Evidence advisory bodies in health policy:

Deepening out understanding of the politics of research utilisation.

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Comparing policy advisory systems

This paper emerges from an on-going programme of work on Getting Research into Policy in Health (GRIP-Health). GRIP-Health focuses on the contested nature of health evidence and the role of institutions in mitigating competing political forces and in facilitating evidence uptake. Whilst recognising the multitude of actors involved in the generation, translation and implementation of research evidence in the policy making process, the project particularly focuses on the advisory bodies within, or sanctioned by, Ministries of Health – deemed by the World Health Organization to be the stewards of national health with a mandate to 'collect and use intelligence' in policy making. The first phase of the project was to conduct a systematic review of empirical works examining the political and institutional factors influencing the use of health evidence. The review identified a large gap in the literature, with few empirical studies based on a rigorous theoretical framework, and little comparative analysis. The relevant literature did, however, indicate the level of political decentralisation, the influence of external donors, and competing value systems as potentially important factors influencing the uptake and use of health evidence. The paucity of studies which deal with these issues makes it hard to draw firm conclusions on these political and institutional variables without further comparative research. The next phase of the GRIP-Health programme, therefore, is to conduct a 6 country comparative study of the political nature of health issues, and the institutional responses of national health advisory bodies. This paper sets out the findings of the programme to date, as well as developing a theoretical framework for conducting comparative case studies in this area.

Introduction

The field of public health has widely embraced the importance of evidence to guide health policy and practice (Alliance for Health Policy and Systems Research and WHO, 2007). Yet the process of actually transferring knowledge into policy and practice has been seen as a continuing problem requiring attention in the field (cf. (Mitton et al., 2007, Lavis et al., 2008, Lavis et al., 2004, Innvaer et al., 2002, Hanney and González-Block, 2011). Many past efforts to improve the use of evidence have focussed on making research findings more available or understandable to decision makers. Yet evidence advisory bodies will play a particularly important role in influencing the use of evidence in health policy making, as they provide the formal structures through which evidence is transferred to decision makers, and their rules and procedures can contribute to informal institutional norms as well on the appropriate or rigorous use of evidence in decision making.

While there are a range of actors attempting to provide inputs into the decision making process, ranging from academic policy labs to think tanks and lobby groups, those evidence advisory bodies that have been officially sanctioned by government to serve a knowledge synthesis function and to provide inputs into decision making processes are arguably of particular importance. Within the health sector, national Ministries of Health have been deemed the 'stewards' of national health systems by the World Health Organization, and this stewardship function includes responsibility for the use of information to guide health systems policy and practice (World Health Organization, 2000). The stewardship concept see Ministries as holding a mandate to ensure appropriate use of evidence to inform health policy decisions and to establish the formal bodies or arrangements for the use of evidence in decision making (Alvarez-Rosette et al., 2013).

The particular form of evidence advisory bodies can vary substantially between governments. A recent discussion paper from the Alliance for Health Policy and Systems Research (AHSR) has described three models of 'embedding' the use of evidence into policy that Ministries of Health typically utilise (Koon et al., 2012): autonomous evidence synthesis bodies; internal departments within ministries tasked with evidence use; or formal arrangements with external (e.g. academic) bodies to synthesise evidence for decision making. This mapping is a useful step in the categorisation of structural forms, but on its own it does not provide insights into how different structures work, or which issues they may better suit. What may be more important than the final form of an evidence advisory body are the functions and roles it plays in ensuring an improved use of evidence in policy making across a spectrum of political issues. How to conceptualise, investigate, and analyse this in practice, has not yet been addressed in depth by public health scholars.

The recent AHPSR paper is one of the first attempts to begin to engage with institutional structures for nationally mandated health evidence advisory bodies. However, there has been a limited engagement with the political nature of health issues in efforts to improve the uptake of evidence in policy and practice. Past approaches which have attempted to make evidence more available or understandable – efforts often conceptualised as attempting to 'bridge the gap' or connect the '2 worlds' of researchers and policy makers – rely on assumptions that evidence can unproblematically be translated into policy, and that there will be a single, obvious policy decision emerging from a given evidence base.

