POWER POLITICS & RESEARCH: A DISCOURSE ANALYSIS OF HEALTH RESEARCH POLICY
Paper 1: Language, Ideas and Policy symposium

Sara E Shaw
Senior Fellow, The Nuffield Trust, sara.shaw@nuffieldtrust.org.uk
Honorary Senior Research Fellow, University College London

ABSTRACT
Social research and related policy involve more than the simple generation and use of knowledge and can be thought of as political exercises, laden with power relations and shaped according to the priorities of particular institutions and individuals. This paper explores the means by which one such area - health research policy - is shaped, enabled and constrained by such relations unpicking the historical, social and political origins of research policy in primary care in England, the key discourses that have dominated debate, and the tensions between such discourses. Using discursive data drawn from sixteen interviews with historical and contemporary policymakers, twenty-nine policy documents and a range of historical literature, the paper reveals how prevailing discourses, ideologies and power relationships work to shape health research policy and, ultimately, the type of research undertaken, by whom and how. For instance, recent policy has been shaped by discourse associated with the knowledge-based economy that emphasises microscopic ‘discovery’, effective development and exploitation of information and the contribution of highly technological activities to ‘UK plc’. Whilst this carries seemingly innocent messages about scientific research, it has a deeper significance in shaping ideas about what might be perceived as ‘worthwhile knowledge’ and framing health research in terms of, for instance, pharmacological and pharmacogenetic development. Such insights challenge apolitical accounts of health research, generate an alternative view of the relations that shape social research and policy and reveal how health research serves particular interests.

INTRODUCTION
Health research policy can be thought of as a political exercise, laden with power relations and shaped according to the priorities of particular institutions and individuals. In this respect, it is like any other area of social policy characterised by ‘a set of shifting, diverse, and contradictory responses to a spectrum of political interests’ (Edelman 1998, p16). For instance, researchers and policymakers question mismatches between national policy initiatives and the varied assessments of research priorities and allied funding.

Considerable energies are then devoted to developing health research policy. However, remarkably little research is undertaken to illuminate how policy is formulated and enacted. In this paper, I aim to address this, exploring the means by which one area of health research policy – that of primary care research - is shaped through the policy process. I employ a policy-as-discourse approach (Bacchi 1999; Shaw 2010), acknowledging that social problems become identified and addressed through the varied activities of interest groups. In adopting such an approach, I unpick historical, political and social origins of research policy in primary care in
England, the key discourses influencing debate, the tensions between such discourses and the implications for those involved.

THE DEVELOPMENT OF POLICY PRIMARY CARE RESEARCH

The field of primary care ranges from first point of contact to everything outside of hospital, encompassing a range of disciplines and professional groups. As such, it reflects complex intersections between science (represented by psychological, physiological and pharmaceutical interventions) and the humanities (as represented by the social contexts, beliefs, narratives and shared mythologies) (Carter & Elwyn, 2003). In this sense, primary care research provides a useful example to explore how and why health research is shaped and moulded and is relatively under explored. However, there is also much that makes primary care research distinctive. In particular, the applied and context-bound nature of primary care research generally requires diverse, interdisciplinary research teams and addresses fundamentally different types of research questions from those relevant to areas such as hospital medicine.

The establishment of the Royal College of General Practitioners in 1952 provided the institutional foundations for what we now know as primary care research. It has since been shaped by diverse political, clinical and professional forces. The financial crisis of the 1970s is an important starting point for considering recent transformations in primary care research policy. This is because the broad policy response to the crisis facilitated economic liberalisation and the orchestration of contemporary science policy (Elzinga & Jamison, 1995; Stein, 2002), as well as linking of science and technology to industrial innovation and academic research to commercialisation (Barben, 2007; Demeritt, 2000). Primary care research received little targeted government attention during this time. However, from the late 1980s successive governments’ strategies for a primary care-led NHS, combined with the perceived need to ‘procure evidence’ to support developments, meant that it became more visible as part of the policy agenda. Such shifts have been accompanied by increasing funds for health research and the infrastructure needed to support it. From the mid-1990s this political impetus has helped to secure increased funding for primary care research (Mant, 1997). More recently a National School for Primary Care Research has been established.

