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

Summary

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

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

The challenge of research transfer

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

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

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

In 1956, Chairman Mao wrote an essay titled “On the ten major relationships” and nominated the key contradictions that had to be recognized and tackled at that particular point in the socialist construction of China. He suggested that the world consists of contradictions and the task was to handle these contradictions correctly (Committee for Works of Chairman Mao Tsetung 1997). He accepted that they may not be resolved to our satisfaction in practice, and they may...
give rise to new contradictions. Nonetheless, the key task was to mobilise all the positive factors in moving forward. It would seem possible to draw some inspiration from this essay in examining the problems of moving from public health research to health promotion. Below, I suggest there are ten major contradictions to be grappled with. I pose these in binary terms in order to sharpen debate, rather than to lock us into fatalism. Indeed, the recognition and management of the dynamic between these contradictions may well pave for “the third way”. While these points are drawn largely from experiences and observations within Australia, I believe they are broadly reflective of the dilemmas faced globally.

The 10 major contradictions

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

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

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

2. Evidence from fundable public health research versus evidence not gathered for policy-oriented research
Research funding bodies have strict criteria related to scientific merit. Rigorous peer review processes give emphasis to credible, well-established methodology. As such, health research funding is inherently conservative and tend to support biomedical and epidemiological research rather than social and qualitative research. Kavanagh et al. (2002) suggest that the filters which limit the choice of methods, and therefore impact on funded research and the public health knowledge base, include: research training, disciplinary affiliation and conceptual frameworks of researchers, research setting, political context and peer review system. Limited resources and competition for resources may also contribute to greater funding for clinical trials and biomedical research, with public health researchers settling for more short-term, cross-sectional studies.

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

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

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

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