11

From research to policy and practice in public health

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Learning objectives

After studying this chapter, you should be able to:

- understand about theories of the policy process
- recognise that complex problems require different solutions and understand the concept of 'wicked' problems
- describe the challenges of moving research evidence into policy and practice
- identify and map actors and processes in networks between health research, policy and practice.

Are politicians blind to public health evidence?

John Snow is celebrated as the father of modern public health. From the late 1840s he investigated London cholera outbreaks. He mapped cholera cases in the Soho neighbourhood and could identify the Broad Street pump as the source of the epidemic. In a letter to the *Medical Times and Gazette* in 1854 (Snow, 1854), he wrote:

> With regard to the deaths occurring in the locality belonging to the pump, there were 61 instances in which I was informed that the deceased persons used to drink the pump water from Broad Street, either constantly or occasionally …

> The result of the inquiry, then, is that there has been no particular outbreak or prevalence of cholera in this part of London except among the persons who were in the habit of drinking the water of the above-mentioned pump well.
>
> I had an interview with the Board of Guardians of St James's parish, on the evening of the 7th inst [7 September], and represented the above circumstances to them. In consequence of what I said, the handle of the pump was removed on the following day. (p. 322)

You would think that immediate political action was taken: one of the worst urban scourges of 19th century Britain could be resolved! Yet, it took another 20 years before the *Public Health Act* passed the UK Parliament – in 1875. As we have seen elsewhere in this book, politics do not respond to crises the way the public health professional would prefer. The effort to maintain public health and health promotion on the political agenda has not been easy, and some would say the struggle has intensified in the last two centuries. Public health evolution has been described in terms of waves – from structural (for example, sewerage systems) through biomedical (adopting the germ theory), clinical-professional (with a growth of social medicine and public health professionalism) and social (a recognition of the role of communities in advancing population health) to cultural (with health becoming a systems paradigm requiring broad governance arrangements) (Davies, 2014). Each of these waves has not merely 'superseded' the earlier one, but has built on, and included, such perspectives in a view of health that has necessarily become more complex and political.

In the 21st century, public health and health promotion professionals know the complex nature of the factors that determine our health. These determinants are sometimes described as proximal (close to the health outcome) or distal (further away). Others distinguish between social, commercial, and political determinants of health. Some frame public health efforts as interventions, and see downstream, midstream and upstream actions. The landmark work of the World Health Organization Commission on Social Determinants of Health has shown that dealing with the complexity of the 'causes of the causes' is possible, feasible and efficient. We would be able to close gaps in health equity, locally and globally, within a generation.

The evidence is clear. The aspirations are transparent. The goals can be specified. We have the (human and material) resources to deal with the causes of the causes of ill health and its unfair distribution in society. In the 19th century it took 20 years to recognise the value of policy to address infectious disease. How much longer will it take in the 21st century to address injustice, unfairness and health inequity, even in the wealthiest of nations? Are politicians blind to the evidence?

Introduction: who gets what?

This chapter looks at the mechanisms and factors that create evidence in such ways that it may be used in health policy development and implementation. It demonstrates that the process of generating evidence, moving it into political decision-making, and then to operational action, is not value-free – it is political. Harold Lasswell (1936), regarded the 'father of political science', defined **politics** as the process in which society (and its chosen representatives) answers the question, 'who gets what, why, when and how?' Taking a health promotion gaze, grounded in the *Ottawa Charter for Health Promotion* (1986), this chapter illuminates the political nature of health action.

Politics
Who gets what, why, when and how; all the processes of conflict, cooperation and negotiation in taking decisions about how resources are to be owned, used, produced and distributed.

First, the chapter introduces you to the discipline of health political science. Understanding and appreciating theories of the policy process will enable the health promotion scholar, policy developer and practitioner to act with greater impact. Second, it looks at the role of evidence in the policy process. As demonstrated earlier, evidence does not necessarily translate into policy or action. The chapter maps the dynamic networking process of evidence generation for policy and practice. The (health) professional can map the elements of this process and network to make sense of it.

Theories of the policy process

Lasswell (1936) defined the enterprise of politics as answering the questions who gets what, why, how and when. The answers lead to policy. What exactly constitutes a 'policy' is contextual and cultural. Sometimes a policy is simply 'The Law' or 'The Plan'; organisations may refer to policy as 'the way we do things around here'. Some policy scientists say that public policy is whatever a government deliberately chooses to do, or does not choose to do. One thing is shared between all these perspectives: policies are made in order to resolve contentious issues in society, and in open societies they respond to needs expressed by particular populations (communities, professionals, business leaders, or aggregate political groupings).

For analytical purposes, a tangible and useful definition of **policy** is 'the expressed intent of government to allocate resources and capacities to resolve an expressly identified issue within a certain timeframe' (de Leeuw, Clavier & Breton, 2014, p. 2). This is useful as it clearly distinguishes between the policy issue, its resolution, and the tools or policy instruments that should be dedicated to attaining that resolution.

Policy
the expressed intent of government to allocate resources and capacities to resolve an expressly identified issue within a certain time frame.

