From Transfer to Transformation:

Rethinking the Relationship between Research and Policy

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Except where indicated otherwise, this thesis is the original work of

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Abstract

The most common and enduring explanation for the way research is used (or abused or not used) in policy is the ‘two communities’ theory. According to this theory, the problematic relationship between research and policy is caused by the different ‘cultures’ inhabited by policy makers and researchers. The most common and enduring types of strategies that are put forward to increase research use in policy involve bridging or linking these ‘two communities’. This study challenges this way of thinking about the relationship between research and policy. Four case studies of national public health policy in Australia—breast cancer screening, prostate cancer screening, needle and syringe programs in the community, and needle and syringe programs in prisons—are used to present the context, events, processes, research, and actors involved in policy making. Three theories are deployed to explore the relationship between research and policy in each of the cases individually and across the cases as a whole. These theories bring different determinants and dynamics of the relationship to light and each is at least partially successful in increasing our understanding of the relationship between research and policy. The Advocacy Coalition Framework (ACF) understands the relationship in terms of a power struggle between competing coalitions that use research as a political resource in the policy process. The Policy Making Organisation Framework (PMOF) understands the relationship in terms of institutional and political factors that determine the way data is selected or rejected from the policy process. The Governmentality Framework (GF) understands the relationship in terms of the Foucauldian construct of power/knowledge that is created through discourse, ‘regimes of truth’ and ‘regimes of practices’ found in public health policy and research. This study has found that in three of the four case studies, public health policy was strongly influenced by research, the exception being NSP in prisons. In all cases, however, it is not possible to construct a robust and coherent account of the policy process or the policy outcome without considering the multifaceted role of research. When these theories are explored at a more fundamental level they support the argument that when research influences policy it is transformed into knowledge-for-policy by being invested with meaning and power. This process of transformation occurs through social and political action that mobilises ideal structures (such as harm minimisation and the World Health Organisation’s principles for evaluating screening programs) and material structures (such as medical journals and government advisory bodies) to resolve meta-policy problems (such as how to define complex public health problems in a way that makes them amenable to empirical research and practical action). This study provides good evidence that the notion of ‘research transfer’ between ‘two communities’ is a flawed way of understanding the research–policy relationship. Rethinking the relationship between research and policy involves building an enhanced theoretical repertoire for understanding this complex social interaction. This step is essential to the success of future efforts to make public health policy that is effective, just and emancipatory. This study makes a contribution to this task.

Preface

Policy making is a value-laden activity regardless of the intellectual rigour with which it is pursued. Research on policy making is no different and the reader is entitled to know about the values I bring to this study.

This thesis grew out of my experience as a Commonwealth public servant involved in policies and projects such as the National HIV/AIDS Strategy, BreastScreen Australia, the Australian Childhood Immunisation Register, the National Drug Strategy, the Public Health Education and Research Program, national public health information infrastructure development, and various public health research projects such as the Longitudinal Study on Women's Health and an analysis of 'returns on investment' in public health. In my attempts to make evaluation, research and information a more influential part of the policy process, I began to read literature on research utilisation. I found that the parts of this literature that took the sociology of knowledge and theories of public policy making seriously were very interesting and I wanted to explore their application in Australia further. However, I also found that most of the literature on how to link research and policy in practice were not informed by this literature. Rather, they were based on the relatively simple idea that the use of research in policy was determined by the interpersonal dynamics of researchers and policy makers and that measures to enable research use in policy should aim to overcome the cultural differences between these 'two communities'. My practical experience told me otherwise. The rise of the idea of 'evidence-based policy' also intrigued me. There was a part of me it appealed to, but there was a larger part of me that wanted to problematise it. This research project is the result of these two strands of interest. In Chapters 1 and 3 I note the ways that my interests and experience informed the design and conduct of this study.

In relation to the role of public health as 'the organised response by society to protect and promote health, and to prevent illness, injury and disability' (Commonwealth of Australia and State and Territory Governments of Australia 1997), I consider myself something less than a true believer. While I have often been an advocate within the Department for greater engagement with and expenditure on public health by the Commonwealth, I have nevertheless tried to maintain a critical perspective. This ambivalence is reflected by the inclusion of the Foucauldian framework of ‘governmentality’ as one of the three theories considered in this study.

I believe that public health policy should aim to be effective, just and emancipatory. ‘Effective’ in the sense that it results in a healthier population and does not cause harm. ‘Just’ in the sense that it strives to achieve the best health possible for the whole population and especially the sickest (who, more often than not, are the poorest). ‘Emancipatory’ in the sense that the process of developing and delivering public health policy should aim to increase the control that people can attain over their lives and their environment.

