GUIDED BY RESEARCH OR A STAB IN THE DARK: THE IMPACT OF HEALTH INEQUALITIES RESEARCH ON BRITISH PUBLIC HEALTH POLICY CREATION

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ABSTRACT

While health is recognised as a characteristic of British citizenship under the protection of the government, from the 1980s, health inequalities have widened in Britain. Due to the complexity and scale of the topic, this research focuses on the policy impacts of two research reports focused on health inequalities: the Black Report and the Acheson Report. Despite embracing these two polemical research papers, administrations in power never adhered to the radical goals offered by researchers. This raises the question: to what extent did government health policy take account of research on health inequalities in the period 1980-2000? This research devises an original long-term assessment of the political and policy impact of public health research in late 20th-century Britain. Through a review of interdisciplinary literature and a close reading of policy papers, research papers, and debates, this research investigates factors which influenced the government response to health inequalities. Several factors are considered in this paper, including the research agenda, the alleged apolitical stance of researchers, and the unrealistic proposals suggested by reports. The policymaker's agenda is also explored, and the influence of the distinctive political circumstances surrounding the release of each report. Understanding the lessons that researchers learned about the differences between the research and political agenda is crucial to understanding the impact that this could have on the translation of research findings into policy and practice. This remains relevant today as the COVID-19 pandemic has reignited a new urgency to deal with rising health inequalities today.

INTRODUCTION

This article seeks to investigate the factors that impacted the extent to which the government of the United Kingdom used research on health inequalities in their implementation of public health policy from 1980-2000. This research will supplement the established scholarship by analysing new sources. The focus of this investigation will be on two reports that centre on health inequality and were commissioned to inform health policy: The Black Report (1981) and the Acheson Report (1998). Many have analysed the reports individually, but by exploring the reports over two decades this article highlights factors which transcend individual administrations. The existing scholarship tends to only investigate either the research agenda or the policymaker's agenda. The separation of these factors fails to allow for analysis of the interaction between the two groups, as the researcher's apolitical stance and unrealistic proposals coupled with the distinctive political environments and agendas of each government all impacted the use of research used within health policy creation. Thus, this article will bring these two perspectives together to offer new insight into the use of research within public health policy.

The Inequalities in Health Working Party Report, also known as the Black Report, was chaired by Sir Douglas Black, and published by the Department of Health and Social Security (DHSS) in 1980 (Townsend and Davidson, 1992). An Independent Inquiry into Inequalities in Health, chaired by Sir Donald Acheson, was published in 1998, and is referred to as the Acheson Report (Acheson, 1998). A wealth of research and policy on health inequalities was developed from 1980-2000; this article will use these sources as a focal point to provide succinct analysis and comparison of the governments' responses. As both reports reach similar policy suggestions, they allow for a long investigation into factors which influenced the governments' action or inaction with regard to tackling health inequalities through health policy.

Health, despite being a contested and complex topic, has been recognised as a human right since the end of the Second World War. The World Health Organisation (WHO) suggest the public have a right to 'the highest attainable standard of health' while the United Nations (UN) suggest only an adequate level of health is necessary, demonstrating the complex concept of health (Oosterhuis and Huisman, 2014, p. 18). Therefore, health, whether adequate or exceptional, is deemed a human right and a duty of the government to protect.

Health inequalities are defined by Marmot et al. (2020, p. 11) as the 'systematic inequalities between social groups that are judged to be avoidable by reasonable means and are not avoided'. This definition suggests that the health of the individual is impacted by their own behaviour and structural factors which are deemed beyond their control. Many, like Baggot (2011), see health inequalities impacted by socio-economic positioning as an issue of social justice. Therefore, individuals cannot take full responsibility for their health due to limiting factors like income, accessibility to resources and social environment (Barr, Bambra and Smith, 2015). In research, the income inequality gap is one of the most important factors determining the rising levels of health inequality. The work of Wilkinson (2005), a leading researcher, investigated the link between income inequality and health inequality, and proved that in post-industrial countries, a higher rate of inequality (measured by the gap in income between the richest and poorest in society) creates worse health conditions for all, impacting those from the lowest social classes to the highest. Health inequalities are addressed as one factor within this work, as despite being able to measure health inequality in separate conditions like mortality rates, life expectancy and the prevalence of certain illnesses like coronary heart disease, the causes are tackled holistically in public health policy and the accompanying research.

