TAKING ACTION ON THE SOCIAL DETERMINANTS OF HEALTH

Insights from politicians, policymakers and lobbyists

SDOHA
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Foreword

A significant milestone in efforts to have Australia take contemporary action on social determinants of health was achieved in March of 2013. With the Australian Government having ignored the 2008 release of the World Health Organisation (WHO) report Closing the gap in a generation: Health equity through action on the social determinants of health, the Labor Party, the Liberal Party, and the Greens, through a Parliamentary Inquiry, agreed in March 2013 that the WHO Commission on Social Determinants of Health report should be ratified by the Australian Government as part of ameliorating the social causes of ill health.

The many involved in bringing about that Parliamentary Inquiry had cause for celebration. It was a breakthrough for tri-partisan validation of social determinants of health to be affirmed by the major political parties in our nation's Parliament, parties drawn from both the left and the right of Australia's political spectrum. There was further cause for celebration in the simplicity of the recommendations the three political parties collectively made; the Inquiry heard complex evidence, heard proposals that engaged whole of government rather than individual portfolios, and the task of deciding what action to take was moderated by a desire to seek a consensus political agreement.

Despite the best efforts of the involved Parliamentarian's and non-government advocates, and a fledgling alliance of national health and social service organisations wanting to build momentum to see the Inquiry's recommendations implemented, there has been little to no action since March 2013 to give effect to the decision of the two main political parties who at all times since Federation have either served as our elected Government or primary Opposition.

There are a set of circumstantial factors as to why momentum has stalled. The sponsoring Minister for Social Inclusion, and the portfolio he served in, are no longer in place. The 2013 Federal Election Campaign was underway at the time of the Inquiry recommendation were made, and the September 2013 change of Government has delivered a new approach to the role of government in relation to people's health. To some these a pretty good reasons to justify absent progress. To me, they suggest we social determinants advocates have yet to find the most effective way of engaging with governments. To me, they suggest we need to find new ways of translating the evidence to better align with government's own operating requirements.

Carey and Crammond's Taking action on the social determinants of health: Insights from politicians, policymakers and lobbyists has a stark message for how the next phase of Australian reform on social determinants is likely to be achieved. They first argue the extent of reform that social determinants advocates have been seeking is out of step with what Australian governments can reasonably deliver. They then argue the siloed departmentalism of Australian government requires social determinant advocates to design their

policy proposal to work within these siloed departments, rather than expecting silos to be swept aside. They conclude by arguing that social determinant advocates should engage in the often emotive ideological reasoning of the contextual political realities, rather than remaining rigidly focused on evidence based positions alone. I'd add that this means in practice arguing to those on the left that social determinants action delivers social justice, and to those on the right that social determinants action enables a growing and more productive economy.

Carey and Crammond's work arrives just at the right time. With the new Government approaching its first year in office, with State and Territory Government's showing genuine interest in what tangible actions they might take on social determinants, it's time for we social determinants advocates to reset our discourse. Carey and Crammond offer an expert informed, independently developed framework for Australian social determinants advocacy to be matured. There is no doubt Carey and Crammond, two next generation academics, will play a key future role in this maturing process.

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Executive Summary

The distribution of social goods like income, education and occupation are key drivers of health and health inequalities. Shifting the distribution of these goods in the direction of greater equity has become a central concern of social determinants of health advocacy. The most prominent strategy for achieving this aim has been lobbying government to enact equity-promoting policy.

Social determinants of health advocacy has struggled to secure the type of broad-scale changes to policy envisaged by key documents such as the World Health Organisation's Commission into the Social Determinants of Health and the more recent Marmot Review of Health Inequalities. This research investigates whether the type of changes being sought, and the methods chosen to achieve them are well-suited to the existing Australian political context.

Participants were chosen from across the policy spectrum, taking in currently sitting politicians, senior bureaucrats and external lobbyists.

