

Perspective

EVIDENCE-INFORMED POLICY: IN PRAISE OF POLITICS AND POLITICAL SCIENCE

David J. Hunter

Centre for Public Policy and Health and WHO Collaborating Centre on Complex Health Systems Research, Knowledge and Action, Durham University, United Kingdom

Corresponding author: David J Hunter (email: d.j.hunter@durham.ac.uk)

ABSTRACT

The shift from evidence-based to evidence-informed policy is a welcome recognition that evidence is neither value-free nor uncontested. The relationship between evidence and policy is complex and not a rational, linear one. The hunger for better knowledge to inform policy and practice has tended to overlook, or deny, the fundamentally

political nature of policy-making and the often limited role of scientific evidence in its outcome. Much can be learnt from the experience of getting evidence into policy and practice in the face of competing notions of what constitutes evidence and where there is scepticism as to its value. Interpreting and using different types of evidence to inform

and change policy is recognized by WHO through the work of the Evidence Informed Policy Network and other initiatives. These acknowledge that complex systems demand new and different approaches in bringing about change, and that evidence is one among many tools in that process.

Keywords: EVIDENCE-INFORMED POLICY, POLITICAL SCIENCE, PUBLIC HEALTH

INTRODUCTION

Perhaps lurking in the mind of every applied researcher is a deep-seated belief in the power of science, with its promise that greater knowledge will reduce uncertainty and release us from what is often perceived to be the dirty business of political decision-making. It is a forlorn hope when the reality is that politics invariably triumphs over evidence (1). And in a democracy that is surely as it should be.

The shift from evidence-based to evidence-informed policy is a welcome and long overdue recognition that evidence is neither value-free nor uncontested. It also acknowledges that policy is shaped by many other factors besides academic evidence. Even so, the hunger for better knowledge to inform policy and practice has tended to overlook, or even seek to deny, the fundamentally political nature of policy-making and the

often limited role of scientific evidence in its outcome (2). As Marmot shrewdly observed, “Scientific findings do not fall on blank minds that get made up as a result. Science engages with busy minds that have strong views about how things are and ought to be” (3). Hence, the term “policy-informed evidence” may more accurately reflect reality than “evidence-informed policy” (4).

PARADIGM WARS AND THE RISE OF EVIDENCE-INFORMED POLICY

The replacement of a narrow, reductionist and largely instrumental view of the relationship between evidence and policy, which underpinned the evangelical evidence-based medicine (EBM) movement, with a more nuanced view of the relationship between evidence and policy is to be welcomed (5). Nevertheless, scepticism about the impact of evidence on policy and

practice remains, and many barriers to its use arising from the nature of the policy process itself have been identified, including (6):

- the complexity of the evidence and arcane disputes over its methodological basis and rigour;
- the intricacies of the policy process, and attempting to balance competing interests and perhaps reconcile the irreconcilable;
- the influence of political priorities when a government asserts it has a mandate from the electorate to drive through certain changes;
- ideological acceptability even to a government that proclaims it is ideology-free;
- the multiple, and possibly contradictory, goals of policy-makers and managers;
- tacit knowledge valued over and above research evidence perceived as irrelevant, out-of-date or inapplicable to local circumstances – a case of she who does, knows;
- lack of consensus about the evidence: whose opinions count – the expert's or the public's?
- the curse of the temporal challenge, whereby the time required to generate evidence exceeds the time policy-makers and managers are willing to wait before taking action; and
- the reality of pressure group politics, whereby some issues rise up the political agenda and others slip down, or off it altogether.

Of particular importance in this list of factors is an awareness that evidence embraces much more than “research evidence” and that other types of evidence, including the tacit knowledge and experience acquired over time by policy-makers and practitioners, are valued (7). Political cultures and evidence cultures go hand in hand and need to be better understood in the pursuit of evidence-informed policy (8). Data-driven health services research has tended to eclipse qualitative research and provide spurious “evidence-based” solutions to complex challenges that ignore context and local contingencies (9).

