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Abstract

"What's the problem of "health inequality" represented to be?": A post-structuralist analysis of English public health policy 1980-2011

Natasha Marie Kriznik

The analysis of policies designed to address health inequalities, or more broadly speaking "differences in health", tends to focus on evaluating policies in order to determine their effectiveness and to improve the design of future interventions. Such approaches are concerned with problem-solving as opposed to problem-questioning. Consequently there is little exploration of how the problem of "differences in health" is problematised in these policies, how policy problematisations change over time, and how governable subjects are produced as a result of problematisations of problems.

Bacchi's (1999, 2009) "What's the problem represented to be?" framework, informed by Foucault's theory of governmentality and methods of problematisation, archaeology and genealogy, was used to analyse 32 English public health policy documents in order to address these questions. Following the analysis, three problematisations of "differences in health" and their corresponding governable subjects were identified: the Informational problematisation and the "responsible chooser"; the Constraints problematisation and the "constrained chooser"; and the Paternalistic Libertarian problematisation and the "flawed chooser".

The archaeological analysis made it possible to identify underlying frameworks of thought which shaped policy problematisations of "differences in health" at specific points in time. The genealogical analysis suggested that while new problematisations emerged over time as the result of contingent conditions allowing for the development of new ideas, ultimately there was a consistent concern across all the period with understanding how individuals make choices about their health and how best to ensure people made healthy choices in order to reduce "differences in health". This is clearly demonstrated through the identification of subjects as "choosers" and helps to explain the continuing emphasis within public health on creating the "right conditions" to allow individuals to make healthy choices, and to encourage individuals to govern themselves when making choices about their health.

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Chapter 1
Introduction

1.1 Introduction

This thesis examines how the problem of "differences in health" has been discussed in English public health policy between 1980 and 2011 from a critical sociological perspective. The research has been informed by social theory, more specifically Foucaultian post-structuralist theory, which has shaped the way that policy is viewed and how it can (or should) be analysed. Social policy is seen as a product of social practices rather than as simply reporting "facts" about problematic issues. Discussions of social problems in policy documents are the result of judgements and choices that are made about how to present the problem in a particular way, which means policy documents contain interpretations, or representations, of social problems rather than unbiased descriptions (Bacchi, 1999: 1). Consequently this leads to the need for a critical analysis of the problem representations within policy documents in order to understand how problems are represented in policy discussions as well as how (and why) these representations change over time.

To paraphrase Bacchi (1999: 68) somewhat, the purpose of this research is to draw attention to the different interpretations of "differences in health" in English public health policy. This does not mean that this research denies the existence of "differences in health" (or health inequality) or questions the reality of the problem. It is not saying that the problem does not exist. Instead the research is interested in examining the ways in which "differences in health" has been discussed in public health policy: how different interpretations have been formulated; what assumptions underpin different interpretations; and how changes in these interpretations over time have been made possible.

The overall aim of this research, therefore, is to investigate how the problem of "differences in health" has been represented in English public health policy between 1980 and 2011. Using Bacchi's (1999, 2009) "What's the problem represented to be?" framework, which is underpinned by Foucault's social theory, the study will focus on identifying and examining the assumptions which underpin policy representations of "differences in health" as well as looking at how these assumptions have changed over time. This will allow for the identification of problematisations, or specific ways of understanding and representing, the problem of "differences in health". From these problematisations it is then possible to

identify the governable subject (Rose, 1999) which emerges as a result of a particular way of understanding the problem of "differences in health". The transitions between problematisations and governable subjects will also be explored in order to demonstrate that the changes in understandings of the problem are contingent upon particular conditions being present rather than being viewed as the result of a clear linear progression in ideas.

1.2 Researching health inequality as a social problem

Since the publication of the Black Report (DHSS, 1980) the issue of observable differences in health of the British population has been present in political discussions concerning health, and indeed the problem of health inequalities remains a contested political issue today. Health inequalities have been described as a paradox for modern welfare states and as "one of the great disappointments of public health" (Mackenbach, 2012: 761) as despite overall improvements in living standards and the advancement of welfare states we continue to see poor health within developed nations. There has been, and still continues to be, an enormous amount of research conducted into the existence and persistence of health inequalities in the UK, and globally, most of which focuses on the conditions, behaviours and social arrangements which have both positive and negative effects on people's health and what can be done to ensure that the positives outweigh the negatives.

Several famous studies and reports have been conducted in the UK which have shaped the research and political agenda on health inequalities. The Black Report (DHSS, 1980) is perhaps the most famous as even though it did not have much impact on political discussions of health inequality at the time it was published it sparked wider research into the problem amongst academics and those within public health (Hunter, Marks and Smith, 2010). Marmot's Whitehall studies (Marmot et al., 1978; Marmot et al., 1991) investigated the social determinants of health of British Civil Servants from the 1960s to the 1980s. The findings demonstrated the existence of a social gradient in morbidity and mortality which related to job positions within the Civil Service. Those who worked in lower grade positions were more likely to become ill and die sooner than those in higher positions. Governments have responded to this body of research by developing policies aimed at reducing the

existence of health inequalities ("differences in health"), although their success in reducing health inequalities is perhaps questionable.

A number of typologies have been produced in the literature which outline the different policy responses to the problem of health inequality (Carlisle, 2001; Exworthy, Blane and Marmot, 2003; Graham, 2004; Whitehead, 2007). While these are useful in demonstrating the types of interventions or the broad understandings of the problem of health inequality, they are often focused on a specific point in time. This means that they lack historical context and, as a result, seem to take the dominant understanding of "differences in health" as health inequality for granted.

What is currently missing from this literature is an analysis of the way in which the problem of health inequalities, or more broadly speaking "differences in health", is represented in English public health policy. As Bambra, Fox and Scott-Samuel (2005) argue the analysis of health policies tends to focus on comparing the pros and cons of different interventions to solve health problems, and do not examine the way in which the problem being discussed is itself understood as problematic in the first place. It seems to be taken-for-granted that policies which are aimed at tackling health inequalities are all talking about the same thing and manage to conceptualise the problem in the same way. As a result, little attention is paid to how understandings of "differences in health" have been presented in public health policy, including the solutions put forward to address the problem, and how these understandings have changed over time, taking into account the need to consider how policy understandings of social problems are part of wider frameworks of thought and how these frameworks of thought are related to forms of government. It is necessary to consider an alternative approach which is underpinned by the understanding that policies only ever contain *representations* of problems rather than objective descriptions (Bacchi, 2009). These representations should be as much a part of the analysis of health policies as the comparison of different solutions to "differences in health". Although Osborne (1997) is initially critical of the contribution that a Foucaultian approach to the analysis of health policy can provide to researchers, he concedes that "[r]ather than seeing the history of health policy in the form of a single continuum, it might be preferable to focus on diverse technologies of health; that is, all the diverse means, projects and devices through which the impossible dream of a healthy population has been made an object of realisation" (Osborne, 1997: 181). It is clearly necessary and useful to consider the contingencies which have allowed for particular understandings of "differences in health" to become dominant at different points in time.

The research will also consider the effects of these representations, particularly the effects of how different groups of people are thought about and the expected forms of behaviour which are presented in health policy documents.

Over the last 80 years or so there have been a number of different perspectives within the study of social problems which have discussed the nature of a social problem and how it should be researched. Traditional understandings of social problems centred on the assumption that problems existed "out there" in society and could be identified by social scientists and policy makers through applying particular forms of statistical measurement and analysis (Hart, 1923: Fischer, 2003: Shaw, 2010). The aim of the study of social problems was essentially to locate undesirable conditions and implement solutions to resolve problems and to encourage the development of desirable conditions (Hart, 1923). This perspective assumed, therefore, that there was a great deal of consensus as to what constituted a social problem and what should be done to resolve identified problems. This view was challenged in the 1930s by social problems theorists who argued that this way of understanding social problems missed out a crucial element in understanding how conditions were considered to be undesirable in the first place. For a condition to be considered as a social problem it was argued that there had to be a value judgment made about the condition in order for it to be viewed as problematic – there is nothing inherent in a set of conditions which makes them problematic (Fuller, 1938; Fuller and Myers, 1941a; Waller, 1936). It was therefore important to study, and teach students to recognise (Fuller, 1938), the role that values played in the creation of social problems. This was particularly important when there were conflicting ideas present about the nature of a problem and what should be done to resolve it. Although there is a sizable gap in the literature from the 1940s, the importance of examining values was picked up on by theorists in the 1970s onwards who developed interpretive approaches to the analysis of social problems. Aided by the emergence and development of the theoretical perspective of social constructionism, these theorists were concerned with researching and understanding the ways in which social problems are constructed. Blumer (1971) highlighted the importance of understanding the process of collective decision-making while Spector and Kitsuse (2001) argued that social problems were the result of claims-making processes rather than the presence of particular conditions. The construction of social problems has been taken further by those in favour of a post-structuralist approach to the analysis of social problems and social policy. These approaches are more interested in exploring the meanings present in existing discussions of

social problems, and how the representations of problems can be used in order to facilitate particular forms of government (Bacchi, 1999; Bacchi, 2009; Bacchi, 2015).

It is clear to see from these theoretical developments that there has been a shift towards questioning problems rather than purely focusing on solving problems (Bacchi, 1999; Bacchi, 2015; Turnbull, 2006). This emphasis on problem-questioning provides new ways of researching social problems and social policy, and new ways of understanding the development of policy discussions of social problems over time.

It is also important to consider the status of the policy document and its role in processes of governing. It is impossible to conceive of government without the presence of documents (Freeman and Maybin, 2011). Policy documents do not simply contain information but should be considered as a key part of governing processes. They express knowledge and ideas about issues and instigate changes in behaviours and the organisation of wider social arrangements (Brown and Duguid, 1996). Policy documents are a key part of communicating these ideas and changes to others (Freeman and Maybin, 2011) and therefore allow political rationalities to be successfully implemented (Rose and Miller, 1992). Policy documents should therefore be studied as a "thing" in their own right (Prior, 2003) as they are clearly more than just information containers.

This research is about applying a new perspective to the analysis of public health policy, and specifically the problem of health inequality, or "differences in health" as it will be referred to here (see section 1.4 for an explanation of the use of this term). It aims to explore the ways in which "differences in health" has been understood in English public health policy, to interrogate the discussions about the problem in order to better understand the assumptions and knowledge which underpins policy discussions of "differences in health" and to examine how these assumptions can, and do, change over time. The research will also examine the role that policies discussing "differences in health" play in the governing of the population, highlighting the emphasis placed on the need for individuals to be aware of their behaviours and to actively self-govern themselves in order to improve their health.

1.3 Research contribution: the result of problematising "differences in health"

The main contribution of this thesis is the outcome of applying Bacchi's (1999, 2009) WPR framework to the problem of "differences in health". Three problematisations of "differences in health" were identified in English public health policy as a result of using the framework, along with a corresponding governable subject. The aim of this contribution is to present a new understanding of the development of policy understandings of "differences in health" from 1980 to 2011 in English public health policy. Table 1 provides a very brief description of the problematisations and governable subjects.

The Informational problematisation focused, unsurprisingly, on the role of information in improving health. The problem of "differences in health" was understood as a problem of information provision. For the government a lack of information was seen to be holding back the development of appropriate interventions to address health problems amongst the population (DHSS, 1988). For the individual a lack of appropriate information meant that people were making poor choices about their health, leading to incidences of "avoidable illnesses". The government therefore needed to ensure that everyone had access to information about behaviours and activities which were harmful to their health. As "responsible choosers" individuals were expected to act on new information provided to them and to change their behaviour accordingly, to make better choices about their health. Clearly there is a concern here with how individuals make choices about their health and this is something which carries through the subsequent problematisations.

The Constraints problematisation shifted the focus towards the conditions in which people make choices about their health. This problematisation emphasised the need to consider wider influences on health which were acting to limit or constrain the choices that people could make about their health. Individuals were therefore conceptualised as "constrained choosers" who made choices within a set of restrictive conditions, and were sometimes unable to make healthy choices because of these constraints. The solutions in this problematisation centred on the need to remove constraints to choices about health. This would be achieved by government interventions to address conditions beyond the direct control of the individual and also ensuring that people had opportunities to help themselves and to improve their health. Individuals were expected to act on the opportunities provided to them in a similar way to how individuals were expected to act on new information in the Informational problematisation.

Table 1 Summary of problematisations and their governable subjects

Problematisation	Brief overview	Governable subject
Informational	Differences in health exist because people lack the right information to make choices to improve their health. More and better information about health must be provided to the public to help them make informed decisions.	The "responsible chooser" who uses information to make better choices about their health.
Constraints	Differences in health exist because certain groups face constraints beyond their control when making decisions which affect their health. Government action needs to be taken in areas which are not under the individual's control and to provide opportunities for people to improve their health.	The "constrained chooser" who makes choices about their health within restrictive circumstances.
Paternalistic Libertarian	Differences in health exist because of differences in lifestyle choices. Government must only intervene when necessary and action should focus on changing the wider context so that healthy choices become the default option.	The "flawed chooser" who requires guidance and nudging towards the right (healthy) choices.

Finally, the Paternalistic Libertarian problematisation retained the focus on the conditions in which people make choices about their health but emphasised the ways in which conditions and contexts can be used to actively shape the choices people make about their health. This was accompanied by a change in understanding about how individuals make choices in the first place. Instead of assuming that people act on information and opportunities which were given to them with their best interests at heart, the Paternalistic Libertarian problematisation understood individuals as "flawed choosers". Actions and behaviours were seen to be contingent upon existing habits, routines and past experiences,

as well as the context in which choices were presented and marketed to individuals. The problem was seen to be the result of people adopting different lifestyles and solutions therefore centred on the need to "nudge" people towards preferred behaviours in order to encourage individuals to adopt a healthy lifestyle, which would ensure that healthy choices would become the norm.

From this brief overview of the problematisations and their governable subjects it becomes obvious that while each problematisation has a distinct way of understanding the problem of "differences in health", there is a consistent underlying concern with needed to understand how individuals make choices about their health and to develop solutions which fit with expectations of individual behaviour. Consequently it is argued here that the problem of "differences in health" is represented as "differences in choice" in English public health policy. This argument will be developed in the findings chapters (Chapters 5, 6 and 7) as well as in the Discussion (Chapter 8) and Conclusion (Chapter 9).

1.4 A note on the use of "differences in health"

Throughout this thesis the problem under investigation will be referred to as "differences in health". This is because over the last 30 years the problem of "differences in health" has been referred to in several different ways within public health policy discussions. Each of these labels is associated with a particular understanding of the problem, how it came about, and what should be done in order to resolve the problem. Despite the fact that the term *health inequality* is used for current research into the problem and in most contemporary social policy documents and debates, the problem will not be referred to as such here because the term *health inequality* actually represents a particular understanding of the problem of "differences in health". It is also important to note that the problem of "differences in health" has not always been labelled as health inequality in public health policy. As will be shown in the findings and discussion chapters, the problem has been labelled as *variations in health* and *systematic variations in health* in the past. All three of these labels encompass very different sets of assumptions about what the problem is, who or what is to blame for the existence of the problem and how it should be addressed. The common link between these labels, however, is the concern with observable differences in health between different groups of the population. Hence the term "differences in health"

will be used to show that this is the overarching issue that is discussed within the policy documents selected for this study.

1.5 Thesis outline

This chapter has briefly outlined the context and rationale for this research. It has demonstrated that while there is a great deal of research into the problem of health inequalities and the types of interventions that should be implemented little emphasis has been placed on how the problem is actually defined within public health policy. By using Bacchi's (1999, 2009) WPR framework to investigate the representation of "differences in health" in English public health policy this research aims to present a new way of understanding the development of policy understandings of "differences in health". Two main contributions will be made from this research, the first being a theoretical contribution in terms of an examination of the usefulness of a Foucaultian post-structuralist approach to policy analysis and the second will be the findings from applying such an approach to the analysis of 31 years of English public health policy.

Chapter 2 will provide an overview of the relevant literature and highlight the gap in knowledge which this research aims to address. It will highlight criticisms of existing typologies of health inequality policy and use this as the basis for exploring why health is often viewed as apolitical (Bambra, Fox and Scott-Samuel, 2005). The chapter will also discuss theoretical developments in the study of social problems more broadly before ending with the research questions which have shaped this research.

Chapter 3 will discuss the Methodology of the research. It will begin with a justification for the use of Bacchi's (1999, 2009) WPR framework, comparing it to Kingdon's (1995) policy windows model and also a broader Foucaultian post-structuralist approach such as the one adopted by Lupton (Lupton, 1995; Petersen and Lupton, 1996). The chapter will then provide an in-depth theoretical exploration of the WPR framework in relation to Foucault's theory and methods, highlighting the concerns with governmentality studies which are raised by each question of the framework. The chapter will then move on to outline the practicalities of the study, namely the sampling method used to identify suitable

documents for analysis and the use of Computer Aided Qualitative Data Analysis Software (CAQDAS) in order to facilitate the analysis.

Chapter 4 is intended as a short overview chapter which will introduce the analysis findings and resulting discussion. It will provide a summary of the key findings and an indication of the conclusions which have been drawn from the analysis.

Chapters 5, 6 and 7 will present the findings of the research in the form of a chapter for each problematisation that was identified in the analysis. These chapters will focus on presenting the archaeological element of the findings, exploring the understandings of "differences in health" at different points and highlighting the key assumptions of each problematisation and concluding with a brief overview of the governable subject associated with each problematisation.

Chapter 8 will present a discussion of the key findings by expanding on each of the governable subjects identified in the previous three chapters. It will explore the transitions between the governable subjects (the genealogical aspect of the analysis) and argue that while each subject is related to a different representation of the problem of "differences in health" they are all clearly concerned with presenting expectations of the ways in which individuals make choices about their health.

Chapter 9 will provide a conclusion to the thesis. It will recap the main findings of the research and provide a clear justification for the use of Foucaultian post-structuralist approaches to health policy analysis. The chapter will also offer some reflection on the research process as well as considering future directions for research.

Chapter 2
Literature Review

2.1 Introduction

As stated in the Introduction chapter the point of this research is to draw attention to the different interpretations of "differences in health" in English public health policy from 1980 to 2011. It is interested in exploring the ways in which "differences in health" has been conceptualised and understood as a social problem requiring attention from social policy, how policy discussions about "differences in health" are underpinned by particular assumptions concerning what the problem actually is, and investigating how changes to policy understandings of "differences in health" have occurred over time.

This research draws on influences and concerns from a number of different fields, including medical sociology, social policy, and the study of social problems. As a result of the interdisciplinary nature of this research it is important to make the theoretical perspective of this research very clear. As Cockerham (2007: 25) states "[t]heory allows us to see how sociologists conceptualise social reality and establish modes or analysis accounting for the dynamics of that reality and its outcomes". This chapter will provide the theoretical, as well as empirical, context for this research in order to demonstrate the value of Foucaultian post-structuralist approaches in the analysis of public health policy. Existing analyses of health policy, and the problem of "differences in health", tend to focus on exploring the content of policies and comparing the advantages and disadvantages of solutions to "differences in health". The chapter will argue that post-structuralist approaches to policy analysis provide a useful way of examining social problems as they are discussed in policies, such as "differences in health", because such approaches recognise the fact that problems are *represented* rather than simply reported in policy documents. It is the way in which the problem of "differences in health" is represented which is of interest for this research.

The chapter will begin with a brief discussion of the field of British medical sociology, highlighting how the theoretical perspective of social constructionism has come to dominate the study of health and illness and also that there has been a shift from collective to individual approaches and explanations for health inequalities within the field. As the research is focused more on public health policy analysis than on research into health inequalities per se, this section will conclude by noting that the context for this research goes

beyond just medical sociology. The chapter will then outline similar developments within the sociology of social problems, specifically the influence of social constructionism on contemporary perspectives. The discussion will turn to the political nature of health and consider why health policy analysis has tended to focus on the pros and cons of particular solutions to the problem of "differences in health" rather than examining underlying assumptions which shape policy discussions of the problem in the first place. The importance of politics will then be discussed in relation to the Black Report (DHSS, 1980) and the Achson Inquiry (Acheson, 1980) in a short reflection on the reaction to both of these reports when they were published. This will then lead into a discussion of existing different typologies of health inequality policies before providing a three point critique of these typologies as they tend to be ahistorical, lack a critical engagement with the nature of social policy, and also take the problem of health inequality for granted. This critique forms the basis of the gap in the literature which this research will address. The chapter will then discuss examples of research which problematise health inequality policies and emphasise the importance of analysing the language used within policy discussions to highlight underlying assumptions about the problem. This will then lead into a brief outline of Foucaultian post-structuralist approaches to policy analysis and an introduction to Bacchi's (1999, 2009) WPR framework, which will be discussed in more detail in Chapter 3. Finally the main research questions which have driven this research will be presented and justified given the literature context.

2.2 British medical sociology

It was not until the late 1960s and early 1970s that medical sociology started to be taught in higher education institutions in Britain, which roughly paralleled the emergence of teaching its parent discipline of sociology (Annandale and Field, 2005). Medicine largely drove the need for medical sociological research at this time, leading to a focus on areas which medicine defined as important to study – including improving patient care, contributing to health policy, and addressing health inequalities (Cockerham, 2007). Annandale and Field suggest that British medical sociology has "an enduring core built around analyses of the experience of illness, health inequalities…and the provision of health care" (Annandale and Field, 2005: 249). Here the interest is in briefly exploring the theoretical underpinnings of British medical sociology and the effects this has had on

research and policies to do with addressing health inequalities as this is the area of concern for the thesis.

2.2.1 The dominance of social constructionism

The dominant theoretical perspective underpinning contemporary British medical sociology is that of social constructionism (Cockerham, 2007). In relation to health and illness it "refers to the view that scientific knowledge and biological discourses about the body, health and illness are produced through subjective, historically determined human interests, and are subject to change and reinterpretation" (Gabe, Bury and Elston, 2004: 130). Essentially this means that ideas are not discovered but are instead socially produced, and so attention needs to be paid to the ways in which ideas and knowledge become accepted.

One text which has contributed to the rise of social constructionism within British medical sociology is Berger and Luckmann's *Social Construction of Reality* (1967). Their work argues that "reality is socially constructed and that the sociology of knowledge must analyse the process in which this occurs" (Berger and Luckmann, 1967: 13). The aim of a sociology of knowledge would be to "deal not only with the empirical variety of 'knowledge' in human societies, but also with the processes by which *any* body of 'knowledge' comes to be socially established *as* 'reality'" (Berger and Luckmann, 1967: 15, emphasis in original). In other words, the sociological study of knowledge should be concerned not only with the different types of knowledge which are present at any given time, but perhaps even more so with the processes and conditions which allow particular forms of knowledge to become dominant and establish a particular reality. Working in a similar vein we find Foucault's (2003) *The Birth of the Clinic* which explored the archaeology of medical knowledge and its definition of the body as an object of study and as subject to medical intervention and control (Cockerham, 2007). In this work Foucault presented histories of how certain forms of knowledge produced expertise which was then adopted by the medical profession, as well as other institutions, in order to shape behaviour.

It is important to note here that there is no "one" social constructionism, and that studies employing social constructionism do so in varying ways. As Cockerham (2007: 46) notes "[t]he more social constructionist work is influenced by Berger and Luckmann, the more agency-oriented it is; the closer to Foucault, the less agency has a role". Here Cockerham points out that the former types of work place greater emphasis on the role of

individual agency in shaping knowledge and behaviour, while the latter is more focused on the role of wider structures. This does not mean that Foucault's work is structuralist, however. He is widely recognised as a post-structuralist (even though he rejected the label) and argues that knowledge (and power) are not simply constraining but can be seen as productive and enabling individuals (Foucault, 1991a). Indeed Foucault's theory provides the theoretical basis for this research and is discussed in more detail in this chapter (see section 2.8) and in the following Methodology chapter (Chapter 3).

Social constructionism has contributed to a shift in the way (medical) knowledge about the body and illness is viewed by medical sociologists. Rather than simply accepting medical perspectives as *the* way of viewing the body, health and illness, social constructionism has opened up new analytical routes for medical sociologists (and sociologists working in other areas as well) which requires a consideration of *why* medicine has become the dominant discourse on health and illness, what other alternative forms of knowledge might exist and challenge medicine's dominance, and even how medicine itself has changed throughout history. This questioning is not just limited to the study of medicine, however; it can be used to examine the experiences of illness and even to look at how health problems become issues for social policy.

2.2.2 From collectivism to individualism

As well as the rise of social constructionism, Annandale and Field (2005) argue that there has been a shift from collectivism towards individualism in contemporary medical sociology. They state that "a new sociological sensitivity has drawn attention away from a hitherto 'disembodied' conceptualisation of the rational individual bound by collectives such as social class, 'race' and ethnicity toward a self-reflexive individual making an array of life-style choices" (Annandale and Field, 2005: 247). This can be seen in the move away from biomedical models towards areas which are more concerned with individual risks, such as advances in genetics and risks to health in everyday life (Cockerham, 2007). What this means is that there is less focus on the "traditional" sociological structures of class, gender and ethnicity which have been seen in the past to shape individual behaviour. These are seen to be less relevant in influencing individual actions and, as a result, sociologists have begun to question their approaches to research within the field of medical sociology.

This seems to particularly be the case within the field of health inequalities research and policy. Annandale and Field (2005) and Cockerham (2007) both point out that research into health inequalities is one of the key themes within British medical sociology. There has been a stronger emphasis more recently in public health policy on the role of the individual in maintaining and improving their own health, which is in contrast to earlier recommendations for more collective responses to the problem. It is these policy explanations of the problem and justifications for particular responses to health inequality ("differences in health") in public health policy which are of interest to this research, how they have been formulated and how they have changed over time.

Historically there has always been an interest with the distribution of health across social groups (i.e. social classes) in Britain. For example, Chadwick's *Report on the Sanitary Conditions of the Labouring Population* in 1842 documented the health of the working population in London after a number of cholera outbreaks. In his report he argued that the health of the poor was directly related to their living conditions, and made clear recommendations for improving sanitation in order to reduce the risk of further outbreaks. These recommendations included introducing a mains water supply and removing shallow drinking wells, installing bathrooms inside houses, and improving drainage to allow sewage to be removed more easily and to avoid contamination with drinking water. Unfortunately due to the cost of his proposed reforms it was some years before Chadwick's recommendations were implemented.

The last 30 or 40 years has seen a proliferation of research into health inequalities. One of the most famous reports into health inequalities is the Black Report (DHSS, 1980). This report was commissioned under a Labour government in 1977 "to review information about differences in health status between the social classes; to consider possible causes and the implications for policy; and to suggest further research" (DHSS, 1980; Foreword). In the first chapter the scope of the report was clearly established:

> *There may be differences between species, races, the sexes and people of different age but the focus of interest is not so much natural physiological constitution or process as outcomes which have been socially or economically determined. (DHSS, 1980: par. 1.7)*

While it was acknowledged that there were certain inevitable (biological) factors which would impact on a person's health, the focus of the report was to be on societally driven factors. It argued that the causes of health inequalities were not natural but rather were man-made. The issue of health inequalities was therefore framed as a social rather than an

individual one which would demand action from government and social policy in order to reduce health inequalities. The report recognised that individual responsibility for health was a determining factor, but argued that greater effects on health were made by conditions which were beyond the control of the individual.

This report was not only famous for the findings it presented but also the reception it received by the Conservative government which was in power when the report was published. The day of the press release was a Bank Holiday and only around 250 copies of the report were produced, which strongly suggested that the government did not agree with its recommendations for improving health. Despite this negative response from the government the report seemed to spark more research within the academic community who were determined to keep the issue in the spotlight (Hunter, Marks and Smith, 2010).

Building on the work of the Black Report sociological research into health inequalities has retained a strong focus on the need to examine, and address, the social determinants of health. The WHO defines social determinants of health as "the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life" (WHO, 2015). While it is recognised that individual lifestyle factors also have an impact on health, most research into health inequalities is concerned with exploring the impact of factors which are beyond the direct control of the individual. Research in this area moved away from simply analysing single risk factors for health and instead concentrated on highlighting structural factors affecting health (Wilkinson, 1996).

Despite the fact that there is a longstanding concern in Britain with the social patterning of health, and the body of research evidence which suggests that health inequalities are caused by wider societal factors beyond the control of the individual, there is a growing "stress upon the individual as the orchestrator of his or her own health" (Annandale and Field, 2005: 254). Annandale and Field (2005) argue that the "new individualism" can be seen within wider public health policy, in particular in the field of health inequalities. It is possible to find discussions across the last 30 years or so in public health policies of the need for people to change their lifestyles and behaviours and so interventions which encourage such changes tend to be more strongly promoted (Secretary of State for Health, 1992; Secretary of State for Health, 1999; Secretary of State for Health, 2004; Secretary of State for Health, 2010).

Consequently researchers in this field have begun to question the theoretical underpinnings of health inequalities research. They argue that there has been little attempt to consider the effects of late (or even post) modernity on "traditional" social divisions, such as class, ethnicity and gender, and instead researchers have stuck with conventional approaches. This means that they tend to ignore potentially useful new methodological and theoretical approaches which would help to explain the distribution of health across the population (Annandale and Field, 2005; Bartley, Blane and Smith, 1998). It could also be that this emphasis on individualism has been partly driven by the policy responses to health inequality and their focus on changing individual behaviour.

2.2.3 Exploring (and questioning) health inequality policy

The purpose of this first section has been to contextualise this research as partially falling within the field of medical sociology. This can be seen from the continued focus within British medical sociology on the problem of health inequality and its role in informing policies to address health inequality. It has also highlighted the dominance of social constructionist perspectives within contemporary medical sociology. It will be demonstrated throughout the rest of this literature review that social constructionism has been a key theoretical approach which has underpinned this research, along with Foucaultian post-structuralist theory.

It seems then that medical sociology in Britain has always had a concern with the problem of health inequalities and the need to inform health policy in order to address the problem (Annandale and Field, 2005). The main emphasis seems to be on collecting evidence to demonstrate the existence of health inequalities and to provide justification for the interventions suggested as appropriate policy responses. This thesis research, however, is not so much concerned with the way in which research into health inequalities is carried out, but rather with the way in which the problem is conceptualised and understood in social policy, specifically English public health policy. Therefore while the initial motivation for this research stems from an existing interest in medical sociology, there has been a need to turn to literature from other fields which focuses on the analysis of health policy more broadly and of policies addressing health inequality ("differences in health") more specifically.

2.3 The study of social problems and social policy

Although this research initially drew inspiration from within the field of medical sociology, it became clear that work reflecting theoretical developments in the study of social problems was also highly relevant. The literature reviewed here spans most of the 20th century and demonstrates a move away from simply focusing on identifying social problems through measurement to recognising the processes through which conditions go through in order to be recognised as a social problem. The study of social problems, like medical sociology, has therefore embraced social constructionist perspectives and so there tends to be greater emphasis placed on how social problems are constructed rather than the actual conditions of the problem.

This section will first briefly outline the "traditional" approach to the analysis of social policy and social problems which focuses on the identification of problematic conditions through statistical measurements and the assumption that such findings constituted a consensus as to what the problem was and how it should be addressed. The discussion will then move onto a critique of such approaches through discussing the emergence of the "Value-Conflict" perspective in the 1940s and the influence of social constructionist approaches in the 1970s. These later perspectives argue that the study of social problems should not simply focus on the conditions of problems, but rather how certain conditions come to be defined and recognised as problems in the first place, thereby rejecting the idea that there is always a consensus as to what conditions are problematic and should be addressed by social policy.

2.3.1 "Traditional" approaches

Early studies of social problems were concerned with the actual conditions of social problems. Hart argued that "the objective of the study of social problems may be stated as the discovery of how to minimize undesirable social conditions and how to maximize desirable conditions" (Hart, 1923: 351). There are two key assumptions to be noted from this definition and perspective on the study of social problems. The first is that there is an understanding that social conditions are objectively identifiable by researchers through the application of appropriate forms of measurement. A great deal of emphasis was placed on the use of statistical methods in order to accurately measure and document the existence of a social problem (Hart, 1923; Fischer, 2003; Shaw, 2010). The use of such methods reflected

the need at the time for the social sciences to emulate the natural sciences in order to be seen to be producing authoritative and reliable data. Research was expected to provide generalisable findings that could be applied to a wide range of problems and contexts, emphasising the objective nature of the study of social problems and their transference into policies (Fischer, 2003).

The second assumption effectively followed from the first. Given the use of statistical methods, which were seen to be reliable and generalizable, it was assumed that there would be a consensus as to what the problem was and how it would be addressed. This drive for rationality in the study of social problems and social policy has led to a clear separation of "facts" and "values". It is assumed that values are not required for the identification of a social problem or for the development of a solution – these are easily identifiable through statistical measurement and rational decision-making processes. The research conducted into social problems is expected to "proceed independently of normative context or implications" (Fischer, 1998: 130). Social scientists should be value-neutral in their search for evidence of problems and base their conclusions only on empirically driven findings. This has meant that technocratic forms of policy analysis have dominated the field with an emphasis on the need for high levels of efficiency and effectiveness in achieving politically determined goals. As Shaw states, there has been "a conceptual separation of policy from politics, with 'policy' indicating a rational, administrative and bureaucratic process and 'politics' the means by which government and social life is organized" (Shaw, 2010: 197-198). The value judgements of politics have been transformed into technically driven ends which are easily to measure and evaluate through the use of quantitative methods (Fischer, 2003). Policies are therefore seen to be able to provide neutral descriptions of social problems based on empirical evidence and the solutions put forward can be traced back through a linear process which emphasises the rational nature of the decision-making process.

2.3.2 The development of interpretivist approaches

The emergence of interpretive approaches for the study and analysis of social problems and social policy can be traced back to the social problems literature in the 1930s and 1940s where concerns were raised about the lack of a theoretical framework underpinning the study of social problems. In addition to this it was felt that the existing assumptions about the nature of social problems had failed to adequately explain dramatic social changes in the 1930s such as the Great Depression (Fuller, 1937; Rubington and

Weinberg, 2003). The focus on conditions as highlighted in the discussion above in more "traditional" approaches led Waller to argue that sociologists had "failed to clearly define their object of study" and had also "failed to achieve a scientifically defensible treatment of social problems" (Waller, 1936: 922). Social problem theorists were unsatisfied with the study of social problems in its present form and argued that a new theoretically informed perspective was required.

A number of authors at this time took issue with the removal of values from the study of social problems. Waller argues that the exclusion of values up until this point "unwittingly [ruled] out the essential criterion by which social problems may be identified" (Waller, 1936: 922-923) while Fuller's comments are more passionate and critical of both research into and teaching of social problems,

> *We have been so zealous in our crusade to remove bias and value-judgements from the mind of the teacher that we have also removed value-judgements from the thing we are studying. This is a fundamental error. We have stupidly ignored the very thing which not only gives rise to the social problem in the first place but which also impedes its solution, and that is the conflict between two or more sets of social values.* (Fuller, 1938: 418-419).

This quotation highlights more concerns than just a lack of application of a theoretical framework to the study of social problems. It also raises questions about the assumption of earlier approaches to the analysis of social problems that there is always a consensus as to the existence of a social problem and what should be done to solve it. In the quotation above Fuller highlights that more than one viewpoint about a problem can exist and these values can come into conflict with one another. Here he presents a challenge to the idea that measurement alone is enough to determine the problem and its solution by arguing that it is in fact social values which play a key role in the identification and understanding of a situation to be a social problem. Indeed Fuller and Myers go on to suggest that the incompleteness of the understanding of what the basis of a social problem is has lead sociologists to deal "with social problems as "givens", rather than as phenomena to be demonstrated" (Fuller and Myers, 1941a: 25).

The inclusion of values in the study of social problems gave rise to the "Value-Conflict" perspective within this field. This perspective did not argue that social problems were the result of values alone. It argued that values were needed in order to make sense of and understand a set of conditions as constituting a social problem. Social problems, therefore, are seen "as a deviation from some social norm which they [(social scientists, policy makers,

politicians)] cherish. Every social problem thus consists of an objective condition and subjective definition…The objective condition is necessary but not in itself sufficient to constitute a social problem" (Fuller and Myers, 1941b: 320). It is not enough for certain conditions to exist to be considered as a problem, they must be interpreted as such through a set of normative concerns and values: "there can be no social problem without a value judgement" (Waller, 1936: 922). There may well even be a conflict of values as to whether a condition should be considered as a social problem, and indeed Value-Conflict theorists considered the existence of conflicting ideas about social problems as one of the main reasons why social problems can go unresolved for long periods of time (Jamrozik and Nocella, 1998).

Although there was a great deal of discussion and debate about the study of social problems from the 1920s to the 1940s there is then a gap in the literature until the 1970s when interpretive approaches come to the fore again. There is no explanation given for the lack of discussion about the nature of social problems, however it may well be due to the rapid expansion of welfare states following World War II where the primary concern would have been to rebuild war-torn nations and to rapidly improve living and working conditions.

From the 1970s, however, the debate over how social scientists should study social problems resumed. Building on the previous Value-Conflict perspective and its concern with the need to consider how values shape the way conditions are understood as problematic, interpretive approaches began to focus more on the social processes which led to conditions being defined as social problems. This idea that social problems are the result of a social process of definition making, which involves decision-making, was first put forward by Blumer in his paper "Social Problems as Collective Behaviour" where he argues that "[s]ocial problems are not the result of an intrinsic malfunctioning of a society but are the result of a process of definition in which a given condition is picked out and identified as a social problem" (Blumer, 1971: 301). Here Blumer challenges the objectivist assumption that social problems are simply "discovered" in society as he states that "the recognition by a society of its social problems is a highly selective process, with many harmful social conditions and arrangements not even making a bid for attention and with others falling by the wayside in what is frequently a fierce competitive struggle" (Blumer, 191: 302). Not all harmful conditions are seen by governments and policy-makers as social problems, which suggests that there is something else going on in the determination of a condition as a social problem aside from their objective reality which is observable through statistical measurements.

Claims must therefore be made as to the nature of the problem, in particular how a set of conditions specifically violates a set of social norms such that action is required in order to restore order. In short social problems are "the activities of those who assert the existence of conditions and define them as problems" (Spector and Kitsuse, 2001: 74). It is these claims-making and decision-making activities which are the focus of the social definition perspective. Spector and Kitsuse make it quite clear that they are not interested in whether or not the alleged condition actually exists as they argue that

> *[t]he central problem for a theory of social problems is to account for the emergence, nature, and maintenance of claims-making and responding activities…We are interested in constructing a theory of claims-making activities, not a theory of conditions. Thus, the significance of objective conditions for us is the* assertions *made about them*, not the validity of *those assertions as judged from some independent standpoint, as for example, that of a scientist.* (*Spector and Kitsuse, 2001: 76, emphasis in original).*

This is not to say that sociologists studying social problems simply do not care about real problematic conditions in society, but rather that the focus of sociological analysis of social problems should lie within the consideration of claims made about the existence of problems rather than with whether or not the alleged condition actually exists. This shifts the focus of the analysis of social problems towards the examination of the social processes which lead to a set of conditions becoming defined as a social problem, rather than taking it as given that certain conditions simply "are" social problems. It is important, and necessary, to consider the types of claims being made about social problems, in particular examining the role that values and normative concerns play in the decision-making processes.

The main aim of interpretive approaches to the study of social problems and social policy has been to develop "a theory *of* social problems distinct from sociological theory used *in* research of undesirable conditions" (Schneider, 1985: 210, emphasis in original). It has attempted to fill a gap first highlighted by the Value-Conflict theorists that the study of social problems lacked any sort of link with sociological theory. The need to examine the values linked with provided researchers with a way of understanding the nature of all social problems, linking them together with theoretical understandings rather than seeing social problems as separate entities which are only studied together under the token heading of "social problems". Researchers need to understand that social problems are socially constructed and negotiated through the collection and interpretation of data about conditions in society based on existing normative concerns and values that are held by

researchers, policy makers and politicians. It is the exploration of this interpretation which is important for interpretivist perspectives – how decisions are made about conditions being social problems and how language puts forward particular ways of understanding conditions as problems. By rejecting the idea that social policy is objective in nature, interpretive and constructionist approaches also reject the notion that social policy deals with problems that are "discovered". Instead, "[p]olitics and public policy are understood to take shape through socially interpreted understandings, and their meanings and the discourses that circulate are not of the actors' own choosing or making" (Fischer, 2003: 13).

In terms of studying public health policy and the problem of "differences in health", it seems there is a contribution to be made from using perspectives underpinned by social constructionist theory. The emphasis in such analysis would be on identifying the values which underpin policy discussions of "differences in health" in order to better understand how "differences in health" is conceptualised as a problem within public health policy rather than simply accepting it as "fact". Despite the fact that this is an interesting way to examine public health policy it seems as though these kinds of approaches are currently underused in the analysis of public health policy.

2.4 The politics of health

Health is clearly a political issue and yet "the politics of health has been underdeveloped and marginalised" (Bambra, Fox and Scott-Samuel, 2005: 188). Hunter (2003) notes that policy making is most definitely a political process, however there has been "a tendency in this fiercely managerial and technocratic age to reduce problems to technical ones and, in effect, to de-politicise them" (Hunter, 2003: 23). The desire to produce conceptions of problems which rely only on the analysis of statistical or calculable data means that there is little to no consideration of the political perspectives which are present in discussions of problems in social policy. This means that problems such as health inequality are often examined only in terms of the different solutions put forward, with the main aims of the analysis focused on identifying the most effective and efficient solution to the problem.

As a result of this focus "the bulk of policy analysis in public health research…is largely concerned with measuring and evaluating policy impacts and outcomes and pays little attention to the policy-making process" (Bernier and Clavier, 2011: 110). Bambra, Fox and

Scott-Samuel (2005) are concerned with this lack of consideration of the political nature of health. They recognise that health is seen as a political issue in a number of ways: some social groups have more health than others highlighting an unequal distribution of a resource; the social determinants of health are amenable to political intervention; and health is considered to be a human right that needs protecting. Oliver (2006) also adds that governments are expected to take care of their citizens beyond the basics needed for survival, and to also recognise that the threat of "AIDs or bioterrorism [for example] are not only public health problems but also, when they reach a certain scale, may become national security issues and thus a potential source of political instability" (Oliver, 2006: 197). Failing to address health problems, then, can have the potential to lead to a breakdown of social order, in particular causing disruptions in the workforce which is seen as central to the smooth running of contemporary societies.

In an exploration of why health, and health policy analysis, has become apolitical Bambra, Fox and Scott-Samuel (2005) put forward a number of potential explanations. Firstly, they argue that health is often conflated with the related, but different, concept of health care. This is particularly the case in the UK with the presence of the NHS, which means that "consequently the politics of health becomes significantly misconstructed as the politics of health care" (Bambra, Fox and Scott-Samuel, 2005: 189). This has arguably led to an "NHS illusion" where the central assumption is that improving levels of and access to health care services will lead to an automatic improvement in levels of health in the population.

Their second explanation centres on the way politics itself is conceptualised. They argue that the dominant perspective of politics, viewed as the activities of the state, heavily influences what aspects of health are seen as political. Once again the example of health care is used. In countries where the state has a significant role to play in the provision of health services and funding health care naturally becomes a central issue for political discussion, which leads to the exclusion of other health issues that come to be seen as non-political, such as inequalities in health. There is a challenge here to rethink how we conceptualise politics in order to politicise issues which are otherwise viewed as outside of the remit of politics and government.

Thirdly, Bambra, Fox and Scott-Samuel (2005) highlight the fact that health has not been studied as a political issue within the political sciences aside from some notable exceptions. Navarro (cf. Navarro and Shi, 2001; Navarro et al., 2006), for example, has shown that political ideologies not only influence the type of interventions put forward to address

health problems but that they can drastically affect the levels of inequalities in societies. Through international comparisons of ruling political ideologies (social democratic, Christian democratic (Conservative), Liberal and Authoritarian) and statistical data on health outcomes (life expectancy and infant mortality) Navarro et al. (2006) demonstrated that countries with redistributionist policies were more often associated with better health outcomes (i.e. increased life expectancy and lower levels of infant mortality). This work highlighted the mechanisms by which politics determines public policy, emphasising the need for public health researchers to consider the "interactions between politics, policy and health outcomes" (Navarro et al., 2006: 1037). Once again, however, the focus of much political science research is on health care and this is partly due to the dominant definition of what politics is, as mentioned above. Political science is concerned with "the processes, conditions and institutions of mainstream politics and government" which means that "[t]he politics of health care is therefore the politics of institutions, systems, funding and elite interactions" (Bambra, Fox and Scott-Samuel, 2005: 191). Health therefore becomes apolitical and is seen as the concern of other disciplines, not for political science.

Fourthly, there is a brief mention of the role of the medical profession in de-politicising health. The transfer of power over health from individuals and the community to the powerful medical elite (which includes doctors as well as international pharmaceutical companies) has contributed to the apolitical nature of health. These professions have a high degree of control over defining and managing health which has meant that individuals often fail to acknowledge the power they have over their own health.

Finally, Bambra, Fox and Scott-Samuel turn to a concern with the ways in which health policy analysis is conducted. They argue that "[h]ealth policy…is usually synonymous with policy content" (Bambra, Fox and Scott-Samuel, 2005: 191) by which they mean that analyses of health policy tend to focus on a discussion and evaluation of the different solutions put forward in relation to different political parties. The reduction of health policy analysis (or arguably any field of policy analysis for that matter) to an examination of the "content" of policies in order to compare the pros and cons of various interventions "diverts attention from, and renders invisible the political nature of the policy process" (Bambra, Fox and Scott-Samuel, 2005: 191). They point out that part of this political nature is a need to consider how political factors shape the way policies are presented. In other words "there is an important need for awareness of how the political context limits how health policy is

formulated" (Bambra, Fox and Scott-Samuel, 2005: 192), including what issues are present and absent in policy discussions and documents.

This final point is picked up on by Vallgårda (2006) in a short paper "When are health inequalities a political problem?". She argues that "[p]olicy making needs evidence, but evidence cannot replace political judgements" (Vallgårda, 2006: 616). Such judgements in relation to health inequalities included the need to decide what illnesses should be considered to be avoidable or unnecessary and a consideration of what situations should be viewed as unjust or unfair (i.e. those situations where the individual is not seen to be to blame for their ill health). She concludes that questions concerning what situations are considered unfair and unjust cannot be solved by more research alone as "the answer will always also depend on the political and philosophical standpoint of the observer" (Vallgårda, 2006: 616).

It seems then that most health policy analysis is still focused on the content of policies rather than considering the processes through which the policies were formed in the first place, including the identification of political values which shape policies. The following section will explore some discussions on the Black Report and Acheson Inquiry which do touch on these areas, in particular highlighting the importance of the political process involved in creating policy. Then the chapter will turn to examine typologies of health inequality policy in the literature which, to varying degrees, touch on the underlying assumptions of such policies in order to understand the different types of responses put forward to address health inequalities.

2.5 Reflections on the Black Report and Acheson Inquiry under New Labour

Following on from this discussion of the politics of health, this section will examine some of the analyses of the Black Report (DHSS, 1980) and Acheson Inquiry (Acheson, 1998) which took place while New Labour were in power, as well as concerns about the use of targets in policy. The historical importance of the Black Report will be noted, as well as reflections on the process of the report's creation and publication. The reception of the Acheson Inquiry will be presented as a comparison, along with an outline of its influence and

critiques. Using the shared criticism of both reports that they did not offer specific policy interventions which could be implemented the discussion will turn to arguments raised about the need for targets in health inequalities policy, and the need for caution when developing targets and measuring progress towards them. Finally this section will touch on the role of typologies in offering potential directions for policy makers to follow, before leading into the next section which will examine selected typologies further.

Around the time New Labour came into power in 1997, there was a strong interest in the Black Report (DHSS, 1980) and its impact after publication, particularly on research rather than on social policy. It is well known that the Black Report did not influence public health policy in the 1980s as "Thatcher did not care too much about health inequalities…[and] her Government barely acknowledged their existence" (Oliver, 2010: 403). Despite this, the Black Report was recognised as a key publication in a long tradition of British public health research that was concerned with health inequalities (Macintrye, 1997; Oliver, 2010). Indeed Macintyre (1997) provides a detailed historical discussion concerning the developments leading to the Black Report, highlighting in particular the changing perspectives on causes of health inequalities which helped to shape the tone of the report itself. Blane (2005) comments that he was initially unimpressed with the report when it was published, but he "learned quickly that the *Black Report* had started a public debate about health inequalities" (Blane, 2005: 17). While the report did not have much of an impact on public health policy at the time of publication, it led to the development of a number of empirical themes in public health research. These included: international comparisons of health data; a growing interest in increasing social class inequalities; highlighting the importance of considering gradients in health; the emergence of discussions of the impact of psychosocial factors on health; and the need for more evaluations of interventions designed to address health inequalities (Macintyre, 1997).

Macintyre (2002) is keen to point out, however, that there is a danger of creating a caricatured history of the Black Report both before and after its publication. She argues that the Black Report did not discover health inequalities as is sometimes implied by international discussions of the report in particular. From her analysis in this article and her previous work (Macintyre, 1997), she concludes that the Black Report "was not the first to show that inequalities in mortality between occupational class groups were not declining" (Macintyre, 2002: 203). She was also keen to emphasise that there was not a taboo on research into health inequalities after the report's publication and somewhat frosty reception by the

Conservative government. There seems to be the suggestion that because the findings from the report were largely rejected, this rejection "blighted research in this field" (Macintyre, 2002: 207). Arguably, however, the opposite took place. The suppression of the report actually stimulated research "behind the scenes" in public health even if it was largely unacknowledged by the government at the time.

Given that the concern with health inequalities has had such a long tradition in British public health, Oliver (2010) questioned why it had taken the authors so long to publish the Black Report leading them to miss the window of opportunity to reveal their findings to a Labour government, who would have been more receptive of the findings of the report, rather than a Conservative government. Having conducted a Wellcome Witness Seminar with members of the Report's committee (Berridge, 2003), Berridge (2002) commented that the process of creating and finalising the Black Report were not entirely smooth. For example, there were difficulties in coming to a consensus as to what recommendations to put forward in the Report, and inevitably these disagreements led to delays which in turn let to the poor political timing of the Report's publication. Civil servants in particular were "sensing the change in political wind" (Berridge, 2002: 11), and were concerned that they needed something to be getting on with rather than continuing to wait. In the Wellcome Witness Seminar Dr. Elizabeth Shore, who was Deputy Chief Medical Officer during the production of the report, stated:

> *I was very aware of the political situation. After all, we nearly had a general election the previous autumn... I was metaphorically jumping up and down on the sidelines saying 'Can we have some quick and dirty general recommendations to get going on?' The basis for the recommendations and the detail, the purity, can come later. (Berridge, 2003: 147)*

Sir Douglas Black, however, was much more interested with getting the Report right rather than bowing to political goals:

> *I think I can say in all modesty that we were concerned to produce something which would last. And it has done so, being quoted even after the demise of the administration which ignored it. (Berridge, 2003: 148)*

> *…we were more concerned with the long term than with any political deadline. (Berridge, 2003: 150)*

These discussions clearly highlighted the importance of timing in the political sphere, in particular emphasising the role that political values play in the adoption (or not) of perspectives to influence policies.

In contrast with the Black Report, the Acheson Inquiry was published in a much more favourable political climate as "the policy rhetoric leant itself towards taking the reduction of health inequalities seriously" (Oliver, 2010: 403). Interestingly, however, while the government welcomed the report it argued that "it was *already* implementing many of the Report's recommendations" (Exworthy, 2002: 17, emphasis in original). Oliver (2010) notes that it is difficult to identify the effectiveness of the Acheson Inquiry on the subsequent policy interventions developed by New Labour, despite the fact that a number of future publications make reference to the Acheson Inquiry. The report therefore clearly provided further justification for existing a future policy interventions, but also had a much wider influence as "addressing health inequalities became a central part of the government's health policy rhetoric" (Oliver, 2010: 410). One element of this was the need for joined-up government, although this seemed to "shine brighter in words than deeds, principally because government departments tend to work in silos, each with their own pressing agendas" (Oliver, 2010: 411).

Although the Acheson Inquiry was better received than its predecessor upon publication, it was not without its critics as Exworthy (2002) discusses. First, while the report highlighted that its first three recommendations were "crucial" it did not make any further prioritisation within the 74 main and subsidiary recommendations. In effect this long "wish-list" went against one of the terms of reference for the report which required "priority areas for future policy development" (Acheson, 1998). Second, no mechanisms or processes for translating the recommendations into actionable policies were mentioned in the report, which meant they were left up to the government to formulate. Third, there were concerns about the mismatch between the amount of evidence and the recommendations put forward, which added to the problems of trying to implement adequate interventions when there was little or no evidence suggesting their effectiveness. Fourth, the recommendations themselves ranged from the general to the specific. Those which were more general meant that they were more open to interpretation in terms of the development of interventions. Those which were more specific seemed to necessitate particular strategies, however the lack of discussion of mechanisms or processes in the report added to the challenge of creating more targeted interventions. Finally, it was noted that no economist sat on the committee and this led to an absence of cost-effectiveness data in the report. Coupled with the lack of prioritisation of recommendations and clear mechanisms for implementing policy, this added to the difficulties of policy makers in developing interventions from the report. These criticisms might not necessarily have been a problem overall, however, given that the

government was already committed to similar policies as noted above, and that it readily received the findings of the report. The report clearly contributed to the general policy direction of the late 1990s, adding further justification to policies which may have been implemented regardless of whether the report had been written or not (Macintyre, 1997).