I realise that these goals may sometimes conflict and that the process of policy making requires more than a statement of values and objectives. The best word I have found to describe what I believe is the essence of good policy making is Aristotle’s ‘phronesis’ or ‘practical judgement’ (Klein 2000: 65). This concept appeals to me because it captures the requirement that policy is based on sound understanding of the way things are and the way we want them to be. As Flyvbjerg has argued, ‘*Phronesis*... is that activity by which instrumental rationality is balanced by value-rationality…’ (Flyvbjerg 2001: 4). Critiquing the exercise of phronesis in any particular situation is dependent on the further exercise of the same ability. It is what Vickers describes as an ‘ultimate category’ (Vickers 1965: 13).

I think that the exercise of phronesis is promoted and protected by the institutions and processes that underpin democracy generally. In specifying these, I am also specifying what I believe are the appropriate processes for giving research its due weight in policy making. I think that public health policy making processes should include a continuous, explicit, rigorous and accountable engagement with research. The goal is not research use for its own sake but the best use of the best available research in the service of practical judgement. What constitutes ‘best use’ and ‘best available research’ is unavoidably contestable. There are qualifications to these general principles that are related to the costs involved in terms of time, money, and the possible risks associated with acting too soon or acting too late. While I have sympathy for Gaughwin’s argument for ‘minimum standards of deliberation’ in making public health policy (Gaughwin 1998), I do not think they could ever be agreed or implemented across Australia’s nine jurisdictions and across all areas of health policy.

I began this study with a general sympathy for the aspiration that research use in policy should be increased. I now think that the goal of increased research use for its own sake makes little sense. I also began this study thinking that one of my goals was to help 'improve' the relationship between research and public health policy. I have gradually abandoned this idea too. I think it is impossible to specify what the relationship between research and policy should be like. The idea that policy should mirror the findings of the best available research or be more 'research-informed' adds nothing to a more general specification of good policy making as set out above. It also suggests that it is possible to bypass the inevitable contests over how research should be interpreted. I find myself agreeing with Janet Weiss, one of a group of social scientists in the United States in the 1970s who studied the use of social science in public policy, when she wrote:

> The study of social science and public policy has recently grown out of its adolescent preoccupation with the struggle of Good (use of social science) and Evil (no use of social science). In the venture toward maturity, we have grown increasingly 'agnostic' about the ultimate value of using social science, and in so doing have dramatically improved our understanding of the links between social science and policy making. (Weiss 1979: 437)
>
> Improved policies... are unlikely to be found in mere increased incidence of use. First, more is not the moral equivalent of better. Second and more important, strengthening the knowledge base of policy making is an important but insufficient condition for improving policy. (Weiss 1979: 457)

I am unsure if my own agnosticism was something that I came to gradually over the course of this study or it if has been latent in my approach all along.

Lastly, there is the matter of whether I think policy making should be more rational. When the goal of rationality in policy making is put forward it is often characterised as the adversary of a too-great influence of values and politics in policy making. I believe that policy making can never proceed independent of questions of values or the contest of politics. In Chapters 2 and 9 I discuss this relationship and argue that the question of the role of values in policy making is of critical importance to the study of research use in policy.

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Abbreviations

ACF	Advocacy Coalition Framework
ACS	Australian Cancer Society
AHMC	Australian Health Ministers' Council
AHMAC	Australian Health Ministers' Advisory Committee
AHTAC	Australian Health Technology Advisory Committee
AIH	Australian Institute of Health (now AIHW)
AIHW	Australian Institute of Health and Welfare
ANAIDUS	Australian National AIDS and Injecting Drug Use Study
ANCA	Australian National Council on AIDS
ANCAHRD	Australian National Council on AIDS, HIV and Related Diseases
BBV	Blood Borne Virus
BCS	Breast Cancer Screening
CARG	Commonwealth AIDS Research Grants
CRC	Colorectal Cancer
DAC	Dominant Advocacy Coalition
EBHP	Evidence-based Health Policy
EBM	Evidence-based Medicine
GF	Governmentality Framework
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
IDU	Injecting Drug User
MJA	Medical Journal of Australia
NAIPIC	National AIDS in Prisons Information Clearing House
NCCI	National Cancer Control Initiative
NH&MRC	National Health and Medical Research Foundation
NSP	Needle and Syringe Programs
PCS	Prostate Cancer Screening
POL	Policy Oriented Learning (part of the ACF)
PMO	Policy Making Organisation
PMOF	Policy Making Organisation Framework
RCT	Randomised Controlled Trial
WHO	World Health Organisation