Recent policy shifts embodied in the publication of a government health research strategy (DH 2006), reflect increased emphasis on the development of the UK as ‘knowledge-based economy’ (Shaw & Greenhalgh 2008), political concerns with science, technology and innovation (Demeritt 2000; HM Treasury 2004) and governments’ growing demand that the science budget supports research of relevance to wealth creation in the UK economy (Stoneman 1999). Health research is now regarded as an important means of generating wealth as well as delivering health improvements (Academy of Medical Sciences 2003; Cooksey 2006; DH 2004b; Hanney & Gonzalez-Block 2006). Fifty to eighty per cent of scientific and technological research now encompasses economic, social, or strategic goals, with government officials and policymakers increasingly focused on the potential means of marrying scientific, economic and social programmes. This reflects a shift away from mono- or multi-disciplinary research undertaken primarily in universities with an emphasis on discovery (mode 1); towards
transdisciplinary, market-oriented research increasingly undertaken outside of university settings and with an emphasis on application and the wider distribution of knowledge (mode 2) (Gibbons et al., 1994). Publicly funded health research now tends to be organized around national ‘mission-oriented’ agencies, such as the UK National Institute for Health Research (NIHR).

Such shifts raise important questions for primary care research. For instance, what kinds of research ‘problems’ are identified and supported? What kinds of primary care research are undertaken and by whom? How do primary care researchers work at the boundaries of policy priorities to address other concerns? And how are tensions between national policies (for instance, between public health and wealth creation) played out and resolved?

APPRAOCH

The study of primary care research policy reflects a broad concern with societal discourse. Such an approach needs to analyse societal discourses in terms of their historical development, account for the interests and values of those engaging with policy, and consider if/how knowledge might be intertwined with mechanisms of political power. Conceptualising policy-as-discourse offers such an approach. Here discourse is about the production of knowledge and evolution of practices through language and interaction, with policy embracing a set of tacit assumptions determined by its relationship to a particular situation, social system or ideological framework and representing a struggle over ideas and values (Bacchi 1999; 2000). Policy is thought of as a set of processes and actions (or inactions) that have some broad purpose (rather than a discrete decision or programme), and embraces both what is intended and what occurs as a result of that intention.

A ‘policy-as-discourse’ approach seeks to understand and explain the means by which social processes and interactions shape different realities (Bacchi, 2000; Fairclough, 2000; Fischer, 1998, 2003); seeks to demonstrate how actions are interconnected and shaped by the social and political context/s in which they take place, and how discourses regulate knowledge of the world and our shared understanding of events (Edelman, 1998). Policy problems therefore need to be analysed qualitatively and in their social and political context (Russell et al., 2008).

Parker’s (1992, 2002) framework for distinguishing discourses was employed to facilitate careful analysis and provide a theoretically relevant starting point encompassing significant conceptual and methodological building blocks (for instance, he describes how discourses are embedded in history which is important to aid understanding of how policy is constrained at different points in time; and three of his 10 ‘criteria’ focus on institutions, power and ideology that are relevant to the institutional structures associated with policy).

Guided by Parker’s framework I began by reading widely, asking questions about the context of primary care research policy and the specifics of policy proposals. This led me to focus initially on three policy documents from different periods (DH 1991, 2004; Mant 1997), exploring what they represented in terms of policy ‘problems’ and how they were situated within a more expansive web of documents. This shaped my final selection of 29 documents covering the period from 1971 to 2005. These drew on the official nature of public policy (such
as government White Papers), as well as a wider range of documents that captured the structural context in which documents were produced (such as House of Lords Select Committee reports). These documents led discursive work raising a number of questions (for instance about who discourses were addressing).

