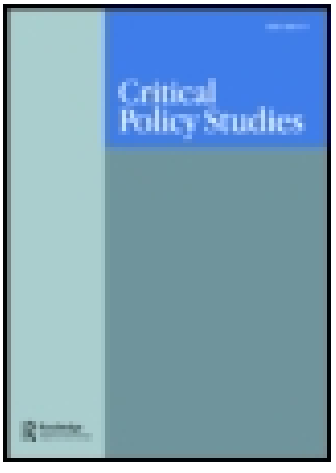


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# The view from nowhere? How think tanks work to shape health policy

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# The view from nowhere? How think tanks work to shape health policy

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Think tanks seek to shape the business of government by offering policy expertise in a number of areas, including health care. This expertise tends to be presented as 'the view from nowhere' – independent, value-neutral expertise that can inform policy. We challenge this view by examining what 'independence' means and how it is performed. We present an interpretive policy analysis of data collected from four UK-based think tanks that have sought to influence health policy. Our analysis demonstrates how a sample of healthcare think tanks publicly positioned themselves as 'independent' organizations. They drew on technocratic health planning discourse to emphasize a range of knowledge-related activities, artifacts and instrumental language that, informants suggested, allowed them to feed emerging evidence into policy and improve health services. Such positioning seemed to provide them with legitimacy in the eyes of decision makers. A parallel set of think tank activities (e.g., meetings with parliamentarians) took place 'back-stage' and focused on influencing health policy and, in the context of recent proposals to reform the English National Health Service, lending broad though not unqualified support to government proposals to extend market principles in health care. Informants appeared to seek to neutralize their presentation of such 'back-stage' influencing through a range of discursive strategies.

**Keywords:** think tanks; health policy; knowledge translation; interpretive policy analysis; linguistic ethnography; case study; UK



## Introduction

'*Independent research organization*', '*research organization*', '*charitable research foundation*', '*research institute*', '*independent, non-party think tank*' and '*policy research organization*'; these are a few of the phrases that participants in our study used to describe their organizations when they spoke to us about the way that think tanks shape health policy. As Rich suggests, such phrases present an account of think tanks as 'independent, non-interest-based, non-profit organizations that produce and principally rely on expertise and ideas to obtain support and to influence the policymaking process' (2004, 11). Such phrases brand think tanks as a disinterested source of policy expertise that work alongside policy makers to identify a range of policy options and select the 'optimal choice'. But why is it that so few participants actually refer to themselves as working in a 'think tank'? What do terms such as 'independent' and 'charitable' mean and what purpose do they serve? In this article we examine the central role that such language plays in framing the work that think tanks do.

Social scientists have a longstanding interest in the role of interest groups, advocacy organizations and corporate interests in shaping health care. Yet few studies have explored

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the work of think tanks in relation to public policy (notable exceptions include Arnoldi 2007; Medvetz 2010; and Korica 2011; though none focus on health policy). Emerging literature on the work of think tanks tends to present them either positively as a source of independent evidence (e.g., McGann and Sabatini 2011; Sherrington 1999) or negatively as having vested interests (e.g., Hassan 2008; Radcliffe 2009; Player and Leys 2011). Our article takes a different approach. We ask: how do think tanks frame and represent their work when they seek to shape health policy? And how do they account for and manage their decisions?

We begin by providing background to the study, outlining think tanks' role in shaping health policy and describing our interpretive approach to studying it. Drawing on a collective case study of four think tanks whose work includes health policy, and especially on an auto-ethnographic account of working in a think tank from the lead author, we then present our findings, examining how these think tanks operated in the healthcare field during the study period, what their goals were and how they sought to accomplish these goals. We conclude by discussing the implications of our findings for those involved in health policy and planning. Our aim is to add to a small but growing body of literature that examines *how* think tanks contribute to health policy and planning (e.g., Ruane 2005; Smith 2013).



## How is a think tank?

The term 'think tank' is embedded within wider systems of social relations and therefore means many things to many people. The term is most frequently used to describe 'organizations that generate policy-oriented research, analysis, and advice on domestic and international issues, therefore enabling policy makers and the public to make informed decisions about public policy issues' (McGann and Sabatini 2011, 14). Such definitions tend to conflate the function of think tanks with their organizational form, using categories such as 'advocacy think tanks' or 'universities without students' (e.g. McGann and Sabatini 2011; Hart and Vromen 2008). They convey the notion of a collection of independent thinkers who generate real-time, value-free facts and neutral commentaries that inform policy and public debate. By trying to define and categorize think tanks in this way – presenting them as bounded organizations – it felt to us that researchers may be constrained by a narrow understanding of think tanks and, as a result, pay limited attention to the people, activities and values allied to think tanks (Shaw et al. 2014).

We embrace an emerging critical tradition that seeks to move beyond categorizing and describing think tanks in this way and acknowledges that what passes under the heading 'think tank' is best understood as a device for gathering and assembling forms of authority (Pautz 2011; Shaw et al. 2014). This tradition builds on the work of writers such as Murray Edelman (1988) Frank Fischer (2003) and Dvora Yanow (1996, 2000) who examine not 'what' but 'how' a policy or organization means. From this perspective, to understand 'how a think tank means' is to understand the language and activities of think tanks and the settings in which they are enacted. This approach aligns with the growing subfield of the 'sociology of expertise' (Eyal 2013), which guides researchers to focus on the process by which specific actors, groups and claims acquire authority. In the context of the study presented here, this led us to examine the central role that language plays in framing the work that think tanks do; critically question the terms 'independent' and 'independence' as used by think tanks (and others referring to them) and explore the

activities, values and interests that lie behind these terms and the work that they do to shape health policy.

## A brief history of think tanks

It is not the purpose of this article to retell the history of think tanks and the social and political environments in which they have emerged (for a detailed account, see, for instance, Cockett 1995; Stone 1996; Mirowski and Plehwe 2009; McGann and Sabatini 2011; Pautz 2012). However, a brief overview is important to appreciate the context of subsequent analysis.