1. Introduction

1.1. Research objective and questions

This thesis addresses the question ‘how might we best understand the relationship between research and public health policy?’. The aim is to contribute to the field of research that studies the use of research in policy. By ‘understand’ I mean theoretically coherent and empirically grounded ways of appreciating the research–policy relationship. Unlike much of the writing and research in this field, this research project is agnostic on the normative questions of whether research is used as much as it could be, or used in the way that it should be. Like Weiss, I consider agnosticism on these questions an aid to better understanding of the relationship between research and policy (Weiss 1979: 437). While Hanney and others might be correct in their assessment that ‘…it is widely agreed that health policies do not reflect research evidence to the extent that in theory they could’ (Hanney, Gonzalez-Block et al. 2003: 2), I distance myself from the assumption that it is possible for any individual or organisation to establish themselves as the final arbiter of what constitutes the correct use of research in public health policy.

The theory of the relationship between research and policy is underdeveloped, a point which Landry has also made (Landry, Amara et al. 2001: 397). While a plethora of ‘models’ of research use have been developed (some are discussed in Chapter 2), there have been relatively few attempts to link the wide range of factors influencing research use in policy into a coherent relationship. I am not proposing that there should be a single general theory to explain all aspects of research use in policy, rather, I am proposing that the field could benefit from increasing its theoretical repertoire and from discussing what the requirements of an adequate theoretical approach might be.

The general lack of attention to theory has meant that one particular theory of the relationship between research and policy, known at the ‘two communities’ theory, has enjoyed remarkable longevity. This theory (sometimes referred to as a hypothesis or metaphor (Dunn 1980)) was first developed in the 1970s when the study of research use in policy was in its infancy. At this time, there were various theories proposed to explain the non-use of research in policy (Caplan, Morrison et al. 1975: x-xi) but the 'two communities' theory is the one that has endured. The theory is an adaptation of the argument advanced by C.P. Snow in Britain in 1956 that 'the intellectual life of the whole of western society is increasingly split between two polar groups…the literary intellectuals… and scientists' (Snow 1963: 11-12). Snow's argument was transposed into a theory on the dysfunctional relationship between social science research and policy as follows:

> …social scientists and policy makers live and operate in separate worlds with different and often conflicting values, different rewards systems, and different languages. The social scientist is concerned with 'pure' science and esoteric issues. By contrast, government policy makers are action oriented, practical persons concerned with obvious and immediate issues. It is argued that the gap between the knowledge producer and the policy maker needs to be bridged through personal relationships involving trust, confidence, and empathy. (Caplan, Morrison et al. 1975: x-xi)

While there are continuing explicit references to the 'two communities' theory in current writing and analysis (Innvaer, Vist et al. 2002: 242; Lavis, Ross et al. 2002: 145; Hanney, Gonzalez-Block et al. 2003: 14), just as important is the continuing emphasis on articulating the differences between researchers and policy makers as a way of explaining perceived problems in research use. For example, Lomas writes:

> …researchers and decision-makers seem to proceed largely independently. Each have their own (often misplaced) ideas about the other's environment. Opportunities for ongoing exchange and communication are few. Because most of the study has emanated from researchers, their activity has focused more on understanding the assembly and dissemination than on the uptake and use of research evidence. Because most of the determinations are made by decision-makers, their focus is on the applicability, usefulness and context dependency of researcher findings. It is like two people trying to assembly a jigsaw puzzle, each with half the pieces… but each working in a separate room. (Lomas 1997: i)

The effect of the 'two communities' theory is to continually focus attention on the interactions between researchers and policy makers rather than on the determinants of those interactions. The study of research use in policy has often been a 'prisoner of the proximate', an expression used by Anthony McMichael to describe the concentration of modern epidemiology on individual risk factors to the neglect of the determinants of the health of populations (McMichael 1998). The parallel with the study of research use in policy is a strong tendency to study individual decision maker's perceptions of their use of research (Innvaer, Vist et al. 2002) as if the way research is used in policy is a simple aggregation of their individual skills, choices and perceptions. The current crop of strategies to increase the use of research in policy, referred to as 'research transfer' and 'linkage and exchange' or 'collaboration' (Lomas 2000; Matthews, Jenkin et al. 2001), owe their design to the 'two communities' diagnosis of the perceived problem. The close connection between these 'solutions' and the 'two communities' diagnosis is shown by the way that the current strategies seem to have advanced very little since they were first articulated alongside the theory in the 1970s (Caplan, Morrison et al. 1975: 50-52; Caplan 1979: 468).