APPRECIATING COMPLEXITY

To appreciate complexity, an important distinction must be made between the complicated and the complex (10). A complicated problem, such as building a rocket, is difficult and may take time to solve but it can be solved and is predictable. In contrast, a complex

problem, such as raising a child, cannot be solved. There are unpredictable and emergent properties as each child is different and solutions are adaptive. Complex systems are based on relationships and their properties of self-organization, interconnections and evolution. Research into complex systems demonstrates that they cannot be understood solely by simple or complicated approaches to evidence, policy, planning and management. A number of interventions can be expected to fail as a matter of course. Uncertainty of the outcome remains a factor in complex systems.

Although research scientists and policy-makers are now more ready to acknowledge the existence of complexity and complex adaptive systems, especially in respect of tackling “wicked problems” of the type to be found in public health, many continue to lack a true appreciation of them. In the case of researchers, this may be because they need the systems to fit into “the traditional mainstream of evaluation approaches”. The United Kingdom Medical Research Council (MRC) guidance on developing and evaluating complex interventions, which appeared initially in 2000 and was modified in 2008, is one such example (11).

Although the guidance includes a range of social science methods, one authority is critical of the remaining shortcomings in the MRC's limited understanding of complexity. Essentially, because it is still wedded to a spurious “scientism”, the attempt to provide an overlay of uniformity and stability on what are in reality unstable and endlessly evolving social systems is unhelpful and, not to put too fine a point on it, “stunted” (12).

Complexity is not simply a case of there being many moving parts but about what happens when these parts interact in ways that cannot be predicted but will nonetheless heavily influence or shape the probabilities of later events (13).

IN PRAISE OF POLITICS AND POLITICAL SCIENCE

The political nature of the policy process is central to any understanding of a complex system (2). Perhaps a distaste of politics underlies our failure to appreciate the political dimension (14). Yet, although “politics may

be a messy, mundane, inconclusive, tangled business, far removed from the passion for certainty”, politics is at the heart of all that happens in public policy and in complex systems, such as health, with their multiple levels of decision-making and myriad groups of practitioners conducting power plays to achieve their goals (15, 16). In such settings, evidence is often used tactically to justify prior decisions or make the case for political and financial support, or invoked as an excuse for inaction.

Political science deals with who gets what, when, and how (17). It is all too easy to oversimplify social complexity by ignoring or understating the interplay of politics and power. In the multiple streams theory of public policy developed by Kingdon, an attempt is made to tease out the process’s messiness, disjointedness, power asymmetry and sheer luck (18). It does so through three streams that flow largely independently of one another: the problem stream, which focuses on a particular problem (such as controlling smoking); the political stream, which is the governmental agenda of problems to be resolved; and the policy stream, which is the decision agenda from which a public policy may be selected (such as a ban on smoking in public places). When these three streams converge, they create so-called windows through which a public policy can result. But political science offers many other theories of the policy process, including the punctuated equilibrium framework, advocacy coalition framework, social movement theory and structural interests framework (19). Many of the core cleavages in health policy reflect political and ethical tensions over the balance to be struck and negotiated across personal and collective responsibility, across public and private interests, and between the rights of the community and personal freedoms. These are intensely political choices. To make sense of health policy, analysts need to understand the frameworks underlying policy-makers’ choices, the institutions within (and through) which governments operate, and the interests of the different political actors involved. Political ideologies and institutions, the power of interest groups, media coverage of issues such as imposing a tax on sugar to reduce the consumption of fizzy drinks and help tackle obesity, public opinion, and so on all contribute to the definition and evolution of health policy. Problems of implementation are often problems in developing the political will to get things done and framing the problem in terms that the relevant

policy-makers can understand (20). Arguably, we need to re-politicize public policy in order to bring about change and improvement (21).

EVIDENCE-BASED POLICY OR POLICY-BASED EVIDENCE?

