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Barriers to Knowledge Production, Knowledge Translation, and Urban Health Policy Change: Ideological, Economic, and Political Considerations

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ABSTRACT *In this paper, we consider social forces that affect the processes of both knowledge production and knowledge translation in relation to urban health research. First, we briefly review our conceptual model, derived from a social-conflict framework, to outline how unequal power relations and health inequalities are causally linked. Second, we critically discuss ideological, political, and economic barriers that exist within academia that affect knowledge production related to urban health and health inequalities. Third, we broaden the scope of our analysis to examine how the ideological, political, and economic environment beyond the academy creates barriers to health equity policy making. We conclude with some key questions about the role that knowledge translation can possibly play in light of these constraints on research and policy for urban health.*

KEYWORDS *Knowledge production, Knowledge translation, Urban health policy, Social-conflict, Power relations, Health inequalities, Ideology, Political economy, Scientific research, Sociology of science*

INTRODUCTION

After more than 20 years of research on urban health inequalities, public health researchers are now beginning to ask, "When do we know enough to recommend action on the social determinants of health?"[1] More work than ever is now devoted to identifying strategies beyond medical care to address urban health inequalities and to achieving health equality through action on social determinants of health (SDOH). Recommending and taking action on health inequalities inevitably leads to the general problem of *knowledge translation*, which refers to "the exchange, synthesis and ethically-sound application of knowledge—within a complex system of interactions among researchers and users—to accelerate the capture of the benefits of research .... through improved health, more effective services and products, and a strengthened health care system."[2] Undoubtedly, knowledge translation is important for acceler-

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ating the benefits of academic research; however, a moment of pause is warranted to reflect on *knowledge production*, or the process of producing knowledge within the ideological, political, and economic realities of modern universities. Taking time to critically reflect on the state of urban health scholarship reveals significant barriers to bridging knowledge and public policy.

In this paper, we consider both the processes of *knowledge production* and *knowledge translation* that have led us to this juncture in research on urban health inequalities. Although there is a long history of social research that examines the effects of social forces on the production and use of knowledge,[3] this work is rarely drawn upon in a self-reflexive way in the public health literature to acknowledge system-level barriers to research-informed public health policy. Here, we examine these forces and raise potentially thorny questions about the limits of knowledge production, policy change, and knowledge translation related to health inequalities. First, we briefly review our conceptual model, derived from a social-conflict framework, to outline how unequal power relations and health inequalities are causally linked. Second, we critically discuss ideological, political, and economic barriers which exist within the research community that affect knowledge production related to health inequalities. Third, we broaden the scope of our analysis to examine how the ideological, political, and economic environment beyond the academy creates barriers to health equity policy making. We conclude with some key questions about the role that knowledge translation can possibly play in light of these constraints on research and policy for urban health.

APPLYING A SOCIAL-CONFLICT PERSPECTIVE TO KNOWLEDGE PRODUCTION AND KNOWLEDGE TRANSLATION

We adopt a social-conflict framework to focus on the social forces that operate as barriers to research-informed urban health policy.[4] Such a framework allows us to see the inherent conflict between social actors that often influences what research questions are asked, which programs of research are well-funded, and whether or not policy makers are receptive to egalitarian research findings. Social conflict analyses point out that rather than being a value-neutral, apolitical, and purely scientific process, knowledge production and transfer are shaped by the ideological values, political and power relations, and economic forces in which they originate and unfold. From this viewpoint, urban health inequalities are the result of unequal power relations (e.g., social class, patriarchy, racism, and heterosexism) and are inherent within market societies where powerful groups benefit more and at the expense of less powerful groups (e.g., mortgage lenders vs. racialized urban dwellers).[5] Policy options informed by a social-conflict perspective also differ, in that, reducing health inequalities requires more than simply increasing the availability of social determinants of health (e.g., narrowing income inequality, increasing education attainment, and providing affordable housing) but requires activism, collective action, and social movements to significantly empower the "disadvantaged" at the expense of the "privileged" (e.g., mobilizing civil resistance, increasing workplace democracy, and electing pro-egalitarian political parties).

