



Sharpening the health policy analytical rapier

Comment on “The politics and analytics of health policy”

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Abstract

This commentary on the Editorial ‘The politics and analytics of health policy’ by Professor Calum Paton focuses on two issues. First, it points to the unclear links between ideas, ideology, values, and discourse and policy, and warns that discourse is often a poor guide to enacted policy. Second, it suggests that realism, particularly ‘programme theory’ are useful tools for health policy analysis. ‘Market reform’ cannot be reduced to a simple ‘four legs good, two legs bad’ verdict, and programme theory might suggest that certain mechanisms may be good for one outcome in a particular context, but bad for another.

Keywords: Health Policy, British National Health Service (NHS), Discourse, Realism

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Sometimes titles do not give much away. ‘The politics and analytics of health policy’ could cover a very wide range of issues. In this article Calum Paton (1) *does* cover a wide range of issues in ‘breadth’ rather than ‘depth’ terms, making many interesting points in a fleeting fashion without having the time or space to develop them further. I am not fully certain what his main ‘take home’ message is, apart from: positivism and neo-liberalism- bad; political science, interdisciplinary study, Hirschmann- good. I have selected from this broad canvas two issues to focus on.

First, Paton discusses ideas, ideology, values, and discourse, but it is not clear whose. He writes that there is a difference in attitude on the part of the *majority* towards collectivism and individualism in access to, provision of and financing of healthcare, and that ideology can shape institutions: approaches to change can affect how politicians *and other actors* behave within political institutions. However, the links between ideas, ideology, values, and discourse and policy are far from clear.

Most opinion poll evidence suggests that the British population are very attached to the principles and values of the National Health Service (NHS) such as tax-funded and ‘free at the point of use’. However, despite governments’ swearing loyalty to these tablets of stone and invocations of the ‘NHS Constitution’, the NHS has not been totally free at the point of use to most or arguably all of its 66-year history. The latest in a long line of Baldrick-line ‘cunning plans’ call for (further) charges in the NHS such as ‘membership’ charges and ‘hotel’ costs, but the NHS is not a gym or a hotel. The implications for policy analysts are how to understand the links between public and policy-makers’ ideas and values and institutional change, and for activists of how to ensure that public values are taken into account in policy making. Perhaps an ‘iron law’ of the NHS is that there is an inverse relationship between the importance of a topic on paper and in practice. The NHS has

‘talked a good game’ on ‘patient and public involvement’ for many years, but the mantra ‘no decision about me without me’ probably vies with ‘we are all in this together’ as the most inaccurate description of current government policy. This is a particular problem when ‘technocratic’ solutions or ‘evidence-based policy’ clash head on with public wishes. For example, evidence may say fewer and larger hospitals, but many communities do not wish to lose ‘their’ local hospital. Similarly, RCTs may say that homeopathy is of little value, but some ‘consumers’ value it greatly.

I am not convinced that ‘discourse’ is a reliable guide to policy. As a mere policy analyst rather than linguistic expert, I prefer to look at what governments do rather than what they say. Paton states that the dominant health policy discourse is now of the market. However, in my view, British governments tend not to say that they wish to ‘marketise’ or ‘privatise’ the NHS [whatever that means- see (2)]. For example, in office, Labour did not favour the ‘M’ and ‘P’ words, and now in opposition, suffers severe policy amnesia, saying that the Coalition has begun to marketise and privatise the NHS, but most commentators point to policy evolution rather than revolution between Labour and Coalition health policy (2,3). Second, Paton discusses the so-called positivist or ‘quantitative’ approach. In particular, he claims that the ‘extreme positivist’ approach has been exemplified recently by research in England which has been used to argue that market forces are beneficial in public healthcare systems on the basis that ‘competition saves lives’. He is correct that correlations without causality are dangerous. However, I wonder if this is an example of ‘shooting the messenger’? Would he be equally critical of quantitative research that (say) links inequality and poor health, or ‘capitalism kills’?

Paton is correct to criticise both crude positivism and ‘anti-positivism’/unhelpful relativism. In my view, an appropriate course to steer between these two treacherous reefs is

realism, or at least 'realism-lite'. Although Pawson and Tilley's (4) famous equation of $C+M=O$ has been reduced to a meaningless mantra by some subsequent commentators, the essence that mechanisms interact in complex ways to achieve outcomes should be noted. This means that 'programme theory' of plausible accounts should be constructed for the quantitative examples above (competition saves lives; capitalism kills). Similarly, 'one size does not fit all' ('organisational copy-cattism' in Paton's terms) suggests that the search for the universal organisational fix or simple policy transfer is likely to be fruitless.

However, it also suggests that a crude favouring of or opposition to 'market reform' may be too simplistic. First, although markets may be dominant in the policy mix, it is necessary to take note of the remaining hierarchy and network elements. The NHS is not a one club market golfer, although it may favour that club over the others in its golf bag. Second, the term disguises a large range of mechanisms in different contexts that may have more impact (positive or negative) on different outcomes. Gingrich (5) challenges the highly ideological debate over markets, arguing that the focus on the 'good' or 'bad' effects of markets obscures the reality of what markets do [see also (3)]. Rather than a simple 'four legs good, two legs bad', programme theory might suggest that certain mechanisms may be good for one outcome in a particular context, but bad for another. In this sense, criticism of market reform needs to be an analytical rapier rather than an ideological bludgeoning club.

In conclusion, Paton raises important issues concerned with 'the politics and analytics of health policy'. As interest (and funding) moves to increasingly quantitative, technical, and 'value-free' 'health service research' which is in danger of telling us the price of everything and the value of nothing, he is correct to remind us of the value of this important and increasingly neglected area.

Ethical issues

Not applicable.

Competing interests

Author declares that he has no competing interests.

Author's contribution

MP is the single author of the manuscript.

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