The term 'think tank' originated in the United States (Stone 2007; Medvetz 2007) and, in the 1960s, came to be associated with a set of military planning groups in the United States. The RAND Corporation in the United States was the prototype: founded originally in 1945 as a private organization developed to connect military planning with R&D decisions and under special contract to the Douglas Aircraft Company, RAND then developed as an independent, non-profit organization established following separation from the company in 1948 (Abella 2009). Meanwhile, generic terms such as 'research institute' were being used to refer to similar organizations (McGann and Sabatini 2011). It was not until the 1970s and 1980s, as the number of organizations devoted to public policy research and planning grew, that the term think tank became part of the political lexicon (Medvetz 2012).

In the United Kingdom, the term emerged as an accessible name for Central Policy Review Staff (CPRS), established in 1970 by Edward Heath, the then Prime Minister, to provide specialist advice to government (Blackstone and Plowden 1990). None of the ideas put forward by CPRS were particularly new, but this body did provide a forum for linking the term 'think tank' with problems of health care (for instance, in debates on the possible dismantling of the National Health Service).

In the 1970s and 1980s, free-market think tanks such as the Adam Smith Institute in the United Kingdom sought to elevate the status of business and commerce and make contributing to economic growth the overriding goal of social, cultural and intellectual activities. The period of Margaret Thatcher's leadership of the Conservative Party (1975–1990) provided fertile ground for the concept of think tanks to become mainstream (Denham and Garnett 1999), with business leaders and right-wing commentators pushing the free-market agenda and encouraging the development of think tanks to develop ideas. This trend has continued following the rise of 'New Labour' think tanks in the United Kingdom in the late 1980s and early 1990s (Mulgan 2006; Pautz 2012), an international trend for emergence of market-oriented think tanks (Stone 1996) and the growing prominence of the mass media, which draws extensively on the outputs of think tanks to convey political messages (Lakoff 2011).

Worldwide an increasing number of think tanks have since emerged, with current estimates at over 6600 (McGann 2013), many with an interest in health and health care. Such growth has been explained in terms of an increase in business interests, a decline in traditional party politics, a blurring of the research–policy interface, increasing globalization and circulation of neoliberal values and increased demand for political commentary from the mass media (Fischer and Forester 1993; Stone 1996, 2007; Medvetz 2007, 2012; McGann and Sabatini 2011; Lakoff 2011). The result has been increased opportunities for a range of public and private actors – including think tanks – to contribute to the business of government (Fischer and Forester 1993; Cockett 1995; Mirowski and Plehwe 2009;

Hajer and Wagenaar 2003; Pautz 2011, 2012) and in new spaces and networks allied to health policy and planning (Degeling 1996; Stone 1996).

In the United Kingdom, a range of organizations have sought to fill these spaces allied to health policy and planning. Again, we give a brief overview to provide context for our empirical study. As in other countries, a number of what might be thought of as traditional or politically oriented think tanks operate in the United Kingdom (including, for instance, the Adam Smith Institute, the Centre for Policy Studies, DEMOS, the Institute for Public Policy Research, Policy Exchange, Reform, the Social Market Foundation and 2020 Health), which are often funded by corporate or other donations, tend to locate themselves (politically and geographically) close to the machinery of government (some having been established by political parties and/or their affiliates) and focus their work on current areas of government reform including – when relevant – healthcare planning. In addition, there is a range of business organizations (for instance, McKinsey & Company, Ernst & Young) that undertake consultancy work in specific areas, including health care, and often provide related policy analysis or advice. A small number of organizations operate in the United Kingdom (the Nuffield Trust, King's Fund and Health Foundation) that are supported by large endowment funds and work exclusively on health policy and planning. These endowed organizations provide an ongoing source of research and policy analysis, as well as a number of additional development opportunities (including, for instance, project funding, leadership courses and fellowships) all specific to health care. Our article embraces the range of organizations outlined above. However, it is important to note that they operate with the wider context of health policy and planning expertise in the United Kingdom that also includes, for instance, university departments, charitable organizations, professional associations and patient groups.



## Methods

Our study emerged from the experience of the lead researcher [SS] working within a think tank from February 2009 to March 2011. SS is a social policy academic who had previously undertaken a PhD and postdoctoral work in health research policy before taking on a role as Senior Fellow in Health Policy at Think Tank B, a UK-based organization that aims 'to make a real impact on healthcare policy and practice throughout the UK' (mission statement 2013), while retaining an honorary university appointment. After 2 years, SS took up a new full-time academic role with an (ongoing) honorary appointment at Think Tank B. This provided a unique opportunity for an academic who was interested in health research and policy to study how it is that think tanks work to shape health policy. We used auto-ethnography, a longstanding approach to ethnographic study 'in which the researcher is deeply self-identified as a member' (Anderson 2006, 374) in order to study the social world/s of which they are a part; and subsequently extended this to undertake a collective case study of four think tanks and their work to shape health policy. We provide an account of that process here and refer readers to Shaw et al. (2014), Shaw (forthcoming), and Shaw and Russell (forthcoming) for further detail on theoretical, methodological and ethical issues.

### *Approach*

Our study is theoretically and methodologically grounded in interpretive policy analysis, an approach that recognizes that knowledge is not disinterested, that policy is constructed in an environment of shared language and practice and that policy analysis is a moral

activity (Edelman 1988; Yanow 1996, 2000; Fischer 2003; Hajer and Wagenaar 2003; Wagenaar and Cook 2003; Wagenaar 2011). Through this lens, health policy and planning can be thought of as a drama (Goffman 1959), occupied by a range of institutions, actors and artifacts, involving a continual process of dialogue and exchange (Shaw 2010) and bringing a range of values, judgments and interests into play (Degeling 1996; Laws and Hajer 2006).