I began this research project because I was dissatisfied with the insights that the research utilisation literature provided to my own work as a public health bureaucrat. I felt that there was no shortage of contact with researchers or with research and that, while there are systematic differences between researchers and policy makers in their worldviews, skill sets and professional values, these did not seem important to the way research is used in policy. From my day to day work in public health, it was clear that some researchers had excellent access to the bureaucracy and some did not. It was also clear that some research was treated with great respect in policy arguments and some was disregarded. None of this seemed to be simply a function of the ability of researchers and policy makers to communicate across what is often described as 'the gap' between researchers and policy makers (Caplan 1979: 460). The quality of the research played a part but not consistently. The political preferences of the government mattered but seldom overwhelmed or excluded all other considerations. To get to the bottom of this, I wanted to pursue ways of understanding the research–policy nexus that did justice to factors such as the role of interest groups, the constitutional realities of making policy in federation, the beliefs, values and assumptions of policy actors, and the subtle but pervasive influences of public discourse. All of these seemed to have some impact on the way research appeared in policy debates, was filtered, shaped, or rejected.

To make this research task manageable, I have broken my general research question into two clusters of more specific questions. First, what role does research play in the policy process? Does research influence policy? If so, in what ways does this occur? How does it occur? To what extent does it occur? Second, what happens when research and policy are at odds? Why does policy sometimes change in response to discrepant research, and sometimes not? I also needed to target my theoretical efforts. Through the process described in Chapter 2, I arrived at and developed three 'focal theories':[1]

- the Advocacy Coalition Framework (ACF) of Sabatier and Jenkins (Sabatier 1993);
- the Policy-making Organisation Framework (PMOF) developed from the work of David Dery (Dery 1990) and elaborated with insights from the public policy literature on the role of institutions;
- the Governmentality Framework based on the work of Michel Foucault (Foucault 1991a) and several of his interpreters, particularly Mitchell Dean (Dean 1999), and Rose and Miller (Rose and Miller 1992).

My specific research question in relation to these theories has been 'what contribution do these theories make to our understanding of the research–policy relationship?'. Further, I have asked 'what do the results of this analysis mean for our understanding of the relationship between research and public health policy in Australia?'.[2] To assist in answering this question I have used a framework developed by Rudra Sil for considering both the adequacy of social theory and the opportunities for theoretical eclecticism (Sil 2000).

Public health policy is a broad and complex field. To make these research questions tractable, I have had to develop a methodologically sound way of scoping and focusing data collection and analysis. I did this by adopting a case study design and selecting four case studies of 'national public health policy'—Breast Cancer Screening (BCS), Prostate Cancer Screening (PCS), Needle and Syringe Programs in the community (NSP-Community), and Needle and Syringe Programs in prisons (NSP-Prisons). The definition and scope of national public health policy are discussed below and Chapter 3 presents a detailed discussion of the case study design and case study selection.

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[1] By 'focal' theories I mean theories that are the focus of empirical analysis in this thesis. Chapter 2 gives a rationale for their selection based on their explicit acknowledgment of research within the process of policy development.

[2] The three research questions are brought together in the Chapter 1 appendices.

1.2. The research–policy problematic

The problem of how we understand the relationship between research and policy is important for four reasons. First, the relationship has long been described as problematic. Second, there are attempts within Australia, in other countries and internationally to try to 'improve' research use in health policy. Third, the idea of Evidence-Based Health Policy (EBHP) is attracting increasing attention and is premised, in part, on the assumption that research use is not all that it could be or should be. Fourth, research use in policy is now being proposed as a measure of the value of research and a yardstick for evaluating the return on investment in research. Each of these aspects of the research–policy problematic will be discussed as a way of locating this research in a wider context and to introduce some of the major themes that will recur during the thesis.

It seems that the most vigorous exponents of the art of problematising the research–policy relationship are researchers who argue the relationship is like 'the sound of one hand clapping' (Lomas 1997) or 'a dialogue of the deaf' (Last 1999). There are many anecdotes to support this rhetoric. Lomas tells the story of how it took the British merchant navy 263 years to introduce citrus juice to prevent scurvy among sailors following the demonstration of its effectiveness in 1601 (Lomas 1997: i). A more recent example is the continuing 40 year struggle to introduce anti-tobacco policies following research showing the damaging effects of smoking on human health (Chapman and Leeder 1991; Fritschler and Hoefler 1996). Policy responses to the growing body of research showing that socio-economic inequalities generate a corresponding gradient in morbidity and mortality seem to follow a tortuous route (Whitehead 1998). McMichael has recently argued that the science showing the deleterious effects of global warming has so far been unable to generate sufficient political will in the United States for that country to support the Kyoto Protocol (McMichael 2001).

