IJHPM
International Journal of Health Policy and Management

Commentary

The paradox of health policy: revealing the true colours of this 'chameleon concept'

Comment on "The politics and analytics of health policy"

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Abstract
Health policy has been termed a 'chameleon concept', referring to its ability to take on different forms of disciplinarity as well as different roles and functions. This paper extends Paton's analysis by exploring the paradox of health policy as a field of academic inquiry—sitting across many of the boundaries of social science but also marginalised by them. It situates contemporary approaches within disciplinary traditions, explaining its inter- and multi-disciplinary character. It also presents a 'way of seeing' health policy in terms of three axes: central/local, profession/management, and health/healthcare. The paper concludes with a call for a new research agenda which recognises health policy's pedigree but also one which carves a distinctive future of relevance and rigour.
Keywords: Health Policy, Context, Power, Implementation
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Citation: Exworthy M. The paradox of health policy: revealing the true colours of this 'chameleon concept'; Comment on "The politics and analytics of health policy". *Int J Health Policy Manag* 2014; 3: 41–43. doi: 10.15171/ijhpm.2014.49

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Health policy has been described a 'chameleon concept' (1), denoting its ability to straddle numerous disciplines in social science (and, as argued below, beyond). Yet, there is a danger that its ability to change colour masks the nature and character of the scholarly activity conducted in its name. This paper examines the paradox of health policy as a central, organising field but equally, one which can be seen as vacuous. There have been relatively few attempts to clarify the scope of this field and to forge a (new) direction for future research. Following Paton (2,3), this paper seeks to move the debate forward. In large part, the paper concurs with Paton's analysis (3) but offer contrasting perspectives in the scope, application and direction of health policy.

Whilst the paper draws ostensibly on the experience of the discipline in the UK, it is arguably applicable to other Western states. Indeed, this comparative aspect of health policy has, in recent years, become more significant, a point developed below.

Health policy—all things to all people?

As Paton (3) noted, the academic hybridity of health policy has long been recognised. For example, it is now 40 years since Klein (1974) referred to its 'intellectual pluralism'. It is not simply a sub-discipline of (what has become) social policy. Its social science parentage is varied, drawing on social policy but also political science, sociology, organisation studies, anthropology, socio-legal studies, economics, geography and psychology. However, it has also been 'adopted' by others beyond social science, mainly in the bio-medical sciences (including health services research); it is unlikely that such adoption is a sign of flattery but rather a tactical, rhetorical device (to signal the impact of research, for example).

Given such hybridity, what might be the tenets of health policy? For sure, health policy is largely rooted in the policy literature (3). Hunter's (2003) observes that "policy is not a rational, objective, neutral activity devoid of values" (4). This perspective gives rise to four defining features (5). First, agents (individuals, institutions and network) will have conflicting values and objectives. Second, their ability to enact these values or achieve their objectives may be compromised by their power (or lack of it). Third, policy is characterised by 'collective puzzlement' (6) in which decision-making is plagued by uncertainty. Fourth, the notion of the policy process directs attention to dynamic and temporal aspects; policy is both a process and a product (7).

Defining 'health' (in health policy) can be equally vague. Invariably, health policy focuses on healthcare (service delivery, organisations etc). However, it also "goes beyond health services" (7) to encompass actions which have an impact on the health of individuals and/or populations. Moving beyond definitions, health policy represents the interplay of configurations of ideas (ideology), interests and institutions. Such configurations shift over time and space. Hence, the role of agency, power and context becomes vitally important to the conduct of health policy research. With its heritage in social science, health policy is marked by a blend of theoretical and empirical approaches, often tending towards the latter in recent years. Equally, the comparative dimension has been more evident as interest in policy learning and policy transfer has risen over this period.

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Health policy in action

While there may be broad agreement about the origins and definitions of health policy, its position and purpose are more contestable. First, a distinction that needs to be re-iterated is between research for policy and research of policy. The ascendency of the former in the past two decades has eclipsed the latter, implying a danger of less critical analysis.

The contractualisation of health policy research has inevitably shaped the context and content of the research undertaken. Whilst funding streams such as the UK's National Institute of Health Research's Service Delivery and Organisation programme (later re-named as Health Services and Delivery Research) have been beneficial to many researchers (given its funding streams), it has also created the sense in which research questions are shaped to meet the needs only of practitioners or policy-makers. Critical and more theoretical perspectives may thus be overlooked. (For example, critical research on central government policy is often absent). Such research programmes have, in turn, further accelerated the rise of 'health services research' as a distinct identity.

The emergence of evidence-based practice and evidence-based policy has not always adopted critical perspectives of health policy, often seeking to ensure a smoother transition of evidence (usually narrowly defined) into practice; notable exceptions are Davies *et al.* (8) and Harrison (9). More recently, 'implementation science' has become a contemporary doctrine which draws on the heritage of policy studies specifically, the implementation literature (10) but usually unknowingly. These trends point towards a positivistic approach in which technical solutions are sought to essentially political questions.

Axes of health policy

One way in which the diversity of health policy research may be captured and exploited is by viewing intersecting axes. These heuristic devices are not mutually exclusive but represent key fault-lines which shape and are shaped by each other. Here, I present three such axes (central-local; profession-management; health-healthcare) as illustrations but others could equally apply (collaboration-competition; public-private; state-profession) (11). They can help counter some recent developments, identified above.

Central-local

The majority of health systems are funded by public spending and so governments play crucial roles in funding, managing and operating health facilities. This central-local relationship inevitably shapes the pattern and character of the health system. For example, the English NHS introduced semi-autonomous Foundation Trusts ten years ago but, despite the expectations of entrepreneurial behaviour, many FTs did not use their autonomy because of the uncertain policy climate and an inurement of centralisation (12). One could easily extend this axis to 'international'. Learning about and from other health systems is now unavoidable and the need for critical comment ever more pressing (13).

Profession-management

The predominance of clinical professional occupations is a hallmark of health policy. Clinical autonomy, as a form of street level bureaucracy, invariably clashes with forms of managerialism, linked in nuanced ways to central policy. Managerialism (and marketization) has not asserted itself in place of professionalism; rather, new forms of professional power continue to emerge which ensure forms of privilege are maintained (or even enhanced).

Health-healthcare

The conflation of health and healthcare has been a common feature of, for example the NHS in the UK and other health systems. Some have termed it a 'sickness' rather than a 'health' service given its focus on hospital-based medicine, often at the expense of primary care and/or prevention. Not only does this conflation point to a power imbalance between models of health but also to the interests within hospitals. Long-called for shifts of care toward the community or prevention have largely remained unheeded.

An emergent research agenda?

Paton's analysis is both apt and timely (3). While we both offer perspectives on the 'discipline' and its applications, it is also worth presenting a research agenda to take forward the preceding discussion. This agenda might include the following:

- A focus on intersecting axes,
- Interplay between and configurations of ideas, interests and institutions,
- Critical challenges to dominant discourses and paradigms, and
- Blending empirical and theoretical perspectives.

Health policy will, by its very chameleonic character, need to assert (and defend) its role in social science (and beyond). It need not be reticent in doing so, since it has the ability to forge inter-disciplinary links and offer critical perspectives. However, it needs to continue to express a critical voice which both recognises the dominant paradigms in practice but also plays it full role in shaping them. Such is the paradox of health policy but also its fascination.

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