Policy documents represented aspirations to a possible future reality. Hence I also collected first-person narrative accounts of the policy process and its impact on primary care research to allow for exploration of audience reaction and ‘implementation’ issues. Sixteen narrative accounts were drawn from face-to-face, in-depth interviews with a sample of policy stakeholders, broadly representing the Department of Health (DH), pharmaceutical industry, the public and a range of stakeholders involved in primary care research (including general practice, nursing and non-clinicians), one of whom had no experience of research policy; and able to discuss a range of experiences from the middle of the 20th century to 2005. Interviews provided a vital source of data in which to more fully distinguish discourses and helped to reveal, for instance, how different discourses influenced policy development and how varied accounts of individual and organisational relationships, policy goals and implementation unfolded over time.

Guided by emerging questions and discourses, I also sought supplementary contemporary and historical information to facilitate appreciation of socio-political contexts. Additional analytic strategies included ‘interrogating’ texts by applying questions drawn from Parker’s framework (for instance ‘What positions are set up here?’) and comparing and contrasting language to explore how things might be conceived and communicated differently.

FINDINGS

The development of a ‘knowledge-based economy’

Following economic decline of the 1970s, the drive for national economic wealth was reoriented in terms of the creation, production, distribution and consumption of knowledge and knowledge-based products. This vision of knowledge as a major aspect to the economy supported the development of ‘new’ knowledge resources (such as intellectual property) over traditional resources (such as manpower). Since this time, successive UK Governments have sought to manipulate the science system through a series of policy reforms and a growing demand that the science budget should support research that will be of relevance to wealth creation in the UK economy (Stoneman, 1999). This was heightened with the election of the 1997 Labour Government whose revised political and economic agenda focused on science and technology as adding value to the UK economy (HM Treasury, 2004). However, whereas earlier conceptions of economy drew on ideas about efficiency and effectiveness, recent emphases have been about national levels of productivity and large-scale consumption.

The science system has now been positioned as an object to be manipulated in order to produce and transfer knowledge, primarily for economic gain. Comparison to other countries constructs a view of what is considered acceptable economic performance for ‘UK plc’ and is underpinned by national administrative data relating to, for instance; labour productivity and R&D investment. Part of the reason for this has been the shift to conceptualising economic activity in global, rather than purely national, terms. For instance, the following text from the
Department of Trade and Industry situates the UK as a global competitor concerned with comparative productivity:

‘The UK has stated objectives to increase economic productivity and global competitiveness. The bioscience industry can play a key role in helping to meet these objectives. The US has held the benchmark for a competitive economy and has a clear strategy. It has moved low value-added manufacturing offshore and has focused on creating a knowledge-based economy, with high value-added jobs. This remains the UK’s aspiration’ (2003: 13).

The increased significance of globalisation has bolstered aspirations to develop the UK as a world-leading knowledge-based economy. This has guided policy, facilitating a greater emphasis on science and technology as a rejoinder to national economic competitiveness within global markets.

**Shifting the balance between health and wealth**

The focus on developing the UK as a knowledge-based economy has led to a closer alignment between science and trade and, thereby, to research being identified as an area of potential national economic benefit. Health research was therefore situated within policy as a solution to two problems of ‘health’ and ‘wealth’. However, findings suggest that discourse on the knowledge-based economy largely shapes both. For instance, one DH policymaker described the ‘best indicator’ for people’s health as one where: ‘they are almost fully employed in businesses that they find engaging and satisfying to contribute to’, thereby reframing health benefits in terms of labour.

Since the early 1990s a series of policy statements and reforms sought to overhaul government support for science and technology. One consequence was to bring health research (traditionally situated in the UK Governments’ Department of Health) closer to economic and trade interests (largely situated in the Department of Trade and Industry). Of particular, significance was the 1996 relocation of the Office of Science and Technology as an integral part of the DTI (and subsequently to the Department of Universities, Innovation and Skills and, more recently, the Department for Business, Innovation & Skills). This not only situated ‘trade and industry’ as responsible for science and technology policy generally, but also aligned research more closely with concerns of national wealth creation.