While it is relatively easy to develop lists of research that has had a tardy or interrupted passage to policy influence, it is much harder to understand why this has occurred. The facile response is to lay blame, either implicitly or explicitly, on the intelligence or principles of policy makers. How else could a policy maker not 'know' that citrus prevents scurvy given its clear demonstration in a scientific experiment and then not give it to sailors? Of course, each of the examples above expands the scope of the policy required to respond to the problem identified by the research. Citrus juice is something that can be delivered locally while the Kyoto Protocol is a policy of staggering complexity. As the scope of policy decisions broadens, so too does the range of parties with vested interests, the research that is germane to the policy, and the room for debate about how to interpret the research and what its policy implications are. It is also worth remembering that it is not just policy makers who have difficulty changing their minds in response to new data or ideas that contradict cherished beliefs and challenge professional or political interests. The history of science is replete with examples of distinguished scientists demonstrating this human foible (Kuhn 1962: 59). In the rush to find fault or 'fix' the perceived problem of lack of research use, it is possible that some more fundamental factors are overlooked. For example, in Mauldon's analysis of the tardy response to the research showing citrus prevents scurvy, she argues that the problem for James Lind, the experimenter, was that he did not believe his own results. 'To begin with there existed no belief system which could account for the apparent effect of fresh fruit on scurvy…' and so for others at the time, his findings were 'effectively irrational' (Mauldon 2000: 41,42).

In light of the above, perhaps the most productive kind of relationship between research and policy would be one that is characterised by perpetual tension. From the policy side, it seems highly impractical and unwise that policy makers should change policy every time a new piece of research appears. From the research side, the evangelical zeal driving some public health researchers means that they see it as their duty to assail the powerful with their research and demand government action and accountability on matters relating to the health of the public.

This tension between deliberation and advocacy is important for considering the theories used to understand the relationship between research and policy. The research utilisation literature, particularly the 'two communities' theory, has difficulty accounting for the role of researchers as advocates. As noted in the quote from Caplan above, researchers are cast in a role where they are in search of the 'pure' and the esoteric and are disinterested in politics. These assumptions simply do not hold in the field of public health. Advocacy is part of the credo for many public health researchers. This is shown by the continuing references in public health discourse to the heroic narrative of John Snow's removal of the Broad Street pump handle in mid-19th century London to prevent the spread of cholera. In this narrative, the researcher identifies a cause of ill health and takes direct action to protect the health of the population by changing the physical environment despite the fierce opposition from vested interests. Samet argues that the Broad Street pump example is the quintessential example of epidemiology influencing policy (Samet 2000). Alex Wodak invokes this narrative to support the actions of public health activists around the world who broke the law in order to introduce Needle and Syringe Programs and protect injecting drug users from HIV and other bloodborne viruses (Wodak 1997). Breslow's reflections on the public health struggle against tobacco in the United States led him to conclude 'Boldness in advocating preventive measures based on strong epidemiological evidence' is the most important thing to learn (Breslow 1996: 375).

The tradition and ethic of public health advocacy resonates strongly with the Enlightenment ideal that science can and should contribute to a better world. Tesh (Tesh 1988: 167) analysed the hidden politics of disease prevention policy and argued that:

> …science is both a collection of ideological beliefs and an agency for liberation. As an agency for liberation it substitutes democracy for political and religious authority. Demanding evidence for statements of fact and providing criteria to test the evidence, it gives us a way to distinguish between what is true and what powerful people might wish to convince us is true.

Donald, like Tesh, invokes the Enlightenment ideal when she argues that Evidence-based Medicine (EBM) has been a liberating force in the UK health system, reducing the negative effects of 'uninformed authority' just as '…scientific rationalism was eagerly promoted by people longing to be free of the blind authority of the Church' (Donald 2001). The views of Donovan, Tesh, Wodak, Samet and others point to a tradition of idealism and activism that leads public health researchers to problematise the research–policy relationship. This is not a recent phenomenon. Writing in 1961, Rosen reviewed the public health struggles over a period of 100 years in the United States and concluded:

> If the history of public health teaches us anything, it is this. Just as the pioneers of public health used facts, figures, ideas and social action to improve the health of the community, we too, if we wish to be true to their spirit, cannot remain content with good intentions but must endeavour to put into practice the knowledge that is ours. Where we do not have it, we must try to obtain it. For we have a professional and moral responsibility to work for a social and cultural environment in which human beings can live a healthier and happier life (Rosen 1961: 1017).

