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From public health research to health promotion policy: on the 10 major contradictions[1]

Summary

The rise of evidence-based medicine has given impetus to calls for more research evidence to be incorporated into health policy. The difficulty in effecting this research transfer has often been attributed to the different "worlds" of researchers and policy-makers. There are other contradictions, however, that must be addressed in attempting to bridge public health research and health promotion policy. These include such issues as: what forms of evidence are required, what types of research are usually funded, the limited scope and duration of health promotion programs, how health policies are formulated, contemporary public sector management reforms, and so on. These contradictions need to be recognized and managed if closer links are to be formed between public health research and health promotion policy.

Keywords: **Evidence-based policy – Research transfer – Health promotion program funding and evaluation – Health policy decision-making.**

The challenge of research transfer

The means by which research is transferred into policy decision-making has concerned researchers for decades. The "research utilization" field grew out of concerns that social science appeared to make little impact on social policy in the US and UK (Weiss 1986). Models of how, when, and why research affects policy development have been proposed (e.g., Short 1997), variously describing the content of the research-policy interface, or the structure and process of such interface. The failure of research transfer has largely been ascribed to the "two communities" hypothesis – that researchers and policy-makers live in different worlds, use different language, have different motives, and face different constraints and incentives. This construction has resonated with the experience of policy-makers and researchers over time and was recently reinforced in a systematic review of health policy-makers' perception of their use of evidence (Innvaer et al. 2002)

Recent calls for evidence-based health policy has gained much impetus from the evidence-based medicine (EBM) movement and drawn on the earlier research utilization literature. The concept has intuitive, common sense appeal and has led to various proposals about how to bridge the differences between the two world of researchers and policy-makers (e.g., Lomas 1997; Gray 1998). The Lomas "Linkage and Exchange" model relies not only on a "translator" or "broker" of knowledge, but also recognizes other contextual factors, such as structures for decision-making, values and beliefs of stakeholders, and the information production process itself.

The "two communities" hypothesis appears to be a well-accepted description of the problem, and the consequent bridge-building solution seemingly obvious. However, perhaps both the explanation of, and solution to, the problem are too simplistic to be accurate or effective. In other words, if it's that straight forward, why hasn't the problem been overcome? It seems there must be a range of other underlying issues and complexities that need to be considered and addressed.

In 1956, Chairman Mao wrote an essay titled "On the ten major relationships" and nominated the key contradictions that had to be recognized and tackled at that particular point in the socialist construction of China. He suggested that the world consists of contradictions and the task was to handle these contradictions correctly (Committee for Works of Chairman Mao Tsetung 1997). He accepted that they may not be resolved to our satisfaction in practice, and they may

[1] With apologies to Chairman Mao.

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give rise to new contradictions. Nonetheless, the key task was to mobilise all the positive factors in moving forward.

It would seem possible to draw some inspiration from this essay in examining the problems of moving from public health research to health promotion. Below, I suggest there are ten major contradictions to be grappled with. I pose these in binary terms in order to sharpen debate, rather than to lock us into fatalism. Indeed, the recognition and management of the dynamic between these contradictions may well pave for "the third way". While these points are drawn largely from experiences and observations within Australia, I believe they are broadly reflective of the dilemmas faced globally.

The 10 major contradictions

1. Evidence from public health research versus evidence for health promotion policy-making

Much of public health research is based on data collection at the individual level, and concerned with specific health outcomes and individual exposure to specific hazards and risks. Health promotion policies are, on the other hand, often concerned about actions and impact at the population or community level. As such, the evidence base required spans both community and individual levels.

For the researcher, the concern is to identify what causes ill-health and what interventions work, in as precise and definitive manner as possible. There is a scientific imperative to confirm the hypothesis beyond reasonable doubt. Policy-makers, on the other hand, are often working amid conflicting interests and demands and attempting to balance multiple objectives. Decisions may be made when the evidence, on the balance of probabilities, points to a particular direction.

Researchers have precise definitions of what constitutes sound methodology and good evidence. Policy-makers accept that evidence includes not only research and expert knowledge but also stakeholder consultations (UK Cabinet Office 1999).