Interpretive policy analysis is a broad field characterized by diverse theoretical vocabularies. While acknowledging such diversity, our study of think tanks has focused on three interpretive frames: field theory, social practice theory and discourse theory (Shaw et al. 2014). Taken together, these encourage scholars to:

(1) see think tanks as operating in different social spaces or fields – knowledge production, politics, business and media – each representing a limited area of society with associated actions and rules (Medvetz 2008);
(2) focus on think tanks' everyday activities as potentially shaping policy and planning (Wagenaar and Cook 2003; Laws and Hajer 2006; Freeman, Griggs, and Boaz 2011) and
(3) understand the way in which language and interaction contribute to shaping policy (Hajer and Wagenaar 2003; Shaw 2010).

These frames are interrelated. Hence while our focus in this article is primarily on (3), this necessarily involves our paying attention to both (1) and (2).

Our methodological approach was linguistic ethnography, which combines ethnography and linguistics so as 'to study language use in a range of social settings' (Maybin and Tusting 2011, 515). We were interested in how the think tanks in our sample framed and represented their work in relation to health policy and planning, the values and ideologies they drew on and the way in which they accounted for and managed their decisions. By combining a focus on social context with an authoritative analysis of language (Rampton et al. 2004, Creese 2008), linguistic ethnography provided a robust means for understanding the role that language and social interaction played in the context of the think tanks' role in health policy.

### *Study design and data collection*

We undertook a collective case study (Simons 2009) of think tanks' role in shaping health policy and planning. Given that the study emerged out of SS's experience of working with Think Tank B, we began by negotiating the study with them before then extending our sample to include a total of four think tanks. There is no definitive list of think tanks operating in the United Kingdom, either generally or specifically in the field of health policy and planning. Hence we undertook a review of academic and grey literature (including websites), developed a typology of UK think tanks that have health and health care as part of their work program, and then used this to inform our sampling strategy.

We identified 13 UK think tanks that met our broad inclusion criteria. In addition to Think Tank B, we selected three think tanks from this list to participate in the study (Table 1), seeking variety in the following criteria: (1) funding sources (including, e.g. endowment, sponsorship); (2) length of time established (from more than 100 to fewer than 10 years) and (3) field of work. Guided by previous work on think tanks (Medvetz 2012), we were keen to ensure our sample included a good spread of organizations working across different fields and hence selected two organizations (think Tank A and

Table 1. Overview of think tanks.

| | A | B | C | D |
|---|---|---|---|---|
| **Focus** | Principally on UK health policy/ reform, including leadership development | Principally on health policy/ reform in the UK | Healthcare features strongly in work program, with a UK/European focus | Healthcare forms a substantive part of work on domestic/UK policy issues |
| **Field of work** | Academic/media | Academic | Academic/ consultancy | Political/media |
| **Funding source** | Primarily via an endowment of c£103 m, supplemented by project and sponsorship funding | Primarily via an endowment of c£65 m, supplemented by project and sponsorship funding | Primarily via project- and program-based grants and contracts | A combination of corporate donations and membership, and project-based funding |
| **Estimated annual income** | £14 m | £2.5 m | £6.5 m | £1.1 m |
| **Staff** | c130 | c30 | c85 | c12 |
| **Governance** | Charity operating under Royal Charter, overseen by a Board of Trustees and Senior Management Team | Charitable Company, overseen by a Board of Trustees and Senior Management Team | Community Interest Company (nonprofit), overseen by a Board of Trustees and Senior Management Team | Charitable Company, overseen by an Advisory Board and Senior Management Team |
| **Time established** | 100+ years | 60+ years | 20+ years | 10+ years |



Think Tank B) whose work focused exclusively on health policy and planning and described much of their work as academic research; one (Think Tank C), a nonprofit organization that had a broader portfolio of work funded partly through research contracts and one (Think Tank D) who were known to work more closely with politicians.

To give our collective study a concrete focus, we made it a requirement that think tanks included within our sample had undertaken work that was relevant, either directly (in three cases) or tangentially (in one case), to a program of NHS reforms in England. These reforms were originally proposed by the government in July 2010 (DH 2010) and, following significant public debate, were passed into law in March 2012 (House of Commons 2012) (see Timmins 2012 for a detailed account). They set out a substantial reorganization of the NHS in England including general practitioners taking over the commissioning of NHS care and a new economic regulator to oversee competition in health services provision (with 'any willing provider' from the public, private or voluntary sector able to supply NHS care).

The nature of contribution (or content of arguments) relating to the proposed reforms was not the main focus of our work: our primary focus was how think tanks talk about

and account for their activity. However, focusing on a concrete instance of health policy and planning provided a tangible 'peg' for our study respondents that was more meaningful than simply asking about activities and ideas in the abstract.

Data collection began with auto-ethnographic field notes taken by SS during her time working within Think Tank B and, subsequently, when conducting the main study (October 2011 to November 2012). Field notes provided a unique account of working within a think tank, providing a sense of the reality of the workplace (Anderson 2006), as well as wider interactions. Having already gained an understanding of their work, we deliberately elected to undertake detailed data collection with Think Tank B in the first instance, allowing us to explore some issues in depth before then testing out emerging ideas and analysis with the other think tanks in our sample.

Data collection in each of the four think tanks began with an informal interview with the lead contact (in one case via email) about the nature and focus of their work. This informed identification of 30 documents, including at least one each of the following in each site: overarching strategy (e.g. annual report); governing document (e.g. memorandum of incorporation); work relevant to current NHS reforms (e.g. policy briefing). We then undertook 10 in-depth narrative interviews with senior think tank representatives (six at Think Tank B, two at Think Tank C and one each at Think Tanks A and D). Hence, our interpretation is most heavily influenced by the case of Think Tank B, with the others providing contrasting cases at a less in-depth level.