Our paper is organized around three barriers to solving health inequalities through research-informed policy. The barriers are: (1) values and ideology, (2) politics and power, and (3) economic. By ideology, we are referring to the values and beliefs that constitute how research is conventionally carried out in academia (e.g., research is value-free). Ideology is often used, implicitly, to justify dominant cultural beliefs (e.g., belief that researchers are dispassionate and detached from their work).

Our focus on politics is essentially about power. We define politics as institutionalized systems by which societies distribute power, set the society's agenda, and makes decisions, and power as the ability to achieve desired ends despite resistance Lastly, economics here refers to how employment contracts, private donors, and the researchers' own social class position affects processes of knowledge production and translation.

BARRIERS TO SOLVING HEALTH INEQUALITIES: THE CONTEXT OF KNOWLEDGE PRODUCTION

Ideology—the Illusion of Complete Scientific Objectivity

Conducting health inequality research within an academia involves reconciling the tension between scientific objectivity and personal values. On one hand, researchers are trained to practice and endorse the Weberian ethos of scientific objectivity,[6,7] a state of personal and professional neutrality in conducting research on health inequalities. It is believed that careful adherence to scientific procedures ensures objectivity and unbiased results. Only by being dispassionate about health inequalities can researchers investigate urban health *as it is* rather than informing others how *they think it should be*.

We counter that the pursuit of scientific objectivity is an ideal rather than a reality[8] and that Weber's ethos is responsible for severely limiting knowledge production on the political and economic determinants of urban health inequalities. First, scientific objectivity is a false ideal because complete neutrality is impossible to achieve when trying to understand value-laden topics such as why or whether certain urban groups are marginalized and oppressed. Second, in Weber's view, detachment is a crucial element of science that sets it apart from other professions. Researchers are supposed to be neutral with regard to the outcomes of their scientific work. However, public health and social epidemiology disciplines are not disinterested disciplines. On the contrary, these are applied sciences that are deeply value knowledge that leads to improved health outcomes (and in the case of urban health research, specifically, knowledge that leads to equity and better health for marginalized groups).

Our argument is not that we should do away with objectivity, but that we should acknowledge that values matter when conducting research on urban health and interventions designed to bring about a desired change. In particular, we should acknowledge that Weber's argument is unfounded, insofar as we can never be completely value-free or even aware of all our biases. Insisting that empirical research on health inequalities be value-free is akin to keeping society free of social change which betrays the objectives of public health, including urban health. Scientific objectivity and partiality are not mutually exclusive. Instead, they are compatible and necessary conditions for conducting rigorous scientific work aimed at progressive social change. One trusted strategy for limiting the impact of personal values is through replication—repeating studies on health inequalities committed to social change and obtaining similar results will overcome the false ideological value of absolute objectivity. As an additional safeguard, researchers can identify and report their personal leanings to help the academic community evaluate their conclusions in the proper context.

Politics—the Apolitical Nature of Social Determinants of Health

A second barrier to health equity knowledge production is that most social determinants of health research tend to be apolitical.[9] By apolitical, we are referring

to how contemporary urban health research often avoids questions related to power dynamics within societies and among nations. The implication of avoiding politics and power relations is that researchers implicitly adopt a structural–functional view of society (e.g., society is guided by social structure and relatively stable patterns of social behavior), which leaves the macro-structural determinants of health inequalities unexamined. Two recent examples of research hinting at a more political direction include the WHO's *Commission on SDOH*[10] and Wilkinson and Pickett's *The Spirit Level*.[11]

The WHO's *Commission on the SDOH* should be lauded for declaring that "social injustice is killing people on a grand scale"; however, it also has two omissions that deserve more attention: how social injustices are generated and reproduced through political mechanisms and which political and policy interventions are potentially the most effective in reducing population-level inequalities.[12] Implicating social injustice as the root of health inequalities is too vague and abstract to be meaningful. What is needed is an interrogation of the political causes of social injustice, which broadens the scope of SDOH research to considering, for example, how political and social class relations reproduce socioeconomic which then result in health inequalities.[13] Though WHO's report is long on describing social determinants of health (e.g., problem space), it is noticeably weaker on recommending politically based solutions, policies, and interventions. This brings to light the ethical imperative on the part of urban health researchers to produce new knowledge on the political determinants of policies which actually reduce social inequalities in health.