2. Evidence from fundable public health research versus evidence not gathered for policy-oriented research

Research funding bodies have strict criteria related to scientific merit. Rigorous peer review processes give emphasis to credible, well-established methodology. As such, health research funding is inherently conservative and tend to support biomedical and epidemiological research rather than social and qualitative research. Kavanagh et al. (2002) suggest that the filters which limit the choice of methods, and therefore impact on funded research and the public health knowledge base, include: research training, disciplinary affiliation and conceptual frameworks of researchers, research setting, political context and peer review system. Limited resources and competition for resources may also contribute to greater funding for clinical trials and biomedical research, with public health researchers settling for more short-term, cross-sectional studies.

Understanding how social, economic, and cultural environments influence health and well-being is vital to effective health promotion policy. The capacity to forecast the distributional consequences of policy decisions – across population groups, geographical space, and generations – is also important for policy development. Yet, these topics are not commonly funded areas in public health research, leading to researchers becoming discouraged to not even apply for funding (PHAA 2002).

3. Evidence from health promotion programs versus evidence for policy-making

In the absence of extensive applied social research in health, evidence from different types of health promotion programs may be useful. Program implementers often prefer formative evaluation to assist with program delivery, but summative evaluation is generally what is desired by policy-makers (Dixon & Sibthorpe 2003). Ideally, continuous and longitudinal data about program activities and impacts in the community should provide the basis for policy decision-making. For the policy-maker, knowing that a program works is important, irrespective of how that evidence is accumulated.

Unfortunately, many health promotion programs are funded on a short-term, time-limited basis (Lin & King 2000). They are often carried out on a small scale or as a pilot, and often without systematic documentation, let alone rigorous evaluation. The impact, if any, is often unknown. The potential transferability of these projects is unexplored.

4. Responsibility for health promotion programs or healthy public policy

Responsibility for health promotion policy-making is usually placed somewhere in the health portfolio. In terms of expenditure, health promotion typically occupies a small single-digit percentage of the national health budget (AIHW 2001). From the viewpoint of the health bureaucracy, then, health promotion policy is mainly a matter of marginal expenditure for small health programs. As such, responsibility for health promotion policy is seldom vested at the highest level of the bureaucracy.

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Table 1

	1930s	1960s	1990s	2020?
Caricature	Manuals and forms	Planning and policy	Management and contracts	Knowledge and energy fields
Core subject	Constitutional law	Policy analysis	Management	Brokering meaning systems
Body of knowledge	Law, history	Social science	Public choice (deductive positivist)	Interpretive (inductive empirical)
Unit of resourcing	Functional sphere	Programs	Individual outputs	Public service outcomes
Problematic	Administration	Poverty, employment	Legitimacy	Coherence of economic, social and human capital
Main tool types	Regulatory budgeting	Planning, management	Competition, productivity	Sustainability, deliberation
Organising focus	Bureau	Programs	Output groups	Networks

International discourse on health promotion policy, however, accepts that effective health promotion depends on the development of healthy public policy. This requires not only high level skills to mingle and negotiate with those responsible for social and economic policy but also the positional right to do so. Effective negotiation requires not only taking the moral high ground about improving the public's health and having sound evidence, but also power, authority, and leveraging ability.

5. Decision-making – evidence-based or a matter of organizational epistemology

Contemporary public sector management places emphasis on accountability, transparency, setting quantifiable objectives and targets and performance monitoring (Boston et al. 1996). In theory, this should encourage the adoption of evidence-based decision-making. David Dery's notion of organizational epistemology, however, suggests that systematic bias occurs in the way that policy-making bodies look for and use data (Dery 1984). The battle to control policy problem definition and policy resolution are intertwined, and these processes can become mutually reinforcing. Thus, an organization's vulnerability to the consequences of error become intimately linked with its capacity to define the "truth" which cannot be challenged by other stakeholders.

In these circumstances, and despite conventional expectation, policy-making organizations are often unreceptive to alternate or equivocal evidence, let alone research that produced contrary evidence. Their quest for "truth" is partial, and to some extent, pre-determined.