### *Data analysis*

Linguistic ethnography typically takes language as its prime point of analytic entry (Creese 2008). In our study, this process began with our engaging in repeated close readings of data. Through discussion we identified a tension between accounts of think tanks as independent and neutral and use of the term 'think tank' implying particular values. We initially explored this observation by looking at how and why particular language (such as 'independent') is employed by think tanks for particular means. Corpus analysis provided a means of systematically examining how and when think tanks use such terms (Baker 2006). We used Antconc (a software program dedicated to analyzing corpora) to undertake analysis of keywords (a simple frequency analysis) and concordance (analyzing target words in context). This provided a useful aerial view of the data, highlighting particularly prominent or puzzling emphases and allowing us to move between elements of our data – keywords, documents and interview transcripts – to examine the language, activities and settings of think tanks' work.

This process raised questions about the particular arguments that think tanks craft as they seek to shape policy, how it is that they construct and maintain these arguments, and how contradictions are negotiated, managed and defended in this process. In particular, it raised questions about what 'being independent' meant in practice. We therefore undertook more detailed analysis, exploring how think tanks work to shape health policy and how they simultaneously negotiate independence. We returned to our data, systematically identifying three strategies that the think tanks in our sample employed to negotiate independence (below) and looking for potential explanations for language use and the people, practices and artifacts that might support it. To examine each of these strategies in depth, we then selected examples of a 'telling case' (Mitchell 1984) for detailed analysis. Analysis was informed by our theoretical interest in language, rhetoric and argument (Russell et al. 2008; Shaw

2010) and by the sensitizing concepts of 'front-stage' and 'back-stage' planning and 'sacred' and 'profane' policy talk (Degeling 1996; following Goffman 1959). The former allowed us to consider the more public and private settings in which health policy and planning took place, and the later to distinguish the theory of policy making – with its claimed values of objectivity and rationality – from accounts of how things worked in practice.

Throughout the analytic process, ethnographic field notes and contextual material (e.g., policy documents) helped to set the scene in which healthcare planning took place.

### *Ethical issues*

Our study received approval from the Research Ethics Committee at Queen Mary University of London (QMREC2011/76). This was important given that the study raised questions about the nature of consent, the accountability of the researcher (who at one stage was an employee of Think Tank B and who later became an honorary staff member with professional and historical commitments) and the analytic process (see Shaw forthcoming for further detail).

Given the smallness of the think tank world and the in-depth nature of our work, it was not feasible to assure organizational confidentiality. We discussed this with all four of the think tanks in our study and initially agreed with each that we would reveal the identity of their organization but assure anonymity for individual participants. Accordingly, participant descriptions are necessarily sketchy when presenting our findings, and we use possessive pronouns (his, her, etc.) interchangeably throughout. As is usual in linguistic ethnography (Rampton et al. 2004; Creese 2008), we provide worked analysis of extended sections of data in order to ground our analysis. At proof stage, at the request of senior staff from some of the participating think tanks, we anonymized all organizations' names.

## Findings

The four think tanks in our sample undertook a range of activities relating to NHS reforms, and to health policy and planning more broadly. For Think Tanks C and D, this involved a limited number of people in specific projects due, at least in part, to limits on funding and capacity (and in particular, dependence on income from grants or consultancy contracts). In contrast, Think Tanks A and B were supported by large endowment funds (Table 1), which enabled them to support a sizeable staff and develop programs of work focused on health care, with often wide-ranging activities relating to research, policy analysis and leadership development (with both organizations linking not only with decision makers, but also healthcare managers and professionals).

Despite such differences, we noted a number of similarities in the way the think tanks in our study operated and the language they used. In particular, we were struck by how they tended not to talk about themselves as think tanks. The term 'think tank' was seen to be useful in some settings (for instance, in discussion with the media) but was regarded as politically laden, suggesting 'ideologically driven organizations' wrought with values and agendas. The think tanks in our sample sought to position themselves as autonomous and value-free organizations, using the terms 'independent' and 'independence' confidently (Table 2), in front-stage, public settings (often in publicly accessible documents, such as strategic plans, priority statements, mission

Table 2. Examples of independence presented by think tanks.

| |
|---|
| [Think tank A] is an independent charity working to improve health and health care in England (*Strategic Plan*) |
| 'So I think in terms of financially we're independent, I think politically we're independent, and in terms of our commentary and analysis, I think that's not, doesn't come from any particular ideological perspective' (*interview with senior executive at Think Thank B*) |
| [Think Tank C] is an independent not-for-profit research institute whose mission is to help improve policy and decision making through research and analysis (*Strategy document*) |
| [Think Tank D] is an independent, charitable, non-party think tank whose mission is to set out a better way to deliver public services and economic prosperity (*Annual Review*) |



statements, annual reports and websites). Such statements situated think tanks as working in a neutral and independent space, free from political agendas ('nonparty'), financial interests ('not for profit') and partiality ('evidence-based'), and therefore making them well placed to improve health and health care, as well as policy and decision making.

For Think Tanks A, B and D this outermost layer of self-presentation drew on their status as charitable companies (Table 1). This conferred on them a legal requirement to undertake a range of activities and to demonstrate that their work was primarily for public benefit and 'not for the purpose of implementing the policies of a governmental authority, or of carrying out the directions of a governmental authority' (Charity Commission 2001). What emerged from this process was a series of statements confirming and reconfirming agreed goals, plans and purposes in fairly general terms (for instance, via annual reports of activities and financial audits) to the Charity Commission, the body responsible for regulating charities. In return, Think Tanks A, B and D received formal institutional confirmation of their independence from the Charity Commission that, together with their own institutional governance arrangements, think tanks described as assuring their impartiality.

These 'front-stage' demonstrations of independence contrasted with internal research and planning meetings, where we rarely observed mention of independence or neutrality. Terms such as 'public benefit, 'public interest' or 'community interest' – requirements for charitable organizations (Think Tanks A, B and D in our sample) and community interest companies (C) – were mentioned rarely and restricted to broad statements in internal documents (for instance, stating that 'Public benefit is clearly a focus of interest for the Charity') or policy statements in formal publications (e.g. 'Monitor [a new economic regulator of healthcare organizations] protects the public interest in ensuring access to services where market failure could not be tolerated').