Another example of encouraging, yet insufficiently political social determinants of health research can be found in Wilkinson and Pickett's *The Spirit Level*, which implicates income inequality as the fundamental cause that affects social capital/cohesion, population health, and health inequalities. Though the income inequality hypothesis has been praised for reinforcing the importance of social determinants of health, Wilkinson and Pickett's thesis suffers from deeper problems ranging from incomplete model specification[14] (e.g., income inequality may be an intermediary factor within a broader causal chain) and "indicator fetishism" (e.g., income inequality measures have been imbued with more explanatory power than theoretically and empirically justified) to psychological reductionism (e.g., explanations for health inequalities are reduced to stress). These limitations all contribute to depoliticizing the discussion and leave little room to consider how relational mechanisms based on politics and economics contribute to health inequalities. For example, investigating the health effects of social class in urban immigrant enclaves would advance discussion beyond abstractions such as improving social cohesion and reducing income inequality toward a more concrete analysis of the relational process in which a dominant group acquires economic benefits from the labor of those who are dominated. Focusing on how valued resources are controlled and allocated acknowledges the inherent political nature of health inequalities and offers innovative policy options (e.g., "flexicure" labor market).

Economics—Funding Sources, Private Donors, and the Class Location of Scientists

Producing knowledge on urban health inequalities is also impeded by economic barriers, including the ways that research investments are made and scientists compensated, and also the social class positions that scientists occupy. First, the scope and nature of urban health research agendas are largely shaped and determined through soft money employment contracts (e.g., the employment

relation in which the wages and job security of academics are dependent on obtaining external grants). Beginning in the 1980s, public health researchers in major U.S. universities were (and are still) expected to attract external funding to help cover their salaries and to carry out their research activities. This most often takes the form of soft money contracts, ensuring compliance between the research priorities of scientists and the research expectations of outside funders. It follows that researchers tend to draft proposals with research questions and methods that match the interests of funders. Soft money contracts seriously limit the intellectual autonomy of scientists, including the freedom to pursue critical research on urban health inequalities. Such compromises not only promote the development of more status quo-preserving research agendas but can also affect the scholarship of future research through the teaching, training, and mentoring of graduate students.[15]

Second, private foundations and donors are increasingly important sources of global health research funding, which has an enormous impact in shaping which health problems are considered priorities and what solutions are recommended. For example, The Bill and Melinda Gates Foundation has donated over $14 billion since 1994 to global health programs[16] that promote technocratic[17] and private market philosophies.,[18,19] Researchers hired or funded by powerful private foundations are increasingly encouraged to investigate technical and market-oriented solutions to health inequities even while the supporting evidence for these approaches remain unsubstantiated (e.g., financial services for the poor such as microfinance and microloans), or controversial (e.g., Mexico's health reform).

Third, most scientists work in major universities and occupy upper middle-class positions—two economic realities that influence their attitudes, values, and behaviors. From a social-conflict perspective, private and public universities in North America are more than meritocratic institutions designed for higher learning and innovative research. Universities also function in various, often subtle ways, as agencies that perpetuate social class inequalities, reinforce acceptance of the status quo, and reproduce the dominant social relations of production (e.g., those of neoliberal capitalism). Potentially, this results in a feedback loop where universities selectively hire and influence the attitudes of academics and academics in turn produce knowledge supporting the dominant ideological, political, and economic systems of these societies, rendering health inequalities unaffected or increasing. Likewise, the upper middle-class position that scientists occupy restrains their intellectual curiosity to challenge the corporate interests of academia reflected by the university's investments and its private donors. These constraints can compel urban health researchers, regardless of their equity-oriented personal values or motivations, to remain class-consistent and to conduct safe and conventional scholarship,[20] for example by changing their substantive foci from politically oriented topics to neutral ones (e.g., reducing social class analysis to income rankings) for fear of economic and professional reprisals.[21*] A trend we see often in social epidemiology, for instance, is what we call “meaning swapping”. This refers to the active exchange

*In the most extreme case, the government may even take strict steps to silence researchers and stop the production of equity-oriented knowledge. Powerful examples of this can be found in authoritarian regimes which subject academics with egalitarian views to various penalties such as labor market discrimination.[19] A particularly notorious example is Franco's regime in Spain (1936–1977), where university professors were jailed and tortured for teaching egalitarian perspectives.

of conflict-oriented concepts for neutral and conservative ones (e.g., social class changes to socioeconomic status, politics changes to governance, class solidarity to social cohesion, etc.)