The research found that participants were uniformly aware of the social determinants of health evidence and were favourable in their assessment of its accuracy. Despite this familiarity, participants believed that policies to equalise the distribution of the social determinants of health were out of step with both the structural and discursive aspects of the political process.

Structural limitations, such as departmental silos, work against large-scale social change and create system-norms which favour the presentation of problems and policies in a way that fits within departmental boundaries. This is driven by: the pace of political and policy decision-making, accountability, risk-management, likelihood of gaining traction with politicians and central departments (where 'messy' problems become difficult to sell) and, ultimately, who gets credit for policy and program success. For the social determinants of health, departmentalism necessitates the breakdown of interventions into more manageable initiatives.

These structural realities where found to create discursive conventions which run counter to current social determinants of health advocacy. While bodies like the World Health Organisation have sought whole-of-government change, this type of change was described by participants as beyond government's sense of its own capacity. Securing substantive change therefore requires a strategic approach that begins with small-scale, solutions-focused interventions that can secure early success. This approach will open doors for researchers and advocates and provide them with a more influential seat within policy agenda setting and decision-making processes.

Finally, the research found that advocates and researchers should not shy away from adopting 'normative positions' or engaging in more and ideological debate. While objective 'evidence-based' approaches have been favoured in recent

years, participants argued that moral and ethical arguments sit at the core of public policy. To disengage with these is to disengage with the issues around with political and policy arguments are fought and won.

Recommendations for those engaged in social determinants of health advocacy and research:

Work within the political and policy structures

- Scale of the problem needs to fit within the remit of specific departments
- Political commitment is often best gained through building community demand for change

Pay closer attention to discursive traditions

- Linear evidence-based policy approaches should be abandoned in favour of a more dialogic approach that embraces philosophical and moral reasoning (alongside evidence)
- The scale of the proposed solutions cannot greatly exceed government's sense of its capacity to act. Larger, structural reform requires slow and strategic introduction via community building and trusted advisors.

Overall, participants were hopeful that action to equalise the social determinants of health could be taken, even by conservative governments, if – at least in the first instance – a targeted, solutions-focused approach was taken that engaged with ideological reasoning.

Introduction

For well over a century, we have known that many of the key drivers of health reside in our everyday living conditions (Rosen 1958, Porter 1999, CSDH 2008). In the last four decades a large volume of research has been amassed which documents the varied ways in which social, economic, political and cultural environments impact upon health. The term 'social determinants of health' has come to refer to any social condition which has an effect on health.

The evidence on the social determinants of health has prompted calls for widespread political action. Led by the World Health Organisation, public health has sought political action on the social determinants of health at both a national and global level (WHO 2008). However translating the desire for action on the macro-level determinants of health into political reality has proven challenging. The "complex and shifting rationalities of public policy-making still largely elude" health researchers, creating barriers to change (Clavier and de Leeuw 2013: 15). Policymaking is a complex, iterative and contextually embedded process – not a linear one.

Greater awareness is needed in population health research regarding the policy and political processes broadly, and specifically deeper knowledge of how those concerned with improving the social determinants of health can best navigate it. Increasingly the challenge for social determinants of health researchers is not documenting the evidence, but better understanding the policy process. This is a 'crucial next step' for the social determinants of health field.

The research presented in this report builds upon this knowledge by turning attention to the 'practice' of policymaking. This focus is consistent with the move in public health to developing 'practice-based evidence' as a means of closing the gap between research evidence and practice (Gabbay & May 2011; Green 2008; Horn et al 2010; McDonald and Viehback 2007). By turning attention to the practitioners of 'the art of government', this research provides insight into how upstream change for the social determinants of health can be secured.

The conceptual starting point for this research is the policy process itself, and how those who operate – at different levels and from different vantage points – within the policy process understand and negotiate it. The research aims to understand the nature of government and policymaking from the perspective of policy actors working in areas that impact the social determinants of health. Our sample included politicians and policymakers across diverse portfolios within government, along with private and not-for-profit lobbyists – all of whom are engaged in political agenda settings and policy action (Kingdon 1984). Through exploring the policy process, we examine how social determinants of health discourses align with existing policy processes in the Australian context.

