

# Policy to tackle the social determinants of health: using conceptual models to understand the policy process

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Like health equity, the social determinants of health (SDH) are becoming a key focus for policy-makers in many low and middle income countries. Yet despite accumulating evidence on the causes and manifestations of SDH, there is relatively little understanding about how public policy can address such complex and intractable issues. This paper aims to raise awareness of the ways in which the policy processes addressing SDH may be better described, understood and explained. It does so in three main sections. First, it summarizes the typical account of the policy-making process and then adapts this to the specific character of SDH. Second, it examines alternative models of the policy-making process, with a specific application of the ‘policy streams’ and ‘networks’ models to the SDH policy process. Third, methodological considerations of the preceding two sections are assessed with a view to informing future research strategies. The paper concludes that conceptual models can help policy-makers understand and intervene better, despite significant obstacles.

**Keywords** Policy process, social determinants of health, health inequalities, research methodology

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## KEY MESSAGES

- Social determinants of health (SDH) represent major challenges to health policy-makers in all countries.
- Models of the policy process are often ill-suited to local contexts and the nuances of SDH.
- A sensitive application of models such as ‘streams’ and ‘networks’ offers significant insights into the nature of SDH policy and the opportunities/constraints facing policy-makers.
- Understanding and explaining SDH policy processes need to be undertaken sensitively, recognizing peculiar methodological challenges.

‘What is striking is that there has been much written often covering similar ground...but rigorous implementation of identified solutions has often been sadly lacking.’ (Wanless 2004, p.3)

This quote was written about UK policy addressing the social determinants of health (SDH) but is applicable to most high or low and middle income countries. Despite mounting evidence of the causes of health inequity, even in the latter countries, attention on the policy process is a notable omission. This may

reflect the epidemiological emphasis on SDH research and/or a lack of engagement between public health and policy analysts. This article seeks to remedy that by closely examining the nature of the SDH policy process, how it might be conceptualized and researched.

## Re-visiting the policy-making process

The term ‘policy’ is so widely used that it often obscures meaning. Searching for definitional clarity can be misleading. Its various uses denote the significance attached to it by multiple stakeholders (Hogwood and Gunn 1989; Buse *et al.* 2005)

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and/or the multiple levels at which it is developed. A useful way of understanding 'policy' is in terms of context, content, process and power (Walt 1994). First, context is the milieu within which interventions are mediated; it therefore shapes and is shaped by external stimuli like policy. Second, content refers to the object of policy and policy analysis, and may be divided into technical and institutional policies (Janovsky and Cassells 1996). Third, Wildavsky's (1979) reminder that 'policy is a process, as well as a product' is crucial because it draws attention to the course of action over time. Finally, power draws attention to the interplay of interests in negotiation and compromise.

The 'policy process' is often presented as a linear, rational process moving from formulation to implementation; for example:

- 'Politicians identify a priority and the broad outlines of a solution...';
- Policy-makers... design a policy to put this into effect, assembling the right collection of tools: legislation, funding, incentives, new institutions, directives;
- The job of implementation is then handed over to a different group of staff, an agency or local government;
- ... the goal is (hopefully) achieved' (UK Cabinet Office 2001, p.5).

This is an over-simplistic view. The distinction between formulation and implementation is rarely clear-cut; intentions and action are often hard to distinguish. It may be more helpful to view the 'policy process' as disjointed and 'messy'. For example, John (2000) argues that there is often no start or end point, only a middle. Policies are developed within a pre-existing context that effectively constrains new opportunities. The legacy of former decisions creates conditions from which policy-makers may find it difficult to diverge, a condition known as 'path dependency' (Greener 2002). Most resource decisions, for example, only consider marginal changes rather than taking fundamental re-assessment of principles. Path dependency limits the range or possibility of radical changes of direction, at least in the short term—often called 'incrementalism' (Lindblom 1959). This perspective also contends that the policy process can often be static for relatively long periods, only to be disturbed by moments of change—disjointed incrementalism and punctuated equilibrium. As a result, the policy process is characterized by (positive and negative) feedback loops and rarely reaches completion. However, Clay and Schaffer (1984), for example, demonstrate the 'room for manoeuvre' that policy-makers can enjoy.