BARRIERS TO SOLVING HEALTH INEQUALITIES: THE CONTEXT OF POLICY MAKING

Ideology—Continual Tension between Egalitarian and Individual Values

So far, we have shown that system-level barriers within the contemporary academy can limit substantially production of socially critical knowledge to solve health inequalities. Now we look beyond the academy to the wider social context, to consider how ideology, politics, and economics likewise limit opportunities for policy making to reduce health inequalities. First, policy action to address urban health inequities is shaped and fashioned by the extent to which a nation, state, or society embraces the ideological values of egalitarianism at one extreme or individualism at the other. Where egalitarianism is dominant (e.g., social democratic traditions), trade unions play an interventionist role in areas such as occupational safety and pay equity and government authorities assume an activist role in social determinants-relevant policies such as child care, job creation, and women's rights, all of which are consistent with the goal of redressing health inequalities.

However, egalitarian values about urban health run against the ideological values of many contemporary societies. Ideological barriers to urban health policies are likely to include but are not limited to individualism (i.e., the ideological stance that individuals are the central unit of analysis; health inequalities result from individual risk factors and behaviors), libertarianism (i.e., the philosophical idea that individuals should be free to do what they want no matter how this affects the needs and wants of others; health inequalities are the natural outcome of individuals maximizing liberty and freedom), and neo-liberalism (i.e., the economic policy that promotes market-oriented societies to allocate resources in production and distribution; private markets hold sway while health inequalities are accepted consequences).

Politics—Varying Importance of Urban Health Inequalities Among Political Traditions

Differences in ideological values are in part a function of the historical trajectory of organizations and social movements, and are reflected in the policies and platforms of political parties. Whether policies to reduce urban health inequities are prioritized among policy makers depends in large part on where the governing parties locate themselves on the political spectrum. This spectrum nowadays ranges from democratic socialism on the left to several varieties of authoritarian regimes on the right. Improving urban health and reducing health inequalities complements a broader egalitarian commitment to social and economic safety nets, including social welfare programs, universal childcare, education, and medical care for the elderly, and other urban health enhancing policies. Conversely, a major barrier to health equity interventions will be political parties and traditions that justify inequality (e.g., Margaret Thatcher's “It is our job to lorry in inequality”), often as part of a market-driven economic agenda.

Economics—the Political Economy of Private Interests Over Public Needs

The third major barrier that limits the development and implementation of health equity policies is the prioritization of private economic interests over public needs.[22] Three economic features are important in discouraging health equity approaches into public policy. First, countries dominated by private interests with high levels of private ownership of wealth-producing assets are less likely to support policies that meet the public health needs of all (e.g., social housing). Second, political economies that encourage the pursuit of private wealth accumulation are less interested in promoting de-commodified goods (e.g., public health). Third, market-oriented systems characterized by market competition and consumer sovereignty advocate for minimal government interference in the production and distribution of public goods, including social determinants of health, which in turn, hinder the successful implementation of public policies to reduce the economic causes of urban health inequalities.

While political economies dominated by private interests might be more productive, measured as gross domestic product, nevertheless, increased economic output does not translate into greater levels of economic equality or reduced urban health inequalities. More than simply, the freedom to act in pursuit of one's self-interest, reducing social and health inequalities, requires freedom from basic want. Achieving urban health equity in market-driven economies would be greatly augmented with accompanying government investments in and widened scope of government regulation and oversight of public goods and services. Several Scandinavian countries have achieved a substantial success following these goals since the second half the twentieth century.

CONCLUSION: KNOWLEDGE TRANSLATION FOR HEALTH INEQUALITIES?