This conceptualisation, however, removes political considerations from the process and, as it cannot address the political processes inherent in decision making, is limiting in how much it can actually help to improve the process of evidence use. If evidence utilisation by policy makers is a function not just of awareness of information, but also of other political factors, then an approach to improving the uptake and utilisation of evidence is needed that goes beyond the assumption that more available or accessible evidence will automatically translate into greater evidence use. Additional approaches are needed to engage with the fact that many public policy decisions are contested, and that decisions are made within institutional structures that mediate the use of evidence in political debates.

These political realities set the context into which nationally sanctioned evidence advisory bodies must operate in their goal to improve the uptake and utilisation of evidence for policy and planning. Advisory bodies must go beyond providing a simple library of information (or simply making evidence available) in two key ways. First they must be structured so as to work effectively within a given national political structure. Secondly, they will need to function in ways that mitigate the politically contested nature of health issues in local contexts.

We argue that what is needed to take the field of evidence-informed health policy forward is a greater engagement with these issues, and the application of these political insights into the structure and function of official evidence advisory bodies. This paper presents initial findings and plans of a 5 year programme of work (begun in January 2012) that attempts to addresses the use of health evidence from a politically informed perspective in this way. The ultimate goal is to provide practical insights that may guide the structure and function of nationally sanctioned evidence advisory bodies

Review of empirical works on the politics of health evidence

The conceptualisation of evidence use as a political process involving socially contested issues and taking place within particular political institutional structures raised two initial questions for our research programme:

1) What is the nature of the political contestation of health issues in local contexts (e.g. are there particular characteristics of certain health issues that lead to their contestation) and how does this influence the use of evidence in policy making?
2) What political structures and institutions most effectively facilitate the use of health evidence in national policy making?

In addressing these questions, our first task was to conduct a systematic review of empirical case studies to gain a better understanding of what has been directly studied and analysed about the politics of health evidence. In order to capture the variety of potentially relevant themes, we maintained a broad understanding of ‘politics’ including both the influences of differing political systems and institutional process, as well as the influence of other contextual, socio-cultural factors that may contribute to the political contestation of health evidence.

Eligible studies were identified through searches of seven health and social sciences databases, the British Library database, and manual searches of academic journals. Individual websites were also reviewed for grey literature, selected on the basis of their relevance to the subject and on recommendation from key individuals working in the field. These included the online repositories of the Program in Policy Decision Making at McMaster University, the Centre for Evidence & Policy at King's College, the WHO Evidence into Policy Network (EVIPNet), and Evidence to Policy Initiative (E2Pi) at the University of California at San Francisco. Relevant findings were then extracted using a uniform data extraction tool and synthesised by narrative review.

After full-text review, 54 studies were selected for inclusion. Relevant political and institutional aspects affecting the use of evidence appeared to be concentration of power and political centralisation, level of democratisation, turnover of staff in government bodies, institutional path-dependency, and the role of external donors and institutions charged with the use of evidence. In addition, our reviews identified a number of contextual factors that may influence and politicise the use of evidence in health policy making, including the pressure of wider policy strategies and political cultures, the alignment of evidence with predominant values or existing political agendas, and existing normative positions such as moral convictions (e.g. about sexuality), religious and cultural identity, and nationalism. Research findings also indicate that policy processes involving the use of health evidence often involve a complex interplay of these factors, both at the national and international level.

A stand-out finding from our review is that little empirical work has been done explicitly analysing the influences of political and institutional factors, with many included studies dealing with them only indirectly. Consequently, our understanding of these issues remains patchy and inconclusive. Despite the fundamentally political nature of decision making processes, the extensive literature on political institutions, and the highly contested nature of many health issues, very few works explicitly applied policy science perspectives to understand the use of evidence in health policy making (Abeysinghe 2012, Beck et al. 2005, Klein 1990, Smith 2007, Smith 2012). As a result, the analysis of political and institutional influences was often limited, with no significant consideration of key issues such as the influence of party systems, the relations between different branches of government, power imbalances and hierarchies, and questions of political legitimacy. Furthermore, we found very few comparative works in this area. This is a major gap, as comparative case study analysis would be particularly useful in facilitating theory development and deepening our understanding of these processes, given the highly contextual nature of the policy process. Similarly, the paucity of 'before and after' temporal perspectives prevented a clear understanding of the effects of political and institutional change on evidence use practices.