The health policy process is also characterized by other features. First, policy decisions rarely take place at a single point in time and can be protracted over months or even years. It is therefore difficult to discern if/when a specific decision was made. Policy decisions often reflect a broad direction (despite conflict) so as to mollify stakeholders' concerns or to denote their power. Second, policy-making rarely occurs in public but rather behind 'closed doors', despite some attempts to make it more transparent. Third, policy-making often results in no decisions or non-decisions. The lack of (observable) action or outcome may actually signify a complex set of forces that have stifled a decision or prevented proposals from being enacted

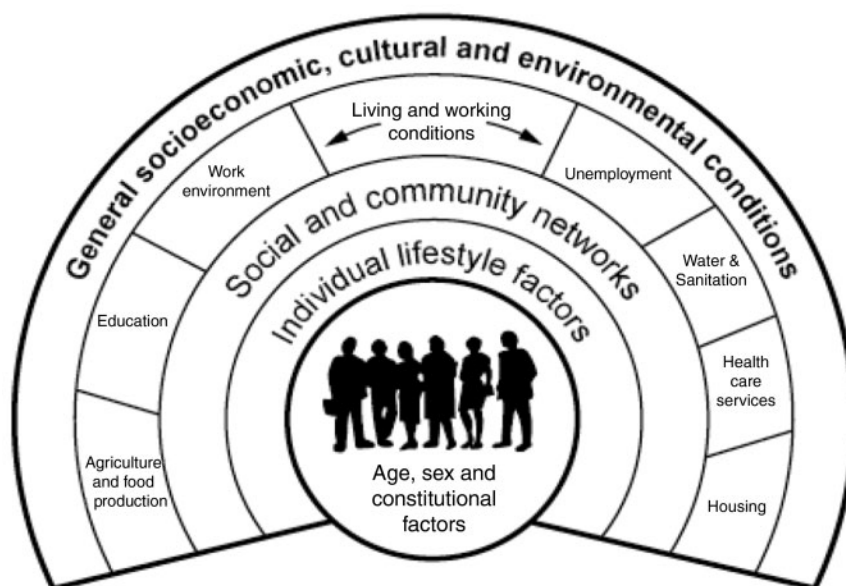
(Lukes 1974). Finally, much of the evidence on the policy process originates from high income countries (HICs); there is thus an empirical question as to whether typical approaches and understanding are valid in low and middle income countries (LMICs). Questions about similar translations between demographic/population and income groups may also be posed.

SDH offer an insightful case study of health policy processes because they have in recent years assumed a more central place in policy processes of many HICs and LMICs; previously, policy analysis has tended to overlook the issue in favour of other policy imperatives. It is, therefore, instructive to learn how the specific nuances of these complex phenomena are articulated in the content, context and process of health policy processes. Such a case study is significant because, on the one hand, SDH are more prominent in topical debates about MDGs and poverty reduction, and on the other, SDH are illustrative of increasingly complex developments in policy process (such as governance and internationalization). However, each aspect that public policy in each country seeks to address is, more or less, a particular configuration of issues. Practically, these issues need to be understood and explained by academics and by policy-makers that they may assess the likely impact of SDH policy.

Broadly, eight challenges to addressing SDH through public policy can be identified. Defining clearly the features of SDH helps to draw sharper implications for policy development and implementation. First, SDH are multi-faceted phenomena with multiple causes. Models of SDH are useful conceptual devices to identify the causal pathways which have differential impacts on health (see Figure 1).

However, SDH models rarely offer policy-makers a clear direction for policy development (Graham 2004). First, some policy-makers believe that the lack of a 'simple problem' hinders the development of 'simple policy solutions' or that policy is ineffective in the face of wider social forces (such as globalization). Others see SDH as 'invisible' (Dahlgren and Whitehead 2006, p.15). As a result, there has often been no policy response to 'act upon SDH' or, where there has been some attempt, a diffuse approach. This has often been hampered by the lack of consensus among academics and policy-makers about the policy solutions required.