In light of what we have reviewed to be seemingly intractable ideological, political, and economic constraints on health equity research, on one hand, and health equity policy making on the other, what can be the role of knowledge translation, which is intended to "move research into policy"?[23] Unfortunately there is scant empirical evidence of the role that science plays in the development of policies that either reduce health inequalities or that maintain/exacerbate them. Consequently, we know little about whether or not knowledge translation interventions produce any significant effect in mitigating ideological, political, or economic barriers to equity, nor can we say with much assurance if research into health inequities achieves substantially better traction among egalitarian-minded decision makers compared to those with opposing values systems. To assess the practical value of health equity-focused research and the viability of knowledge translation strategies for health equity interventions, rigorous, comparative analysis of uses and even abuses of science in the making of social policies affecting public health are required. For example, neoliberal governments are likely to be indifferent if not hostile to ideas about and arguments for more egalitarian policy decisions.[24] However, what needs to be much better understood whether these regimes actually review and appraise available scientific evidence on the social determinants of health and health inequity outcomes and then reject it, whether they do not know about the research at all (e.g., the evidence does not rise up high enough to make it into briefing notes for policy

makers' consideration), and/or if (as we assume) they do not care to know about it and make intentional choices not to appraise it.

More important is to ask about the converse situation. Past research shows that political parties committed to egalitarian goals are significantly more amenable to acting on health inequalities; that is, there is a much greater likelihood of equity values being translated into equity policy among these actors.[25] In terms of knowledge translation, the question is whether they are also more likely to translate equity-focused science into their equity-focused policies. Do egalitarian-oriented governments encourage and invest in critical health equity knowledge production, and do they utilize the research output in their decision-making? And if they do, what is the research used for, and how is it generated? Do these governments tend to communicate frequently with researchers? Is the research community independent and intellectually autonomous, or closely connected to the decision-making offices?

For example, a recent inspiring case of health equity advancement comes from Chile, a middle income country. In Chile, center-left coalition governments under Presidents Lagos and Bachelet have made significant progress to promoting population health through action on SDOH.[26] Over the past two decades, poverty has significantly decreased (from 39 % in 1990 to less than 14 % in 2006), housing stock has improved, and levels of education have increased.[27] As the quality of social determinants improved, significant reductions in mortality and health inequalities have resulted. Reductions have also occurred between the poorest and richest district quintiles.[28] However, there is little information available about the role of health equity research evidence and researcher activity in this important and dramatic unfolding.

Another example comes from the Scandinavian countries, a handful of which have implemented Health in all Policies (HiAP) approaches to advance public health and health equity.[29] HiAP and intersectoral action for health are innovative policy strategies that emphasize better health and reduced inequalities as shared goals across local, regional, and national levels of government.[30] By incorporating health impact assessments in diverse sectors, HiAP supports governments in addressing social determinants of health more systematically. Early outcomes are encouraging and support HiAP as an important framework for overcoming ideological, political, and economic barriers to health inequalities in modern societies.[31] However in documenting and reporting on HiAP, insufficient attention has been given to whether, when, and how, the central agencies or the diverse participating departments utilized research knowledge to guide their process.

At its core, urban health is a field of applied research that is overtly committed to improving the health of the marginalized and oppressed populations. Any and all factors that contribute to urban health inequalities should be included within the scope of urban health research. Hence, the field should not be limited to documenting associations between social determinants and health outcomes but needs also to interrogate ideological, political, and economic barriers to achieving health equality. The purpose of this paper has been to consider ways in which research knowledge can and cannot contribute to policy making that reduces urban health inequities. We argue that urban health research should also include, as part of its scope of analysis, for critical inquiry into the social contexts of urban health knowledge production, on the one hand, and knowledge translation into policy, on the other. This kind of inquiry is necessary to discern how and whether researchers and research knowledge into urban health inequities, have a chance of contributing to health equity policy change. Such questions deserve rigorous in-country and cross-country comparisons, especially in contexts where ideology, politics, and

economic forces may be most conducive to progressive social change, and where urban health equity knowledge and the researchers who produce this knowledge, should have the best chance of making an impact.

One important implication of being an applied science involves viewing health inequality research as a technology similar to how urban planning or environmental science are designed to guide urbanization toward desired results (e.g., creation of mixed-income neighborhoods, limiting the emission of environmental hazards). Public health researchers should view as more than a scholarly tool to generate new knowledge (and advance academic careers), and treat research as a strategy to bring about desired population health change. This invites researchers to be both an objective observer of social reality and a participant in advancing social change.

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