Despite these limitations, our review contributes to improved recognition of the political dimension of health evidence utilisation, and can thus stimulate critical thinking about current policy debates. For example, some consensus has emerged in recent years about the benefits of closer interactions between researchers and policy-makers, from the early stages of research processes. As recent initiatives illustrate, such interactions have the potential to promote the generation of policy-relevant research in different contexts, and in theory could facilitate the creation of research findings that align with existing political needs Hanney and González-Block 2011). However, such efforts typically overstate the ability of better linkages between researchers and policy makers to facilitate evidence use, or understate the importance of political factors. Given the high turnover of politicians and administrators in key decision making positions (Flitcroft et al. 2011, Smith 2012), training or linking of individuals may not produce sustained improvements in evidence use. This reiterates the importance of establishing evidence advisory bodies that can institutionalise improved uses of evidence in policy, as well as the need for institutional analysis to study the enduring structures, rules, and norms which shape the evidence to policy process.

Our review also suggests that over-simplified concepts of 'evidence based policy' may not be conducive to good governance practices. For instance, political pressures may encourage a selective use of evidence that can then be framed as 'evidence-based' as a rhetorical device to support predetermined policy choices or ideological positions. Similarly, calls for policies to be 'based' on clear bodies of evidence may delay decision-making on contentious issues while less contentious topics with clearer, uncontested evidence bases are followed. Such shortcomings are likely to be amplified when there is a lack of institutional capacity or structures able to provide competent and independent scientific advice. Yet, a number of studies included in our review indicate that even institutional bodies that operate according to the most rigorous procedures may be vulnerable to distortions and/or the influence of interest groups. For example, one study on the public health crisis of 'mad cow' disease in the UK suggested that expert advice is more likely to be subject to the influence of pressure groups in a highly centralised political systems where government-appointed scientific committees have little public oversight (Beck et al. 2005). Another study found that the discursive hegemony of clinicians and health economists at the National Institute for Clinical excellence (NICE) may result in decisions that are based only on quantitative data, neglecting subjective, experientially based evidence (Milewa and Barry 2005). Thus, as these cases illustrate, more attention needs to be paid to the specific kinds of evidence used at different stages of the policy making process, and the ways in which different political and institutional drivers may contribute to more or less appropriate evidence utilisation.

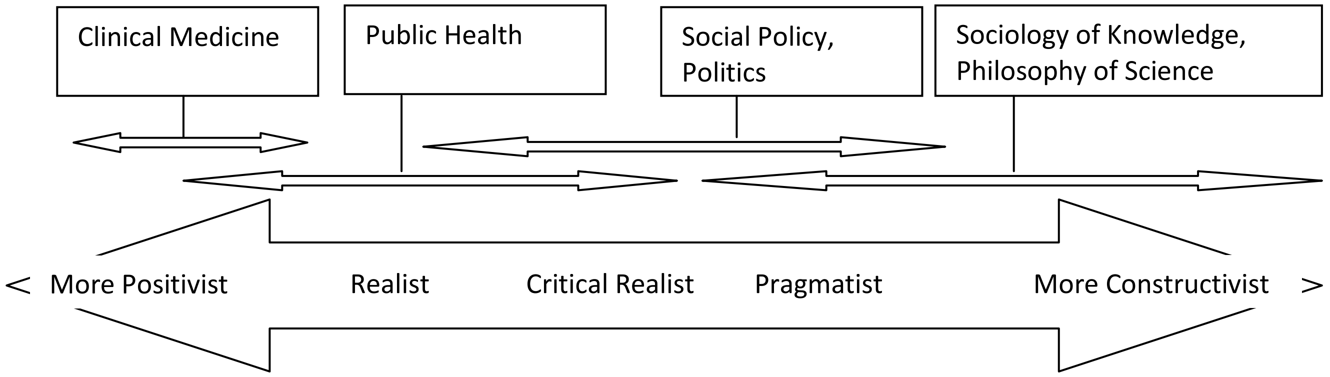
Building a conceptual framework

The systematic review of empirical works has shown that there have not been many case studies conducted to specifically study the ways health evidence is politicised, nor how political institutional structures affect the uptake and utilisation of health evidence given that politicisation. Only a few empirical cases have looked at the functioning of specific evidence advisory bodies, with many questions raised about how they function, and for which issues they may be more or less effective in their roles. Research in this area therefore has a practical concern to help improve the use of evidence in policy making, or more specifically at times to improve the functioning of those evidence advisory bodies tasked with doing so. However, undertaking research of this nature from an academic perspective requires consideration of a range of conceptual, normative, and theoretical issues.