6. Decision-making and organizational culture – learning organizations vs the "doing" organizations

Contemporary management theory has placed much emphasis on continuous quality improvement, which requires organizations to receive feedback and to make adjustments on the basis of that learning. In theory, an organization committed to evidence-based decision-making is one that is willing to learn and adapt as its "environment" (customers, employees, trade relations) changes.

Health policy-making organizations (a.k.a. health departments) do not necessarily exhibit the traits of a "learning organization". Beyond the need to control the policy agenda, as discussed above, there is the need to ensure successful implementation of policies within the electoral cycle. As such, these organizations are concerned with "getting things done". The health promotion policy advocate who comes to the executive table and recommends the adoption of noble causes and long-term objectives (even as mundane as encouraging staff to use the staircase to combat the rising epidemic of obesity in the community) is often acting out of character with the dominant short-term organizational culture. Exclusion from decision-making can be a consequence.

7. Information uncertainty or value uncertainty

Policy-making necessarily prioritizes particular issues over others, and may embrace particular approaches over others. As such, policy-making is an exercise in making judgment and assigning value – and not necessarily done on a "scientific" basis. Debates surrounding health promotion policy, in particular, typically revolve around core issues and approaches that have been remarkably resilient over time: addressing the gap between the rich and the poor versus targeting the poor, social engineering versus individual behaviour change, etc. It is highly value-laden.

The promotion of evidence-based policy needs to recognize the limitations of much of public health research. Public health research most often offers additional information and helps to fill the evidence gap. Unless specifically designed to do so, most health research does not shed light on what the community values, whether the community values different things under particular circumstances, or what values are traded off at the point of policy-making. Research can thus address information uncertainty, and improve the rigour of decision-making. Its capacity to address value uncertainty on the part of decision-makers is limited.

8. Managerialist reforms or improving accountability

The rise of evidence-based policy in the 1990s has coincided with the managerialist reforms and instrumental practices of public administration in recent decades. The increasing importance of DALYs and cost-effectiveness analysis sits comfortably with the broader emphasis placed on effectiveness and efficiency in public sector management. A technocratic logic supports both managerialist reforms and evidence-based policy (Marston & Watts 2003).

In theory, when such evidence is brought into the policy-making process, it makes the basis for policy decision-making more transparent. As such, it has the potential to improve accountability of the policy-makers. Problems arise, however, when the evidence is complex or eclectic, and thus understood by few. In these circumstances, the power of decision-making may become concentrated with those who are able to interpret and argue cogently about the evidence. Technocratic logic is not necessarily a democratising force.

If health promotion policy is concerned with creating an environment that enables people to take control over their lives, then a major challenge is to find ways that make researchers and managers accountable, along with policy-makers.

9. Knowledge management in public administration – positivist or constructivist/interpretive approach

Public administration in the 20th century embodied different worldviews, different stands of knowledge, and different approaches to administration. Hess and Adams (2002) suggest that public administration has evolved over the 20th century from a focus on manuals and forms in the 1930s, to planning and policy in the 1960s, then to management and contracts in the 1990s. The body of knowledge that has underpinned these developments has shifted from law and history to social science, then to public choice theory. The major tools adopted by administrators have moved from regulation, to program planning, and then to competition.

They suggest that changes in the relationship between markets, states and communities, at the dawn of the 21st century, are placing new demands on governments. They predict that the policy-making world will shift away from searching for the "right" definition of ideas and applying objective knowledge to the rational pursuit of policy objectives. Instead, the policy process will entail a fluid movement of ideas emerging and shifting as they are debated across policy networks. This fluidity will require a constant search for new ideas and approaches, and for new intellectual foundations for public administration and policy-making.

If Hess and Adams are correct in their history as well as their forecast, public health research is somewhere between the 1960s and 1990s in its alignment with public administration. Health promotion policy, on the other hand, will required a knowledge base and an approach to knowledge generation is still evolving.