Second, the life-course perspective (Blane 1999) presents a challenge to policy-making processes whose timescales are rarely measured over such long periods. The life-course perspective posits that early life influences (say, upon diet or education) have life-long impacts that will only be evident many years hence. This perspective contrasts with the tenure of elected and/or appointed officials (which is usually measured in years, rather than decades), the electoral cycles in parliamentary or presidential democracies (usually measured from 5 to 7 years), and organizational reporting cycles (e.g. for budgetary purposes usually measured annually). Moreover, coalitions of interests in support of SDH policies may be unsustainable over the time periods necessary to witness significant change, thereby presenting a challenge to create and sustain commitment to and involvement in the policy goals and process. Partly as a result, attention of the public (often supported by the media) and some practitioners has tended to reinforce such short-term timescales. This second feature is



**Figure 1** The main determinants of health.  
Source: Dahlgren and Whitehead (1991).

thus a challenge to integrate long-term approaches with short-term organizational/political imperatives.

Third, SDH necessitate policy action across different organizations and sectors (not least, the health care sector) (Hunter 2003; Gilson *et al.* 2007). Often, policy responses are only disease-specific rather than addressing SDH. Inter-organizational and inter-sectoral partnerships are critical to formulating and implementing policy towards SDH. However, evidence shows that partnerships at all levels are hampered by cultural, organizational and financial issues (Lee *et al.* 2002; Sullivan and Skelcher 2002). Different values, different accountabilities and performance measures/criteria, and different reasons for collaborating are among the challenges for partnerships. Moreover, the 'health'/SDH agenda may be marginal to collaborating organizations, SDH being perceived as beyond their core purpose. It can also be argued that action on SDH requires intervention beyond state/government, by civil society organizations or even private sector agencies. Such collaboration regarding SDH is likely to be even more problematic.

Even within governments, inter-organizational collaboration has often been poorly developed. Traditionally, government agencies tend to be organized vertically (Ling 2002; Bogdanor 2005). For example, education ministries are largely focused on running schools, health ministries on delivering health care services, etc. Yet, such 'silo' or 'chimney' approaches are not well suited to tackle cross-cutting issues. A strong coordination role, say, across government or by an external (international) agency might offset the 'silo' approach but the balance of power usually remains with ministries.

Fourth, SDH are one of many competing priorities for policy-makers' attention and resources. Economic, foreign or development policies might take precedence over SDH, *inter alia*. More specifically, SDH may be over-shadowed in the policy process by health care itself. As most states take a prominent role in the financing and/or delivery of health care to its population (Saltman 1997), it is perhaps inevitable that states

take a close interest in such matters. However, this *health care* focus is often to the neglect of *health* and *SDH per se* (Gilson *et al.* 2007). That said, other spheres of policy (such as education or transport) can be informed by SDH.

Fifth, SDH are so complex that the cause-effect relationships are not readily apparent. Moreover, some evidence is equivocal about these associations. For example, statistical correlations are common in epidemiological studies which inform policy-making, but they rarely demonstrate causation. Knowing and understanding causal pathways is a first step in devising appropriate policies but many gaps in knowledge remain, especially in LMIC contexts. Attributing policy mechanisms to their impact upon health can often be obscured because:

'Policy cannot be intelligently conducted without an understanding of mechanisms; correlations are not enough' (Deaton 2002, p.15).

As a result, policy levers (such as legislation and resource allocation) are seen as blunt instruments in tackling SDH, whose consequences are not, and sometimes cannot be, ascertained with sufficient clarity.

Attribution of policy interventions to outcomes is problematic. Such outcomes may not be evident for many years, if at all, as indicated by the life-course perspective. Consequently, there is often a reliance on 'process' measures as indicators of progress, assuming that they are associated with outcomes. This may be particularly problematic the higher the level of analysis, such as macro-economic policy (Turrell *et al.* 1999), or as policy is transferred from HICs to LMICS. Attribution may also pose dilemmas for targets given the multi-faceted nature of policy outcomes.

Sixth, the identification, monitoring and analysis of epidemiological changes over time, is crucial to inform the policy-making process. Yet, routine data are not always available, are of poor quality or have been collected over insufficient periods

to aid policy-making (Center for Global Development 2006; Exworthy *et al.* 2006). Data categorization by population groups (e.g. ethnicity, gender) or geographically is often poor. However, whilst data are necessary, they alone are not sufficient to secure policy implementation.