The Research

Our sample included politicians and policymakers across diverse portfolios within government, along with private and not-for-profit lobbyists – all of whom were engaged in political agenda settings and policy action (Kingdon 1984).

Qualitative semi-structured interviews were conducted with 21 policy 'practitioners', including: former federal and state ministers, shadow ministers, senior advisors to government, senior current and ex- public servants (e.g. Secretaries and Deputy Secretaries) in areas including: Treasury, Finance, Prime Minister and Cabinet, and Education.

A range of high profile lobbyists were also identified for inclusion in the study, on the basis of their having achieved success in creating policy change in the following areas: education, disability, welfare policy, health, and public health. Hence, many participants had direct carriage for action on specific social determinants of health (e.g. education and welfare policy). A list of the participants' positions appears in Table 1.

Table 1. Research Participants

Position*	No.
Former or current ministers	2
Senior policymaker	7
Lobbyist	10
Senior Policy Advisor	4

** Some individuals are accounted for more than once due to career changes*

Participants were provided with a one-page description of current social determinants of health work, drawing on the WHO Commission on Social Determinants of Health Report (CSDH 2008) and the Marmot Review (Marmot et al 2010). During the interviews, participants were asked to reflect on the policy process, and the nature of government and politics. Based on that reflection participants were asked to evaluate the 'fit' and potential of the social determinants of health discourse and evidence to motivate policy change. Interviewees were also asked to describe how they would approach lobbying for political and policy change on the social determinants of health.

Findings

The research drew on Kingdon's (1984) model of political agenda setting. This model depicts three streams running through the 'policy system':

- **Problems** – the problem stream is concerned with how certain issues are brought to the attention of policy actors
- **Policies** – the policy stream refers to the set of solutions from which policy actors can select to address the problems that have gained traction and are seen as requiring action
- **Politics** – the politics stream is composed of issues occurring in the wider environment of policymaking (such as national mood, community concerns, normative ideological positions) – that shape whether issues are understood to be 'problems' and what policy options are thought to be possible and palatable

When these streams come together a 'policy window', or opportunity for action, is created.

Consistent with Kingdon's model, participants identified barriers relating to the problem (how the social determinants has been framed as an agenda for political action), policy (the nature of government and the policy making process) and politics. Within each of these streams structural and discursive elements were identified (see Figure 1.).

Fig 1. Structural and discursive challenges

	STREAMS		
	Problem	**Policy**	**Politics**
Structural dimensions	Accountability & rewards	Government silos & departmentalism	Community concerns & political incentives
Discursive dimensions	Pitching the problem/ solution	Non-linear policy processes	Normative positions

In contrast to Kingdon's (1984) model, we found that the three streams were entwined through structural and discursive interdependencies. Creating change was not seen in terms of waiting for a policy window to 'open', but required actors to work within the structural constraints and discursive conventions of policymaking, through which opportunities for action would be built over time.

Structural Dimensions

The existence of government silos has been widely commented on in both the public health and broader policy literature, where they are seen as barriers to effective policy (Marmot et al 2011; (Marmot and Wilkinson 2006, Raphael 2006); Kickert et al 1997). Efforts have been made in a range of fields to break down these silos: Health in All Policies is the most recent attempt in social determinants of health and there have been joined-up/whole-of-government programs in everything from crime (Homel & Nutley et al 2004) to housing (Department of Family and Community Services 2005).

Participants emphasised, in contrast, that departments exist for a reason: they enable governments to break down the complexity of citizens' lives and thereby simplify the task of governing.