10. Convergence or reclaiming the territory

The increased interest in evidence-based health policy can be seen in both researchers' and policy-makers' worlds. From the viewpoint of the "two communities" hypothesis and the "linkage and exchange" model of research transfer, this convergence is a harbinger of good things to come. When attitudes shift and coincide, behaviours might change. Apparently, mutual yearnings for convergence are now being expressed from both "worlds".

Or are they? Marmor and Okma (1999) make the observation, from a cross-national examination of health policy developments, that the same words are being imported and used in policy processes across countries. Yet, on closer examination, these words do not appear to mean the same thing. So, have researchers and policy-makers merely adopted a similar rhetoric? Are the contexts (and contents) of their words the same? Or, have they been adapted to suit differing purposes, while tailored to give the appearance of shared worldviews? This language of seeming agreement may be a way of (re)claiming the territory.

Foucault's (1980) notion of "governmental rationality" may be useful here. He argued that power and knowledge are closely connected and regarded public health as a tool of government in the 18th century. The notion of governmentality goes beyond the institutional expression of the sovereign state. It refers to particular mentalities in the conduct of society. This framework calls into question the notion of research transfer; it questions the motives of the research and suggests that it is as much a player in the exercise of (state) power as bureaucrats and politicians. If correct, it requires researchers and policy-makers to reflect on their role and contribution to the policy discourse. Policy problems may also require re-framing to allow for broader civil discourse. This may be where public health research and health promotion policy will meet and both be re-framed.

Conclusion: moving forward

The aim of discussing the 10 contradictions above is to suggest that the problem of linking public health research and health promotion policy is complex and dynamic. Starting from the idea that research and policy-making are both processes, rather than products, Lomas (1997) suggests three strategies to overcome the apparent gulf between them:

1) Develop new organisational models within research organisations as well as decision-maker organisations, through dissemination planning, issue-based briefings, developing organisational links, and training efforts for researchers and policy-makers,
2) Instigate appropriate activities and processes, including audience-specific priority-setting, consequent changes in funding, and encouraging and funding research overviews and synthesis,
3) Foster human resource development by incorporating research literacy into training programs and developing research and policy-brokers.

These relatively mechanical solutions are a good start but may not be sufficient. While we move ahead with these seemingly obvious solutions, we also need to be mindful of how the reality might shift. We would do well to understand those deeper patterns, and to acknowledge and manage those contradictions.

Policy is about exercising judgment in the face of uncertainty. Evidence helps provide greater certainty, but the moral judgment remains the responsibility of the policy-maker. There will be health promotion policies that reflect a strong analytical element, but there will also be policies where political contingencies will be dominant. In the constant interplay between ideas, evidence, interest groups, and institutions that characterises the policy process, the challenge is to develop evidence-based policy entrepreneurship and to secure processes that ensure what Peterson describes as substantive and situational social learning (1997). Ultimately, the achievement of good health promotion policy outcomes – real differences for the communities concerned – will depend on mechanisms and processes for policy and research governance.

Conflict of interest

The author serves on numerous boards of professional, community, and government bodies in Australia and consults for a range of international organizations. The author is also presently involved in organizing of a number of international meetings – in health promotion, health surveillance, and health services research. There is, however, no conflict of interest in relation to this paper.

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Zusammenfassung

Von der Public-Health-Forschung zur Gesundheitsförderungspolitik: zu den 10 Hauptwidersprüchen

Das Aufkommen von evidenzbasierter Medizin hat der Gesundheits-Policy neuen Auftrieb gegeben, mehr Forschungsevidenz zu berücksichtigen. Die Schwierigkeit des Wissenstransfers wurde oft den unterschiedlichen „Welten" von Wissenschaftlern und Politikern zugeschrieben. Beim Versuch, die Brücke zwischen Public-Health-Forschung und Gesundheitsförderungspolitik zu schlagen, müssen jedoch weitere Widersprüche einbezogen werden. Dazu gehören folgende Themen: welche Formen von Evidenz sind angemessen, welche Art Forschung wird finanziell unterstützt, begrenzter Geltungsbereich und Dauer von Gesundheitsförderungsprogrammen, wie wird Gesundheitspolitik formuliert, heutige Reformen der öffentlichen Verwaltung usw. Diese Widersprüche müssen erkannt und bewältigt werden, wenn Public-Health-Forschung und Gesundheitsförderungspolitik enger verbunden werden soll.