An important event that reinforced this was the requirement for all government departments to produce science and innovation strategies under ministerial guidance and ‘focusing on how they can maximise the potential of science and technology activities and how they can drive innovation’ (Secretary of State for Trade and Industry, 2000: 41). Deriving from the DTI this shaped emergent policy across government departments in line with requirements for developing a knowledge-based economy. Whilst recognising the different departmental programmes of work, key elements required within such strategies included information relevant to research priorities, programmes and procurement strategies as a means of facilitating knowledge production and transfer. The inclusion of these ‘key elements’ shaped the construction of particular policy problems. For instance, the DH Science and Innovation Strategy that then emerged informed policy development for areas such as the strategic development of
genetics, biotechnology and vaccine development; and support for the pharmaceutical industry to ensure the UK remains an attractive base for industry.

Discourse on the knowledge-based economy has been sustained by facilitating linkages between science systems and the private sector as a means of speeding knowledge transfer. Fostering commercial links is thereby crucial, with the contribution of the pharmaceutical industry emphasised as one of the key drivers for developing economic growth via health research:

‘...the medical-pharmaceutical etc. industry is actually a major contributor to United Kingdom plc...it was experiencing more and more difficulties in working with the NHS which should be a really powerful deliverer of health research. And Government clearly wanted to support its industrial wealth component, it wanted to recognise that good health and wealth went together and that this might well be based on the delivery of high quality research’ (Senior DH policymaker, research capacity building).

Whereas considerable detail was provided within policy documents relating to economic benefits, national wealth creation, potential benefits for specific groups or organisations, the development of the UK economy and the potential for increased competitiveness and innovation, very little space or depth was given to the social benefits of the growth of research (beyond the implied benefits assumed to be associated with economic growth). Where documents referred to both social and economic benefits of research investment, these were often broadly conceived – for instance, ‘relating to growth and improvements in public services wherever the opportunities present themselves’ (HM Treasury 2004, p10) – rather than tangible recommendations.

**Scientific colonisation of health research**

The dominance of discourse on the knowledge-based economy meant that science policy began to be conceived differently, playing a key role in sustaining discourse and providing impetus for social, technical and political developments in the field of science and technology to be nurtured to improve wealth creation and quality of life. There was a shift away from earlier scientific models of industrial technology associated with large-scale production and onto microscopic ‘discovery’ and the effective development and exploitation of information. This vision of science has come to frame 21st century health research policy with the principal emphasis being on, for instance, biotechnological, pharmacological and pharmacogenetic development and discoveries relating to nano-technology, molecular biology and biomaterials. This vision dominated the policy documents studied and was frequently portrayed as ‘commonsense’ and the ‘natural’ course of events. However, in constructing science in this way and presenting it as an homogenous space health research policy effectively supported particular approaches, institutions and individuals to the exclusion of others. Examples of dramatic discovery, new knowledge and modernity were frequently intertwined and called upon to reinforce this. These referred to stem cell research and genomics, in particular, though less dramatic examples were also evident. For instance science was described as:

‘...already central to modern healthcare, generating dramatic improvements in childhood cancer, new keyhole surgery techniques, and providing a step change in
research into genetic causes of major diseases.’ (Secretary of State for Trade and Industry, 2000: 2).

Such statements carry seemingly innocent messages about scientific research. However, they have a deeper significance in contributing to what might be perceived as worthwhile knowledge relevant to healthcare.

This vision of contemporary science was evident in recent restructuring of national health research. Two documents explicitly informed recent government policy and the reorganisation of research infrastructure from 2004 onwards; one concerned with academic medical careers (Academy of Medical Sciences, 2003) and the other with the bioscience industry (DTI, 2003). Very little was made of primary care within these and subsequent documents. This indicated the significance of delimited scientific discourse colonising health research. The significance of this was, in turn, recognised by those broadly representing government and general practice. It was summarised by one senior academic general practitioner reflecting that the development of primary care research has been made:

‘more difficult [with] the enormously exciting growth of biomedicine: the gene laboratory-based science, huge technology, and wonderful advances that are world study’.

This was seen to encourage particular routes to change with the diversion of ‘an ever-increasing amount of attention, emotion and resource to that kind of research’.