Framing
the social construction of sets of concepts and theoretical perspectives on how individuals, groups and societies organise, perceive and communicate about reality.

Policy framing

'**Framing**' is the shaping of perceptions through cunning narratives that are often ideological and cleverly rhetorical (Benford & Snow, 2000). Expressing the contentious issue and having it deliberated in the political sphere, and then debating the allocation of resources to resolve the particular frame the policy issue has assumed, is the business of politics. For instance, a charity advocating the interests of long-term unemployed single mothers may send a letter to the prime minister explaining that the health of the children of those mothers may be at risk – the contentious (policy) issue may still be framed in very different ways by different (often ideologically driven) political world views, for instance:

- Unemployed single mothers are not seeking work with sufficient enthusiasm, hence risking the health of their offspring.
- Single mothers cannot take proper care of their offspring and need to find partners.
- The health of all children is at risk, and the health of children of single mothers even more so.
- The health of children of unemployed mothers is not good, especially when those mothers' wellbeing is at risk.
- Everybody has the right to employment. All children have the right to equitable primary health care.

Public health and health promotion specialists have a tendency to present reasonable, balanced, just and statistically appropriate arguments – but the above interpretations of one and the same contentious issue demonstrate that considered arguments may not necessarily lead to a constructive and consensual political approach to considering what the problem exactly is.

Depending on the initial representation of the issue, the discourse towards an (implicit or explicit) policy solution unfolds: the nature of the problem determines the nature of the solution. If obesity is seen as being caused by over-eating, then the solution may be sought in telling people to eat less. If it is seen to be caused by a lack of footpaths and bike lanes, the solution would be an engineering one.

Lowi (1972) suggests that governments have different ways for addressing the resolution of problems: making rules (the legislative approach; for example, regulating and sanctioning primary care access to all children), distributing available resources (for example, making available particular facilities for children in challenged environments), or redistributing those resources (for instance, no longer spending taxes on aged care but on the health of children of unemployed mothers). Others label these types of policy solutions as the regulatory, facilitative and communicative interventions. The latter is particularly interesting: mass media campaigns (with, for example, television advertisements and billboards) appear to show that government cares for (a solution of) the problem, but evidence from the health field shows unequivocally that most media campaigns are not 'best buys'. For instance, in tobacco control, taxation

and regulation are vastly superior in reducing tobacco consumption to any communicative approach. The latter example shows that a majority of government agencies around the world does not adopt 'best practice' in health promotion – they keep putting up billboards. This is called 'symbolic policy'.

Why would this be?

Power, politics, policies and theory

The answer, again, is found in Lasswell's definition of politics. Deciding who gets what, why, when and how is a matter of power, not (just) of reason, fairness, solidarity or moral commitment. Leftwich's (2015) definition of politics clarifies this, describing politics as regulated conflict to reach decisions on the distribution of resources.

The factors that contribute to this process are mapped and explained by theories of the policy process. A theory is a clear and logically interrelated set of propositions, some of them empirically falsifiable, to explain fairly general sets of phenomena. Applying this presupposition to the field of **political science**, Sabatier (2007) finds a distinction between conceptual frameworks, theories and models which operate on a continuum from broadly applicable to any situation to (preferably mathematical) modelling for highly specific situations. A 'good' theory of the political process should explain goals and perceptions, actions and events, among potentially hundreds of stakeholders in the process, leading to specific sets of policy deliverables and outcomes.

Political science a social science that makes generalisations and analyses about political systems and political behaviour and uses these results to predict future behaviour.

The traditional perspective of the policy process is that of the 'stages heuristic': the idea that the policy process follows clearly distinguishable, linear steps from problem definition, through alternative specification, to resource allocation and implementation. Although this conceptual framework has served a purpose since Lasswell (1956) originally proposed it (for example, Cobb & Elder, 1971), it has become the subject of devastating criticism, predominantly focusing on the fact that the stages heuristic fails to address the dynamics of multiple, interacting, iterative and incremental cycles of action at many different levels of mutual and reciprocal action at the same time (deLeon, 1999). Anyone active at the policy development coalface realises that, though thinking in neatly compartmentalised stages serves an analytical purpose, the muddling-through character of policy development makes for often messy decision-making. There are so many existing contextual factors that 'problem definition', for instance, cannot and should not be separated from predetermined implementation challenges. Thus, where policy development work in neat stages might be beneficial for the sanity of bureaucrats and practitioners, it is an unsuitable approximation of the ever-changing, fluctuating and pulsating policy game. Often, the rules of the game seem counter-intuitive, as influential economist John Maynard Keynes famously stated: 'There is nothing a Government hates more than to be well-informed; for it makes the process of arriving at decisions much more complicated and difficult' (Keynes & Moggridge, 1982, p. 409). Theories of the policy

process have therefore increasingly divorced themselves from stages and levels. They are now described as being cycles with feedback loops where many elements of the process are managed dynamically.