Résumé

De la recherche de santé publique à une politique de promotion de la santé: les 10 contradictions principales

L'essor de la médecine fondée sur des preuves a stimulé la recherche de données probantes incorporables aux politiques de santé. La difficulté de réaliser cet objectif a souvent été attribué au fait que les chercheurs et les personnes de santé publique vivent dans des mondes différents. Il y a cependant d'autres contradictions qui doivent être prises en considération pour relier la recherche de santé publique et les mesures de promotion de la santé. En particulier, quels types de données probantes sont requises? Quels types de recherche sont habituellement financés? L'envergure et la durée des programmes de promotion? Comment les politiques de santé sont-elles formulées? Quelles sont les réformes dans le management du secteur publique actuel? Etc. Ces contradictions doivent être reconnues et prises en charge si l'on souhaite établir des liens plus étroits entre la recherche de santé publique et la promotion de la santé.

References

Australian Institute of Health and Welfare (AIHW) (2001). National Public Health Expenditure 1998–99. Canberra: Australian Institute of Health and Welfare.

Boston J, Martin J, Pallot J, Walsh P (1996). Public management: the New Zealand Model. Auckland: Oxford University Press.

Committee for the Works of Chairman Mao Tsetung (1977). Selected works of Mao Tsetung, volume V. Peking: Foreign Languages Press: 284–307.

Dery D (1984). Problem definition in policy analysis. Kansas City: University Press of Kansas, Kansas State University.

Dixon J, Sibthorpe B (2003). The Limits to Technical Rationality in the Health Inequalities Policy Process. In: Lin V, Gibson B, eds. Evidence-based health policy: problems and possibilities. Melbourne: Oxford University Press: 237–49.

Foucault M (1980). Truth and power. In: Gordon C, ed. Power/knowledge selected interviews and other writings, 1972–1977. London: Harvester Wheatsheaf.

Gray JAM (1998). Where's the chief knowledge officer? BMJ *317*: 832.

Hess M, Adams D (2002). Knowing and skilling in contemporary public administration. Aust J Public Admin *61 (4)*: 68–79.

Innvaer S, Vist G, Tommald M, Oxman A (2002). Health policymakers' perceptions of their use of evidence: a systematic review. J Health Serv Res Policy *7*: 239–44.

Kavanagh A, Daly J, Jolley D (2002). Evidence, methods and public health. Aust N Z J Public Health *26*: 337–42.

Lin V, King C (2000). Intergovernmental reforms in public health. In: Bloom A, ed. Health reform in Australia and New Zealand. Melbourne: Oxford University Press: 251–63.

Lomas J (1997). Beyond the sound of one hand clapping: a discussion document on improving health research dissemination and uptake. Sydney: NSW Health Department Research and Development Centre.

Marmor T, Okma K (1999). Taking stock and looking forward: what have we learned from the Four Country Conferences on Health Care Policies and Health Care Reforms? Paper prepared for the Five Country Conference on Health Care Policies and Health Care Reform, Sydney.

Marston G, Watts R (2003). Tampering with the evidence: a critical appraisal of evidence-based policy making. Drawing Board *3*: 143–63.

Peterson M (1997). The limits of social learning: translating analysis into action. J Health Polit Policy Law *22*: 1077–114.

Public Health Association of Australia (2002). Survey of members about experiences of NHMRC. Available at http://www.phaa.net.au/phrag/survey/htm.

Short S (1997). Elective affinities: research and health policy development. In: Gardner H, ed. Health policy in Australia. Melbourne: Oxford University Press: 65–82.

UK Cabinet Office (1999). ModernisingGovernment White Paper. London: Centre for Management and Policy Studies.

Weiss C (1986). The many meanings of research utilization. In: M. Bulmer et al., eds. Social science and social policy. London: Allen and Unwin.

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