Discourse on the knowledge-based economy perpetuated this vision of science through the use of data such as bibliometrics to substantiate cross-national comparisons and inform UK policy relating to competitiveness and productivity. For instance, one White Paper referred to the UK as having 1% of the world’s population, 4.5% of the world’s science and 8% of the world’s scientific papers (Secretary of State for Trade and Industry, 2000). Such use of journal citations facilitated measurement of productivity at a national level whilst hiding meso- or micro-level practices and thereby the heterogeneity of scientific endeavour. Such analyses indicated the UK’s position in relation to other countries but presented a decontextualised version of scientific activity that, for instance, hid particularly strong areas of medical or social science research, the context in which they were undertaken, by whom and their impact on changing practice. For primary care research, the mutual support between delimited discourses of science and knowledge-based economy has meant that the system within which it is operating is predisposed to basic science and quantitative measures relating to productivity and return on investment.

**Primary care as a strategic resource for clinical research**

From 2004 UK health research policy has undergone considerable reorientation in line with the vision to develop the UK as a world leader in clinical research. As one interviewee reported:

‘all of those reports have come up essentially with the same conclusions...their vision is that the UK is the most important place in the world to do clinical research’ (Senior representative, UK pharmaceutical industry)
The establishment of a UK Clinical Research Collaborative by the government in 2004 was a means of facilitating this vision. The emphasis was on large-scale, multi-centre trials organised around ‘managed’ clinical research networks. Such emphases shaped the means by which (a) health research is undertaken (with randomised controlled trials remaining the perceived most effective means of investigating clinical and pharmaceutical concerns); and (b) who undertakes it (with quantitatively skilled, clinical scientists located in centres of excellence seen as most able to deliver this).

Documents studied from 2000 onwards assumed a more flexible and accessible clinical trials infrastructure may lead to increased clinical trial activity, which in turn may lead to improved health and wealth. For instance Bioscience 2015 states that:

‘Increasing participation in clinical trials will also play a crucial part in modernising the delivery of healthcare, as protocol driven care improves both patient outcomes and the skills of healthcare professionals’. (DTI, 2003: 9).

Such proposals constructed clinical trials in light of wider policy concerns for evidence-based practice and drug development. This approach to knowledge production was conceived as enabling scientific and economic competitiveness on a global scale, with several documents framing clinical trials as the only means of ensuring knowledge-based decision-making and rapid access of patients to effective therapies. In contrast, there was little acknowledgement of the need for patient input to decision-making or alternative models of healthcare delivery such as shared decision-making with which primary care research is concerned (see, for instance, the work of Elwyn).

The construction of clinical trials as the most ‘natural’ infrastructure for research called into question the multi-method foundations of primary care research characterised, not only by randomised controlled trials, but also epidemiology, cohort studies, qualitative methods, and research synthesis. Increasingly, primary care research is seen not as an interdisciplinary speciality in its own right (considering primary care problems from clinical, behavioural, social and psychological perspectives) but as a sub-discipline within public health or epidemiology. This shift objectifies primary care research, with dominant discourse characterising research on primary care and involving recruitment of patients to clinical trials, rather than research in or by primary care involving multiple methods and approaches. This objectification was reflected by those representing government and industry. For instance, a senior representative from the UK pharmaceutical industry described the NHS primary care system as one of the ‘unique selling points for the United Kingdom’. Drawing on the language of marketing, s/he describes the ‘system’ of primary care as a means of increasing the feasibility of UK clinical research, particularly alongside infrastructure investment in information technology and electronic patient records. In this way, primary care was positioned as an economic and marketing resource, facilitating the recruitment of patients to clinical trials within the new infrastructure. This was further reflected in recent proposals to incentivise research that placed financial rewards for primary care firmly in relation to numbers recruited to trials (DH, 2004).

This positioning was supported through distinctive use of language. Whereas policy relating to the development of UKCRC tended to emphasise the goal of reaching understanding
between key players, policy relating to how the primary care system facilitated clinical research tended to orient to instrumental goals and getting results.

Scientific discourse was also scientistic in that it supported particular approaches, institutions and individuals. This was evident in the prominence afforded to clinical research within policy that not only shaped the work undertaken but also who does it:

‘But we’re in that space now - and this is very important for primary care - we’re in that space now where we are trying to create networks and support mechanisms in some relatively well understood areas but on the way towards trying to create generic structures which would support anybody who wanted to do an important clinical trial in anything’ (Senior DH policymaker, research policy development).