Notably, it is important to consider issues such as what constitutes 'evidence,' and what uses of evidence will best suit the field of public health. There is a vast array of social scientific and public health thought surrounding the idea of valid evidence or knowledge, and its use (c.f. Krieger 1992; Berridge and Stanton 1999; Howick 2011) A vast range of work exists addressing important concepts of relevance to the understanding of evidence, ranging ontologically from extreme postitivism on the one hand, to social constructivism on the other. Several disciplines can also be identified, typified by different epistemological perspectives – ranging from clinical medicine, with its focus squarely on individuals and biomedical explanations of disease; to public health (which in theory must recognise social structures and broader health influences, but is often rooted in clinical thinking); through to philosophy of science and sociology of knowledge approaches which are decidedly constructivist in nature.

The following diagram attempts to map out some of the most relevant approaches to the nature of evidence as well as the main disciplines in terms of where they may fall (acknowledging the broad ranges that can exist) along the spectrum.

Ontological spectrum of approaches to Evidence and policy in health



Existing work from a public health perspective attempting to improve the use of evidence has rarely engaged with the political nature of decision making or contested views over evidence. Yet these realities of the policy process cannot be ignored. We therefore argue that the field of public health has been limited by reliance on overly positivistic conceptualisations of evidence use. There is a need to shift public health approaches to evidence and policy to the right on the above figure, towards a more politically informed position that recognises the contested nature of evidence, but which still maintains a critical realist recognition that bodies of research evidence have their own internal validity which must be acknowledged, and operationalisable policy actions must be chosen guided by normative principles.

Such a shift can be realised if it is built into the structure and functioning of influential evidence advisory bodies. Setting the institutional parameters of such bodies tasked with the use of evidence, however, raises a set of conceptual and normative questions to consider:

1) Who should be responsible for establishing the rules and arrangements through which evidence gets used?
2) What would be seen as a 'good evidence' if multiple evidence types are relevant to decisions?
3) What would be seen as a 'good use of evidence' if evidence utilisation is seen as part of a political process?

Clarity on each of these is necessary to establish a firm conceptual grounding on which to undertake research, and a normative position from which to make recommendations on how to improve evidence advisory bodies for public health planning. Each is discussed in turn below.

Responsibility for evidence advice - stewardship

The first question presented above is essentially a normative one when considering that the policy process is constituted by a range of actors and interest groups aiming to influence decisions, with multiple possible agencies claiming expertise over, or access to, evidence of relevance to decision making. Recent debates in public administration have further raised questions about the capacity and role of the state, with growing scepticism over the state's ability to achieve policy outcomes (Richards and Smith, 2002, Bell and Hindmoor, 2009). The shift away from national state government provision to more decentralised or delegated task management has led to a shift in vocabulary amongst many scholars from 'government' to that of 'governance' – with governance representing a de-centering of the state and a shift in the process of government to multiple actors in a range of settings. This shift has equally been seen in the arena of health systems governance at national and sub-national levels (Kickbusch and Marinker, 2002, Lewis et al., 2006).

The shift from government to governance in health and other sectors initially appears to problematise the idea of establishing a single evidence advisory body that might be tasked with providing inputs into policy making. However, the World Health Organization (WHO) has championed the concept of stewardship of health systems as an essential function of national ministries of health in the 2000 World Health Report (World Health Organization, 2000). While the terms governance and stewardship are often used interchangeably, The WHO's concept of stewardship particularly reflects a consideration of ultimate responsibility, as when it says:

> "The ultimate responsibility for the overall performance of a country's health system lies with government, which in turn should involve all sectors of society in its stewardship... The health of the people is always a national priority: government responsibility for it is continuous and permanent. Ministries of health must therefore take on a large part of the stewardship of health systems"(World Health Organization, 2000)(p. xiv).