In summary, decisions about solving contentious social (and health) issues involve stakeholders mobilising their resources to advance their most preferred positions – and negotiation as well as trade-offs where possible and required. The 'truth' (value-free factual, often epidemiologically generated, evidence) may have to be sacrificed to reach those positions.

Spotlight 11.1

Developing and implementing policy and setting its priorities are subject to political deliberation. Some have called this a game. Indeed, if you want to practice your political skills you can do so in cyberspace role-playing games such as 'eRepublik' or 'Democracy'. These would hone your political astuteness in identifying policy stakeholders, their relative power positions and potential responsiveness to incentives, and the games they are willing to play to maintain power. These games generally allow you to develop complex virtual worlds, and they may assist in creating useful 'mind maps' of the factors that contribute to the feasibility of policy proposals.

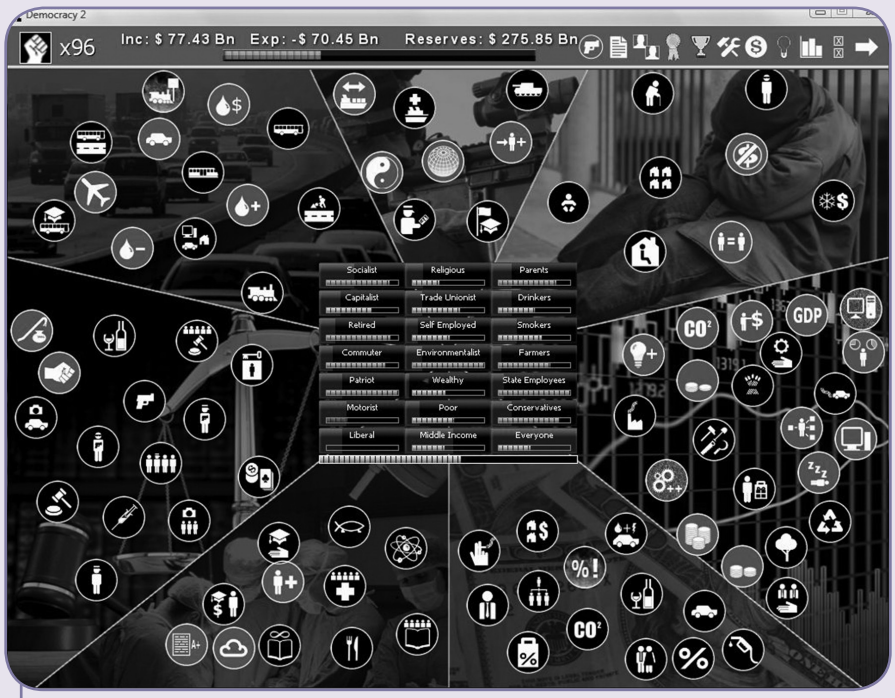

Figure 11.1 Mind map ('Democracy 2')

Policy analysts in the real world similarly use such approaches to map political opportunity. An early paper and text based version of such 'serious gaming' was the Prince system. In 1972, William Coplin and Michael O'Leary published *Everyman's Prince: A Guide to Understanding Your Political Problems*. 'Prince' was an acronym for the four steps in the process: '**Pr**obe, **In**teract, **C**alculate, **E**xecute.' In a series of workbooks, Prince allowed the serious policy gamer to identify the players, their interactions, and conditions for shifting their positions to make particular policy approaches more feasible.

Michael Reich, a professor of health political science at Harvard, turned some of these ideas and principles into a web based tool called 'PolicyMaker' (http://www.polimap.com/poliwhat.html) (Reich, 2002). The tool is used in many government offices and university classrooms around the world.

But one thing that these approaches as yet do not deliver is a tool to analyse the shrewd use of emotive language to massage and manipulate stakeholders and constituencies into holding some truths to be self-evident.

Question

Do you believe that a 'proper' playing of such a policy game takes hours, days or weeks? Why?

Complex problems require 'wicked' solutions

The global burden of disease has shifted from infectious to chronic, although in many areas in the Global South there still is a severe double burden of disease. Chronic disease is also called 'non-communicable disease' (NCD) and has become a concern of international proportions. In 2011, the United Nations General Assembly convened a high-level meeting for only the second time in its existence, devoting its attention to a health matter (the first was HIV/AIDS in 2001) and viewed the emerging global NCD pandemic as a major threat to human development. In the political declaration, world leaders formally committed to resolve the NCD crisis.

NCDs progress slowly and are devastating to the individual and their community. There are different categorisations to classify them (for example, into neoplasms, metabolic conditions or cardiovascular conditions) but any categorisation is bound to miss significant conditions. For instance, the World Health Organization website dedicated to NCDs (http://www.who.int/mediacentre/factsheets/fs355/en) does not mention mental illness, the (health and disability) consequences of accidents and violence, and obesity as major contributors to the global burden of NCDs. Obesity is seen as 'just' a risk factor.