This initial analysis raised questions about what 'being independent' meant in practice. We therefore undertook more detailed analysis, exploring how think tanks in our study work to shape health policy and how they simultaneously negotiate independence. In the remainder of our findings section we examine three strategies that we felt each of the four think tanks employed (to varying degrees) to negotiate independence: the rhetoric of balance, emphasizing objectivity and academic expertise 'front-stage'; and situating political influencing 'back-stage'. It is important to note that the distinction between these strategies is blurry and that our use of the analytic categories of 'front-stage' and back-stage' is not fixed or rigid (what counts as back-stage in one context may well be described as front-stage in another, and vice versa).

However, for analytic purposes – and to aid presentation of findings – it is helpful to consider each of these three strategies separately here.

### *The rhetoric of balance*

The think tanks in our sample varied in their engagement with and response to the proposed NHS reforms. Think Tank C, for instance, made no public response to government consultations about NHS reforms. Its only link to them was a commissioned research project focused on one specific aspect of policy – a potential indicator within the NHS Outcomes Framework. In contrast, Think Tanks A, B and D engaged in numerous ways with different aspects of the proposed reforms – via government consultations, as well as their own (often extensive) work programs, activities, meetings, seminars, events and more – focusing particularly on proposals to extend competition in health care, develop clinical commissioning and implement reforms at pace. In public forums and formal publications these three think tanks presented what Degeling (1996) refers to as 'front-stage' accounts of proposed reforms that at times echoed the language of government proposals to reform the NHS. Each referenced specific areas of proposed health reforms to make points about their own work and their ability to contribute to the reform process (with Think Tank C reporting limited capacity to respond to reforms in this way). The emphasis was on balancing values of fairness and efficiency.

Efficiency and fairness are not 'neutral criteria' (Stone 2008, 34). When asked to reflect on their use of such language and underpinning values at interview, informants engaged in what might be termed 'neutralizing work', using somewhat vague rhetoric to situate themselves near the ideological center of a policy debate. Take the following example from an interview with a senior executive at one think tank, following a question about the organization's position on the proposed NHS reforms:

> I don't think, I wouldn't say we've got a line, at least there's no overt line, there's no editorialising of any sort. I think we probably, if anything, believe in the National Health Service and want to see its development and good health well into, you know, into its hundredth year. I think we're all backing that. And I think if there's any ideology that is it really. And that's not just from our own value system. And I think the value system of the people here is to protect solidarity very firmly, more than anything else. But it is because, for pragmatic reasons, that actually it's a really good way of financing health care and we produce good value for money. So and other systems that rely much more on co-payments are less equitable and we don't favour that. We believe in fairness, you know. So I think if anything we are – I think we're, I think if we were to be mapped on a spectrum, regardless of what other people say we are, I think we would consider ourselves to be bang in the centre. And I think we would be pretty, yes we are on, we think that there is evidence to say why some competition is a good thing for provision. Do we think there's a role for private financing? Not convinced. You know, so there are, but there are, you know, there is – is competition going to be the thing that improves the National Health Service? No. You know, other things are more important, like data, like the right kind of leadership, the right kind of regulation. […] [M]any people out there are just so archetypal and unsophisticated, they will just say, 'Oh you think competition is a good thing, you must be a Right wing think-tank.' And that's completely and utterly, you know – so we're getting the kind of treatment that Tony Blair and Alan Milburn* got, by the Left. And then the Right will say 'You don't support co-payments; therefore you don't support rank competition', which we don't. So anyway we can't please them, and as we talked last time, the names I mentioned on the Left…and many on the Right. But we are firmly in the middle trying to protect solidarity. But at the same time trying to progress the health system and nudge it towards progression in a

way which any sophisticated health system is doing, mirrored by attempts abroad, all of whom are trying to protect solidarity but can't freeze an aspect of the '48 model.

* Tony Blair and Alan Milburn were Prime Minister (1997−2007) and Secretary of State for Health (1999–2003) in the last Labour Government.

This interviewee emphasizes the think tank's position as being grounded in fairness (drawing on images of social insurance characteristic of the foundations of the NHS and the 'model of '48', in which the logic of 'solidarity' extends medical care to all in need), but then talks about 'trying to progress the health system', 'nudge it towards progression' and being unable to 'freeze an aspect' of the original NHS model, thereby giving voice to government proposals for change. As with government policy (e.g., DH 2010), this opens the door for efficiency to enter into debates about reform, referencing two key areas of policy – competition and copayments (described elsewhere as the two 'flashpoints' of health policy). Accounts from Think Tanks A, B and D emphasized the need to move away from the established NHS model in this way ('can't freeze an aspect of the '48 model') and to progress the health system by introducing provider competition ('we think that there is evidence to say why some competition is a good thing for provision').

This 'policy talk' – referencing and echoing formal government proposals – was most visible in the think tanks' official publications. In theory these were publicly accessible documents (freely available via think tank websites) aimed at a wide-ranging audience (e.g. NHS managers, commissioners, patient organizations). In practice such publications used technical language that limited their accessibility and suggested that they were targeted mainly at healthcare planners and decision makers. For instance, echoing the content and terminology of the proposed NHS reforms, they emphasized such things as: 'reduced costs through integration and competition', 'improving productivity in the areas set out in the Operating Framework', 'the need for local legitimacy and accountability in the NHS', and 'supporting regulations for NHS procurement'.