Public health, as defined by Baggott (2012), includes the strategies which governments use to tackle the main causes of

mortality and morbidity within a society. No definition of public or community health is given in the Black Report; however, government documents from 1988 define public health as 'the science and art of preventing disease, prolonging life and promoting health through the organised efforts of society', thus this is the definition against which public health policy is set (Mold et al, 2019 p. 10). Public health changed from being guided by a social-liberal idea of citizenship, in which healthcare is a right, to neo-republican and neo-liberal ideas in which the public have a duty to lead a healthy lifestyle and healthcare is seen as a 'favour' to the public (Huisman and Oosterhuis, 2014). As the topic of health is imbedded in discussions of rights and citizenship, public health is inherently political in nature and sparks debates and remains a polarising subject.

METHODOLOGY

In this article, both the Black Report and the Acheson Report have been analysed with inspiration from the postmodern linguistic turn, focusing on the language to understand reasonings and ideology underpinning the research. This is a popular method within the study of policy analysis, as noted by Fischer and Forester (1993). Bruner (2000) focuses on collective engagement when investigating resources which have been gathered by a group of public health researchers. He proposes a 'community' (Bruner, 2000, p. 2) has been created in the research field; this has allowed for researchers to support, collaborate, and defend each other's work. Rosenzweig and Thelon (1998) attest to the importance of looking to past experiences impacting present reactions: this is helpful in revised editions of reports, as the authors reflect on their own work and the response it gained from the government and public. This community of researchers continually reflects on the past, as demonstrated by the continual reference to the Black Report and its impact on more recent research: for example, in the preface of the Acheson Report. These reports offer not only recommendations, but an invaluable insight into the researcher group as a community, as well as personal testimony on previous failures to implement policy.

This article focuses on the immediate political reactions raised by the reports through the use of debates and health policy which was developed within a year of the Black and Acheson report's publication as evidence of the use of health inequality research within policy implementation. These responses include both official responses such as press briefings and contributions within debates in the House of Commons. The understanding of the research community is investigated through contributions to medical journals, once again using the Black Report and the Acheson Report as key words, and searching for researchers within the community, those who had authored the reports and provided evidence. Other official publications used to inform this research include comments in parliamentary debates; these allow for an understanding of individual politicians' reactions to policy proposals and the research presented.

Witness seminars and personal testimonies have proved to be an invaluable source within the exploration into the researcher's role within policy creation. The two witness seminars used as evidence within this article were held years after the reports were published. Despite a delay of twenty years from each report's initial publication to these round-table discussions, they provide useful insight into the authors of Black and Acheson reports and help highlight their reasoning for the limited use of research in health policy. Politicians have benefited from these delayed discussions: one such personal testimony by Patrick Jenkin (2003), the Secretary of State for Social Services at the time of the Black Report, is a prime example. Jenkin was allowed to defend accusations that he was involved with suppressing the Black Report from the public and parliament two decades after the incident. These personal testimonies allow for reflection, but as John Tosh (2010, p. 93) notes, the historical actors have had time to provide a 'coherent selection of events', which can slightly alter the account, or provide reasoning for actions on reflection. Consequently, these sources are treated with slight caution regarding their factual merit; they are, however, revealing of personal ideas and conceptions of the past. Witness seminars, such as *Public Health in the 1980s and 1990s: Decline and Rise?*, organised by the Wellcome Trust, handpicked collaborators to discuss historical events in which they were either participants or witnesses. These events have been described by Berridge (2003) as 'a group exercise in reminiscence', as they offer opportunities for individual memories to be applied in the context of official events, like the Thatcher administration's alleged suppression of the Black Report. However, Wineburg (2001, p. 250) warns of this collective approach leading to 'reductionism and essentialism', as a group creating a collective memory can override the nuances and multiplicity of individual experiences. Therefore, the use of structured policy reports reveals both personal and political opinions, found mainly in reports' forewords and introductions. Debates in Parliament, with the political agenda heavily embedded within responses, contrasted with the witness seminars conducted after the period in which the reports were released, allow for more informal and individual responses and a balance of individual and personal experiences. These reflective sources offer wider political and social experiences which impacted the use of research on health inequality in public health policy between 1980-2000.