Seventh, globalization and multi-lateralism are significant factors in delivering 'global public goods' such as health (Chen *et al.* 1999) but such goods have been influenced by the changing role of the nation state in policy-making (Lee *et al.* 2002; Labonte and Schrecker 2007). Powers have been re-located to supra-national organizations such as the European Union, World Trade Organization, International Monetary Fund and World Bank. In particular, these supra-national institutions tend to promote a neo-liberal agenda (Raphael 2003). Governments' ability to shape and mould the SDH with the goal of improving their population's health is becoming limited as many of the 'causes' of poor health (Wilkinson and Marmot 2003) no longer fall within their responsibility. They, therefore, need to rely on influence and leverage in multi-national networks. By contrast, decentralization to regions and cities has had a similar effect on the policy-making capacity of governments. Decentralization in HICs and LMICs can be seen as an attempt to make public services more responsive to local needs (and in that sense, improve intra-area/population equity). However, despite its popularity, decentralization in LMICs and HICs is rarely achieved in full or within parameters defined by central government (Bossert 1998; Atkinson *et al.* 2002). As such, decentralization might be seen as less of a threat to national policy-making than globalization, since the implementation of the former lies mainly within governments' control.

These seven challenges of the contemporary policy process as applied to SDH are summarized in Table 1.

The challenges demonstrate that, despite the growing volume of evidence on SDH, understanding of the particular demands of the policy process around SDH in particular contexts has been limited. In short, despite the growing attention on SDH, understanding of the policy process in particular contexts has been missing. Policy models and frameworks can help in developing the theory and practice of policy development to tackle SDH.

## Policy models and their application to SDH

Conceptual models can provide tools to describe, understand and explain policy processes. Such models are important for

two reasons. First, much health policy practice has been developed (and researched) in HICs and 'transferred', often uncritically to LMICs. However, the variability of context and nuances of individual policies make generalizability problematic. Exporting policies within or between countries is often discounted on the basis that the 'context' is different and hence lessons from host countries cannot be learnt. However, a focus on conceptual models can obviate some of these problems by addressing key issues such as power and resistance. By applying concepts of the policy process, it is thus possible to discern meanings and motives, similarities and differences in patterns and practices across context. Second, as SDH present specific challenges to the policy process, the configuration of SDH and policy context in each country demands that typical policy frameworks are adapted to local contexts.

Despite the extensive literature on this topic and for sake of brevity, this article focuses on selective models as illustrations of the ways in which they contribute to improved understandings of how the SDH policy process, specifically, may be approached by policy-makers. The three models do represent, however, major approaches within the extensive literature, though they do not provide, by any means, a comprehensive assessment:

1. streams
2. networks, and
3. stages.

### 'Streams' model

This model is concerned with how issues get onto the policy agenda and how proposals are translated into policy. Kingdon (1995) argues that 'windows' open (and close) by the coupling (or de-coupling) of three 'streams': problems, policies and politics. The model (and its variants) has been applied to analysis of policy change around health inequalities and SDH (e.g. Exworthy *et al.* 2002; Sihto *et al.* 2006). This model is especially pertinent to SDH because, in many (HIC and LMIC) countries, SDH have struggled to reach the policy agenda, let alone become implemented. This is despite mounting (epidemiological) evidence (Wilkinson and Marmot 2003) and policy proposals.

### Problem stream

Conditions or issues (such as SDH) only become defined as 'problems' when they are perceived as such. Often, only those 'problems' which are (potentially) amenable to policy remedies

**Table 1** Link between features of social determinants of health (SDH) and the impact on policy-making

Features of SDH	Impact on policy-making
Multi-faceted phenomena with multiple causes	Coordinated strategies are difficult to achieve
Life-course perspective	Long-term approach does not match policy timetables
Inter-sectoral collaboration and partnership	Partnerships are problematic
Dominance of other priorities	SDH often neglected
Cause-effect relationships are complex; attribution difficulties	Attribution problems hamper policy; reliance on process measures
Data	Routine data that is of high quality, timely and available, are often lacking
Globalization (and decentralization)	Policy-making involves more stakeholders at multiple levels, hampering governmental action

are recognized; many will remain unaddressed. The issues might be brought to attention by:

1. Key events (such as crises or critical incidents) and/or
2. Publication of 'evidence' (such as research studies or inquiries) and/or
3. Feedback from current policies (via the media or public opinion).