Overall, then, it seems that the main concerns about both the Black Report and Acheson Inquiry centre on their lack of clear actionable recommendations which could easily be translated into effective policies. On the one hand the Black Report did not contain specific recommendations, while on the other the Acheson Inquiry had an abundance of recommendations but with no clear priorities as to which should be addressed first. In addition, both reports did not focus on the cost-effectiveness of implementing particular types of policies which added to policy makers' difficulties in translating the findings of these reports into specific interventions. It seems in terms of reporting findings to policy makers that there tends to be a trade-off between creating the "ideal" scenario, as Douglas Black himself argued for, and developing actionable policies.

In addition to these discussions about the importance of the Black Report and Acheson Inquiry, and possibly because of the lack of clear actionable recommendations from either report, there were debates concerning the importance and use of targets in public health policy. Whitehead (1998), for example, was initially critical of New Labour's green paper *Our Healthier Nation* (Secretary of State for Health, 1998). Not only was she concerned as to whether there was a real need for a new strategy, but, more importantly, she argues that "[a]s it stands, the Green Paper provides little detail of *how* the desired improvements are to be brought about and maintained" (Whitehead, 1998: 2). Perhaps again then, like the Black Report, there seems to be greater emphasis placed on presenting the "ideal" rather than pinning down exactly how changes would be brought about. Indeed she notes that "while narrowing the health gap is one of two key aims of the strategy, no specific national targets have been set for achieving this aim" (Whitehead, 1998: 2). It seems then that targets are a viewed as a key feature of policy and facilitate the development of "how" changes will be achieved.

This concern with targets in policies addressing health inequalities specifically was also raised by Bauld, Day and Judge (2008) in their comparative analysis of devolved policies in the United Kingdom. They noted that while there is "a large degree of rhetorical convergence on the topic [between England, Scotland, Wales and Northern Ireland], there are notable policy divergences on strategies for reducing health inequalities and methods of

collecting data and interpreting indicators relating to inequality" (Bauld, Day and Judge, 2008: 439). This highlights the issue that setting targets is perhaps more complex than is usually recognised.

Indeed the authors put forward four key problems "in using targets as a purposeful instrument in health inequalities policy" (Bauld, Day and Judge, 2008: 446). The first is based on conceptual dilemmas, and they cite the example of the UK's use of the infant mortality indicator. They closely examine the data for infant mortality in the UK and identify a problem with the particular use of the NS-SEC categories used by the ONS in relation to the target group for infant mortality. In particular they question whether the NS-SEC group 5 should be included given that it had a relatively good infant mortality rate, and why the NS-SEC Other category is excluded from the target group. They conclude that "the definition of the existing health inequalities target is contentious in that it does not properly reflect the underling nature of contemporary social inequalities relating to infant mortality" (Bauld, Day and Judge, 2008: 448).

The second problem relates to the biased reporting of data. They point out that targets set which only focus on improving the health of the poorest can mean that inequalities widen in terms of the relative differences between social groups, but problems also arise when there are variations in reporting and recording data by social groups. Through their secondary analysis of Scottish data which measured smoking during pregnancy by social group, the authors found that while the data initially suggested that there had been a more dramatic reduction in smoking by women in the most disadvantaged areas compared to the most advantaged, on closer inspection it seems that this "reduction" was actually driven by an increase in the proportion of pregnant women in disadvantaged areas whose smoking status was either unknown or ambiguous. The authors note that setting a target which draws attention to adverse behaviour can have unintended consequences and can, in fact, exacerbate the problem. It seems that the heightened awareness of the fact that women should not smoking during pregnancy has led some women to not report that they are, in fact, smokers, "coupled with the reluctance by some midwives to ask about smoking status or explore the issue in any depth" (Bauld, Day and Judge, 2008: 449). All this means that statistics collected on such an issue need to be treated with caution, and may compromise measuring progress towards a particular target.

The third problem relates to the implementation failure of targets. Drawing on fieldwork research conducted with NHS and local government staff, the authors point out

that the key message from the findings was that "the infant mortality target was not sufficiently known or understood" (Bauld, Day and Judge, 2008: 450). This meant that when interventions were implemented, there was little understanding of how the interventions would necessarily help to meet the target and indeed it seems there was little evidence available as to the effectiveness of such interventions. Bauld, Judge and Day do point out, however, that since then "the latest strategies for action are now more detailed and finely tuned" (Bauld, Judge, and Day, 2008: 450-41). In order for targets to be successfully achieved, it is obvious that there needs to be a clear understanding of what the target means and that there is evidence to support the implementation of successful interventions.

Finally the authors also briefly discuss the issue of statistical fallacy. Here they draw on the work of Scanlan (2006) who is sceptical of research into health inequalities because "it fails to take account of the relationships between the rates at which two groups experience (or avoid) an outcome and how these relationships are influenced by the prevalence of the outcome" (Bauld, Day and Judge, 2008: 451). Essentially he argues that this means that measuring whether or not inequalities are increasing "is at best misunderstood or at worst simply unknowable" (Bauld, Day and Judge, 2008: 451). Strategies employed by governments may therefore fail simply due to conceptual or methodological reasons rather than social welfare ones.

Despite these problems with using targets in health inequalities policy, they point out that "[t]he immediate answer cannot be to get rid of targets altogether, as is sometimes suggested" (Bauld, Day and Judge, 2008: 452). Instead they suggest that targets need to make sense for the context in which they are used, the targets and progress towards meeting them need to be closely monitored, and the results from continuing analysis should be disseminated for both public and expert scrutiny whether or not progress is being made to reach the target.

One key point from this article, besides the in-depth analysis of the use of targets in addressing health inequalities in policy, is that the authors make reference to a particular typology of health inequalities policy developed by Graham (2004) when they highlight that there are multiple paths available for policy makers to follow. Arguably typologies such as Graham's are useful in that they highlight existing approaches being used by grouping policies together under common assumptions and approaches, and put forward particular directions which policy makers can follow in order to develop interventions and related targets in order to address a problem. These might therefore act as a useful tool for policy

makers trying who are trying to establish clear mechanisms for how interventions might work. As the next section will discuss, however, there are some problems with the existing typologies in the literature.

This section has explored some of the wider discussions of health inequalities policies under New Labour. In particular this discussion has focused on the analysis of the Black Report and Acheson Inquiry, two key reports which helped to shape not only the policy agenda but also had an impact on academic research into public health from the 1980s onwards. There were clearly concerns that both reports did not provide as much information to policy makers about specific interventions or mechanisms to implement or suggest targets to work towards as perhaps they should have done. Even when targets are included in policies, however, it is important to note that they need to be approached with caution, especially if there are differences in the way targets are conceptualised and in the data used to measure progress toward targets. One way to try to understand different policy responses to health inequalities is to draw on typologies which identify specific ways of conceptualising the problem and therefore will tend towards particular solutions being adopted. These are not entirely unproblematic, however, and there are criticisms to be made of the way typologies are conceptualised.

2.6 Typologies of policy responses to health inequality

Following a systematic review of the literature four typologies of health inequality policies were found and will be explored here (Carlisle, 2001; Exworthy, Blane and Marmot, 2003; Graham, 2004; Whitehead, 2007). As each of these typologies categorises policy responses to health inequalities in slightly different ways they will be outlined and compared in this section. Graham (2004) and Exworthy, Blane and Marmot's (2003) typologies present broadly descriptive accounts of different policy responses to the problem of health inequalities. These descriptive accounts are useful insofar as they outline the different understandings of the problem and the interventions which go with them, but as will be shown in the discussion below there are limits to how informative such typologies can be. Carlisle (2001) and Whitehead's (2007) typologies go a step further in that they explore some of the underlying assumptions of different responses to health inequality, highlighting the political nature of defining the problem and identifying appropriate solutions. All four

typologies, however, suffer from focusing only on the present and thereby lack a historical analysis which is important for understanding changes in policy over time.

Firstly Graham's (2004) typology focused on examining the heath inequality policies of New Labour over a six year period from 1997 to 2003 and found that there was a "continuum" of understandings of the problem of health inequality. She noted there were three main points along this continuum. The first was those policies which discussed health inequalities in terms of the need to "remedy health disadvantages" which were typified by solutions that were targeted at the bottom of society. The second point was the need to "narrow health gaps". This view suggested that there was a "gap" between the health of the poor and the rest of society which had to be reduced, and again therefore tended to focus solutions on the most disadvantaged. The final point on the continuum was "reducing health gradients" and this perspective advocated the need for a population-wide approach to address health inequalities as it emphasised the relationship between socioeconomic position and health. While this typology demonstrated that within New Labour's health policy there seemed to be three different ways in which the problem of health inequality was conceptualised, all of which involved different types of solutions to be implemented, there was little attempt to link these understandings of health inequality to New Labour's wider political ideology. In particular there was little exploration of the assumptions of each point on the continuum in terms of examining underlying frameworks of thought which may have been related to the policy discussions, either relating to health or social inequalities or even to perspectives on how social policy should operate. As such this typology therefore remains largely descriptive of New Labour's policy on health inequality rather than exploratory.

The second typology presented by Exworthy, Blane and Marmot (2003) also seems to lack an engagement with New Labour's political values. Their typology focused on highlighting the different policy domains in which health inequalities were being addressed. These domains were: a life course approach with a focus on early years; area-based initiatives with a focus on disadvantaged areas; redistributive policies; health care; policies associated with targets and performance culture; and policies working on "joined-up government". While the development of this typology was arguably not the main aim of their work, there is little exploration of it aside from highlighting examples of strategies that were in place in order to highlight "the progress and pitfalls" of UK health inequalities policy. It is useful to see the broad range of policies that have been implemented in order to tackle

health inequalities, but it would be interesting to consider what the underlying assumptions of the problem are from these different policy domains in order to ascertain whether there is a consensus as to what health inequalities are and what the most effective solutions will be.

What their discussion does add, however, is a consideration of how health inequalities became part of the political agenda using Kingdon's (1995) "policy windows" model. They argue that while health inequality is firmly on the political agenda, it does not meet all three policy streams as identified by Kingdon: problems, policy and politics. It is widely recognised that health inequality has been identified as a problem through the accumulation of evidence and the publishing of reports, thereby meeting the problems stream criteria. It does less well with the policy and politics streams, however. There are questions as to how feasible and effective strategies to address health inequalities will be leading to issues in terms of the creation of policies, and there are doubts as to whether or not there is sufficient political commitment to support policies to tackle health inequalities. The authors argue that this suggests that "accumulation of evidence about health inequalities is a necessary, but not sufficient condition for policy change. Issues need to be seen or defined as "problems" that are amenable to policy interventions" (Exworthy, Blane and Marmot, 2003: 1916). It is perhaps interesting that despite this admission there is little consideration given to the assumptions underlying why health inequality is seen as a problem in the first place, either as a whole or through their typology.

The second two typologies presented here emphasise the need to explore further the policy understandings of health inequality by considering underlying frameworks of thought associated with particular framings of the problem. Rather than simply identifying and describing different ways of discussing the problem of health inequality, these two typologies go a step further and attempt to identify key assumptions associated with each understanding of the problem.

Carlisle (2001) argued that it was necessary to consider the role and influence of discourses in shaping understandings of health inequality as "[t]he term discourse draws attention to the importance of understanding how language is used to construct the social world in various ways" (Carlisle, 2001: 271). Social policies, therefore, do not simply reflect reality but are used to put forward a particular view of a problem. Different understandings of the same problem can be identified through analysing the language used in policy documents. The analysis of the language of social policy therefore helps to reveal the

underlying assumptions which shape or construct understandings of the problem being discussed and presented in particular policies. Carlisle notes that there has always been more than one explanation for health inequality and these explanations have always been contested when it comes to developing and implementing policy interventions to solve the problem. She identified three contemporary explanations for health inequality (poverty/deprivation, psychosocial stress, and individual deficits) before relating each to one of Levitas's (1998) three discourses (Redistributionist, Social Integrationist, and Moral Underclass respectively). By doing this Carlisle was able to demonstrate the contested nature of health inequality policy with a number of competing causal explanations and different solutions present at the same point in time. This lack of consensus according to Carlisle "provides the flexibility and ambiguity cherished by policy makers" (Carlisle, 2001: 278) as it means they are able to effectively avoid policies addressing structural issues while still looking as though they are dealing with the problem.

The contested nature of explanations for health inequality is picked up on in Whitehead's (2007) typology. She argues that the aim of her paper "is to help broaden the understanding of the range of different interventions available and their potential effectiveness for the task in hand, and to avoid the tendency to focus on one type of intervention neglecting the others" (Whitehead, 2007: 473). Her typology therefore aims to demonstrate to academics and policy-makers alike the different sorts of explanations which are used in order to frame the problem of health inequality, and to argue that all of these need to be considered when interventions are being developed. One important feature of Whitehead's typology is the focus she places on identifying and examining what she calls the "theory" underlying policy interventions as "all intervention programmes are based on theories" (Whitehead, 2007: 473). Her typology is therefore interested in highlighting "the underlying programme theory of how the action [to tackle health inequalities] is expected to bring about the desired change" (Whitehead, 2007: 474). Understanding the theory behind different actions to reduce health inequality, she argues, will help policy-makers to determine which courses of action are the most appropriate to take. She identifies four main types of action and their associated underlying theories.

The first understanding and response to health inequality is the need to strengthen individuals where there is "a perceived personal deficit in some respect" (Whitehead, 2007: 474). Whitehead notes that this category tends to "theorise the problem mainly in terms of an individual's personal characteristics, and the solution in terms of personal education and

development to make up for these deficiencies" (Whitehead, 2007: 474). The second category in her typology focuses on the need to strengthen communities where the cause is "related to greater social exclusion/isolation and powerlessness in hard-pressed communities" and the theory behind the cause is that "some of the most health damaging effects of social inequality are those that exclude people from taking part in society, denying them dignity and respect" (Whitehead, 2007: 474). The third category is focused on improving living and working conditions as "greater exposure to health-damaging environments, both at home and at work, with declining social position" (Whitehead, 2007: 474) are seen to be the causes of health inequality. The solutions are theorised in terms of public health measures which "are perceived as having the potential to benefit the health of the population in general, but especially that of the people living in the worst conditions" (Whitehead, 2007: 475). Finally, the fourth category is that of promoting healthy macro-policies. The cause of health inequality is deemed to be "the overarching macroeconomic, cultural and environmental conditions prevailing in a country, which influence the standard of living achieved by different sections of the population" (Whitehead, 2007: 475). The problem is therefore theorised as existing in wider power structures which must be addressed if health inequality is to be reduced or removed entirely. The focus is on "altering the macroeconomic or cultural environment to reduce poverty and the wider adverse effects of inequality on society" (Whitehead, 2007: 475).

Both of these two final typologies highlight the fact that there are competing explanations for health inequality, and these therefore provide different options for politicians and policy-makers to subscribe to and to put into place through social policies. These typologies also highlight that there are different "levels" of explanation, from the individual being largely responsible for their health, to needing to provide help and support at the community level, to the need for large-scale macro policies designed to address structural issues affecting people's health. While all these explanations are present at the same time, it is usual that one will dominate the policy discussions and the types of solutions that are implemented, hence Whitehead's (2007) concern that there needs to be greater awareness of alternative viewpoints and the underlying theories behind explanations in order to help determine what solutions are suitable. As Carlisle (2001) discussed, the complex nature of the problem of health inequality and the lack of consensus surrounding what should be done leaves us with a level of ambiguity that can be exploited by policy-makers. A number of different discourses can therefore be used to shape the understanding of health inequality, and perhaps could leave researchers to question whether everyone is

talking about the same thing when there are discussions of "health inequality" given that there are many ways of thinking about the problem.

In summary, the first two typologies outlined largely focused on providing descriptive accounts of health inequality policy. Exworthy, Blane and Marmot's (2003) work highlighted key policy areas which were seen to be central for addressing health inequalities while Graham's (2004) continuum highlighted the three main ways New Labour presented health inequality in their policy discussions. These two typologies are useful insofar as they highlight the fact that there are different definitions of health inequality in policy documents (Graham, 2004) and that the problem is dealt with across a number of policy areas suggesting that there is a need to address health issues beyond the narrow field of health care (Exworthy, Blane and Marmot, 2003). While Exworthy, Blane and Marmot (2003) relate their discussion to the "policy windows" model in order to examine the emergence of discussions of health inequalities on the political agenda, they did not offer much in the way of exploring the underlying assumptions concerning the actions being taken in the domains of policy they identified. Graham's continuum contains little reference to the wider political ideology and context of New Labour despite the fact that she examines six years of their health policy. The final two typologies discussed, however, saw the need to examine the underlying assumptions of different perspectives and approaches to addressing health inequalities. The discourse analysis by Carlisle (2001) helped to reveal the ways in which discourses actively shape understandings of the problem of health inequality while Whitehead (2007) went on to consider the need for alternative perspectives to be considered. Each of these typologies highlighted underlying concerns within each of the perspectives they identified which were then used to explore the causal explanations for health inequality and the proposed solutions within each perspective.

Although these typologies do provide some interesting insights into the problem of health inequality there are some criticisms of all four typologies which should be highlighted here. The first is that they all focus on the problem of "differences in health" as "health inequality". As noted in the Introduction chapter the term health inequality is used to present a particular understanding of the problem of "differences in health", hence why "differences in health" is used in this research to describe the problem under investigation. There is no consideration of other terms used to label the problem in any of the typologies. Secondly these typologies seem to only focus on examining understandings of health inequality at a specific point in time. There is little attention paid to the historical

development of explanations for and policy responses to health inequality. Although Graham's (2004) typology examines 6 years of New Labour's policies there is no attempt to contextualise or compare New Labour's framing of the problem with past approaches. Comparisons of policy understandings of "differences in health" over time would provide an interesting way of exploring how we have reached present policy understandings of "differences in health". Finally there is little, if any, consideration in these typologies about the subjectification effects (Bacchi, 1999; 2009) of policies which present understandings of "differences in health". Different understandings of the problem will encompass different assumptions about how individuals behave and respond to interventions and will therefore produce different governable subjects (Rose, 1999).

2.7 A critique of existing typologies of health inequality

The typologies discussed above are useful in that they provide information, albeit in varying amounts of detail, about the different policy approaches taken to address health inequality. There are, however, three main criticisms which can be made of these typologies and these will be examined in this section. These criticisms will be used to highlight the gap in knowledge which this thesis aims to address.

2.7.1 The importance of history

The first criticism centres on the fact that these typologies, with possibly the exception of Graham's (2004) to an extent, lack any sort of historical dimension to their analysis. Each typology seems to be focused on the present, on presenting and discussing contemporary solutions to the problem of health inequality. As a result these typologies are ahistorical and do not actively consider past policy approaches to health inequality (or "differences in health") and how things might have changed or perhaps even remained the same. Greater emphasis is placed on "the current contents of health policy…as opposed to their transformation over time" (Bernier and Clavier, 2011: 110-111). Arguably Graham's (2004) typology does contain a historical element as she studies six years of New Labour's policies on health inequalities, however this typology is still historically limited as she only explores policies under New Labour and does not consider how the problem was

conceptualised and addressed in previous governments. As a result this typology still lacks historical context.

Part of the problem seems to be that social scientists, politicians, public health practitioners, and even historians, "are only just beginning to wake up to the idea that the past 50 or so years are history too" (Berridge, 2001: 611). History is often perceived of as being far in the past and not within living memory. Yet as Berridge (2001) notes there have been significant changes within public health thinking even just over the last 50 years or so. Armstrong (1993) demonstrates this through his discussion of public health "spaces", in particular the move from a focus on personal hygiene to the New Public Health in the latter half of the 20th century. This recent history needs to be better explored in order to provide a new way of researching and understanding policy developments over time. It is important to note here, however, that providing a history of public health and its developments should not be simply reduced to providing a list of achievements. An approach to studying public health policies, and the problems contained within them, needs to not only recognise that approaches to public health problems have changed over time but to explore the points or periods in which ideas change in some depth in order to understand the conditions which provided the context for changes to happen in the first place. As Perdiguero et al. (2001: 670) point out "many health problems would be much better tackled if we could situate them – and the affected populations – in a wider time span in order to explain their current situation".

2.7.2 Questioning the policy process

The second criticism centres on a lack of engagement with critical perspectives concerning the nature of social policy. Across all four of these typologies policy seems to be largely viewed as a means to an end, and ultimately as a way of solving social problems. This can lead to the view that social policy, including public health policy, sits "outside" of society and provides neutral, unbiased responses to problems which are based on evidence. This also seems to present a very simplistic view of social policy. The identification and resolution of a social problem is seen to be "a relatively unproblematic process" (Bacchi, 1999: 18) in which "[d]ecision-makers first identify empirically the existence of a problem, then formulate the goals and objectives that would lead to an optimal solution" (Fischer, 2003: 4). Little attention is paid to "how social policy is itself implicated in the processes it claims to study" (Twigg, 2002: 423). Social policy does not simply report problems and produce solutions to

problems – it has an active role in organising society and shaping the subjects which it ultimately governs. Carlisle's (2001) typology does touch on the nature of social policy given that she argues that policies are made up of shifting discourses which allow policy makers to exploit the ambiguity in understandings of health inequality and this "facilitates claims of government leadership in tackling the issue through the publication of consultation and policy documents, whilst simultaneously avoiding dramatic action at the level of the social structure" (Carlisle, 2001: 278). This seems to highlight the fact that there is often a gap between what the research findings say about the problem of health inequality and how policies actually respond to the problem (Smith, 2013; 2014). Greater attention should be paid to the nature of social policy and its role in society rather than assuming that the policy process is unbiased and linear, and that evidence will automatically be translated into policies.

2.7.3 Taking social problems for granted

The final criticism is that these typologies take the problem of "differences in health" as health inequality for granted. It seems as though health inequality is seen as *the* way of understanding "differences in health" within the typologies explored here and there is little consideration for alternative assumptions which have previously underpinned responses to "differences in health". Little attempt is made to consider other ways in which "differences in health" has been understood as a social problem in social policy: why "differences in health" is seen as problematic in the first place; how the problem has been labelled in policy; what solutions have been put forward in the past to address "differences in health"; and how these approaches have changed (or not) over time. This final criticism comes as a result of the previous two criticisms. The lack of historical analysis means that there is no real context provided for contemporary understandings of "differences in health" and how these have developed. The lack of critical engagement with the nature of social policy means that definitions of social problems, in this case "differences in health" as health inequality, go unchallenged as they are seen as "the" way of understanding the problem. There is little attempt to examine the implicit and explicit meanings which are present in policy discussions of social problems in order to highlight underlying assumptions which can shape the discussion of the problem – i.e. what can and cannot be said about the problem.

Discussions concerning politics and beliefs about social problems seem to be absent in social policy analysis, and in particular in health policy analysis. There is little consideration

of the impact of particular ways of conceptualising a problem, how and why a specific understanding of the problem is possible and becomes dominant at particular points in time, and whether certain assumptions concerning the way society works (or assumptions about how it should work) change or remain consistent over a period of time. It may seem as though this type of thinking is too abstract for something like the study of social problems, given that there is clearly a need to identify and reduce the existence of problems in society. It will be argued in this research, however, that exploring the ways in which the problem of "differences in health" is conceptualised in English public health policy is crucial for understanding the development of policies to address the problem, and will perhaps provide a reason for why policies still seem to centre on the individual despite the evidence which suggests that wider factors are involved.

2.7.4 The research gap

The three criticisms discussed here highlight the gap which this research attempts to fill. There is currently a need for a form of health policy analysis which is not simply concerned with finding the best solution to the problem of "differences in health", but rather which examines the ways in which social policy effectively constructs the problem of "differences in health" in policy discussions over time. The term "constructs" is not used here to suggest that policies fabricate social problems but rather is used to indicate that discussions of social problems in policy are not unbiased; they are underpinned by particular sets of assumptions which allow certain things to be said about a problem while excluding other viewpoints. This type of analysis will highlight the meanings which are present in social policy discussions of "differences in health" and would recognise the importance of identifying and exploring underlying knowledge and assumptions which shape policy conceptualisations of social problems. In addition this analysis should pay greater attention to the role of social policy in the process of governing the population, given that policy discussions of social problems "signify who are virtuous and useful and who are dangerous or inadequate, which actions will be rewarded and which actions will be penalised. They constitute people as subjects with particular kinds of aspirations, self-concepts, and fears, and they create beliefs about the relative importance of events and objects" (Edelman, 1988: 12). Social policies, then, actively shape society not only in terms of changing the organisation of institutions but also have a key role to play in developing and sustaining perceptions of

problems and groups of people within society, the responsibilities they have and what help they can expect from the government.

2.8 Problematising health inequality policies

Health policy analysis, therefore, needs to acknowledge and examine the political nature of health, paying particular attention to the ways in which health problems, such as "differences in health", are articulated in social policy. This involves rejecting the idea that health problems are "givens" and requires researchers to consider why particular conceptualisations of problems are given precedence over others. By recognising that the language used in policy documents not only reflects reality but presents a particular understanding of reality based on politically driven values and normative concerns and assumptions, it is possible to analyse health policy in new ways. Such analyses do not focus directly on evaluating what types of solutions should be put forward but are instead interested in what these representations reveal about the policy understandings of health problems.

It is important to highlight here that language is central to an understanding of social problems and of social policy. Understanding language "is essential for any understanding of the reality of everyday life" (Berger and Luckmann, 1967: 52). Indeed it seems as though social scientists seem to forget that social policy is made of language, and the use of language and argumentation is key in all stages of the policy-making process (Majone, 1989). More attention needs to be paid to the language used in policy documents to define and describe social problems as these help to reveal the underlying assumptions and normative concerns which are used to shape the way problems are presented or framed in political discussions. Framing can be defined as

> *a way of selecting, organising, interpreting, and making sense of a complex reality to provide guideposts for knowing, analysing, persuading, and acting. A frame is a perspective from which an amorphous, ill-defined, problematic situation can be made sense of and acted on. (Rein and Schön, 1993: 146).*

Framing an issue is useful because it provides a way of distilling the complex elements of a problem into a manageable schema which can be used to develop knowledge and direct

action. As Rein and Schön point out, however, "[f]raming is problematic because it leads to different views of the world and creates multiple social realities". This is because different groups of people, whether that be politicians, academics in different disciplines, or even individuals from different backgrounds, "have different frames that lead them to see different things, make different interpretations of the way things are, and support different courses of action concerning what is to be done, by whom, and how to do it" (Rein and Schön, 1993: 147). The existence of competing explanations for health inequality has been shown in the above discussions of typologies, notably the typologies by Carlisle (2001) and Whitehead (2007). This ties into concerns raised by Value-Conflict theorists that competing ideas about an issue can exist at any point in time but arguably the concept of framing provides a clearer conceptualisation of the existence of different viewpoints. In particular it allows the researcher to investigate the different framings of a problem through examining the forms of knowledge that are used to construct the frames in the first place.

In their analysis of Canada's "Health for All" document Iannantuono and Eyles (1997) make it clear from the start that it is important to consider language and meaning in the analysis of policy documents as "[p]olitical documents…assert their authority through language, imposing a power to their words, not because of what they purport but because of what they represent (the dominant vision of truth in a dominant discourse)" (Iannantuono and Eyles, 1997: 1611). Policy documents, then, are not simply neutral descriptions of problems and proposed solutions. They are the result of a process of deliberation and consideration through which a dominant way of understanding and conceptualising a problem becomes apparent, and becomes *the* way of representing a problem in policy. Interestingly they also were keen to emphasise the silences in the document, things that weren't mentioned or discussed explicitly. Their key finding here was that there was little direct mention of the idea that "we can no longer depend on the state to provide all our health care requirements" (Iannantuono and Eyles, 1997: 1619). Most of the document was centred on galvanising individuals to take more responsibility for their health, either through changing behaviours or contributing to the creation of healthier environments. They note that this document was pivotal in terms of influencing future publications and forms of government. Not only did it help to widen the debate on determinants of health and illness but they argue that "its language (and its power) is embedded in the documents of "health reform" that have become significant elements in the Canadian health care landscape in the 1990s" (Iannantuono and Eyles, 1997: 1619). The themes and assumptions presented in this document were visible in later publications and intervention approaches. They conclude that

"policy language influences the focus and understanding of health" (Iannantuono and Eyles, 1997: 1619) and it is important and necessary for policy analysts to consider textual analysis as "[t]hrough an articulation of meaning in policy and tacit knowledge (silent meaning) the analyst exposes the powers of a policy text to change our vision of the world and how it ought to work" (Iannantuono and Eyles, 1997: 1620). The way that problems and their solutions are presented and discussed has the potential to change or cement understandings of reality and the way society operates, or should operate.

The presentation and framing of health inequality was examined by Vallgårda (2006, 2007, 2008, 2010) who used Foucault's concept of problematisation in her comparative analyses of Scandinavian, Nordic and English health inequality policies. She argues that "[t]he process of problematisation is a necessary step in any political process. It is a discursive process whereby issues are framed and made accessible to political action" (Vallgårda, 2008: 72). She is interested in investigating how the problem of health inequality is framed in particular ways and how the problem is made amenable to interventions. In her later works comparing health inequality policies internationally, Vallgårda makes use of the concept of problematisation to emphasise the fact even though the policies she examined all discuss the problem of "health inequality", each country seems to present a different understanding of the problem. In her comparison of Denmark and Sweden, for example, she noted that the policies "differed in all aspects of the problematisation: timing, reason for dealing with the issue, descriptions, explanations and suggested solutions" (Vallgårda, 2007: 54), which challenges the idea that Scandinavian countries constitute one single welfare model. This welfare model is further disputed by the wider comparison of the Nordic countries' (Denmark, Finland, Norway and Sweden) health inequality policies as while they may all have universal welfare policies, their strategies to tackle health inequalities once again differed from one another. Policies in Denmark and Sweden tended to focus on targeting strategies at those who were the most disadvantaged, while Finland and Norway's policies proposed universal measures aiming to address the whole population (Vallgårda, 2010). Vallgårda is keen to emphasise the fact that different problematisations will lead to different policies and different outcomes and effects of those policies, despite the fact they are all supposed to be addressing the same issue: "social inequality in health is not simply a problem to be recognised. Rather, it is created as a problem, and the problematisation process may follow different paths" (Vallgårda, 2008: 78).

The work from these researchers clearly emphasises the need to look more closely at health policies, in particular health inequality policies, in order to better comprehend the occurrence of different representations of the problem. As pointed out above in section 2.5 on the typologies of health inequality it is possible for a number of different understandings to be present at any one time, and from the work carried out by Vallgårda it is important to investigate why one or some of these understandings come to dominate over others, in particular taking into account the political ideological context in which these policies are formulated (Vallgårda, 2006).

It seems, then, that there is clearly a need for a theoretically informed approach to underpin health policy analysis which not only takes account of but actively emphasises the political nature of health and health problems, in the case of this research "differences in health", and recognises that social policy has a contingent nature. This includes the role of values and normative concerns in shaping understandings of "differences in health", the way(s) in which "differences in health" is represented in policy over time, and considering how health policies "fit" into wider processes of governing.

2.9 Foucaultian post-structuralist approaches to policy analysis

In answer to this call for a theoretically informed approach to the analysis of health policy the following section will discuss the contribution a Foucaultian post-structuralist perspective can make to this field. Post-structuralist approaches not only argue that social policies create particular understandings of social problems by drawing on particular forms of knowledge, but that social policies and their discussions of social problems create particular *subjectivities* for individuals which are amenable to governing. These approaches therefore have a different focus from interpretive approaches, discussed above in section 2.3.2, which are interested in examining the processes by which people make claims about social problems. Foucaultian post-structuralist approaches are more concerned with examining the meanings which exist in representations of problems, or problematisations, how these problematisations change over time (including examining the conditions which allow for change rather than simply stating change as a logical progression) and how these representations are used as part of the processes of government (Bacchi, 2015).

Foucaultian post-structuralist approaches to policy analysis draw on Foucault's theory of governmentality in order to provide the theoretical context to their research. Policy analysis conducted using an analytics of government looks beyond the problems that are presented and discussed in social policy and considers how those representations of problems demonstrate particular practices of government. If we wish to analyse government we must consider "those practices that try to shape, mobilise and work through the choices, desire, aspirations, needs, wants and lifestyles of individuals and groups" (Dean, 2010: 20). Social policy is one such practice of government which is part of this process of shaping and mobilising wants and behaviours. It involves the statement, both implicitly and explicitly, of normative concerns about the organisation of society and the behaviour of particular groups with regards to a particular issue, as well as utilising technical means to formulate interventions that are seen to be necessary to improve a situation or to alter forms of behaviour. Social policy should therefore be seen as a technology of government, it is an instrument used in order to perform a set of tasks. It is important to recognise, however, that while social policy is used to direct forms of action based on assumptions and normative concerns as well as evidence (Vallgårda, 2006), it is also subject to its own rules and norms which may well affect the structure of policy discussions and indeed shape the types of responses that are put forward.

There are clear links between the role of government and Foucault's discussions on the role of discipline in societies. In *Discipline and Punish* he comments that "'politics' has been conceived as a continuation, if not exactly and directly of war, at least of the military model as a fundamental means of preventing civil disorder" (Foucault, 1991a: 168). The military relies heavily on discipline in order to control soldiers, to ensure that specific forms of behaviour, manoeuvres, are carried out precisely and in the same manner repeatedly, and to form a body of men which are able to perform useful functions. Politics makes use of what Foucault calls the "docile body", a body "that may be subjected, used, transformed and improved" (Foucault, 1991a: 136). Foucault suggests that during the eighteenth century, but arguably continuing today, a "political anatomy" was developed which "defined how one may have a hold over others' bodies, not only so that they may do what one wishes, but so that they may operate as one wishes, with the techniques, the speed and the efficiency that one determines" (Foucault, 1991a: 138). The "docile body" can therefore be transformed by these disciplinary procedures which seek to not only make people behave a certain way, but to make sure that these new forms of behaviour stick through the provision of opportunities and tools which might be required to sustain it. Thus a normalisation of disciplinary

techniques occurs which means that little interference from higher forms of government is necessary, and this self-regulation without the need for coercion is the most effective form of social control for Foucault (Lister, 2010).

Foucault's concept of governmentality therefore attempts to "draw attention to a certain way of thinking and acting embodied in all those attempts to know and govern the wealth, health and happiness of populations" (Rose and Miller, 1992: 174). By drawing attention to particular ways of thinking this provides the possibility of opening them up to questioning by researchers, challenging their taken-for-granted nature. Lupton argues that "[a]s governmentality incorporates an analysis of both the coercive and the non-coercive strategies which the state and other institutions urge on individuals for the sake of their own interests, it provides a means of understanding the social and political role of public health and health promotional discourses and practices" (Lupton, 1995: 9). As mentioned above, social policy should be considered as a key practice of government. It provides a space where normative concerns can be presented and specific forms of knowledge and evidence are used in order to justify the consideration of a problem and the proposed interventions to resolve the identified problem. By understanding government as a set of activities which aims to invest the population with wealth, health and happiness, with the return of a productive and prosperous economy, it is possible to view social policy as a key technique of governing, and the presentation of social problems in particular ways within social policies as part of the set of practices associated with policy-making.

One recent example of a Foucaultian post-structuralist approach to policy analysis is Bacchi's (1999, 2009) "What's the problem represented to be?" (WPR) framework. Using Foucault's theory, along with social constructionism, the WPR framework contains six questions which researchers can use to interrogate policy discussions of social problems in order to better understand the implicit assumptions which have shaped particular interpretations of the problem under investigation. The framework can also be used to examine changes to interpretations, or representations, of problems over time in order to understand how policies focused on a particular problem have developed through an exploration of the conditions which allowed changes to occur in the first place. Bacchi therefore rejects the idea that policy developments are "linear" and represent a clear progression in ideas, rather that policy developments are the result of contingent conditions which allow for new perspectives to be put forward about an issue which were previously

closed off. There will be a more in-depth discussion of the WPR framework and its theory underlying it in Chapter 3.

2.10 From problem-solving to problem-questioning

Turnbull (2006) argues that there is a need to rethink the problem orientation of the analysis of social policy and social problems. If we continue to make problem-solving the basis of policy theory then we are left with "inadequate conceptual tools" (Turnbull, 2006: 4) with which to analyse social problems. We need to not only question the formulation of social problems in social policy but to also consider their contingent nature. Hunter (2003) argues that much health policy is built on puzzlement and uncertainty as politicians and policy-makers alike are unsure of the health status of the population, how they should go about improving health, and what the role of the NHS should be (i.e. should it just be dealing with ill-health or should it also be promoting good health). The view of social policy as a discipline which identifies problems, provides neutral descriptions and explanations, and puts forward rational solutions all while being situated outside of society and its social processes has been challenged by social constructionist perspectives and its contingent nature has been demonstrated by existing research using such perspectives in health policy analysis.

Policy analysis should be concerned with the processes and mechanisms by which conditions come to be understood as social problems, rather than just with a direct interaction with the conditions themselves (i.e. identifying problematic conditions and developing interventions to solve them). Social problems are not simply "out there" in society waiting to be discovered by researchers and faithfully documented and described by policy-makers and politicians alike without bias or judgment. This political dimension of policy has arguably been ignored due to the desire for policy analysis to remain "scientific" in nature and to retain some sort of distance from society and value-judgements. It has been shown in the above discussion, however, that social policy is clearly not separate from society with it being subject to social processes of decision-making and also its wider impact in terms of prescribing changes through the policies it promotes.

Policy analysis, then, needs to start to question policy-making processes, to examine in more detail how policies are formulated (both at the decision-making stages and the in publication of official documents) in order to provide an understanding of how social problems are presented in these policies. Social problems should therefore not be taken as "givens" but rather need to be "demonstrated" through the process of social inquiry. While it is clear that these perspectives have existed for some time in the wider literature on social policy and social problems analysis, it seems that they have only recently been applied to the field of health policy.

2.11 Research questions

The aim of this chapter has been to highlight the existence of a gap in the literature on policies aimed at addressing "differences in health". As the above discussion has demonstrated there is a need for the analysis of public health policy to consider the historical development of policy discussions of "differences in health", to critically engage with social policy as a discipline and as a technology of government, and finally to recognise that the problem of "differences in health", particularly when it is discussed as health inequality, should not simply be taken-for-granted as a social problem.

In order to address the gap in knowledge highlighted in this chapter the following research questions were used to guide the research from the outset:

1. **How is the issue of "differences in health" understood as a social problem in English public health policy between 1980 and 2011?**
2. **What forms of knowledge are drawn upon in order to legitimise policy responses to "differences in health"?**
3. **How have policy understandings of and approaches to "differences in health" remained the same or changed over time?**
4. **How are individuals viewed in policies concerning "differences in health"?**

The first question is interested in looking at "differences in health" is viewed as a problem in English public health policy and could be considered as a question in its own right as well as the overarching aim of the research. The way this question is phrased could imply that there is only one way of viewing "differences in health" in English public health policy.

The aim of this research, however, is not to come up with a definitive view of what the problem actually is, but rather to consider and explore the ways in which "differences in health" has been understood as a problem in English public health policy. In some ways this question encompasses all the following questions, but it does have a distinct purpose of its own. This question aims to provide a way into the analysis by examining what the problem actually is seen to be, considering who or what is seen as the cause of the problem, what types of solutions are put forward to address the problem, as well as considering the arguments as to why this is seen as a problem which social policy should address. This provides an overview of what the problem is and how it is framed in policy discussions, and allows for further interrogation.

The second question is very similar to the first, but emphasises the need to consider the assumptions which underpin the understandings of "differences in health". Once there is an initial sense of how policies discuss "differences in health" it is necessary to consider the logic behind a particular understanding of the problem and the solutions which are put forward. There must be a clear rationale behind both policy understandings of and solutions to problems otherwise they would not be considered a legitimate way to respond to an identified issue. These forms of knowledge can include both evidence produced within policy documents, such as statistics, but also normative concerns and values. Although evidence is used in policies in order to develop solutions to problems, it is also important to consider the role of political ideas as "evidence cannot replace political judgements" (Vallgårda, 2006: 616).

The third question highlights the need to provide a historical comparison of policies and their understandings of "differences in health". In order to fully understand the development of policy understandings and responses to "differences in health" it is necessary to undertake research over a longer time period, hence the 31 year time span for this research. This question also emphasises the fact that perspectives and understandings can change over time, and these changes need to be explored in order to better understand how contemporary policies have been allowed to develop. This comparison will not only allow for the consideration of differences between policy understandings of "differences in health", but will also be able to highlight where there might be similarities between policy discussions of "differences in health" or where past ideas have been included in new understandings of "differences in health".

Finally the fourth question looks specifically at the way in which individuals are conceptualised within policy discussions of "differences in health". This question expands the need to consider assumptions about a problem by looking specifically at assumptions and expectations surrounding individuals and their behaviour. Examining the proposed solutions to the problem of "differences in health" will help to clarify expectations about how individuals are expected to respond to proposed interventions, which in turn will illuminate underlying assumptions about how individuals (should) behave. This is important to consider as it will help to understand how policies produce subjects which are seen to be responsive to government. In addition, there has been little consideration of how subjects are produced in policy discussions of "differences in health" and how these subjects have changed over time, if at all. Combining questions 3 and 4 will provide an interesting insight into the ways in which individuals have been conceptualised in policies regarding "differences in health".

2.12 Conclusion

This chapter has set out the literature context for the research and identified a clear gap in the existing literature on health inequalities and social policy. There is a need for a form of analysis which does not simply end up presenting different approaches to the problem of "differences in health". As the discussion in this chapter has demonstrated, it is necessary to consider the underlying assumptions and concerns which are in turn reinforced by the use of wider discourses in order to present a particular understanding of the problem, and quite often the most appropriate solution given the viewpoint presented. Understandings of the problem of "differences in heath" are therefore strongly influenced by underlying political concerns, values and beliefs, and these should be taken into consideration when conducting health policy analysis in order to provide a full picture of how the problem of "differences in health" is presented in public health policies. Exploring these underlying concerns is therefore a key aspect of considering health as a political issue and opening up new avenues for policy research and analysis. There also needs to be greater emphasis placed on the importance of studying these assumptions over time in order to identify when assumptions change and to question why these changes have occurred, examining the wider policy and political context in order to identify the conditions which allowed for a change in views. Equally important is the identification and consideration of

assumptions which remain constant over time and how these influence what can and cannot be said about an issue, and how new sets of assumptions might fit within an existing framework of thought. The research questions outlined in section 2.10 highlight these concerns.

Social policy, then, is not just a way of developing solutions for social problems that are already known to exist but is a key part of the process of the construction of problems in the first place (Bacchi, 2009; Shaw and Greenhalgh, 2010; Twigg, 2002). Post-structuralist approaches to policy analysis highlight the need to examine how policies shape the way social problems are understood through an examination of underlying assumptions and values visible in the language used to discuss the problem, which in turn reflect wider discourses and indicate where there may be limitations placed on how a problem is thought about (Bacchi, 2000; Fairclough, 1992; Fischer, 2003). As such, problems become problematised in particular ways. Policy analysis should therefore focus on the *problem representations* contained within the problematisations, as well as exploring problem representations in order to compare them over time in order to provide a "history of the present" of the social problem under investigation.

The following Methodology chapter will begin by examining the reasoning behind choosing to use Bacchi's (1999, 2009) WPR framework for the analysis of policies on "differences in health", comparing it to Kingdon's (1995) policy windows model and a broader Foucaultian approach adopted by Lupton in her work on public health (Lupton, 1995; Petersen and Lupton, 1997). It will then provide an in-depth exploration of the WPR framework, focusing in particular on the use of Foucault's "methods" of problematisation, archaeology and genealogy and how they have been used in the subsequent analysis of policy documents and discussion of the findings. The chapter will also discuss the benefits of documentary analysis for sociological research as well as outlining and justifying the use of CAQDAS (Computer Aided Qualitative Data Analysis Software) in the analysis.

Chapter 3
Methodology

3.1 Introduction

As the previous chapter has shown there have been significant developments in the theory of social policy and social problems, particularly around the nature of both social policy and social problems and how they should both be analysed. These developments can be summarised in the shift from the need for analyses that solely focus on problem-solving to developing forms of analysis which focus on problem-questioning. The taken-for-granted nature of policy discussions of social problems, such as "differences in health", needs to be challenged by social researchers and policy analysts. It must be recognised that discussions of social problems in social policy documents are not wholly objective, neutral descriptions but are the outcome of social and political processes of claims-making and decision-making. The challenge for researchers is to examine the representations of problems in policy documents in order to better understand how the presentation and discussion of social problems links to wider frameworks of thought which are used in the processes of governing. Indeed, this challenge was highlighted in the work by Bambra, Fox and Scott-Samuel (2005) who argued that the analysis of health policy tended to focus on comparing the pros and cons of particular solutions to health problems rather than highlighting the ways in which problems are presented in the documents, which helps to obscure the political nature of the policy process.

This problem-questioning can be taken a step further to include the consideration of how problems are used in processes of governing, as demonstrated by Foucaultian post-structuralist approaches to policy analysis. Social policy does not sit outside of politics or society, but instead is embedded within both and has wide-ranging effects not only in terms of the distribution of resources, organisations and people, but also in terms of how particular groups in society are classified and viewed through the ways in which problems come to be represented in policy discussions. Governable subjects are produced through policies, and their problem representations, which are necessary in order to make a particular situation or social phenomenon amenable to government (Rose, 1999). Particular forms of knowledge are used in order to present a situation as problematic and to legitimise action to address problems (Rose and Miller, 1992). As such, the main focus of Foucaultian post-structuralist

approaches to policy analysis is the examination of how forms and practices of government shape the conduct of others, paying particular attention to the knowledges that are used to shape subjects (Marston and McDonald, 2006).

This chapter will set out how this research has examined the emergence and maintenance of governable subjects in relation to the problem of "differences in health" in English health policy between 1980 and 2011. It will begin with a discussion of the rationale for adopting Bacchi's (1999, 2009) WPR framework to conduct the analysis, comparing it to Kingdon's (1995) policy windows model and broader applications of Foucault's theory to public health (Lupton, 1995; Petersen and Lupton, 1996). It will be argued here that the WPR framework addresses the key concerns highlighted in the research questions (see Chapter 2 section 2.10) and also offers a systematic way of applying Foucault's theory to the analysis of (health) policy. The chapter will then present an in-depth exploration of the WPR framework in order to demonstrate how the framework reflects the concerns of governmentality studies and how it makes use of Foucault's "methods" of problematisation, archaeology and genealogy. Finally the chapter will discuss the processes of sampling and data collection, and the use of CAQDAS (Computer Aided Qualitative Data Analysis) in the research,

3.2 Deciding on the approach to the analysis

This section will discuss the rationale behind choosing Bacchi's (1999, 2009) WPR framework to conduct the analysis of English public health policy documents. Two alternatives will be discussed before introducing the WPR framework as the approach of choice for this research. Kingdon's (1995) policy windows model will be discussed first, highlighting the lack of engagement with what the underlying values are which can cause problems in both the problems and policy streams of the model. This will be demonstrated through examining Exworthy, Blane and Marmot's (2003) analysis of health inequality policies. Then there will be a discussion of Lupton's (Lupton, 1995; Petersen and Lupton, 1996) work which adopted a broad Foucaultian approach to the analysis of the New Public Health. While this perspective clearly has a better fit with the research questions outlined in the Literature Review (section 2.10), it will be argued that there is a lack of discussion concerning how Foucault's theory was applied and used in the analysis which makes it

difficult to replicate. The main advantage of the WPR framework is its design of six questions which can be applied to any area of policy analysis, and which are all thoughtfully underpinned by Foucaultian theory.

3.2.1 Kingdon's policy windows model and health inequality policy

Kingdon's (1995) policy windows model was mentioned in Exworthy, Blane and Marmot's (2003) typology of policy responses to health inequality. Policy windows are seen as brief opportunities "for advocates of proposals to push their pet solutions, or push attention to their special problems" (Kingdon, 1995; 165). The model is useful as it "explains how and why issues get onto the policy agenda, as the prelude to implementation" (Exworthy, Blane and Marmot, 2003; 1916). In order for policy windows to "open" three streams must combine together.

The first is the problems stream, which consists of conditions which the public, politicians and/or policy makers want to be addressed (Zahariadis, 2014). Problems are brought to light through indicators, such as repeating surveys or one off special studies (e.g. the Acheson Inquiry) (Robinson and Eller, 2010). In order for issues to be addressed by social policy they must first "be seen or defined as "problems" that are amenable to policy interventions" (Exworthy, Blane and Marmot, 2003; 1916).

The second stream is the policy stream. Ideas and initiatives float around in a "primeval soup" and compete against one another to win acceptance in policy networks (Zahariadis, 2014: 33). Certain initiatives are only selected "when they satisfy three criteria: technically (sic) feasibility, congruence with the dominant values, and anticipation of future constraints" (Exworthy, Blane and Marmot, 2003; 1916). Decisions about which interventions are selected are made in a closed-off space involving policy specialists, and there is little discussion of public participation at this point (Robinson and Eller, 2010).

The final politics stream consists of three key elements according to Zahariadis (2014: 34), "the national mood, pressure group campaigns, and administrative or legislative turnover". As such this stream is largely characterised by "bargaining, negotiation, and compromise between interest groups and power bases" (Exworthy, Blane and Marmot, 2003; 1916). This stream is largely concerned with the wider political make-up and mood, which includes the evolution of political ideology as well as "specific institutional windows for political choice – notably national elections" (Robinson and Eller, 2010: 202).

Exworthy, Blane and Marmot (2003) use Kingdon's (1995) policy windows model as part of their analysis of existing health inequality policies by examining how well each of the three streams has been met. They begin by arguing that because of the mounting evidence demonstrating health inequality as a problem, the problem stream is largely met. The only issue would be in keeping it within the problem stream and therefore on-going measurements would need to make it clear that it was still a problem. In terms of the policy and politics streams, however, Exworthy, Blane and Marmot suggest that these two streams are not well met. In the policy stream there is little clear evidence demonstrating how technically feasible solutions will be, especially the effectiveness of policies. In addition they note that "value congruence appears moderate" (Exworthy, Blane and Marmot, 2003: 1917) as while reducing health inequalities was seen as desirable in policy circles it did not seem to be seen as an issue in the public mind. Finally in the policy stream they comment that little had been done to consider future constraints on policies: "Most initiatives to tackle health inequalities have been one-off, short-term projects; projects remain marginal to mainstream policy and provision" (Exworthy, Blane and Marmot, 2003: 1917). The politics stream was also seen to be problematic as they noted that at the time it was difficult to tell if there were enough civil servants and ministers within the government who were committed to tackling health inequalities. There was not a clear policy community centred on health inequalities, which meant that there was a lack of networks of information and experience. They concluded that while not all the streams had been fully met, there was enough progress across each of the three streams which helped in "opening the U.K. "policy window" ajar" (Exworthy, Blane and Marmot, 2003: 1918).

Although Kingdon's (1995) policy windows model is an interesting way of conceptualising and analysing the policy process, there are a few issues with the model which mean that it is not particularly appropriate for this study.

The main issue is that there is no real exploration of what values actually drive the problem and policy streams. In the work by Exworthy, Blane and Marmot (2003), for example, they do not explore what the dominant values are which leads to a poor coupling between health inequality and the policy stream. As the discussions in the previous chapter noted, the values and assumptions underlying problems are a key factor in determining what can and cannot be said about a problem and indeed whether it is seen as a problem in the first place. The research questions outlined in the Literature Review emphasised the importance of examining underlying assumptions about the problem of "differences in health" and it seems

as though this is not as central to the policy windows model as there are other aspects of the policy process which are investigated as well.

Another problem is that there is no clear indication of whether a historical comparison is important or necessary when using this model. The policy windows model seems to be more focused at particular points in time when windows open (or close), rather than perhaps considering how the conditions change over time which allows windows to open or close. One of the research questions is specifically concerned with a historical comparison of policies, and this approach therefore will not provide a satisfactory answer to this question as there is no obvious mechanism which allows for comparisons over time.

Finally the problem under investigation seems to be taken-for-granted from the outset. There is little questioning about how the problem itself is discussed and defined before it enters the problem stream, or indeed what happens to it when it is in the problems and policy stream. This relates to the first criticism concerning a lack of engagement or critical analysis of the dominant values which allows or restricts particular issues to be discussed and deliberated. In addition to this it seems as though social policy is viewed as a means to an end – the fact that it is essentially to solve problems. This means that there is no critical engagement with the nature of social policy and little consideration of its role in governing and the construction of particular identities for groups or individuals through policy discussions of problems and their solutions.