LITERATURE REVIEW

This next section will survey research into the factors which impacted public health policy creation between 1980-2000. Historians who have investigated the role of the research agenda in determining the government's reaction to health inequalities suggest several components which impacted the use of research in policy formation. Those like Macintyre (2003) suggest that a continual debate within the research field surrounding the understandings of what causes health inequalities has affected the use of research. The main understandings of health inequalities can be broken into two groups: social structure versus social behaviour. Scientists either place blame on individual decision making for poor health outcomes, or view structural factors as having a larger impact on the health of the public. These conflicting explanations have split the research community, and many spend large sections of their work defending their belief on the root cause of health inequalities. This contested debate has been present throughout this period, and Clark (2021) has investigated the implications of this conflict between researchers on the Black Report and the Whitehead Report. The historic links to explanations of health inequalities are illustrated by Webster (1988), as he suggests the government were reacting to appease the popular ideology, and thus research that was not in line with the popular ideology was not accepted. Carlisle (2001), and work by Oliver (2010), show how these contested notions have continued to negatively influence the use of research within policy. Another problem with the research reports identified by Bambra et al. (2011) was the presentation of solutions by researchers as they attempted to tackle health holistically with suggestions of restricting the welfare state, which was deemed unrealistic by those in power. Porter (2002) believes that it is hard to put these holistic solutions into policy, and that instead researchers need to present specific factors and targets to make conclusions drawn in the research more realistic and achievable to implement. The role of those involved with the research reports commissioned by the government has been thoroughly investigated and many

point to the research field limiting the usefulness of their own work in policy creation.

The politicisation of research, and subsequent denial of the political implications by researchers, is a crucial factor impacting the extent to which research recommendations were used in health policy between 1980-2000. Those like Berridge (2008) and Porter (2002) suggest that different styles of public health policy have long political links; thus, historical context is crucial to evaluate responses. Key researchers, like Townsend (2010), continually deny the political influences, in some cases to present findings as politically neutral. However, Klein (2003) suggests that by not accounting for the political and economic context, researchers undermined their own work. As the key points and theories were similar across the two reports in the 20-year period but with different government reactions, this suggests that other factors influenced the government, a mixture of 'socioeconomic, political and ideological change' all create the environment for which research can be received (Bambra et al., 2011, p. 402). Nutbeam (2003) argues that practicality is a major element which needs to be considered when presenting research for policy formation and highlights the differing responses to the Black and Acheson report to evidence this. From the recommendations to the formatting of the research, many factors have been presented which point to problems with the research as a major factor determining policy creation.

The role of policymakers in the extent to which research was considered when creating health policy has been investigated by historians. Many argue that findings of reports have been suppressed because they do not match the budget or beliefs of the government; those like Small (1989, p. 140) suggest 'policy makers know what they wish to hear, and they are very pleased to hear it'. Exworthy (2003, p. 292) states that there was an 'open policy window' for the Acheson report and that the different government reactions were driven by their different objectives in office. There have also been suggestions from Oliver (2010) that the manner in which recommendations were made should have been tailored to the government's beliefs to reach a middle ground. Waddington (2011, p. 5) suggests similarly that under Thatcher there was a rise in support for privatisation, along with an attack on 'dependency culture' which was imported from North America and conflicted with the recommendations set out by researchers. Bambra (2011, p. 399) declares that the Black Report was a 'report waiting to be rejected' due to the political environment, whereas some, like Smith et al. (2014), suggest that the political context of the Acheson report makes it difficult to ascertain how it influenced the government's response.

FINDINGS AND DISCUSSION

The role of researchers in policy creation

Certain elements of the health inequality research field, including the rising and diminishing popularity of the research topic along with the conflicting explanations of underpinning health inequality, damaged the momentum of the researchers of the Black and Acheson reports' ability to influence health policy with their work. The limited use of research in policy creation can be attributed to certain characteristics of the research field, especially as they were not able to unite above the different schools of thought—the individual versus structural factors influencing health—and were not able to provide solid policy recommendations as they were focusing on providing evidence to support their beliefs on the existence of the health inequality in Britain.