The growing volume of research evidence has highlighted SDH but many 'policy-makers may even be unaware of the magnitude and trends of existing inequities in health among their people' (Dahlgren and Whitehead 2006, p.16). This underlines the fact that researchers are but one stakeholder and evidence is just one source of information in policy processes (Trostle *et al.* 1999). The lack of consensus about evidence among the research community may hamper their influence in defining the 'problem'. The role of key events and feedback (e.g. funding crises or negative public opinion) should not be overlooked in accounting for the policy experience of specific countries. Also, stakeholders or interest groups (e.g. medical profession or community groups) might play a prominent role in highlighting specific issues and bringing them to the attention of policy-makers (often via the media). The publication of a key research report [such as the UK Acheson Inquiry (1998) on health inequalities or the World Health Organization Commission on SDH] may be such a prompt (Exworthy *et al.* 2003).

#### **Policy stream**

The multiple strategies and policies may be advanced not just by civil servants or professionals but also by interest groups. Some may be 'kite-flying exercises' (testing support for particular strategies) or concrete proposals. However, for any strategy to be enacted, it must meet a minimum threshold of:

1. Technical feasibility,
2. Congruence with dominant (socio-political) values, and
3. Anticipation of future constraints of the strategy being proposed.

Many SDH policy proposals may fail to reach these thresholds and so fail to offer coherent solutions. For example, policies may not be technically feasible. Though desirable, policies may not be (proven) effective. Moreover, addressing SDH or health inequalities may run counter to dominant values and shifting political values would also threaten further this criterion. The paucity of evidence about cost-effectiveness of policy solutions (e.g. Wanless 2002) illustrates this aspect as it might militate against the relatively newly dominant paradigm of proving impacts in this way (Davies *et al.* 2000). Future constraints may include, for example, the (unintended) consequences of tackling a particular condition (e.g. obesity).

#### **Politics stream**

This refers to the lobbying, negotiation, coalition building and compromise of local, national and international interest groups and power bases. In terms of SDH, such political debates can be vociferous, as they often challenge the power of existing social, economic and political systems or practices. For example, in the UK during the 1980s and early 1990s, (right-wing)

governments rejected the notion of health inequalities (Berridge and Blume 2002); this effectively stifled any policy development towards SDH.

#### **Coupling the streams**

These three streams may be coupled by chance factors, political (e.g. elections) or organizational cycles (e.g. staff turnover), or by the actions of a policy entrepreneur. The 'policy entrepreneur' (such as a government minister, leading doctor, civil servant or academic) facilitates the coupling process by investing their own personal resources (namely, reputation, status, time):

'Policy entrepreneurs are people willing to invest their resources in return for future policies they favour' (Kingdon 1995, p. 204).

De-coupling may also occur if/when conditions in each stream are not met. For example, the policy entrepreneur may move position. Equally, there may be a change of government or other issues assume greater importance. The 'policy window' will, therefore, close. The ability of policy-makers to 'fix the window open' (by integrating SDH policy into 'mainstream' policy processes) will largely determine the long-term viability of the policy.

Coupling the streams is not guaranteed; failure may be more likely (Wolman 1981). Failure to join these streams can result in disillusionment and claims that policies are purely symbolic (Edelman 1971). For example, the inability to couple 'streams' (in terms of SDH) may be indicative of wider constraints:

'Many declarations to tackle inequities... appear to be merely rhetorical, as they have not been followed by any comprehensive policies and actions to address the problem' (Dahlgren and Whitehead 2006, p.16).

Other policy models adopt a similar 'streams' approach, involving the conjunction of separate dimensions. Webb and Wistow (1986) and Challis *et al.* (1988) argue that three streams (policy, process and resource) need to be conjoined to complete the policy process.

1. The *policy stream* is concerned with policy aims and objectives;
2. The *process stream* is concerned with policy means (the instruments or mechanisms to achieve the policy ends);
3. The *resource stream* is concerned with the human, financial and material resources needed to facilitate the process stream.

A 'successful' policy will comprise clear objectives, mechanisms that achieve those objectives and the resources to facilitate the process (Powell and Exworthy 2001). However, aspects of technical and political feasibility make the process stream highly problematic for SDH policy. Moreover, SDH must compete for resources (including staff time and finances) among other priorities.