3.2.2 Applying a Foucaultian post-structuralist approach to public health policy analysis

Lupton is a strong proponent of using a Foucaultian post-structuralist approach in order to analyse public health and health promotion. Across two of her books (Lupton, 1995; Petersen and Lupton, 1996) she adopts a critical stance to the implementation of the New Public Health (NPH) across Western societies. She is keen, however, to offer a more nuanced critique of the NPH than to simply write it off as being too controlling or as not doing enough to support individuals. Instead she is interested in exploring "the ways in which some of the knowledges and practices of public health and health promotion in western societies have been developed and articulated, how they are justified, what ends they seek, their alliances and dependences, and how they are embedded into broader historical, socio-cultural and political settings" (Lupton, 1995: 4). While that quotation was her statement of the aims of

her book *The Imperative of Health* the sentiments are clearly visible in her work with Petersen *The New Public Health: Discourses, Knowledges, Strategies* (Petersen and Lupton, 1996). In this book Lupton and Petersen are critical of the uncritical way in which the NPH has been widely adopted as *the* solution to public health problems. Instead they argue that "[t]he NPH can be seen as but the most recent of a series of regimes of power and knowledge that are oriented to the regulation and surveillance of individual bodies and the social body as a whole" (Petersen and Lupton, 1996: 3). If nothing else the NPH is "a set of discourses focusing on bodies, and on the regulation of the ways in which these bodies interact within particular arrangements of time and space" (Petersen and Lupton, 1996: 11). The NPH, therefore, is seen as another way of framing and understanding health problems, rather than as something which offers unproblematic solutions to health problems. Its assumptions therefore require exploration and critique rather than simple acceptance.

These quotations seem to echo Armstrong's (1993) work on public health "spaces". Armstrong argues that there have been four distinct phases of public health since the 19th century which focused on particular spaces and led to the development of particular identities for individuals. The first phase Armstrong identifies is that of quarantine. He argues that this view of health saw illness as located within certain geographical spaces: "Under a system of quarantine, illness somehow resided in places, as it was places that had to be kept separate" (Armstrong, 1993: 395). Sick individuals were isolated in their own homes to prevent the spread of disease. This changed with the development of sanitary science, the second phase Armstrong identifies. In sanitary science there are two spaces that have to be monitored, the natural environment (and also man made features of the environment such as buildings) and the human body. The introduction of the human body led to the development of a hygiene strategy and Armstrong argues that these new strategies "shift[ed] their attention from monitoring movement from one place and another place to between the human body and its geographical context" (Armstrong, 1993: 396). The focus on the geographical context allowed central administrative forms of surveillance to be established; particularly those associated with regulating building construction and sanitation facilities.

These centrally driven forms of surveillance were found to be unsustainable, however, and so individuals were 'recruited' in new forms of surveillance through personal hygiene. In this phase it seems as though individuals are afforded much more responsibility for their own health than they had been in previous phases of public health. Armstrong argues that "personal hygiene delineated a psychosocial space" (Armstrong, 1993: 404). The

location of disease was between bodies in a social space which was both physical and also contained personal relationships, as contact with others could be dangerous and lead to the spread of illness. Therefore individual surveillance was required in order to manage this psychosocial space across which disease could spread.

Finally, Armstrong briefly discusses the advent of the New Public Health. He states that "the new danger arises not from nature as under sanitary science, nor from other individual bodies as under personal hygiene, but from the interactions of those other bodies with nature" (Armstrong, 1993: 404). The New Public Health is concerned with the impact that society has had on the natural environment and the subsequent health problems that have ensued from that interaction. It is also concerned with 'lifestyle' factors at the individual level. Unlike in his discussions of the other phases, Armstrong doesn't specifically identify a space in which disease is located for the New Public Health. He describes it instead as creating political awareness, both about health and environmental issues.

The problem with Armstrong's paper is that he does not explain the shifts from one phase of public health to another. He identifies the four phases and does, to an extent, allude to the reasons why there was a change in focus. It could be argued that this is not the focus of this paper as he is concentrating on the creation of identities through the discourses around public health. However, his arguments about the changes in individual identity would be supplemented by a greater focus on the turning points in public health thinking.

Although Lupton (1995) broadly agrees with Armstrong's (1993) analysis of the development of public health, she is nonetheless critical of "[t]raditional historians of public health [who] have tended to describe a narrative of progression" (Lupton, 1995: 16). Such progressive narratives tend to oversimplify the step from one particular regime or set of practices to the next. Armstrong examines each of these phases as if they are fairly separate and distinct sets of thought on public health. Although it is useful to distinguish between different phases of public health in some respects, it can give the impression that there are clear breaks between sets of ideas relating to public health and that the change is clear cut. Instead, Lupton advocates the use of genealogical approaches as developed by Foucault in order to present histories of public health. Genealogical histories "have demonstrated that a close analysis of the emergence and development of the public health movement reveals not a steady progression from a primitive, 'unenlightened' thought to 'modern' ideas and practices, but a series of eras characterised by regressions and political struggles" (Lupton, 1995: 17). It is much more useful to view the changes between regimes as transitions with

blurred boundaries where old and new ideas overlap for some time, perhaps with older ideas never really being completely disputed or replaced by new ones.

Returning to Lupton's work, she is not only concerned with the identities that are created as the result of the NPH discourse but also with the effects on the way in which individuals are governed as a result of the promotion of particular identities. Petersen and Lupton (1996) argue that the as the language of PH is oriented around ideas about self-help, this helps to obscure wider power changes and also redefines the rights and responsibilities of citizens. The NPH "constructs the individual subject and other entities as rational, autonomous actors whose behaviour can be guided or shaped through rational planning" (Petersen and Lupton, 1996: 1). This echoes Edelman's (1998) comments about the creation of expectations of individuals through the ways in which social problems are constructed and presented. For Petersen and Lupton these expectations can be seen through the continued emphasis on working on one's own body to achieve health which has "become a crucial means by which the individual can express publicly such virtues as self-control, self-discipline, self-denial and will power – in short, those qualifications considered important to be a 'normal', 'healthy' human being" (Petersen and Lupton, 1996: 25).

Petersen and Lupton are also clearly aware of the socially constructed aspects of health problems as they point out that "[t]he very choice of what phenomena require measurement and surveillance is a product of sociocultural processes" (Petersen and Lupton, 1996: 39). Here they are specifically concerned with the use of epidemiology in public health, but the sentiment of this quotation can be extended to cover all policy areas and it highlights the fact that certain societal conditions are chosen over others to be examined, measured, monitored and addressed. Lupton (1992) is keen to emphasise the usefulness of discourse analysis approaches in order to highlight the social nature of health problems as she comments that "discourse analysis has the potential to reveal valuable insights into the social and political contexts in which varied discourses about health take place" (Lupton, 1992: 146). This seems to take account of the importance of language in policy discussions concerning social problems which was highlighted in the discussion of interpretive approaches to the study of social problems (see section 2.3.2). Lupton goes on to add that

> *The very characteristic which defines discourse analysis as a poststructuralist activity, differing from traditional content analysis, semiotics and ethnomoethodology, is its goal in identifying cultural hegemony and the manner by which it is reproduced…The identification of such interests, the revealing of the taken-for-granted forms by which*

> *cultural hegemony is established and maintained, many of which are effectively buried in discourse, both official and popular, is a means by which discourse analysts may challenge the status quo"* (Lupton, 1992: 149).

Here it is possible to highlight the key contribution of a Foucaultian post-structuralist approach to health policy analysis (and arguably all areas of social policy). It is to identify key underlying interests or ideas which work to shape the ways in which health problems, in the case of this research "differences in health", are viewed and presented and to use the identification of underlying modes of thought in order to challenge the existing state of affairs. Bacchi (2015) seems to agree with this as she argues that the use of social constructionist theories help to examine "the extent to which our understandings of the world are the product of social forces" (Bacchi, 2015: 5).The aim of the use of such theory is to "*trouble* consensus" (Bacchi, 2015: 8, emphasis in original) which is seen as problematic and to avoid focusing solely on problem-solving.

The use of a Foucaultian post-structuralist approach seems to have a better fit with the research questions outlined in the Literature Review. Much more emphasis is placed on the need to question existing knowledge and frameworks of thought rather than accepting them uncritically. In the case of the NPH Lupton's aim was to demonstrate that the NPH was simply another way of viewing public health and how to approach health problems rather than offering all of the answers. There is also a much greater sense of the need for comparing developments over time, in particular focusing on how underlying frameworks of thought shape what can and cannot be said about public health, for example, and how identities are created within particular discourses.

Although this broad approach seems at first to be very useful in terms of the current research, it is perhaps difficult to understand how it would be best to apply Foucault's theory given that there is no real indication of Lupton did this in the first place. She is clearly viewing public health through a Foucaultian lens but does not make it clear exactly how she applied Foucault's theory to her analysis. This is not particularly useful to researchers wishing to follow a similar style of analysis as it is difficult to replicate it.

3.2.3 Bacchi's "What's the problem represented to be?" framework

Another example of a Foucaultian post-structuralist informed approach to policy analysis is Bacchi's (1999, 2009) "What's the problem represented to be?" (WPR) framework

consisting of six questions which researchers should consider when analysing social policy. The questions are as follows: What's the 'problem' represented to be in a specific policy?; What presuppositions or assumptions underlie this representation of the 'problem'?; How has this representation of the 'problem' come about?; What is left unproblematic in this problem representation?; What effects are produced by this representation of the problem?; How/where is this representation of the 'problem' produced, disseminated and defended?.

Bacchi originally developed the WPR framework in order to examine the way in which women had been represented in a number of different areas of social policy: pay equality, discrimination, education, childcare, abortion, domestic violence and sexual harassment (Bacchi, 1999). In her newer book *Analysing Policy: What's the problem represented to be?* (Bacchi, 2009) the WPR framework is explored in much greater depth and applied to a number of policy areas in order to demonstrate its versatility and utility. The WPR framework emphasises the constructed nature of social policy and social problems while at the same time allowing the researcher to actively question how the problem under investigation contributes to the particular "mentality of government" present at specific points in time.

Bacchi argues that her WPR framework has a completely different rationale compared to more traditional approaches to policy analysis which tend to focus on developing better solutions to a defined problem. The WPR framework begins from a fairly commonsensical insight - "how we perceive or think about something will affect what we think should be done about it" (Bacchi, 1999: 1). Instead of viewing statements about problems as unbiased descriptions, Bacchi argues that we need to consider these as representations of problems given that they contain within them assumptions about how the problem is perceived, what has caused the problem to occur, who or what is to blame for its existence, and what should be done to resolve the issue (although often assumptions about what the problem is emerge from reading the proposed solutions to the problem). She argues that with policy analysis from her perspective, "the goal is to understand how policy decisions close off the space for the normative debate because of the impression that indeed they are the best *solution* to the problem (Bacchi, 1999: 20, emphasis in original). She points out that it is impossible to separate the solution to a problem from its initial definition at the outset of the policy process. The two are inextricably linked as "every postulated 'solution' [to a problem] has built into it a particular representation of what the problem is, and it is these representations, and their implications, we need to discuss" (Bacchi, 1999: 21). The

emphasis then is not on finding the correct solution to the problem, but instead examining the ways in which policies *represent* problems and their proposed solutions through problematisations.

Bacchi (2009) also contends that problematisations are used in forms of governing. This is because problematisations can limit our awareness of other troubling issues by channelling our attention and making certain problems (or, more precisely, representations of problems) more central to public and political discussion and debate than others. The language used to frame and discuss problems in social policy means that "it is inappropriate to see governments as responding to 'problems' that exist 'out there' in the community. Rather problems are 'created' or 'given shape' in the very policy proposals that are offered as 'responses'" (Bacchi, 2000: 48). We should therefore study *problematisations* rather than *problems* as these have consequences for forms of governing. As policies make proposals for changes to particular situations they must hold both explicit and implicit details about what is considered to be problematic. This means that representations of problems are then created through understandings of what the problem is seen to be. Bacchi is keen to point out, however, that this does not mean that we are simply left with competing definitions of what a problem is. She moves beyond the Value-Conflict approach to social problems and instead she argues that "a WPR approach makes the case that policies create *representations* of 'problems' that *take on lives of their own* because they affect materially and symbolically how we are governed and how we live" (Bacchi, 2009: 263, emphasis in original).

The WPR framework is therefore designed to have a much broader focus than more traditional and interpretive approaches to social policy studies and analysis (as discussed in Chapter 2 sections 2.3.1 and 2.3.2). The main aim of the WPR framework is to explore "how rule takes place, how we are governed" (Bacchi, 2009: 25), and this can be achieved through the close examination and consideration of the way(s) in which 'problems' are represented in social policy. This is very different from other forms of policy analysis which, as Bacchi (1999) discusses, tend to focus on how policies can be made better through improving the definition of 'problems' and thereby improving the interventions which are put in place to solve these 'problems'. In these approaches there is no real consideration of the wider forms of thought which might be influencing the definition of 'problems' in the first place, of the context in which certain 'problems' come to light, and of the effects that defining and discussing 'problems' in particular ways will have on the groups of the population that this 'problem' affects or is considered to be caused by.

Although Bacchi's (1999, 2009) WPR framework has not been widely applied to the analysis of public health policy, it is clearly a systematic approach to the analysis of social policy which is underpinned by Foucaultian theory and methods. This is not to say that Lupton's approach was not systematic, but rather saying that the WPR framework establishes a clear set of questions which researchers can follow when conducting their analysis. This makes it very easy for researchers to apply the framework to the area of policy they are investigating, and arguably there might not be much need for the researcher to engage with the underlying theory unless they absolutely needed to (the following section will present an in-depth theoretical exploration of the WPR framework in order to further demonstrate the relevance and usefulness of this framework in analysing health policy).

The WPR framework also places greater emphasis on the methodology of policy analysis. Bacchi's (2009) discussion of the theoretical underpinnings of the framework is refreshingly open and easy to understand which makes it much easier for researchers to apply the WPR framework in their own work. In addition it is clear that the underlying theory fits well with the initial research questions and aims of the research in researching underlying assumptions and knowledge, providing a historical comparison over time, and also examining the wider role of social policy in the process of governing.

3.3 The WPR framework, governmentality concerns and Foucault's "methods"

The previous section argued for the use of the WPR framework in this research as it offers a clear and systematic way in which to use Foucault's theory in order to analyse social problems and their presentation in social policy. This section will present an in-depth exploration of the WPR framework, in particular highlighting how the framework addresses a number of concerns within governmentality studies and how Bacchi employs Foucault's "methods" of problematisation, archaeology and genealogy in order to analyse social policy and social problems from a post-structuralist perspective.

The WPR framework comprises six questions which, Bacchi (2009) argues, can be used to interrogate any field of social policy and the problems that policy deals with. In the case of this research, the problem of "differences in health" within the field of health policy

will be investigated using this framework. The problem under investigation has been labelled as "differences in health" rather than as "health inequality" as the term "health inequality" represents a particular way of understanding the problem of different levels of health in the population and what should be done to rectify these differences. In addition, and as will be demonstrated in the analysis of the policy documents, "health inequality" has not always been used as the name of the problem. As such the label "differences in health" provides a broad term which highlights the problem under investigation, namely how different health outcomes are understood to exist and what solutions are put forward to address these differences, without placing an emphasis on one particular way of presenting the problem. The aim of this research is to examine how different understandings of "differences in health" have been represented in English public health policy, how and when they have emerged and how these representations have changed over time.

While existing typologies of health inequality were outlined in the previous chapter, it was argued that these typologies did not go far enough in terms of considering the types of subjects that are produced through policies designed to address health inequalities or "differences in health". They also lacked a historical dimension or comparison in their analysis; in particular there was a lack of attention paid to policies which existed before the term "health inequality" was introduced into public health policy. In addition to this, a number of existing analyses of health inequality policy do not seem to take into account the role of health policy in the processes and practices of government. As has been outlined in Chapter 2, policies do not simply report on the existence of problems but rather actively create understandings of social problems through representing problems in specific ways. Problems are represented in specific ways in order to make them amenable to governing, and this includes the presentation of particular types of subjects in order to understand how people behave and how they should be behaving. More specifically in terms of policy relating to "differences in health", the explanations for why differences in health exist will involve creating particular identities for groups of people, particularly those who suffer the worst health. This helps to conceptualise the behaviour, aspirations and expectations of different groups in society in relation to health. That is not to say, however, that all health policy is concerned with is individual behaviour, but that Foucaultian post-structuralist approaches to policy analysis are concerned with government as "the conduct of conduct". Policy analysis therefore needs to take into consideration the ways in which expectations of individuals or groups are outlined within problem representations, i.e. the assumptions that are made about individuals or groups of people. In addition, policy analysis should take into account

the fact that problematisations, and their problem representations, change over time. It is therefore necessary to not only identify particular problematisations that appear at specific points in time, but also to examine the shifts between problematisations and to consider the contexts in which these shifts occur.

Bacchi's WPR framework is well suited to these tasks. Not only does it provide six questions which should be used by social researchers to interrogate policies and the problems they aim to address, but these questions reflect key concerns within the field of governmentality studies. Table 2 provides a summary of the relationship between the WPR framework and the concerns of governmentality studies. Firstly there is a clear concern with the concept and process of problematisation. Bacchi (2009) argues that using the concept of problematisation is crucial for opening up problem representations for analysis and investigation. It requires the researcher to not only identify how the problem is discussed in the documents but to actively question and analyse why the problem is presented in that particular manner. This leads onto the second question which focuses on the relationship between thought and government, emphasising the role that knowledge plays in the representation of problems. The different forms of knowledge used can be discerned from the assumptions that are made about the problem through archaeological analysis. The aim here is to identify discourses which are central to the representation of the problem. The third question addresses concerns about the legitimacy of forms of governing by examining

Table 2 The WPR framework and governmentality concerns

Bacchi's WPR framework	Concerns with governmentality studies
1. **What's the 'problem' represented to be in a specific policy?**	Problematisation
2. **What presuppositions or assumptions underlie this representation of the 'problem'?**	Relationship between thought and government
3. **How has this representation come about?**	Legitimacy and government
4. **What is left unproblematic in this problem representation?**	Consideration of excluded and alternative views
5. **What effects are produced by this representation of the 'problem'?**	Effects of problematisations
6. **How/where is this representation of the 'problem' produced, disseminated and defended?**	Technologies of government

the development and dominance of particular representations of the problem. This is achieved through using genealogical analysis which involves considering change over time in order to explore explanations for why particular problem representations dominate at specific points in time and how there have been transitions from one problematisation to another. This is particularly important in order to provide an account of present understandings of the problem. The fourth question allows for the consideration of alternative or excluded viewpoints, and complements the analysis conducted in questions 2 and 3. This question highlights the fact that opposing perspectives about the nature of the problem under investigation will exist and may well be closed off by the way in which the problem is represented. The fifth question is concerned with the effects that are produced by a problem representation, and in particular the focus for this research is on the subjectification effects, i.e. the creation of governable subjects. This question requires a consideration of the assumptions made about the problem and about specific groups or people associated with the problem (question 2) and how they relate to "the conduct of conduct". The final question examines the technologies of government associated with a particular problem representation. It looks at the measurements, mechanisms and tools used within a problem representation to make the problem "real" and to instigate change.

The following discussion will explore these concerns in greater depth and relate these concerns to the methods of problematisation, archaeology and genealogy in order to demonstrate their importance for the analysis of health policy. The first sub-section will consider the importance of problematisation for the analysis of social problems within social policies, emphasising that the process of problematising an issue does not only lead to a particular understanding of the problem but also, and perhaps more importantly, makes the problem "real". As Osborne notes "[p]roblematisations are not modes of constructing problems but active ways of positing and experiencing them" (Osborne, 1997: 174). This concern ties into the need to consider the effects of problematisations, which will be discussed in the section on genealogy. The second sub-section will link Foucault's archaeological method with the interrelated concerns of the relationship between thought and government and the consideration of alternative perspectives on the same issue. This will highlight the role of knowledge in processes of governing, the importance of using knowledge to delineate exactly what is viewed as problematic and how it is viewed as problematic. The third sub-section will discuss the relevance of genealogical approaches to study the legitimacy of particular ways of understanding problems and hence particular forms of government, and to consider the wider effects of problem representations and how

both of these may or may not change over time. The final sub-section will examine the need to consider the importance and role of technologies of government in the analysis of social policy. This includes the consideration of how social policies employ particular forms of measurement and classification in order to make sense of a problem, and how social policy itself is subject to particular rules and norms which influence how issues are presented. In particular, the role of the policy document will be highlighted as policy documents are the source of data for the research.

3.3.1 Problematisation

Question 1: What's the 'problem' represented to be in a specific policy?

Foucault's concept of problematisation is central to understanding both the first question in the WPR framework and also the reasons behind the development of the framework as a whole. Bacchi opens her initial discussions about the nature of policy problems with the following common-sense statement: "how we perceive or think about something will affect what we think ought to be done about it" (Bacchi, 1999: 1). She suggests that policy analysts need to change the focus of their analysis "from policies as attempted 'solutions' to 'problems', to policies as constituting competing interpretations or representations of political issues" (Bacchi, 1999: 2). Policy analysis should therefore focus on problem-questioning rather than problem-solving (Bacchi, 2009; Turnbull, 2006), allowing researchers to query the supposedly objective nature of problem descriptions in social policy. The first question of the WPR framework initially seems to only be asking for a description of what is seen to be problematic, however the concept of problematisation is about more than providing a description. It is concerned with the identification and examination of structures of thought and the forms of knowledge used to make an object knowable.

It is important to state early on that problematisation is not about revealing hidden meanings or uncovering myths or manipulations of truth (Bacchi, 2012; Deacon, 2000). Instead, with the concept of problematisation Foucault set out "to reveal what is so obvious and so superficial that it is passed over and accepted without further comment" (Deacon, 2000: 129). The idea of the concept of problematisation is to question those aspects of social life which are often taken-for-granted and to examine the frameworks which lie behind forms of understanding and the ways in which objects for thought are created. This is particularly important when considering that the wider concerns of the WPR framework are

linked to understanding forms of governance. It is necessary to actively question the ways in which problems are represented in social policy because "we are governed through problematisations that influence who we are and how we think" (Bacchi, 2009: 264).

Throughout his work, Foucault used the concept of problematisation in two ways, both of which can be seen to influence the WPR framework. The first use of the term describes a method of analysis which is focused not on finding the correct response to an issue but to question why "at specific times and under particular circumstances, certain phenomena are questioned, analysed, classified, and regulated, while others are not" (Deacon, 2000: 127). This relates to Bacchi's concern with the need to examine different conceptions of the same issue rather than focus on developing the best solution to a problem. This leads on to the use of Foucault's archaeological method in question 2 and the consideration of alternative and excluded views in question 4 which are discussed below. In the case of this research, the interest is in examining the potential reasons as to why the problem of differences in health has been a contentious issue in English health policy. Foucault's second use of problematisation refers to "a historical process of producing objects for thought" (Bacchi, 2012: 1) where the interest is in how certain phenomena emerge as problematic and how they are then constructed as something which requires consideration. This second definition and use of problematisation strongly relates to the genealogical method in question 3 and the effects of problematisations in question 5 which are discussed in more detail below. This research is interested in exploring how we have come to understand "differences in health" as a social problem contemporary health policy by examining previous conceptions from 1980 to 2011, as well as considering how different ways of thinking about and labelling the problem have different effects on how different groups in society are themselves labelled and encouraged to think about themselves in relation to their health.

The concept of problematisation is central to this first question, and indeed underpins the whole WPR framework, because problematisations are the object of investigation in Bacchi's approach to policy analysis. Problematisations "formulate the fundamental issues and choices through which individuals confront their existence" (Gutting, 2005: 103) which means that representations of problems are not simply impartial descriptions of reality. For Bacchi problematisations in policy, or the representations of problems, "*create* particular understandings of what the 'problem' is" (Bacchi, 2009: 263, emphasis in original). Policies inevitably state, either implicitly or explicitly, what issues are

of central concern for society at any point in time and how these issues should be dealt with. Indeed, as Rose and Miller point out government itself "is a *problematising* activity…The ideals of government are intrinsically linked to the problems around which it circulates, the failings it seeks to rectify, the ills it seeks to cure" (Rose and Miller, 1992: 181, emphasis in original). The problems that governments deal with and the way they are represented in policies reflects underlying assumptions and normative concerns about the state of society, and expectations of how society should be.

It is these formulations or representations of problems which Bacchi is interested in investigating as she directly challenges the assumption that descriptions and discussions of social problems in social policy are, or can be, wholly objective in nature. The ways in which problems are defined and discussed are contingent upon wider underlying frameworks of understanding and knowledge which are often unconsciously employed by social actors, i.e. politicians and policy-makers. She argues that problematisations not only "make a 'problem' exist as a particular type of 'problem'" (Bacchi, 2009: 263), i.e. they usually provide a narrow way of understanding why a situation is problematic with little consideration of alternative perspectives on the same issue, but that they also have a direct effect on the way in which we are governed because problematisations in policy limit our awareness of other concerning issues in society. Certain issues are made central while others may be ignored entirely. This is not necessarily because they are not thought to exist, but because they do not "fit in" with the current framework of understanding society and how it operates. As these underlying frameworks change, so do the types of issues which are brought to the fore in social policy. The understandings of existing problems may also change. Policies therefore constitute social problems – they present understandings of what the problem is and what should be done about it through discussions and the presentation of evidence, thereby locating the causes of problems within particular areas of society and these often become "fixed" within social policy. These representations are not objective, however, as they are contingent on the underlying frameworks that shape understanding.

Bacchi notes that this kind of assessment "is clearly contentious and gives a whole new meaning to policy 'evaluation'" (Bacchi, 2009: 43). The idea is not to produce a cost-benefit analysis or develop more efficient solutions to a "problem" but rather to instigate discussions about where problematisations have led and where they may lead in the future. The assessment or interrogation of problem representations through their effects offers a new form of policy analysis, one which emphasises the need to consider how a problem is

thought about in the first place, what consequences this will have, and whether there are alternatives with fewer potential negative consequences.

Problematisation is ultimately concerned with "the practical conditions that make something into an object of knowledge, specifically to the networks of power, institutional mechanisms, and existing forms of knowledge that direct the attention of theorists to specific phenomena and thereby produce new knowledge" (Deacon, 2000: 131). This is what Bacchi's WPR framework aims to do through the six questions that used to interrogate policies and their problematisations. At its heart are concerns with power relationships and the use of existing and creation of new knowledge which make a set of conditions an object for social policy to deal with. The first question in the WPR framework deals with problematisation on a fairly superficial level, simply asking what the policy considers the problem to be, while the rest of the framework utilises problematisations as the object of study. Studying problematisations in social policy is an innovative way to "make politics, understood as the complex strategic relations that shape lives, visible" (Bacchi, 2012: 1).

3.3.2 The archaeological method and alternative viewpoints

Question 2: What presuppositions or assumptions underlie this representation of the problem?

Question 4: What is left unproblematic in this problem representation?

As discussed in the previous section, problematisations, and the problem representations they contain, are the main focus for Bacchi's WPR approach. Not only are problematisations important for identifying the problem being discussed, but they are also necessary for understanding social policy's contribution to wider governing processes. This sub-section will move on to explore questions 2 and 4 of the WPR framework. Question 2 is concerned with the use of Foucault's archaeological method in order to uncover the assumptions of policy representations of problems, which in turn is linked to question 4 concerning the consideration of alternative and excluded viewpoints. By examining the assumptions of problems it is possible to begin to understand why certain conceptions of problems are present at particular points in time, and it allows the researcher to reflect on different ways of thinking about the problem both within the identified set of assumptions and without it, i.e. considering alternative perspectives. This follows on from the use of problematisation in the first question of the WPR framework to investigate why, at particular

points in time and under specific conditions, certain social phenomena are questioned and regulated as opposed to others. The assumptions made about a particular phenomenon or condition will determine what can and cannot be said about the phenomenon; which viewpoints are considered acceptable and which is rejected as explanations for the existence of the phenomenon. Bacchi (2009: 48) suggests that the discovery of such assumptions can be made using a form of Foucaultian archaeology in order to uncover "underlying conceptual logics and political rationalities in specific policies".

Foucault's archaeological method stemmed from a discontent with the existing way in which history was researched and presented. In *The Order of Things* Foucault outlines and defines his research project in the following way:

> *what I am attempting to bring to light is the epistemological field, the episteme in which knowledge, envisaged apart from all criteria having reference to its rational value or to its objective forms, grounds its positivity and thereby manifests a history which is not that of its growing perfection, but rather that of its conditions of possibility; in this account, what should appear are those configurations within the space of knowledge which has given rise to the diverse forms of empirical science. (Foucault, 2002: xxiv)*

The main issue for Foucault is "not so much what is said, or better the truth of evidence for what is said, but rather how what is said arises from what can be said, or at least legitimately said, at a particular time and place" (May, 2006: 44). In the case of *The Order of Things* Foucault is interested in the development of science, but not in the "conventional" way that the history of science is presented as being a linear progression towards its "growing perfection". He argued that it was not enough to simply discuss the theories of individual thinkers as this ignores "the underlying archaeological frameworks necessary to grasp their ultimate significance" (Gutting, 2005: 39). Individual thinkers thought within a set of limits that would have constrained their thinking without them even realising it. Archaeology is about revealing these underlying assumptions and frameworks that make particular ways of thinking possible, the "configurations within the space of knowledge", and this allows the historian or researcher to consider why other possible modes of thought were not possible at specific points in time. It also allows for the consideration of alternatives within a particular set of ideas and assumptions.

The archaeological method is therefore not just about providing different perspectives on a subject over time. Instead, it is about providing "an analysis of the conditions necessary for a given system of thought to come into being and to impose itself

authoritatively" (Downing, 2008: 9). Foucault is more interested in providing an insight into the general mode of thinking (or *episteme*) that lies behind sets of practices than providing a narrative of different perspectives on a particular issue (Gutting, 2005).. This analysis of the conditions necessary for a given system of thought allows for an examination of the "inaccessible rules, codes and beliefs that have effects in the world; but effects which appear as facts of nature" (Downing, 2008: 10). Essentially, Foucault is questioning what is viewed as a "normal" way of thinking and is interested in discovering how it becomes *the* way of organising thought at a specific point in time.

Bacchi's WPR framework makes use of the archaeological method in question 2 by asking researchers to consider the underlying assumptions of problem representations in order to identify "conceptual logics and political rationalities" (Bacchi, 2009: 48) which help to shape the representation of the problem identified by question 1. The consideration of underlying assumptions allows researchers to consider the "systems of rules which make it possible for certain statements but not others to occur at particular times, places and institutional locations" (Fairclough, 1992: 40). These systems of rules are what Foucault refers to as discursive formations (Foucault, 2002).

It is possible through working with questions 2 and 4 of the WPR framework to begin to explore the relationship between thought and government, which starts to address wider concerns of governmentality studies which underlie the framework. This relationship involves considering thought "as it becomes linked to and is embedded in technical means for the shaping and reshaping of conduct and in practices and institutions" (Dean, 2010: 27). Studies on various different areas of government have shown

> *that the activity of government is inextricably bound up with the activity of thought. It is thus both made possible by and constrained by what can be thought and what cannot be thought at any particular moment in our history. To analyse the history of government, then, requires attention to the conditions under which it becomes possible to consider certain things to be true – and hence to say and do certain things – about human beings and their interrelations as they produce, consume, reproduce, act, infract, live, sicken, die. (Rose, 1999: 8)*

Here Rose is reiterating what Foucault outlines in the Preface to *The Order of Things* where he discusses the need to investigate the "conditions of possibility" which shape thought, but is relating these concerns to that of government and governing. It is important, therefore, to understand the "conditions of possibility" under which particular representations of

problems emerge and "stick" as dominant representations, and this leads onto the use of the genealogical method in question 3.

The concern with thought and government is picked up on in the literature on the politics of health, which highlighted the central role that ideas play in the creation of health policy but noted that they are often neglected in policy analysis. It is quite clear that values influence the type of issues which are discussed in policy, as Bacchi (1999) noted, but the archaeological analysis is not just about identifying the values and ideas which shape policies. It is also concerned with placing these normative concerns within a wider frame of understanding, which in turn shapes the ways in which ideas are then implemented in policies leading to practical forms of action.

For Foucault, theory (understood as knowledge and thought) and practice (understood as relations of power) are not opposed to one another but are instead closely interconnected (Deacon, 2000). Knowledge is embedded in our practices and one key implication of this is that our forms of knowledge change as our practices change over time (May, 2006). That is to say "we will know things in different ways depending on the state and structure of our practices at a particular time" (May, 2006: 20). How we gain knowledge from the world develops and changes over time which means that "we will know differently at different periods". This is not only evident in the types of problems or perspectives on problems that are openly discussed in social policy but also those which are ignored or overlooked. Knowledge and thought (which includes normative concerns) limit the conditions or situations which are viewed as problematic. How governments think about something will determine whether they consider it to be a problem, and if so what action should be taken to resolve this problem. As Bacchi (2009) argues, we are governed through problematisations in policies as they channel our understanding of troubling issues and effectively render some troubling conditions invisible.

The main limitation with the archaeological method is that it is not able to describe the effects of sets of practices. It is a synchronic form of analysis which focuses on static states and while it may reveal shifts within epistemic thinking, the method does not allow for the explanation of causes (Gutting, 2005). Archaeology also does not offer "cures" for incorrect or misguided beliefs as it "simply describes what it uncovers or lays bare, as the metaphor of 'archaeology' would suggest" (Downing, 2008: 10). It does, however, offer the opportunity for alternative ways of thinking to be presented and considered, given the initial uncovering of the underlying system of rules which permit statements and perspectives to

be put forward. Questioning the problematisations of problems in order to reveal the assumptions underpinning the way the problem is thought about is the key aim of using the archaeological method in the WPR framework. The shifts in assumptions, and the effects that different sets of assumptions have, are considered in questions 3 and 5 as they draw on Foucault's genealogical method.

3.3.3 The genealogical method and the effects of problematisations

Question 3: How has this representation of the 'problem' come about?
Question 5: What effects are produced by this representation of the 'problem'?

Mirroring Foucault's advances in methodology the framework then turns to consider the genealogy of problem representations, which is highlighted by question 3. As genealogical analysis is concerned with the ways in which subjective identities and power relations are created and change over time, it is necessary here to also address question 5 which looks at the effects produced by problematisations. Part of the genealogical analysis, therefore, will involve the consideration of how certain problem representations "stick", or are legitimised in policy.

Again arising from a critique of historical methods, Foucault's genealogical approach helped to deal with the inadequacies of the archaeological method, in particular the inability of archaeology to explain the effects of practices. Archaeology dealt with describing conceptual systems of practices, not the changes in practices over time. The synchronic nature of archaeological discoveries means that different static states can be compared over time, whereas the diachronic nature of genealogical analysis means that the changes from one state to another can be investigated in greater depth (Gutting, 2005). That is to say, the archaeological method can be used to uncover different problem representations at different points in time while genealogical analysis can be used to look at the shifts between these representations over time.

Foucault was critical of the traditional reading and writing of history as he argued that it often presented "grand teleological narratives" (Gutting, 2005: 46) with the implication of movement towards specific goals over time. He rejected this view in his genealogical method stating that

> *Genealogy does not resemble the evolution of a species and does not map*
> *the destiny of a people. On the contrary, to follow the complex course of*

> *descent is to maintain passing events in their proper dispersion; it is to identify the accidents, the minute deviations – or conversely the complete reversals – the errors, the false appraisals, and the faulty calculations that gave birth to those things that continue to exist and have value for us; it is to discover that truth or being does not lie at the root of what we know and what we are, but the exteriority of accidents. (Foucault, 1984: 81)*

Here Foucault is arguing that history (as genealogy) does not provide a perfect route towards a pre-determined goal. He is keen to record all the nuanced changes and developments that occur rather than focusing on "seismic shifts" (Downing, 2008: 15) which tend to emphasise one cause for historical change. In fact numerous discoveries throughout history that are perhaps presented as the "rational" outcome of a series of events are, more often than not, the result of numerous accidental progressions. The idea of genealogy is to preserve and record these "small and multiple changes that lead to alterations in trends of thinking and operating in any given epoch" (Downing, 2008: 15). It is these small changes which are important for Foucault and his explanations for change over time.

Question 3 in the WPR framework, "How has this representation of the 'problem' come about?", is essentially asking the researcher to provide a "history of the present" which is how Foucault described his genealogical method. The main aim of the genealogical method was "not to understand the past but to understand the present; or, to put the point with more nuance, to use an understanding of the past to understand something that is intolerable in the present" (Gutting, 1994: 10). The object under investigation using the WPR framework is a representation of a problem in a current area of social policy. It is necessary to look at the recent past in order to understand why it is considered to be a troubling issue in the present, and this involves identifying small and possibly subtle changes that have occurred which have either allowed the issue to be viewed as a problem or for explanations as to why it is problematic to change over time. In terms of examining the problem of "differences in health", genealogical analysis will help to explore the reasons why contemporary representations of "differences in health" come to dominate. Bacchi (1999: 40-41) states that genealogy is "recommended as a technique to historicize claims to knowledge, indicating shifts in thinking and acting around particular issues". The aim is to examine the practices and processes which have led to the dominance of the problem representation being studied and to see how these have potentially changed over time. The WPR framework therefore allows for an examination of the underlying archaeological frameworks throughout the period of investigation and to look specifically at the transitions between different problematisations of "differences in health".

This also relates to the concern in governmentality studies with the legitimisation of governments and their problematisations. In order to understand the acceptance of contemporary forms of rule and the problematisations that are used to generate particular representations of problems, it is necessary to examine past problematisations and forms of rule. Using the genealogical method it is possible to examine the changing conditions of possibility and "to use an understanding of the past to understand something that is intolerable in the present" (Gutting, 1994: 10).

The WPR framework also requires researchers to consider the effects of problematisations. Bacchi (2009) suggests that there are three main effects that need to be considered when analysing problematisations and their problem representations. The first is discursive effects. This involves considering how the problem and its subjects are constructed through the language and discourse (knowledge) that is drawn upon. The second is subjectification effects produced by the problem representation. Here researchers should consider the types of subjects that are produced by policy discussions of problems, and the analysis should result in the identification of the "governable subject" (Rose, 1999) highlighted by particular understandings of problems. The final effect requires a consideration of the lived consequences for people who are affected by changes in policy. This might include considering whether people have better access to essential services, or whether it might mean that certain groups are excluded from services and benefits. This research will focus more on discursive and subjectification effects than lived effects, though all three are interrelated. The way in which people are represented in policy through discourses will influence the type of governable subject that is produced, which in turn will affect what types of resources people are allowed to access. In terms of the problem of "differences in health", for example, it seems as though often health problems are seen as being located at the level of the individual. This means that the idea of the responsible health aware individual is created, and particular services are only readily available to those who are deemed to be in the most disadvantaged situations. The identification of the governable subject of a problematisation results from the archaeological analysis. Through examining underlying assumptions and frameworks of knowledge informing the assumptions in the first place it is possible to construct the subject that is assumed to exist and around which the policy is designed. The governable subject is particularly important as it demonstrates a particular understanding of the way individuals behave and how they should behave.

The genealogical method, then, builds on the archaeological method in that it allows for the comparison of problematisations over time. By recognising that history is not a linear subject it becomes possible to explore the wider context in which problematisations of "differences in health" emerge and to consider the transitions between problematisations. These transitions do not necessarily signify "progress" in a traditional sense of the word. The change in the dominant problematisation denotes a shift in emphasis within an existing framework of thought, and the aim of genealogical analysis is to examine these changes in the use of discourses to understand and represent the problem of "differences in health".

3.3.4 The technologies of government

6. How/where is this representation of the 'problem' produced, disseminated and defended?

The final question in the WPR framework highlights the role of technologies of government in the representation of social problems in policy. Foucault was interested in the ideas, concepts and knowledges shaped and produced by technologies as opposed to their material nature, however he never explicitly theorised the nature of their involvement in governing practices (Henman, 2006). Rose and Miller (Miller and Rose, 1990; Rose and Miller, 1992; Rose, 1999) have sought to theorise the relationship between technologies and governmentality. As part of their understanding of government they state that

> *Government is a domain of strategies, techniques and procedures through which different forces seek to render programmes operable, and by means of which a multitude of connections are established between the aspirations of authorities and the activities of individuals and groups. (Rose and Miller, 1992: 183).*

They argue that all these diverse mechanisms constitute the definition of technologies of government, and that it is through the use of these technologies that political rationalities "become capable of deployment" (Rose and Miller, 1992: 183). Technologies of government are therefore vital for political programmes to be implemented, and any study of governmentality should examine "the mundane mechanisms by which authorities seek to instantiate government" (Rose and Miller, 1992: 183). It is also important for researchers to recognise that the use of technology is not neutral. It is not just that policy-makers or politicians apply technologies to problems they wish to solve and policies they wish to enact. Technologies act in much more subtle ways which not only affect whether a policy can be successfully implemented in the first place, but also the way in which policies and problems

are thought about in the first place, shaping the types of knowledge available to policy-makers.

Henman (2006) identifies number of contributions that technologies have made to social policy and in the ways in which they shape the nature of social policies. The first is that as administrative technologies are the central means through which policies are realised or enacted, if a suitable means is not available then "the policies remain unfulfilled fantasies" (Henman, 2006: 211). Policies can only be implemented if suitable mechanisms are available and in place, which may mean that policies become shaped by the existing technologies which will allow the policy to go forward. Policy-makers therefore may face constraints as to what they can do given the means that they have to work with. This leads onto the second contribution of technologies to social policy. Technological innovation can occur where existing technologies limit the scope for social policies, as a reaction against the closing off of spaces for policy development and implementation. Not only will this expand the "toolkit" of the policy-maker in terms of providing them with more means to achieve ends, but it may also change the way they think about policies and problems, which may in turn give rise to new policies. Technologies can therefore both constrain and open up the field of possibility for thought and understanding in much the same way as discourses do.

The use of administrative technologies typically produces large amounts of data, particularly through the application of new technologies and measurements to existing data. The analysis of this data will then generate new forms of knowledge which will then provide the basis of new understandings of existing areas of policy. As such, the data then "defines and problematises new domains of government" (Henman, 2006: 211). Once again new spaces for knowledge and thought are opened up through technologies. However, this may lead to a narrowing of "conceptual spaces" as only certain types of data are collected. In social policy it is more often the case that quantitative data are collected over qualitative data, though one could argue that qualitative data in terms of responses to consultations and green papers are important for shaping the direction and types of policies that go forward. While there may be technological innovations which allow policy-makers to view policies in a new light and to collect new data, these new forms of measurement may come to dominate and once again act as constraints around what policy can and cannot do.

The use of technologies in government is therefore much more complex than it first may seem. Technologies are not simply used to achieve the objectives of government, and nor do they simply reflect and reproduce existing practices and relations of power. They may

well do both of these things, but it is important to recognise that "there are occasions when the existence and employment of technologies gives rise to changes in the way government is thought and practiced" (Henman, 2006: 209). Thus the use of particular technologies may well give rise to new forms of knowledge and also create new sets of relationships between different domains allowing for new policies to be implemented or for existing policies to be thought about in a new way. As the discussion has noted, however, these technological innovations can also act to close off these "conceptual spaces" through, for example, changing the type of data that is required to be measured for a particular technology to prove useful.

The final question in the WPR framework asks the researcher to consider how a particular representation of a problem is produced in policy. It requires a consideration of the different and diverse mechanisms used to substantiate claims about a particular understanding of the problem, and arguably helps to tie all the questions in the framework together. This question does not just deal with discourses as forms of knowledge but also how technologies are used to *create* new forms of knowledge and understanding. Technologies do not describe reality but rather allow for the creation of realities. They help in the process of representing reality in a way which is then responsive to forms of governing, as Rose and Miller state: "Governing a sphere requires that it can be represented, depicted in a way which both grasps its truth and re-presents it in a form in which it can enter the sphere of conscious political calculation" (Rose and Miller, 1992: 182). As Henman (2006) notes, technologies can both open up and constrain ways of thinking about social problems and social policies much in the same way as discourses do (which is dealt with by questions 2 and 4 of the WPR framework). As such, knowledge remains a central concern for this final question as technologies actively shape and influence the knowledge that is used to identify problems and develop suitable policies. The way that certain forms of knowledge are used to create boundaries concerning what is acceptable and what is not, but also the effects of new knowledge which can be formulated through technological innovation. The framework is brought together in this final question because technologies are required for the realisation of policies. Without technologies of government the ideas of politicians and policy-makers would remain as ideas rather than be put into action. In the case of this research the policy document is the central technology which is being analysed.

3.2.4.1 The policy document as a technology of government

The policy document itself could be considered as a technology of government. Policy documents are a key part of government as they are not only a way of recording evidence and discussions about social problems and other issues; they are also a key way to communicate with large numbers of public servants who may be located in different places in order to ensure that action across a particular policy area is carefully coordinated. Once an idea has been documented it is also then accessible to future politicians and public servants to act as a reference point (Freeman and Maybin, 2011). This means that future documents draw on past documents, and this can be seen through direct references to previous policies and also more latent references to previous ideas which are present in preceding publications. Each policy document can be seen as a node within a network, a network of references. Not only do documents draw on others but they can also generate further publications which help to reproduce the need for documents.

Policy documents allow political rationalities and assumptions to be formalised and laid bare to inform and also to be available for debate, criticism and future development. It is a necessary mechanism through which policies can be implemented and is also a key feature of the bureaucratic nature of modern governments. Indeed Freeman and Maybin (2011: 155) suggest that "[g]overnment is unthinkable impracticable, not feasible, without documents". The evidence, findings, conclusions, problems and solutions are all presented in documents and policy documents are used to "document past and forthcoming (or foreshadow potential) changes in legislation and/or the organisation of society and its institutions" (Rapley, 2007: 13). The policy document represents "the progression and movement of knowledge into action and research" (Freeman, 2006: 52). They therefore are not only an instrument used to express knowledge and ideas, but they also work to organise and change behaviours and social arrangements (Brown and Duguid, 1996). The knowledge and understanding presented within policy documents is used to instigate changes in order to solve or alleviate problems identified within the policy. Policy documents make these representations "stick" because of their authority (Bacchi, 2009).

Policy documents then are a central technology of government and are necessary for societal changes to be implemented. When documents (in general not just policy documents) are used in social research they are often approached "in terms of their content rather than their status as 'things'" (Prior, 2003: 3) in their own right. As has been discussed here, it has been shown that policy documents have a very specific status as instigators of

social change. It is not just the content of policy documents that is important but the consideration of outcomes that are produced from the implementation of the content, in particular the subjectification effects of problem representations which are identified as a key effect of problem representations.

3.4 Relating the WPR framework to the research questions

The focus of the research is on the ways in which the issue of "differences in health" has been problematised within English public health policy. While the emphasis is mainly on the problem of "differences in health", as demonstrated by the research questions below, it is important to note that the focus is actually on the way in which the identified differences in health outcomes have been conceptualised and viewed within social policy. Labelling the issue as "health inequality" is one way which this problem can be viewed and while perhaps now it is the dominant term within debates about health policy, if not in the policy itself, it has not always been the case. This is why the label "differences in health" has been adopted throughout the research in order to identify the fact that the research is interested in examining policy understandings of differences in health outcomes. This section aims to clarify the research questions which are used to inform the research, thereby linking the more theoretical concerns of the research with the practical methods used in order to investigate the nature of "differences in health" as a social problem in English social policy.

The initial research questions, as stated in Chapter 2, are shown here again in Figure 1. These questions were helpful in the decision to adopt Bacchi's WPR framework as the approach of choice for this research. The concerns with governmentality underpinning the WPR framework seemed to fit with the interests of the initial research questions.

> 1. *How is the issue of "differences in health" understood as a social problem in English social policy?*
> 2. *What forms of knowledge are drawn upon in order to legitimise policy responses to "differences in health"?*
> 3. *Have policy understandings of and approaches to "differences in health" remained the same or changed over time?*
> 4. *How are individuals viewed in policies concerning "differences in health"?*

Figure 1 Initial research questions

- *Practical and contextual information about the document:*
  - *What type of document is this? (i.e. Green Paper, White Paper, commissioned report, update on policy, etc.)*
  - *When was it published and by whom?*
  - *Which government was in power at the time?*
- *How is "differences in health" problematised/viewed as a problem?*
- *Who/what is considered to be responsible for the existence of "differences in health"? (i.e. how has it come about/to exist)*
- *What assumptions are made about this representation of "differences in health"?*
- *What bodies of knowledge are drawn upon to legitimise (or not) the issue of "differences in health"?*
- *Is there anything that is left unproblematic in this definition? (i.e. things that are "hidden" or not discussed)*
- *How is "differences in health" measured or recorded?*
  - *What diseases are used?*
  - *What social categories are used?*
  - *What comparative statistics are used?*
- *What solutions to the problem of "differences in health" are proposed?*
  - *Does this change the focus of the original definition (if one is given)?*
  - *What else does the solution tell us about the problem of "differences in health"?*
  - *Are there focuses on particular illnesses?*
- *Are any references made to other sources you are using?*
  - *Are they direct quotations or indirect references?*

Figure 3 Combining the initial questions with the concerns of the WPR framework

Practical Information -What type of document is this? (i.e. Green Paper, White Paper, commissioned report, update on policy, etc.) -When was it published and by whom?	How is "differences in health" problematized/viewed as a problem?	Who/what is considered to be responsible for the existence of "differences in health" (i.e. how has it come about/to exist).	What assumptions are made about this representation of "differences in health"?	What bodies of knowledge are drawn upon in order to legitimise (or not) the issue of "differences in health"?	Is there anything that is left unproblematic in this definition? (i.e. things that are "hidden" or not discussed).	How is "differences in health" measured or recorded? -What diseases are used? -What social categories are used? -What comparative statistics are used?	What solutions to the problem of "differences in health" are proposed? -Does this then change the focus of the original definition (if one is given)? -What else does the solution tell us about the problem of "differences of health"? -Are there focuses on particular illnesses?	Are any references made to other sources that you are using? -Are they direct quotations or indirect references?
			MARGARET THATCHER - CONSERVATIVE					
Inequalities in Health: Report of a research working group (the Black Report (1980)	There are differences in health between people in different social classes and these differences are	The causes of health inequality are considered multiple and complex. They are the result of man-made	Social model of health and illness In the first chapter the report notes that it will	There is a long discussion in the first chapter about the definition of the terms "health" and "inequality".	Individual responsibility for health is mentioned and discussed, however the focus is mainly on external	The report mainly measures "differences in health as measured over the years between the	Three recommendations for policy focus are made: 1) Children at the start of life – improving children's	

Figure 3 Document matrix questions example

These initial research questions and the six questions of the WPR framework were then combined to produce a new set of questions in order to help with the analysis and comparison of a large number of documents (see section 3.5 for sampling) and can be seen in Figure 2. These questions were used to create a matrix of data from the analysis which could then be used to compare documents over time and to look at changes in the way "differences in health" had been represented. Initially individual files were created which contained answers to each of the questions for each specific policy document, before they were then combined into one file where each question (or small set of questions) formed a column in the matrix while the document names formed the rows (see Figure 3). The notes created about each document were based on the coding of each document and initial thoughts and comments recorded in memos in NVivo. The use of NVivo is discussed in more detail below in section 3.6. These questions were used as a way of "getting into" the documents, opening them up for further scrutiny, and to identify the representation of "differences in health". Once the matrix was completed it was then possible to examine the documents over time by reading down each column and comparing the statements made about each document. This helped to facilitate the genealogical analysis, along with further examination of instances of coding.

3.5 Sampling and data collection

In order to conduct the analysis appropriate documents were sourced for the research. As Table 3 shows 32 documents in total were used for the analysis and were a range of different types. A full list of the documents used for the analysis can be found in Appendix A.

Table 3 Types of documents used in the analysis

Type of document	Number
Green paper	2
White paper	4
Consultation document	2
Commissioned report	4
Government report	16
White paper follow-up	4
TOTAL:	32

In some instances it was difficult to identify which category a document should fit into. For example, while *Choosing Health: Making healthy choices easier* (Secretary of State for Health, 2004) was labelled as a public health white paper by New Labour the paper preceding the white paper, *Choosing Health? A consultation on action to improve people's health* (DH, 2004), was labelled as a consultation document rather than a green paper. This is in contrast to *Our Healthier Nation* (Secretary of State for Health, 1998) which was the green paper preceding the white paper *Saving Lives: Our Healthier Nation* (Secretary of State for Health, 1999).

The sampling strategy for this research took the form of purposive sampling. As a form of non-probability sampling, purposive sampling offers researchers some control over their data collection (Barbour, 2001). Initially documents were selected which were known to discuss the problem of "differences in health". Known commissioned reports and public health white and green papers were sourced first along with other key publications, for example New Labour's action report on health inequalities *Tackling Health Inequalities: A programme for action* (DH, 2003). Documents from New Labour and the Coalition governments were found first as it was relatively easy to find appropriate documents from these governments. Locating suitable documents from the Conservative governments in the 1980s and 1990s proved more difficult partly because they were not as readily accessible and also partly because of unfamiliarity with these publications. These documents were found by working "backwards" from New Labour publications in order to find out what their initial public health papers had been in response to. Documents were added to the analysis as they were discovered through reading the initially selected publications and finding appropriate references to previous publications.