Think tanks in our sample did not overtly support government proposals: notable challenges from Think Tanks A, B and D included questions over the speed of implementation, the potentially negative impact of price competition and the level of central control as potentially stifling local innovation. But such direct challenges were rare. All appeared to use policy talk in an effort to address and engage decision makers by emphasizing shared beliefs (e.g. 'moves to increasing competition are right'), appealing to key people ('As David Cameron [the current UK Prime Minister] said in May 2011…'); using similar terms and phrases (e.g. referring to 'the Nicolson Challenge', a mandate from the NHS Chief Executive to find 'efficiency savings' of £20 billion), presenting briefing papers or policy responses in the same genre as government policy and guidance; and citing many of the same sources (e.g. government and think tank publications).

A range of 'neutralizing work' was evident in our interviews as a way of further balancing values. As in the above extract, informants depicted their think tank as politically neutral by using spatial metaphors ('bang in the center', 'we are firmly in the middle', 'there's no overt line', and elsewhere 'the center of expertise', 'even handed', 'doing the middle path'); appearing to draw attention away from contentious areas of policy talk such as competition to more neutral and disinterested areas ('like data, like the right kind of leadership, the right kind of regulation') and situating themselves in opposition to 'archetypal and unsophisticated' people on both the Left or Right of the political spectrum. When we asked think tanks to describe their work

to us, informants from all four frequently reverted to describing what they were not (for instance, 'we don't have a particular voice to represent', 'we don't have an obvious position to take'), which tended to present the think tank as situated in an unclassified and neutral space.

### *Emphasizing objectivity 'front-stage'*

The process of engaging with – and distancing from – the political process seemed to require think tanks to engage in a continual process of framing, shaping and guiding the different messages that they wanted audiences to receive. Our data suggested that much time and effort was sometimes spent by think tank staff in drafting, redrafting, editing and re-editing certain elements of their work, to improve alignment with – and responsiveness to – proposed NHS reforms in areas where the think tank supported those reforms. This process involved senior executives (for instance, think tank directors or directors of programs) in detailed editorial work, with support from communications and public affairs teams (ranging from one or two key people, to a large and established department).

This editing process tended to be focused on 'front-stage', public accounts of research and policy analysis. This also encompassed, for instance, media discussions, websites or conference presentations. But it was publicly accessible written accounts that played a particularly key role in providing weight to think tanks' arguments and framing them as legitimate 'experts' able to feed into the policy process. Take the following extract, from an interview with a think tank senior executive, discussing what has enabled them to influence the evolving NHS reforms:

> I have come to realise that writing it down actually does matter a great deal, oddly.
>
> **Why do you think that is?**
>
> So, I think it gives you the authority. And in a lot of the process, well, people either want something to go, you know, in a lot of these processes they want something to go back to… and with a kind of, a kind of audit trail…. There's a sort of seemliness to that process. So I think, I think it's very difficult actually to influence without the sort of, without having the written analysis to underpin it, which you have published. And actually, of course, in the parliamentary discussions where our work was quoted, they don't quote a conversation they've had with you, they quote what you've written… And that discourse is a very important part of this. Now what is really helpful is combining that writing with the explaining personally. And also the warming people up to the fact that you're going to write, and in many cases I had prior conversations with people about how I was going to word this – sought their advice on [discussion about specific reforms]. And I changed some of the wording to, having reflected on their advice.
>
> **Okay, almost framing of what you were going to say?**
>
> Yes. So I iterated. So I did, I didn't, I didn't do things quite so sequentially. I guess I did the – and the, if, I guess the engagement with people was a two-way process where I was trying to influence them, but I was also taking their advice. So that what we would say was capable of being more influential.
>
> **OK. And you felt that process worked very well with what came out at the end of it?**
>
> Yes. Because I mean I think what we recommended then was things that, you know, and that is a classic Civil Service, you know, kind of: 'So if I change that word here, will you sign up to that? Right, I'll check that with that person there'. And 'if we do that, can you live with that?' 'Yes, check that back.' You know, that's what you do as a civil servant, you get something that people can move behind and move forward.

This interviewee emphasizes the importance of formal written accounts in providing weight to think tanks arguments ('writing it down actually does matter a great deal', 'it gives you the authority') and a tangible, traceable and citable source of ideas ('they quote what you've written', 'a kind of audit trail') that decision makers can draw on ('in the parliamentary discussions', 'classic Civil Service'). Far from being an internal think tank process, the production of formal front-stage accounts involved an interactive process ('a two-way process', 'combining that writing with the explaining personally', 'warming people up'), establishing a common base between think tankers and decision makers ('changed some of the wording', 'reflected on their advice') and co-producing accounts of NHS reforms on which both could then draw ('So if I change that word here, will you sign up to that?'). This process opened up possibilities for think tanks to interact with key areas of policy and influence NHS reform ('what we would say was capable of being more influential', 'get something that people can move behind and move forward'). This production of written accounts was visible to varying degrees in the activities of each of the four think tanks, with Think Tanks A and B appearing to place more emphasis on internal publications, Think Tank D on more media-oriented accounts (both written and spoken) and Think Tank C on academic papers and reports (though as noted above, this organization had only a tangential involvement with the NHS reforms).

Think tanks' formal accounts of their work linked with 'sacred language' of policy and planning (Degeling 1996), drawing on modernist conceptions of health policy that describe the policy process as an exercise in informed problem solving, and in which a problem is identified, data collected and analyzed, and evidence provided to policy makers on which they can then base decisions. In their 'front-stage' accounts think tanks emphasized a set of technical skills and activities (for instance, 'experimental intervention', 'innovative quantitative analysis', 'examining active age management', 'evaluating the impact'), which informed precise 'research and policy analysis' that, in turn, fed into 'the administrative machinery' of government. This was underpinned by an emphasis on evidence-based research and policy, with all four think tanks drawing on established standards of rigor and underpinned by an instrumental rationality that excludes ethical and moral concerns from rational consideration (Sanderson 2006). While terms such as 'care', 'people', 'public' and 'patients' were used, these tended to be depersonalized and emphasize technical systems and processes (e.g., 'unwarranted variations or gaps in care', 'capture people's experiences').

