken by managed care and other organizations has indeed resulted in a surface level change. Under the increasing constraints of oversight, standardization, and evaluation, medical professionals have been not so much disempowered as obliged to revise and recapitalize their power around the merits of their practices (Brown 1998). Medical standardization as it has been used by managed care organizations in the US fits with the current political and economic tensions around health care (Belkin 1998) rather than with medicine's concerns.

However, while evaluation tries to study and control biomedicine, it cannot operate on the "mental forces at work within the economy of health care" (Frankford 1994: 782) and the relationship between biomedicine and evaluation ends up being symbiotic rather than antagonistic. This is demonstrated by the ownership of "evidence based medicine" that the elite of the medical profession are claiming through the Cochrane collaborations (Harrison and Ahmad 2000). Clinical oversight and evaluation has been incorporated into health policy, and accepted by the medical profession. This has resulted in a minor shift in the health policy equilibrium.

#### *Incorporation with modification*

This category is illustrated by examining another challenge to biomedicine. Community health refers to ideas about health that cast community based care as preferable to institutional care, and community involvement as a central organizing principle of health services. Community involvement does not fit well with the notion

of professional expertise and authority, but community health ideas mainly act at the surface level, challenging traditional approaches to locating and delivering services rather than replacing biomedicine. We could therefore expect that community health policies might impact at the surface level and be reworked to fit with biomedicine's interests. These ideas could be expected to result in incorporation with modification, acting only at the surface level and leading to a minor change in the policy equilibrium.

Community based programs arrived in the 1960s in the US, with the establishment of national networks of neighbourhood health centres and community health centres (Schlesinger 1997). Through these programs, communities were to become the central organizing principle of health care and new programs were to be organized so as to allow participation by community representatives. The Community Health Program introduced in Australia in 1973, aimed to encourage the development of a wide range of health resources emphasizing prevention, as well as promoting a shift away from institutional to community care (Hospitals and Health Services Commission 1973; 1976). Many of this program's principles of community involvement and health promotion were similar to those in the Alma Ata declaration (World Health Organization 1978).

After the introduction of this program in Australia, community health services continued to envision prevention as individual based interventions (Milio 1983), and services remained disease focused. In order to survive, community health withdrew from attempts to change the overall priorities of the health system in the face of determined opposition from the medical profession (Australian Community Health Association 1989). This program still exists, but in a very limited form compared with its original intentions. Schlesinger documents similar opposition to community health from the medical profession in the US, and a comparable emphasis on responding to the interests of individual consumers rather than the collective concerns of local communities (Schlesinger 1987; 1997).

More recently in the US, discussions about community oriented health policies only touched the surface of debates when plans to reform health care were in full swing in the early 1990s. Different views of health were absent from this debate (Kallick 1994; Freeman and Robbins 1994). Schlesinger (1997) suggests that this is because neither the public nor federal policy makers are convinced that communities should have responsibility for addressing health problems.

Community health ideas have been modified and incorporated by deeper ideas related to biomedicine and the expertise of the medical profession. Where community health approaches have been introduced, they have been remade to fit within the accepted bounds of health policy. The challenge to the deep structure was reduced by operationalizing community health so that it became individualized, targeted at lifestyles, and administered by doctors in traditional clinical settings. The deep structure substantially reshaped community health ideas so they could be incorporated, and the result was a minor change to the policy equilibrium.

### *Transformation*

This final category requires a more hypothetical examination of the contemporary social determinants approach to health. Transformation generated by deep structure change, as defined in this paper, relies on ideas that essentially replace the biomedical model. For major impacts at the deep structure end of the continuum, ideas would have to be directed at changing the definition of health and illness – at cultural authority rather than policy making authority (Lewis 2002). The earlier examples of challenges to biomedicine from social determinants or community health ideas show how these have made either no impact on health policy or have been modified so that impacts were confined to the surface level.

While these examples indicate how we can tell that this kind of change has **not** occurred, the question remains, how would we recognize deep structure change? For a social determinants approach to be seen to have replaced biomedicine as the foundation for thinking about health, there would need to be agreement that this was a recognisable, settled and generally uncontested view of health. Policy makers and health professionals (especially the medical profession) would have to take on the alternative view put forward by the social determinants model and there would also need to be a widespread recognition by the general public of the multiple and often non-medical factors that influence health.

The new and stable policy equilibrium would have those characteristics outlined earlier in relation to a social determinants approach. Health would be understood as being produced by the environments in which people live and work rather than solely as a function of their genetic make up and their own (health and illness producing) lifestyle decisions. Health policy would not be confined to health bureaucracies and health politicians, but would be a cross portfolio consideration and a whole of government concern. The medical profession would not sit at the pinnacle of expertise as the dominant arbiter of health advice. Rather, a range of professionals would be seen to have expertise and these would include people working in urban planning, social policy, transport, education and so on.