In terms of data collection it was relatively easy to get hold of the documents that were required for this research. The majority (those published post-1997) were available as webpages or PDFs online which could easily be imported into NVivo. Documents that were published pre-1997, with the exception of the Black Report (DHSS, 1980) a copy of which exists online, were only available as hard copies which had to be scanned in using an OCR scanner in order to import them into the NVivo project as text files. The hard copies were kept alongside the text files for the analysis to correct any mistakes from scanning the documents.

3.6 Using CAQDAS

It was decided that a CAQDAS (Computer Aided Qualitative Data Analysis) software package would be used to facilitate the analysis of such a large amount of data. NVivo was chosen as this was accessible on the university network and I have had previous experience with using NVivo to analyse data. This section will discuss the uses of CAQDAS for qualitative researchers and how NVivo was used in this research.

NVivo provides researchers with a number of different tools for their analysis. It is important to recognise that NVivo, like other qualitative data analysis software, primarily works to allow researchers to organise their data in order to facilitate their analysis. In comparison with quantitative data analysis packages, qualitative software does not conduct the analysis for the researcher. In statistical programmes, for example, the researcher enters in their data (usually survey results) and selects appropriate tests to run on specified variables, and the programme will provide them with the result along with a statement of statistical significance. Qualitative software does not provide researchers with "results" as such; it only provides them with a set of tools with which to analyse their data (Weitzman, 2000). Arguably statistical tests are tools which are applied to quantitative data – but with qualitative data the researcher has to develop their own way of interpreting their data through the use of coding, writing memos or summary documents, adding notes onto the data, creating relationships between concepts or items of data, and generating models to summarise or further organise their data. Indeed, NVivo offers researchers a wide variety of tools with which to conduct their analysis but it is ultimately up to the researcher to decide which tools they will use and which they do not require (Richards, 1999).Using software is not a substitute for analysis methods as "the researcher must know what needs to be done, and do it" (Weitzman, 2000: 805). Gibbs (2002: 10) suggests that "the function of qualitative analysis software is more akin to that of a database" as it provides researchers with a way of storing large amounts of data and tools with which to organise their data. Welsh (2002) adds that researchers should exploit the administrative nature of such software in order to organise data effectively and efficiently.

The main features of NVivo used in this analysis were the creation of nodes for coding data, the use of memos to write summaries of documents and initial thoughts, the use of annotations directly in the documents, the creation of relationships between documents that were directly referenced, and using classification sheets to categorise the documents.

The nodes that were created came from the reading of the data and were guided by the research questions outlined in **Error! Reference source not found.**. The aim of the oding was to highlight instances of particular forms of knowledge or discourses that were used in the documents (archaeological analysis), and to see how the use of these discourses changed over time (genealogical analysis). As each document was labelled with its date of publication, the codes appeared in chronological order in each node which made looking at changes over time under each node possible, facilitating the genealogical analysis. The list of nodes that were used in the analysis and their descriptions can be found in Appendix B.

NVivo provides researchers with several different ways in which to make notes or comment on the data in their project file. A project diary document was set up at the outset of the work in order to keep a record of what had been analysed each day and to start to develop ideas about the data. This could then be referred back to as the analysis continued. Memos were used in this research to hold a summary of each policy document and to highlight key quotations or points made in the document. Initial comments and thoughts about the significance of particular statements and the document as a whole would be made in the memos. These notes, along with the coding, would form the basis of the answers to the questions in the research matrix. Annotations were used to directly annotate sections of documents, commenting on particular statements and highlighting them as noteworthy. This might be where a new idea was introduced for the first time, or where a potentially controversial statement was made.

As mentioned above, the key feature NVivo offers researchers is the opportunity to organise data in different ways. As well as using coding to organise the data, this research made use of NVivo's classification sheets and the ability to create relationships between the documents in order to make further sense of the data. Classification sheets were used to group the documents according to the period in which they were published (set according to terms of government) and also according to the type of document they were (refer to Table 3 for types of documents). Relationships were created between documents that had direct references to one another, i.e. which were directly mentioned in the text or referenced in the bibliography of a document. This helped to show the links between sets of documents and resulted in the creation of a model of these reference relationships as shown in Figure 4. This made it possible to see which documents were most often referenced, and also to tentatively identify three main networks of documents: one with Conservative publications
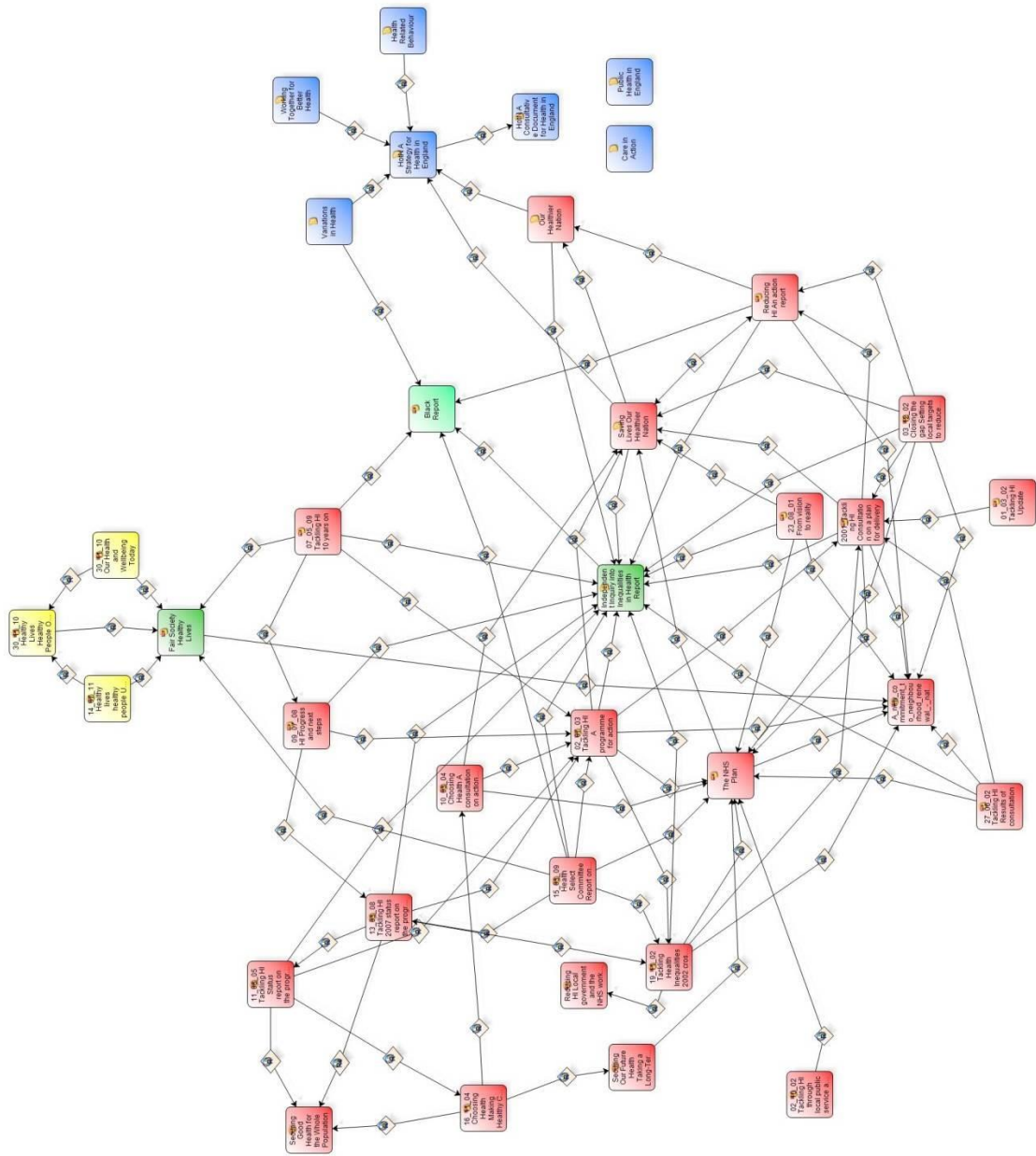
Key:

Blue – papers published under Conservative governments 1980-1997

Red – papers published under New Labour governments 1997-2010

Yellow – papers published under the Coalition government 2010-2011

Green – government commissioned reports

Arrows point towards documents that are referenced in that publication

Figure 4 NVivo generated diagram showing document relationships by direct reference from one document to another

 (in blue), one with New Labour publications (in red), and one with Coalition publications (in yellow). This reflects the idea of the policy document as a technology of government which not only contributes to social change but also allows for the publication of future documents, and reinforces the need for the existence of policy documents (Freeman and Maybin, 2011). The most referenced source in this research was the Acheson Inquiry (Acheson, 1998) and this seems to demonstrate its importance within the New Labour publications. This importance will be emphasised in Chapter 6 which seen through the three networks identified above. This diagram helped to set up the analysis as it allowed for a consideration of where ideas crossed over between governments and so helped in examining the transitions between problematisations of "differences in health".

3.7 Reflecting on the Methodology

This short section will reflect on the process by which it was decided that Bacchi's WPR framework was the most appropriate choice for this research. Initially I was very sceptical of using Foucault and approaches which are influenced by his theories. I was keen not to be seen to be using his work uncritically, as his work on discourse seemed to be the most obvious approach to take when undertaking this kind of research. I spent quite a long time reading other theories of discourse, in particular the work of Fairclough on Critical Discourse Analysis and related approaches. In the end, however, I found that frameworks influenced by Foucault were, in fact, more appropriate for this study because they aligned closely with the aims of the research, outlined in the research questions in the Literature Review (Chapter 2 section 2.10).

There was one point in particular where I was unsure whether I should proceed with Bacchi's WPR framework or if instead I should use Fairclough and Fairclough's (2012) approach focused on practical argumentation for the analysis and discussion of policy documents. The original proposal for this research was primarily based on literature which emphasised the role of argumentation in social policy, such as Majone (1989) and Fischer (2003). My initial literature searches were focused within this area as a result, and led me to Fairclough and Fairclough's (2012) work *Political Discourse Analysis*. This seemed to be promising at first given that the approach recognised the fact that politics involved processes of deliberation and decision-making given that there would be conflicting interests and

values at play, reflecting to an extent the Value-Conflict and interpretivist approaches to social problems (see section 2.3). I found, however, that while this approach was very interesting and did offer a rigorous way in which to analyse political discourse it did not completely match with the overall aims of my research.

The first reason for this was that I was more interested in identifying and examining key assumptions and discourses which emerged from the analysis of policy documents, as opposed to examining the development of one specific argument through the use of rhetoric. It became clear from a closer reading that Fairclough and Fairclough's approach, while very interesting and well developed, was almost a very close technical linguistic analysis as opposed to the analysis of wider ideas which influenced political discussions of problems. Linguistic analysis was not an area with which I was familiar, and nor was it really related to the overall aims of the research. I was much more interested in identifying the wider ideas and "frameworks of thought" which influenced particular ways of understanding the problem of "differences in health" as opposed to an in-depth linguistic-style analysis of the texts in order to examine the exact logical structure of the arguments.

The second reason was that Bacchi's WPR framework was clearly much more suited to the continued analysis and comparison of multiple documents, and in relation to this the third reason was that the WPR framework offered much more flexibility in terms of analysing documents over time. The WPR framework does highlight that it is important to consider how and why a particular representation is dominant at a specific point in time (archaeology), however it also emphasises the need to consider changes over time (genealogy). Fairclough and Fairclough's approach seemed to focus more on arguments made in specific documents or speeches, and did not offer a clear way of explaining change over time. The need to be able to explore changes in representations of the problem of "differences in health" was a central aspect of this research and required the ability to rigorously examine multiple individual documents as well as being able to provide a clear account of change over time. The WPR framework fulfilled both of these criteria, as well as emphasising the role that discourse and ideas play in the representation of problems in the first place.

Finally Fairclough and Fairclough's approach is clearly intended to be used to analyse the dialogue of speeches and political discussions. This means that it is not that well suited to the analysis of a policy document which is essentially a monologue. Their approach would require further development in order for it to be used successfully to analyse policy documents, in comparison to Bacchi's WPR framework which is designed to be used to

question documents specifically but can also be applied to other texts such as speeches and media discussions of political issues.

Having concluded that Bacchi's WPR framework was the most appropriate out of these two approaches for this research, it became obvious that understanding Foucault's theories of problematisation, archaeology and genealogy were key to being able to successfully conduct a rigorous analysis of English public health documents. This helps to explain why a great deal of this chapter explores the WPR framework in depth as I felt it was necessary to be extremely clear about how Foucault's work was useful for analysing social problems in social policy, and to demonstrate that the choice to use the WPR framework was not taken lightly.

3.8 Conclusion

This chapter has set out the methodological rationale for this research and the justification for using Bacchi's (1999, 2009) WPR framework to conduct the analysis. The problem, as identified in the Literature Review in Chapter 2, is that often the analysis of health policy is focused on the advantages and disadvantages of different solutions to health problems such as health inequality or "differences in health". Typologies of health inequality policy do not go far enough as they tend to be ahistorical, lack a critical engagement with the nature of social policy, and also take the problem for granted.

The chapter began by comparing and critiquing two existing approaches to health policy analysis, Kingdon's (1995) policy windows model and a broad Foucaultian post-structuralist approach, before arguing that the WPR framework is the most appropriate approach to use for this research. The WPR framework will help to address the gap that currently exists in the literature on typologies of health inequality policy as it actively encourages the researcher to compare problem representations over time, to consider the role of social policy in the processes of governing (including the construction of identities for groups and individuals), and also strongly encourages critical questioning of existing policy discussions of social problems in order to examine underlying assumptions pertaining to the identification of, and proposed solutions to, social problems.

The discussion then provided a more in-depth theoretical exploration of the WPR framework and used this exploration to identify the three key parts of the analysis. The first, following Foucault's concept of problematisation, will identify the way in which the problem of "differences in health" has been represented at different points in time. The second, using the archaeological method, will explore these problem representations in order to discover the underlying assumptions and frameworks of thought which shape the problematisations, focusing in particular on the different discourses which are utilised in discussing the problem and its solutions. Finally, using the genealogical method, this research provides a history of the development of problematisations of "differences in health" in English health policy, focusing particularly on the emergence and transition between different problematisations. The chapter has also outlined the sampling strategy for the analysis and the use of NVivo to facilitate the analysis and provided a short reflection on the process of developing the methodology.

The following four chapters will present the findings of this research, outlining and discussing three problematisations of "differences in health" and identifying the governable subjects that are produced by these problematisations, which is possible through the use of a post-structuralist approach to policy analysis.

Chapter 4
Introducing the analysis

Three problematisations of "differences in health" have been identified as a result of the use of Bacchi's (2009) WPR framework in the analysis. That is to say, three different (though not mutually exclusive) ways of understanding and representing the problem of "differences in health" are visible in English public health policy between 1980 and 2011. The archaeological analysis made it possible to ascertain these different ways of representing the problem, while the genealogical analysis related the emergence of each problematisation to specific contextual changes and wider frameworks of thought. The transitions between each problematisation were also considered as part of the genealogical analysis in order to demonstrate the underlying assumptions of policies and the frameworks of thought which shaped them over time. By approaching the analysis from a Foucaultian post-structuralist perspective it has been possible to not only identify the problematisations but to question them, to reveal underlying assumptions about the problem of "differences in health", to relate these assumptions to the dominant *epistemes* at different points in time, but also to ascertain the governable subjects produced by each problematisation.

The following three chapters will outline each problematisation in turn. Chapter 5 will discuss the "Informational" problematisation, Chapter 6 the "Constraints" problematisation and Chapter 7 the "Paternalistic Libertarian" problematisation. Table 4 provides an overview of each problematisation and its governable subject. In summary the Informational problematisation was concerned with improving health through the provision of information to the public to help them make informed choices about their health. The governable subject of the "responsible chooser" emerged as a way of presenting expectations that people would make responsible choices about their health, particularly when information was provided which suggested they should change their behaviour. This problematisation corresponded with public health thinking in the 1980s and early 1990s. The Constraints problematisation replaced the Informational problematisation from the late 1990s and was concerned with addressing the constraints people face when making choices about their health, and these constraints were mostly argued to be beyond the control of the individual. The governable subject of the "constrained chooser" emerged as a way of representing the fact that people may have limited choices they can make when it comes to

Table 4 Problematisations of "differences in health" and their governable subjects

	Informational	**Constraints**	**Paternalistic Libertarianism**
Governable subject	*Responsible chooser*	*Constrained chooser*	*Flawed chooser*
Context	- Rise of a new health consciousness (healthism) - Challenges to medical dominance - Concerns surrounding welfare spending	- Information alone is not enough to improve health - Conservative government's first health strategy - Introduction of New Labour's "Third Way" welfare approach	- Changing assumptions about how individuals make choices - Influence of behavioural sciences on policy - Importance of lifestyle choices
What is the problem?	People lack appropriate information to make decisions about their health	People's health and the choices they make about their health are affected by their socio-economic standing	People's choices about their health are influenced by external cues and existing habits leading to poor choices
Why is this problematic?	Potential reduction of healthy workforce, and facing increasing spending on welfare state	Health inequalities are avoidable, unjust and unfair. People should be able to flourish regardless of their position in society	People are harming themselves by following poor lifestyles, leading to increasing levels of illness
Solutions	Provide people with more and better information to make choices about their health	Provide more opportunities for people to improve their health	Shape and guide the kinds of choices people make about their health by "nudging" people towards particular choices

their health, and highlighted the need for a commitment by the government to remove these constraints and to provide opportunities for people to improve their circumstances. The Constraints problematisation was dominant from the late 1990s until the late 2000s when the Paternalistic Libertarian problematisation developed. Following challenges to traditional ways of understanding how individuals make choices, this problematisation was concerned with how the surrounding physical and social context could be used in order to shape the types of choices people made about their health. Individuals were viewed as "flawed

choosers" who required "nudging" towards particular lifestyle choices in order to improve their health.

It will become clear in the discussions the following chapters that while each problematisation is associated with a particular government, the transitions between problematisations are much more fluid, with shifts towards a new problematisation visible before there is a change in government. This demonstrates Foucault's (1991b) argument that rationalities of government are not reducible to party politics but instead form part of an underlying framework of thought which shapes political thinking. It is also important to note that the transition from one problematisation to another does not involve a "paradigm shift" to a completely new way of thinking rejecting previous understandings of "differences in health". As will be shown in the following chapters elements of the previous problematisation can be found in the emergence of a new problematisation.

As the concept of problematisation involves what can and cannot be said about a particular object, the following chapters aim to outline the discursive formations produced by each problematisation. The discussions will not only highlight the key assumptions which underpin policy understandings, or representations, of the problem of "differences in health", they will also involve the identification and exposition of the *governable subject* produced by each problematisation. The governable subject involves the consideration of the assumptions made about human practices (Rose, 1999), specifically concerning motivation to act in certain ways and having the capacity to take that action through agency (Le Grand, 2003), which in turn help to shape the way problems are viewed and the types of solutions put forward. It is possible to see from the governable subjects highlighted in Table 4 that there is a clear emphasis on choice in relation to the problem of "differences in health" given that they are all suffixed with "chooser". As will be highlighted in the following three analysis chapters (5, 6 and 7) and the resulting discussion (Chapter 8), it seems as though the problem of "differences in health" in English public health policy has always been underpinned by a need to understand how individuals make choices about their health, and to act according to those understandings in order to ensure that people make healthier choices.

Chapter 5
The Informational Problematisation

5.1 Introduction

This chapter will outline and discuss the first of the three problematisations of "differences in health" as found in the discourse analysis of English health policy. As suggested by its title, the Informational problematisation is concerned with the provision and use of information in relation to people's health. Its main focus is with the need to provide appropriate information to the public to ensure that people make better decisions about activities and behaviours that will impact their health. The way to improve health, and therefore reduce "differences in health", is to provide people with information which will allow them to make choices that will positively impact their health. Individuals are conceptualised as "responsible choosers" within the Informational problematisation. This problematisation recognises that people not only have choices open to them affect their health, for example how much they smoke, drink and exercise, they also have the capacity to successfully make choices that will affect their health. This means that individuals have to accept responsibility for the choices that they make not just for how those choices impact on themselves but the potential wider consequences of those choices as well, particularly relating to the need to use health services. It is assumed, therefore, that people have a degree of control over the decisions they make and these decisions can be improved through the provision of information from the government, thereby helping to improve health and reduce "differences in health".

The chapter will begin with a discussion of the context for the emergence of the Informational problematisation. This will involve an examination of a number of influences on the development of public health in the 1980s including; concerns about the state of the nation's economy and spending on the NHS; challenges to the dominance of medicine in public policy through the rise of the perspective of the New Public Health; and the rise of ideas about "healthism" which underlined the importance of individual responsibility for health. The chapter will then turn to discuss the role of information in relation to improving health for this problematisation, exploring the importance of information for improving the choices people make at the individual level and for improving efficiency at the government

level. Finally the chapter will discuss the production of the "responsible chooser" as the governable subject for the Informational problematisation.

This chapter will be organised in a more thematic manner than the following two analysis chapters. This is due to the fact that there are only a few documents from the period which demonstrated the Informational problematisation (DHSS, 1981; DHSS, 1988; Secretary of State for Health, 1991; Secretary of State for Health, 1992) and therefore it makes better sense to focus on the overarching themes of the Informational problematisation rather than presenting a more chronological analysis. The lack of documents relating to public health over this period may well be reflective of the problematisation itself, given the emphasis placed on the need to provide information to the public in order to make them "responsible choosers". This would have meant that there would have been little need for continuing interventions from public health policy if the main responsibility was with individuals to make healthy choices. This would also help to explain why the Conservatives during the 1980s were criticised for lacking a health strategy (Baggott, 2004; Wainwright, 1996), and why the publication of *The Health of the Nation* (Secretary of State for Health, 1992) was considered a turning point in public health policy. If their belief was that people would make the right choices given the right information to help them make decisions, then there would be no need for more interventionist strategies.

The three problematisation chapters will still be comparable despite their difference in format. This is because Bacchi (2009) does not stipulate a particular way of organising findings when using the WPR framework. While the analysis involved the use of the six questions in the WPR framework, the chapters do not work through each question one by one in order but rather combines them in order to prevent a strong account of each problematisation. The results that have been shown across the three chapters are the most relevant and powerful parts of the analysis which demonstrate the presence and defining characteristics of each problematisation.

5.2 The emergence of the Informational problematisation of "differences in health"

As the Informational problematisation is the first to be explored in these analysis chapters it is necessary to provide some background context in order to discuss the emergence and dominance of this problematisation of "differences in health" throughout the 1980s and early 1990s. This section will highlight the emergence of the New Right political perspective in relation to concerns about spending on the NHS and the development of computer technologies establishing the pre-conditions for managerialism approaches. The increasing emphasis on individual responsibility for health will be demonstrated through the emergence of "healthism" (Crawford, 1980). It will also briefly examine the development of public health perspectives in the 1980s and the challenges these posed to medicine's dominance over health issues.

Klein (2006) argues that the politics of the health policy arena of the 1980s was largely shaped by the adverse economic effects of the oil crisis in the mid-1970s. The economic downturn which followed meant greater competition for increasingly scarce resources, and raised concerns about current welfare spending and in particular spending on the NHS. As Powell (1997: 68) notes "[t]he era of national economic growth that had made it relatively easy to finance annual increases in public expenditure halted". Although the NHS remained relatively protected from spending cuts "in comparison with past growth rates, it was pinched" (Powell, 1997: 68). Continued growth in expenditure in the previous decades had led to expectations that money would always be available to accommodate the expansion of services and the funding of new treatments. As a result of the economic crisis government exerted much greater control over financial spending which "focused even greater attention on the need for greater efficiency in order to maximise the use of existing resources" (Baggott, 2004: 93). This in turn led to a politics of conflict between the main political parties as to what should be done to alleviate the situation. The economic crisis essentially "compelled a choice between continuing to expand the public sector and maintaining disposable consumer incomes" (Klein, 2006: 78).

When Thatcher was elected in 1979 the ideology of the New Right became the dominant political force which continued to shape policies, including those around health, throughout the 1980s and early 1990s (Lister, 2010). Lister (2010) summarises the ideology of the New Right under two separate, but related, strands of thought. The first neo-liberal economic strand emphasised the role of the market and of individual rights. The second neo-

conservative strand acted as a moral guide for the New Right, underlining the importance of social institutions rather than the state and of particular social values such as personal responsibility. Both of these strands were instrumental in the development of health policies in this period.

The more economically focused neo-liberal strand of New Right thinking questioned contemporary approaches to public spending on welfare and was specifically interested in ways of reducing state spending. Indeed an overall ideological goal of the New Right was to reduce the state's role in the provision of welfare and to replace it with a market of different welfare providers (Lister, 2010). The government soon realised, however, that there were limits as to what the market could replace, and the NHS was one such area where they faced problems. Instead of replacing the NHS the government turned to examine how spending could be reduced, but soon found that "it proved politically impossible to reduce NHS expenditure" (Powell, 1997: 73). This meant that attention shifted to maximise the outcomes from existing expenditure and concerns were raised about the efficiency and effectiveness of the NHS.

Discussions concerning the efficiency of the NHS largely dominated health policy of the period. The New Right perspective stressed the importance of management and the effective use of resources in health care which meant that the NHS could not escape "increased emphasis upon private sector management principles and techniques, a stronger focus on efficiency, cost control, and performance management, and ultimately processes that were intended to mimic market mechanisms" (Baggott, 2004: 99), which acted as a compromise for being unable to replace the NHS with a market system in its place, such as the creation of the internal market for health care (Gabe, Bury and Elston, 2004). If the government was to successfully curb spending on the NHS then it needed to use its existing resources to greater effect and it was argued that better management of the NHS would contribute to greater levels of efficiency. Public health also found itself under scrutiny given this new emphasis on managerialism and the importance of targets to evaluate performance. Indeed the later Conservative public health white paper *The Health of the Nation* (Secretary of State for Health, 1992) included a range of targets designed to improve health outcomes, and ultimately to help reduce demand on the NHS and its services. While the paper argued that the targets were necessary in order to better organise the government's priorities for public health, critics of the strategy argued that the targets were simply "extrapolations of existing trends, designed to make sure that the government would be able to congratulate

itself on making good progress towards them" (Powell, 1997: 83) rather than using the targets to instigate real changes that would lead to further improvements in health beyond these trends.

It is important to note here that while *The Health of the Nation* was criticised for the way it set targets, it was recognised as a turning point in public health as it was the first time that a Conservative public health strategy had acknowledged the existence of wider societal influences on health. The importance of this development will be outlined and discussed in the following chapter on the Constraints problematisation as it helped to pave the way for an alternative policy understanding of "differences in health". The paper included elements of both the Informational and Constraints problematisations as although the paper did recognise that wider action beyond the provision of information to the individual should take place, there was still a strong emphasis on the responsibility of the individual for their health.

Technological changes also paved the way for approaches based on managerialism to become possible. Rapid developments in computing technology meant that more data could be gathered, stored and analysed than had been possible before. More complex forms of analysis could also be carried out which meant it was easier to establish and observe trends, making establishing targets and monitoring progress towards targets much more feasible.

The second neo-conservative strand of the New Right not only reinforced the idea of rolling back the state in terms of providing welfare, but also emphasised the role of individual responsibility (Lister, 2010). Le Grand (2003) argues that there was a change in understanding of individual motivation and agency from the 1980s onwards. Instead of viewing individuals as passive subjects people were seen to be more self-interested and wanted to have choices available to them. People were no longer content putting up with sub-standard services simply for the collective benefit of society. They wanted to be able to make more choices themselves which better suited their needs, which obviously entailed increased responsibility for the individual. This is particularly pertinent to the following discussion of public health in the 1980s and early 1990s in this chapter as approaches were underlined by an understanding that individuals must take greater responsibility for their health. Individual responsibility went hand in hand with the view that individuals have choices about their health and they should be able to exercise their right to make choices.

This increasing emphasis on individual responsibility was reflected in the broader discourse of "healthism" which Crawford (1980) defines as "the preoccupation with personal health as a primary – often *the* primary – focus for the definition and achievement of well-being" (Crawford, 1980: 368). The idea of being healthy, or disease-free, is something which was put forward as highly desirable. While there is some acknowledgement that there are wider influences on health, the perspective of healthism is primarily interested in promoting the idea of individual responsibility for health. Crawford identified this tendency more in the field of self-help than of holistic approaches to health, but noted that they both "seek to reduce the reliance of individuals on medical practitioners and substitute individual and group activities aimed at improving health, coping with chronic disease, acquiring diagnostic and therapeutic skills, and adopting disease prevention strategies" (Crawford, 1980: 366). Solutions to health problems, then, were seen to lie within behavioural factors which are ultimately the responsibility of the individual.

The New Public Health movement gained momentum in the 1980s, particularly as a result of Thatcher's government effectively ignoring the findings and recommendations of the Black Report (DHSS, 1980). The report had been commissioned under a Labour government but reported to a Conservative one, arguing that health inequalities were the result of structural and material factors leading to disadvantages adversely affecting health. Despite the fact that the government chose to disregard the report it played a vital role in stimulating debates in the wider public health and academic communities (Hunter, Marks and Smith, 2010). The New Public Health movement developed around this time and was concerned with "enabling people to increase control over and improve their health" (Ashton and Seymour, 1988: 25). While the New Public Health was concerned with noting the importance of environmental and social factors on health there remained a strong emphasis on the role of lifestyle choices at the individual level, on how individuals interacted with their environment (Armstrong, 1993). The Conservative governments of the 1980s and 1990s did not readily accept the wider structural explanations for "differences in health" but were keen to adopt explanations around individual choices which provided a better "fit" with their political ideology and the desire to increase individual responsibility for health.

It is clear, then, that a number of factors played a role in shaping the context for the Informational problematisation to emerge. The rest of this chapter will focus on presenting the analysis of documents from between 1981 and 1992, demonstrating the influence of New Right thinking on public health approaches during this time and in particular highlighting

the focus on individual behaviour as the main explanation for "differences in health". As a result of this emphasis the Informational problematisation produced the "responsible chooser" as its governable subject, presenting the ideal individual as someone who makes responsible informed choices about their health which not only benefits the individual themselves but also helps to reduce demands on the NHS through the prevention of avoidable illnesses.

5.3 Using information to change health behaviour

The Informational problematisation emphasises the role that information can play in changing people's behaviour at the individual level. As such, the individual is considered to have a high level of responsibility for their own health and the key assumption within this problematisation is that behaviours can be changed through the provision of more and better information to the public.

From *Care in Action* (DHSS, 1981) to *The Health of the Nation* (Secretary of State for Health, 1992) it is clear that the Conservative government placed a great deal of emphasis on personal responsibility for health. Their views on individual responsibility can clearly be seen in the opening paragraph to chapter 2 of *Care in Action* entitled "Prevention":

> *The prevention of mental and physical ill-health is a prime objective, and an area in which the individual has clear responsibilities. No one can wholly escape illness or injury, but there are plenty of risks to health which are within the individual's power to reduce or avoid. Too many endanger their health through ignorance or social pressures. Public action can give people the information they need to make sensible decisions about personal health, and encourage in the community a responsible attitude towards health matters. (DHSS, 1981: par. 2.1)*

This paragraph not only highlights the importance of individual responsibility for preventing illness or injury but also of the role that information should play in changing behaviour. It is assumed that the provision of information alone will alter the choices people make as once they have been informed that certain behaviours are harmful to health they will be able to "make sensible decisions about personal health". Individuals are seen to be responsible actors who will act on information given to them and will change their behaviour accordingly. The paper went on to argue that action at the local level was required in order to "help

appreciate that much illness is avoidable and that avoidable illness pre-empts resources needed for the treatment of the unavoidably sick" (DHSS, 1981: par. 2.8). This provides more of a context for increased individual responsibility as there are links to the concerns with the efficient and effective use of resources. Individuals should therefore be made aware that they have a responsibility to prevent themselves falling ill not just for their own benefit, but for the benefit of others who are seen to be more in need of limited resources.

Here we can see the use of Crawford's (1980) "potential sick role". In contrast to Parsons' (1952) "sick role" where the individual is not seen to be responsible for their illness and are allowed temporary respite from normal social roles while they recover with the aid of medical help, the "potential sick role" emphasises that individuals have a responsibility *not* to fall sick in the first place: "As potentially sick, individuals are experiencing more intense social pressures to act in ways to minimise that potential" (Crawford, 1980: 378). This means that when people do fall ill there is a sense that this reflects a moral failing on the part of the individual, or a weakness of character. While there may be wider influences on health, within this problematisation the onus is placed on the individual to effectively manage external influences by controlling their own behaviour. As Crawford argues the solutions to health problems within such thinking "rests within the individual's determination to resist culture, advertising, institutional and environmental constraints, disease agents, or, simply, lazy or poor personal habits" (Crawford, 1980: 368).

Consequently public health thinking at this time emphasised the importance of considering the impact on lifestyle choices on health. The broader definition of public health put forward in *Public Health in England* (DHSS, 1988) highlighted this new area which required addressing. Following this new definition the paper stated that

> *The importance of advice and information in helping people to maintain good health and to prevent disease has been recognised for many years…* **However, it is the growing awareness of the importance of individual behaviour in determining the patterns of health and disease in the population which represents perhaps the greatest single change affecting public health in recent years.** *Today it is widely recognised that smoking, diet, and lack of exercise are factors which contribute to many premature deaths from lung cancer and cardiovascular disease and, together with the untoward effects of alcohol, play a major part in many other forms of ill health.* **Our ability to reduce such premature deaths is to a substantial extent dependent on social attitudes and individual understanding and behaviour.** *(DHSS, 1988: par. 4.20, emphasis added).*

The highlighted sections of this paragraph demonstrate the emphasis placed on the importance of individual behaviour in relation to health outcomes. It seems as though ultimately individual behaviour is the driver behind observed patterns in health and illness, and that changing the mind set or attitude of individuals is key to reducing levels of disease in the population. This is because the types of behaviours individuals engage in on a daily basis affect their health. Lifestyle choices therefore are an important factor in determining the health of individuals, and changes to lifestyles are needed if avoidable illness is to be prevented. The continuing emphasis on lifestyle choices can be seen in *The Health of the Nation* when it discusses the role of health education initiatives in ensuring "that individuals are able to exercise informed choice when selecting the lifestyles which they adopt" (Secretary of State for Health, 1992: par. 1.6). In order to make informed decisions "people need information to help make the right choices" (Secretary of State for Health, 1992: par. 3.8). The aim of the provision of information, therefore, was to encourage people to change their lifestyles and behaviours to those which are conducive to good health and to understand that future health is dependent upon the choices that they make in the present.

Individuals are therefore expected to prevent "avoidable" illnesses through changing their behaviours as a result of new information or advice about the harmful or beneficial effects of particular lifestyle choices. Not only is individual responsibility for health emphasised by this perspective, but there is also a clear underlying assumption driving this perspective about how individuals (should) behave. The assumption is that individuals are responsible actors who will change their behaviour when presented with new information or options that will allow them to improve their health. People are therefore expected to act on such information in order to prevent future illness as part of a wider understanding of rational action. It assumes that people have the capabilities to make such decisions freely and even in a similar way as a consumer would rationalise the purchase of a product. The reduction in health care spending could only come through solutions which prevent people from becoming ill in the first place and using resources unnecessarily. This prevention would be achieved through better informing people about lifestyle choices that affect their health, and allowing people to make the "right decisions" about their health. There is also a sense that people should be made to feel guilty if they fail to make the "right decisions" and become ill due to lifestyle excesses because of the fact that the resources available to treat the sick are limited. It seems as though there is a dichotomy of the "deserving" and the "undeserving" sick.

5.4 Using information to increase efficiency

The provision of information to the public in order to improve their decision-making was not the only role that information had to play in the Informational problematisation. It was recognised that the government itself required more and better information about the health of the population in order to develop more effective, and most importantly efficient, policies relating to both public health and the health care system (DHSS, 1988).

As discussed section 5.2, one of the key contextual developments which gave rise to the Informational problematisation was the financial crisis in the 1970s. This crisis changed policy thinking and, combined with the rise of the ideology of the New Right, led to increasing concerns with the way economic resources were managed and with the efficiency of existing services such as the NHS and public health. The state of the nation's economy was seen to dictate how scarce resources were to be allocated in the future, and this is demonstrated to be the case with health care services in *Care in Action* (DHSS, 1981) by Patrick Jenkin, the then Secretary of State for Social Services, in his opening letter:

> *I am sure that you do not need reminding that the Government's top priority must be to get the economy right; for that reason, it cannot be assumed that more money will always be available to be spent on health care. (DHSS, 1981)*

The government's desire to reduce, or at least curb, spending on the NHS is reasoned here as being because the government must focus on improving the economy rather than due to ideological concerns regarding the state's role in welfare. The paper highlights the issue of health care spending further by commenting that:

> *constraints will be tight for the foreseeable future; decisions have yet to be taken as to the amount that can be devoted to health beyond 1982/83. Against this background the document emphasises the need to obtain the best value for money in terms of health care for the public, and the need for a proper ordering of priorities. (DHSS, 1981: par. 1.3)*

Once again this emphasises the need for spending on health care services to be reconsidered in light of economic constraints, but also touches on the issue of the efficient use of existing resources in order to "obtain the best value for money". This would be achieved through a reconsideration of the use of existing resources and priorities within the health service and public health.

The publication of *Public Health in England* (DHSS, 1988) provided some answers to the problem of efficiency in the field of public health. The report was commissioned in 1986

after two major disease outbreaks which led to public inquiries; salmonella food poisoning at the Stanley Royal Hospital in Wakefield in 1984 and an outbreak of Legionnaires ' disease at Stafford in 1985. This document was not only tasked with considering "the future development of the public health function" but also need to recognise "a continued need for improvements in effectiveness and efficiency" (DHSS, 1988: par. 1.1) within public health. The paper echoed concerns raised in *Care in Action* (DHSS, 1981) that the resources that could be devoted to health care were limited and strongly advocated preventative approaches to disease in order to reduce demands on the NHS. As such, the paper proposed the use of public health measures in order to prevent disease outbreaks such as those which triggered the need for the report in the first place.

The paper opened its discussion of public health with a new working definition of public health as "the science and art of preventing disease, prolonging life and promoting health through the organised efforts of society" (DHSS, 1988: par. 1.3). It was noted that in the past public health had often been narrowly defined and associated with sanitary hygiene and the control of epidemics. The broader definition adopted by the paper, however, "gives as much weight to the importance of lifestyle as to environmental hygiene in the preservation and promotion of health" (DHSS, 1988: par. 1.3). The importance of lifestyle choices on health is discussed in more detail in section 5.5 below.

If the government were to successfully act on this new definition of public health, the paper argued that the government would require more information about the health of the population. The paper raised concerns that there was a "lack of specific focus at the centre with the capacity to monitor the health of the population and to feed the results of any analysis into the development of health policy, strategy and management" (DHSS, 1988: par. 4.5). This included not only information regarding mortality and morbidity rates but also about risks to health, which could then be readily communicated to the public or used to develop more effective health policies. In order to address this organisational and informational gap, *Public Health in England* advocated the use of epidemiology which it defined as "the study of the distribution and determinants of health and disease in populations" (DHSS, 1988: par. 3.6).

Epidemiology was seen as an essential tool which could be used to develop effective policies and interventions at the national level, as well as helping to identify priorities in different areas for local government. It was suggested that, in order to achieve the full benefits of what epidemiological studies could offer, the government should establish a

central unit which would bring together a variety of disciplines and skills to monitor the health of the public. Indeed this recommendation was followed up and by the publication of *The Health of the Nation* (Secretary of State for Health, 1992) the government had set up the Central Health Monitoring Unit which aimed to "improve the Department of Health's analyses of the epidemiological data which underpins the formulation and implementation of policy" (Secretary of State for Health, 1992: par. 5.3). The white paper recognised that a wide information base was needed "to develop the health strategy and monitor progress" (Secretary of State for Health, 1992: par. 5.3) which not only included the Central Health Monitoring Unit but also the development of a new national health survey, the assessment of health outcomes, annual reports from Directors of Public Health, information from the NHS, and data from the Department of the Environment on levels of pollution. All of these facts would contribute to the Department of Health's information strategy.

Increasing the amount of research in epidemiology was also seen as necessary for the creation of clear objectives and specific targets for health policy. The importance and centrality of targets was made clear in *The Health of the Nation* green paper:

> *These give a common sense of direction and purpose and a tangible result at which to aim, and stimulate the development of the ability to assess, compare and contrast performance. They also provide a measure by which to decide action and use of resources and by which to judge success. (Secretary of State for Health, 1991: par. 2.8)*

The introduction of targets into health policy reflected a drive towards managerialism and performance management, highlighted in the thinking of the New Right. Not only did targets help to organise the priorities of policy makers, allowing them to focus on a specific set of issues, they also provided a way of monitoring the use of resources and whether or not progress was being made towards reaching the proposed target. Interestingly the language used to describe the observation of progress towards achieving targets as well as the changing levels of health and illness in the population changes quite dramatically from *Public Health in England* (DHSS, 1988) to *The Health of the Nation* (Secretary of State for Health, 1992) white paper. It is possible to discern a shift in emphasis from the need for "surveillance" of the population and progress to the need to "monitor" interventions and health trends. Table 5 demonstrates the number of times that the words "surveillance", "monitor", "monitored" and "monitoring" occur in *Public Health in England* and *The Health of the Nation* green and white papers. Even between the publication of the green and white papers there is a significant move away from using the word "surveillance" in favour of "monitoring"

progress and the population. This could possibly be due to "surveillance" conveying authoritarian undertones of an ever watchful state, while "monitoring" perhaps suggests a less intrusive form of observation.

Table 5 Count of words used to describe the progress towards targets and observations of population health

	Public Health in England (1988)	*The Health of the Nation* green paper (1991)	*The Health of the Nation* white paper (1992)
Surveillance	44	13	4
Monitor	11	23	12
Monitored	0	8	11
Monitoring	22	29	34

The Health of the Nation (Secretary of State for Health, 1992) emphasised the importance of targets in the development of "a strategic approach to health" and set a precedent for future public health strategies as one of the aims of the document was to identify key areas where progress could be made. The paper was hailed as the start of "a continuing process of identifying priority objectives, setting targets and monitoring and reviewing progress" (Secretary of State for Health, 1992). Targets and objectives would therefore change over time, but the premise of new strategies would be the same – to establish priority areas for action and to monitor progress in the work towards reaching set aims and targets. Research and monitoring of progress were also considered to be "especially important in tackling the variations in health between different groups in the population" (Secretary of State for Health, 1992: par. 2.5).

The new forms of data collection and monitoring offered by epidemiology represented the inclusion of new technologies of government in order to better understand the distribution of illness in society, the effectiveness of existing measures of improving health outcomes, and to use this new information to develop new policies in the future. Identifying the most powerful determinants and those groups which were seen to be most "at risk" from particular diseases would then help the government to establish priorities and targets which it could focus on. Another consequence of the use of epidemiology was the creation of a new subject – those who were "at risk" of falling ill. Not only were there people who were already suffering from poor health and those who had high levels of health, but now there was another group who had the potential to fall ill if no preventive action was taken.

It was therefore necessary to develop solutions which were focused on the prevention of ill-health. Within the Informational problematisation solutions were centred on the provision and use of information about health, not just for the government but, more importantly, for the individual as well. The discussion will now turn to look at the emphasis the Informational problematisation placed on individual responsibility for health, and how the provision of information would shape that responsibility.

5.5 The need for the "responsible chooser"

As discussed throughout this chapter the Informational problematisation of "differences in health" is primarily concerned with the need to provide the public with more and better information with regards to choices about behaviours and activities which can positively or negatively impact on a person's health. Public health's main task, therefore, was to inform the public about risks to their health and how to avoid unnecessary risk in order to prevent avoidable illness and injury. It was thought that this would allow individuals to make informed decisions about their health which would not only benefit the individual in terms of them achieving better health; people making choices which improved health and preventing illness would help to reduce demands on the NHS allowing existing resources to be used more effectively, and would also contribute to the meeting of government targets relating to health trends across the population.

The governable subject of the "responsible chooser" arose from the development of more individualist discourses around health and from the need to improve efficiency in the NHS. In the case of the Informational problematisation, the "responsible chooser" can be seen as both a way of policy makers conceptualising individuals' motivation and agency, the assumptions about which shaped policy responses to "differences in health", and also as a set of expectations about how individuals should make decisions about their health. The main underlying assumptions of the "responsible chooser" are, following the ideology of the New Right, that everyone has the same capability to make choices regardless of their social position and that as a result of this autonomy individuals must be responsible for the choices they make, the results of which can be viewed in their current state of health. Echoing neo-liberal economic thinking individuals are understood to be consumers of health, and as such they have the capability and responsibility to make choices about their health. The

Informational problematisation recognises, however, that people-as-consumers require information in order for their decisions to be fully informed. The state must, therefore, provide information to the public in order to encourage them to make the "right" choices, particularly when it comes to lifestyle options (i.e. diet, alcohol consumption, smoking, and exercise). The observed variations in health were seen to be the result of poor information provision, leading to individuals making bad choices about their health. While the health strategy outlined in *The Health of the Nation* (Secretary of State for Health, 1992) acknowledged differences in health outcomes according to social class, there was still a strong emphasis placed on the individual to make responsible decisions about their health.

The need for people to take greater responsibility for their own health also stems from concerns with spending on health care services and a need for efficiency within the NHS to be improved. The prevention of "avoidable" illness was viewed as a way of reducing demand on the NHS which would allow existing resources to be used more efficiently, and allow spending to stabilise rather than increase. The "responsible chooser" then has a responsibility not just to themselves, but to wider society about the choices they make.

This section has been titled "The need for the "responsible chooser"" because the solution of better information provision will only work if individuals recognise their responsibilities when making choices about their health. It seems as though the government is telling people how they should be making choices, to be more aware of the consequences of their actions, and to exercise self-control where necessary. People should be aware that failing to prevent avoidable illness is not only a problem for the individual, but also for the NHS in terms of the effective use of resources. The public are therefore expected to act on information and guidance provided by the government in order to make informed decisions about their health which take into account these wider responsibilities to themselves and society.

The Informational problematisation and the governable subject of the "responsible chooser" remained the dominant conceptualisation of "differences in health" throughout the 1980s and early 1990s. The emphasis on individual responsibility for health reflected New Right understanding of behaviour. This problematisation rejected the view that "differences in health" were caused by external influences on health, and argued instead that it was differences in individual behaviours that caused these variations in health. People needed to be made aware of poor lifestyle choices and were expected to resist outside

influences, such as advertising, and make informed choices about their health based on information provided by reliable sources.

5.6 Conclusion

This first findings chapter has outlined and discussed the emergence of the Informational problematisation of "differences in health". It has identified the importance of economic concerns and the development of wider discourses on individual responsibility stemming from New Right ideology as the key drivers for this problematisation. The documents discussed in this chapter presented arguments that given the concerns with the nation's economy, greater attention had to be paid to the prevention of ill health if spending savings and improvements to efficiency were to be made.

The role of information in preventing illness and improving levels of health is central to the Informational problematisation. Following an outline of the context surrounding this problematisation, the chapter discussed the role of information in changing individual behaviour. It was assumed in the documents discussed that the provision of information would encourage people to change their behaviour, in particular through avoiding activities or choices that would be harmful to their health or alternatively making decisions that would improve their health. The chapter then discussed the government's need for information in order to inform developments in health policy. By adopting an epidemiological approach to the study of public health the government could use the data gathered to create more effective policies, in particular through targeting specific interventions at groups who were found to be most at risk of morbidity or mortality.

The governable subject of the "responsible chooser" emerged from these two key characteristics of the Informational problematisation. It was assumed that individuals were responsible actors who would act in their best interests, including changing their behaviour where that behaviour was harmful to health. There also seemed to be an expectation that setting out this particular subject would ensure that people acted in this way.

It has been shown that the provision of information was a central aspect of public health approaches in the 1980s and early 1990s, in particular to address the problem of "differences in health". From the early 1990s, however, it is possible to see changes in the

understanding of "differences in health" as a social problem and consequently how public health policy should address it. Instead of viewing the cause of the problem as the result of differences in behaviour and choices, "differences in health" started to be seen as the result of wider influences that were beyond the individual and these influences could act to constrain the types of choices people were able to make about their health. The following chapter will turn to examine the emergence of this Constraints problematisation which argued, broadly speaking, that individuals want to make healthy choices but may face limitations about the choices they can make given their socio-economic position in society.

Chapter 6
The Constraints Problematisation

6.1 Introduction

As the last chapter has shown, the Informational problematisation of "differences in health" dominated public health policy throughout the 1980s and into the early 1990s. Public health approaches during this time emphasised the importance of personal responsibility for health and the need for individuals to make responsible choices regarding their health. Indeed it was even argued that individual behaviours were the main driving force for patterns of health and disease in the population (DHSS, 1988). The problem of "differences in health" was seen to be a problem of information provision, leading to people making poor choices about their health and falling ill with "avoidable" diseases. This not only led to increasing poor health but also a perceived increased demand on NHS resources which were already being scrutinised as part of the government's drive to improve the efficient use of existing resources given that they were unable to successfully reduce spending on the NHS. Prevention of unnecessary illness was therefore a key aim for public health. As a result, solutions to "differences in health" revolved around the need to change people's behaviour and the provision of better information was viewed as the main strategy of public health at this time. The "responsible chooser" emerged as the governable subject of this problematisation and not only reflected assumptions about how individuals act but also outlined expectations of how people should make choices about their health. Given the assumption that everyone had the same capability to make choices, it was expected that people would act on new information and guidance to make informed lifestyle choices. These changes in behaviour would then translate into improvements in health and a reduction of demand on the NHS.

From around 1992 onwards, however, it seems that there was a change in policy thinking about "differences in health". The publication of the Conservative public health white paper *The Health of the Nation: A strategy for health in England* (Secretary of State for Health, 1992) was hailed by many as a turning point in public health (Baggott, 2004; Klein, 2006; Powell, 1997). This was the first paper which acknowledged that there were wider influences on health, and the choices that individuals could make about their health, that lay beyond the control of the individual. As a result discussions about the solutions that the

government should implement went beyond the provision of information to the public. As the Constraints problematisation emerged and developed more fully in the public health policies developed by New Labour, it becomes apparent that understandings of the way individuals made choices about their health had changed somewhat from the Informational problematisation. The Constraints problematisation is primarily concerned with the ways in which people's ability to make decisions about their health are constrained by wider factors beyond the control of the individual. This required more concerted action from national and local government in identifying and addressing these wider constraints and taking action in order to ensure that individuals could take greater control over their own lives, and in so doing enabling individuals to make better choices about their health.

This chapter will be organised as follows. Section 6.2 will examine the emergence of a Conservative public health approach given that there was not much policy discussion of public health in the 1980s. Section 6.3 will then explore the development of the assumption that people may face constraints to choices they can make about their health. It will begin with a discussion of the publication of *The Health of the Nation* and its recognition of wider influences which may impact on people's choices about their health. The section will then turn to examine New Labour's approach to public health through the use of the social model of health in order to conceptualise the constraints that people face when making choices about their health. The importance of mainstreaming health, or ensuring that health is a central issue for all government departments, will also be discussed here. Section 6.4 will then discuss the importance of providing opportunities to reduce constraints on choices to health in order to empower individuals and give them more control over their lives. It will specifically focus on opportunities in education, employment and involvement in the local area as these were seen to be key ways to help individuals improve decisions about their health. Finally section 6.5 will discuss the emergence of the "constrained chooser" as the governable subject for the Constraints problematisation. This governable subject emphasises the change in thinking concerning how individuals make decisions about their health, arguing that people make choices under constraints. While this represented a new way of conceptualising individual behaviour in health policy, it is possible to see some elements of the "responsible chooser" from the Informational problematisation are present in the "constrained chooser" and these will be discussed. The chapter will conclude with a discussion of the continuing role of choice in public health, and the beginnings of the transition towards the final problematisation of "differences in health".

6.2 The emergence of a Conservative health strategy

It is widely acknowledged that Thatcher's Conservative government in the 1980s was opposed to a health strategy (Baggott, 2004; Wainwright, 1996), but in the early 1990s Major's government published *The Health of the Nation* (Secretary of State for Health, 1992) which proved to be a turning point in public health policy in the UK. Not only was it the first real instance of a Conservative government developing and committing to a health strategy but it was also the first time that "the Government acknowledged that it had responsibilities for the health of the population that went beyond the provision of a health care system" (Klein, 2006: 167) and "paid dues to social and public health, or collective as opposed to individual, issues in improving health" (Powell, 1997: 83). That is to say the paper recognised the need for the public health function of government, and solutions which involved more action from the government and other organisations rather than just the individual. Despite the fact that the Conservatives were, traditionally, ideologically opposed to public health interventions due to their collectivist nature (Baggott, 2004) there were a number of reasons as to why this change occurred.