Another related model by Richmond and Kotelchuck (1991) concerns the development of 'health policy priorities' by

integrating the evidence base, social strategies and political will which equates with a 'public mandate for policy action' (Nutbeam 1998, p.31). Similarly, Nutbeam (2004) claims that policy implementation is most likely when there is a synthesis of plausible evidence, political vision and practical strategies (see also Petticrew *et al.* 2006).

### 'Networks' models

The policy process rarely operates in isolation but rather through networks of stakeholders, each with their own interests and motivation. These networks involve interactions between communities of stakeholders (inside and beyond the policy process):

'Although decision-making bodies have some room for manoeuvre, they usually depend on each other, and thus form close relationships within a policy sector' (John 2000, p.83).

Kickert *et al.* (1997) argue that policy-making takes place in 'networks consisting of various actors (individuals, coalitions, bureaux, organizations), none of which possesses the power to determine the strategies of other actors' (p.9).

Whilst networks might develop high degrees of trust and dependence, they can equally exclude others from the policy process. Close network relations can also foster learning and development as they are grounded in practical experience. As such, networks can foster bottom-up policy developments. These broad principles are illustrated by two main 'network' models: (1) policy and issue networks, and (2) the advocacy coalition framework (Hudson and Lowe 2004).

#### (1) Policy and issue networks

The distinction between policy networks and issue networks revolves around the degree to which stakeholders are involved directly in the policy process. Four features characterize networks:

- Membership (number and type of members),
- Integration (frequency, continuity and consensus),
- Resources (their distribution), and
- Power (balance between members) (Marsh and Rhodes 1992).

Policy networks comprise civil servants, politicians and co-opted members (for example, academic experts). These networks

involve stable relationships among a limited group of stakeholders with shared responsibility and high degree of integration. By contrast, issue networks are oriented around specific 'issues' and tend to comprise loose, open connections amongst a shifting group of stakeholders. Hecló (1978) proposed that issues are not defined by members' interests but rather the issues themselves become their interests (Nutley *et al.* 2007, p.108).

Applied broadly to SDH, issue networks (relating, say, to public health or community groups), which seek to raise attention to the 'problem', promoting solutions and lobbying policy-makers, have become commonplace. An 'SDH policy network', by contrast, has traditionally been absent or poorly developed, as it implies cross-departmental working (which has typically not been the *modus operandi* of governments). There are signs that such networks are becoming more established as (some) governments begin to take action on SDH (e.g. Judge *et al.* 2005; Stahl *et al.* 2006), partly due to the influence of issue networks and supra-national institutions (e.g. World Health Organization and European Union). A schematic summary indicates that 'SDH policy networks' tend to be small, weak and poorly integrated (though the assessment is dynamic and peculiar to each country) (Table 2).

Across any government, there are potentially several policy networks relating to SDH. These networks will inevitably involve trade-offs, say, between public health and health-care, between ministries, between SDH policies and routine service delivery, and between equity and other principles (such as efficiency). In short, there are (greater or lesser) signs of an uneasy integration of issue networks into policy networks, as SDH become established as a legitimate sphere of government competence in many countries. However, as this happens, new patterns within policy networks are emerging, although the SDH discourse has yet to fully permeate all corners of any government (Exworthy *et al.* 2003).

#### (2) Advocacy Coalition Framework (ACF)

Sabatier (1991) (among others) has argued that the policy process involves the formation and maintenance of complex coalitions (networks) of interest as well as the top-down prescription (for example, in terms of achieving 'perfect implementation') (Hudson and Lowe 2004, p.212).

Sabatier's ACF model views the policy process as a series of networks which are composed of all the organizations and

**Table 2** Assessment of policy networks and issue networks in relation to social determinants of health (SDH)

Network characteristic	Assessment criteria in relation to SDH	Policy networks	Issue networks
Membership	1) Number of participants 2) Types of interest	1) Low 2) Focused	1) High 2) Highly varied
Integration	1) Frequency 2) Continuity 3) Consensus	1) Low but growing 2) Low 3) Weak especially regarding interventions	1) High 2) High/medium 3) Weak
Resources	Distribution	Mainly hierarchical	Loose affiliation
Power	Balance of power	Strong. Balance of power tilted towards government ministries and towards health-care	Weak but varied.