Within its conceptualisation of stewardship, the WHO further elaborates that 'collecting and using intelligence' is a key dimension. Later discussions of the stewardship concept appear to have unfortunately stretched the concept beyond its potential usefulness of the term – either by equating it with normative concepts of democracy, or conflating it further with governance and multi-level governance(c.f. Alvarez-Rosette et al., 2013). Indeed, the term no longer features in many WHO documents. But we argue that the conceptually useful element of the stewardship concept remains the notion of ultimate responsibility, as well as the inclusion (in almost all conceptualisations) of a role for some element of intelligence, knowledge or evidence, as important to guide planning.

These components allow for Ministries of Health to take a leadership role in establishing the official evidence advisory bodies to inform health planning in countries. The form and shape of those bodies may vary, and many of the tasks may be delegated to other actors in line with modern governance models. Yet the ultimate responsibility over the form and function will lie with government (and Ministries of Health in particular), providing a useful point of entry to establish the legitimate institutional forms, rules, and norms through which evidence will be used for policy making. It can be argued, therefore, that the WHO's championing of Ministries of Health to serve as the stewards of national health systems provides legitimacy and primacy to the evidence advisory bodies officially mandated by those Ministries. It is these advisory bodies which therefore should be targeted to embed a more politically informed use of evidence.

Good evidence for decision making

Once an evidence advisory body is mandated to synthesise or otherwise utilise evidence for policy and planning, a second question that arises is to identify what can be considered 'good evidence' on which to base health policy decisions. The Evidence-Based Medicine (EBM) movement championed in the field of health care has been an important voice calling for clinical practice to follow rigorous reviews of the best quality evidence of effectiveness for interventions, in order to maximise benefit with a particular concern with reducing or eliminating bias from the process of evaluating interventions (cf. (Starr et al., 2009, Howick, 2011, Kelly and Moore, 2012). The language of EBM has flowed into calls for Evidence-Based Policy (EBP) as a correlate, arguing that policy decisions equally must be based on un-biased reviews of 'what works'.

Clinical medicine is steeped in positivist traditions, and many commentaries about the need to increase the use of evidence for policy arising from the medical field have called for EBP to follow the same rules of EBM, such as the application of 'hierarchies of evidence' to policy decisions (such hierarchies typically place experimental trials – or randomised controlled trials (RCTs) at the top as the best methods to measure intervention effect) (Cookson, 2005, Berridge and Stanton, 1999, Glasziou et al., 2004). Many from the public health community uncritically accept these calls for EBP, presenting a view that there is a distinction between evidence on the one hand and politics on the other, and valuing evidence as 'best' when it adheres to particular methodological forms. As such, public health discourse often uses the term EBP in ways which imply that there is a single policy choice that is 'based' on evidence, presumably also implying that other policy options must therefore be in contrast to (or in spite of) evidence. Even though the call for evidence-based policies are often made with the intention of removing values from decision making, this very conceptualisation of the policy making process imposes a particular value system in which clinical outcomes in terms of morbidity and mortality (on which health evidence bodies are based) are prioritised to the complete exclusion of other social concerns (Parkhurst, 2012, Barnes and Parkhurst, 2013 (in press)).

A basic understanding of the political nature of policy making illustrates the limitations of this conceptualisation of evidence use. Policy making typically involves deciding between competing and contested social outcomes (Lasswell, 1990(1936), Stone, 2002), into which health outcomes (morbidity and mortality) are one possible consideration alongside a range of others (social acceptability, equity, justice, etc.). A number of health policy scholars have essentially noted this point as well (c.f. (Cookson, 2005, Lin and Gibson, 2003) and many authors now speak of 'evidence informed' policy to move away from the seeming reductionism in the EBP terminology (c.f. ,(Levacic and Glatter, 2001, Tranfield et al., 2003, Bowen and Zwi, 2005, Lavis et al., 2008).

The existence of other competing decision criteria, however, does not eliminate the need for consideration of evidence or judgement of evidentiary quality. Rather, each criterion will have its own 'evidence base' which decision makers will need to consider. Questions of ethics, justice, or equity remain important decision criteria, but relevant evidence for these will come from non-experimental sources in many cases, and therefore evidence from these other concerns should not be evaluated according to any hierarchy of evidence developed for clinical evaluations of effectiveness (Petticrew and Roberts, 2003, Glasziou et al., 2004). Surveys of social desirability, for example, should be judged in terms of their sample size, and potential for bias in their questioning – while considerations of equity will require review of cross sectional statistical data – again with its own criteria for quality and rigour. Of importance is to recognise that for many important considerations, the type of evidence that is relevant or best to answer the public health policy makers questions is not necessarily that which derives from clinical trials.