The first reason centres on two related concerns with the NHS. The Conservatives were frustrated that the NHS was not "delivering the goods" (Klein, 2006: 167) when it came to improvements in health, in the sense that large numbers of people were still falling sick despite the presence of the NHS, and there were still concerns with the amount of money being spent on the health service. Despite the fact that there were continuing developments in medical technologies which were providing new curative treatments and ways of managing diseases, there was a realisation that "every leap forward in medical technology extended the scope for more expenditure" (Klein, 2006: 167). Instead of decreasing demand for health services the advances in technology were creating higher demands in terms of the need for more resources. The public were still also seen to be heavily reliant on the NHS which meant that demand for services was not decreasing either. The need to reduce this perceived demand and how much money was spent funding the NHS were not new issues, having been discussed in policy documents under Thatcher. In the early 1990s, however, public health approaches were offering a viable way for the government to develop a "strategy which appeared to promise turning off the tap of demand at source" (Klein, 2006: 168). By addressing the causes of illness not just at the individual but at a wider societal level, it would seem that the Conservatives had hit upon a solution which would not only improve the health of the population but also reduce demands and spending on the NHS. This was

also combined with the inclusion of targets in the strategy in order to ensure better value for money in existing services (Baggott, 2004).

The second reason for this change centred on the need to be seen to acknowledging problems with addressing public health crises which happened in the 1980s. This resulted in a perceived lack of trust from the public in the government's ability to manage the health service and deal with health problems. The 1980s saw the HIV/AIDs epidemic and the BSE crisis which created problems and panic amongst the population. While the government did respond to these events at the time, including publishing *Public Health in England* (DHSS, 1988), it was clear that these events had undermined public confidence in the Conservatives' commitment to public health (Webster, 2002). The government needed to take action in order to restore trust and to reassure the public that they took public health issues seriously. Part of this action involved adopting large scale health promotion campaigns which "though ostensibly aimed at getting people to change lifestyles also portrayed the Government as concerned about the people's health" (Baggott, 2004: 339). By demonstrating to the public that the government possessed knowledge about how to improve health and was readily disseminating this information to the public it was hoped that this would restore faith in the government and their commitment to the public's health. It was noted by critics, however, that silences in the paper were obvious: "[g]overnment action on unemployment, housing and pollution was conspicuous by its absence" (Powell, 1997: 83). In addition it was clear that both Thatcher and Major's governments were reluctant to acknowledge the existence of "differences in health" as "heath inequalities". Government ministers under Major noted that "variations in health" could be problematic in terms of improving overall population health but the issue of socio-economic disadvantage continued to be ignored (Baggott, 2004). The change in perspective and language used to describe "differences in health" is discussed further below in section 6.3.1.

The third reason why the Conservatives began to adopt a more collectivist approach was because there was a realisation that the provision of information was not enough to ensure improvements in health. At the start of the 1990s Parish argues that "[t]here was a dawning recognition that health education in isolation from other measures would not necessarily result in the radical changes required to herald a new era of improved health" (Parish, 1995: 14). As such, a strategy which involved interventions beyond the focus of the individual was necessary and involved greater emphasis on health promotion initiatives as outlined in the previous paragraph. This is not to say, however, that individual responsibility

was ignored in *The Health of the Nation* as the impacts of individual lifestyle choices were heavily stressed: "The way in which people live and the lifestyles they adopt can have profound effects on subsequent health" (Secretary of State for Health, 1992: par. 1.6). The paper did, however, acknowledge that the government should be doing more to address or control external threats over which individuals have little control, as well as recognising that policies from different areas of government, not just the Department of Health or the NHS, "have, to a greater or lesser degree, an impact on health" (Secretary of State for Health, 1992: par. 3.7). Policies, therefore, needed to be assessed for their consequences on health issues if progress was to be made.

While these three reasons suggest that the adoption of a more collectivist approach to health issues through addressing public health concerns was a fairly logical step for the Conservatives take do given the wider context, Wainwright (1996) argues that there may well have been other reasons as to why greater attention was paid to public health and the problem of health inequalities, or "differences in health". The 1990s signalled a change in attitudes towards research demonstrating the existence of health inequalities, such as the Black Report (DHSS, 1980), which meant that "what was once dismissed as the product of flawed research or political bias, is now being embraced by government, although tentatively" (Wainwright, 1996: 67). Although it seems as if those lobbying for the inclusion of health inequalities on the political agenda had succeeded to a degree Wainwright argues that that "what appears to be the triumph of rational analysis over party political dogma may turn out to be something altogether more sinister" (Wainwright, 1996: 68).

The inclusion, or at least the consideration, of health inequalities, or "variations in health" as they were labelled in policy documents at the time (see section 6.3.1 and Chapter 7 section 7.3), was "driven by the possibility of appropriating the issue as a mean of solving problems faced by the state" (Wainwright, 1996: 71) rather than being a response to the demands of the working-class or those academics working in the field of health inequalities research. He highlighted three problems which "could be addressed by policies disguised as a means of addressing health inequalities" (Wainwright, 1996: 71). The first was the "the problem of governance, of the maintenance of social order" (Wainwright, 1996: 71). The state needed to ensure compliance and order despite the fact that the neutralisation of the trade unions as a way of expressing opposition from the working class. The second problem was concerned with the "social reproduction of the conditions for capital accumulation" (Wainwright, 1996: 71), in particular the need to maintain and encourage a healthy

workforce in order to sustain economic growth and prosperity. The final problem was concerned with the "restructuring of the welfare state" (Wainwright, 1996: 71). The consequences of the oil and economic crises of the 1970s were still present in terms of the difficulties associated with maintaining the expansion of the public sector amid financial constraints. This relates to the concerns raised in the previous chapter with the need to reduce spending on the NHS. There was a clear need to "reduce the costs of governance and social reproduction by encouraging the self-regulation and self-surveillance of working-class communities" (Wainwright, 1996: 71).

One interesting point that Wainwright made was that the inclusion of health inequalities on the political agenda, however tentative, would have appealed to future Labour administrations "because they enable the problems facing the state to be addressed within a discourse that still has rhetorical significance for the Party" (Wainwright, 1996: 72). The existence of policy discussions of "variations in health" would have provided the conditions for New Labour to expand this discussion within their own ideological perspective.

Despite Wainwright's (1996) scepticism about the inclusion of health inequalities into the Conservatives' political agenda, it is still possible to see the emergence of a new way of thinking about "differences in health" which centres around more collectivist approaches to public health emerging at the beginning of the 1990s. *The Health of the Nation* marked a change in the way in which health was perceived by government at the time as "there was an attempt to talk openly about the importance of health rather than health care in isolation" (Hunter, 2003: 51). While there may have been underlying motives other than the improvement of population health for the inclusion of a public health approach in developing their new health strategy, it is clear that issues directly related to *health* rather than just *health care* needed to be considered and that responsibility for health perhaps lay beyond that of the individual.

6.3 Identifying constraints to people's choices about health

Beginning with *The Health of the Nation* (Secretary of State for Health, 1992) this first section will explore the emergence and development of the need to identify and address constraints to people's choices about health. This represents a change from the previous Informational problematisation, which focused purely on the provision of information with the expectation that individuals would change their behaviour given new information about lifestyle behaviours. In contrast, the Constraints problematisation argues that not everyone

has the same capability to make choices about their health because they face social and economic limitations which impact on the choices they can make. This perspective or understanding of the relationship between individual choice and health was first seen in *The Health of the Nation* but is more strongly associated with New Labour's approach to public health which began in 1998 with *Our Healthier Nation* (Secretary of State for Health, 1998). It is in New Labour's publications that the Constraints problematisation becomes the main way of understanding the problem of "differences in health", and in the development of opportunities to remove constraints to choices about health. This will be shown through the use of the social model of health in order to conceptualise the different types of constraints that people may face when making choices as well as through their commitment to make health a central issue for society as well as government policy.

6.3.1 The significance of *The Health of the Nation* and its working papers

As discussed above, *The Health of the Nation* (Secretary of State for Health, 1992) has been recognised as a landmark paper in English public health policy. It marked a turning point for public health policy as it included discussions of wider responsibility for health beyond the individual, as well as touching on the elephant in the room of health inequalities.

In the Foreword to the green paper preceding *The Health of the Nation* the then Secretary of State for Health William Waldegrave stated that "[t]he development of a health strategy is a new concept for England" (Secretary of State for Health, 1991: Foreword). This green paper acted as a consultation for this new health strategy in England. Waldegrave highlighted that he envisioned a greater focus on illness prevention and health promotion, as well as emphasising the need for individuals to change their behaviour. He noted, however, that a new perspective was required if progress were to be made:

> *For too long, however, the health debate has been bedevilled by the two extreme claims of, on the one hand, "It's all up to individuals" and, on the other, "It's all up to Government". We need a proper balance between individual responsibility and Government action. Government must ensure that individuals have the necessary information with which they can exercise informed free choice. Education is the key. Equally, Government undertakes a variety of measures designed to ensure that people live in physical and social circumstances where such free choice is possible. (Secretary of State for Health, 1991: Foreword).*

It is interesting to note that this statement focuses on access to choices about health as opposed to health per se. Rather than simply focusing on individual responsibility for choices about health, Waldegrave argued that the government also had a responsibility for ensuring that people were actually able to make choices about their health. This seems to be the first time that the impact of external influences or constraints to people's choices about health is put forward in health policy which goes beyond the need for more information, along with the argument that the government has a responsibility to ensure that the physical and social conditions are in place which will allow individuals to make healthy choices. There is still, however, clearly a strong emphasis on the role of lifestyles in determining health outcomes. The idea that the government needed to do more in order to improve the circumstances under which individuals could make better choices about their health was reflected in the white paper and the publications from working groups.

The Health of the Nation (Secretary of State for Health, 1992) highlighted two key areas in which action could be taken in order to ensure that such "free choice" (Secretary of State for Health, 1991) about health would be possible: "healthy settings" and "healthy alliances". Action in both of these areas aimed to ensure that individuals were more able to make choices about health, in terms of accessing better information as well as additional help and support in particular settings and by working with others to improve health.

The identification of different "settings" for health allowed the government to focus their attention on specific areas where health promotion was seen to be a priority. The paper identified seven healthy settings: cities, schools, hospitals, workplaces, homes, prisons and environments. These seem to have been chosen in order to reflect the different places which most people will spend their lives moving between. The discussion of what should be done in each setting is quite brief, however the inclusion of such a wide range of places suggests that there was a broad acceptance of the argument that health, and choices about health, could be influenced by being, working or living in a number of these settings. It also highlights the fact that health should be considered across a range of government areas and policies, given that a number of these places are largely outside the remit of the Department of Health (apart from hospitals).

The development of "healthy alliances" was also advocated by the white paper. Although there was still a strong emphasis on the role that education and information provision could play in improving health, the paper recognised that "the impact on health can be much greater when individuals and organisations work together" (Secretary of State

for Health, 1992: par. 3.9). The aim was to establish links between different organisations, as well as between the public and organisations, to ensure that people obtained information and education about health, and the paper emphasised that these links could be made within healthy settings as well in order to boost the influence of different settings on health. The paper argued that "[r]eliable health education in its widest sense is essential for this - pervading education at school and also the many sources of information for people generally about health and its determinants" (Secretary of State for Health, 1992: par. 3.8). These sources of information (the NHS, local authorities, the Health Education Authority, voluntary organisations, the media and in the workplace), therefore, had a clear responsibility to provide the best information possible to the public and to work with people in order to harness this information and to encourage people to make better decisions about their health, which reflects the assumptions of the previous Informational problematisation.

The Wider Health Working Group provided further clarification and guidance on healthy alliances in *Working Together for Better Health* (DH, 1993). In her opening statement to the paper Virginia Bottomley, the then Secretary of State for Health, argued that "[w]orking together we can better make sure that services and facilities are in place and used, that the environment in which we live, work and play is safe and conducive to health, and that people have the clear and consistent information they need to help themselves maintain and improve their health" (DH, 1993). This paper aimed to highlight and demonstrate where healthy alliances could be made and how they could help to improve people's health. A healthy alliance was defined as "a partnership of individuals and organisations formed to enable people to increase their influence over the factors that affect their health and well-being - physically, mentally, socially and environmentally" (DH, 1993). It is worth mentioning here that New Labour also had a similar idea for people and organisations to come together in order to address the determinants of health. This was initially called the "contract for health" (Secretary of State for Health, 1998) but changed to a "three-way partnership" (Secretary of State for Health, 1999) between individuals, local authorities and the government. These changes in language will be discussed in section 6.3.2. Returning to healthy alliances for now, discussions concerning the need for healthy alliances argued that they would be beneficial in terms of seeing more effective use of existing resources and services, broadening responsibility for health, improving knowledge about health and health problems, increasing the amount and quality of information about health exchanged between partners in the alliances, and for developing local health strategies (DH, 1993). In particular local authorities were seen to be well placed in order to develop alliances: "Local

and regional alliances provide an ideal framework for developing local health strategies. They provide opportunities for assessing needs, setting priorities, identifying resources and agreeing what action to take" (DH, 1993). The responsibilities of local authorities included ensuring that organisations worked together at the local level, that these organisations involved patients and other members of the public, and that they worked towards reducing the impact of external factors on health. *Working Together for Better Health* therefore identified the need to widen responsibility for health beyond the individual, but still emphasised the need to behaviour at the individual level. In order for people to change their behaviour it was noted that "they need to be well informed, motivated and supported" (DH, 1993), reflecting earlier concerns from the Informational problematisation. This quotation is interesting, however, as it does not just suggest that individuals need to be well informed (through the provision of information); it suggests that people require motivation and support in order to successfully make changes to their behaviour. This seems to reflect the recognition that people need to work together in order to improve health. People need to know how to use the information they are provided with, and how to access support and further guidance where appropriate. The paper does state that information is still important in helping people make decisions and get the most out of services they can access, but overall the paper is concerned with promoting the idea that people need to work together if improvements in health are to be made.

Another of the working groups from *The Health of the Nation* published an interesting paper which acknowledged that the observed "variations in health" were not solely caused by individual behaviours. Instead *Variations in Health: What can the Department of Health and the NHS do?* (DH, 1995) argued that despite overall improvements in population health there were still "systematic variations in health", variations that were underpinned by fundamental factors shaping the health of the population. The paper focused on highlighting these wider influences on health and the importance of addressing these influences if reductions in "systematic variations in health" were to be seen.

The paper noted that during "the last twenty years an extensive research literature has been published which has shown continuing, and in some cases increasing, differentials in mortality and morbidity rates between socio-economic groups, men and women, regions of the country, and ethnic groups" (DH, 1995: par. 2.2). Existing research into "differences in health" was therefore acknowledged in this paper and this quotation in particular shows that explanations for the distribution of health went beyond variations at the individual level.

More significantly the paper cited the findings of the Black Report (DHSS, 1980) and the discussion acknowledged the report's importance in stimulating wider research into "variations in health", both in the UK and internationally. In terms of the documents analysed for this research this was the first instance where the Black Report had been referenced and its findings discussed in some depth. The findings were not simply dismissed as they had been by Thatcher's government. Instead *Variations in Health* directly engaged with the explanations provided by the Black Report for the existence of "variations in health". The paper did not, however, accept "inequalities in health" as the label for the problem, preferring to use "systematic variations in health" as an alternative. This perhaps reflected continuing unease with the use of the term "inequalities" given that there was still a Conservative government in power at the time.

The paper focused its discussion of the Black Report on the key arguments of the report, emphasising the fact that the observed "variations in health" were clearly "systematic". Firstly the paper dismissed arguments that the measured variations were simply a statistical artefact, or the result of health related mobility. It argued that methodological improvements to forms of measurement were not seen to "appreciably change the broad picture of variations" (DH, 1995: par. 2.12) and "selective social mobility based on health cannot explain away the broad picture of poorer health associated with social disadvantage" (DH, 1995: par. 2.13). While the explanations for "systematic variations in health" did not dismiss the role of individual behaviour, it was clear that behaviour was only one of several interconnected explanations as to why these variations existed. Indeed the paper argued that behavioural choices "explain only a part of social class or regional gradients" (DH, 1995: par. 2.14) which suggested that other factors influenced health behaviour.

Two such factors highlighted in *Variations in Health* were interactions with the environment and psycho-social factors. The environment was discussed in terms of the effects of geographical location and on living and working conditions. While some variations could be explained by biological or genetic elements, the paper argued that a person's interaction with their surrounding environment played an important role in determining their health. Drawing on evidence from studies of migrants in Britain it was noted that "migrants tend to take on the health patterns of the regions to which they migrate, suggesting a limited role for genetic explanations of regional differences" (DH, 1995: par. 2.15). The environment in which a person lives should therefore be given more importance

than individual biological factors in shaping health outcomes. This seemed to echo the more structural and material explanations for "differences in health" highlighted in the Black Report and similar research.

The concern with psycho-social factors arose from the observation that "the relationship between social class and health tends to follow a regular gradient…rather than there being a cut-off point below which people have poorer health than the rest of the population because they are deprived of adequate food, housing, warmth etc." (DH, 1995: par. 2.17). In referring to the Whitehall II study the paper noted that "The lower the social status, the greater the frequency of reported financial problems, stressful life events, inadequate social supports and, at work, low control, little variety and use of skills, and low satisfaction" (DH, 1995: par. 2.17) all contributed to poorer health. This social gradient demonstrated a systematic patterning of health and gave weight to the label of "systematic variations in health". It argued that differences in individual behaviour could not explain the extent or persistence of this gradient in health according to social class.

It is clear from the outline of these explanations that *Variations in Health* was concerned with emphasising factors that influenced health which went beyond simply focusing on individual behaviour. The paper even highlighted the existence of the social gradient of health according to social class, something which had not been readily acknowledged before in Conservative health policy. This was perhaps due to the fact that previous the previous public health approach had emphasised that changing one's behaviour was an individual's responsibility and there was an assumption that everyone had the same capacity and capability to make changes. Little attention was paid to factors which could impact on an individual's ability to make choices about their health. The discussions in *Variations in Health* were keen to stress that while there clearly was a role for the individual in improving their health, the continuing emphasis on individual behaviour alone was not going to provide sustained improvements in health. The paper acknowledged that while certain lifestyle behaviours contributed to ill-health and that there was much the individual could do to reduce the likelihood of preventable illness, it was important to recognise that "personal, social and economic circumstances may affect the ability of some groups to modify their behaviours" (DH, 1995: par. 3.12). As such, certain groups in the population may face constraints to the types of choices they can make about their health. This demonstrates a change in understanding of how individuals make decisions about their health. Within the Informational problematisation, discussed in Chapter 5, it was assumed that individuals had

the same capability to make decisions and that they had a great deal of control over the choices they made. People were expected to make responsible choices about their lifestyles given the right information. The above quotation from *Variations in Health*, however, seems to suggest that not all individuals have the same capability to change their choices at will even if they are provided with the right information. People may be limited by their personal, social and economic circumstances and therefore unable to make healthy choices.

The key thing to note about *Variations in Health* (DH, 1995) is that it helped to establish a change in understandings of how individuals make decisions about their health, and consequently to the types of solutions put forward to address "systematic variations in health". The paper clearly reflected the perspective raised in the green paper (Secretary of State for Health, 1991) that action is required to address circumstances which impact on the ability of individuals to make choices about their health, and that solutions must go beyond the provision of information. *Variations in Health* made an important claim that the behaviours that people engage in can be limited by their social and economic situation. This suggests that the individual cannot be held wholly accountable for his or her choices if they face constraints which are beyond their control and effectively limit the choices they can make. If everyone were to have the same access to and responsibility for choices then action must be taken to address these wider constraints which shape individual behaviours.

The final follow-up paper from *The Health of the Nation* (Secretary of State for Health, 1992) was *Health Related Behaviour* (DH, 1996) which seemed to present a very different picture compared to the explanations discussed in *Variations in Health* (DH, 1995). The rationale for *Health Related Behaviour* was to "provide a reference document which brings together a broad range of up-to-date statistics on health-related behaviour". This paper was clearly a response to the comments made in *Public Health in England* (DHSS, 1988) which had emphasised the need for the government to acquire more information, specifically epidemiological information, about the health of the population in order to develop appropriate interventions to address health problems, including "differences in health". This document was focused on presenting data related to lifestyle choices made by individuals and the then Chief Medical Officer Sir Kenneth Calman made clear that lifestyle "underlines the key role of behaviour and I believe that an understanding of health related behaviours and the factors which influence them (i.e. "behavioural epidemiology") is one of the most important public health issues for the future" (DH, 1996: Foreword). The behaviours the paper examined reflected the targets outlined in *The Health of the Nation* and therefore

included statistics on diet, alcohol consumption, physical activity, cigarette smoking, screening for cancer, excessive sun exposure, suicide, sexual behaviour, drug misuse, and the rate of accidents. This paper seems to return to a primary focus on individual behaviour as although a number of the statistics were presented in terms of social class distribution, there was little attempt to engage with wider factors which could influence individual behaviour. No solutions were presented or discussed in this paper as it was intended as a reference document for future policy. This perhaps demonstrates that there was some confusion at the time as to where the focus for public health should lie – should it concentrate on identifying and addressing wider influences on health, or should it continue to place more emphasis on the role of individual behaviour.

This sub-section has demonstrated that the publication of *The Health of the Nation* (Secretary of State for Health, 1992) and its follow-up papers was a key turning point in public health policy in England. Although there still seemed to be a strong emphasis on individual responsibility for health and the need to change individual behaviour, there was some indication that wider influences affecting people's ability to make choices about their health had been acknowledged. It had become clear that these wider influences needed to be addressed if progress towards improvements in health were to be seen. This marked a change from previous publications which had argued that the provision of information alone was enough to change health behaviours, as *The Health of the Nation* argued that more had to be done to ensure that the circumstances in which people made decisions did not negatively affect the choices people made about their health. These papers set the context and groundwork for New Labour's public health approach which exemplifies the Constraints problematisation of "differences in health".

6.3.2 New Labour's introduction and use of the social model of health

One of the main criticisms levelled at the previous Conservative public health strategy by New Labour when they came to power was that its "vision for health was limited, mainly because of its reluctance to acknowledge the social, economic and environmental causes of ill health" (Secretary of State for Health, 1998: par. 4.12). It was argued that too much emphasis was placed on individual responsibility leading to the view that "individuals are solely to blame for their own ill-health" (Secretary of State for Health, 1999: par. 1.22) and there was little real consideration of the wider influences on health, although this seems to be more of a political criticism. As has been shown in the previous section this criticism is

not strictly true as *The Health of the Nation* (Secretary of State for Health, 1992) and its follow-up papers did discuss the fact that there were wider influences on health which needed to be addressed if improvements to health were to be seen. In particular New Labour were keen to highlight the need for government action and responsibility on "powerful factors beyond the control of the individual which can harm health" (Secretary of State for Health, 1999: par. 1.27), but still recognised that individuals "are responsible for their own actions in health as in other areas" (Secretary of State for Health, 1999: par. 1.26). Individual responsibility still played an important role in improving health, but it was noted that the government needed to take a lead in "creating the right conditions for individuals to make healthy decisions" (Secretary of State for Health, 1999: par. 1.37). As such, greater attention needed to be paid to the wider causes of ill-health which were beyond the control of the individual and which were negatively impacting on the ability for people to make healthy decisions. Constraints to healthy choices needed to be identified and acted upon. This seemed to call for a reconsideration of the relationship between health outcomes and the organisation of society in order to identify and resolve these external constraints.

The idea that the way society is organised impacts on health was not new when New Labour came to power. Indeed, the Black Report (DHSS, 1980), commissioned under a Labour government but published under a Conservative one, was interested in examining those "outcomes which have been socially or economically determined" (DHSS, 1980: par. 1.7) and emphasised that social structure, exemplified by social class, undoubtedly influenced health. The Conservative publication *Variations in Health* (DH, 1995) had observed "systematic variations in health" which reflected the key findings of the Black Report, but the New Labour government, echoing the Black Report, termed these variations "health inequalities" as they were seen to be "a consequence of existing the widening social and economic inequalities" (Secretary of State for Health, 1998: par. 4.50). The use of "health inequalities" also seemed to demonstrate a moral imperative that action should be taken to address the problem as it represented a fundamental unfairness within society. A more detailed discussion of the transition in the language used to label the problem of "differences in health" over this period can be found in Chapter 8 section 8.2. New Labour, therefore, made societal organisation a central issue when discussing the problem of health inequalities and the solutions put forward to address it.
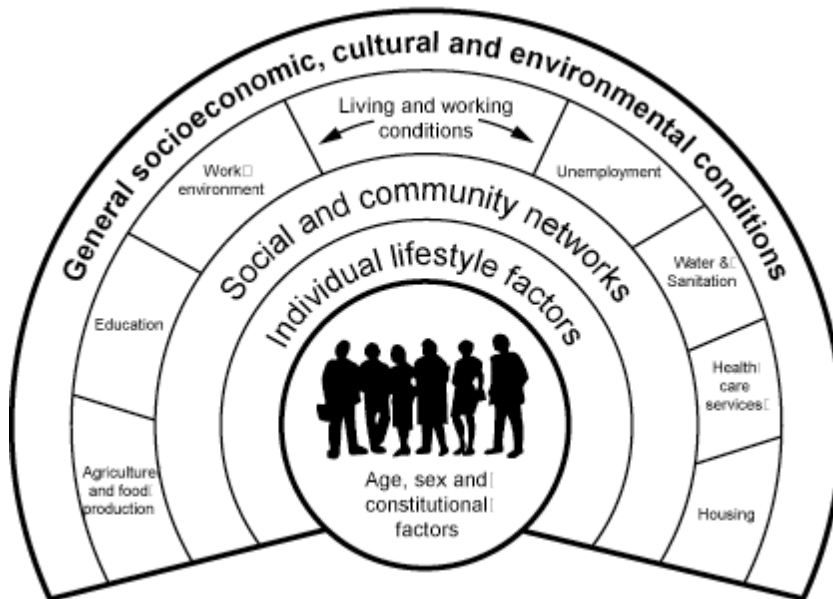
Figure 5 Dahlgren and Whitehead's (1991) model of the determinants of health as used in the Acheson Report (Acheson, 1998)

The Acheson Report (Acheson, 1998) was instrumental in its use of the social model of health to examine and explain contemporary health inequalities. The report used the model to "trace the paths from social structure, represented by socioeconomic status, through to inequalities in health" and argued that "health inequalities are the outcome of causal chains which run back into and from the basic structure of society". Figure 5 replicates the diagram used in the report to represent the different determinants of health, based on work by Dahlgren and Whitehead (1991) for the World Health Organisation. The social model of health not only highlights factors at the individual level which influence health but emphasises the need to take into account the wider societal context in which the individual lives, and recognise that a number of negative influences on health are avoidable.

The model summarises the main external influences on health which are seen to impact and constrain individual ability to make healthy choices. At the centre is the individual with their biological traits which are largely fixed and uncontrollable. The next layer recognises the importance of lifestyle factors for the health of the individual, but the model shows that these lifestyle choices are themselves influenced by the social networks the individual is involved in as well as the broader socio-economic conditions of the society in which that individual lives. What is important to note about the model is that it not only demonstrates the different influences on individual health, but it also shows that the further out from the centre you go the less direct control the individual has over those conditions which impact on their health. This suggests, then, that individual choices are influenced by their social surroundings which may include constraints to the choices that they can make,

for example through having a low income or poor education. As a result individual behaviour can, and should, be explained by "focusing on the constraints under which individuals operate" (Le Grand, 2003: 14).

The social model of health proved instrumental in highlighting the constraints which affected the ability of individuals to make healthy decisions. *Reducing Health Inequalities* (DH, 1999), the *2002 Cross-cutting Review* (DH, 2002a) and the *Programme for Action* (DH, 2003) all highlighted a number of wider influences on health such as tax and benefit schemes, education and skills development, the environment and pollution, crime levels, as well as access to adequate transport and services. These publications therefore strongly emphasised the need for a broader approach to health which involved action from the government and organisations beyond the level of the individual, and to an extent reflected the idea of "healthy alliances" discussed in *The Health of the Nation* (Secretary of State for Health, 1992) and *Working Together For Better Health* (DH, 1993).

The government introduced this approach early on in its public health strategy within its first public health green paper *Our Healthier Nation: A Contract for Health* (Secretary of State for Health, 1998). The paper set out the idea of a "Contract for Health" which would involve "Government and National Players", "Local Players and Communities" and "People". Those at the national level were to "provide national coordination and leadership" in government and had an important role to play in the assessment and communication of risk: "the public are entitled to know what the odds are so that individuals can make their own judgments" (Secretary of State for Health, 1998: par. 3.23). It was noted that local authorities "have the capacity to make a very real impact on the health of the communities they serve" (Secretary of State for Health, 1998: par. 3.53) given their existing responsibilities for the local provision of services and education. As such, local authorities were responsible for identifying and dealing with health problems in their area. Finally the individual was expected to "take responsibility for their own health and make healthier choices about their lifestyle" (Secretary of State for Health, 1998: par. 3.9) as "[n]ational and local activity can help provide the right environment to encourage healthy choices but it is finally for individuals to choose whether to change their behaviour to a healthier one" (Secretary of State for Health, 1998: par. 3.68). Indeed the paper noted that this contract "will only work if everyone plays their part, and if everyone is committed to fulfilling their responsibilities" (Secretary of State for Health, 1998: par. 3.8). This reflects the idea of rights and responsibilities which were a central part of the ideology of the Third Way and underpinned New Labour's political

thinking. Interestingly in *Saving Lives: Our Healthier Nation* (Secretary of State for Health, 1999) the label for this strategy was altered to "three-way partnership" as opposed to "contract for health". There is no explanation given for this change in language, but despite this the stance of the strategy remained the same; in order to tackle health inequalities, and to ensure individuals made healthy choices, action was required across all levels of society with clear responsibilities and expectations at each level.

New Labour's discussion of the need for a "three-way partnership" in order to successfully address health inequalities echoes the discussion in the Conservative paper *Working Together for Better Health* (DH, 1993) concerning the need for "healthy alliances". It could be argued, therefore, that the idea of different levels of society working together was not a New Labour idea but rather an altered version of a previous policy discussion. The emphasis within New Labour's strategy, however, seemed to be more centred on addressing wider influences on health whereas the Conservative model seemed to remain focused on finding ways of changing individual behaviour. The change in language used to label this strategy is quite interesting and worth a little exploration. In terms of the shift from "healthy alliances" to "contract for health", this is most likely explained by the fact that New Labour wanted to differentiate themselves from previous approaches and to be able to use their own language to describe their approach. The change from "contract to health" to "three-way partnership" is perhaps the more interesting of the two. As mentioned above there is no explanation given for the change in language; the new label simply appears in their public health white paper. One plausible explanation is simply that the term "contract" sounded too formal and binding, perhaps with an implied hierarchy of the contractor telling the contracted what to do. The word "partnership" on the other hand seems to suggest a much more co-operative relationship between the different parties involved. The use of "partnership" therefore seems to have better reflected New Labour's aim of encouraging different levels of society to work together in order to foster discussion and the development of suitable interventions to address health inequalities.

The adoption of the social model of health to explain "differences in health" as health inequalities also led to the inclusion of moral discourses in policy discussions. From their first public health white paper New Labour introduced discussions around the creation of a fairer society and the need to promote social justice. In the accompanying paper *Reducing Health Inequalities* it was noted that "[b]uilding a fairer society is a central commitment of this Government" (DH, 1999: par. 2.3). *The NHS Plan* stated that "[n]o

injustice is greater than the inequalities in health which scar our nation" (DH, 2000: par. 13.1). The *Programme for Action* argued that health inequalities should be addressed in order to "create a fairer and more just society that will allow all individuals and communities to fulfil their potential" (DH, 2003: par. 1.2). The *2002 Cross-cutting Review* echoed the sentiments of the Black Report stating that "[s]ome differences in health status are unavoidable, the consequence of genetic and biological differences in individuals. But many others are avoidable, the consequence of significant differences in opportunity, access to services and material resources, as well as in personal lifestyle choices" (DH, 2002a). It is these avoidable differences, or inequalities, which must be addressed if the goal of creating a fairer society was to be achieved.

6.3.3 Mainstreaming health

As a result of the use of the social model of health to explain the causes of health inequalities, New Labour was keen to ensure that health issues became central to all areas of policy. Indeed the first recommendation from the Acheson Report suggested that "all policies likely to have a direct or indirect effect on health should be evaluated in terms of their impact on health inequalities" (Acheson, 1998), and the report emphasised the need for action on a broad front to tackle health inequalities. New Labour was keen to dispel the argument that "Individuals are solely to blame for their own ill-health" (Secretary of State for Health, 1999: par. 1.22), emphasising instead the role that national and local government had to play in improving health. Moving on from simply asking "What can the Department of Health and NHS do?" (DH, 1995) to address "differences in health", New Labour argued that most, if not all, government departments held some responsibility for tackling health inequalities and it remained a central part of New Labour's health policy throughout their three terms in office (Acheson, 1998; DH, 2002a; DH, 2002b; DH, 2003; DH, 2008; DH, 2009; Marmot, 2010; Secretary of State for Health, 1999; Secretary of State for Health, 2000).

It is important to note here that while this seemed like a new idea at the time, in fact the need for all government departments to consider the impact of their policies on health was highlighted in *The Health of the Nation* (Secretary of State for Health, 1992). The paper stated that "[m]any policies have, to a greater or lesser degree, an impact on health. It is important, therefore, that as policy is developed the consequences for health are assessed and, where appropriate, taken into account" (Secretary of State for Health, 1992: par. 3.7).

Departments, therefore, should be mindful of the potential impact their policies might have on health and the ability of people to make choices about their health.

The social model of health allowed the New Labour government to allocate new responsibilities across government departments as it highlighted a number of influences and constraints on health which were directly related to different areas of policy other than the Department of Health. If health was determined by factors beyond the health service and the individual it made sense to attempt to instigate wider awareness in other government departments about how their policies might affect people's health. The *2002 Cross-cutting Review* (DH, 2002a) made it clear that health inequalities should be "at the heart of Government policies rather than a marginal "add on"". Consequently the government was keen to mainstream health as an issue that should be taken into account across a range of policy areas.

In 2001 the government embarked in a consultation for their strategy to address health inequalities which focused on the "delivery of both the NHS and wider Government commitment to reduce health inequalities" (DH, 2001a). It was argued that health inequalities "are a consequence of significant differences in opportunity, in access to services, and in material resources, as well as differences in personal lifestyle choices" (DH, 2001a: par. 1.1). Although the consultation recognised that lifestyle choices played a role in a person's health, greater emphasis was placed on addressing the wider influences on health. The paper noted that the recent Acheson Inquiry (Acheson, 1998) had "identified the compound effects on health of poor living and working conditions that are a product of income, education, employment and housing" (DH, 2001a: par. 1.2) and found that "people who experience one or more of: material disadvantage, lower educational attainment and/or insecure employment are likely to experience worse health than the rest of the population" (DH, 2001a: par. 1.3). Consequently, the consultation aimed to identify key policy areas where the government could take action on health inequalities and outlined six priority areas for consultation discussion: "Providing a sure foundation through a healthy pregnancy and early childhood", "Improving opportunity for children and young people", "Improving NHS primary care services, "Tackling the major killers: coronary heart disease and cancer", "Strengthening disadvantaged communities", and finally "Tackling the wider determinants of health inequalities". These six areas demonstrated the broad stance that the government wanted to take on health inequalities.

The results of the consultation were released in 2002 and while there was general agreement with the ideas the consultation had set out it was commented that changes were needed to the priority areas that the government should focus on. From the evidence gathered during the consultation it became clear that "much of the change needed falls outside of the territory of the NHS. There should be more emphasis on the role of other government departments and local strategic partnerships in tackling the wider determinants of health inequalities" (DH, 2002b: par. 4.2). Consequently in the final publication *Tackling Health: A Programme for Action* (DH, 2003) the six priority areas were narrowed down to four key themes: "Supporting families, mothers and children", "Engaging communities and individuals", "Preventing illness and providing effective treatment and care", and "Addressing the underlying determinants of health".

By using the social model of health to explain the existence of health inequalities through highlighting constraints to health, the government was able to successfully broaden the debates around health issues, and inequalities, to the whole of government, rather than just limiting policies to the NHS or Department of Health. The social model of health provided a strong conceptual framework on which to base policies aimed at addressing health inequalities. Making health a central concern for government was a key aim for New Labour, as evidenced by these publications, although as noted above the idea had been put forward in *The Health of the Nation* (Secretary of State for Health, 1992). It is important to note, however, that the issue of individual choices in health remained a central concern of the Constraints problematisation. The constraints highlighted by the social model of health and subsequent policy discussions were not just viewed as constraints to health, but constraints to healthy choices.

6.4 Providing opportunities to remove constraints

The main solutions put forward under the Constraints problematisation were improving the provision of and access to opportunities which would help in "creating the right conditions for individuals to make healthy decisions" (Secretary of State for Health, 1999: par. 1.37). It was argued that public health should not be about "nannying" the public or telling them how they should be living their lives as "[p]eople make their own choices about this" (DH, 2001b). Public health should be about recognising that people want to make

healthy choices but may face constraints which limit their range of options, and can therefore lead to poor decisions which impact on health. Understanding that these constraints exist and their impact on individual decision making was central to the Constraints problematisation, and was stated early on in New Labour's first public health green paper *Our Healthier Nation*:

> *Although people may know what affects their health, their hardship and isolation mean that it is often difficult to act on what they know. The best way to make a start on helping them live healthier lives is to provide help and support to enable them to participate in society, and to help them improve their own economic and social circumstances. That will help to improve their health. (Secretary of State for Health, 1998: par. 2.7, emphasis added)*

Even when people know they need to change their behaviour or make a particular choice related to their health, for example in terms of the food they buy, they may find that they are restricted as to what they can do because of their social and economic situation. People therefore may face constraints to the types of choices they can make about their health. This quotation suggests that action is required to remove these constraints and this can be achieved through encouraging participation in society. This would lead to a sense of empowerment and control, and allow individuals to make healthier choices. The government needed to ensure opportunities were available for people to actively participate in society.

Opportunities were concerned with removing constraints to choices about health. They should allow people to improve their own social and economic situation whilst at the same time giving them greater control over their own lives. This remained a key theme for New Labour's public health policies. Indeed the central aim of the Marmot Review, published twelve years after the green paper, was "to create the conditions for people to take control over their own lives" (Marmot, 2010: 38) and this was emphasised further in its second policy objective which aimed to "Enable all children, young people and adults to maximise their capabilities and have control over their lives", reflecting the persistence of this assumption.

Education, employment and greater prospects for involvement in the local area and community were seen to be three key ways in which to provide people with opportunities to remove constraints and improve control over their lives, and consequently the choices they make about their health. Education was viewed as an important way of improving life chances, especially for children and young people (DH, 2003). The Acheson Inquiry had noted that education

> *has an important role in influencing inequalities in socioeconomic position. Educational qualities are a determinant of an individual's labour market position, which in turn influences income, housing and other material resources. These are related to health and health inequalities. As a consequence, education is a traditional route out of poverty for those living in disadvantage. (Acheson, 1998).*

These statements clearly underpin later strategies and the emphasis placed on the need to improve access to educational opportunities in order to increase the likelihood of good employment in adulthood. The Marmot Review argued that "[i]nequalities in educational outcomes affect physical and mental health, as well as income, employment and quality of life" (Marmot, 2010: 24) and that "[i]f we are serious about reducing both social and health inequalities, we must maintain our focus on improving educational outcomes across the gradient" (Marmot, 2010: 104). Not only was education important in terms of allowing young people to obtain qualifications which would help them in later life, but schools were seen to have a significant role in educating children and young people about health issues and how to remain healthy. There was a need to "strengthen the teaching of personal, social and health education…to improve social and health skills, and behaviour so as to improve the opportunities for learning" (DH, 2003: 26). Greater promotion of health teaching was seen as a key way of shaping individual behaviour from a young age (Secretary of State for Health, 2004). The Marmot Review also made it clear that education did not stop after leaving school but continued into employment. This meant that in order to "enable people to fulfil their potential, opportunities for lifelong learning and skills development need to be promoted, not only in formal education settings but also in the workplace and in communities" (Marmot, 2010: 104). This emphasis on lifelong learning would not only reap benefits in terms of providing qualifications and skills necessary for initial employment as well as career development; there would also be benefits in changing behaviours as it had been shown that "participation in adult learning in itself impacts on health behaviours and outcomes" (Marmot, 2010: 108). Improving access to and the standard of education would not only bring benefits to the individual in terms of improved employment prospects, it was also seen as a way of equipping individuals with the knowledge and skills required to make healthy decisions.

Employment was also seen as an important area where opportunities were needed to improve healthy choices. Two related aspects of employment were seen to affect people's control over their health. The first is around the material benefits gained from being in employment, namely the income derived from paid work. Having a regular income increases

the feeling of financial stability and control and enables individuals to pay for goods and services which influence their health, for example shopping and utility bills. The Marmot Review recommended the introduction of a "minimum income for healthy living…[which] would ensure that all would receive an appropriate income for their stage in the life course" (Marmot, 2010: 120). This would require a review of existing and implementation of new taxes, benefits, pensions and tax credits in order to achieve the healthy living income.

The second aspect is the impact of work on mental and emotional wellbeing. The relationship between control over work and health was first highlighted in *Saving Lives: Our Healthier Nation* which stated "[e]vidence has shown that working in jobs which make very high demands, or in which people have little or no control, increases the risk of coronary heart disease and of premature death" (Secretary of State for Health, 1999: par. 3.11). This emphasised the need for people to have control over their work situation if they were to avoid becoming ill because of their work. The Marmot Review commented that "[b]eing in good employment is protective of health. Conversely unemployment contributes to poor health" (Marmot, 2010: 26). Indeed the wider benefits of being employed on wellbeing was highlighted in *Health Inequalities: Progress and Next Steps,* a follow-up paper from the *Programme for Action*, which stated that "[h]ealth is good for work, and good work is good for health" (DH, 2008: par. 3.29). This paper advocated a greater focus on "helping more people are currently without work to move into sustained employment" (DH, 2008: par. 3.31). While ensuring people are in employment was necessary, it was also important to consider the quality of the jobs people have. Jobs should therefore "include not only a decent living wage, but also opportunities for in-work-development, the flexibility to enable people to balance work and family life, and protection from adverse working conditions that can damage health" (Marmot, 2010: 26). Employment should, therefore, not only provide material benefits to individuals but also improvements to their sense of self. By having the opportunity to advance in a career and to be employed somewhere which offers flexible working options when necessary people would find they had greater control over their lives.

Finally fostering greater involvement in the local area and community is the final key area suggested that will improve individuals' control over their lives. There are two related aspects to this involvement. The first, which was emphasised by the *Programme for Action*, was greater inclusion of the public in local decision-making processes, particularly around health services. This was part of the second key theme of the paper "Engaging communities and individuals". It aimed to see local people "involved in identifying local needs, influencing

decisions making and evaluating their local services" which it argued would "help people take control of their lives, promote a better local environment and quality of life and provide more appropriate services for the community" (DH, 2003: par. 4.10). More work needed to be done in order to "develop new ways of engaging communities in the planning and provision of services, and promoting community networks to stimulate greater community participation in decision making" (DH, 2003: par. 4.11). By involving people from the local area in decisions concerning health services it was hoped that not only would people become more aware of the problems facing their area, they would also be able to share their views and shape the way services were delivered and how problems were addressed. This would help to give them a sense of purpose and increase their feeling of control over wider issues affecting their community.

The second aspect of participation in the local community centres on the benefits that being involved in wider social networks can bring to health. The importance of involvement in social networks was highlighted in *Saving Lives: Our Healthier Nation* which stated that "[i]nadequate social support or lack of social networks can…have a harmful effect on health and on the chances of recovering from disease" (Secretary of State for Health, 1999: par. 3.11), and later in *Choosing Health* which argued that networks "provide support for individuals who are trying to make healthy choices through opportunities that they cannot provide for themselves" (Secretary of State for Health, 2004: 78) and they are considered vital for "promoting individual self-esteem and mental wellbeing and reducing social exclusion" (Secretary of State for Health, 2004: 79). The Marmot Review built on these arguments by describing the social ties between people as social capital which, it argued, "can provide a source of resilience, a buffer against particular risks of poor health, through social support and connections that help people find work or get through economic and other difficulties" (Marmot, 2010: 126). People need to have access to social networks and ties within their communities in order to feel included and to be able to seek support when necessary, for example in times of financial hardship or when facing serious illness. Marmot went on to argue that social capital "needs to be built at a local level to ensure that policies are drawn on and owned by those most affected and are shaped by their experiences" (Marmot, 2010: 136). Barriers to community participation needed to be removed if access to the benefits of social networks and social capital on health were to be achieved. The *Programme for Action* advocated the supporting of local enterprises which would encourage "community entrepreneurship" This was carried forward in *Choosing Health* which recognised the importance of the establishment of local businesses or organisations which

encouraged participation in healthy activities, such as fitness or gardening. Providing people with the opportunity to create networks and join existing ones would allow sustainable communities to grow and flourish, and would deliver improvements in health through the uptake of healthy activities as well as improving people's access to support networks.

This section has explored opportunities around education, employment and greater involvement in the local community in order to demonstrate solutions put forward under the Constraints problematisation to tackle the constraints that reduce people's control over their own lives. Having control was seen as a key factor in being able to make healthy decisions. While certain risks to health would be mitigated through national and local government action there was a clear expectation that individuals would take up the opportunities made available to them in order to help themselves. Individuals were given the right to access forms of help when and where necessary, but they were also expected to act where opportunities were available and take responsibility for their action or in-action. This leads into the following discussion of the "constrained chooser".

6.5 The "constrained chooser"

The Constraints problematisation of "differences in health" is primarily concerned with the need to reduce the constraints that individuals face when making choices about their health. This has been shown through initial ideas posited in *The Health of the Nation* (Secretary of State for Health, 1992) and its working group papers, as well as in the introduction and use of the social model of health in public health policies by New Labour. Under the Constraints problematisation it was recognised that while individuals do make choices about their lifestyle that may negatively impact their health, they make these choices within a set of constraints which are largely beyond their control. It was argued that government action across a range of areas (DH, 2003) and better provision of opportunities (DH, 2002a; DH, 2003; Marmot, 2010; Secretary of State for Health, 1998; Secretary of State for Health, 1999) was necessary in order to reduce the impact of these constraints on individual choices on health.

As a result the "constrained chooser" emerged as the governable subject within the Constraints problematisation and represented a new way of conceptualising individual

behaviour, one which emphasised the influence of conditions under which individuals make choices about their health. It was assumed that people wanted to be healthy and to make choices that would benefit their health, but some groups faced limits as to what choices they could make because of wider social and economic influences and constraints over which they had little or no control: "[i]t is a fact of life that it is easier for some people to make healthy choices than others. Existing health inequalities show that opting for a healthy lifestyle is easier for some people than others" (Secretary of State for Health, 2004). This emphasises the fact that certain groups face greater barriers to making healthy choices than others. Interestingly this quotation also seems to suggest that health inequalities are the result of people making poor choices about their health, and this will be discussed further in Chapter 7 section 7.3. It is this difference in the ability to be able to make choices about health that influenced policies within the Constraints problematisation. There was a clear need to reduce the constraints people faced and to enable people to make better choices about their health. In order to empower people to make better decisions about their health it was argued that the government needed to provide people with opportunities not only to improve their health but to improve their own situation and social standing. This view is exemplified in *Choosing Health* (Secretary of State for Health, 2004) which stated that "[h]ealthy choices are often difficult for anyone to make, but where people do not feel in control of their environment or their personal circumstances, the task can be more challenging". By providing people with opportunities to improve their social and economic situation, such as through education and work opportunities, it was argued that people would be better prepared and better able to make healthy choices. The provision of opportunities would allow individuals to regain control over their lives and allow them to make better decisions about their health.

Although the "constrained chooser" provided a new understanding of individual decision making in relation to health, it is important to note two main similarities with the previous governable subject of the "responsible chooser" under the Informational problematisation. The first is a shared concern with the fact that individuals should be able to make informed decisions about their health. The Informational problematisation argued that the public required better information in order to make responsible choices about their health, while the Constraints problematisation emphasised the need to increase awareness about risks to health. *Our Healthier Nation* stated that "the assessment and communication of health risks needs to be done better", requiring "a more thoughtful approach" (Secretary of State for Health, 1998: par. 3.20). Indeed *Saving Lives: Our Healthier Nation* (Secretary of

State for Health, 1999: par. 3.19) noted that "[t]he whole question of risks to health, how they are analysed, assessed, communicated and reduced, has come to the fore during the 1990s". People needed this information in order to make informed decisions about lifestyle choices. The second related similarity between the "responsible chooser" and the "constrained chooser" is the shared emphasis on taking responsibility for choices. While the government should do more to improve the provision of information about potential risks to health and provide opportunities for people to avoid these risks, it was argued that it was still ultimately up to the individual to make the decision having been informed of the risks to health and the opportunities available to them: "It's not the Government's job to tell people what to do. It is the Government's job to spell out the facts and quantify the risks on which individuals can make informed decisions." (Secretary of State for Health, 1999). It was argued in the *Programme for Action* that individuals had to accept responsibility "for their own health and that of their children by making appropriate and informed lifestyle choices on smoking, diet and exercise" (DH, 2003: par. 5.36). People were expected to act on the information provided by the government and other reliable sources about health and to take responsibility for their actions. It is important to note, however, that the Constraints problematisation recognised that individuals needed to make informed decisions "against the background of such powerful determinants" (Secretary of State for Health, 1999: par 1.29) which sets it apart from the Informational problematisation which largely ignored the impact of wider influences on how individuals made choices regarding their health. There was a clear need to balance the empowerment of individuals through opportunities for personal development with the recognition that individuals must accept responsibility for the choices they make.

6.6 Conclusion: the continuing role of individual choice in public health

This chapter has outlined the second problematisation of "differences in health", the Constraints problematisation. The chapter began with an exploration and explanation of the transition between the Informational and Constraints problematisations, arguing that *The Health of the Nation* (Secretary of State for Health, 1992) marked the beginning of the shift towards the Constraints problematisation. *The Health of the Nation* arguably still placed a

great deal of emphasis on the role that information could play in improving health through allowing individuals to make informed choices, the paper conceded that local and national government had a responsibility to address wider influences on health, and choices about health, which were beyond the control of the individual. Although New Labour's approach to health and health inequalities was argued to be a response to the perceived failure of the previous Conservative government's strategy for health, it seems as though it was actually the publication of *The Health of the Nation* which signalled a change in direction for public health policy thinking and this paper laid the foundations for New Labour's public health approach to establish itself.

The importance of wider influences on health is demonstrated in the Constraints problematisation through the adoption of the social model of health as a way of conceptualising and explaining the constraints that people might face when making choices about their health. The "constrained chooser" emerges from this problematisation as it is assumed that people want to make health choices but may face limitations to realising those decisions. A number of these constraints are argued to be external to the individual and largely beyond their control, so it is the responsibility of national and local government to provide opportunities for people to improve their health and to ensure that individuals are empowered to take greater control over their lives.

It is clear from the discussion in this chapter that choice remained a central concern within the Constraints problematisation. The removal of constraints to choices about health was seen as the best way for people to improve their health and to reduce health inequalities (DH, 2003; Secretary of State for Health, 1991; Secretary of State for Health, 1999). While this chapter has outlined and examined policy discussions concerning the widening of responsibility for health beyond the individual to include the role that local and national government has, these discussions and actions were underpinned by the need to ensure that individuals could make choices about their health free from external constraints. While it was argued that these policies would help to reduce health inequalities by addressing underlying determinants of health, it seems as though what they were really aimed at was ensuring that everyone had the same opportunity to make healthier choices.

The continuing concern with individual choice can clearly be seen in New Labour's second public health white paper *Choosing Health: Making healthy choices easier* (Secretary of State for Health, 2004) which took a slightly different approach when it came to discussing how to enable individuals to make healthy choices. The paper argued that "[o]ur

fundamental aim must be to create a society where more people, particularly those in disadvantaged groups or areas, are encouraged and enabled to make healthier choices" (Secretary of State for Health, 2004), echoing earlier policy discussions about the provision of opportunities to those facing the most constraints to making healthy choices. In order to enable people to make healthier choices the paper suggested that the context of the consumer society must be acknowledged in order to develop suitable interventions that would improve people's choices. While the negative effects of capitalist society were noted, "market systems – which are designed to promote choice – bring inequalities in terms of opportunities to make healthy choices in where we live, what food we eat and how we spend our leisure time" (Secretary of State for Health, 2004), interestingly the paper advocated the use of marketing techniques in order to enable people to make healthy choices. Social marketing strategies would be used to promote health and to "build public awareness and change behaviour, making behaviour that harms less attractive and encouraging behaviour that builds health" (Secretary of State for Health, 2004). This move towards changing the environment such that healthy choices became the "sexy ones" (Secretary of State for Health, 2004) was part of the groundwork for the emergence of the Paternalistic Libertarian problematisation. There are still elements of the Constraints problematisation here as the paper clearly recognised that people's choices were restricted through the effects of a market society. The slight difference, however, is in the assumptions about how individuals make choices. Rather than assuming that individuals simply make choices based on the available information and opportunities available, *Choosing Health* entered another variable into the mix – the effects of marketing. The discussions in this paper suggested that perhaps individuals did not always make calculated decisions about their health, but rather could be persuaded by the way a product or choice was marketed to them. Consequently this paper advocated the use of social marketing techniques in order to successfully market health to the public, effectively fighting marketing with marketing. This new approach was, therefore, not just concerned with informing people and allowing them to make their own decisions, but about persuading people to change their decisions through marketing, effectively "nudging" people in the right direction towards particular decisions over others.