> *It is quite contrary to the way that governments are structured. Governments deal with all aspects of our lives... and they do that by creating departments. [P11]*

> *The causal processes [of the social determinants of health] are diffuse... they are diffuse processes of the interaction of people and their environments and those processes and those models of causation don't fit with the way that government sees the world. [P8]*

They argued that there is a need to acknowledge, and work within the constraints of, departmentalism; departmentalism reflects the structures through which governments are able to provide for their citizens. Moreover, while joined-up government might be preferable, it is prohibitively difficult to create on a broad scale. This is not to say joined-up working does not occur, but rather major interventions that aim to reform policy-making processes in a joined-up manner are extremely difficult to implement effectively:

> *We run in silos, we're trying to get cross-departmental stuff happening, but this is walking, talking chewing gum – walking and talking in five languages – and chewing gum. [P1]*

> *You might say government doesn't work the right way and that's the problem... [but] the reality of what [policymakers do] when they go to work on Monday mornings [is] deal with the infrastructure of government, the conventions and the routines of government, the way in which decisions and advice is sought, the way in which policy [is] shaped within the structures that are. [P2]*

This is consistent with the public administration literature, which notes that after sixty years of attempting to break down departmentalism, knowledge of how to create integration is still in its infancy (Keast 2011).

An unavoidable consequence of departmentalism is a desire for problems, policies and programs that fit neatly within departmental boundaries. Consistent with Exworthy's (et al 2008) observations about the unwieldy nature of the social determinants of health as a policy concept, participants' contrasted the narrow accountability of departments with the more 'diffuse' nature of the social determinants of health:

> *Politicians need something where [they can say] 'what am I trying to do here?' and 'how would I know if it happens?'... [so you need to] chunk it down into areas that ministers can get hold of and get some traction on and win some arguments in cabinet. [P10]*

> *The impacts are generally sort of medium to long term [with the social determinants of health], it is often not clear where that credit would lie for them so a particular minister or government can't identify 'we have this outcome'. [P3]*

A number of interconnected needs drive this desire for problems and solutions that can be compartmentalised within the scope of single departments: accountability, risk-management, traction with politicians and central departments (where 'messy' problems become difficult to sell) and, ultimately, who gets credit for policy and program success. While admirable, seeking broader structural change was thought to be unsuccessful because of the culture created by these structural realities:

> *Creating and aligning the capacity to act in an integrated, coherent way on many different levels of government and across the many different functions of government...poses the biggest challenge ...because it's not how government thinks of itself... It's very very difficult for them to conceptualise a process of integrated change. [P8]*

> *We do everything incrementally, we break things up into small packages: we avoid the risk of the big thing going belly-up so the Minister or the public servant or the department will be embarrassed. [P19]*

Participants pointed to the risk-adverse nature of the public service, which limits innovation and large-scale, or 'transformative', policy change (see also Matthews and Lewis 2009). Less commented upon in the literature, however, was the suggestion that governments' 'sense of its own capacity' is a significant barrier. Again, this statement draws attention to cultural constraints placed upon innovation within government, which is becoming an area of significant interest to public administration researchers (Lewis, Considine & Alexander 2011). To date, this research has demonstrated that innovation within the public service is incremental and difficult (Lewis et al 2011), though not impossible (Mathews and Lewis 2009), to achieve.

Until this point, analysis has concentrated on public service-led change, which we might conceptualise as being 'bottom-up' change within government. Participants also described the need to create 'top-down' change through politically motivated action. Political action was seen as more likely to secure transformative change than efforts targeted at public servants:

> *You are never, ever going to get the silos of government to take shared responsibility unless you have prime minister or ministers' ... in place. [P4]*

Gaining this top-down support would require researchers to build community momentum, rather than appeal directly to policymakers or politicians:

> *Politicians don't care if the community isn't pushing them. It doesn't matter how strong your argument is, if it's given to a politician in the closed confines of the politician's room and then they go outside and people are complaining about the level of [tax] ... then that's what they'll listen to. [P19]*

Similarly, another policymaker reflected on their experience of being told by politicians and political advisors to not bring forward policy ideas based (solely) on scientific evidence:

> *We were told by an incoming minister... very clearly that we didn't need to bother to come forward with anything ... unless it was (a) already part of the party's policy, [or] if it was outside of that then (b) we needed ... a compelling case not based on the science but on what the impact would be in marginal seats.*

> *[Just because] something might be printed in the New England Journal of Medicine, or the Lancet or the BMJ ... it wouldn't get the time of day unless it was accompanied by market research that showed what the impact of that would be in marginal seats. [P5]*

Hence, political structures mean that evidence takes a back seat to issues that will win votes.