Sociologists of health and illness challenge public health planners further in their consideration of evidence by commenting how on an over-emphasis of individualistic explanations of health outcomes can lead to under-acknowledgement of the broader social determinants and social structures which are critical to shaping population health outcomes (Cockerham, 1992, Willis and White, 2003, Marmot, 1996). If the goal of public health is to improve population health as a whole, then narrowly focussing on individual determinants and immediate causal effects of treatments may prove greatly limiting (or even counter-productive according to some - c.f. (Illich, 1978)). Others have further identified how illness categories, the construction of data, and the classifications of risk groups are also be socially constructed and politically influenced – with very real implications for which issues get considered and how health promotion efforts unfold (Krieger, 1992, Navarro, 2009). Research findings, therefore, reflect the aims, and methodological and analytical processes of those conducting the research. This means that it is important to interrogate the goals and perspectives that underpin any piece of research. The implications of these insights are that public health professionals, in pursuing their pragmatic goal of improving population health, must broaden their conceptual gaze away from individual and disease oriented determinants of health, and must be aware of how the definitions and classification systems used may have important implications for what they do.

A broader conceptualisation of evidence, and a shift in ontological perspective, does not abandon the importance of judging the quality of evidence, and avoiding deliberate manipulation of evidence. A more critical perspective would still recognise that research findings can be interpreted in either accurate or in biased ways according to the methods that created those data (that is to say, there is potential that they can be used in ways that were not intended or suggested by the research iself); and research itself is underpinned by assumptions that must be taken into account (the choice or form of methods are an artefact of a social processes). Similarly, a larger body of evidence can be reviewed and summarised in a rigorous or systematic way, or in a piecemeal and selective way, even with recognition of the constructed nature of that body of evidence. As such, the practical relevance of a shift in the ontological spectrum for public health should not be to abandon concerns with quality, rigour, and bias, but rather to broaden understandings of relevant concepts that can help the public health practitioner achieve his or her ultimate goals.

'Good evidence' for health decision making, therefore, requires a shift away from blind application of a single hierarchy of evidence to a position of *appropriateness*. Equating good evidence with that which is appropriate to a specific social issue or policy decision allows explicit recognition that health issues may touch on other important social concerns, such as equity, desirability, ethics, or justice, for example. There may be evidence to guide a decision maker on those areas, but the type of evidence will not necessarily be of the same form as that which emerges from trials of intervention effectiveness. Yet each evidence type will need consideration in rigorous (non-selective) ways, in accordance with its own relevant quality criteria.

Public health remains a pragmatic field with its ultimate goal to alleviate human suffering and improve population health. As such the discipline would be unable to undertake programmatic action if it continually challenged the ontological basis of (socially constructed) health 'outcomes' as a subject of public action. Yet the field can consider the evidence bases that relate to additional social concerns alongside clinical outcomes, and further apply a sociological lens to recognise both the socially constructed nature of health categories and the limitations of methods designed for clinical medicine when applied to population health.

The good use of evidence – towards good governance of evidence in decision making

The preceding two sections aimed to establish that officially sanctioned evidence advisory bodies have a legitimate position to establish the rules and expectations of evidence use as part of Ministries of Health's stewardship function (thereby setting the norms for evidence use), and that 'good evidence' will consist of evidence from a range of sources, determined according to their appropriateness for achieving health policy goals. A third conceptual question then is to ask what constitutes the 'good use' of evidence within the policy process itself.

Recognition that policy decisions involve competing social needs and values was already noted to broaden the field of evidence beyond hierarchies of clinical effectiveness. Yet even with a broader understanding of appropriate evidence, there is still a further need for social values to guide decision making processes in public health (Clark and Weale, 2012). Indeed, Tesh (1988) argues that health policy debates involve much more than immediate health outcomes, but rather also encompass broader social issues such as the fundamental nature of human existance, or what society should look like more broadly (Tesh, 1988).