Although this extract suggests a breadth in research infrastructure achieved through developing generic networks, the final sentence reframes this to clinical work. This reflected the problematisation of clinical research within policy generally, with leading roles assigned to clinical scientists (including specialist and generalist academic doctors, as well as those such as physicists working in medical sciences) involved in the production and transfer of scientific and technological knowledge. However, other areas remained unproblematised with little to overtly recognise the full range of clinical and non-clinical researchers (such as economists or statisticians) required to deliver R&D strategy. This was reliant on ideologically based notions of what makes worthwhile knowledge and the production of an ‘appropriate’ workforce.

THE INFLUENCE OF ‘EXPERTS’

While there is more to policy development than the interaction of ‘experts’, they were influential in reproducing, sustaining, or transforming power relations. Several actors appeared frequently and explicitly as contributors to the policy process including DH representatives, as well as wider government and health representatives; several primary care representatives (all general practitioners); with wider representation via academic and charitable organizations. However, difficulties were evident in terms of balancing representation. As one senior academic nurse queried:

‘Are you inclusive and therefore risk being a bit waffley and trying to be all things to all men or do you decide to go for a sharper focus?’.

A ‘sharper focus’ appeared to have been adopted with a number of key individuals located within primary care more closely involved with the production of policy. All were general practitioners suggesting that general practice was the acceptable and representative face of primary care within policy circles. This was reinforced by interviewees citing these same individuals with one senior GP academic suggesting that their own contribution to policy had emerged as a result of being regarded as ‘acceptable’ in terms of fitting within existing organizational and professional boundaries and suggesting that those responsible for seeking policy advice tend to focus on those within existing institutional and political structures.
DISCUSSION

Health research policy is generally presented as an objective and purposeful process, supporting a wide range of activities and interests. Adopting a policy-as-discourse approach, my analysis has presented a different account that challenges apolitical accounts of health research, reveals how health research serves particular interests and generating an alternative view of the relations that shape research and policy. By revealing the influence of the discourse of a knowledge-based economy (the predisposition to productivity and return on investment, and to the basic sciences), findings challenge the perception of health research policy as a value-free endeavour. Instead, I show how primary care research policy is tied up with ideological views of what good research is, what knowledge society wants, and what government’s role is in producing such knowledge. By situating primary care research in relation to discourse on the knowledge-based economy, health research policy has re-positioned primary care research less as an independent enterprise and more as a strategic resource and ‘population laboratory’ for large-scale clinical trials.

Policymaking involves intricate negotiations between officials and unique access to intelligence and where the rest of the population are excluded (Edelman, 1988). Findings suggest that the focus on particular political structures, professional and medical representation, and access to information relevant to policymakers’ decision needs, rules out wider primary care research from this ‘special world’ of policy. This potentially reinforces dominant views of ‘acceptability’: those researchers considered ‘good’ in terms of ideological views of what makes worthwhile knowledge being more likely to become rewarded by being included within policy processes and, thereby, reproduce them.

Findings illustrate the success of population or molecular levels of analysis in contrast to the integrating disciplines that study people in context which have had to struggle to achieve recognition. However, other starting points are possible (for instance, different clinical settings) that may lead to differently conceptualised areas of research. Arguably, the diversity of methods and approaches embodied in primary care research - along with expertise in evaluating complex interventions - provides a greater insight into health, illness and disease-related issues than a focus on clinical issues assessed via clinical research and trial methodologies alone. However, the construction of perceived areas of worthwhile knowledge within contemporary policy has meant that the system within which primary care research is operating is predisposed to basic science and quantitative measures relating to productivity and return on investment. Since completing my research, little has changed in terms of the direction of health research policy and the influence on primary care research. The recent change of government suggests opportunities for change. However, the dominance of specific interests and values within political structures and the continued ascendancy of discourse on the knowledge-based economy suggest that primary care research will be forced to define itself in relation to such discourse.
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