Participants explained that these political and policy structural realities create discursive conventions, which govern how problems and solutions need to be framed in order to gain traction across problem, policy and politics streams.

Discursive Dimensions

'Discourse' refers to bodies of language that are unified through shared assumptions. It is similar to 'ideology', but is not necessarily concerned with politics or class.

Reflecting the turn towards discourse, which has occurred in the public policy literature in the last decade, (Scollon 2008, Fisher 2003) participants identified the ways in which evidence and arguments are presented as being at least as important as the evidence itself when seeking to achieve policy change. More specifically, they argued that the way the social determinants of health is put forth as a 'problem' for political action needs to align with the structural dimensions of the policy process outlined above and also provide social determinants of health advocates with a seat at the policy table.

Consistent with previous research on political action on the social determinants of health (Baum et al 2013, Exworthy 2008), the scope of the problem was seen as prohibitive to action:

> *What's the outcome you want? It's a very nebulous outcome. So for me it's sort of like, you could say they are already doing it. People's smoking rates have dropped, that's good. And you're talking generational change, you know this isn't going to happen overnight. The whole timeframe, the whole horizon for the policymakers needs to be nuanced enough to work on the small changes, the doable changes now, while keeping the long term in mind. [P1]*

Instead participants argued that the 'problem' of the social determinants of health needed to be 'broken down' into parts, which correlated with the structures of government. That is, they needed to fit within specific departmental boundaries and – by extension – accountability and incentive structures:

> *Lobbying always works best when it's very ... targeted and a fairly discrete issue. So it's contained within a portfolio and you can lobby a particular minister and there are very clear interest groups. And you can sort of trace the causal... chain from a policy or initiative to an outcome, so it is clear who gets the credit. [P3]*

> *Within that environment, a successful advocacy initiative for social determinants chunks up the different bits. It gets the evidence of which intervention works for who, and it then takes those individual interventions to those appropriate parts of government that are looking for the solution. [P4]*

Participants viewed government as having limited policy options, which are often smaller in scale than those proposed within the social determinants of health literature. As well as 'breaking down' the problem to fit within departments, participants also felt that the scale of the solutions had to align with what is seen as achievable:

> *The challenge we've got is that very often the advocates, whether they are individuals or organisations, often make the most bold leaps from the evidence they have collected to public policy ... You have to make sure there is a move from the evidence collected to what the policy options are that are available to government". [P20]*

Hence, advocating for changes that are beyond government's sense of capacity to act was thought to be unproductive. Policy options must be advocated for well before action is required to build the receptiveness of policy actors and the community (Kingdon 1984).

In addition to being amenable to action by single departments and seen as 'do-able' by government, participants felt there was a need to put forth solutions and take a constructive approach:

> *...it's important to look for some early wins. Politicians, like anyone else, want to get some wins on the board... a lot of the longer term aims are just a bit sort of out of reach at the moment. So identify something that could be done within the shorter term that would get some runs on the board, give them some credibility. [P3]*

> *If you're always running into a friend or colleague who is continually giving you shit...you kind of avoid them. I think that the psychology of the social determinants of health, I think a lot of it is very negative about what governments aren't doing. So the challenge is going to be how you get people who are concerned and are of good faith to get that perspective seeded more in government, into those opportunities where they are more listened to. [P2]*

The importance of offering solutions in political debate has long been considered as important as establishing what the problem is.