The Black Report managed to overcome the lack of unification of research into health inequality and offered evidence to support argument that structural factors were more important than individual behaviour. Researchers on health inequalities in the 1980s, such as Stuart, Webb, and Hewitt, had not accepted the impact of structural factors on health, and this conflict limited research informing policy: more time was spent providing evidence on the link between socio-economic position and health status than on policy recommendations. Having to continually evaluate the explanations of health inequalities rather than potential policies and their effectiveness within reports made it challenging for the government in charge to transfer this knowledge into reality. The immediate policy reaction to the Black Report was disappointing: the report was concealed by the government through limited publication and restricting access to many as the report was set at a high price. However, after outcry from the research team involved in the Black Report and subsequent media attention a new cycle of health inequalities research was triggered with less focus on individual behaviour as the root cause of ill health and health inequalities. Media attention included both medical journals and the press: for example, The Financial Times (1987) said the Black Report 'rekindled' and 'stimulated' the topic and debate over health inequalities. The media focused on the Black Report as it offered a renewed perspective on health inequalities, Webster (2003) saw the Black Report as renewing interest in the wider debate on social inequality as the 1980s as it refocused on environmental matters instead of individual actions. While the Black Report was not immediately considered for policy recommendations, its impact was noticeable later in the public health community. This is evident in the influence accredited by projects like the North Karelia Project in Finland. The Black Report had a subtle impact as the recommendations were not translated into policy until Labour were elected again in 1997; this was described as a process of 'enlightenment' by Booth (1988, p. 43). Within a British Medical Journal article, Smith (1990), a prominent member of the public health community, suggests the relevance of the Black Report is continuing to increase with time; despite the data becoming out of date, the explanations and recommendations remain inspirational to the field and do not succumb to the cyclical nature. This explains why many researchers cite the Black Report in their work. The Acheson Report (1998) as one example, wrote that despite being 20 years apart and using updated data, their reports come to the same conclusions. Thus, the Black Report has been labelled by Freeman (2008, p. 53) as 'symbolic' and 'seminal' as it acted as a foundation piece, by constantly inspiring the field as it has been citied in most research on health inequalities in Britain since publication. Therefore, the Black Report and researchers involved were able to break the cyclical nature of health inequalities research.

The nature of public health and the debate on explanations have been described as a 'decline and then rise … reorientation and redefinition' by the community, as the Black Report acted as a polemical piece within public health (Berridge, 2004). Therefore, the Black report was impacted by the cyclical nature of socioeconomic public health research but was integral to breaking this pattern and had lasting impacts on public health policy rather than immediate implementation during the Thatcher government. When the Labour Government of 1997 introduced minimum wage and other measures to tackle health inequalities through income redistribution, this was widely accepted due to the dissemination of knowledge attributed to the Black Report (Townsend, 1992). The changing popularity of health inequalities as a research topic did not hinder the Acheson Report in the same way as earlier research as they did not have to defend their belief that structural factors impacted health to a greater extent than individual actions.

Political nature of the health inequality research field

While there was a conflict of opinions on the root cause of health inequality separating public health researchers, this division also had political undertones and impacted the extent to which research was used in policy creation between 1980 and 2000. Right-wing parties like the Conservative Party supported research demonstrating that individual actions were the main cause of poor health, while left-wing associations like the Labour Party supported research proving wider structural forces were to blame. Berridge (2002, p. 91) affirms that 'social medicine in Britain was affiliated to a set of political objectives' from its creation: this can impact how the government receives research, as they are unlikely to support policies which are not in line with their agenda. Despite this, the research community attempted to remain uninvolved with the political dimension of their topic.

From the 1960s, community health researchers proposed that there should be a separation of 'pure research from politics', as they saw the association with political objectives as a hindering factor in implementing change. Researchers fervently denied the political nature of their research to avoid clashing with a government who embraced a conflicting ideology; thus, they limited themselves in their ability to debate in policy creation and assert that health was a civil right but also a social justice issue. After the rejection of the Black Report due to an ideological clash with the government, reports that followed like *The Nation's Health: A Strategy for the 1990s* explicitly state that they are not making political statements when presenting evidence. When commenting on the joint publication of the Black Report and the Health Divide, Professor Townsend declares that the 'scandal of wide inequalities in health is based on sound scientific evidence and not on political dogma as some ministers would like to imply' (Financial Times, 1988). The fascination with disconnecting politics and explanations of health inequality has been debilitating within this area of research, as it has hindered the ability for researchers to act as political activists and fight for their ideas.