Obesity is 'wicked'

One of the most important and complex drivers of the NCD emergency is the obesity pandemic (Swinburn et al., 2011). Addressing obesity is a good example of the multitude of processes, actions, actors and policies that is required to achieve better health, and more equitable health. The British Government Office of Science sought to develop a comprehensive map of determinants, drivers and contexts for the increasing rates of obesity (Vandenbroeck, Goossens & Clemens, 2007). This 'Obesity System Map' (available at https://www.gov.uk/government/publications/reducing-obesity-obesity-system-map) shows the enormous complexity of the problem.

Wicked problem
a complex problem that is deceptive and defies logic.

Problems such as the one mapped in the Obesity System Map are called '**wicked problems**' (also fuzzy or messy problems). The term 'wicked' in this case does not mean 'nasty' or 'cruel' (or, in some 21st century slang, 'impressive' or 'cool'), but rather deceptive and defying logic.

Characteristics of wicked problems such as health inequity or obesity are:

1 The problem is not understood until after the formulation of a solution.
2 Wicked problems have no stopping rule.
3 Solutions to wicked problems are not right or wrong.
4 Every wicked problem is essentially novel and unique.
5 Every solution to a wicked problem is a 'one shot operation'.
6 Wicked problems have no given alternative solutions (Rittel & Webber, 1973).

Dealing 'simply' with wicked problems will lead to a waste of resources and capacity. For instance, looking at the Obesity System Map, policy-makers may find it tempting and easy to consider only the behavioural aspects of individual food choice, and just develop policies and programs that would advocate nutrition behaviour change. The evidence on the complex nature of the social, political and commercial determinants of the obesity problem, however, indicates that such policies would be ineffective unless wider-ranging, multi-level and systemic interventions are put in place (Smedley & Syme, 2001).

It is important that public health professionals and health promoters, community health advocates and health researchers are aware of the complex and wicked nature of most current NCD challenges in society. This awareness may be amplified by rigorous scientific views of complexity (Hunter & Perkins, 2014; Van Beurden et al., 2013).

Spotlight 11.2 Obesity, EPODE and OPAL

Health promotion researchers, practitioners and policy developers around the world fortunately are coming to grips with the massive complexity of the obesity issue. Examples are starting to emerge that it is possible to develop multifaceted policies, programs and interventions, and that those complex solutions to the wicked problem are effective. A

first indication of success came from the French EPODE project (*'Ensemble, Prévenons l'Obésité des Enfants'* – 'Together Let's Prevent Childhood Obesity' http://epode-international-network.com), which developed spin-offs around the world, in Australia for instance OPAL ('Obesity Prevention and Lifestyle' – http://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/healthy+living/healthy+places/where+we+live+and+play/opal). The defining policy characteristic of all these programs is that they explicitly acknowledge and embrace networks of stakeholders at both the proximal and distal level of determinants of health and wellbeing. A policy analysis, following any theory of the policy process that includes network linkages between actors, would show that strengthening the policy system in this way has allowed for flexibility in the engagement of contextually diverse groups, communities and principals (for example, from schools or chambers of commerce) in ongoing and responsive, community-based programs that are jointly owned by all.

How would this have happened in some places, and would it be a challenge in so many others? A 'naïve' observer would likely see two factors that made EPODE-enabling policies possible: (1) recognition of the severity of the problem; and (2) the presence of political will. A political science scrutiny of the processes would cast a somewhat more critical view. The nature of a problem in and of itself is no prompt for social and political agenda-setting. An issue needs to be framed, morphed, shaped and negotiated into a narrative that has appeal to a range of social and political audiences (for example, Cobb and Elder (1971) define a number of characteristics that enable social issues to become political issues, and Benford and Snow (2000) show that strong narrative frames can mobilise communities towards political action). Second, 'political will' does not emerge on a sunny Sunday morning over a well-cooked breakfast. Political will, like issue identification, is shaped through context, commitment, perception and political astuteness for how being seen to adopt a cause will advance electoral and constituent gain. Lasswell has identified this process, perhaps a bit too pejoratively, as political psychopathology.

But a realist political view of obesity has made EPODE possible – an important lesson for health promoters.

Question

What key characteristics of 'good' theories of the policy process would you think about when starting action on wicked problems?

From evidence to policy and intervention

Public health scholars have embraced the mantra of evidence-based policy and practice. The same seems to be true, at least in rhetoric, in circles of practice and policy.

But all too often solid evidence does not find its way from research into practice, or practice is not adequately reflected in the scientific endeavour. This remains a frustration for the public health community. This gap between effectiveness on evidence, policy development, and practical intervention design and fidelity (implementing what was designed) has achieved increasing systematic attention since Sir Archibald Cochrane (1972) wrote *Effectiveness and efficiency: Random reflections on health services*. One result was the international Cochrane Collaboration, a global endeavour to systematically review and analyse what works in health.

However, accumulation of 'evidence' did not equate to advances in the development and implementation of evidence-based policy. In the health field, the common analysis was that the nature of the evidence knowledge that was created was not attuned to the needs of policy-makers and practitioners, and that therefore this knowledge needs to be 'translated' into a shape or process that would align better with policy and practice realities (see also chapters 9 and 10). The idea of 'knowledge translation' has become a major industry in the health field. Critics of the concept view it as a bad metaphor (Greenhalgh & Wieringa, 2011) that may have done the field more bad than good.