Although the relationship between evidence and policy is a complex and often fuzzy one, policy-makers continue to proclaim their commitment to “what works” and governments continue to be major funders of research. Yet, despite the pressure to attach greater priority to evidence-informed policy, the reality is still too often opinion-based policy (22). In a highly critical report following an enquiry into the use (and non-use) of research in the health inequalities policy, the United Kingdom Parliamentary Health Committee cited several initiatives that had been introduced without any prior evaluation. The reasons are both complex and not well understood. Given that the United Kingdom Government, like many other governments, funds most of the research that is conducted in respect of health policy, it may appear odd that research should fail to inform policy because of an inability to align it with the needs of those who may be expected to use and implement it. The expectations of policy-makers may also be unrealistic. As one witness told the Committee, “too many users of policy research still expect clear answers about impact when a more realistic product of evaluation is that [it] contributes to a process of enlightenment about highly complex processes that are interpreted by different actors in multiple ways” (23).

THE EVIDENTIAL PARADOX: WHERE NEXT?

What can we learn from the experience so far of trying to get evidence into policy and practice in the face of competing notions of what constitutes evidence and where there is scepticism as to its value? Greater humility on the part of evidence purveyors would be a good start, given that the relationship between evidence and policy is complex and not a rational, linear one. As noted, where evidence does already exist, often it is either not used or ignored or types of evidence other than academic research are privileged. It is certainly rarely applied consistently,

continuously or proportionately. Marmot states that “[p]eople’s willingness to take action influenced their view of the evidence, rather than the evidence influencing their willingness to take action” (3). Another study concludes its review of evidence-based policy by noting that government programmes are largely driven by informed guesswork, expert hunches, and political and other imperatives (24).

The research community must also accept its share of responsibility for the failure to produce research of the type wanted and on time. As the WHO Commission on Social Determinants of Health put it, “Research is needed to generate new understanding in practical accessible ways” (25). However, academics sometimes struggle with producing research findings that are either practical or accessible. Collusion between those academics who may prefer to refrain from muddying their hands in the real and messy world of policy and the premium that universities continue to place on academic peer-reviewed publications rather than on evidence of impact on policy may be contributing factors.

While public health is both an art and a science, it should not be an act of faith. For reasons touched on earlier, policy will rarely, if ever, be wholly, or possibly even largely, evidence based. Nor should it be, as research findings are rarely so definitive or uncontested that they rule out alternative interpretations. Trade-offs and judgements need to be made, which should ultimately remain the responsibility of elected politicians who will on occasion privilege local expertise and experience over other forms of evidence. This is not to deny the important role evidence can and should have in posing questions that give pause for thought. Nor is to deny the important political or advocacy role that public health practitioners play alongside their evidentiary one. Indeed, political activism and advocacy are vital ingredients in the attempt to secure evidence-informed policy (26).

To take an example, regardless of how sound the evidence may be in tackling equity in health, if policy-makers do not view this to be a public policy problem requiring a policy response, then no action will follow. Policy-makers’ priorities may lie elsewhere, for example, in reforming social welfare to reduce what they perceive to be unnecessary dependence on the state or in reducing budget deficits, which risks

a deterioration of public services. If there is a desire to shift the policy discourse in a different direction then it will be necessary for policy-makers and their advisers to use evidence in ways that frame issues and set agendas so that health equity rises up the policy agenda. For this, they need to be equipped with the requisite soft skills to create and exploit Kingdon’s “windows of opportunity”. They also need to accept and work with the essentially political nature of complex systems in order to bring about sustainable improvements in health and well-being. The skills required for such work include those involved in framing the problem to engage policy-makers, setting the agenda, identifying and nurturing change agents or policy entrepreneurs, building alliances and partnerships, negotiating for better outcomes, and communicating key messages.

But all is not lost and encouraging developments are under way, which both endorse and build on the analysis presented here. Interpreting and using different types of evidence to inform and change policy is recognized by WHO through the work of the Evidence-informed Policy Network (27), the *Health in all policies training manual* (28), and through related initiatives such as the WHO Nordic Baltic Flagship course in equity in Health in all policies held from 8 to 10 June 2016. These all start from the premise that complex systems demand new and different approaches in bringing about change and that evidence, in its various forms, is one among many tools in that process but that it needs to appreciate the political context influencing its uptake.

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