The Constraints problematisation was central to New Labour's health policy from 1997. It is argued here that it is most visible in New Labour's policies from 1997 up until the mid-2000s. From the mid-2000s, however, it is possible to see the emergence of another problematisation of "differences in health" which eventually crystallised in the Coalition government's public health white paper *Healthy Lives, Healthy People* (Secretary of State for

Health, 2010). The development of the Paternalistic Libertarian problematisation began in the later years of New Labour's three terms in government and overlaps with the Constraints problematisation outlined in this chapter. The final problematisation builds on the idea that people's choices about their health can be constrained by the surrounding context, but it does not just focus on how contexts and circumstances can constrain choices; instead the Paternalistic Libertarian problematisation is concerned with how choice can be shaped by contexts. As part of the solutions put forward to address "differences in health" the Paternalistic Libertarian problematisation argued that it is the environment in which choices are made that needs to be altered in order to guide people towards the "correct" choices. This also challenged the assumption that individuals always make rational, calculated decisions which suggests that the way in which individuals make choices is, in fact, flawed and needs to be reconsidered in order to create more effective policies.

The final analysis chapter will turn to examine the emergence and development of the Paternalistic Libertarian problematisation of "differences in heath". It will begin with an exploration of the period when the Constraints problematisation seems to overlap with the Paternalistic Libertarian problematisation, highlighting the wider policy literature which draws upon research from the behavioural sciences which was used to underpin this third problematisation. The discussion will then turn to examine the Paternalistic Libertarian problematisation in greater depth, in particular its changing assumptions concerning how individuals make choices leading to the emergence of the "flawed chooser" as its governable subject.

Chapter 7
The Paternalistic Libertarian Problematisation

7.1 Introduction

This chapter will examine the final problematisation of "differences in health", the Paternalistic Libertarian problematisation. Chapter 5 outlined the emergence and dominance of the Informational problematisation in the 1980s and early 1990s, which argued that the problem of "differences in health" was primarily a problem of information provision. The inability of people to make healthy choices was caused by a lack of information. As people were "responsible choosers" it was assumed they would respond appropriately to information provided to them about behaviours and activities which were good and bad for their health. The early 1990s saw a change in thinking, however, with the publication of *The Health of the Nation* (Secretary of State for Health, 1992) which included discussions about the need to widen responsibility for health beyond the individual. This saw the emergence of the Constraints problematisation, discussed in Chapter 6, which became the dominant understanding of "differences in health" under New Labour from 1997 until the mid-2000s. The Constraints problematisation argued that there were wider constraints acting on individuals which could limit the choices they could make about their health. In order to help the "constrained chooser" it was necessary to remove constraints to choice and to provide individuals with opportunities to help themselves. As was noted at the end of the last chapter, however, this problematisation began to fragment from around the mid-2000s, although it remained the dominant problematisation until the Coalition government came to power in 2010.

The previous two chapters seem to show that the problematisations of "differences in health" focus on understanding how people make choices about their health and developing solutions which will ensure people make healthy choices. The Paternalistic Libertarian problematisation is still concerned with how people make choices about their health, but it poses an important challenge to a key assumption which underpinned both the Informational and Constraints problematisations. From around the mid-2000s the traditional understanding of individuals as rational, calculated decision-makers was questioned. The idea of the rational decision-maker assumes that individuals are aware of and act on all the

information or opportunities provided to them in order to benefit themselves and their welfare. Research from the behavioural sciences, however, began to question this assumption and put forward an alternative understanding of the process of how individuals make choices which argued that often individuals make flawed decisions. This was, in part, due to the fact that individuals do not always take all the available information into account, or that they rely on a "rule of thumb" to guide them. In addition to this individuals respond to contextual cues, both physical and social, when making choices (Institute for Government, 2010).

The Paternalistic Libertarian problematisation, underpinned by libertarian paternalism (Thaler and Sunstein, 2009), therefore placed greater emphasis on the need to change the context in which people made choices about their health in order to make healthy choices the default option. Interest in the surrounding context in which choices are made clearly reflects a concern raised in the Constraints problematisation that the context in which a person lives can act to constrain choices. The Paternalistic Libertarian problematisation differs, however, in that the focus is not just on how contexts can constrain choices but rather how contexts can be used to shape choices in a particular way, in this case to encourage the choosing of a healthy choice. What is important here is that choice should not be restricted where possible but that healthy choices should be the easier choices to make. People would still have the option to make the unhealthy choice which ensures that freedom of choice is retained, but the idea is that the healthy choice would become the default option.

The chapter will be organised as follows. The first section will outline the transition from the Constraints problematisation to the Paternalistic Libertarian problematisation. It will provide an exploration of New Labour's second public health white paper (section 7.2.1) and consider the emergence of the political perspective of libertarian paternalism and its influence on wider discussions concerning how social policy should address problems (section 7.2.2). The chapter will then examine how the problem of "differences in health" is normalised as a social problem in the Coalition's papers and how this encouraged the renewed emphasis on individual behaviour as the focus of public health policy. The next three sections will discuss three key aspects of the Coalition's public health approach which also make up the main characteristics of the Paternalistic Libertarian problematisation. Section 7.4 will explore the reframing of "differences in health" as the result of poor lifestyle choices. This will then lead into section 7.5 which discusses the need to adopt a life course approach in order to address poor lifestyles and encourage healthy lifestyles. Section 7.6

then discusses the mechanism by which this behaviour change would take place – the adoption of "nudge" interventions into public health policy. Finally the governable subject of the "flawed chooser" will be outlined, demonstrating how the "flawed chooser" emerged as a viable alternative to the "constrained chooser" given the changes in understanding concerning how individuals make choices.

7.2 Challenging existing understandings of individual behaviour

As has been shown in the previous two chapters, the problem of encouraging and enabling people to make choices about their health has been a core concern of English public health policy since the 1980s. While both the Informational and Constraints problematisations had different ways of conceptualising how individuals make decisions, one key assumption which linked the two governable subjects of the "responsible chooser" and the "constrained chooser" was that people would make better decisions about their health when provided with better information or when opportunities were made available to them. It was assumed that individuals were rational decision-makers who would make calculated decisions based on the information and opportunities they had access to which would lead to better health. This began to be challenged from around 2004 onwards, both in terms of changes in perspective within New Labour's public health policy and from wider government discussion papers which began to examine new theories on how individuals make choices. These theories suggested that individuals do not always make the best decisions because they are strongly influenced by their surrounding social and physical contexts which may not only restrict the choices available to them, but also can point them in the direction of a particular choice over others even if this choice is bad for them.

The political perspective of libertarian paternalism also emerged around this time and tied into the discussions concerning how individuals make choices. This perspective is most notably advocated by Thaler and Sunstein in two key papers (Sunstein and Thaler, 2003; Thaler and Sunstein, 2003) and their book *Nudge* (Thaler and Sunstein, 2009). Broadly speaking libertarian paternalism is in favour of a degree of paternalism in shaping the types of choices people can make, in particular ensuring that the default choice was one which was beneficial to people. Even if they did not actively make a choice people would still benefit, for example introducing an automatic "opt in" system for pension contributions so that

employees would have to actively opt out of the system if they did not want to build their pension. The emergence of the political perspective of libertarian paternalism undoubtedly played a role in the transition from the Constraints to the Paternalistic Libertarian problematisation and this will be explored below in this section but also referred to in the rest of the chapter.

This section will now go on to explore these two key changes which allowed for the transition from the Constraints to the Paternalistic Libertarian problematisation of "differences in health". In the first sub-section New Labour's second public health white paper *Choosing Health* (Secretary of State for Health, 2004) will be discussed as it put forward interesting, and original, arguments concerning the role of marketing in shaping people's choices, and what this meant for understanding how people make choices about their health. The emergence of the term "health friendly environments" will also be considered in this sub-section. The second sub-section will outline the political perspective of libertarian paternalism in more detail and move on to discuss its influence in three key policy discussion papers which examined alternative explanations for how individuals make choices

7.2.1 Exploring how social and physical environments influence choices about health

The context in which individuals make choices about their health was of central concern for the previous Constraints problematisation. This problematisation recognised that contexts can act to constrain the choices that people can make about their health. This surrounding context not only included physical features of the environment, such as the existence of green spaces and the location of shops and services, but also wider societal and economic aspects could act to limit choices available to people, such as the amount of income a person received. The solutions put forward in the Constraints problematisation aimed to remove these constraints to choices with action from the government and local authorities, as well as providing opportunities for individuals to improve their own situations. The context in which individuals make decisions about their health is also central to the Paternalistic Libertarian problematisation, but for a different reason. It is not just about individuals overcoming constraints within their social and economic situation and their surrounding physical environment, but about how the context itself, or the surrounding

environment, can be used to shape the decisions people make about their health in a particular way.

The idea of using the surrounding environment to actively shape people's decisions about health is first discussed in the consultation paper preceding New Labour's second public health white paper (DH, 2004). The following paragraph demonstrates that at this point there seemed to be a growing concern about not only enabling people to make healthy choices by themselves but also with the impact of the surrounding environment on choices:

> *Improving health and narrowing health inequalities are issues for society as a whole, not just the Government. The Government **cannot force people to make healthier choices nor should it tell people how to live their lives**. But the Government can and should **provide information, encouragement and support to enable everyone to make healthier choices** no matter where they live, who their parents were or how affluent they are. And that includes making sure people whatever their background can access information and advice so that they can make informed decisions within **health friendly environments**. **Government's role is to ensure that the right balance is struck between individual freedoms and the public good**. (DH, 2004: 7, emphasis added).*

The first sentence here seems to reinforce the perspective from earlier papers, such as *Saving Lives: Our Healthier Nation* (Secretary of State for Health, 1999), that addressing health inequalities are not simply the responsibility of the government but rather there is something that everyone can do. This reflects the need for the "three-way partnership" outlined in *Saving Lives*. It then goes on to argue that the role of government is not to force people to live in particular ways as people do not want to be told what to do. This seems to suggest there is a libertarian element to this perspective as it suggests that people want to make their own choices without interference from the government. There then seems to be almost a return to the Informational problematisation as the government's role seems to be reduced to simply providing information to the public in order for them to make their own choices. Then there is the introduction of the phrase "health friendly environments" into the discussion. This seems to be a reframing of an old concern with the surrounding context in which people make choices about their health. The paper does not make it clear what is meant by this phrase, however it seems as though there is a recognition that there is a need to ensure the environments in which people make choices are actually conducive to healthy choices. Interestingly the idea of "health friendly environments" is picked up on several years later in the review paper *Health Inequalities: Progress and Next Steps* which argued that when it came to reducing health inequalities policy makers faced "a dual challenge: to help

and support individuals directly, and to *change the environments in which they make their decisions so that the healthy decisions are the easiest to make*" (DH, 2008: par. 4.6, emphasis added). Again although the paper does not expand on this statement, there is a clear emphasis here on the need to take into account environmental cues which shape individual decisions about health, and to shape environments so that people are more likely to make healthy choices. This idea about changing the environment in some ways is not new, particularly around changing the physical environment to encourage exercise, for example. What is new is the fact that concerns with choice seem to overtake concerns with forms of social inequality driving health inequality which is a departure from previous New Labour policies on health inequality (see for example Acheson, 1998; Secretary of State for Health, 1999; DH, 2003).

This shift in concern seems to become clearer in New Labour's second public health white paper *Choosing Health* (Secretary of State for Health, 2004). As can be seen from the title alone, this paper placed much more explicit emphasis on the role of choice in determining health outcomes than in previous New Labour publications. The paper argued that "inequalities in health are not acceptable. Our fundamental aim must be to create a society where more people, particularly those in disadvantaged groups or areas, are encouraged and enabled to make healthier choices" (Secretary of State for Health, 2004: 11). Clearly the focus of this paper is about how to improve peoples' choices about health, particularly because this quotation seems to suggest that the reason there are inequalities in health is precisely because certain individuals are unable to make healthy choices. The paper began its analysis of the current situation by arguing that we live in a consumer society and, as a result, "[m]any of the choices that affect our health – what we eat, the facilities and services we use – are choices we make as consumers" (Secretary of State for Health, 2004: 19). Conceptualising people are consumers led to considerations about how people make choices as consumers and how these assumptions could help to change the choices people make about their health. Compared to existing New Labour approaches to health inequalities this seemed to ignore the wider social determinants of health which had previously been at the centre of discussions about "differences in health", and instead placed much greater emphasis on individual choice as the driving factor in "differences in health" or health inequalities.

As part of this emphasis on choice the paper used economic language in order to frame the problem of "differences in health" as one of supply and demand. The paper aimed

to work towards "developing new demand for health" but noted that "creating demand for health is not enough on its own. If people want better health, we need to make it easier for them to do something about it" (Secretary of State for Health, 2004: 12). From very early on it is clear that the paper draws on economic language and theory in order to understand why people do not make healthy choices about their lifestyle despite the amount of information and guidance stating why they should and the opportunities available to them. In order to increase the number of people making healthy decisions the paper argued that a market for health had to be created but that "both consumer demand and market provision need to be influenced" (Secretary of State for Health, 2004: 19), as while there may be a demand for health the market was not currently supplying this demand, i.e. there were not enough healthy choices available to meet the demand for them.

One of the key things the paper argued was that health and the idea of a healthy lifestyle required an image change:

> Alcohol and fast food are portrayed as offering excitement, escape and instant gratification. Television, computer games and the sofa offer attractive entertainment options. In contrast, the portrayal of healthy lifestyles by government can seem preachy, boring and too much like hard work. (Secretary of State for Health, 2004: 21)

Firstly this quotation suggests that more should be done outside of government to promote health and to make it seem more appealing. The government did not want to be seen to be telling people what to do, but they clearly still had a vested interest in improving health. More importantly this quotation seems to recognise that the reason why people might not make healthy choices is because they are not presented as being exciting or enticing, thereby reflecting the consumer mentality of the paper. Indeed the paper said that the consultation took advice "from people who help make the less healthy choices the sexy ones" (Secretary of State for Health, 2004: 21) and introduced them to the idea of social marketing which the paper argued "could be used to build public awareness and change behaviour, making behaviour that harms health less attractive and encouraging behaviour that builds health" (Secretary of State for Health, 2004: 21).

There is a silence in the above quotation which is interesting to explore briefly. The problem seems to be that certain activities, most of which are harmful to health, are marketed to the public in ways which make them very appealing. The solution put forward in the paper is to effectively fight marketing with marketing by trying to market healthy alternatives in a similar way to these more harmful activities. What is interesting is that there

doesn't seem to be any consideration of challenging the marketing techniques that are used and imposing some sort of regulation on marketing products, like alcohol, which can cause serious health problems. The problem is therefore to do with the way in which healthy activities are presented to the public rather than the way in which harmful activities are marketed.

The discussions about the need to better market health to the public seem to present a challenge to traditional ideas of how individuals make choices. Instead of assuming that individuals make rational decisions based on all the information and opportunities available to them choices can, and often are, influenced by external cues including marketing and advertising. Healthy choices do not become the ones people choose simply through better provision of information or opportunities; they need to be made "easier" to adopt if people are to change their behaviour, and the paper advocated the use of social marketing strategies in order to achieve this change. . It is interesting to note, however, that on the same page which put forward the idea of marketing health to the public in order to create demand for health the paper criticises the effects of a market system on health: "Differences of income and wealth mean that market systems – which are designed to promote choice – bring inequalities in terms of opportunities to make healthy choices in where we live, what food we eat and how we spend our leisure time" (Secretary of State for Health, 2004: 20). It seems odd that on the one hand the paper argues that market systems are detrimental to health because they create unequal access to opportunities and choices about health, and on the other they advocate the use of markets in order to promote health and make healthy choices "easier" for people to adopt.

This white paper, therefore, seems almost something of an anomaly in terms of New Labour's policies on public health and health inequalities. Instead of focusing on the wider barriers to health that had been outlined in previous papers and which had formed the basis of their *Programme for Action* (DH, 2003), this white paper centres the issue of health inequalities on individual lifestyle choices. While it is being argued here that the idea of choice has played a central role throughout all three problematisations of "differences in health", up until this point New Labour's publications had not specifically focused on lifestyle choices as one of the key reasons why health inequalities existed. The prevailing understanding of behaviour was based on the assumption that people want to be healthy but that some groups face constraints to opportunities that would allow them to improve their health. Solutions were therefore based around removing constraints to choices and

providing access to opportunities across a range of policy areas that would address existing inequalities as well as improving health. *Choosing Health* provided a different understanding of behaviour, one which was based on the assumption that individuals make choices based on cues and influences from their surroundings, in particular through the way products and lifestyle choices are marketed. This challenged the assumption which underpinned both the Constraints and Informational problematisations that individuals were rational decision-makers who would change their behaviours given new information or opportunities which allowed them to do so. The fact that individual choice is influenced by more than a rational sensibility for one's own welfare suggested that perhaps a new approach to understanding individual behaviour was required in order to develop more effective responses to the problem of "differences in health", as well as across other policy areas.

7.2.2 Libertarian paternalism and social policy

In two papers (Sunstein and Thaler, 2003; Thaler and Sunstein, 2003) and their seminal book *Nudge: improving decisions about wealth, health and happiness* (Thaler and Sunstein, 2009) Thaler and Sunstein put forward their arguments in favour of libertarian paternalism, a new way of understanding and shaping human behaviour. While they note that their work has mainly developed from examples in the private sector, they argue that "many of the most important applications of libertarian paternalism are for government" (Thaler and Sunstein, 2009: 14) and that libertarian paternalism should appeal to all political parties as it is "neither left nor right, neither Democrat nor Republican" (Thaler and Sunstein, 2009: 15). After all, governments want to ensure the wealth, health and happiness of their populations. Drawing on arguments and evidence from the field of behavioural economics, Thaler and Sunstein argue that libertarian paternalism offers a new solution to an age old problem – how to change people's behaviour for the better.

In outlining their perspective, Thaler and Sunstein (2003: 175) note that "[m]any economists are libertarians and consider the term "paternalistic" to be derogatory", conjuring images of an overbearing state coercing individuals to act in particular ways and reducing their freedom of choice. The phrase libertarian paternalism to some is considered an oxymoron; however Sunstein and Thaler (2003) argue that the two seemingly opposing ideals can be combined to form a new perspective on understanding the way people make choices. In *Nudge* Thaler and Sunstein distinguish between two types of individuals, "Econs" and "Humans". They state that most people, whether or not they have studied economics,

hold the view that individuals are extremely good at making choices for themselves and make a better job of choosing for themselves than anyone else would do. Most people subscribe to the idea of "*homo economicus*, or economic man – the notion that each of us thinks and chooses unfailingly well" (Thaler and Sunstein, 2009: 7, emphasis in original). Econs, then, are "required to make unbiased forecasts" which, while they may be wrong in the end, should not be "systematically wrong in a predictable direction" (Thaler and Sunstein, 2009: 8). Econs also respond to incentives, such as an increase in taxes on a product, but are not influenced by "irrelevant" factors such as the order in which products are placed in a supermarket. As the authors demonstrate, however, most people are not Econs but Humans, who make predictable errors and who are influenced by environmental cues and "nudges". The perspective of libertarian paternalism argues that we need to reconsider individuals as Humans rather than as Econs, thereby challenging conventional wisdom about how individuals make choices, and this perspective ultimately aims to shape the choices that people make to ensure that everyone is better off even if they accept the default option.

While Thaler and Sunstein accept that initially people may be put off by the phrase libertarian paternalism because of the perceived threat to freedom of choice, they argue that this "anti-paternalistic fervour expressed by many economists" (Thaler and Sunstein, 2003: 175) is based on a false assumption and two related misconceptions. This false assumption is concerned with how people make choices in their everyday lives. It is often argued that "almost all people, almost all of the time, make choices that are in their best interest or at the very least are better, by their own lights, than the choices that would be made by third parties" (Sunstein and Thaler, 2003: 1163). They argue that there is little empirical evidence to support this assumption and that research has actually raised questions around the idea of individuals making rational decisions and judgements (Thaler and Sunstein, 2003).

Following on from this initial assumption the first misconception is the belief that alternatives to paternalism exist. They argue that in most situations "some organization or agent *must* make a choice that will affect the behaviour of some other people" (Sunstein and Thaler, 2003: 1164, emphasis in original). The example they provide to illustrate their argument is that of a cafeteria. Decisions have to be made about what food to serve, the ingredients that are used in the food, and also how food choices are laid out to customers. This is considered to be paternalistic because the customers have to accept what is on offer that day (they cannot have unlimited choice as to what to eat), they must trust that the kitchen has used appropriate ingredients for the meals, and customers may choose different

meal options depending on the order in which the food is presented. The second misconception is that paternalism always involves or requires a form of coercion. As demonstrated through their cafeteria example, the order in which food is presented to customers does not force anyone to choose a particular meal but it may mean that some options are favoured over others. Indeed they suggest that it is perhaps beneficial to place certain foods before others, for example presenting fruit and salad before desserts in schools to encourage healthy eating. As such, they argue that "[s]ince no coercion is involved, we think that some types of paternalism should be acceptable to even the most ardent libertarian" (Sunstein and Thaler, 2003: 1166). The paternalistic element takes the form of "nudges" to change behaviour, but still retains the libertarian element in that people are still free to ignore the nudge and to select other choices.

In order to address the fact that people do not always make the best choices for themselves, Thaler and Sunstein (2003, 2009) suggest that we need "choice architects" who have "the responsibility for organising the context in which people make decisions" (Thaler and Sunstein, 2009: 3) and who know how to make people's lives "longer, healthier and better" by the social and physical environment in order change behaviour and to "make the choosers better off" (Thaler and Sunstein, 2009: 5). One important aspect of good choice architecture is the need to implement a good "default option". This takes into account the fact that most people "will take whatever option requires the least effort, or the path of least resistance" (Thaler and Sunstein, 2009: 93). There must always be an option if the individual decides to do nothing, which may simply be that nothing changes. This option, however, should ensure that the chooser is in a better position than if they didn't have the option of the default.

As Thaler and Sunstein (2009) had hoped, discussions of libertarian paternalism and its potential uses in government made their way into wider policy debates in the UK. Three notable discussion papers were published in the later terms of New Labour's time in government which explored alternative understandings of individual behaviour and the impact these could have on social policy. These papers were *Personal Responsibility and Changing Behaviour* (Strategy Unit, 2004), *Achieving Cultural Change: A policy framework* (Strategy Unit, 2008), and *MINDSPACE: Influencing behaviour through public policy* (Institute for Government, 2010).

Personal Responsibility and Changing Behaviour (Strategy Unit, 2004) opened up this field for debate. The overall aim of the paper was to put forward alternative explanations for

behaviour change, emphasising the fact that there were many different influences on people's behaviour including "individual dispositions, family upbringing, the customs and habits of our society, as well as previous lifestyle choices" (Strategy Unit, 2004: 14). While the paper argued that most theories of behaviour change in policy were often rooted in economic thinking which meant conceptualising the individual as a rational decision-maker, it was suggested that the government should consider alternative approaches to understanding behaviour and behaviour change which were developed from psychology, noting that this psychological literature "remains largely untapped by policymakers" (Strategy Unit, 2004: 14). In particular it was argued that this as yet unexplored literature needed to be considered in relation to new debates about personal responsibility. While the paper noted that the division of responsibility between the individual, community and society was a hotly contested issue, it argued that personal responsibility should be seen as "a good in its own right" because individuals "generally want to be able to control their own lives" (Strategy Unit, 2004: 7). It was recognised, however, that exercising personal responsibility through choices comes at a cost to the individual as they have to take time to consider all the available information before coming to a decision, although people would often use rules of thumb in order to reduce the time that this would take. As such, there is a clear role for the state in ensuring that "the default choice is a safe and appropriate one" (Strategy Unit, 2004: 9). This needed to be balanced with a renewed consideration of the idea of personal responsibility as "[p]olicy should not simply proclaim personal responsibility or blame, but needs to be shaped around the ways in which people actually think and feel, and the social and psychological forces that influence behaviour" (Strategy Unit, 2004: 67). The idea was to develop "co-production" between the public and government, whereby the public would be encouraged to help themselves and would be more engaged with political and policy outcomes. This would not only lead to more effective policies, but also allow individuals to feel more in control over their lives.

The following discussion paper, *Achieving Cultural Change: A policy framework* (Strategy Unit, 2008) built on these initial discussions and even set out a framework which could be applied in different policy settings in order to instigate the "culture change" which was seen to be necessary in order to improve the outcomes of social policy interventions. By culture the paper referred to "the set of influences on how individuals, groups and society see the world and react to it" (Strategy Unit, 2008: 23). The paper argued that while the traditional policy actions of regulation, legislation and incentives had often proved effective to an extent, policy makers needed to take into account the role of cultural factors as

determinants of behaviour. Citing Bourdieu's concept of "cultural capital" the paper contended that cultural change complemented existing research into behaviour change helping to "provide a fuller explanation of why people behave in certain ways" by placing "emphasis on understanding the environmental circumstances in which cultural capital is formed, how it evolves over time and influences behaviour" (Strategy Unit, 2008: 6). Policy makers, therefore, were expected to have a greater awareness of the positive and negative effects of their policies on cultural capital. As with the previous paper, *Achieving Cultural Change* concluded that this was still a relatively underexplored and underappreciated field within social policy. It argued that more research was needed "into the role attitudes, values and aspirations play in driving actions and behaviour and encouraging this to be more systematically used in the development of government policy" (Strategy Unit, 2008: 136).

The final publication, *MINDSPACE* (Institute for Government, 2010), drew on the previous debates as well as more recent findings from the field of behavioural science. The paper stated that the basic insight of the behavioural sciences and behavioural economics in particular, is that our behaviour is not guided by a perfect logic that takes into account all the available information and produces a cost-benefit analysis of every action we partake in but is instead "led by our very human, sociable, emotional and sometimes fallible brain" (Institute for Government, 2010: 13). It was argued that there are two main ways of thinking about behaviour and behaviour change. The first is focused on changing the mind of the individual and starts from the assumption that "citizens and consumers will analyse the various pieces of information from politicians, governments and markets, the numerous incentives offered to us and act in ways that reflect their best interests" (Institute for Government, 2010: 14). It was argued that this understanding has underpinned much social and economic policy, emphasising the rational nature of individual decision-making. Rather than focusing on minds the second perspective, derived from behavioural science, turns attention to the context in which individuals make decisions. This understanding assumed that "people are sometimes seemingly irrational and inconsistent in their choices, often because they are influenced by surrounding factors" (Institute for Government, 2010: 14). The emphasis of this second perspective is that action should be taken to consider the context in which behaviours take place, thereby "changing behaviours without changing minds" (Institute for Government, 2010: 14). The paper argued that a focus on behavioural approaches would offer policy makers "a powerful new set of tools" with the potential to develop "low cost, low pain ways of nudging citizens - or ourselves - into new ways of acting by going with the grain of our automatic brain" (Institute for Government, 2010: 73). The

paper noted, however, that the application of behavioural economics to social policy "certainly does not mean giving up on conventional policy tools such as regulation, price signals and better information" (Institute for Government, 2010: 77). Policy makers should therefore continue to use more traditional methods where they still work, particularly because there is still more work to be done in this area. They should, however, be more aware of the fact that individuals are influenced, and influence others, all the time and that "government often forms a significant part of this environment, whether intentionally or not" (Institute for Government, 2010: 73).

All three of these discussion papers emphasise the need to consider behaviour change as an important aspect of social policy. It was suggested that governments could make greater gains "by using their limited resources to engage, involve and change the behaviour of users and other parties" (Strategy Unit, 2004: 7) as "[m]any policy outcomes clearly depend on how we – as individuals and groups – behave" (Strategy Unit, 2008: 19). Indeed, it was recognised that "influencing behaviour is central to public policy" (Institute for Government, 2010: 12). All three papers highlighted the need to consider alternative explanations of behaviour beyond economic accounts which were generally favoured by policy makers, but they recognised that these new theories should be used alongside the more "traditional" policy instruments of incentives, regulation and legislation.

7.3 The normalisation of "differences in health" as a social problem

The Coalition government noted that despite the fact that "people in England are healthier and living longer than ever before" (Secretary of State for Health, 2010: par. 1.1) differences in experiences of health were observable and "[n]ot everyone has gained as much as they could have" (DH, 2010) in terms of improving levels of health. Some groups of the population saw greater improvements than others, and this discrepancy needed to be addressed. Indeed the accompanying publication to their white paper *Our Health and Wellbeing Today* (DH, 2010) contained an entire chapter outlining and exploring this issue. Despite acknowledging this fact, however, the discussions presented in the Coalition's papers seem to suggest a normalisation of the problem of "differences in health".

To begin with there is some reluctance to commit to a particular phrase or label for the problem of "differences in health". Although the chapter in *Our Health and Wellbeing Today* is titled as "Health inequalities" the chapter also refers to the problem as "differences in health and wellbeing" (DH, 2010: par. 5.1), refers to the need to reduce "systematic patterns in those differences" (DH, 2010: par. 5.1), and also examines ways of measuring "differences in health experience" (DH, 2010: par. 5.1). It is interesting that these three phrases seem to be used as synonyms for "health inequalities" when arguably they could represent different understandings of the problem. The use of the word "differences", for example, could be suggesting that the observed disparities are simply natural differences in the population which are to be expected, which seems to reflect the earlier label of "variations in health" discussed in the Conservative's public health white paper *The Health of the Nation* (Secretary of State for Health, 1992). The need to look at "systematic patterns" seems to be very similar to the label "systematic variations in health" used in *Variations in Health* (DH, 1995), which was used in order to acknowledge that something was underlying the variations in health but did not go as far to suggest that these variations should be considered as inequalities. *Our Health and Wellbeing* did argue, however, that "patterns of ill health are too large and systematic for purely pre-determined factors to be anything but a small factor in the overall health experience" (DH, 2010: par. 5.17) and noted that "serious health inequalities do not arise by chance, their drivers are many and complex" (DH, 2010: par. 5.17). This suggested, rather like previous commissioned reports into health inequalities (Acheson, 1998; DHSS, 1980; Marmot, 2010) and New Labour's *Programme for Action* (DH, 2003), that there were wider factors influencing health which must be addressed.

Despite the concern with, and statistics showing, the existence of "differences in health" in *Our Health and Wellbeing Today*, there is a sense that "differences in health" were seen to be a normal state of affairs for countries like England as demonstrated by the following quotations:

> *Looking at differences in mortality across individuals in different countries, the evidence suggests that the scale of differences between individuals is not a unique challenge for England and is, in fact, a challenge in most countries…The differences between wealthy countries appear small and England is unexceptional. (DH, 2010: par. 5.2)*

> *England is not unique in experiencing health inequalities according to socioeconomic status. Comparisons of socioeconomic inequalities in health across countries suggest that England has similar challenges to other wealthy northern European countries. (DH, 2010: par. 5.8)*

Both of these quotations demonstrate the thinking that while England does suffer from differences in mortality and morbidity rates across the population, it is not a challenge faced exclusively by England. As noted here, other wealthy developed countries face similar challenges. This suggests that England's situation is nothing out of the ordinary, and it could be argued that it is even expected that these differences will exist in developed countries. While the white paper and this accompanying document recognise that "differences in health" should not be ignored, there is a clear attempt here to put England's situation into context and to demonstrate that it is not the only country facing these problems. Action should be taken in order to reduce "differences in health", but there is a sense here that they are simply a normal part of developed countries.

There is no explanation given for the use of the synonyms in *Our Health and Wellbeing Today* (DH, 2010). Perhaps they were used simply to avoid using the same term repeatedly. It seems, however, that there was an unwillingness to commit to using "health inequalities" which would have suggested that greater responsibility for improving health lay with the government. This perspective on "differences in health" is quite different from previous New Labour discussions. New Labour's framing of health inequalities was that they were avoidable, unfair and unjust. There seemed to be much more of a sense of urgency within New Labour's papers that health inequalities must be addressed in order to achieve their goals of a fairer society, and they emphasised that health inequalities were not inevitable.

As will be discussed further in the sections below, the Coalition's approach to public health placed much greater emphasis on the responsibility of the individual to adopt a healthy lifestyle in order to see greater improvements in health across the whole population. It is not the "differences in health" as such which is seen as the problem but rather the lifestyle choices that individuals make which affect their health. The use of the term "health inequalities" does not seem wholly appropriate given this framing of the problem as the focus has turned towards the individual and their own actions rather than wider social structures and institutions. That is not to say that the wider social context is ignored in the Coalition's public health approach as it is clear that they were interested in how contexts could be used to encourage people to make healthy choices and to adopt a healthy lifestyle. What is interesting, however, is this return towards placing much more emphasis on the individual and focusing on changing individual behaviour in order to improve health.

7.4 The problem of lifestyle choices

The Coalition's white paper noted that public health had achieved much over its history, stating that one of public health's biggest successes had been the implementation of large scale immunisation programmes which had "consigned to the history books the infectious diseases which once dominated death certificates" (Secretary of State for Health, 2010: par. 1.1). The update to the white paper recognised that it was "an historic time for public health" (Secretary of State for Health, 2011: par. 2.9) as public health faced new challenges and required new thinking and approaches to addressing these challenges. These challenges were framed in terms of the illnesses caused by poor lifestyles. Although public health had achieved much there were new threats to health from "'diseases of lifestyle', where smoking, unhealthy diet, excess alcohol consumption and sedentary lifestyles are contributory factors" (Secretary of State for Health, 2010: par. 1.2).

Both *Healthy Lives, Healthy People* (Secretary of State for Health, 2010) and *Our Health and Wellbeing Today* (DH, 2010) were concerned with lifestyle choices and argued that healthy habits should be established from an early age in order to encourage people to choose healthy lifestyles once they entered adulthood. It was noted that "lifestyle behaviours and habits established during school-age years can influence a person's health throughout their life" (DH, 2010: par. 6.21), reflecting earlier concerns that experiences early in life can have long lasting effects on health. Local communities and schools were highlighted as being central to promoting health to young people and the government expected that shifting power from central government to local authorities would provide "new opportunities and incentives to forge local partnerships to deliver better health outcomes for children and young people" (Secretary of State for Health, 2010: par. 3.13). Once people became adults the concerns about lifestyle choices were linked to how people lived and how they worked. As with childhood, it was noted that "[c]hoices and behaviours during adulthood can have profound impacts on people's health for the rest of their lives" (DH, 2010: par. 6.39).

The concept of lifestyle was an important feature of the Coalition's approach to public health, and for the Paternalistic Libertarian problematisation of "differences in health". The main problem seemed to be that individuals were engaging in behaviours which were harmful to their health and that it was difficult for them to change their behaviour because they had adopted a particular lifestyle. Although there is no clear definition of lifestyle provided in any of the documents analysed for this research (even in earlier papers which

touch on the topic), it is possible to argue that lifestyles are sets of behaviours which become routine for people to follow. The idea of following a lifestyle suggests that individuals essentially subscribe to a set of behaviours and activities which reflect a particular ideal, such as being healthy. These behaviours eventually become second nature and habitual, which often means that people actually make fewer choices in their lives than perhaps is usually assumed. That is not to say that lifestyles remove choices completely, but rather people tend to select options from a more limited list as the options should reflect the general ethos of the lifestyle.

In terms of considering its importance for the Paternalistic Libertarian problematisation, the concept of lifestyle poses a challenge to previously held assumptions about how individuals make choices. The discussion in the previous paragraph seems to suggest that past understandings of the process by which individuals make choices is flawed. By placing the emphasis on lifestyles there is a suggestion that people do not always make rational choice based on new information and opportunities, but rather they simply follow existing habits and go with what is familiar to them. This means that policy responses should perhaps consider the fact that people tend to stick with a familiar set of behaviours, and it is therefore important to instigate the adoption of a particular set of behaviours if people are to improve their health.

7.5 Adopting a life course approach

The Coalition had identified illnesses attributed to poor lifestyles as the main challenge facing public health and therefore advocated the need for people to adopt healthy lifestyles in order to improve and maintain health. The Coalition advocated the use of a life course approach within public policy following the recommendation of the Marmot Review (Marmot, 2010) and as part of their desire to change people's behaviour and to encourage the adoption of healthy lifestyles. *Healthy Lives, Healthy People* was the Coalition's response to the Marmot Review and it recognised the need for an approach "which addresses the wider factors that affect people at different stages and key transition points in their lives" (Secretary of State for Health, 2010: par. 3.1). The Marmot Review argued that a life course approach was needed in public health as it would recognise that "individual development takes place from birth to death" (Marmot, 2010: 40) with a number of influences shaping

health right from conception, through to the experiences people are exposed to as they develop and grow. The life course approach was therefore important in understanding the accumulation of both positive and negative effects of health and wellbeing throughout life.

It is important to note here that the idea of the life course had been used in public health policies before, particularly in the *Programme for Action* (DH, 2003). These previous uses of the life course, however, tended to focus on the early years of life and this can be seen in discussions of mothers, families and young children within public health policy. The Coalition's use of the life course differed in that it recognised that health challenges were not only present in the first few years of life, but right across a person's lifespan from birth to old age.

The introduction of a life course perspective into public health marked a change in the way health problems were conceptualised in policy. In both the Informational and Constraints problematisations the main challenges to health were considered in terms of distinct policy fields. In both the Acheson Inquiry (Acheson, 1998) and *Reducing Health Inequalities* (DH, 1999), for example, key policy areas for action were identified, including tax and benefits, transport, housing, and education. The use of the life course perspective in the Paternalistic Libertarian problematisation, however, meant that a more "bottom-up" view was taken of health problems as the focus turned to "the reality of people's lives, rather than on policy areas considered in isolation" (Secretary of State for Health, 2010: par. 3.3). *Our Health and Wellbeing* argued that the life course approach was necessary in order to gain a fuller picture of health across a person's life:

> *From birth, we are then exposed to a wide range of experiences – social, economic, psychological and environmental – that can affect our health and wellbeing. These change as we progress through the different stages of life such as pre-school, school, employment/training, family-building and retirement. (DH, 2010: par. 6.1)*

This approach recognised that experiences early in life "can have life-long effects on health" (DH, 2010: par. 6.2), both positive and negative. It was therefore necessary to consider the impacts of these early experiences on health. The experiences people face change as they progressed through life, which meant that new experiences would also affect health. The white paper

Applying a life course approach to health policy placed emphasis on challenges that people face at different points in their lives, particularly at transition points between different phases of the life course, for example between school and employment. It also

allowed for the consideration of how people accumulate experiences which affect their health. It was argued that by focusing key transition points in the life course it would be possible to influence behaviours more effectively in terms of encouraging healthy lifestyle choices.

7.6 Using insights from behavioural science to influence behaviour

As discussed above, the Coalition had identified that the main challenges facing public health were "diseases of lifestyle" (Secretary of State for Health, 2010: par. 1.2). The problem was that people were making poor lifestyle choices and, because lifestyles involve the need to adopt a specific set of behaviours in order to demonstrate that you follow that lifestyle, as a result poor health behaviours became habitual and routine. There was a need for people to adopt "healthy lifestyles", i.e. sets of behaviours and habits which are conducive to good health and the prevention of disease. This helps to explain the focus on the life course in the Coalition's public health approach. There was a need to identify key points when people's behaviour could be most strongly shaped. The use of the life course also demonstrated that it was possible to change behaviour at any stage of a person's life; it was not just all about making changes in the early years. Now the Coalition required a mechanism in order to address the problem of poor lifestyle choices and this was to be found through the introduction and use of "nudge".

From early on in *Healthy Lives, Healthy People* it was clear that the Coalition wanted to make use of new research from the behavioural sciences and argued that they could be "harnessed to help enable and guide people's everyday decisions, particularly at the key transition points in their lives" (Secretary of State for Health, 2010: par. 2.3). The life course approach was clearly an important part of the development and implementation of behavioural science perspectives into public policy. Within each phase of the life course it was possible to identify key challenges which could shape the decisions people made about their health, and it was necessary to act on these challenges and at specific points in the life course in order to influence the lifestyle choices people adopted. There seemed to be an implicit understanding that individuals needed more guidance in selecting choices which

were beneficial to their health. There was a role for government and organisations to play in shaping choices about health, but it was noted that this role should not involve intervening unnecessarily in people's lives. In their *Programme for Government* David Cameron and Nick Clegg argued that

> *…there has been the assumption that central government can only change people's behaviour through rules and regulations. Our government will be a much smarter one, shunning the bureaucratic levers of the past and finding intelligent ways to encourage, support and enable people to make better choices for themselves. (HM Government, 2010: 7-8)*

There was a clear desire to move away from previous approaches to changing behaviour and instead adopting new and seemingly more "intelligent" ways of supporting individual choices. This statement suggested that these traditional measures of policy are not the only method that can be used to change behaviour and it becomes clear upon reading their public health white paper that they adopted a new approach to addressing the problem of poor lifestyle choices and their effect on health. Indeed the Coalition was keen to adopt an approach which did not simply involve attempts to "ban everything, lecture people or deliver initiatives to the public" (Secretary of State for Health, 2010: par. 2.28).

The Coalition recognised that it was necessary to have some level of intervention from central government in order to ensure that people made the "right" lifestyle choices which would benefit their health. The government therefore had a role to play in "intervening effectively" in people's lives but it was argued that it would "balance the freedoms of individuals and organisations with the need to avoid harm to others" (Secretary of State for Health, 2010: par. 2.19). This suggested that there was a need to ensure that individuals, and organisations, retained the ability to choose freely but that the government could legitimately act to reduce choice where it was deemed that certain choices caused too much harm. This relates back to an earlier concern with the need for government intervention in certain circumstances raised in New Labour's consultation paper for their second public health white paper (DH, 2004), highlighted in section 7.2.1.

The need to retain choice was a central concern for the Coalition's public health approach. It was argued that

> *Few of us consciously choose 'good' or 'bad' health. We all make personal choices about how we live and behave: what to eat, what to drink and how active to be. We all make trade-offs between feeling good now and*

> *the potential impact of this on our longer-term health. In many cases,*
> *moderation is often the key. (Secretary of State for Health, 2010: par. 2.29)*

Here it was recognised that people make their own choices about their health, and sometimes do make poor choices as a compromise for short-term gains and without perhaps considering the impact on future health. Public health, and the government, should therefore encourage people to make better choices but without taking away unhealthy options as this would impact on individual freedom of choice.

Solutions, therefore, should not be about restricting choices through legislation, but instead should be based on the following: "strengthening self-esteem, confidence and personal responsibility; positively promoting 'healthier' behaviours and lifestyles; and adapting the environment to make healthy choices easier" (Secretary of State for Health, 2010: par. 2.31). The last two points are somewhat related in that not only should healthy lifestyle be promoted, they should be made easier to choose and adopt. This suggests an implicit understanding about individual behaviour – that individual choices are often shaped by habits which become ingrained over time and the contexts in which they live, and this makes it difficult for people to change their behaviour even when they are aware that it may be harming their health. Making healthy choices easier to adopt through changing the environment in which people make choices was therefore seen as key to encouraging a change in people's habits and to ensure that these changes "stick".

In order to make healthy choices easier the Coalition proposed a more nuanced approach to intervention than had been put forward previously. Rather than simply being faced with the extremes of "intrusive intervention into people's lives" in order to change the choices people could make or being "completely hands-off" in order to preserve total freedom of choice and leave individuals to decide for themselves (Secretary of State for Health, 2010: par. 2.20), a "ladder of intervention" was proposed as the best way forward. Figure 6 shows this ladder as it appeared in *Healthy Lives, Healthy People*. As you go up the ladder the interventions become more intrusive and have a greater effect on limiting the choices that people can make. The Coalition was keen to use the least intrusive methods when government action was required and ultimately wanted to "use approaches that focus on enabling and guiding people's choices wherever possible" (Secretary of State for Health, 2010: par. 2.33).

Figure 2.1: A ladder of interventions

Greater levels of intervention →

Eliminate choice: regulate to eliminate choice entirely.

Restrict choice: regulate to restrict the options available to people.

Guide choice through disincentives: use financial or other disincentives to influence people to not pursue certain activities.

Guide choice through incentives: use financial and other incentives to guide people to pursue certain activities.

Guide choice through changing the default: make 'healthier' choices the default option for people.

Enable choice: enable people to change their behaviours.

Provide information: inform and educate people.

Do nothing or simply monitor the current situation.

Figure 6 The ladder of intervention as taken from Healthy Lives, Healthy People (Secretary of State for Health, 2010)

Making healthy choices easier to adopt meant making changes to the environment in which people make choices about their health. This not only included the physical environment but also, and perhaps more importantly, "changing social norms and default options so that healthier choices are easier for people to make" (Secretary of State for Health, 2010: par. 2.34). Here the influence of behavioural sciences can clearly be seen as there is the emphasis is on "nudging people in the right direction rather than banning or significantly restricting their choices" (Secretary of State for Health, 2010: par. 2.34). This clearly reflects the work of Thaler and Sunstein (2009) who argued that libertarian paternalism was not about restricting choice, but about encouraging people to make a particular choice which would be beneficial to them. Understanding that individuals often make flawed decisions based on environmental and social cues, rather than calculated rational decisions based on all the available information, means that changing the context in which decisions are made is vital if people are to be encouraged to make a particular choice over other options available. Crucially, however, the other options should still be available for someone to choose if they want to reject the nudge towards the preferred option. Choices would only be restricted or removed entirely where it was felt that the government should step in to protect the public from doing themselves serious harm.

For the Coalition the implementation of a behavioural science approach in public health allowed them to consider ways of changing the "default" lifestyle choices that people make. This solution was based on the assumption that individuals do not always make the

best choices for themselves, or in this case they do not always make healthy choices, and therefore require encouragement in the form of a nudge in the right direction in order to change their lifestyles.

7.7 The "flawed chooser"

As has been shown in the above discussion in this chapter, it is clear that from around the mid-2000s understandings about how individuals make choices began to change. Although the Constraints problematisation and its governable subject the "constrained chooser" remained dominant at this time, it was clear that the governable subject was being challenged; however there was not a well-defined alternative to fully replace the "constrained chooser". Public health policies still recognised the need to encourage and support people to make healthy choices, but attention had started to turn towards how the surrounding context could be used in order to shape the choices people made. Concerns with the impact of the context, both physical and social, in which people make choices were raised in the Constraints problematisation which argued that contexts could act to limit the types of choices people could make about their health. Rather than simply viewing contexts as constraining choices, however, the developing discussions focused on how contexts could be used to influence choices in particular ways. In the case of public health this meant developing contexts in which healthy choices were easier to make.

In addition to this there was also an increasing emphasis placed on the role of habits and how these influenced the choices people made. This can be seen in the Coalition's public health white paper through the discussions of the need for people to adopt "healthy lifestyles". Lifestyles encompass habitual behaviours and expectations about how people should behave if they are to demonstrate that they follow that particular lifestyle. Habits and routine behaviours can mean that people do not often make conscious choices about, for example, the activities they engage in or the food they buy because they tend to follow what is familiar and what they are used to. There was a need to ensure, therefore, that the habits people adopted were conducive to health.

This shift in emphasis on how contexts and habits could be used to influence people's choices signalled the change in understanding about how individuals make choices. It was no

longer assumed that individuals made calculated choices based on the information and opportunities provided to them. People's choices could be influenced by the context in which choices were placed as well as by existing habits and behaviours. As a result the subject of the "flawed chooser" emerges from the Paternalistic Libertarian problematisation.

The "flawed chooser" represented a new way of conceptualising individual behaviour with regards to health. It challenged existing explanations for individual behaviour and decision-making which had underpinned previous solutions to the problem of "differences in health". By understanding that individuals are likely to make flawed choices due to existing habits and in spite of the existence of information and opportunities to make better choices about their health, there was a need to find a way of ensuring that people adopted the right (i.e. healthy) behaviours in order to make healthy choices the default option. As the problem of "differences in health" was seen to be the result of people adopting poor lifestyles which were harmful to their health, the concept of lifestyle is important here as adopting a healthy lifestyle would encourage people to develop healthy habits, which would mean that healthy choices would effectively become the default option. The life course approach was used in order to identify key points at which behaviour could be influenced in order to encourage people to adopt healthy behaviours, and "nudges" would be employed in order to instigate these changes. This problematisation is paternalistic in the sense that individuals would be nudged towards particular choices through engineering the context in order to ensure healthy choices were easier to select, but it is also libertarian because there would be other options available apart from the nudge so people could reject the nudge if they wanted to. The idea was, however, that if healthy behaviours became normal and routine for people then people would automatically select the healthy option and opting out of the nudge would require greater effort and consideration.

7.8 Conclusion

This chapter has outlined and explored the Paternalistic Libertarian problematisation as the final problematisation of "differences in health" in English public health policy. It has argued that this problematisation began to emerge in the mid-2000s in public health, and its development is noticeable in New Labour's second public health white paper *Choosing Health* (Secretary of State for Health, 2004). This paper put forward the view that social

marketing strategies should be used in order to make healthy choices more appealing and "easier" for people to adopt. This suggested a move towards new explanations for why people make certain choices and how best to influence people's choices such that they choose healthy lifestyles. It was no longer simply enough to provide people with information or opportunities to improve their health and to expect individuals to make the best decision taking everything into account. *Choosing Health* recognised that external influences, such as the marketing and advertising of products, were shaping the lifestyle choices people made and this helped to explain why people still made poor choices. If people were to be encouraged to make healthier choices then it was reasoned that by adopting techniques used in social marketing it would be possible to not only help create a demand for healthy choices, but to make healthy choices more enticing than other options.

The chapter then turned to examine the Coalition's public health strategy more closely as it was argued that this is where the Paternalistic Libertarian problematisation becomes the dominant understanding of "differences in health" and how the problem should be addressed. The discussion began with considering how the problem of "differences in health" had become normalised in the Coalition's papers, which had emphasised that "differences in health" were not just a problem for the UK and that the UK's situation was not that different from other similar developed countries. This normalisation led to an increasing focus on individual behaviour, and more specifically with the lifestyles that people followed. The concept of lifestyle emerged as an important framing device for the Coalition as it was used to identify the main problem facing public health as one of illness as the result of poor lifestyle choices. It also provided a way of shifting the focus back towards the individual, and the individual's responsibility for health. The introduction of a life course approach provided a useful way of understanding the importance of lifestyle choices throughout a person's life. It also allowed for the consideration and identification of key transition points in people's lives, which were argued to be significant times when individual behaviours could be influenced. This then led into a discussion of the use of a behavioural science approach to public health, which acknowledged that people do not always make calculated rational decisions and instead were strongly influenced by the context in which they make choices. The government was keen to adopt a strategy which would require as little intervention as possible in order to preserve freedom of choice, while at the same time nudging people towards particular choices in order to change their lifestyle behaviours. Unhealthy choices would not be restricted or regulated unless they caused too much harm to the public. There was a clear desire to implement a public health strategy which would

not impede on the freedom of individuals to make their own choices, but to also allow the government to act where necessary in order to protect the health of the population.

Finally the "flawed chooser" was outlined as the governable subject for the Paternalistic Libertarian problematisation. It was argued that under this problematisation individuals are understood to make flawed decisions because they often make choices based on surrounding social and physical cues which direct them towards a particular choice over others, even if that choice could be harmful to them. Choices are also strongly influenced by habits and routine behaviours. The "flawed chooser" therefore needed to be encouraged to make the "right" choice, not through coercion or through restricting the choices available but instead by nudging individuals towards choices which reflected healthy lifestyles. This would mean changing the environment or the context in which choices were made. In particular the Coalition highlighted the need for changing social norms so that healthy choices would become the default option. Unhealthy choices would still be available and people could reject the nudge if they wanted, but it was thought that it would become easier for people to adopt healthier lifestyles if healthy choices required the least effort to make.

The following chapter will provide a discussion of each of the three problematisations by focusing on the governable subjects which were produced by each problematisation. Each chapter has provided a brief outline of the governable subject within the context of its own problematisation. Chapter 8 will provide more of a genealogical analysis, exploring the transitions between the governable subjects in greater depth in order to better understand how we have reached the "flawed chooser" in public health problematisations of "differences in health".

Chapter 8
Discussion: The creation, fragmentation and reformulation of the governable subject

8.1 Introduction

The previous three chapters presented and discussed the three problematisations of "differences in health" that were identified in the analysis of English public health documents between 1980 and 2011. Each chapter outlined and explained each problematisation in detail, highlighting the key assumptions underpinning each representation of the problem of "differences in health", thereby presenting the archaeological analysis of the data, and closed with a short discussion of the governable subject which emerged from each problematisation. To repeat the table from Chapter 4, Table 6 provides a summary and comparison of the three problematisations along with the identified governable subjects.