Source: Adapted from Marsh and Rhodes (1992).

stakeholders (inside and beyond the policy process) with a particular interest in that policy sphere.

‘Whatever the motivation for action, it is essential to find potential allies and partners sharing common or converging values and objectives, or to find acceptable trade-offs when conflicting interests are unavoidable’ (Ritsatakis *et al.* 2006, p.146).

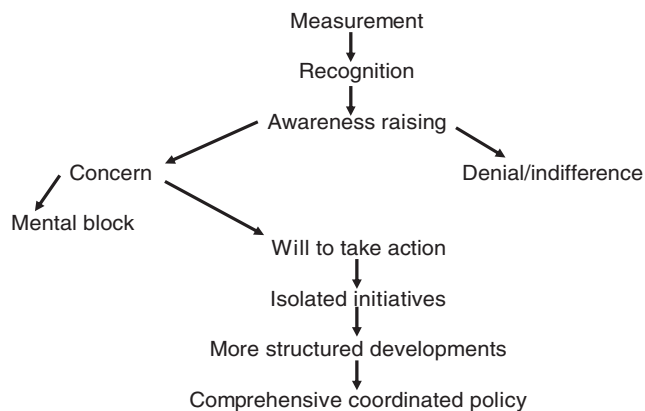
These networks comprise a ‘coalition of advocates’ and are termed ‘sub-systems’. They are defined by a set of core values and beliefs which are resistant to changing ideas and new policies. Although sub-systems are constantly involved in examining and learning about their policy environment, change is only likely to occur when a significant amount of those values are challenged successfully.

It has become apparent that, over the last decade or so, coalitions of advocates have been forming in many countries around a set of core beliefs (relating to SDH) which are challenging existing dominant values. Such beliefs have been heavily shaped by the challenge of the SDH research paradigm, as in the case of the UK’s Acheson report (1998). According to Sabatier, the impact of such shifts in core beliefs upon policy might only be apparent after a decade or more. Thus, for SDH policy programmes which have only recently been established, it is too early to judge their success. New coalitions may not always be effective as resistance to new paradigms and approaches might be expected from (coalitions of) interests within and beyond the policy process.

**‘Stages’ models**

Some commentators have sought to clarify and explain the complexity of the policy process by developing models which identify a linear progression through stages of policy development. They offer a heuristic value in understanding the evolution of policy and may help identify, for example, potential points at which policy may falter through the use of (negative) feedback loops (such as implementation failure, leading to a re-formulation of the ‘problem’).

The most commonly applied example of ‘stages’ in relation to SDH is by Dahlgren and Whitehead (2006) who identify seven stages towards action (Figure 2).



**Figure 2** Action spectrum on health. Source: Dahlgren and Whitehead (2006, p.95).

Ritsatakis and Jarvisalo (2006) offer a variation of the Dahlgren and Whitehead ‘stages’ model:

1. Reaching policy-makers and the public (raising awareness);
2. Securing the information (such as international databases, presentation and discussion, parliament);
3. Policy formulation and implementation (inter-sectoral committees, leadership, consensus conferences, formal consultations in drafting legislation, public referenda, informal contacts);
4. Seeking partnerships and alliances; and
5. Provisions for implementation.

No single policy model offers a fully comprehensive description or understanding of the policy process as each answers somewhat different questions. The selection and appropriate application of these models to health policy analysis is crucial in understanding and explaining the ways in which SDH are addressed in specific national contexts.

**Conducting research on the SDH policy process**

Understanding better the policy process is a crucial step in applying it to the SDH context. However, it is also important to understand how such processes affect the conduct of research about the policy process. Five considerations are noteworthy (Table 3).

First, the long-term nature of policy development (arising from the life-course perspective and engrained nature of SDH in society) presents a challenge for research which is often funded on a short-term basis in the hope of seeking quick answers and remedial solutions. Tracing policy developments over the long-term involves different methodologies too. For example, as outcomes may not be observable for some time, intermediate measures of progress are often sought.