'Translation' as an inappropriate metaphor

'Translation' as a metaphor would relate either to linguistics or to mathematics – but not to the social and political science perspective we have demonstrated above as necessary to be applied to policy and practice development. Translation as a linguistic metaphor would imply that health researchers speak a different language from those that develop policy and/or implement it – this is also referred to as the 'two communities hypothesis', an idea that has been rejected as mechanistic and stagnant (Lin & Gibson, 2003). It also might imply that one language is not just different, but superior to the other – a notion that aligns well with patterns of professionalisation in the clinical community.

There are also conceptual and substantive problems with the 'knowledge translation' suite of approaches (defined as a 'dynamic and iterative process that includes synthesis, dissemination, exchange and ethically-sound application of knowledge to improve health' (Straus, Tetroe & Graham, 2009, p. 165). First, it is grounded in a presumed value-free Cartesian worldview where facts are facts, and only facts matter. We have shown that facts, particularly in policy development and politics, are always subject to framing, morphing and negotiation. Facts are thoughts, thoughts are perceptions, perceptions are emotions, and we do not tend to think of emotions as facts. Second, the problem of the failure of evidence leading to appropriate policy and interventions is not unique to the health field – it is a challenge found in virtually every field of human endeavour, including agriculture, engineering, education, development assistance and humanitarian aid. Oddly, none of these fields uses the

'knowledge translation' concept or 'translation' metaphor. One might assume that something could be learned from non-health domain efforts to close the gap between research, policy and practice.

The nexus

We have called the areas of overlaps and connections between policy, research and practice the **nexus**. What happens at the nexus, and connects or separates the three domains of policy, research and practice, can and should be studied. Understanding processes and structures that determine overlaps and connections would enable us to generate better ways of generating knowledge for practice and policy. This is a key focus of the work of the Victoria Health Promotion Foundation (VicHealth). VicHealth has a strong and formal commitment to evidence-based health promotion in the sports, community and arts sectors. VicHealth funds applied health promotion research and contributes to the systemic accumulation of practice and policy relevant health evidence of effectiveness. In the early 2000s, the board of VicHealth was interested in confirming 'best practice' in acting at the nexus between their research, policy impact and instrumental health development endeavours. A systematic review was to elicit two things about this interest (de Leeuw, McNess, Stagnitti & Crisp, 2007; de Leeuw, McNess, Crisp & Stagnitti, 2008): (1) what tried-and-tested theoretical and conceptual models for work at the research-policy-practice nexus have been reported in the international peer-reviewed scholarly literature, and (2) are there organisations or groups that have a reputation for success in acting at the nexus, and do they follow the processes and parameters identified theoretically and conceptually?

Nexus alignment, touching or overlapping of boundaries of research, policy and practice.

Nearly 30 different theoretical frameworks specifically dealing with actions at the nexus emerged. For analytical purposes we grouped them into seven categories, which could then be put into three groups (see Table 11.1 and Figure 11.2).

Table 11.1 Seven categories of theories and conceptual frameworks that explain what happens between research, policy and practice for health

Label	Focus
Institutional Re-Design	→ theories about changing the rules of the game
Blurring the Boundaries Utilitarian Evidence Conduits Alternative Evidence	→ theories about the structural interaction of actors and how the nature of evidence plays a role in this interaction
Narratives Resonance	→ theories about ways to communicate at the nexus