Previous research on the social determinants of health has found that policymakers prefer (and need) more solutions (see Baum et al 2013). Participants in this research described solutions as not simply desirable, but as prerequisites to engagement with the policy process. That is, constructive solution-based approaches would open doors for researchers and advocates and provide them with a more influential seat within policy agenda setting and decision-making processes.

Without solutions, advocates were not seen to be relevant to decision-making. Hence, starting with discrete, solution-based approaches could enable social determinants of health advocates to gain access to the influence they seek. If their proposed interventions are seen to be successful, then advocates will have positioned themselves as useful and trustworthy sources of advice. From this, participants argued, more structural and wide reaching change could be sought. Insights from participants suggest that the 'practice of policy' requires a highly strategic approach, which requires a long-term strategy based upon a vision of incremental change.

Finally, participants argued that greater recognition and understanding of the 'messiness' of policymaking was required for those seeking to influence change. Increasingly, there is a shift away from linear models of policy making, such as 'stages of change' (i.e. where the policy process follows distinguishable steps) (Sabatier (2007; Carver & DeLeeuw 2011). While such models can provide useful 'mental maps' for policy actors (i.e. to think through actions), they are now widely regarded as being highly divorced from practice (deLeon 1999 – see Carver & de Leuw).

Policymaking is now understood to be messy, involving dynamic relationships between multiple stakeholders, institutions, traditions, conventions and contexts (Sabatier 2007). Consistent with these shifts, our participants criticised evidence-based policy paradigms, where 'evidence gaps' need to be overcome through the refinement of research evidence and better uptake by policymakers (Russell et al 2008):

> *[People] imagine [that policy development involves] collecting evidence and then conceptualising it, analysing it, synthesising it, developing it into a range of policy options [which are then] presented to a minister who would choose between those options. ... And then it would be delivered. Next... would be to engage in the evaluation... That doesn't happen. The nature of public policy tends to be very iterative, opportunity driven, highly responsive to events. [P20]*

> *The uselessness of that world view of decision making: [The view] that if researchers and academics work closely with bureaucrats and or politicians and convince them that their evidence, the evidence from research, is robust and provides a basis for change, then change will happen. [P14]*

While reports on the social determinants of health have emphasised the objective, evidence-based nature of the field and the problems identified (WHO 2008, Marmot et al 2010, Wilkinson & Pickett 2009), interestingly our participants argued that separating evidence from moral 'normative' positions was a mistake. Rather, they advised that social determinants of health advocates should utilise and engage with ethical and moral arguments about inequality:

In terms of having a more equal fair egalitarian society is rarely going to be driven by health in the cabinet room. It is driven as an objective in its own right. [P21]

I think the instrumental arguments are the weaker arguments for reducing inequality. I think in some sense the use of them has portrayed a lack of confidence among many advocates in the sort of core moral principles. I think the right argument is [it's the right thing to do], not 'let's reduce inequality because it will reduce crime'. [P16]

As soon as a senior official, a minister or an advisor to a minister sees data they kind of switch off. The power to persuade... is not based upon evidence. It is based upon constructing an intellectual appeal and coherence of argument. In some ways it is more philosophical. [P7]

Moral and ethical arguments were understood as sitting at the core of public policy. As Kingdon (1984) suggests, policymaking is a contest over ideas and worldviews. To not engage with this contest is to sidestep the ground upon which policy arguments are fought and won. Moreover, policymakers and politicians were said to make assumptions about the normative positions of researchers and advocates if they were not declared. This breeds distrust, leading 'evidence-based' advice to be discounted:

A lot of academics in my experience... find it quite hard to draw distinctions between normative positions, which get reflected in advocacy work,... and the so called objectivity [of research]... Academic research and think tank work and advocacy work that uses evidence to try and make a case can in the end shoot itself in the foot if it is associated with a normative position [without declaring it].