Thus, the quest to get policy to respond to research is not new and researchers have often seen it as their moral duty and their historically ordained role to harangue reluctant governments into action. Seen in this light, the roles played by public health researchers in the case studies that follow will come as no surprise. The capacity of the 'two communities' theory to cope with this feisty view of the role of the researcher is limited.

This is not to say that there is consensus among public health researchers on the matter of advocacy. There are some public health researchers who eschew policy activism and think that they should stick to science (Samet 2000). In the case of Needle and Syringe Programs for example, Moss regrets the implications for the perceived independence of epidemiology occasioned by epidemiologists engaging in 'moral crusades' (Moss 2000a). Des Jarlais disagrees with him, arguing that when lives are at stake, research and advocacy are inseparable (Des Jarlais 2000). Those coming from the perspective of the critical social sciences, particularly feminist researchers, are willing to join epidemiologists in advocacy on behalf of disempowered groups (Lawless, Kippax et al. 1996; Waterston 1997).

It should also be mentioned that there are other perspectives that question the Enlightenment view of science and its historic mission. This critical view of public health will be elaborated in the discussion of the Governmentality Framework in Chapter 2.

The concept of Evidence-based Health Policy (EBHP) has highlighted a conceptual and normative problem for the study of research use in policy, which is the difficulty in specifying the goal of research utilisation. In 1980, Dunn asked the question 'Knowledge utilisation for what?' and challenged the implicit assumption that knowledge utilisation automatically results in effective problem-solving (Dunn 1980: 532). Lavis and others also note that research use per se does not result in well-informed policy (Lavis, Ross et al. 2002: 140).

The concept of EBHP provides something of an answer to the question of the purpose of research use in policy, but not a complete one. In an article titled 'Evidence-based policymaking: Research must inform health policy as well as medical care', Ham and others argued that health service 'reforms' should go through a period of pilot testing before being introduced. They also argued that there should be an independent institute for health policy analysis with an independent source of funding to ensure that unpalatable research results were not buried. The institute would act as a ‘bridge’ between research and policy. They also proposed that new policies should be ‘…accompanied by a statement of the evidence that was consulted in their preparation’. This might not stop ‘oddball’ policy completely, but ‘…it would at least give politicians pause for thought’ (Ham, Hunter et al. 1995). Seen in abstract terms, Ham and others were proposing five principles for making evidence-base policy: a commitment to evaluation research and the pursuit of policy that is effective and efficient; an independent policy research infrastructure; increased accountability of policy makers; more structured engagement between research processes and policy processes; and, an explicit and transparent engagement by policy makers with research.

There are two points to make in regard to Ham and others’ prescription. First, they argue for separate roles for research and policy, imply that there will be strong tensions between those roles, take a pejorative view of policy vis-à-vis research, but still argue for co-operation across ‘bridges’. This might be thought of as the ‘conflict’ version of the ‘two communities’ theory, one that Caplan refers to in his original outline in 1975 (Caplan, Morrison et al. 1975: xi). In my reading of the literature, this version of the ‘two communities’ theory is much less in evidence than the version that focuses on differences in culture, expectations and language that can be overcome with better communication and opportunities for collaboration, linkage and exchange. This issue will be taken up towards the end of the thesis in further discussion of the ‘two communities’ theory. The second point to note here is that discussions of EBHP should be thought of as discussions about how policy should be made. That is, they are attempts to propose a policy on policy making or, as I argue in Chapter 9, they are attempts to make ‘meta-policy’. In Chapters 9 and 10 I take this discussion further and specify the challenges associated with making meta-policy in public health. Further, I argue that the field of research on research use in policy requires a thorough discussion on this matter if it is to progress beyond the normative and theoretical hurdle that is presented by the question ‘research use for what?’.

There is one further matter that makes this research project timely and relevant and that is the politics and policy making around health research funding. In 1998, the Commonwealth Government commissioned the Health and Medical Research Strategic Review which, among other things, recommended increased resources for ‘priority driven research’, ‘strategic research’, and ‘health services research’ (Health and Medical

Research Strategic Review 1998). The National Health and Medical Research Council has recently been considering how it should fund such research and make sure it makes an impact on policy. Jonathon Lomas was invited to present to them on this matter recently (Lomas 2003). Landry has also noted the increasing need for research to demonstrate its value for money by showing impact on policy (Landry, Amara et al. 2001) and the same matter is now on the agenda of the World Health Organisation (Hanney, Gonzalez-Block et al. 2003: 2). The question of whether research should be evaluated in terms of its impact on policy is an important one that is dependent, as least in part, on how we understand the relationship between research and policy. This matter is considered in Chapter 10 in the light of the findings of this research.