The Acheson Report embraced the political nature of health inequalities: the opening of the report leads with a statement that public health is 'fundamentally a matter of social justice' and emphasised that the recommendations 'are based on scientific and expert evidence', and therefore objective (1998, p. 1). While the reports may be subtly politically charged throughout, the authors maintain that the findings were not involved with political activism, as this puts the research at risk of being disregarded by either the right or left for not confining to their worldviews. The Acheson Report embraced the political change it could inspire, and research was translated into policy; however, this report was welcomed by a government which traditionally accepted structural views and more direct intervention into public life to tackle the widening gap of health inequalities (Exworthy, 2012). It was easier for the Labour government to accept findings that supported income redistribution as it aligned with their stance on how best to challenge health inequalities, and so it is hard to attribute the extent of political awareness as the main factor influencing the use of research. It can be deduced from the above findings that the apolitical stance of researchers was used in the 1980s in an attempt to present findings as objective. However, when the researchers involved in the Acheson Report considered the political climate and expressed this within their work, they were successful at influencing policy with their recommendations.

The impact of policymakers on the use of research in policy creation

After focusing on the role researchers played, this article will now investigate the role of policymakers and their impact on the use of research will be investigated. The role of policymakers, including those in the government and civil service, in Britain offers an 'paradigmatic opportunity for examining the relationship between party ideology and healthcare policy' as Klein (1984, p. 86) investigates primary care health policy, however a similar process occurred within public health policy. The discourses subscribed to by each main political party from the 1980s explain to an extent the acceptance or refusal of the different reports, as the Black and Acheson Reports both arrived at 'very similar conclusions', yet immediate policy impact of both reports varied dramatically (Gordon and Shaw, 1999, p.vii-viii).

The neo-liberal Conservative Party, a new branch of conservatism under Thatcher, supported a 'moral underclass discourse', believing that individual and social behaviours were the most important factor impacting health outcomes and therefore the promotion of health and education was the best route for improving overall health (Carlisle, 2001, p. 278). Refusal to acknowledge differences in health was part of a wider agenda to drive 'class conflict off the agenda': both Thatcher and Major held this position (Clark, 2021, p. 243). Reports which continuously proved that health outcomes were worse for those in lower classes compared to higher socio-economic classes disproved the 'classless society' Major aspired to have (Clark, 2021, p. 244). Casey (2021) believes that government ideology impacted the policies chosen as they attacked 'dependency culture', and supported prevention instead of direct intervention through increased social security as was suggested by the Black Report. Wainwright accused the government of attempting to 'discredit the growing body of evidence' (1996, p.73). The main ideology underpinning the Conservative Party of the 1980s consequently affected health policy formulation, as research proposing that structural factors caused health inequality was rejected by the administrations.

As the Conservative government's ideology conflicted with the understandings of health inequalities, there were limited partnership attempts between the governments in power and the leading researchers. Exworthy (2012, p. 175) suggests the 'policy window' remained shut from the 1980s up until the election of Labour in 1997, because the political values of the Conservative administration did not align with tackling health inequalities via increased state intervention. The stance of the Conservatives under the leadership of Thatcher is summarised by researchers when they stated that the 'governments have accepted only a limited responsibility for the health and welfare of individuals' (Jacobson, Smith and Whitehead, 1992, p. 23). The party ideology included limited involvement in the health of individual citizens, preferring to believe that overall change to the economy was the easiest way to impact the public. This can be seen in the limited interaction between policymakers and research produced from the Black Report. Those who were involved in the public health circles in the 1980s suggest that 'work was out of favour in official circles', due to the Conservative government's political ideology (Berridge, 2004). Thomas (1983, p. 114) similarly believes 'that research which bears out the predilections of administrators or their ministers is far more likely to be used than research which runs counter'. Due to the conflicting ideology between government and research, there was limited opportunity for researchers to present findings on health inequalities as the governments in the 1980s. The Conservatives refused to acknowledge evidence supporting structural factors as the leading cause of health inequalities and proposals that an increased role of the state was necessary to solve public health problems.