The aim of this chapter is to establish an overall narrative of the data and of the problem of "differences in health" using a genealogical approach. The following discussion will focus on the subjectification effects of the problematisations, which relates to question 5 of Bacchi's (2009) WPR framework "What effects are produced by this representation of the problem?" (see section 3.3.3 in Chapter 3 Methodology for a more detailed explanation of Foucault's genealogical method and its relevance for the WPR framework). The governable subjects identified within each problematisation, the "responsible chooser", "constrained chooser" and "flawed chooser", will be explored in greater depth and importantly the transitions between governable subjects will be highlighted through a discussion of the fragmentation of the governable subject and its reformulation over time.

The discussion will outline each governable subject, its formation, fragmentation and reformulation, in order to present the genealogical narrative. This will emphasise the fragility and contingency of subjects produced by policy representations of the problem of "differences in health", showing that the governable subject is not a fixed entity and is susceptible to modification and change. These changes in the governable subject, however, do not necessarily demonstrate a neat progression in ideas but rather will be

Table 6 Problematisations of "differences in health" and their governable subjects

	Informational	Constraints	Paternalistic Libertarianism
Governable subject	*Responsible chooser*	*Constrained chooser*	*Flawed chooser*
Context	- Rise of a new health consciousness (healthism) - Challenges to medical dominance - Concerns surrounding welfare spending	- Information alone is not enough to improve health - Conservative government's first health strategy - Introduction of New Labour's "Third Way" welfare approach	- Changing assumptions about how individuals make choices - Influence of behavioural sciences on policy - Importance of lifestyle choices
What is the problem?	People lack appropriate information to make decisions about their health	People's health and the choices they make about their health are affected by their socio-economic standing	People's choices about their health are influenced by external cues and existing habits leading to poor choices
Why is this problematic?	Potential reduction of healthy workforce, and facing increasing spending on welfare state	Health inequalities are avoidable, unjust and unfair. People should be able to flourish regardless of their position in society	People are harming themselves by following poor lifestyles, leading to increasing levels of illness
Solutions	Provide people with more and better information to make choices about their health	Provide more opportunities for people to improve their health	Shape and guide the kinds of choices people make about their health by "nudging" people towards particular choices

shown to be contingent upon a wider policy, research and societal context, as well as being contingent upon previous governable subjects. The emergence of subsequent governable subjects does not simply signify a clear break from past assumptions; it is important to acknowledge and explore periods where subjects overlap for a time before new ideas and assumptions become the dominant representation. This discussion will provide the groundwork for the final Conclusion chapter which will focus on explaining how the problem

of "differences in health" has been represented in English public health policy as well as considering the contributions of a post-structuralist approach to policy analysis.

8.2 The emergence of the "responsible chooser": rational choice explanations

The first governable subject to be examined here is that of the "responsible chooser". The "responsible chooser" emerged from the Informational problematisation of "differences in health". As was discussed in Chapter 5, the Informational problematisation emphasised the importance and role of information in improving health. The Conservative governments of Thatcher and Major required more information about the health of the population in order to better prioritise policies and interventions on health and health care given self-imposed spending constraints (DHSS, 1988; Secretary of State for Health, 1992). The public also required better information and advice with regards to activities which could harm their health and what they could do to prevent "avoidable" illness. The individual was made aware of their responsibility not to fall ill unnecessarily, which would not only harm themselves but also lead to costs for wider society in terms of treatment and care via the NHS at a time when the government were keen to at least limit, if not reduce, spending on the health care system (DHSS, 1981). This section will explore the "responsible chooser" in greater depth, highlighting the key assumptions which shaped the subject of the "responsible chooser" and how these impacted on the types of policy solutions put forward to deal with "differences in health", before turning to examine the unravelling of the "responsible chooser" and the challenges that were made to this governable subject in the early 1990s.

Three key assumptions relating to individual agency underpinned the "responsible chooser". These were that individuals are autonomous, that they are self-regulating and able to look after themselves. *Care in Action* (DHSS, 1981), for example, made it clear that individuals would make more informed decisions about their health given new information about the effects of particular behaviours on their health. Individuals were expected to be self-sufficient and not rely on the state for help except in extreme circumstances. In relation to health this meant that individuals should be able to monitor their own behaviours and to regulate the activities they are involved in to avoid adversely affecting their health. The result

of these assumptions was a focus on choices about health. As individuals were assumed to be able to look after themselves and to regulate their behaviour it was expected that individuals would make their own choices about their health, and the government should help to facilitate these informed choices through the provision of information. Choice was therefore viewed as an important part of understanding the health of individuals. People should be able to make choices about their health as part of being an independent self-governing individual.

The discussions concerning the need for better provision of information highlighted these main assumptions about individuals and how they behave. Both *Care in Action* (DHSS, 1981) and *Public Health in England* (DHSS, 1988) made it clear that the public required more and better information about health in order to allow them to make "sensible decisions" (DHSS, 1981: par. 2.1) and informed choices about their health. Clearly the role of the government as the provider of information is important to consider here as well as the role of the individual as the "responsible chooser". The government was seen to be a reliable and trustworthy source of information given its authoritative position. As to why the government was committed to providing information it seems as though this was based on the assumption about how individuals made choices. The assumption of the autonomous individual suggests that individuals were afforded a high level of confidence in their capacity to make choices and this is demonstrated through the government's response of improving information provision. Importantly it was expected that individuals would use the information provided to make *responsible* informed choices, those choices which led to improvements in health or at least the maintenance of health (i.e. healthy choices). On receipt of new information about certain behaviours and their effects on health, such as drinking or smoking, individuals would adjust their behaviour accordingly, taking this information into account when making choices related to the identified behaviours. It was also expected, therefore, that individuals would make calculated decisions based on all the information available, weighing up the relative costs and benefits of partaking in a particular activity or behaviour in relation to their overall health. Because of the idea that all that was required was to provide better information to the public to change their behaviour, the responsibility for making choices rested with the individual themselves. They were ultimately responsible for the choices that they made, and were therefore responsible for their own health. It was still possible, however, that people would not choose the best option for their health despite the warnings about the harmful effects of behaviours. The policy discussions

did not make it clear who would be responsible for health in this case, although the NHS would still treat people who fell ill.

In particular the documents highlighted a clear responsibility to prevent "avoidable" illnesses. These illnesses were seen to be caused by poor behaviour and poor choices made by individuals due to a lack of appropriate information available. These illnesses were viewed as avoidable because it was assumed that all that needed to be done was to get individuals to firstly recognise that certain behaviours were damaging to their health through health campaigns and providing more information and secondly to change their behaviour as a result of receiving this new information. Becoming sick from an avoidable illness was presented as morally reprehensible as not only did it clearly lead to the individual harming themselves unnecessarily but it also meant that scarce healthcare resources would be directed away from those who were seen to be "unavoidably" sick, as was discussed in *Care in Action* (DHSS, 1981: par. 2.8). Individuals therefore had a moral responsibility to ensure they made the right choices so as not to waste limited resources. They should be making choices about their health, as well as other aspects of their lives, and recognising the impact of the choices they made. The "responsible chooser" therefore contained a moral dimension to individual conduct as well as putting forward the process by which individuals make decisions. The "responsible chooser" exemplifies both an understanding of how individuals behave but also expectations concerning how they should behave. On the one hand it presents the conceptualisation of individual behaviour as being the calculative, rationally-minded chooser while on the other hand it puts forward expectations of individuals through the need for individuals to accept responsibility for their health and to make choices which will lead to the preservation or improvement of their health.

The "responsible chooser" emerged at a time when public health faced new challenges and breakthroughs. In the 1980s the HIV/AIDs epidemic was at its height and the link between smoking and lung cancer was firmly established. Following on from this need to prevent avoidable illnesses it could be argued that the provision of information was seen to be necessary because individuals simply did not know any better. They required more information in order to demonstrate that the types of behaviours they were engaging in were harmful to their health, and in order to make informed decisions to change their behaviours. Consequently it seems plausible that the provision of information was viewed as a key way to inform the public and to encourage them to change their behaviours, particularly when a number of avoidable illnesses were argued to be related to lifestyle choices (DHSS, 1988).

The problem of "differences in health" was therefore largely explained as a problem of information provision. Differences in availability and suitability of information were seen to be the reasons why there were "differences in health". People were unable to make informed choices about their health due to a lack of information, which meant people were making poor choices and led to poor health as a result. As it was assumed that everyone had the same capacity and capability to make calculated choices it was necessary to ensure that appropriate information was made available to the public so that individuals were better informed about health damaging behaviours and so would be able to better choices about their health. This information would need to come from a reliable source, i.e. the government, in order for people to accept that they could trust the information provided to them and use it to make informed choices.

The assumptions underpinning the "responsible chooser" (that individuals are autonomous, self-regulating and able to look after themselves) clearly impacted on policy responses to "differences in health". Improving the provision of information to the public to allow them to make informed choices about their health is a clear example of encouraging people to look after themselves. In addition to this there seems to be an underlying moral sense of worth rooted in the subject of the "responsible chooser". The reward for making informed, responsible decisions that did not adversely affect your health or others around you would be that you would be seen as a capable and sensible citizen. Your level of health, i.e. whether or not you were ill, was therefore seen as a reflection of your moral standing as a citizen. This reflects Crawford's (1980) discussion of the emerging "consciousness" of healthism where he argues that healthism "[a]s an ideology…which focuses so exclusively on behaviour, motivation, and emotional state, and as an ideology of self-improvement which insists that change and health derive from individual choices, poor health is most likely to be seen as deriving from individual failings" (Crawford, 1980: 378). These failings referred to an inability to control oneself, and a lack of focus on self-improvement. His discussion of the "potential sick-role" (which is discussed in more detail in Chapter 5) highlighted the fact that individuals faced increasing pressures to prevent themselves from becoming sick in the first place, and essentially illness came to be seen as a moral failing.

Towards the end of the Conservatives' time in government, however, the subject of the "responsible chooser" began to fragment. The publication of *The Health of the Nation* (Secretary of State for Health, 1992) and its working group papers (DH, 1993; DH, 1995; DH, 1996) put forward the beginnings of an alternative subject as these documents began to

accept that the observable trends in health outcomes were not reducible simply to individual differences. Policies began to identify and discuss wider factors shaping patterns of health, which meant that individuals could no longer be blamed outright for poor health. In particular these discussions began to emphasise arguments that the surrounding context in which an individual lived could greatly impact on the types of choices that people made about their health, as well as on the capability of individuals to make choices (DH, 1995).

The discussion of these wider societal explanations for "differences in health" was new within public health policy, and raised a number of challenges to the existing governable subject of the "responsible chooser" which had been used to shape public health policy throughout the 1980s. These challenges came from the acknowledgment of the findings of the Black Report (DHSS, 1980) which were only referenced and discussed in *Variations in Health* (DH, 1995), 15 years after the publication of the report itself. Firstly, questions were raised about the assumption that everyone had the same capacity and capability to make choices. Policies began to acknowledge and discuss the issue that not everyone had access to the same types of resources (e.g. material, educational) and this in turn could affect the ability of individuals to make choices about their health. Secondly arguments that the surrounding social, economic and physical environment in which individuals live could work to limit the choices that were available to individuals were more strongly emphasised in policy discussions about "differences in health". These first two criticisms culminated in the third challenge which questioned the idea that individuals were wholly responsible for their health through the behaviours they chose to engage in. If individuals lacked the capacity and capability to make choices because of their social and economic status, and the choices that were available to them were poor ones because of the area they lived in, then how was it possible to expect individuals to change their behaviour simply based on the provision of information? It seemed as though individuals and their level of health were actually the product of society rather than autonomous actions, and this would therefore require a different understanding of individual behaviour and a different response to "differences in health".

Finally there was a challenge in terms of the language used to describe the problem and this changed quite dramatically over the period of about 7 years. In both *The Health of the Nation* green and white papers the problem of "differences in health" was referred to as "variations in health". The term "variations in health" is arguably quite a neutral way of describing the issue of "differences in health". This implies that the existence of these

differences could be natural, that one would expect there to be variations in health in any population. Explanations of and solutions to the problem were therefore focused on the individual. The main solution to reducing these variations in health was focused on the production and dissemination of suitable information to the public, allowing them to "make the right choices" (Secretary of State for Health, 1992: par. 3.8) with regards to their health.

A change in language occurred, however, in *Variations in Health* (DH, 1995) which was one of the follow-up papers from the white paper. Here the problem was described as "systematic variations in health" in order to reflect the acknowledgement that something was underlying the observed patterns of health and illness which gave them a discernable order. Differences in health behaviours were not seen as sufficient to account for the observed variations and the paper concluded that

> *It seems likely that cumulative differential lifetime exposure to health damaging or health promoting physical and social environments is the main explanation for observed variations in health and life expectancy, with health related social mobility, health damaging or promoting behaviours, use of health services, and genetic or biological factors also contributing. (DH, 1995: par. 7.2).*

The paper recognised that reducing the prevalence of health damaging behaviours was still important but that it was necessary to understand that "personal, social and economic circumstances may affect the ability of some groups to modify their behaviours" (DH, 1995: par. 3.12). This meant that simply providing better information to the public would not necessarily lead to people making more responsible choices about their health as their behaviour was affected by their surrounding circumstances.

When New Labour came to power in 1997 they used the term "health inequalities" right from the start of their time in government to label and describe the problem of "differences in heath". Their first public health green paper *Our Healthier Nation* stated that "Inequalities in health have worsened in the past two decades. They are a consequence of the widening of social and economic inequalities" (Secretary of State for Health, 1998: par. 4.50). The label "health inequality" is much more striking and thought-provoking compared to the labels of "variations in health" and "systematic variations in health". While "variations in health" implies a fairly neutral conception of the problem of "differences in health", and "systematic variations in health" goes a little further to suggest that something is underlying these differences, the idea of "health inequality" suggests there is something fundamental within the organisation of society which is causing these differences and that these

differences are immoral. The inclusion of the term inequality immediately represents the problem as requiring immediate action, that there is a moral imperative that something should be done. It suggested that the observable "differences in health" were caused by wider societal factors which impacted on individuals and their health and that these negative effects were not necessarily inevitable and nor were they fair. There was clearly a moral obligation to work towards reducing these inequalities and preventing them through action at a societal level. This moral imperative to address the problem of "health inequalities" differed significantly from the morality discussed under Thatcher's government, which focused on the moral responsibility of individuals not to fall sick. In contrast, for New Labour the moral responsibility fell with the state to act in order to reduce, and eventually eradicate, unjust inequalities.

These challenges to the understanding of the problem of "differences in health" meant that the idea of the "responsible chooser", who was autonomous and ultimately responsible for their own actions and health, was no longer tenable. A new governable subject was required in order for policies to adopt this new perspective and explanation for the existence of "differences in health".

8.3 The reformulation of the subject as the "constrained chooser": restricted choices

It is with the publication of *The Health of the Nation* that it is possible to see the idea of the "responsible chooser" breaking down. That is not to say that the idea of the "responsible chooser" disappeared completely, but the assumptions underpinning the problem of "differences in health" began to change in English public health policy and this affected the understanding of the governable subject from around 1992 onwards. Discussions of and explanations for "differences in health" in public health policy began to recognise the importance and impact of social and economic circumstances on health outcomes, and in particular how these circumstances are created by wider societal conditions which lie largely beyond the control of the individual. This meant that the idea of the "responsible chooser" as the governable subject no longer fitted with the explanations given for the problem of "differences in health". As public health policy emphasised the need

for action from national and local government to tackle "systematic variations in health" under the Conservative government and "health inequalities" under New Labour, understandings and assumptions regarding the governable subject changed and led to the reformulation of the subject as the "constrained chooser".

Initially it is possible to see how the assumptions underpinning the "constrained chooser" differed from the "responsible chooser". The main assumption, to paraphrase Marx somewhat here, was that while individuals did make choices about their health they did so in conditions that were not of their own choosing. Public health policies readily acknowledged that the conditions under which individuals live and work could profoundly affect the types of choices they were able to make, and even potentially limiting the choices they could conceivably choose from. This idea was first put forward in *Variations in Health* (DH, 1995) as discussed above and it was taken up by New Labour in their approach to public health. Individuals were therefore viewed as products of the society in which they live, and this included their social and economic position. While it was recognised that the "constrained chooser" does have access to choices relating to their health and they should be able to make choices about their health, it was argued that the effects of wider determinants can limit the choices people can make about their health and as individuals are unable to control or affect these wider determinants, they should not be blamed for their ill-health. The effects of context constraining choices was first noted in *Our Healthier Nation* which argued that "[a]lthough people may know what affects their health, their hardship and isolation mean that it is often difficult to act on what they know" (Secretary of State for Health, 1998: par. 2.7).

It is clear, then, that there are differences between the assumptions underpinning the "responsible chooser" and the "constrained chooser" and at first glance they initially seem to be unrelated to one another. While the subject of the "responsible chooser" assumed that individuals had the same capacity and capability to make choices about their health given the right information and that individuals were ultimately responsible for their level of health, the "constrained chooser" argued instead that individuals faced constraints to healthy choices which went beyond the provision of information, for example access to and quality of education, the availability of local health services, living in poor housing and neighbourhoods, and as these constraints were often beyond the direct control of the individual it meant that individuals could not necessarily make healthy choices even when they knew they should. Consequently the "constrained chooser" made choices within a

specific physical, social and economic context which could influence the types of choices people had access to. The "constrained chooser" placed the individual and their health within a wider context and extended responsibility for health beyond the individual whereas the "responsible chooser" led to the association of a moral status with the ability to self-regulate the choices an individual made about their health, thereby placing the responsibility for good health entirely with the individual.

In contrast with the "responsible chooser", then, it is possible to see the conceptualisation of the "constrained chooser" as a situated subject in public health policy. Differences in poor health were not seen to be the result of differences in information provision; they were seen to be the result of the effects of existing social inequalities which acted to constrain the choices people were able to make about their health. Not everyone had access to the same types of choices. People made the best choices they could within their own personal circumstances and immediate social and physical context, without often having much control over the latter.

It is important to note, however, that despite the differences highlighted here certain assumptions regarding expectations around individual action underpinned both the "responsible chooser" and the "constrained chooser". Although it was understood that the "constrained chooser" was living and making choices within conditions that were not of the individual's choosing, there was a clear expectation that when constraints to choices were removed or reduced individuals would accept the responsibility to take up new opportunities that were made available to them (DH, 2003; Secretary of State for Health, 1998; Secretary of State for Health, 1999). As was stated clearly in New Labour's first public health white paper *Saving Lives: Our Healthier Nation* "[p]eople need to take responsibility for their own health" (Secretary of State for Health, 1999: par. 1.33). This is similar to the expectation of the "responsible chooser" to act on new information provided to them and more specifically to change their behaviour accordingly to improve their health. The "constrained chooser" was, therefore, not expected to simply accept government help indefinitely, but to actively take up opportunities and choices that were made available to them as a result of government action. These opportunities were not only designed to improve access to choices about health directly, for example by ensuring access to health services, but also indirectly through improving access to education, training and employment which in turn would help people to support themselves.

This concern with emphasising individual responsibility reflects Giddens' (1998) arguments he made in his discussion of The Third Way. He argues that rather than having a *welfare state* we should have a *social investment state* as "[g]overnment has an essential role to play in investing in the human resources and infrastructure needed to develop an entrepreneurial culture" (Giddens, 1998: 99). This suggests that both national and local governments have a responsibility for "investing" in individuals in society and ensuring that they have the resources and ability to access opportunities which will allow them to advance in society. In the case of public health it is necessary for the government to provide opportunities for people to better themselves, gain control over their lives and to improve access to healthy choices. Giddens argued that in order for welfare to succeed and not be divisive it needed to be available to everybody, not just the worst off or most disadvantaged. This was embodied in his idea of positive welfare and he noted that "[i]n the positive welfare society, the contract between individual and government shifts, since autonomy and the development of self – the medium of expanding individual responsibility – become the prime focus" (Giddens, 1998: 128). The return on the investment in the individual, therefore, is for the individual to become independent and responsible for their actions. They become able to manage and control their lives and are less reliant on the government or other organisations for help and support.

The public health policy discussions of the need to develop and improve access to opportunities to allow individuals to improve their situation, and their health as a result, strongly emphasised the expectations of the "constrained chooser" as an active subject whilst at the same time acknowledging that the context surrounding the individual could limit the choices they could make. It seems as though the "responsible chooser" overplayed the autonomy of the individual while the "constrained chooser" argued instead that people were restricted in the choices they could make about their health due to wider factors which were largely beyond their direct control. One of the main reasons given for providing opportunities to individuals was to give people greater control over their lives. A number of factors which influenced a person's health were identified by the social model of health, first outlined and employed in the Acheson Inquiry (Acheson, 1998) and subsequently used to underpin New Labour's public health approach, and several of these factors were argued to be beyond the direct control of the individual. These included education, work and employment, the environment, and the location of and access to health services. The responsibility for taking action on these highlighted areas was across national government, local authorities and communities, as well as the individual. This was first highlighted in *Our*

Healthier Nation (Secretary of State for Health, 1998) as the "contract for health" and subsequently in *Saving Lives: Our Healthier Nation* (Secretary of State for Health, 1999) as a "three-way partnership". National and local government would act on determinants or influences which were outside the control of the individual, but they would also provide opportunities for individuals to help improve their own social and economic situation with the assumption that individuals would take up these opportunities which would allow them to regain control over their lives. By having greater control over their lives it would become possible for individuals to make better choices about their health, particularly through opening up new choices. Individuals would therefore still make rational decisions relating to their health as it was assumed that people wanted to improve their health but could find the options to do so were limited by factors beyond their control. The provision of opportunities around education, employment and engagement in the wider community (discussed in more detail in Chapter 6 section 6.4) were viewed as significant ways to empower individuals. Education was seen as particularly important as not only would a better education lead to an increased potential for good employment, it was also seen as an important way of disseminating information about health and adopting a healthy lifestyle. For example, the Acheson Inquiry noted that education was important in ensuring that children "have the practical, social and emotional knowledge and skills to achieve a full and healthy life. These include knowledge of the wider determinants of health, not just health related behaviour, skills in developing relationships and dealing with conflict, and practical skills such as budgeting and cooking" (Acheson, 1998).

The problem of "differences in health" under the Constraints problematisation was therefore explained as being the result of wider influences on health rather than just from differences in information provision. The Conservatives in *Variations in Health* (DH, 1995) conceded that there were "systematic variations in health", but when New Labour came to power the problem was discussed as "health inequalities" which put forward a moral imperative that this problem should be addressed. "Differences in health" as health inequalities under New Labour were argued to be unfair, unjust and not inevitable and the idea of the "constrained chooser" emerged as the governable subject as a result. Individuals were therefore not seen to blame for their health given that wider societal factors acted to restrict the choices they could make about their health, but individuals were expected to accept more responsibility for their health by taking up opportunities that were made available to them once constraints to choices that affected their health were removed or reduced. Collective action across society was required in order to tackle health inequalities,

as it was recognised that health inequalities were not simply an individual's private trouble but rather a societal issue.

As was discussed in Chapter 6, the governable subject of the "constrained chooser" was the dominant conception of individuals and how they make choices about their health under New Labour. It is interesting to note, however, that during New Labour's second and third terms in office it appears that the "constrained chooser" does start to fragment, but arguably remained as the main governable subject until the Coalition government came to power. Developments in New Labour's public health approach, their market reforms of the NHS, wider policy discussions about how to understand individual behaviour along with the need to start asking difficult public health questions about problems such as binge drinking, smoking and obesity all posed challenges to the "constrained chooser" as well as how to best tackle the problem of health inequalities. The subject of the "constrained chooser" perhaps became incoherent towards the end of New Labour's time in government, but as there was no viable alternative model or understanding available to replace it the "constrained chooser" continued to be seen as the governable subject for public health policy.

New Labour's second public health white paper, *Choosing Health* (Secretary of State for Health, 2004), seemed to pose some initial challenges to the perspective put forward in their previous public health white paper *Saving Lives: Our Healthier Nation* (Secretary of State for Health, 1999). Arguably *Choosing Health* was still concerned with how people made choices within a set of personal, social and economic constraints but it placed much more emphasis on the role of marketing and advertising in shaping the choices that people made, particularly choices related to lifestyle. Indeed the then Secretary of State for Health John Reid linked the problem of health inequalities directly with the types of choices people made: "It is a fact of life that it is easier for some people to make healthy choices than others. Existing health inequalities show that opting for a healthy lifestyle is easier for some people than others." (Secretary of State for Health, 2004).

Two main issues emerged from this white paper. The first was the new focus on how people's choices could be shaped by marketing products or activities in particular ways. It seems as though the effects of advertising had not previously been considered by previous governments in their approaches to public health. As discussed in Chapter 7 section 7.2.1, from 2004 the New Labour government were keen to utilise the techniques of social marketing in order to promote health more effectively than in the past and to create a demand for health which would lead to changes in industry to accommodate this new

demand – effectively marketing against marketing. The issue of marketing products and marketing health raised an initial challenge to the idea that individuals always make rational, calculated decisions when making choices about their health. The fact that choices can be influenced by the way products or activities are marketed or presented to individuals suggests that individuals do not always make choices based on all the available information and guidance – instead they go with what is most appealing to them. To some extent this questions one of the key assumptions of both the "constrained chooser" and the "responsible chooser", the fact that individuals are capable of calculated decisions, and leads to the need to consider whether individuals can be trusted to make healthy choices themselves when there are clearly external forces encouraging them to choose otherwise.

The second interesting point to develop from *Choosing Health* was the increasing emphasis placed on the impact of a person's lifestyle on their health, and the need for people to choose a healthy lifestyle. While lifestyle had already identified as a factor in determining a person's health, previous New Labour public health papers had tended to focus more on wider social and economic causes of health inequalities while still acknowledging the impact of individual lifestyle on health. *Choosing Health*, however, focused on the need to encourage people to choose a healthy lifestyle. Although there is no clear definition of what is meant by the concept of "lifestyle" in this paper the following quotation seems to provide some sense of what it refers to:

> *People want information about what they can do that will make a difference to their health, as well as access to the options that can help them in adopting a healthy lifestyle – choice in what they eat, how and where they take exercise, and in how they access support services.(Secretary of State for Health, 2004: 19-20)*

It is the second part of the sentence which provides us with an idea of what is meant by lifestyle and it seems to essentially be the set of things that people do and how they behave. Different lifestyles, then, encompass different sets of behaviours and choices. The idea of a "healthy lifestyle" must include behaviours and activities which are beneficial to health. In the Foreword Tony Blair noted that it was necessary to not only "inform and encourage people as individuals" but also to "help shape the commercial and cultural environment we live in so that it is easier to choose a healthy lifestyle" (Secretary of State for Health, 2004: 3). This neatly links the paper's concerns with social marketing and lifestyle and suggests that more needed to be done to encourage and motivate people to choose a healthy lifestyle, but that the government should not be overbearing in its actions. People want to be able to make

their own choices without undue interference from the government, but it was clear that they would benefit from greater access to healthy choices which would help them to adopt a healthy lifestyle. Most of the discussion in the paper focused on how healthy choices should be made available to people to make a healthy lifestyle easier to adopt, in particular through "creating demand for health through marketing campaigns, and making it easier for individuals to choose healthy lifestyles in a consumer society" (Secretary of State for Health, 2004: 30). The concept of lifestyle emerged as a central feature of the Coalition's approach to public health and this is discussed in more detail below in section 8.4.

The emphasis in *Choosing Health* on social marketing and lifestyles suggested a profound change in the emphasis of public health approaches from this period onwards to the problem of "differences in health". The focus seemed to shift away from mainly structural explanations and solutions back towards examining cultural influences on health. Changing individual behaviour was highlighted as a central part of public health, hence the renewed emphasis on lifestyle. New theories and perspectives about individual behaviour were also being discussed and considered in wider social policy which seemed to support the need for a reconsideration of the individual in public health.

From 2004 onwards a number of policy discussion papers were published which aimed to examine new and alternative ways of conceptualising individual behaviour that had been developed from psychology and behavioural economics and to consider their relevance and usefulness for social policy as a whole (Strategy Unit, 2004; Strategy Unit, 2008; Institute for Government, 2010). These papers are discussed in more detail in Chapter 7 section 7.2.2. These discussions posed a fundamental challenge to the assumptions of public health policy and the way it conceptualised individual behaviour as well as public health problems and their solutions. These papers argued that policy makers and politicians needed to rethink the subjects of policies. Previous public health policies had been focused on changing the mentality of the individual and encouraging them to make healthy choices through providing information or opportunities with the assumption that the individual makes calculated decisions by taking account of all the available material, information, opportunities, etc., and would make the best choice as a result, in this case the healthy choice. Perspectives from the behavioural sciences, however, argued that policies should focus more on the context in which choices are made as the social and physical context had been shown to heavily influence the choices that individuals made. It was also important to recognise that the process by which people make choices is flawed as "people are sometimes seemingly

irrational and inconsistent in their choices, often because they are influenced by surrounding factors" (Institute for Government, 2004: 14). This suggested that perhaps when individuals made choices they were not quite as calculated or rational as policy makers would have hoped. People not only needed encouragement to make healthy choices through better provision of information or access to opportunities, they required "nudging" towards healthy choices by using the surrounding social and physical context to shape the choices people made.

This issue of choice was also present New Labour's healthcare policies. From the early 2000s New Labour began their market reforms of the NHS which were designed with the assumption that "competition among providers creates incentives for them to improve the efficiency and quality of their services to meet the demands of purchasers [i.e. patients]" (Mays, Dixon and Jones, 2011: 10). Choices for patients increased over this time. *The NHS Plan* (DH, 2000) initially set out plans for patients to be able to choose the date and time of appointments. This level of choice was then increased to include the opportunity to choose treatment from an alternative provider if the NHS was unable to provide treatment within six months in *Delivering the NHS Plan* (Secretary of State for Health, 2002). Choice was viewed as a right for patients and in order to allow people to make informed choices there needed to be more information available to the public about GPs and hospitals (DH, 2000). There seemed to be, then, a continuing theme of choice within New Labour's healthcare and public health policy. This helped to retain and emphasise the importance of maintaining choices for individuals, as well as the need to better understand how individuals make choices about their health and health care.

Finally in the late 2000s, and leading up to the general election in 2010, difficult questions were being asked about public health and its approaches to dealing with persistent and emerging health problems and challenges. As was noted in *Health Inequalities: Progress and Next Steps* "[i]nequalities in health persist and, in some cases, have widened" (DH, 2008: par. 1.2). While the approach set out in the *Programme for Action* (DH, 2003) had recognised the need for a long term commitment to tackling health inequalities there was still a sense that not enough had been done to reduce health inequalities. Alongside this perceived failure were the continuing public health problems associated with smoking, alcohol consumption and the emerging issue of obesity. *Progress and Next Steps* contained a chapter dedicated to exploring these factors which argued that "[m]any inequalities in health are a preventable consequence of the lives people lead – the behaviours and lifestyles that cause

ill health and that relate to socio-economic factors" (DH, 2008: par. 4.2). As such the focus of the chapter was on discussing how the lives people lead impacts on their health and how lives should be changed to ensure that people prevent avoidable illness. The nation seemed to be becoming sicker and public health needed to respond to new challenges which seemed to focus more on individuals and their lifestyles rather than wider societal conditions. Interestingly public health also seemed to start to warm to the idea of more paternalistic interventions, and this was clearly demonstrated with the issue of smoking. Smoking in enclosed work places was banned in 2007, shops were required to hide their tobacco displays in 2012, and more recently there has been a decision by the government to introduce plain packaging for cigarettes. This more paternalistic element of public health seemed to contradict previously held ideas about individuals having free choice over what they choose to consume or behaviours they engage in, and started to set the scene for the final governable subject: the "flawed chooser".

8.4 Challenging previous assumptions with the "flawed chooser": people need nudges

The final governable subject identified in the analysis was the "flawed chooser". The "flawed chooser" developed in 2010 in the Coalition's public health white paper and represented a clearer reformulation of the "constrained chooser" which had undergone a number of challenges as discussed above. While the idea of the "constrained chooser" had become somewhat confused during New Labour's later time in power, it was never fully replaced as it seemed there was no viable alternative model given the political perspective of New Labour and because of the existing interventions which were in place to tackle health inequalities from the *Programme for Action* (DH, 2003). New Labour's increasing interest with the need to provide and enhance choice to individuals, both in terms of public health and in the NHS, as well as the wider policy discussions concerning how to conceptualise individual behaviour allowed for the reconsideration of how individuals actually make choices and how this could impact public health approaches. *Choosing Health* (Secretary of State for Health, 2004) highlighted the role of marketing techniques on influencing the choices that individuals as consumers made and argued that the government should make more use of social marketing techniques in order to "market" health to the public and to

encourage them to make healthy choices and adopt healthy lifestyles. Policy discussions by the Strategy Unit (2004, 2008) and Institute for Government (2010) drew upon the ideas put forward by behavioural economics which seemed to provide a novel approach to understanding individual behaviour through focusing on how physical and social contexts influence behaviour rather than assuming that individuals are rational decision-makers. These papers suggested that this perspective had not yet been fully explored or utilised by policy makers but could offer a new set of tools for policy makers to successfully change individual behaviour (Institute for Government, 2010). These discussions occurred around the same time as public health began to face increasing challenges from the problems of smoking and rising rates of obesity. Questions started being asked as to whether current approaches to tackle these problems, as well as "differences in health", were suitable. It seemed as though the drive towards improving access to choice for individuals through policies around public health and health care had not necessarily resulted in better health overall, and so questions about whether greater interventions were required from the government in order to protect the public from harm. This can clearly be seen in the case of smoking. Here the government was directly interfering with where people could legally smoke and, in turn, changing social attitudes towards smoking and smokers themselves. The government therefore began to take on a more interventionist role and this seemed to be reflected in the turn towards libertarian paternalism.

These developments culminated in the Coalition's public health white paper *Healthy Lives, Healthy People* (Secretary of State for Health, 2010) where the governable subject of the "flawed chooser" emerged as a comprehensible alternative to the "constrained chooser" in light of these wider developments in public health and social policy more broadly. The "flawed chooser" was underpinned by one major assumption which contradicted previous understandings of individual behaviour. Instead of assuming that individuals would always make the best choice, i.e. the healthy choice, given a set of options and information and opportunities associated with those options, it was assumed that the context, both physical and social, had a greater impact over the types of choices people made. This encompassed physical cues, how choices were presented and organised, and social cues, including social norms and the influence of social networks. The context could also include individual circumstances which would then influence the routines and habits that people adopted and followed. This suggested that the choices individuals made were not simply the result of considered decisions based on the information or opportunities available, but rather could be influenced by external forces as well as existing habits. The idea of habits and routines

influencing choice is an interesting one, as there is a question here about whether people really do make choices when they are following habitual behaviours. This point is discussed below in more detail in relation to the Coalition's use of the concept of lifestyle in their public health approach.

Building on the assumptions of New Labour's 2004 white paper and on-going research in the behavioural sciences, the Coalition successfully modified the existing subject of public health policy, that of the rationally-minded individual. Although both the "responsible chooser" and "constrained chooser" offered very different explanations as to how people make choices about their health and why people make poor choices, they were both underpinned by the assumption that people would always act with their best interests at heart and that given enough information and/or opportunities to improve health, individuals would make informed choices when it came to their health and would make the healthy choice. The "flawed chooser", on the other hand, represented a subject whose choices were often influenced by factors other than reliable information and opportunities, i.e. the context in which a choice was made and personal habits and routines.

The assumptions of the "flawed chooser" reflected the political ideology of libertarian paternalism, a perspective which had gained considerable support since Thaler and Sunstein initially discussed its rationale in 2003 (Sunstein and Thaler, 2003; Thaler and Sunstein, 2003) before publishing their book *Nudge* (Thaler and Sunstein, 2009). One of the key principles underlying libertarian paternalism was that people's choices are often influenced by the surrounding context in which choices are situated and made. The perspective also recognised that the process by which people make choices is flawed given that people often tend to go with choices that they are familiar with, and these may become habitual (Institute for Government, 2010; Thaler and Sunstein, 2009). As a result, people do not always make choices in a rational manner based on all the available information. Instead they may follow a flawed heuristic which leads them to a poor choice. If there is a need to encourage or ensure people choose a particular option then this should be made the default option by adapting the "choice architecture", or the way choices are presented. The paternalistic element is the need for developing and selecting what the default should be as well as how the default option is presented so that it becomes the default choice. This does not mean that other choices should simply be removed so that the desired choice is the only one left. On the contrary, other choices should be available in case someone wanted to reject the default option – this is the libertarian element. This approach was seen as necessary and

acceptable given the assumption that people make flawed choices, however the paternalistic element should be carefully controlled so that it did not affect the individual's capability to make other choices.

It is clear from their white paper that the Coalition were enamoured towards the use of perspectives and understandings from the behavioural sciences. Indeed they made it clear that "[t]he latest insights from behavioural science need to be harnessed to help enable and guide people's everyday decisions" (Secretary of State for Health, 2010: par. 2.3). There are a few possible reasons as to why this type of approach to public health problems was adopted by the Coalition. The first is that, quite simply, they wanted to show they were doing something different from the previous New Labour government to mark their approach to public health as unique, as seems to be the tradition when a new government comes to power. In his opening statement to the white paper the then Secretary of State for Health Alan Milburn argued that "it is simply not possible to promote healthier lifestyles through Whitehall diktat and nannying about the way people should live" (Secretary of State for Health, 2010: 2), and therefore a new approach to public health was required. The second possible reason could be due to the fact that the behavioural sciences were seen as a new "fashionable" subject area that the Coalition wanted to take advantage of, perhaps in order to demonstrate that it was more innovative in its policy making than previous governments. Alternatively pragmatic reasons may have driven the Coalition's public health strategy. The adoption of a behavioural science may simply have been a response to claims that previous approaches had failed to improve health and reduce "differences in heath". The behavioural science approach offered a new way of understanding individual behaviour and provided a set of new possibilities for policy makers to change and shape individual behaviour, particularly in terms of "changing contexts" (Institute for Government, 2010) in order to develop "low cost, low pain ways of nudging citizens - or ourselves - into new ways of acting by going with the grain of our automatic brain" (Institute for Government, 2010: 73). It therefore made sense to apply this new perspective to public health, particularly given the historic emphasis placed on choice within public health discussions and the continuing need to manage the costs of public health interventions and the NHS.

The "flawed chooser" is reflected in two key aspects of the Coalition's approach to public health. The first is through the importance placed on people needing to adopt a healthy lifestyle. The concept of "lifestyle" is particularly interesting as it suggests that the behaviours people engage in are not necessarily the result of choices but rather are related

to routines and habits. Although one might choose to adopt a lifestyle, there is a question as to whether people really do make choices when following a particular lifestyle. The second demonstration of the "flawed chooser" can be seen in the discussions around the need to use "nudge" strategies to make healthy choices easier.

The concept of "lifestyle" played a significant role in the Coalition's public health strategy as it was used to frame contemporary challenges facing public health as well as informing the solutions put forward to address "differences in health". This seemed to reflect concerns about lifestyle raised in *Choosing Health* (Secretary of State for Health, 2004). In *Healthy Lives, Healthy People* "diseases of lifestyle" (Secretary of State for Health, 2010: par. 1.2) were seen to be the main problem for public health. While there is no explicit definition in any of the Coalition's papers as to what is meant by "lifestyle" it is possible to infer from discussions across their papers that it refers quite simply to the things that people do, rather like in *Choosing Health*. Expanding on the identified problem of "diseases of lifestyle" the Coalition's white paper stated that "smoking, unhealthy diet, excess alcohol consumption and sedentary lifestyles are contributory factors" (Secretary of State for Health, 2010: par. 1.2) while in the accompanying paper *Our Health and Wellbeing Today* argued that "[m]any deaths and illnesses could be avoided by adopting healthier lifestyles...This could be done mainly through a combination of reducing smoking rates, improving diet and increasing physical activity" (DH, 2010: par. 3.9). Both of these statements refer to activities or behaviours that individuals engage in which seems to suggest that lifestyle therefore represents the types of things that people do in their daily lives. As highlighted in the quotation from *Our Health and Wellbeing Today* there is a need for people to adopt "healthier lifestyles", which suggests that the activities and behaviours people currently engage in are detrimental to their health. Both papers mention the existence of "harmful lifestyles" as a problem and so there is a strong emphasis on the need to change the way people do things to ensure that they engage in healthy behaviours and activities.

The concept and understanding of lifestyle helps to explain why the life course approach was adopted in the Coalition's public health strategy. As discussed in the previous chapter, it was argued that there were key transition points in people's lives where behaviour could be shaped. At these points it was essential to encourage people to adopt healthy lifestyles – i.e. routines, practices and habits which were argued to be beneficial to health. It was especially important to encourage healthy lifestyles from a young age as "[g]ood parent–child relationships help build children's self-esteem and confidence and reduce the risk of

children adopting unhealthy lifestyles" (Secretary of State for Health, 2010: par. 1.22) and "[t]here is evidence that lifestyle behaviours and habits established during school-age years can influence a person's health throughout their life" (DH, 2010: par. 6.21). This second quotation in particular emphasises the fact that lifestyles represent habits and routines that people follow, and it was seen as crucial to ensure that people adopt healthy habits and routines if improvements to health were to be made. This suggests that while lifestyles were "fixed" in the sense that they would shape the types of activities and behaviours people routinely engaged in, they could be changed and therefore enable people to do different things – in this case take up healthier behaviours. Lifestyles, therefore, influence the types of choices people make about their health although there is a question here of whether people really do make "choices" if what they are doing is practising habits and routines rather than making an informed choice based on available information and opportunities. It could be said that lifestyle is in fact a "meta-choice" in that while people make choices about what lifestyle to follow; lifestyles themselves encompass a set way of doing things and a set of behaviours and activities. This would mean that if people adopted routines which involved habitually making healthy choices then there would be little need for the government or other organisations to change people's behaviour through altering the "choice architecture" in some way.

The initial work to change people's lifestyles, however, would require action from the government. For example, it was noted in *Healthy Lives, Healthy People* that the environment played a key role in shaping the type of lifestyle adopted by individuals:

> *Improving the environment in which people live can make healthy lifestyles easier. When the immediate environment is unattractive, it is difficult to make physical activity and contact with nature part of everyday life. Unsafe or hostile urban areas that lack green spaces and are dominated by traffic can discourage activity. Lower socioeconomic groups and those living in the more deprived areas experience the greatest environmental burdens. (Secretary of State for Health, 2010: par. 1.37)*

As highlighted by this paragraph there was clearly a need to ensure that the immediate environment or context in which people live is conducive to healthy behaviours and supports the development of a healthy lifestyle, where lifestyle refers to routines, habits and things that people do and engage in. This was particularly important in disadvantaged areas and neighbourhoods where people were more likely to be exposed to poorly maintained environments. In order to encourage healthy lifestyles the Coalition adopted "nudge" as their public health approach.

The Coalition had already made it clear in their *Programme for Government* (HM Government, 2010) that they were keen to move away from simply using rules and regulations to change behaviour and were open to exploring new ways to encourage people to make better choices. In this case, better choices referred to healthier choices. In order to effectively govern the "flawed chooser" and ensure that people made healthy choices it was therefore necessary for the government to do more than simply provide information and opportunities to people and let them make choices themselves. If choices were influenced by the immediate context as well as existing habits and routines, then it was important to ensure that the context was conducive to healthy choices and encouraging new healthier habits.

The Coalition were keen to adopt techniques from the behavioural sciences in order to "nudge" people towards particular choices rather than restricting choices outright. To this end they proposed the use of the "ladder of intervention", which can be seen in Chapter 7 section 7.6, in order to "promote positive lifestyle changes" (Secretary of State for Health, 2010: par. 2.32). The overall aim was to act to ensure that "healthier choices are easier for people to make" (Secretary of State for Health, 2010: par. 2.34). The ladder was made up of eight steps, with each step up the ladder becoming more intrusive and restrictive ultimately leading to regulation to remove choices. The first step simply indicated that the situation should be monitored while the second step reflected the Informational problematisation in that the emphasis was on providing information and educating people about healthy choices and lifestyles. The third to sixth steps were focused on nudge through enabling people to change their behaviours as well as guiding them in a number of different ways. Enabling choice would happen through interventions such as improving the environment. The first type of guidance was to "make 'healthier' choices the default option for people", the second was using incentives to encourage people to pursue particular activities, and the third was using disincentives to discourage people from partaking in particular activities. The seventh step involved restricting choices where appropriate, while the eighth step involved developing regulation to eliminate choice entirely. This meant that public health interventions could become more paternalistic where necessary, however it seemed as though the more attractive option for the government was to follow the first step which was "Do nothing or simply monitor the situation". This is interesting given the number of arguments stating that action was required to shape or change contexts to ensure that people made healthy choices, reflecting the assumptions of the "flawed chooser". It seems as though while the Coalition wanted to adopt nudge as an approach to public health, which

was underpinned by libertarian paternalism, they were reluctant to engage with the paternalistic element unless absolutely necessary. Indeed it was made clear in the white paper that there was a need to "balance the freedoms of individuals and organisations with the need to avoid harm to others" (Secretary of State for Health, 2010: par. 2.19). If higher level interventions were suggested then the government would "look carefully at the strength of the case before deciding to intervene and to what extent" (Secretary of State for Health, 2010: 2.23) and "[w]here the case for central action is justified, the Government will aim to use the least intrusive approach necessary to achieve the desired effect" (Secretary of State for Health, 2010: par. 2.33). This could be an indication that they did not want to appear to be interfering in people's lives, but this seems to contradict the point of nudge which is to actively shape the choices people make.

Social networks were also seen to be an important part of the surrounding context influencing people's choices. The white paper emphasised that the behaviour and habits of those surrounding the individual could shape the types of choices they made and activities they were involved in: "[r]ecent search has shown that social networks exert a powerful influence on individual behaviour, affecting our weight, smoking habits and happiness" (Secretary of State for Health, 2010: par. 1.15). The Coalition was keen, therefore, to highlight the importance of changing social norms and expectations, for example about drinking or smoking, in order to shape individual behaviour and to encourage people to make healthy choices. It was hoped that, in turn, this would help to change people's lifestyles in order to make healthy choices easier.

In some ways it could be argued that the need for a public health strategy involving nudges suggests that there has been a return to the idea that individuals simply do not know any better, an idea which is discussed above in section 8.2 under the "responsible chooser". The need for nudges and interventions at key points in people's lives to change behaviour suggests that there is an assumption that people simply blindly follow behaviours without recognising the consequences for their health or realistically being able to change them for the better. The need for nudges also suggests that perhaps it is naïve to assume that individuals will always make better choices for themselves given more information or access to new opportunities. It is therefore necessary for the government to intervene, acting as an expert, in order to protect people's health. People need to be nudged towards behaviours that are conducive to good health as this will not only benefit the individual in terms of improving their health, but also wider society as it will also work to prevent ill-health and

reduce the need for spending on the NHS as a result. This also provides some justification for the use of more paternalistic interventions where necessary, although it is clear that the Coalition were keen to avoid regulation and preferred to retain the status quo where possible.

The problem of "differences in health" seemed to be understood in terms of the effects of lifestyles on the choices that individuals made, where lifestyles referred to routines, practices and habits. The concept of lifestyle seems to be a mediating factor between context and the types of choices people make. As was noted in the Coalition's public health white paper, the environment in which a person lives influences their lifestyle, the types of things that they do and engage in, which in turn then shapes the choices people make based on their routines and habits. There is some crossover here with the assumptions underpinning the "constrained chooser" given the focus on the effects of the surrounding context and environment on choices, however the focus with the "flawed chooser" is on how the context acts to shape rather than limits choices. Rather than assuming that individuals make lots of choices about their health, the introduction and use of the concept of lifestyle suggests that perhaps people do not make as many choices as was once assumed. Lifestyles essentially come with a set way of doing things, a set of expectations about behaviours and activities that individuals should engage in if they are to effectively demonstrate they follow a particular lifestyle. The idea of a healthy lifestyle, therefore, encompasses behaviours which one would associate with living a healthy life – eating a balanced diet, exercising regularly, not smoking, only occasionally drinking alcohol, as well as encouraging others to do so. Given the identified relationship between context and lifestyle, the Coalition was keen to establish a context which was conducive to healthy lifestyles. This not only meant changing the physical environment but also social attitudes and norms so as to encourage people towards establishing a healthy lifestyle, which explains the use of nudging in the Coalition's public health approach. These discussions seemed to place the responsibility for health largely with the individual and clearly make it a problem to do with behaviour and the things people do and while the types of lifestyles people adopted were linked with the surrounding context in which an individual lives and works, there seemed to be a stronger emphasis on the role of the individual than on wider social and economic determinants of health as had been highlighted under New Labour.

Policy discussions concerning the "flawed chooser" emphasised the fact that individuals do not always make the best choices for themselves, and indeed seemed to question whether people really do make choices at all. Here the concept of lifestyle

highlighted the fact that there are sets of behaviours which are acceptable and conducive to good health, and sets of behaviours which lead to poor health. While people make choices about their lifestyles it can be argued that they then do not make that many choices other than from within a set of options which match the expectations of that particular lifestyle. This suggests that the problem is to do with people making choices about their lifestyle rather than making choices per se. To some extent it could be argued that lifestyles are in fact a constraint to choices given that there are limitations as to what people can choose to do within a given lifestyle – but they also directly shape the choices people make with regards to their health and this can be used to an advantage. If people's choices are constrained in what is viewed to be a "correct" way, i.e. within a healthy lifestyle, this would mean that people would be much more likely to make healthy choices simply because there is an expectation that they would engage in healthy behaviours and activities. In order to govern the "flawed chooser" effectively it is therefore necessary to

8.5 Conclusion

The aim of this discussion has been to focus on the governable subjects produced by each problematisation identified in the previous three chapters in order to provide a genealogical analysis of policy understandings of the problem of "differences in health". By examining the governable subjects in greater depth, their emergence, the key assumptions underpinning them, challenges made to their position and their ultimate reformulation, it has been possible to show that the development of each governable subject was not simply the result of a natural progression from one understanding of "differences in health" to the next but rather was the result of a set of contingent circumstances which shaped policy understandings of "differences in health". It is important to recognise that social policies produce governable subjects through their representations of social problems, and that these governable subjects reflect key assumptions and understandings about problems and their solutions as well as emphasising how we should be governed.

The final chapter will go on to conclude this thesis through a discussion of the key findings and contributions to the field of public health policy. It will also identify future directions for research and discuss the importance of adopting a Foucaultian post-structuralist approach to the analysis of public health policy.

Chapter 9
Conclusion

9.1 Introduction

The previous chapter presented the genealogical analysis of the data by examining the emergence, dominance and reformulation of the governable subject of public health policies addressing "differences in health". It aimed to demonstrate the fact that subjects develop and remain dominant for a period of time until there is uncertainty about the understanding of the subject (and explanations for the problem) at which point new ideas are considered, and a new subject is formed from a combination of existing and fresh understandings.

In some ways the transitions between the subjects are the most interesting because they opened up the possibility for alternatives to be considered which demonstrates a key characteristic of social policy. Social policy can constrain what can be said about a problem and represent the problem in a specific way as a result, but it can also be open to changes and accept the possibility of alternative explanations. The consideration of alternatives is one of the key contributions which can be made by the WPR framework despite the fact that it is not heavily emphasised in the six framework questions.

This final chapter will draw together the analysis chapters (Chapters 5, 6 and 7) Discussion chapter (Chapter 8) in order to provide a conclusion to the thesis. First the chapter will provide an answer to the overarching question of "What's the problem of "differences in health" represented to be?" by referring back to the initial research questions outlined in the Literature Review (Chapter 2). This will focus on the empirical findings from the policy documents drawing on the problematisations and their governable subjects. The chapter will then examine the theoretical contribution that can be made by adopting a Foucaultian post-structuralist approach to policy analysis, and more specifically by adopting Bacchi's (2009) WPR approach. This will refer back to the empirical findings where appropriate in order to provide examples. The chapter will then explore the idea that there is a missing question from the WPR framework concerning the need to consider alternatives, and how this might work by using the data from this research to provide examples. There will then be a brief reflection on the research considering its limitations before turning to potential ideas for

future research. Finally the chapter will conclude with a summary of the thesis and the main findings.

9.2 What's the problem of "differences in health" represented to be?

Following on from the previous four chapters this section will provide an answer to this overarching question by revisiting the four research questions outlined in the Literature Review (Chapter 2). It will provide answers to the four questions which have been used to guide the research, along with the questions in Bacchi's (2009) WPR framework. This section will argue that the problem of "differences in health" is ultimately represented as a problem of "differences in choice",

9.2.1 "How have policy understandings of and approaches to "differences in health" remained the same or changed over time?" and "What forms of knowledge are drawn upon in order to legitimise policy responses to "differences in health"?"