Bodies of evidence therefore do not speak for themselves on policy grounds. Accordingly, as Brecht has explained, scientists can support decision-making processes (e.g. by deciding how to measure particular outcomes accurately), and can inform policy makers, but they cannot decide the right or wrong policy choice; nor decide on which pieces of evidence policy should be based (Brecht, 1959)

Scientists cannot serve this role because, in Brecht's conceptualisation, those elements must be dictated by social values which do not derive from the methods of science. Accordingly, scientists may be the legitimate guardians of methodological rigour, but they lack the legitimacy to represent the values and desires of society. That must instead fall to individuals or groups mandated to represent the citizenry. Forms of political representation vary of course, but ultimately, this points to the need for evidence informed policies to adhere to principles of good governance, and not just good evidence.

Principles of 'good governance' range widely. The United Nations argues that 'good governance' has eight characteristics, claiming "[i]t is participatory, consensus oriented, accountable, transparent, responsive, effective and efficient, equitable and inclusive and follows the rule of law"[1] . There are countless other authors who have included or excluded some of these principles in discussions of governance or good governance. Ultimately, however, discussions of governance centre around how political agencies articulate and pursue societies' collective interests (Pierre, 2000) - that is to say the arrangements that represent and work to achieve the interests of local citizens.

Accordingly, combining the above concepts allows a normative conceptualisation of the 'good governance of evidence' that can be used to guide, national evidence advisory bodies. These bodies would aim to ensure evidentiary rigour and consideration of the multiple bodies of evidence relevant to a decision; but they would not replace the key valuation function of decision makers who are accountable to, and ultimately representative of, local citizens.

Future research areas - Re-politicising evidence-informed health policy making

The above sections have presented work done to date as part of the GRIP-health programmes research agenda to investigate the political nature of health issues and provide inputs to advise or support national evidence advisory bodies in their use of evidence to inform health policy. The first task was to conduct a literature review which established there was a relative lack of empirical studies investigating the political nature of health issues and the ways in which political institutions affect the use of evidence for health policy making. Following this, however, a normatively grounded conceptual framework was developed to establish a concept of the 'good governance of evidence' to which national evidence advisory bodies may wish to work.

The next stage of the research programme (set to commence early 2014) will be to undertake a set of 6 country case studies to investigate these academic and practical issues in greater depth. The lack of existing comparative work in this field points to a particular need for such efforts to allow greater theory development and more detailed analysis of evidence use through the decision making process. Our selection of countries will be driven by an attempt to capture a wide range of political environments that are seen to be influential to decision making. The field of public administration in particular focuses on a state's governing political structures, and their functioning, to explain policy outcomes. It provides theories on the factors which shape the capacity of governments to develop effective policies. These factors include: the 'territorial' structure of the

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[1] http://www.unescap.org/pdd/prs/ProjectActivities/Ongoing/gg/governance.asp accessed 25/05/2013.

state – such as whether it is a unitary (centralised) or a devolved (e.g. federalist) state (Rhodes et al., 2008); the democratic structure (such as the degree of political pluralism and freedom in the country); and the role of the bureaucracy (in particular their degree of control over the policy advice given to decision makers) (Peters, 1995). Our initial literature review further confirmed the importance of these and other related features, with the level of centralisation, role of the bureaucracy, and influence of external donors all seen in included works. This has provided us a set of criteria on which to initially sample countries: National income level (according to World Bank income rankings); the level of democratistaion or freedom of participation in policy making (according to Freedom House's *Freedom in the World Survey*[2]; the level of government effectiveness (according to the World Bank's *Worldwide Governance Indicators*[3]); and the centralisation of decision making (according to the CIA *World Factbook*[4] and other sources). These factors produce a matrix of possible country choices. A most-different design allows capture of a wide range of political arrangements, although having 2 or more countries with a shared attribute allows increased analysis of how key political features function in different settings.

Within each country we intend to choose a set of three health issues to focus our analysis: one for which evidence was seen to be used unproblematically (or well); one where evidence use was seen to be politicised and problematic; and a tracer issue that is a health priority in all settings, but where evidence use may be varied. By tracing the process of evidence use through national decision making bodies (including any officially sanctioned evidence advisory bodies) we hope to be able to learn academic lessons about the political nature of health issues as well as the institutional factors shaping evidence utilisation within local political contexts. However, given national and international concern with building capacity for the improved uses of evidence (Alliance for Health Policy and Systems Research and WHO, 2007), we further hope to be able to apply our normative model of the good governance of evidence to provide advice or inputs into local and global efforts to shape and strengthen nationally mandated evidence advisory bodies.