The Conservative Party, who came into power in 1979, had a clear agenda that supported individual behaviours over larger welfare reforms; however, previous governments also supported this of policy despite following left-wing ideology. When observing what came before the Black report, *Prevention and Health: Everybody's Business*, published in 1976 by DHSS under Labour Prime Minister Harold Wilson, an individualistic approach to public health is emphasised, placing the responsibility of improving health out of the control of the health service or the government. The above analysis suggests political ideology can be attributed to the government's reactions to research to an extent, but it is not always a conclusive factor in the decision to implement certain policies recommended by research. There is a suggestion by Clark that 'individual responsibility' was not a new concept introduced by the New Right Conservatives but was already ingrained in the DHSS as it was popular in 1976, and therefore it was not the governing ideology that played the largest role but the cyclical nature of research. The prevailing explanation of health inequality is more relevant in the reaction and use of research by policymakers, as the Labour Party in government before Thatcher supported research which was not in line with their wider political views to create their public health policy (Clark, 2020, p. 994).

Research was supported or rejected by administrations based on whether it supported their political agenda and the reports on health inequalities also become symbolic and accrued political affiliation. The Black Report became symbolic for the opposition. Young (1981) stated in a debate: 'I know that Labour Members pay considerable attention to the report's recommendations', as Labour supported the work of researchers who offered an alternative solution to Thatcher's limited response to health inequalities. This overwhelming, sudden support from the opposition may have created an urgent need for the government to prove that this research was not radical or life-changing, as it could not be realistically implemented in one term in order to weaken Labour's support of the Black Report. Thus, the Black Report was not only in defiance of the government's ideology but also fully supported by the opposition, making it less appealing to the Conservative government to embrace.

The New Labour party commissioned and championed the Acheson Report, as this research aligned with their political ideology. Despite making grand claims and explicitly supporting tackling health inequality on a structural level, the New Labour party were inclined towards rhetoric rather than action. New Labour, after defeat in 1983, underwent a 'process of transformation' in which they began to follow measures which would renew social fabric with communitarianism; this included state intervention providing universal entitlements, but independent public action or personal responsibility was required, and a reliance on neoliberal market dynamics (Foley, 2002). While the Labour Government of 1997 welcomed the Acheson Report and were already working towards key recommendations on health, they published both a White Paper and an Action Paper. After following the recommendations outlined by Acheson they remained on a similar budget to the previous Conservative government. This demonstrates that a shift in ideology was a key factor in accepting research and creating partnerships with researchers, as the economic conditions and budget had not changed between the administrations under Major and then Blair. However, in the Action report, which was less widely distributed, the more 'radical' plans to tackle health inequalities including income redistribution were suggested (Townsend, 1992). The White Paper mentions minimum wage and other benefits but the structural action necessary to transform the growing health inequalities in England is not pushed (Townsend, 1992). However, the suggestions by Acheson were in line with the government's time frame and budget, suggesting that political ideology but also the realistic nature of policy recommended helped the Blair administration accept the findings of the Acheson report.

Overall, the political ideology of the government in power is a major factor influencing the extent to which research was taken forward; however, with nuances in Labour's policies still following neoliberal economics but also focusing on increased social security, this suggests factors such as economic constraints and limited time frames also impacted policymakers' decisions to use research.

Funding research over policy implementation

The positive relationship and complementary ideology between the New Labour Party and public health researchers created a climate for the use of research in policy creation, but research was commissioned to stall policy implementation. The Labour Party were accused of 'bottling out' (Buckby, 1998) as they reduced twenty-seven targets set by the Acheson Report to four, and this lack of targets reduced accountability. This government was accused of having fallen prey to the constraints of time and funding like the previous governments before them. Labour were accused of funding more research to take the heat off their commitment to more radical policies in parliamentary debate (Pavitt, 1981). This is supported by the sociology study by Nazroo (1998) which points out that states commission research as a political action.