By employing such 'sacred' planning discourse front-stage, the think tanks in our sample publicly deferred to values such as rationality, objectivity, due process and consultation and established a sense of commonality and legitimacy with healthcare planners and decision makers. This reinforced their self-presentation as independent organizations and situated them as legitimate advisors on the problems – and potential solutions – of NHS reform.

### *Situating political influencing 'back-stage'*

The think tanks' desire to inform health policy meant that, while simultaneously presenting themselves as independent organizations, they also needed to signal their willingness to engage with the political process, and undertake activities that enabled them to influence policy. Use of policy talk and deference to 'sacred' planning discourse signaled to decision makers that they both knew about and adhered to the rules of the game 'front-stage'. This enabled think tanks to identify, engage and interact with decision-makers in other settings, to access other spaces, places, people and possibilities for shaping health

policy and to speak about and practice planning in ways that gave more explicit recognition to its political dimensions. Take the following extracts from interviews with senior executives at two of the participating think tanks, each talking about their work to engage with government proposals:

> So when it's at White Paper stage, you know, the White Paper and the consultations is very much a [Department of Health] exercise. And so our normal approach around those is, we would, in order to help then inform our position, we quite often bring people together. So I'm sure we had dinners and events, – I can't remember now, but I could find out – during that period on topics relevant to the White Paper. And that would, we'd use those discussions, usually invite some officials – so they hear first hand ours and other's views – but also what we would be hearing from others would help inform our position…And we would also, if we had the opportunity, hold private meetings with officials just to sort of ask questions like, you know, 'On this what exactly does that mean and what's intended and…' So there were those. And I mean I do remember there was a meeting with Lansley and Ian Dodge* who came here, but I can't remember whether that was the White Paper stage or at Bill stage.
>
> * at the time of the study Andrew Lansley was the UK Secretary of State for Health, and Ian Dodge the Director of Policy Unit at the Department of Health
>
> …the battle lines had been really – I mean remain so unfortunately – but kind of, I think, retrogressively very drawn on choice, competition, public, private, these sort of really unhelpful polarities….And so that was when we started publishing on innovation and did a lot of work with Stephen Dorrell[≠] on productivity and events with him and trying to find, trying to sort of gee up the conversation in a slightly different way, which is to say, you know, let's not talk about competition, but let's just talk about new and better ways of doing things because we really need them.
>
> [≠] at the time of the study Stephen Dorrell was Conservative Member of Parliament and Chair of the Health Select Committee

These extracts highlight think tanks' focus on – and engagement with – a small group of powerful people involved in shaping policy ('there was a meeting with Lansley and Ian Dodge', 'did a lot of work with Stephen Dorrell'); emphasizing the importance of relationships with decision makers ('bring people together', 'hearing from others'), and engagement with institutional agendas ('the White Paper and the consultations', 'a DH exercise') in shaping NHS reform. This engagement took place in back-stage settings ('we had dinners and events', 'hold private meetings with officials', 'there was a meeting with Lansley and Ian Dodge who came here'). While interviewees referenced policy talk ('choice, competition, public, private'), their emphasis was less on gaining legitimacy (this already having been established 'front-stage') and more on opening up potential for negotiation and debate about health policy ('they hear first hand ours and other's views', 'trying to sort of gee up the conversation in a slightly different way', 'let's just talk about new and better ways of doing things'). The planning language shifts from 'sacred' to 'profane' ('hearing from others', 'inform our position', 'gee up the conversation', 'let's not talk about competition') in recognition of the messy realities of doing policy.

This 'back-stage' activity contradicted 'front-stage' performances of planning discourse. 'Back-stage' interactions were regarded by think tanks as an important part of 'policy work' but rarely resembled the process of identifying and comparing options associated with instrumental planning discourse (above). While informants often described to us their focus on the 'administrative machinery' of government, back-stage activities focused on 'political machinery' – linking with decision makers, senior healthcare managers and professionals, academics and business representatives in particular to debate, negotiate and influence NHS reform.

Think tanks undertook a considerable amount of work 'back-stage' to bring together specific actors, activities, artifacts and interactions. 'Back-stage' events tended to involve a detailed process of selection, ranging from reviewing existing members (e.g. in internal databases) and inviting those with related interests (e.g. on commissioning) to targeting invitations to specific decision makers (e.g. from Department of Health, Monitor), other stakeholders (e.g. NHS Confederation) and sponsors or funders. Take the following field note, reflecting on a conversation with a think tank senior executive about how their organization goes about shaping policy:

> He then turns to use his blank piece of paper, drawing a curve at the bottom to represent the NHS and an arrow above it to represent time and using this to emphasise to me how one needs to be in and around the NHS for at least 10 years to really understand it, be able to appreciate the different 'contours' and to be able to both dissect and synthesise it. He continues that 'there are only a few who get it enough to have a valuable opinion about where it should go' and [they] seek to find these people, cultivate and fast-track them…This, he says, is what the conference is about, bringing together people who are on this track… What kind of people are these? People who have a 'cast of mind', who make 'sensible comments' and are as objective as possible, drawing on evidence, being reasonable and 'not ideologically driven'. (1 February 2012)

Think tanks' 'back-stage' activities (e.g. seminars, formal and informal meetings, breakfasts, dinners, media appearances, emails, letters) involved specific actors ('only a few who get it', 'people who have a cast of mind'), drawn particularly from government/civil service, business and academia. These actors did not appear from nowhere, but had been 'in and around the NHS for at least 10 years' and had demonstrated their willingness and ability to negotiate both 'front-stage' planning discourse ('make sensible comments', 'being reasonable and not ideologically driven') and 'back-stage' debate ('appreciate the different contours'). Such demonstrations enabled access to think tanks resources (fast tracking, cultivation) and 'back-stage' activities ('the conference', 'bringing people together').