Second, tracing causes and effects of policies presents attribution difficulties. Tracking the pathways from epidemiological data to policy responses and their impact is complicated by the ‘open systems’ within which SDH operate. Counter-veiling forces (such as the economic climate or globalization) might

**Table 3** Researching the social determinants of health (SDH) policy process

Features of SDH policy-making	Impact upon researching the policy process
Long-term perspective	<ul style="list-style-type: none"> <li>• Long-term research</li> <li>• Search for process measures</li> </ul>
Attribution	<ul style="list-style-type: none"> <li>• Programmes of research, examining range of issues</li> <li>• Development of monitoring techniques</li> </ul>
Non-decisions	<ul style="list-style-type: none"> <li>• Participant-observation</li> <li>• Policy ethnography</li> </ul>
Multiple agencies and stakeholders	<ul style="list-style-type: none"> <li>• Research into cultural, organizational and political practices</li> </ul>
Multiple policy programmes	<ul style="list-style-type: none"> <li>• Programmes of research, examining range of issues</li> <li>• Long-term research</li> </ul>

undermine or counteract policy effects in unintended or unobservable ways. Methodological responses to such dilemmas might include research projects examining discrete interventions but this loses the inter-connectedness of SDH (Milward *et al.* 2003). Research programmes (with several projects) might mitigate this, but doing so on an international scale is often prohibitive.

Third, the opaqueness of policy-making (and especially non-decisions) is problematic for researchers. Gaining access to organizations is a perennial issue for researchers but it is perhaps even more difficult to observe policy-making processes in action. Moreover, the ways in which decisions ‘emerge’ (rather than taking place at a single moment and often unobservable to the researcher) are particularly problematic. Participant-observation is a strategy that is seemingly easy to adopt but difficult in practice. There is perhaps understandably a reliance on semi-structured interviews and documentary analysis.

Policy ethnography is a developing methodology which involves long-term immersion in a policy domain (Flynn *et al.* 1996; Exworthy *et al.* 2002). Nonetheless, it is difficult to construct an authentic account of the policy-making process that captures its nuances and complexity over the long-term. Becoming too closely associated with policies can create a bias as researchers can become apologists for the policy that they are investigating. Decisions and non-decisions taken elsewhere may thus become less apparent. Case studies and witness seminars (involving stimulated recall of the key actors; Berridge and Blume 2002) can also be useful techniques.

Fourth, capturing the views of multiple stakeholders and tracing the influence of each organization’s practices and culture upon the policy process are complex tasks and time-consuming. Studies of inter-organizational relationships have a long lineage and researchers should draw on this extant knowledge (Ferlie and McGivern 2003). However, the scale of the task in terms of SDH should not be under-estimated given the multiple agencies that could (potentially) be involved in SDH policy (Nutbeam 1998).

Fifth, by its very nature, tackling SDH implies a multi-faceted approach. Whilst much public policy tends to focus on single strategies for particular population groups in specific circumstances, there is a need to examine the inter-connectedness of components of SDH. The breadth of such research is daunting and therefore requires large-scale, longitudinal research programmes (including policy research). This observation implies a multi-disciplinary approach which is often antithetical to the organization of universities, their criteria for appointments and tenure, and the publication of research. Large-scale research programmes may offer insights into the ways in which international institutions are shaping the cross-national causes of SDH; whether political action will be forthcoming to address SDH globally is arguable.

## Conclusion

Partly as a result of methodological difficulties, there is often a search for conceptual development and theoretical elaboration in health policy research. The policy process has been described as an exercise in ‘collective puzzlement’ (Hecló and

Wildavsky 1974, p.305). In puzzling about possible policy options available to policy-makers, there is an implicit imperative for making choices and for understanding the ways in which policy-makers learn from themselves (e.g. Freeman 2006; Marmor *et al.* forthcoming). Conceptual models are useful techniques in such learning.

This paper has sought to raise awareness of the ways in which policy towards SDH may be better described, understood and explained. By identifying the components of the policy process and the ways in which features of SDH require the adaptation of traditional approaches, it is possible to apply conceptual models which offer new insights about SDH policy-making. Researchers must therefore adapt and apply existing methodologies to the specific nuances of SDH policy. Together, conceptual models and appropriate methodologies may contribute to improved policy-making which may, in turn, ameliorate conditions for many of the poorest across the world.

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