My solution is not to de-couple [evidence and advocacy]... I think the approach is to critique the notion of evidence-based policymaking and to get behind the notion that public policymaking is about ethics and reality. The philosophical cannot be ignored and it cannot be circumnavigated by data and analysis. [P7]

Several participants argued that creating political action requires one to present a vision of the future, which policymakers do through speeches and language – or rhetoric. Rhetoric, in the original sense, refers to the use of moral political discourse for the purposes of persuasion (Keith & Lundberg 2008; Russell et al 2008). In doing so, politicians use normative positions. Hence, if policy making revolves around ethics, morality, and different understandings of 'reality' and what should be done (i.e. normative positions), social determinants of health advocates need to engage with and use ethical and moral arguments. They are part of the context of policymaking.

Conclusion

Much of the literature on the barriers to political action on the social determinants of health centre on the question of evidence (Petticrew 2004; Brassalotto; Marmot 2010). Here, action on the social determinants of health is seen as being constrained either by: an inability to get evidence into policy and practice (i.e. knowledge translation), or the need for further refinement of the evidence itself:

> The evidence on its own does not provide a complete recipe for success, nor an imperative for action. The evidence needs further refinement if it is to be useful in everyday practice (Kelly et al 2004: 14).

In contrast to these perspectives, our participants were aware of, and conversant in, the social determinants of health literature. They did not contest the reliability of the evidence or its persuasiveness and they did not discuss traditional knowledge translation barriers. As summed up by one participant:

"[They may] not be thought of in the terms that you use, but the notion of these linkages within society and how society works is pretty well appreciated. The notion of the interconnectedness of it all I think is very well appreciated. That there is a relation between social determinants of health is pretty well know" *[P21].*

Baum, Lawless and Williams et al (2013) suggest that where the social determinants of health are understood by policymakers, they are seen as 'conditions', rather than 'problems' (see also Dahlgren and Whitehead 2006, p.15). In contrast, participants in this research saw inequality and its impact on people's lives as a 'problem' that warranted policy solutions. The barrier to action on the social determinants of health was seen instead as a misalignment between the messy reality of the policy process and the efforts of social determinants of health advocates. The type of evidence which exists, the way it is framed in policy proposals, and the way it is presented by researchers and advocates all reflect a belief that providing enough evidence of the problem will be sufficient to spur political action.

In Kingdon's (1984: 20) theory of political agenda setting, the three streams – problems, policy and politics – are thought to be "largely independent of one another, [with] each develop[ing] according to its own dynamics and rules". In contrast, our participants conveyed a view of policymaking and agenda setting where streams were intertwined with, and interdependent upon, one another.

For example, how problems are pitched discursively needs to correspond with accountability and reward structures, which are determined by the structure of government (e.g. departmentalism) and the political system (where politicians need to gain the favour of their constituents by acting on their immediate concerns). Without continuity across streams, at both a discursive

and structural level, the chances of securing change were seen to be limited. This means proposed actions to improve the social determinants of health needs to be 'broken down' so they can be communicated in ways that 'fit' discretely within government departments. Furthermore, solutions need to be conceptualised in ways that do not jar government's sense of its own capacity to enact reform.

Advice for future action

Based on our findings, we provide a number of recommendations for securing political and policy commitment for the social determinants of health:

1 Work within the political and policy structures

- Scale of the problem needs to fit within the remit of specific departments
- Political commitment is often best gained through building community demand for change

2 Pay closer attention to discursive traditions

- Linear evidence-based policy approaches should be abandoned in favour of a more dialogic approach that embraces philosophical and moral reasoning (alongside evidence)
- The scale of the proposed solutions cannot greatly exceed government's sense of its capacity to act. Larger, structural reform requires slow and strategic introduction via community building and trusted advisors

Much of the existing advocacy for improving social determinants of health imagines a policy process more logical and more rational than the one that exists. The politicians and policy makers in this research, in contrast, encourage social determinants of health advocates to find ways of working within the currently segmented, non-linear and values-based process. Following this advice should lead us to ask not 'what are the barriers to implementing social determinants of health policy?' but rather 'which pieces of social determinants of health evidence are most relevant to policy?'.

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