1.3. Scope and definitions

1.3.1. 'Public health' and 'national public health policy'

Researching the role of research in health policy faces many methodological problems, not least of which is how to construct a typology and sampling frame of health policies (Lavis, Ross et al. 2002: 126-32). This problem was resolved by choosing to focus on a particular area of Australian health policy that can be described as 'national public health policy'. 'Public health' is taken to mean 'the organised response by society to protect and promote health, and to prevent illness, injury and disability' (Commonwealth of Australia and State and Territory Governments of Australia 1997). Thus, it is primarily concerned with those aspects of health policy variously described as health protection, health promotion and disease prevention. This study does not attempt to deal with health policy relating to primary health care, acute care or aged care though it is often difficult to draw strict boundaries between these and public health as defined above (Starfield 1996). I also recognise that 'public health' is not a static concept. It would be possible to do another thesis on the role of research on changing conceptualisations of public health. This would cover, for example, the impact of bacteriology on the 'new public health' of personal hygiene in the early 20th century, and the impact of epidemiology and health promotion on the 'new public health' of lifestyle modification of the late 20th century (Nutbeam 1986; Fee 1991; Holman 1992).

There is no single, integrated government document that carries the title 'Australia's national public health policy'. Rather, over a period of decades, the Commonwealth and the States and Territories have agreed to policies and programs that are accorded the status of 'national policy' or 'national strategy' or something similar. These vary in their scope and focus and in the resources devoted to them. The main reason for this evolutionary approach is that under the Australian Constitution, responsibility for public health as defined above rests with State and Territory Governments. The only exception to this is human quarantine which the Commonwealth is responsible for. Ever since a national program of grants to the States to combat tuberculosis and venereal disease began in 1915 (Rydon and Mackay 1989: 206), the Commonwealth Government has been involved in an increasing number of public health matters. Using section 96 of the Constitution it has provided Specific Purpose Payments to State and Territory Governments for an increasing number of programs (Rydon 1989: 23). These institutional factors receive some attention but not as much as they could in a study with a different focus. It would be possible, for example, to conduct research on the role of research in what Lavis and others would call the overall 'trajectory' (Lavis, Ross et al. 2002: 132) of the public health effort in Australia, but that would be a much larger study than that which is pursued here.

The primary way chosen to represent and discuss 'national public health policy' is in terms of policies that the Commonwealth and State and Territory Governments have deemed to be such. The list of these policies has varied over time. The list I used for selecting case studies in 1999 came from a document endorsed by the National Public Health Partnership, the most senior committee of Commonwealth and State and Territory Government officials that deals wholly with public health policy (National Public Health Partnership 1999). It is a subcommittee of the Australian Health Ministers' Advisory Committee. The list of policies and the sampling strategy are set out in Chapter 3.

1.3.2. 'Research'

What do I mean by 'research'? The Organisation for Economic Cooperation and Development definition is:

> creative work undertaken on a systematic basis in order to increase the stock of knowledge, including knowledge of man [sic], culture and society. (OECD 1994) (Short 1997: 66)

I think this is a useful starting point. The focus of this study is public health research, by which I mean research that seeks to increase the stock of knowledge about the health of human beings, or measures to improve the health of human beings. Also relevant to the study is research that could be used to make informed judgements about how government might best act to improve the health of the population. One further qualification is important—the focus is on research that is published in some form or another. When the word 'research' is used, it is in this sense of citable, population-health-relevant research. Lavis and others use the concept of 'citable research' in their study of research use in Canadian health policy (Lavis, Ross et al. 2002: 134).

I have chosen to exclude public opinion polling because the primary purpose of that research does not seem to be about health per se. It is relevant to the research–policy nexus, not because it fits the definition of research but because it is another input to policy-making processes.

I do not use the word 'evidence' interchangeably with 'research', though many writers such as Elliott and Popay (Elliott and Popay 2000) and Black (Black 2001) do. This appears to be a confusion brought about by the EBM movement where 'evidence' sometimes appears to denote a status given to published research after it has been evaluated and synthesised in a systematic review, but not always. The process of selecting research and constructing a new entity called 'evidence' seems to have the intent of investing research with additional status in the policy process. This process is part of what will be studied in this thesis and the distinction between 'research' and 'evidence' will be maintained throughout.

1.3.3. 'Policy'

Definitions of 'policy' are something that even the largest public policy textbooks avoid (Wildavsky 1979: 2; Parsons 1995: 1-16). However, a brief discussion of definitional issues will highlight a critical issue for this study.