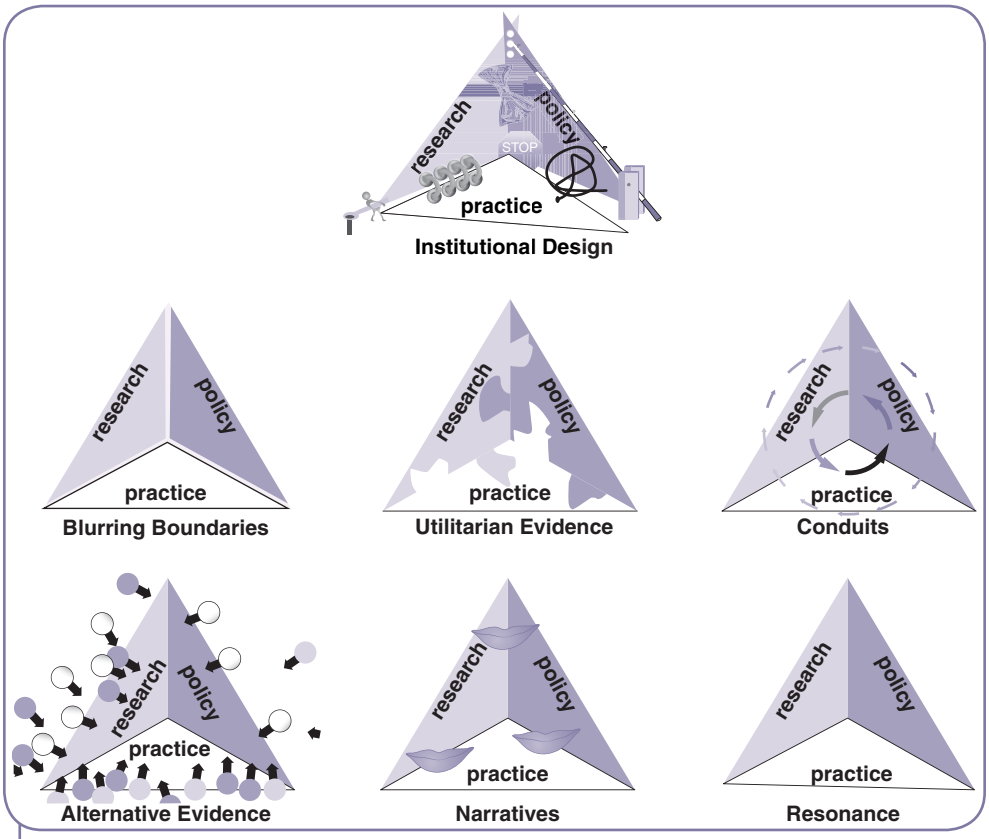

Figure 11.2: Seven models for acting at the nexus between research, policy and practice (de Leeuw, McNess, Stagnitti & Crisp, 2007; de Leeuw, McNess, Crisp & Stagnitti, 2008)

All of these, we could assert from the literature, have a noticeable impact on activities at the nexus towards better integration.

Institutional Re-Design

The *Institutional Re-Design* category of theories recognises that stakeholders in the policy–research–practice 'game' work in their own areas, and in their interactions, in a web of implicit and explicit rules. The operations of that web are governed by sets of rules, known sociologically as 'institutions'. As Ahrendt (1970) has said, an institution is a body of people and thought that endeavours to make good on common expressions of human purpose. Klijn and Koppenjan (2006) are two policy network theorists, and they show that those 'rules' can be changed: actors in the network can try to change rules or set new rules. Actors engaged in policy networking may at times want to change the rules that formally or informally apply to the network, thus influencing their policy outcomes. They may attempt to influence the shape of the network (by changing or consolidating actor relations, adding or changing procedures for access, or shifting external determinants of actor positions through, for instance, regulation), network outcomes (by changing performance indicators), and network

interactions (by laying down instructions on conflict regulation, or the governance of interaction).

Nutley, Walter and Bland (2002) follow these propositions that good systems for working at the nexus can be designed. They posit eight conditions for the use of evidence: (1) the nexus should be open to evidence and argument; (2) in a climate of reasoned exchange; (3) is not connected to emotive responses or popular or official passion; (4) is facilitated when policymakers are specialist experts in their field rather than political operators; (5) is connected to a vibrant social science community that continues to feed the policy process; (6) while there are agencies that have the capacity to have their feet across the nexus; (7) exchange opportunities exist between analysts and policy agents; and (8) there are reputable organisations that compile and communicate evidence.

Blurring the Boundaries

The *Blurring the Boundaries* model claims that it is possible to work towards evidence use in harmonious rather than conflictual ways, through trust, understanding and confidence between researchers, along with enhancing opportunities for research uptake. This model rejects the idea that there is a separation between scholars, practitioners and policy developers. Ideally, understanding 'the other' facilitates the development of shared understandings between these communities.

For example, the 'Boundary Management' framework (van Buuren & Edelenbos, 2004) promotes interaction from the outset of a research project. This framework shows that co-owning research and policy priorities from the start is important (Hanney 2004; International Development Research Centre, 2004) and that expressed respect for each other's position must be a starting point (Kogan & Henkel, 1983). 'Collaboration should ideally start from a joint recognition of a problematic issue, and not from an ideology that dictates partnerships' (de Leeuw, 2006, p. 334). This view of shared ownership also creates a situation where actors feel they jointly own the knowledge that has been generated. This, then, leads to the development of a joint language and vocabulary (Nahapiet & Ghoshal, 1998), which makes joint policy action easier.

Huberman (1989) gives another example in what is called 'sustained interactivity'. This shows that joint action contributes to better understanding and insight in each other's' activities. Expectations of policy and research outcomes then become more realistic (Hanney, 2004). Including practitioner views in research reporting also creates greater receptiveness among practitioners of the evidence (Hargreaves, 1996).

Utilitarian Evidence

The *Utilitarian Evidence* model states that research should be 'useful' (have utility) in order to be applied in policy and practice. This model describes how principles for the utility of research are different between researchers, practitioners and policy-makers. It is important to frame the research in such a way that it has usefulness to all stakeholders. As in the 'Blurring the Boundaries' model, the interaction of researchers with policy-makers and practitioners can provide researchers with insight into how to most effectively direct new knowledge at policy-makers and practitioners. For instance,

'Utility-Driven Evidence' (de Leeuw & Skovgaard, 2005) explains that research from the outset should aim to be useful across stakeholder groups. Other theoretical approaches say that the processes leading to utility happen relatively autonomously. One of them is the 'Multiple Streams' idea where a policy entrepreneur tries to connect perceptions about policies, problems and politics. Another, the 'Percolation' idea, describes how new evidence slowly seeps into daily lives of politicians and practitioners (Overseas Development Institute, n.d.).