Think Tanks A, B and D appeared to seek to build coalitions of 'likeminded' people ('usually a select bunch of high powered policy makers, leads, managers', fieldnote) and to provide discrete forums for debate about issues pertinent to health reform (e.g. competition and integration, economic regulation). Such 'back-stage' debate often invoked the Chatham House rule, a device that explicitly situated talk as 'off the record' and encouraged participants to share information with others in the same situation.

## Discussion

Much though not all of the existing literature perpetuates think tanks' claim that they do not represent vested interests but conduct independent research and policy analysis for the sake of building a body of knowledge, raising public awareness, serving the public interest, and improving health care (Shaw et al. 2014). Our findings challenge this view, revealing how the think tanks in our sample did considerable work to foreground reason, objectivity and independence; while at the same time signaling that they were available to (and dependent on) political institutions and decision makers to talk about health policy away from public view. This resulted in a series of tensions and contradictions in their work that required them to consciously and continuously negotiate the different elements of their work and the different front-stage and back-stage settings in which it took place. They employed a number of rhetorical strategies to achieve this, simultaneously seeking to shape and influence NHS reforms, while neutralizing the values

and positions that underpinned such work. Such language masked a set of values, interests and networks that shaped and underpinned their agendas for healthcare reform. These language games seemed to be crucial to the think tanks' presentation of themselves as legitimate and trustworthy sources of value-free advice to decision makers. Combined with back-stage activities – and a willingness to talk privately with trusted colleagues – this afforded them opportunities to influence the content and process of NHS reform. Our data supported an account of these think tanks as presenting the 'view from nowhere' (devoid of values, people and interests); while at the same time employing policy talk and networks of clients to promote ideas about how to reform the NHS. We felt that far from being neutral, these ideas (and the activities, artifacts, actors, interactions and arguments allied to them) lent credibility to government proposals to extend market principles within the health service – though this was not the view of many participants, who felt that the position of their think tank was much more nuanced than this.

Our research, while preliminary and based on a small study of only four think tanks in a single area of policy, adds to a growing body of empirical work that challenges an instrumental approach to thinking about policy and that characterizes policy as social action and policy making as iterative and subject to value judgments (see, for instance, Degeling 1996; Russell et al. 2008; Shaw 2010; Smith 2013; Wagenaar 2011). It accords with an emerging literature about think tanks that describes their basic mission as 'a game of gathering, balancing, and assembling various institutionalised forms of capital, especially academic, political, economic and media capital' (Medvetz 2012, 140). To our knowledge, ours is one of the first to adopt an interpretive approach to studying think tanks in health care. We have deliberately adopted an approach that is grounded in micro-analysis of think tanks' practices and language across different settings and the use of thick description (cf. Geertz) of a small sample of cases that enabled us to study rarely accessed organizations in-depth. This builds significantly on much of the research undertaken previously.

There are, however, limitations to this study, particularly in considering the transferability of our findings to other settings. For instance, to the extent that findings from the four organizations in our sample can be extrapolated, they suggest that think tanks in England tend to present similar views on healthcare reform and suggest a convergence of values, activities and people in the way they undertake their work. However, this apparent convergence may reflect our small sample undertaking work in the context of a specific set of healthcare reforms, and failed to reveal the breadth of think tank values and activities within and outside of the United Kingdom. Elsewhere, there appears to be more divergent values, interests and views represented by a spectrum of think tanks, for instance, in the United States (Medvetz 2012) or Europe (Sherrington 1999). Further research is therefore needed to investigate whether the theorization presented here holds true in other settings and political contexts, explore whether and how 'the view from nowhere' is performed by think tanks elsewhere in the world, examine how think tanks position (and reposition) themselves over the course of different political cycles and understand how specific networks and relations form and the way that think tanks across settings do or don't inculcate these.

In the interests of more fully understanding the work that think tanks do to shape health policy – and avoid reinforcing an instrumental approach to thinking about and analyzing health policy and planning (Parsons 2010) – we urge researchers to adopt an interpretive approach that can examine the values and relationships that contribute to think tanks' work and the process of shaping health policy across different settings and understand how the practical rationalities of think tank members, health care planners and other players are negotiated moment-to-moment in their work.

The UK state currently has limited capacity to design and action solutions for public problems: the usual approach is to bring together and sustain coalitions of stakeholders to feed into policy making. Our article has drawn attention to the increasing visibility of think tanks in this process and the ways in which they seek to shape health policy and planning. But think tanks are not the only players: policy makers, universities, media, business, professional organizations and citizens all seek a stake in shaping current reforms (see, for instance, Player and Leys 2011). All develop and participate in strategies to try to promote and maintain particular interests, gain political power and, ultimately, shape the policy agenda (in this case, NHS reform). All likely adopt similar strategies in order to gain legitimacy and voice in debates about healthcare policy and planning. We advocate further research to examine the overall contribution of think tanks to health policy and planning discourse (as opposed to other organizations or networks), and the receptivity of relevant decision makers to their work.

Just like other players, think tanks have a history, a position and an agenda. Our findings suggest that think tanks provide a forum for health policy ideas to emerge independently of public discussion. While many UK-based think tanks are charitable organizations, requiring them to work in the public interest, few consult or involve patients or citizens directly in their work and tend, instead, to involve those drawn from elite sections of society (e.g. politics, professions). This represents a 'democratic deficit', with debate dominated by coalitions of experts and prospects for political equality (i.e. where every citizen potentially affected by a decision has an opportunity to affect that decision) diminished. This democratic deficit urgently needs addressing by enabling a fuller range of stakeholder concerns and interests to be taken into account in policy making. There are opportunities for new forms of think tanks to develop that encompass such a wider network of experts (see, for instance, Lakoff 2011). However, despite opportunities for think tanks to open up public debate – and a requirement for many to serve the public interest – current evidence suggests that (at least in relation to the sample studied here) this is happening far less in practice than is often implied.



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