This involves a revolutionary shift in how health and illness are conceived of in government and in society. However, partial shifts towards alternative models have proved unstable, as the earlier example of community health programs demonstrated. If the medical profession were to embrace a social determinants model of health but also argue that they should maintain their position as the dominant experts in relation to health policy making, the shift would be unstable and health would soon return to being seen as health services, organized and delivered by doctors, as in the community health example.

Similarly, if governments were to move towards such a model without recognizing the multi-sectoral nature of such an approach, then the determinants of health would remain the concern of health bureaucracies. This would neither increase the standing

of this approach within the health sector, nor move health policy onto the agenda of other important governmental agencies. Such a partial shift would soon see health policy retreating from larger social and economic concerns and returning to notions of health as separate from other aspects of life.

Finally, if the medical profession and governments were to take on board a new view of health without public opinion shifting, this partial shift would still not be stable. If the public continued to see the medical profession as the experts and health as solely a product of lifestyle and genes, there would soon be pressure on governments to rethink its priorities. A continuance of the view that health is only about seeking treatment once you are sick and that doctors are the experts on every aspect of health, and an uncoupling of health from environmental conditions would destroy any chance of this shift being stable. Instead, a similar situation as in the managed care example would arise, where public opinion is not in line with elite views.

In the UK, policy pronouncements in the last few years have been directed at moving to a model of health that is more related to health improvement than health care, and takes into account deprivation and social exclusion in new policies (Department of Health 1999; 2001). A policy document on the NHS (Department of Health 2000) also committed the government to establishing national health inequalities targets, which were announced in 2001. Alongside these developments were a number of policy actions aimed at promoting opportunity and economic regeneration and reducing social exclusion through tackling poverty and low income, improving educational and employment opportunities, rebuilding local communities and supporting vulnerable individuals and families (Nutbeam 2003). A review of spending across departments has been established to consider the distribution of benefit to health of a range of programs in education, welfare, criminal justice, environment, transport and local government. Delivery is structured by a cross-Department group of senior officials, chaired by the Treasury, and accountable to a Cabinet sub-committee which is chaired by the Deputy Prime Minister.

Nutbeam (2003) argued that the success of this plan relies on connecting health care reforms with the wider set of UK public sector reforms, and so addressing the underlying determinants of health inequalities. However, the difficulty of shifting to such a different way of thinking about health and illness should not be underestimated. These policy documents reveal the lack of any major change towards a different model of health in the UK since the Black report was released twenty years ago. Some are expressing scepticism that government policy will change dramatically (Evans 2002), arguing that traditional approaches to health continue.

This major overhaul of policy in the UK appears to be working from a deep structure idea of putting in place a new model for thinking about health and illness, and therefore, for making health policy in the UK. It provides a good hypothetical example (since we cannot know yet what the long term changes and impacts on the policy

equilibrium will be) of the types of policy ideas required for deep structure transformation to occur.

## Conclusions

Biomedicine is a powerful idea which circumscribes health policy making through its emphasis on diseases, individuals and curative care. It underpins the position of the medical profession in culturally determining health and illness, even when the profession is being significantly challenged. Policies aimed at replacing the biomedical model represent a fundamental opposition to deep structure ideas about health. Such policies have remained unrecognized or appeared too far fetched (impermeability), or have been reshaped to fit prevailing conceptions of health and existing professional interests (incorporation with modification).

Policies directed at reducing medical autonomy by increasing managerial control, performance measurement and standardization affect the surface level but not the deep structure end of the ideation continuum. These threaten professional autonomy, but they provide no direct challenge to biomedicine and result in incorporation. Transformation requires a fundamental rethink of how health is understood – that is, it requires radically changing how health and illness are conceived of by government and society.

It is now often argued that the autonomy of the medical profession has diminished. This reflects a focus on surface level turbulence and a fascination with the medical profession rather than the ideas that underpin its position. The social power of biomedicine, and the profession's ability to achieve acceptance for its own concept of health is not threatened by much of the surface level change that is easily observable. The deep structure of health continues to limit change possibilities, with health policy debates tending to focus solely on medical care, not health care or health.

I have argued that a typology of policy change, based on ideation and a set of consequent impacts on the policy equilibrium, provides new ways of understanding health policy change. Scrutinising ideation reveals much about the nature and scope of policy change. The typology of impermeability, incorporation and transformation presented uncovers why some ideas (alternatives to biomedicine) have proved too far removed to have any impact, while others are incorporated if they can be reworked to fit foundational ideas. It explains why apparently radical ideas result in only minor shifts in the policy equilibrium. A novel set of ideas about what health means rather than incremental shifts directed at important actors, is required if health policy is to be significantly transformed.

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