Conclusions

This paper presents an overview of thinking and findings to date of a 5 year programme of research on the political nature of evidence use in health policy. Many past public health efforts have conceptualised the supposed failure to take up evidence as an issue of a gap between researchers (or research findings) and decision makers. A political lens, however, allows further consideration of the contestation of health issues and the institutional structures and functions that mediate the process of evidence use. Applying these insights to evidence advisory bodies, however, requires a conceptual framework that can broaden the understanding of evidence beyond clinical or epidemiological methods, and a normative position on which to evaluate an 'improved' use of evidence in practice.

We began with a literature review that identified a relative dearth of empirical studies that explicitly look at these issues for health evidence utilisation, although several insights could be drawn from existing works to help guide future efforts in this way. The few empirical studies that made note of institutional or political structural variables as influential pointed to factors such as the level of

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[2] http://www.freedomhouse.org/report-types/freedom-world
[3] http://info.worldbank.org/governance/wgi/index.asp
[4] https://www.cia.gov/library/publications/the-world-factbook/

centralisation, democratisation and participation, or donor dependence as influential. Unsurprisingly, many of these overlap with the most common political characteristics seen within the field of public administration to be influential to decision making processes.

Our next step was to build a conceptual and normative framework around which to study the functioning of evidence advisory bodies from a political lens, while enabling recommendations or inputs into discussions around how to improve the use of evidence for public health planning. Three driving questions were developed around: who should be responsible for establishing the rules and structures of evidence use, what is 'good evidence' for public health goals, and what is the 'good use' of evidence in political processes.

We argued that the stewardship concept championed by the WHO in its 2000 world health report clearly establishes a mandate for ministries of health to lead health systems policy and planning, which can encompass the use of evidence. As such it can be seen as establishing the legitimate evidence advisory bodies that can establish the norms and expectations of evidence use in decision making processes. Understanding good evidence for health decisions required broadening the view of health away from hierarchies of clinical effectiveness to a focus on the appropriateness of different bodies of evidence (and different methodologies) for the range of decision criteria involved in health policy making. Population health is a social goal, and a shift in ontological perspective away from purely positivist notions to more of a critical realist position was further argued as necessary to allow health planners to recognise the competing political needs within health policy decisions, while also recognising how the construction of variables such as illness definitions or population classifications may reflect particular political ideas or discourses. This critical perspective will allow planners to consider if alternative conceptualisations or categorisations might be more useful to help them achieve their ultimate policy goals – such as population health improvement or greater health equity. Finally, we applied concepts of 'good governance' with their central focus on decision making as representative of, and accountable to, local populations. Combining these concepts permitted the construction of a concept of the 'good governance of evidence' in which nationally mandated evidence advisory bodies would use a range of different evidence types in rigorous and unbiased ways in order to provide inputs into decision processes that are ultimately made by individuals or agencies attempting to represent the needs to the citizenry.

Lastly, we outlined a proposed body of empirical work that we hope to undertake to provide greater insights into the issues covered in this paper. We hope to be able to provide both academic and pragmatically useful insights that can guide future efforts to improve the use of evidence. An institutional approach, however, is particularly important in this endeavour – both to enable analysis of key institutional variables affecting the use of evidence which may have been neglected by past works, but further to consider how to establish structures, standards, norms, and procedures within evidence advisory bodies.

The conceptual approaches of public administration, sociology, and political science provide a useful means to guide strategies to improve the use of evidence in health policy making. They allow consideration of multiple competing social outcomes, multiple evidence sources, and institutional structures mediating the use of evidence, without sacrificing the more practical concerns with evidentiary quality and a desire for 'truth' (typically interpreted as effective health outcomes) – simply expanding the remit of 'truth' to broader issues influenced by social values and political realities. This conceptual approach goes beyond existing efforts which have been limited to 'user push', 'provider pull' or 'bridging the gap' – efforts which have attempted to improve knowledge translation, but typically ignore the nature of political systems and the contestation over policy issues. 'Improvement' in the use of evidence, however, is a normative concept and requires some standard against which 'better' use of evidence can be judged. In this paper overviewing our programme of work we have attempted to develop one possible framework that can help guide those tasked with establishing, reforming, or strengthening evidence advisory bodies in public health settings.

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