The Acheson Report discusses many new research groups as opposed to policy recommendations, demonstrating how research was used as a buffer for action. For example, more research into healthy eating in schools was commissioned by the government while the Acheson Report was being written, authors of the Acheson Report deemed these as 'laudable plans, they are unlikely to have a major impact on health inequalities at a national level' (Gordon and Shaw, 1999, p. vii-viii), showing they did not support more research. Booth (1988) contends that research and policy can be a political activity to delay action. An unnamed New Labour government minister when interviewed on public health policy said: 'we'd have done most of what we did whether Acheson had done his Report or not' (Smith, 2008, p. 15). This demonstrates that new research, in the form of the Acheson Report, had little impact on the Blair administration's health policy as they were already informing their health policy with recommendations proposed by the Black Report. However, the minister goes on to say that the government wanted a new 'Black Report', therefore demonstrating the Labour government was directly influenced by research from 20 years prior as they wanted to recreate their own. Even recommendations from the Acheson Report in 1999 reflect those suggested in the Black Report, namely the Health Action Zones and the New Deal for Communities. Many of the recommendations set out in Acheson were embodied by an earlier Labour White Paper (1999), *Our Healthier Nation,* which 'expressed its determination to tackle the root causes of health' (Acheson, 1998, p. 7). This implies the Blair administration took inspiration from the Black Report, and funding more research was not necessary, they simply wanted a longer period of time to work with the treasury to commit to new policies. As these recommendations were already part of policy before the Acheson Report was released, the Blair administration did not use the research they had commissioned to create their policy tackling health inequality. However, this does reflect an explicit stance by the government, and an ability to work in partnership with research bodies to create solutions, a very different environment than the 1980s. Labour had already introduced the national minimum wage and *Welfare to Work* as measures to tackle income inequalities. Despite this, if the government was set on introducing changes before the research presented in the Acheson Report was released, but

gained inspiration directly from the Black Report, then the Blair administration's policy was still being informed by research.

CONCLUSION

In conclusion, much of the literature investigates the role of researchers and the role of policymakers separately; however, in this article, a close reading of reports and other sources has proven that both researchers and policymakers play large roles in the use of health inequality research in policy creation. The route from research to policy implementation remains complex.

The Thatcher and Blair administrations appear to take little research into account with their health policies, as the Black Report was rejected outright while the Acheson Report supported policies which were already in action. The Black Report's lasting legacy suggests that the Blair administration did utilise its ideas and recommendations, as it wanted to produce its own Black Report in the form of the Acheson Inquiry. The acceptance of structural factors as the main explanation of health inequalities and proposal of indirect policies to tackle health inequalities can be seen as a lasting influence of the Black Report. The process of the dissemination of knowledge was long but helped open the route to more radical change in public health policy by the 1990s, as the Labour Government in 1997 cite the Black Report as inspiration for many of their health policies and welfare reforms.

The cyclical nature of the topic, along with connections of explanations of health inequalities to political ideology, was a limiting factor in the governments' use of research. This is most notable for the Black Report, with limited policy implementation occurring immediately from this report. The conflict of ideology on both the research and the policymakers' behalf explains the limited use of research until the late 1990s. This is best demonstrated in the different responses and engagement from the government with the Black Report and the Acheson Report. The Black Report, published during a time of transition, was an easy way for the government to reject the research that critiqued and was underpinned by socialist ideology, conflicting with the neo-liberal agenda of the Thatcher administration.

This Acheson Report represents a clear area of mediation in which researchers and policymakers collaborated with more mutual respect for both parties' expectations. The terms of reference were set in a direct manner as to complement the ideology along with economic conditions. While party beliefs, and the specific administrations aims under Thatcher and Blair, showcase that policy was not guided by research, it was only when party beliefs were confirmed by these reports, did reports guide policy. Although the acceptance of the Acheson Report can be attributed to the specific terms of reference laid down by the Labour government, this research was tailored to the political and economic climate and was easily translated into policy due to these considerations. Despite New Labour following policies more in line with social liberalism, they followed fiscal policy set out by the previous Conservative government. However, they were able to offer more public health policies: raising child benefits and enforcing minimum wage. This demonstrates that economic restrictions had a lesser impact than ideology on policy creation. However, the Labour Government did not follow more radical plans set out in their action plan in response to the Acheson Report; this highlights that despite ideologically being more inclined to tackle health inequalities in line with research presented in the Black and Acheson Reports, there were other restrictions in place.

Following Oliver and Nutbeam's (2003) idea that policy is not an 'event' but a process, in which many factors come together to impact the use of research, a culmination of factors influences the extent to which government use research in their policy formulation. Ultimately, the brevity of government terms in conflict with the long-term plans set out by public health research is the most important factor stopping research from being translated into policy, as the policy must be realistic but also be able to provide successful results for the government. The research team's ability to present realistic policies which could be implemented into a short time scale and complement the political ideology and economic context are all necessary features for successful translation of research into policy.

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