Considine says a 'standard definition' of policy is '…an action which employs governmental authority to commit resources in support of a preferred value' (Considine 1994: 3). Palmer and Short's definition of health policy is consistent with this but less specific about what kind of 'action' has to take place before it can be called 'policy'. They say that health policy is '"…courses of action that affect that set of institutions, organisations, services, and funding arrangements that together is called the health care system" (Palmer and Short 1994: 23)' (Short 1997: 66).

These definitions do not include policy discourse or policy argument within the ambit of policy. A post-modernist perspective argues that the language, rhetoric and metaphor used in policy are critical to understanding its power and authority (Majone 1989; Fischer and Forester 1993; Rein and Schon 1993; Danziger 1995; Legge 1996). As will become clear in the case studies, unless we include language and argument within our conceptualisation of policy there is a chance that a primary point of articulation between research and policy will be missed (Weiss 1991). For example, the language of problem definition and agenda setting are well recognised as key aspects of the policy process (Dery 1984; Miller 1999; Parsons 1995: 87-92). Failure to capture these within the definition of 'policy' would mean that the basic task of epidemiology in identifying the size, causes and characteristics of a disease outbreak or some threat to the health of the population is lost from view.

The above definitions also do not include the possibility that government *inaction* may be as much a deliberate policy as government *action* (Heidenheimer, Heclo et al. 1990: 5). Two of the case studies explore the role of research in the decisions not to introduce Needle and Syringe Programs in Australian prisons or Prostate Cancer Screening and, therefore, inaction is included within the definition of 'policy' used here.

1.4. Thesis overview

The next chapter reviews the literature on the relationship between research and policy. It identifies the problems with that literature in terms of the lack of an adequate theory of the research–policy relationship. The three focal theories are then introduced. It is argued that they each show promise in overcoming the problems in the current literature. Chapter 2 also introduces Sil's framework for theoretical eclecticism (Sil 2000) that will be used to compare and evaluate the three focal theories and enable the development of criteria for an adequate theory of the research–policy relationship. Chapter 3 outlines the research methods including the rationale for case study selection and analysis.

Chapters 4 to 7 present the four policy case studies—Breast Cancer Screening (BCS), Prostate Cancer Screening (PCS), Needle and Syringe Programs (NSP-Community) in the community, and Needle and Syringe Programs in prisons (NSP-Prisons) respectively. These chapters are presented in two halves. The first half presents an account of the policy process, the political context, key events and the actions of policy actors. The second half analyses this data using the three focal theories to identify particular patterns and causal relationships between various events and factors in the research–policy nexus. There is a ‘Key Events Table’ for each case study in the Appendix. These present the chronology of the policy process. There are also tables of Australian research, who it was done by, the affiliations of the researchers, and their position with regard to the policy issue at hand. At the conclusion of each of the case study chapters is an evaluation of the three theoretical frameworks and a discussion on the more general theoretical issues raised by the focal theories. This is guided by Sil’s framework. The concluding section of each case study gradually builds a theoretical argument that is brought together in Chapters 8 and 9.

In the first part of Chapter 8 I conduct a cross-case analysis. The study design of three focal theories and four case studies creates many possible combinations and permutations for cross-case analyses. I have chosen to focus on the contribution of each of the focal theories to our understanding of the research–policy nexus. In the second part of Chapter 8, I continue the process of general theorisation, building on the discussions at the end of each of the case study chapters.

In Chapter 9 I discuss the quest for EBHP, drawing on the findings and ideas from the previous chapters. I argue that discussion of the concept of EBHP is still in its formative stages and that some fundamental conceptual work is required before this discussion can proceed. The particular issue addressed at the beginning of Chapter 9 is that there is no consensus on a definition of EBHP and the quest for EBHP has not yet been adequately specified. I argue that this quest is an attempt to make meta-policy, or policy on policy-making. When this is recognised, a number of meta-policy-making challenges emerge. The second part of that chapter discusses the application of the new knowledge developed from the case studies to the resolution of these challenges in the everyday world of policy making.

In Chapter 10 I revisit the ‘two communities’ theory and highlight the way it is still being used as the default explanation for the dynamics of the research–policy nexus in the most recent literature on research use in policy. I then identify ten assumptions that underpin the ‘two communities’ theory and strategies such as ‘research transfer’ and argue that the data from this study suggests they should be abandoned. I conclude the thesis by arguing that the way forward in the study of research use in policy requires the development of new metaphors, a wider theoretical repertoire, more sophisticated methodologies, and attention to the task of making meta-policy. I identify the contribution made by this thesis to each of these and discuss the limitations of this study.