This first sub-section will explore two of the research questions together as the evidence used to answer each question overlap. In order to understand whether or not policy understandings and representations of "differences in health" have changed over time it is necessary to consider the knowledge that has been drawn upon in order to represent the problem in a particular way in the first place. The archaeological and genealogical analyses have demonstrated that there are three main problematisations of "differences in health" between 1980 and 2011 along with periods of uncertainty between the problematisations. The following overarching narrative can be presented about the problem of "differences in health" in English public health policy from 1980 to 2011, drawing on the discussions of the three problematisations and their governable subjects from the previous four chapters.

The Informational problematisation argued that "differences in health" were the result of differences in the provision of information which in turn led to differences in

individual behaviours. As a result this first problematisation was primarily concerned with the role that information could play in improving health. It highlighted the need for better information to be gathered at the national government level about population health and the risks to health in order to better inform public health and health care policies. This would not only help to improve health and prevent illness but would also contribute to the effective and efficient use of existing resources. This problematisation also stressed the importance of providing Information to the public in order for individuals to make informed choices about their health. It was assumed that the provision of more and better information would lead to people making better choices about their health. After being properly informed of the risks or benefits of particular behaviours people would change their behaviour accordingly. The "responsible chooser" emerged as the governable subject of this problematisation as it was expected that people would act on new information provided to them in a responsible manner and also that they would accept responsibility for the choices they made.

Attention soon turned, however, to the context in which individuals live and how this impacted their health and the choices they could make relating to their health. The Constraints problematisation argued that "differences in health" were not simply the result of poor information provision, although it recognised that information was still an important factor in allowing people to make informed choices. Instead "differences in health", or health inequalities, were argued to be the result of wider social and economic conditions which effectively worked to limit the choices that certain groups of the population could make. These constraints were highlighted in the use of the social model of health. The governable subject was reformed into the "constrained chooser" to emphasise the fact that while people were making choices about their health they were acting in conditions which were not of their own choosing. Action was required by national and local governments to identify and reduce these constraints to choices as many of the constraints lay beyond the direct control of the individual and there was a moral imperative driving this action. The idea of individual responsibility for health remained, however, and people were therefore strongly encouraged to take up new opportunities made available to them through government intervention in order to improve their social and economic situation and to access healthy choices. It was not the intention that people should remain dependent on the state; the government would provide the means for people to help themselves.

The issue of people making choices in context continued with the Paternalistic Libertarian problematisation, although the emphasis was slightly different. Instead of simply viewing contexts as constraining choices this final problematisation made it clear that contexts could be used to shape choices in order to encourage people to make certain choices. This problematisation largely rejected the assumption that individuals can make the "right" or healthy choices given enough information or appropriate opportunities. Instead individuals were seen to be "flawed choosers" who require "nudging" towards particular choices that would be beneficial to their health. Drawing on contemporary developments in the behavioural sciences and from the political perspective of libertarian paternalism, the Paternalistic Libertarian problematisation challenged conventional wisdom about how people make choices. Instead of assuming that individuals always act in their best interest by taking account of all the relevant information and opportunities, this problematisation recognised that individuals can be influenced by their immediate context, how other people around them behave and act, and also by their own routines and habits – by their own lifestyle. "Differences in health" were seen to be the result of differences in lifestyle choices by different groups of the population. The need for people to adopt a healthy lifestyle was therefore a central concern for the Paternalistic Libertarian problematisation and strategies involving nudges towards healthy lifestyles were strongly advocated, particularly at key transition points in people's lives where it was said people were most likely to be influenced.

This narrative clearly demonstrates that policy understandings of "differences in health" have changed over time. Each problematisation has its own clear understanding of what the problem of "differences in health" is and each draws on a specific set of knowledge in order to represent the problem in a particular way. There was one area, however, which remained a key concern for the problematisations of "differences in health". All three problematisations were concerned with understanding how individuals make choices about their health and how to make healthy choices easier for people to make. This seems to be central for understanding how the problem of "differences in health" is represented as a social problem.

9.2.2 How is the issue of "differences in health" understood as a social problem in English social policy between 1980 and 2011?

What all these problematisations have in common is a consistent concern with how people make choices about their health and how healthy choices can be made easier. Each problematisation has its own explanation and reasoning for the existence of "differences in health" and while these do differ there is clearly an underlying concern with understanding how individuals make choices and using this knowledge to develop solutions which will encourage those who do not, or cannot, make healthy choices to do so.

Table 7 Problematisations and their perspectives on choice

Problematisation	Governable subject	What prevents individuals from making healthy choices	How to make individuals more able to make healthy choices	How individual behaviour is conceptualised	View of health
Informational	Responsible chooser	Lack of information	Provide more and better information	Rational actors	Individual responsibility
Constraints	Constrained chooser	Social and economic circumstances	Address social inequalities and provide opportunities	Influenced by social and physical surroundings	Health outcomes related to organisation of society
Paternalistic Libertarian	Flawed chooser	The surrounding context, others' behaviour and existing habits	Use social marketing strategies / Use insights from behavioural science, e.g. "nudge" theory	Influenced by physical and social context and existing habits	Type of behaviour that can be adopted

It seems as though the problem of "differences in health" is therefore ultimately represented as a problem of "differences in choice about health" in English public health policy. Each of the governable subjects identified and discussed in Chapter 7 reflected underlying concerns with how individuals make choices about their health, and these assumptions underpinned the solutions put forward in each problematisation as to how to

deal with "differences in health". A summary and breakdown of the problematisations and their respective views on choice can be seen in Table 7. What is important to note about this table is that it attempts to demonstrate that although each problematisation contained its own particular understanding of how individuals make choices, these understandings also merged into subsequent problematisations. Previous ideas were not simply discounted and this can be seen in the problematisation chapters (Chapters 5, 6 and 7) and the Discussion chapter (Chapter 8).

Compared to subsequent problematisations the Informational problematisation has a fairly simplistic understanding of how individuals made choices. Individuals as "responsible choosers" simply required more information in order to make healthy choices. By providing people with evidence demonstrating that the behaviours they were engaging in were harmful to their health it was expected that individuals would use this information to inform their choices and to change their behaviour where necessary in order to make healthy choices. As a result of this, the responsibility for health lay largely with the individual as it was up to individuals themselves to make changes if they wanted to improve their health. The problem was "differences in choice" due to differences in information provision. Once this imbalance of information had been addressed, it was assumed that people would act to change their behaviour.

The provision and use of information was still seen as important in the Constraints problematisation; however the central concern of this problematisation was with how choices were limited. In the Constraints problematisation individuals as "constrained choosers" faced limitations to choices they could make largely due to conditions beyond their control. People were making choices from a restricted range of options, which could mean that the only had unhealthy options available to them even when they knew these choices were bad for their health. Constraints needed to be removed in order to allow people access to healthy choices and this access would be achieved through government action. Opportunities for individuals to improve their own situation were also viewed as necessary in order to encourage people to help themselves and to ensure access to healthy choices. As was discussed in Chapter 7 section 7.2.1 and Chapter 8 section 8.3, however, a new perspective on how individuals made choices was put forward during the time when the Constraints problematisation was dominant which emphasised how choices could be influenced by advertising and marketing strategies. This was the first time that any government had considered using social marketing strategies in order to promote health.

The emphasis had started to shift from examining how contexts could constrain choices to how contexts could be used to shape the choices people made.

The use of contexts to shape choices was a central feature of the Paternalistic Libertarian problematisation. Here the traditional view that individuals made calculated decisions based on all the information, opportunities and choices available was challenged by the idea that individuals are in fact "flawed choosers". Instead choices could be swayed by the surrounding physical and social contexts in which people live, which included the behaviour of those close to them and an individual's own habits and behaviours. Health was therefore essentially viewed as a behaviour that could be adopted by people following a healthy set of behaviours, a healthy lifestyle. People needed to adopt a healthy lifestyle so that healthy choices would effectively become their default choice as lifestyles encompass expectations about behaviour and essentially come with a set of options which match those expectations. As such the problem was not so much to do with ensuring people made the right choices but rather that they adopted the right behaviours and habits. This would be achieved through nudging people towards healthy behaviours and habits at key points in their lives.

The preservation of choice is an imperative which is emphasised in each of the problematisations and through their governable subjects. Having choices and being able to make choices is seen to be a key marker of individual freedom and control. There is a sense that the government does not want to act in ways to remove choices from the public, even within the Paternalistic Libertarian problematisation which allows in extreme cases for the strict regulation and banning of choices. Governments have to manage a balance between protecting individual freedoms and ensuring the public does not come to harm. As such there seems to be a strong desire throughout all three problematisations and their governable subjects to allow individuals to make their own decisions, although as the "flawed chooser" suggested this might not always be desirable if people consistently choose the "wrong" (unhealthy) choice. Indeed within the Paternalistic Libertarian problematisation it is possible to argue that with its focus on the need to ensure people adopt healthy lifestyles this problematisation challenges the assumption that people do always make choices about their health. As discussed in Chapter 7 section 7.4, the whole point of a lifestyle is to adopt habits and routines which become normalised and effectively remove the need to make choices all the time. Lifestyles come with a set of expectations as to how you should behave if you are to successfully demonstrate to others that you follow that particular lifestyle. There may well

be a set of options from which you make choices from time to time but the whole idea of adopting a lifestyle is to normalise particular forms of behaviour, thereby effectively removing choices.

The discussions across all the problematisations about the role of choice in ensuring good health seems to reflect Rose's (1999) observation that people are made to understand their current health through choices they have made. They are also, therefore, expected to consider their future health by considering choices they have yet to make. This not only frames public health problems in terms of choices but also essentially individualises public health problems, and focuses discussions about the problem and solutions on how to make people change their behaviour and make healthy choices, or adopt a healthy lifestyle.

9.2.3 How are individuals viewed in policies concerning "differences in health"?

Having explored the different problematisations of "differences in health", the transitions between the problematisations, and how they all essentially represent the problem as one of "differences in choice", it is now necessary to explore how subjects are produced by each of the problematisations. Each of the governable subjects has been labelled as a specific "chooser" as policy discussions and responses to "differences in health" are primarily concerned with understanding how individuals make choices about their health and working with that understanding of behaviour in order to implement appropriate solutions.

Throughout all the problematisations there is a clear emphasis on the need for individuals to govern themselves when it comes to making choices about health. This can be seen in the discussion of the governable subjects Chapter 7. The "responsible chooser" was expected to make informed choices based on available information and to change their behaviour accordingly. The "constrained chooser" was expected to take up opportunities to remove further constraints to choices and to use these opportunities to improve their social and economic situation as well as their health. Finally the "flawed chooser" was expected to develop a healthy lifestyle over their life course in order to establish healthy choices as their default option.

All three governable subjects seem to demand a level of awareness from individuals about their own health, their current behaviours and how they can act to change these behaviours in order to improve their health. This self-awareness ties in with the need for people to understand their health through the choices they make. People are expected to be aware of the consequences of certain behaviours or choices and to ultimately accept responsibility for their actions.

Another interesting element which has emerged from the analysis is the idea that individuals need to regain control over their lives in order to make healthy choices. Once individuals have that control, then they are expected to be able to effectively govern themselves with little need for further intervention from the government. For the Informational problematisation control seemed to be related to the ability of the individual to manage their behaviours and the choices they made. In order to successfully manage their choices people required relevant information, and so the solution was to provide the public with "the information they need to make sensible decisions about personal health, and encourage in the community a responsible attitude towards health matters" (DHSS, 1981: par. 2.1).

Under the Constraints problematisation it was argued that the government had a key role to play in "creating the right conditions for individuals to make healthy decisions" (Secretary of State for Health, 1999: par. 1.37). These conditions seemed to include the need for individuals to be in control of their lives. *Choosing Health* stated that "[h]ealthy choices are often difficult for anyone to make, but where people do not feel in control of their environment or their personal circumstances, the task can be more challenging…People are more likely to take more control over their own health if they have more control over their lives." (Secretary of State for Health, 2004: 13). This was then emphasised again six years later in the Marmot Review whose "central ambition…is to create the conditions for people to take control over their own lives" (Marmot, 2010: 38). The Constraints problematisation used the social model of health to highlight the fact that the constraints to healthy choices that people face are often beyond the direct control of the individual, for example laws concerning employment conditions and pay and the provision of services in the local area (e.g. green spaces, shops, doctors surgery, transport links, etc.). Action to create these conditions involved the government addressing existing social and economic inequalities, i.e. removing constraints, in order to ensure that "the conditions of daily life are favourable" (Marmot, 2010: 38) for people to take control over their lives and make healthy choices.

Finally the Paternalistic Libertarian problematisation recognised that while people make choices "we do not have total control over our lives or the circumstances in which we live. A wide range of factors constrain and influence what we do, both positively and negatively" (Secretary of State for Health, 2010: par. 2.20). The Coalition made use of the life course approach outlined in their white paper as a way of creating the conditions for people to take control of their own lives. This was seen as particularly important for young people as they "move through their teenage years and make the transition into adulthood, our aim is to strengthen their ability to take control of their lives, within clear boundaries, and help reduce their susceptibility to harmful influences, in areas such as sexual health, teenage pregnancy, drugs and alcohol" (Secretary of State for Health, 2010: par. 3.17). This would be achieved through "[i]mproving self-esteem and developing positive social norms throughout the school years" (Secretary of State for Health, 2010: par. 3.18). Ensuring people felt confident about themselves and their situation was therefore a key factor in encouraging people to take control of their own lives.

The policies analysed in this research clearly contribute to the shaping of subjects and practices of the self. Not only do they create understandings of individual behaviour, they also encompass expectations about how people should behave and how best to encourage that particular behaviour. There are clearly expectations around personal discipline when it comes to making choices about health. Once the "right conditions" have been created for people to make healthy choices according to the problematisation and problem representation, the main expectation is that individuals will act in order to make healthy choices and that people will accept responsibility for the choices that they make. Giving people control and empowering them to make their own decisions was also part of the move towards encouraging self-governing individuals, and also to contribute to the reduction of state intervention in people's lives.

9.3 Adopting a post-structuralist perspective for the analysis of (public health) policy

This section will examine the usefulness of adopting a post-structuralist approach to policy analysis, specifically one underpinned by Foucault's theory and "methods". Although there is an in-depth exploration of Bacchi's (2009) WPR framework in Chapter 3 and its

relationship with Foucault's theory, it is important to highlight the wider contributions that can be made by adopting this type of approach in the analysis of social policy.

The WPR framework is not only concerned with highlighting the ways in which problems are thought about in social policy but to also indicate that the representations found in policies are not the only ways of thinking about and solving problems, and can be used to consider alternatives or excluded views. These problem representations are contingent upon particular historical contexts which shape what can and cannot be said about an issue, and indeed whether or not an issue is deemed problematic enough for social policy to deal with in the first place. The framework is also linked to governmentality studies, particularly through the continued examination of the relationship between thought and government throughout the six questions. There are clearly going to be political differences in thinking about how people should be governed and while the WPR framework takes this into account, there is also a need to go beyond the conflicting ideas which might be present about a particular issue and to examine, through archaeology, the *archives* of thought which drive understandings at points in time. These understandings are then legitimised through the establishment of relationships which involve the public as well as existing institutions, or perhaps require the creation of new institutions or new sets of relationships. Governments need to legitimise their form of rule and governance otherwise they risk being ousted from power. As a result of this legitimation process, which involves the use of existing forms of knowledge as well as the creation of new knowledge, policy representations of problems tend to "stick" for long periods of time. There is also a concern with the effects of problem representations, not just in terms of the development of new institutions or the reorganisation of existing ones but also in terms of the subjectification effects of problematisations. The way in which individuals or groups are conceptualised, such as whether people are to blame or whether they are the victims of a set of conditions, will have an impact on people's lived experiences. It must be recognised, therefore, that social policy does not just describe situations and provide solutions but is actively involved in the creation of understandings about social problems, and about the people that are affected or implicated within these problems.

This final point seems to be the key contribution that can be made by a Foucaultian approach to the field of social policy analysis. Bacchi's WPR framework can be used to demonstrate "how social policy is itself implicated in the processes it claims to study" (Twigg, 2002: 423). Social policy does not stand outside of society and provide neutral descriptions

about its current state. By defining some situations or phenomena as problems it does not just describe reality; it helps to construct the understandings of conditions or people as problematic. The problems discussed in political circles and in social policies "signify who are virtuous and useful and who are dangerous or inadequate, which actions will be rewarded and which actions will be penalised" (Edelman, 1988: 12). These then have very real effects on the population, particularly on groups who are viewed as dangerous and in need of punishment or strict regulation. That is not to say that those who are considered virtuous are not regulated, as this regulation might take the form of self-surveillance, self-policing, or self-management. There is an expectation that individuals will actively take part in, and accept responsibility for, actions that they take and choices that they make. This is an assumption which is readily adopted by contemporary social policy, and which clearly influences the way in which policies are created and what actions are put forward (Rose, 1999). In the case of this research into "differences in health" there is a clear emphasis on the need for individuals to be aware of the choices they make that will impact on their health, and more recently for individuals to recognise the importance of adopting healthy lifestyles in order to more effectively manage the types of choices they make.

Social policy is influenced by existing frameworks of thought which guide the way we see the social world, but it is important to note that these *epistemes* are not fixed and can, and do, change over time as practices change. These will influence what can and cannot be said on social issues as they provide a framework for understanding, applying and gaining knowledge. This can clearly be seen in the transition periods between dominant problematisations of "differences in health" where uncertainties about the existing problematisation are raised and new possibilities for understanding "differences in health" become apparent. The transition from one problematisation to another is contingent upon the right conditions being present in policy discussions to allow for alternative ideas to be considered, and these transitions will often incorporate previous knowledge and understanding in the new problematisation. As social policy is involved in the creation of new knowledge and the use of existing knowledge, it contributes to both sustaining the existing mode of thinking and also to the possibility of changing the mode of thinking. There are a number of implications which result from understanding social policy in this way.

Firstly, there is a clear rejection that social policy can be "objective" in its descriptions of social problems. Statements that are made about the existence of problems, about certain groups in society, or about strategies to improve particular situations are not simply

descriptions but represent particular ways of understanding social phenomena which are consistent with dominant political ideology and wider modes of thinking at a particular point in time. These then have effects on the population in terms of the identities placed on different groups, and also whether or not people are entitled to access to certain resources such as benefits or specific forms of care, for example. Studying problematisations using the WPR framework allows researchers to access these forms of representing problems, to open them up for close inspection and interrogation, to reveal underlying *epistemes* influencing problem representations, and to consider the effects of problem representations.

The second implication is that it is possible to view policy as a discourse. This follows on from the first implication in that discourses shape what can and cannot be said about something. In this case, social policy largely controls what can and cannot be said about a problem. It is also, as mentioned above, influenced by wider epistemes of thought which in turn shape the way social policy itself is conducted. In the WPR framework Bacchi (2009: 48) advocates using archaeology as a means of uncovering "underlying conceptual logics and political rationalities" in order to understand what assumptions are being made about the existence of a problem.

Thirdly, using a Foucaultian perspective in the analysis of social policy challenges the idea that developments in social policy are the result of a continuous logical progression towards a certain goal. This stems from Foucault's perspective on history and his discussions of the genealogical method. Discussions of past approaches to public health tend to paint a picture of a set of logical developments which have led to the most recent approach being discussed or implemented. This can be seen both in the academic literature (cf. Armstrong, 1993) and also in public health policy documents themselves. A number of the documents analysed in this research had an account, usually near the beginning of the document, of the progression of public health and its achievements (Acheson, 1998; DHSS, 1988; Secretary of State for Health, 1992; Secretary of State for Health, 1999; Secretary of State for Health, 2010). These achievements, which included improving sanitation, the implementation of immunisation programmes, and increasing the awareness of environmental conditions and their effects on health, were often presented in chronological order as they were first introduced into public health. These discussions were used mainly in order to justify the need for a public health response and in order to contextualise the content of the paper itself. From a Foucaultian perspective the presentation of these developments as though they were simply a logical progression is not particularly useful. It does not tell us very much other than

the order in which these events occurred. As Foucault argues "[t]he history of 'ideas' or 'sciences' must no longer be written as a mere checklist of innovations, it must be a descriptive analysis of the transformations effectuated" (Foucault, 1991b: 58). History should be seen as a set of contingencies rather than as a linear progression and it is argued here that this perspective should be applied to understanding developments and changes in areas of social policy. Rather than being solely concerned with charting the development of ideas and problems in policy by assuming they are clear steps towards a predefined goal, the focus should be instead on the conditions which allowed such ways of thinking to become established and also on examining the shifts between different modes of thought, while considering that there may have been alternative routes that could have been adopted but were not. This clearly involves the application of both archaeological and genealogical methods in order to both uncover the different modes of thought shaping policy at specific points in time and to analyse the changes between these modes of thought and how they occurred.

These three points can be seen in the identification and examination of each of the three problematisations of "differences in health" as well as through the exploration of the transitions between each problematisation. Each problematisation contains within it a particular problem representation of "differences in health" with its own sets of concepts and understanding of what the problem was and how it should be dealt with. The Informational problematisation viewed the problem as a lack of adequate information provision to allow people to make informed choices about their health. For the Constraints problematisation the problem was that people's choices about their health were limited by the context in which they lived. And finally the Paternalistic Libertarian problematisation argued that the problem was the result of differences in lifestyle choices. While each problematisation indicates that at specific points in time there was a dominant understanding of the problem which restricted what policies could say about the problem, the periods between each problematisation demonstrate that there were times when there was a shift in ideas which allowed for alternative explanations and ideas to come to the fore. The move towards a new problematisation of "differences in health" was therefore contingent upon particular conditions being in place in order to instigate new discussions about the problem and for new representations to become the dominant way of understanding the problem.

Finally, the WPR framework touches on issues of power within social policy, something which is missing from more traditional forms of policy analysis. Post-structuralist approaches to policy analysis recognise that the state is "a key site for the exercise of regulatory and disciplinary power" (Twigg, 2002: 424). One of the main concerns of the WPR framework, therefore, is with how knowledge is used to govern – how and why it is created in the first place, what knowledge is actually made use of, and how it is utilised to shape policy discussions about problems. The relationship between thought (or knowledge) and government and the ways in which knowledge is used to legitimise forms of rule are opened up for investigation in the WPR framework. There is a clear implicit link made here between knowledge and power. For Foucault, power is not a "thing" which some people have more of than others, but rather is something which results from a set of relationships:

> *In short this power is exercised rather than possessed; it is not the 'privilege', acquired or preserved, of the dominant class, but the overall effect of its strategic positions – an effect that is manifested and is sometimes extended by the position of those who are dominated. Furthermore, this power is not exercised simply as an obligation or a prohibition on those who 'do not have it'; it invests them, is transmitted by them and through them; it exerts pressure upon them, just as they themselves, in their struggle against it, resist the grip it has on them. (Foucault, 1991a: 26-27).*

Considering this quotation in terms of the position of social policy, it is possible to argue that policy makers (and politicians) are in a position to exert power over the population. They exist within a particular structure of relationships which not only provides them with an authoritative position but also a set of practices (i.e. the creation of social policies) through which governing occurs. For Foucault "knowledge is situated in our practices" (May, 2006: 20). The practice of social policy requires the gathering, analysis, interpretation and implementation of forms of knowledge about social problems. This not only refers to statistical data, for example, but also knowledge in terms of normative concerns and political assumptions which underpin how problems are discussed and represented in policy documents. Ultimately social policies are concerned with the regulation and management of the population and these different forms of knowledge play an important role in the way in which power is exercised over the population, not just in terms of changes that might be made to existing organisations or structures but in terms of how individuals are conceptualised and made amenable to governing. As Bacchi (2009) argues, policies have subjectification effects which should be considered in the analysis of social policy.

This final point is reflected in the discussions of the governable subjects produced by each of the three problematisations. Policies have the power to construct subjects and to make them amenable to governing through the way in which individual behaviour is conceptualised and presented. This research has shown that there are three clear governable subjects linked with problematisations of "differences in health": the "responsible chooser", the "constrained chooser" and the "flawed chooser". As has been shown in the discussions in this and the previous chapter, each of these governable subjects is based on particular understandings of how individuals make choices about their health. These exercise disciplinary power over the population as there is a clear expectation that individuals will change the choices they make, or adopt a healthy lifestyle, in order to improve their health.

Osborne (1997: 173) comments that Foucault's work might be of little direct use to health policy as he "offers no positive conceptions as to how health might be regulated, only historical studies relating to how systems of knowledge concerning the health of populations came to be linked to styles of power and procedures of state". While this might be the case, this research has provided suitable justification for the need of such historical studies in relation to the field of social policy, and the implications this has for our understanding of how social policy operates and is involved in forms of governing. It is important to consider the role that health policy has in relation to governing because, as Bacchi (1999, 2009, 2012, 2015) and Twigg (2002) have discussed, policy is tied up in the very processes that it purports to study from a distance. A great deal of what is discussed in health policy, the conditions and behaviours that impact on health, can reveal normative considerations about society, such as the imperative need for a healthy population, and expectations about behaviours, for example individuals making healthy choices, both of which shape the way in which problems relating to health are understood and acted on.

9.4 The "missing" question from the WPR framework: What alternative ways of representing the 'problem' and its solutions could be considered?

Throughout her work, Bacchi seems very keen to avoid to be seen to be providing advice or suggestions for how policy makers might better do their jobs. In *Women, Policy and*

Politics she positions the WPR framework almost in strict opposition to those perspectives which aim to improve how problems are presented in policies as she argues that "a What's the Problem? approach is not interested, or at least not directly, in making analysts better at their jobs" (Bacchi, 1999: 20). In her later work she argues that Foucaultian post-structuralist approaches to policy analysis are concerned with interrogating existing representations of problems in order to consider ingrained conceptualisations, rather than with training policy makers to be better at problematising social problems as is the aim with Interpretivist approaches (Bacchi, 2015). Arguably this gives weight to Osborne's (1997) concerns with Foucaultian approaches to the study of health policy given that it seems the overall aim is not to suggest how things could be done differently but rather to analyse existing meaning. Here, however, it is argued that the WPR framework does offer a practical contribution to the field of health policy analysis, as well as providing a new approach to understanding the historical development of health policy.

This contribution would be better highlighted by a seventh question which asks analysts to consider alternatives to the problem under scrutiny. Part of question 4 in the WPR framework does address this by asking "Can the 'problem' be thought about differently?" as a sub-question to "What is left unproblematic in this problem representation?", but arguably the need to consider alternative ways of thinking about a problem and its solutions should have its own separate question. This is because the need to consider alternatives actively encourages the researcher or analyst to question the existing understanding of the problem, in the case of this research the problem of "differences in health". Bacchi is right to highlight the fact that "the WPR approach does not propose *particular* policies. It consists, after all, of *questions* not proposals" (Bacchi, 2009: 272, emphasis in original). The framework does not aim to suggest which problem representations are correct and which are wrong, or which solutions are better than others. It does, however, strongly encourage the need for constant questioning of problem representations in social policy. The WPR framework also highlights the fact that "policy decisions close off the space for normative debate because of the impression that indeed they are the best *solution* to a problem" (Bacchi, 1999: 20, emphasis in original), and clearly the framework as a whole can contribute to opening up this "space for normative debate" by actively questioning problem representations. The consideration of alternatives is a key way in which this space can be reopened.

This consideration of alternatives should not, however, simply be a case of providing a list of contrasting understandings which rest on different assumptions, although this is very

useful and is clearly one of the aims of the WPR framework when looking at problem representations over time and how they change. Instead the focus should be on encouraging people (politicians, policy makers and even social scientists) to logically think through the effects of assumptions which underpin problem representations, and to highlight where assumptions and existing social or organisational or societal arrangements come into conflict with one another. This requires the addition of a qualitative understanding of social problems as opposed to a continued sole focus with quantitative measures and framing of problems. One of the key contributions the WPR framework makes more broadly is to highlight the importance of ideas and assumptions which shape problem representations, which goes against the popular idea that all policies are evidence based. This has been clearly demonstrated in the field of health inequalities by Vallgårda (2006, 2010) and Smith (2013, 2014). This research has shown that normative assumptions about how individuals act are central to shaping the understanding of and policy responses to the problem of "differences in health". One of the main findings from the analysis of 31 years of public health policy which has aimed to address "differences in health" has been the identification and discussion of the governable subjects which are produced within each problematisation of "differences in health". These subjects have been shown to be related to and based on existing assumptions about how individuals currently act, and what should be done in order to encourage them to act in a particular way (i.e. how to get people to make healthy choices).

In order to demonstrate this need to think through the consequences of existing assumptions three potential ways of dealing with the problem of "differences in health" will be presented here, based on the key underlying assumption present in all three problematisations – the importance of understanding how individuals make choices and using these mechanisms to improve health. The issue of preserving choice, however, seems to come into conflict with the effects choices have on health. There seems to be a continuing paradox within public health policy relating to health and choice. On the one hand there is a continuing strong desire to maintain people's freedom of choice as this is viewed as a marker of individual freedom and a key part of a liberal society. People should be able to choose what they want to do and consume without undue interference. On the other hand there seems to be a concern with the fact that people cannot make good choices about their health, as demonstrated by the "flawed chooser" outlined within the Paternalistic Libertarian problematisation.

The first suggestion here would be to follow through the logic of Paternalistic Libertarianism to its end and ban activities or consumables which are ultimately harmful to health. If people really cannot be trusted to make their own choices about their health and just cause problems for themselves in terms of long term illness and problems for society in terms of escalating health care costs, then the government should step in to remove the choice entirely as part of its duty of protecting the population from harm. While this is stated as a possible action within the Coalition's public health approach, and there have been moves towards it with smoking for example, it seems as though they are unwilling to commit to banning activities or products and are instead content with monitoring the situation which seems to conflict with their understanding of how best to improve levels of health in the population.

The second suggestion would be a more technocratic response. Instead of removing harmful choices, such as smoking and fast food, they could be used as rewards for people who engage in healthy behaviours. In some ways this reflects part of the "ladder of intervention" outlined by the Coalition government where one of the steps offers incentives for people to make healthy choices. Access to unhealthy foods and cigarettes could be regulated through a scheme where a person's physical activity, calorie intake and current weight (for example) would be monitored and if a person was deemed to be healthy enough from the analysis of particular metrics they would be allowed to purchase products which were seen to be unhealthy. This monitoring could easily be achieved through the use of wearable health technology, such as wristbands which are currently experiencing a period of popularity with consumers, which could automatically sync data to a phone app or be downloaded to a computer. Admittedly the logistics of being able to only allow certain members of the public to access particular goods on a day-to-day basis would be difficult to work out, and a whole new computer system would be required to process the data collected and allocate more freedoms to some than others. This sort of approach would be much easier to implement within organisations which have a cafeteria, for example, or perhaps within schools.

The final suggestion would be to fully embrace the idea of consumer sovereignty and to allow people to make whatever choices they want to – but the consumer would then have to fully shoulder the responsibility of the consequences of their choices. This alternative would be the most libertarian of the three alternatives suggested here. The problem with this scenario in contemporary Britain is the existence of the NHS. The NHS provides a fall-

back for consumers when something goes wrong, i.e. when they fall ill because of poor choices. In this case if the priority was to preserve individual choice then the logical step would be to remove the NHS and replace it with an insurance system. If you are keen to give people greater control over their lives, as many policies relating to "differences in health" state, then why not give them full control over their choices along with the responsibility for those choices.

These are all possible scenarios which could be considered given the underlying presence of assumptions about choice within policies which aim to address "differences in health". The aim here has been to show that the consideration of alternatives needs to take into account the assumptions which underpin problem representations rather than to suggest which might be better. There are undoubtedly other variations on these alternatives which could be further explored; those presented here are provided as examples of ways of thinking through the underlying concern with choice in relation to health, and how to better encourage people to make healthy choices. Alternatives can be underpinned by completely different assumptions, but it is also important to think through different consequences which can result from one particular way of understanding a problem.

This more qualitative consideration of alternatives is useful for policy makers, policy analysts and social researchers alike. It encourages people to think through the assumptions they have made about a problem and how it should be addressed, and to consider the outcomes and effects that this particular problem representation will produce – particularly the lived effects for people. It also encourages a continuous cycle of questioning and critical thinking about social problems and how they are represented in policies, whilst at the same time highlighting the fact that problems in policies are just that, representations rather than unbiased, objective descriptions. The WPR framework therefore does have a practical contribution to make to the way in which health policy (and other areas of policy as well) are made.

9.5 Reflections on the research

This is intended to be a reflective section which records some of my thoughts about the research project as a whole. Here I will reflect on the use of the WPR framework, my

findings, how this research has changed my view on social policy, and on positioning my research.

Firstly I would like to discuss the use of Bacchi's (1999, 2009) WPR framework. I feel that this is a very useful framework for policy analysis, and in particular for health policy analysis given that there is little attention paid to the assumptions underlying policy representations of problems. It is a very clever framework as the questions manage to both highlight individual components (i.e. problematisation, archaeology and genealogy) which are necessary for the successful questioning of policies and the production of a history of policy developments around a particular problem, whilst at the same time ensuring that they are all considered simultaneously. This encouraged me to develop a critical historical (genealogical) perspective whilst conducting the analysis of public health policy documents. As a result the WPR framework has made me much more critical of the way in which problems in social policy are articulated, in terms of considering what assumptions underlie particular ways of presenting problems and solutions to problems.

The framework also encouraged me to engage with the social theory used to underpin the questions in the framework. Sometimes I worried that I was getting too caught up in the theory behind the method, but in the end I thought it was necessary to clearly demonstrate my own perspective and how I was approaching the research. I have found that this is always the case with research into health inequalities as researchers often do not make their position explicit (Wainwright and Forbes, 2001) and therefore it made it more important that my starting perspective was clearly defined. I was concerned that my analysis could come across as cynical rather than critical, but I discovered that feeling secure in the theory underpinning my the WPR framework helped me to make much more sense of what I found during the analysis and it was instrumental in bringing my data together in order to write up my findings and conclusions. Two things that worried me most throughout the research were firstly the idea that what I was putting forward was a case of simply stating the obvious, and secondly that I was reading too much into the documents or I was finding things that simply were not there. Again, referring back to theoretical discussions and the WPR questions whilst analysing the documents was helpful in keeping my thoughts on track and ensuring I focused on providing a systematic analysis across the time period.

Despite the fact that the theory did give me direction there were still times when I felt "lost" in a sea of documents and perspectives. At times it was difficult to see what it was I was really looking at and to make sense of the data. I was very aware that I did not want to

produce a simple history of the development of policies addressing "differences in health" which would lead to a discussion which would sound like "first this happened, then this happened". I found that I had to go through several iterations of the three findings chapters (Chapters 5, 6 and 7) in order to develop a satisfactory narrative. Initially the chapters focused on the three main governments (Conservative, New Labour and Coalition) and so the emphasis was on the approaches each government had taken to address "differences in health". While this was useful to an extent, I was not convinced that this was the best way of presenting my findings. For one thing I felt that the complexity of the shifts between policy responses to "differences in health" were not easily conveyed by focusing on successive governments. I realised that the analysis should instead be presenting different problematisations of "differences in health" in order to demonstrate that the boundaries between different government's perspectives were blurred rather than clear cut. One of the aims of the WPR framework is to produce a genealogical account of policy developments in order to demonstrate the contingent nature of changes in policy. This proved both interesting and difficult as it provided me with a new understanding of policy whilst at the same time challenged me to identify specific conditions which made changes between problematisations possible. The whole process was very iterative, constantly comparing sources in order to find commonalities within a similar period of time as well as across the whole period studied, and I found myself referring back to the data whilst writing up my findings to ensure that the narrative I put forward reflected the data.

One of the problems with using the WPR framework is that the analysis is restricted to policy documents. This means that the findings are largely reliant on the skill of the researcher and their interpretation of how to apply the framework to their analysis. Arguably it would have been useful and interesting to conduct interviews with policy makers who were involved in the production of the policies analysed here in order to question their experiences of policy making and to perhaps "test out" the interpretations which were found using the WPR framework. This would have provided a way of seeing whether the underlying emphasis on individual choice was an explicit concern or something which was implicit in the work they had done. This was not done in this research for two main reasons. Firstly it would have been difficult to locate and interview policy makers, particularly those who have worked on more recent policies, and they may not have been forthcoming with information. Secondly as the research was already looking at 31 years of public health policy documents there was a lot of data to work with and analyse, so it made sense not to add more data for the sake of it.

In addition, there is potentially a problem with what the WPR framework can contribute to the future development of policy given that it actively avoids offering solutions to the problems under investigation. This could be seen as problematic given that social policy is generally about doing something (or not doing something) in order to solve a problem. The need for problem-questioning as well as problem-solving has been discussed at some length in this thesis (see Chapter 2 and Chapter 3) and so will not be repeated here. The contribution that the WPR framework makes is not practical in terms of offering solutions, but practical in terms of offering a new way of thinking about social problems and social policy (see section 9.4). It encourages people (politicians, policy makers and even social scientists) to rethink their understanding of the nature of social problems and social policy. It encourages people to qualitatively think through and consider the consequences of particular understandings of problems and the solutions which are put forward, rather than simply relying on statistical analysis and modelling. In effect the WPR framework encourages the development of a particular disposition to the analysis of social policy, one which is akin to the "sociological imagination" and which emphasises the need for constant historical critical engagement with social policies.

In terms of reflecting on my findings I was pleased with how everything came together in the end. I was able to successfully identify problematisations of "differences in health", provide an archaeological analysis of each problematisation focusing on the key assumptions and knowledge which underpinned each problematisation, and finally presented a genealogy of policies addressing "differences in health" by focusing on the governable subjects which emerged from each problematisation. I was not expecting to find that the emphasis on individual choice, and the need to ensure people make healthy choices, was so ingrained across the time period analysed for this research. For one thing it has changed my impression of New Labour's approach to "differences in health" in particular, as their responses are generally viewed as the closest to a collectivist response. This research has shown, however, that on closer inspection ultimately this collectivist ideal is underpinned by a focus on how to get people to make healthy choices, thereby still reducing the problem to the individual to an extent. I was also surprised at how obvious the presence of the governable subject was across all three problematisations. This has made me more aware of how policies create subjects through discussions of problems and how these are a crucial part of formulating policy understandings of social problems (Edelman, 1988). This seems to be particularly important in the field of health given the increasing, but continued, emphasis given to the role of the individual in maintaining their health.

As a result of using the WPR framework I am very aware that my own view of social policy has been altered quite dramatically. I no longer view policy as something which works outside of politics and society – indeed hopefully this research has demonstrated that the opposite is true. In the past I viewed social policy documents as the definitive position on social problems. Now I feel that more research needs to be done into the social nature of the policy process, rather than simply relying on abstract linear models of the process which ultimately reduce the complexity of policy making. Social policy is, in effect, an institution with its own norms, values and rules as to how policies can, and should, be made. It seems, then, there is a need for something akin to a Science and Technology Studies approach to the study of social policy in order to better understand the social practice of policy making. This is a potential direction for future research, although potentially this would be very difficult to carry out. In addition the WPR framework has made me much more aware of the role of social policy in governing, something which I had not really considered before. As a result I am also interested in the way in which social policy can mobilise and normalise particular forms of behaviour, particularly the continuing emphasis on self-governance and monitoring, thereby contributing to the overall governing and management of the population.

Finally I would like to add that one of the biggest challenges I have found is locating where I "fit" within the social sciences. I am trained as a sociologist by education and had an existing interest in medical sociology which sparked the interest in health inequality policy, but I have ended up doing policy analysis from a sociological perspective. This made formulating the context of the research very complex and made writing the Literature Review (Chapter 2) quite a challenge. As the research draws on ideas from different fields it was quite difficult to order the literature in such a way as to construct a coherent argument in order to demonstrate the gap in the literature which the research would fill. One of the main problems was getting the right balance between the literature on health research and health policy while also introducing theoretical developments in the study of social problems. This meant the Literature Review went through several revisions to ensure that all the components were in the right place in order to justify the need for this research. This complexity in developing the context for the research has also made me unsure of as to where I should best place myself within the discipline as a researcher. The conferences I have presented at throughout my PhD have all had a health element to them as that is where I felt most comfortable, however I feel I might have missed something by not presenting at events more focused on social policy and policy analysis. This is something I am still grappling

with as I come to the end of my thesis as I seem to straddle concerns within medical sociology, the study of social problems, and policy analysis, and it has sometimes made it difficult to explain to others exactly what it is I am doing.

9.6 Directions for future research

As the WPR framework is designed to be applicable to any area of social policy and the analysis of any social problem (Bacchi, 2009), it seems unnecessary to list all the potential problems which could be analysed using this framework. Staying with the field of public health policy, however, it would be interesting to apply the WPR framework to other problems which are identified in public health and which are related to "differences in health". One such example would be the problem of obesity. There are clearly interesting questions to be asked about why obesity is a problem, when was it first recognised as a serious problem for public health and the NHS, who or what is seen to blame for rising rates of obesity, and where the responsibility lies for addressing it. The analysis could move beyond just the analysis of policy documents to include news articles in order to see how the media represent the problem of obesity, and whether this compares or contrasts with the official government line on the problem. To extend the research a little, and to include an interpretivist element, it would be interesting to interview policy makers involved with the creation of policies on obesity in order to find out more about the policy making process and the content of policies from their point of view.

Following the governmentality thread instead, there is an interesting avenue of research to be pursued in terms of examining how people actually manage the types of choices they make about their health. In other words looking at how people become aware of their health and how they govern themselves in order to maintain good health. An example of this would be perhaps to explore the use of fitness trackers, small wearable devices which measure anything from the number of steps taken a day, to your heart rate, to your calorie intake, to how long you sleep at night. All of this data can then be uploaded to a program which provides the user with results and recommendations as to how they can improve their results. The data can even be compared with friends in order to encourage a sense of competition and a motivation for increasing the number of steps you take a day, for example. There are interesting questions to be asked here about why people use fitness

trackers in the first place, how useful they find them, whether wearing such devices makes people more aware of choices they make about activities and behaviours they engage in, and, crucially, what happens to the huge amounts of data which are uploaded and stored.

9.7 Conclusion

The purpose of this thesis has been to demonstrate the contributions which can be gained from adopting a Foucaultian post-structuralist approach to the analysis of the problem of "differences in health" in English public health policy. The research aimed to address a gap in the literature where the focus for policy analysis had been concerned with evaluating policies in terms of their outcomes and the pros and cons of particular approaches (Bambra, Fox and Scott-Samuel, 2005) rather than considering how the problem was thought about and represented in such policies. Bacchi's (2009) WPR framework was used to guide the analysis of 31 years of English public health policy which ultimately found that the problem of "differences in health" is represented as a problem of "differences in choices about health".

The theoretical contribution of this thesis can be summarised in two points. First of all this research has highlighted that policies do not simply report social problems but are an essential part of how problems are represented in political discussions. The problematisations identified and explored in Chapters 5, 6 and 7 have demonstrated that the same problem, i.e. "differences in health", can be presented and understood in different ways. The policy documents used for this research have been analysed in such a way as to question the way in which the problem of "differences in health" is discussed in order to examine the assumptions which underpin each different representation of the problem. Secondly this research has shown how "messy" social policy can be, particularly in terms of the progression of ideas and perspectives on an issue. The discussions of the transitions between problematisations in the Chapters 5, 6 and 7 and between the governable subjects in Chapter 8 have shown that the development of policies cannot be seen as a simple linear progression of ideas. Foucault's method of genealogy has been used in this research to demonstrate that in fact the transition between each problematisation does not necessarily simply represent progress towards an overall goal; instead the subsequent problematisations are contingent upon the wider context being conducive to new ideas and

perspectives. Indeed even within problematisations the problem representation can become fragmented as was shown by the introduction of techniques of social marketing into the Constraints problematisation.

The substantive contribution of the thesis can be seen in the subjectification effects of policies addressing the problem of "differences in health", and the subsequent representation of the problem as "differences in choices about health". Different representations of the same problem produce different governable subjects which are underpinned by particular assumptions and expectations. In the case of this research the governable subjects had one key characteristic in common – a concern with how people make choices about their health. Policies have the power to construct subjects and make them amenable for governing. These subjects demonstrate assumptions concerning who or what is to blame for the problem in the first place, how people who face the problem are to be viewed and treated, and what needs to be done to help people and to resolve the problem. By conceptualising individuals as "choosers" the policies analysed in this research centred on finding ways of changing people's behaviour and encouraging them to make healthy choices. This suggests that greater attention should be paid to the role that social policy plays in governing the population and shaping practices of the self within the field of health policy analysis.

Appendix A
List of policy documents

This appendix contains a comprehensive list naming all the documents and their type that were analysed for this research in chronological order.

1980s

Department of Health and Social Security (DHSS) (1980) *Inequalities in Health: Report of a working group*. London; The Stationery Office.	Commissioned report
Department of Health and Social Security (DHSS) (1981) *Care in Action: A handbook of policies and priorities for the health and personal social services*. London; THE STATIONERY OFFICE.	Government report
Department of Health and Social Security (DHSS) (1988) *Public Health in England: The Report of the Committee of Inquiry into the Future Development to the Public Health Function.* London; Stationery Office Books.	Commissioned report

1990s

Secretary of State for Health (1991) *The Health of the Nation: A consultative document for health in England*. London; The Stationery Office.	Green paper
Secretary of State for Health (DH) (1992) *The Health of the Nation: A strategy for health in England*. London; The Stationery Office.	White paper
Department of Health (DH) (1993) *Working Together for Better Health*. London; The Stationery Office.	White paper follow-up
Department of Health (DH) (1995) *Variations in Health: What can the Department of Health and the NHS do?* London; The Stationery Office.	White paper follow-up
Department of Health (DH) (1996) *Health Related Behaviour: An epidemiological overview*. London; The Stationery Office.	White paper follow-up

Secretary of State for Health (1998) *Our Healthier Nation*. London; The Stationery Office.	Green paper
Acheson, D. (1998) *Independent Inquiry into Inequalities in Health*. London; The Stationery Office.	Commissioned report
Secretary of State for Health (1999) *Saving Lives: Our Healthier Nation*. London; The Stationery Office.	White paper
Department of Health (DH) (1999) *Reducing Health Inequalities: An action report*. London; The Stationery Office.	Government report

2000s

Department of Health (DH) (2000) *The NHS Plan*. London; The Stationery Office.	Government report
Department of Health (DH) (2001) *From Vision to Reality*. London; The Stationery Office.	Government report
Department of Health (DH) (2001) *Tackling Health Inequalities: Consultation on a plan for delivery.* London; The Stationery Office.	Consultation
Department of Health (DH) (2002) *Tackling Health Inequalities: Update*. London; The Stationery Office.	Government report
Department of Health (DH) (2002) *Tackling Health Inequalities: The results of the consultation exercise*. London; The Stationery Office.	Government report
Department of Health (DH) (2002) *Tackling Health Inequalities Through Local Public Service Agreement.* London; The Stationery Office.	Government report
Department of Health (DH) (2002) *Tackling Health Inequalities 2002 Cross-Cutting Review*. London; The Stationery Office.	Government report
Health Development Agency (2002) *Closing the Gap: Setting local targets to reduce health inequalities*	Government report
Department of Health (DH) (2003) *Tackling Health Inequalities: A programme for action*. London; The Stationery Office.	Government report

Department of Health (DH) (2004) *Choosing Health: A consultation on action to improve people's health*. London; The Stationery Office.	Consultation
Department of Health (DH) (2004) *Choosing Health: Making healthy choices easier*. London; The Stationery Office.	White paper
Department of Health (DH) (2005) *Tackling Health Inequalities: Status Report on the Programme for Action*. London; The Stationery Office.	Government report
Department of Health (DH) (2008) *Tackling Health Inequalities: 2007 Status Report on the Programme for Action*. London; The Stationery Office.	Government report
Department of Health (DH) (2008) *Health Inequalities: Progress and Next Steps*. London; The Stationery Office.	Government report
Health Committee (2009) *Health Inequalities: Third Report of Session 2008-09*. London; The Stationery Office.	Government report
Department of Health (DH) (2009) *Tackling Health Inequalities: 10 years on*. London; The Stationery Office.	Government report

2010s

Marmot, M. (2010) *Fair Society, Healthy Lives.*	Commissioned report
Department of Health (DH) (2010a) *Healthy Lives, Healthy People.* London; The Stationery Office.	White paper
Department of Health (DH) (2010b) *Our Health and Wellbeing Today*. London; The Stationery Office.	Government report
Department of Health (DH) (2011) *Healthy Lives, Healthy People: Update and way forward*. London; The Stationery Office.	White paper follow-up

Appendix B
NVivo nodes and descriptions

This appendix contains a list of all the nodes that were used for the coding of the documents and a short description of the node. Parent nodes are indicated by bold text while child nodes are indicated by italicised text.

Node	Description
Aims of the paper	Statements which set out what the document aims to achieve, or what the document is about.
Behavioural science	Mentions or discussions about the use of behavioural science in public health.
Choice	Instances where the issue of choice or ideas about choices relating to health are discussed.
Control	Discussions relating to issues of control, in particular individual control over their lives.
Cross-government department co-operation	Discussions concerning the need for government departments to work together on health issues.
Describing distribution of health	Parent node for different ways of describing the distribution of health.
Differences in health	Instances where "differences in health" is used to describe the distribution of health.
Health disadvantage	Instances where "health disadvantage" is used to describe the distribution of health.
Health gap	Instances where "health gap" is used to describe the distribution of health.
Health inequalities	Instances where "health inequalities" is used to describe the distribution of health.
Social gradient	Instances where "social gradient" is used to describe the distribution of health.
Systematic variations	Instances where "systematic variations" is used to describe the distribution of health.
Variations in health	Instances where "variations in health" is used to describe the distribution of health.

Economy	Instances where economic concerns are discussed.
Market discourse	The mention of markets or discourses related to markets.
Resources	Instances of discussion about the use or distribution of resources.
Empowerment	Discussions or mentions of the need to empower people. May have links to control.
Epidemiology	Discussions of epidemiology either through training, the use of statistics, the need for it, advantages and disadvantages, etc.
Equality	Discussions about the need for equality in relation to health, and ideas about an equal society.
Fairness	Discussion of the need for a fair society, or policies that promote fairness.
Health determinants	Instances where the phrase "health determinants" is used to identify influences on health. Also when specific determinants are mentioned.
Community	The influence of community on health.
Education	The influence of education on health.
Health education	Discussions about the need for health education.
Employment	The influence of employment on health.
Environment	The influence of the environment on health.
Poverty	The influence of poverty on health.
Health promotion	Discussions around the need for health promotion strategies and particular examples of health promotion.
Healthy public policy	Discussion about the need for policies outside of the DoH to take account of health issues.
Information	The need for and use of information in order to promote or improve health.
Knowledge	Instances where knowledge is discussed, mainly in terms of a lack of knowledge. This is not the same thing as "Information" which is much more related to the need to provide information to the public.
Life course	Discussions about the importance of the life course in relation to health, and in relation to how policies should be targeted and implemented.
Lifestyle	Discussion of the ways in which peoples' lifestyles may impact on their health.
Localism	Initiatives or plans which give much more control to local areas.

Long-term commitment	Comments where long term targets, measures of ideas are discussed or alluded to.
Mainstreaming	Idea of raising health inequality as a mainstream issue for policy rather than a marginal one. Mainly a New Labour term.
Measurement	Mentions of issues to do with measurement in policies.
Modernisation	Discussion of the need to "modernise" health policy. Mainly a New Labour term.
Opportunity	Discussions about the need for opportunities in relation to health issues. May link to choice, control, empowerment, responsibility.
Equality of opportunity	Specific mentions or discussions of equality of opportunity.
Partnership	Discussions about the need for partnerships between different levels in society. Specific uses of the word "partnership".
Policy design and implementation	Comments made about policy design and implementation, either in terms of abstract concerns or comments on the design of particular policies.
Prevention	Mentions or discussion of the need for prevention of ill health or of particular preventive methods.
Public health	Discussions around the definition of public health or the need for it.
Responsibility	Instances where ideas about responsibility for health are mentioned either explicitly or implicitly in the text.
Department of Health responsibility	Specific measures that at the responsibility of the Department of Health.
Duty to help others	Instances where there are mentions about helping other people, either individuals helping others or larger organisations helping others.
Government responsibility	Instances where the Government's role in health is emphasised and its responsibilities noted.
Local area responsibility	Discussions about what responsibilities local government has for health.
NHS responsibility	Discussions about the responsibility of the NHS for health.
Personal or individual responsibility	Sections which specifically mention the role individuals have in maintaining their health including what sort of responsibilities they have.
Working together	Instances where the idea that there needs to be a joint effort to improve health. Similar to partnership but has a much broader meaning.

Risk	Instances where ideas about risk are discussed or mentioned.
Social exclusion	Uses of social exclusion when discussing inequalities. Mainly a New Labour idea.
Social model of health	Discussions about the social model of health and its role in understanding health problems and developing appropriate health policy.
Social networks	Discussions of the importance of social networks in relation to health.
Surveillance	Discussion of the idea of surveillance, or instances where it is felt that the idea of surveillance is mentioned implicitly as well as explicitly.
Targets	Instances where targets are discussed (might not always include all instances of actual statistical targets). More focused on ideas about the need for targets, or any quasi-theoretical discussions.
Wellbeing	Any mention or discussion of the idea of "wellbeing" in relation to health and health policy.

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