Conduits

Third is the *Conduit* model. The 'conduit' informs different communities – policy communities, practice communities, the 'general' community – of research developments and outcomes. A 'conduit' works to disseminate new knowledge in a format that is accessible and acceptable across groups (for example, using more common, everyday terms, using graphs and avoiding jargon). The 'conduit' agent facilitates collaboration between the communities for the ongoing engagement of all partners in research (Bernier, Rock, Roy, Bujold & Potvin, 2006). The 'conduit' is an advocate and provides a platform for communities to express their concerns, in particular those who have fewer material and symbolic (for example, skills and resilience) resources. Also, in disseminating new knowledge in an accessible manner, 'conduits' are at the ready to feed knowledge into fertile ground.

Alternative Evidence

Sometimes research outcomes are not at all consistent with current political agendas or organisational practice. *Alternative Evidence* says that if research does counter current political agendas/paradigms, its immediate impact will be muted. However, there may come a time where the volume of counter evidence can no longer be ignored – or at least not without creating organisational and political upsets or outrage (Hanney, Gonzalez-Block, Buxton & Kogan, 2003). In any event, researchers should also keep in mind that 'at the end of the day, policies … are constantly framed and reframed in response to changing contexts' (Choi et al., 2005).

'Alternative Evidence' finds that impact of research outcomes on policy and practice communities conforms to the 'Enlightenment' function of research (Weiss, 1977). It can contribute towards a more gradual paradigm shift (Krastev, 2000; Neilson, 2001; Sabatier & Jenkins-Smith, 1993). This contrasts with other models that claim that research can have a relatively immediate impact, depending on how appropriately research is 'pitched' at policy-makers and practitioners. In the case of 'alternative evidence', the usage of research as political ammunition has integration value if evidence is consequently part of the standard repertoire of members of policy and practice communities.

Research Narratives

Research Narratives aim to create a human dimension to research by including personal stories. Through personal stories, they inject 'common man' experiences into

research outcomes (Sutton, 1999; see also Chapter 9). The narratives humanise the research, but can also bring a sense of immediacy to the research topic that a 'dry' presentation of results might otherwise lack. Given policy-makers' wish to include experience and common sense (over esoteric science) in their 'selection' of evidence (Booth, 1988), the inclusion of narratives in the overall presentation of research would be appropriate. The narratives support the research, and they highlight practitioner experiences.

Also, they can illustrate research findings and simplify complicated findings. Connecting 'Research Narratives' with the first four models – where actors try to blur boundaries, demonstrate usefulness, act as conduits, or generate alternate evidence – enhances the integration of research, policy and practice.

Resonance

The *Resonance* model works on the idea that researchers or conduits should have their 'finger on the pulse' of belief systems. In doing so, they can link their research outcomes with popular or emergent belief systems (for example, 'social inclusion', a 'safe environment for all individuals'). When research resonates with what people believe, they find it easier to accept evidence.

An example of resonance is found in the work of the Australian Research Centre in Sex, Health and Society to attract organisational and public interest in health issues affecting homosexual adolescents. Through crafting a publicity campaign that related the health issues to the theme of individual safety, they increased the receptivity of communities to their health issues compared to their previous campaign which had focused on the more contentious issue of 'morality'.

Discourses around 'moral' issues such as HIV/AIDS, birth control, or euthanasia, have often been framed from a religious starting point. It would not be helpful to argue that moral foundations are 'wrong', as they are strongly connected to people's life worlds. However, trying to make the evidence resonate with other belief systems could advance the application of new knowledge.

The 'Research Resonance' model argues, for instance, that connecting the HIV/AIDS discourse to issues of 'safety', and the euthanasia discourse to 'dignity', rather than to 'morality', is helpful in integrating research, policy and practice. Issues of safety and dignity are issues that any individual, irrespective of their belief system, can identify with. Widdershoven (1999) has documented this for the euthanasia debate in The Netherlands. The 'Research Resonance' model demonstrates how the 'spin' which promotes research can influence the level of public and organisational interest in the research.

Brokerage, entrepreneurship and boundary work

The seven theoretical and conceptual models that were found had all been tested under research conditions by teams of scholars, sometimes in collaboration with policy-makers and practitioners. This research was published mainly in the scholarly

press – an interesting phenomenon as few policy-makers and practitioners actually study that literature.

The seven models were tested. In a process of snowball-sampling groups or agencies in Australia were found that had a reputation for successfully acting at the nexus between research, policy and practice. Executives were interviewed to explore which models they used.

The Brotherhood of St Laurence (a non-government social work agency working with marginalised populations), the VicHealth Centre for Tobacco Control, the Primary Health Care Research and Information Service, the Department of Sustainability and Environment, the Australian Housing and Urban Research Institute, the Australian Research Alliance for Children and Youth, and the Australian Research Centre in Sex, Health and Society were part of this effort. They all noted that working at the nexus is a talent, and that the effective operator at the nexus is a modest, creative, flexible and politically astute personality. To describe their roles, they used terms also identified by Skok (1995) such as 'social entrepreneur', 'issue initiator', 'policy broker', 'strategist' or 'caretaker' in addition to 'boundary worker', and 'issue manager'.

In assuming these roles, they eclectically chose various elements from the conceptual models best suited to the particular social, political and issue context they found themselves in. These findings, however, did not mean that any of the models could be simply dismissed as esoteric, abstract or theoretical. All stakeholders, and in particular VicHealth, found the listing and categorisation of models and its range of elements useful as a 'mind map' (for example, Wheeldon & Faubert, 2009) to structure their thinking and logically approach the challenges in acting at the nexus.

Spotlight 11.3 Chatham House Rules and policy dialogue

The 'secret' to successful operations at the nexus between research, policy and practice was explored with many executives. The director of one agency stated that it was important to create an environment of trust between stakeholders. The agency often convened meetings where a broad range of – often oppositional – community, government and non-government groups were represented. Those meetings were governed by a number of principles, framed by the director as 'Nothing said here leaves this space', and 'We are interested in dialogue, not debate'.

Implicitly and intuitively, this agency followed some celebrated rules that govern diplomatic efforts. The first one is the 'Chatham House Rule' – 'participants are free to use the information received, but neither the identity nor the affiliation of the speaker(s), nor that of any other participant, may be revealed.' The second is a recognition that debate is different from dialogue (see Table 11.1).

Lavis et al. (2009) show that these structures and processes enable an environment in which the political theories of policy development theories described above play out

Table 11.2 The difference between dialogue and debate (Jones & Mittelmark, 2007)

Dialogue	Dialogue
Collaborative	Oppositional
Common ground	Winning
Enlarges perspectives	Affirms perspectives
Searches for agreement	Searches for differences
Causes introspection	Causes critique
Looks for strengths	Looks for weaknesses
Re-evaluates assumptions	Defends assumptions
Listening for meaning	Listening for countering
Remains open-ended	Implies a conclusion

constructively, and create a situation where agreements on ways forward (and on issues that cannot – yet – be resolved) are more easily framed.

Question

Can you compare the debate–dialogue distinction with the seven nexus models? How do you think they align?

Summary

Through this chapter, you have learned matters relating to the implementation of public health research into public health policy. As discussed in the chapter, there are many salient issues relevant to this process. These are summarised below.

Theories of the policy process

We looked at policy and its development process. They are determined by politics: the game of deciding who gets what, why, when and how. Addressing those questions is ideological and contextual, and intimately connected to issues of power. Within the political sciences, theories have been developed and tested that show how actors and events come together in shaping the opportunities for policy.

Complex problems require different solutions: the concept of 'wicked' problems

We described how modern public health problems, dealing with chronic conditions and social determinants of health, are necessarily subject to long-winded political deliberation. Those

complex problems necessarily require complex solutions. Some of these complex problems take on characteristics of 'wicked' problems. We described the nature of such problems and found that they are elusive and require further interaction and negotiation between all stakeholders involved. Such a perspective aligns well with current insights in the policy process.

The challenges of moving research evidence into policy and practice

The role of research evidence in the policy process is critical. Evidence comes in different forms and is shaped ('framed') to suit the needs of different groups (sometimes called coalitions or networks) of actors in furthering their agendas. Seven conceptual models were identified, explaining what happens at the nexus between research, policy and practice at different levels of structure and agency.

Actors and processes in networks between health research, policy and practice

Case studies, however, showed that the knowledge utilisation reality is different at the coalface than conceptually (even when tested empirically). It is important to build systems and situations of trust, respect and confidence for policy dialogues to happen. For this to take place you will need to map actors and factors, processes and rules that play out in the game.

This chapter has provided health professionals with the tools to map such processes and networks.

Tutorial exercises

1. Find a contentious policy issue – a social and political problem that has some proponents and opponents (think, for instance, about euthanasia or marriage equality). Describe the issue in terms that are as unequivocal as possible and define what policy outcomes could be pursued (for example, regulating the issue, communicating about the issue, or establishing facilities to mitigate the issue).
2. Make a table in which you match proponents and opponents with the policy outcome you have selected. These are the 'policy stakeholders'.
3. Make an analysis of networks of policy stakeholders and how they could form coalitions with each other to advocate for and against the policy outcomes and their associated policy instruments (for example, subsidies, regulations and sanctions). Apply one of the theories of the policy process alluded to in this chapter (for example, 'Advocacy Coalition Frameworks' or 'Multiple Streams') and speculate how this conceptual approach would explain how any political conflicts might be resolved (for example, through building new coalitions, or through connections between frames of policy, politics and problem definitions).
4. Find a piece of evidence (either from the peer-reviewed scholarly literature or from popular media) that advocates your policy preference.
5. Consider how the policy stakeholders may use this evidence to shift positions to make policy more (or less!) feasible.

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