

Policy is political; our ideas about knowledge translation must be too

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This article argues that in public health research, standard approaches to knowledge translation are based on (1) an invalid model of the relationship between research knowledge and policy and (2) an oversimplified concept of 'knowledge'. Standard approaches tend to focus primarily on communicating research knowledge to policy makers in order to increase the impact of research on policy making.^{1,2} However, the process of policy making is complex and political (in the broad sense); it is not a neutral or technical exercise that simply requires greater use of scientific evidence to improve decision making. Neither is research knowledge neutral or wholly technical; it is produced in social contexts and also operates in societies in uneven ways. There is significant socio-political literature which has analysed the relationship between knowledge and policy, including how they are embedded in social and political contexts, but this is rarely drawn on in public health research.³⁻⁶ Knowledge translation in public health is a challenging area which could be informed by this literature; key ideas are briefly outlined here.

THE ROLE OF KNOWLEDGE IN POLICY MAKING

Several well-established models describe the role that research knowledge plays in the policy making process. This list is a selection of models based on several identified by Smith:⁶

1. Technocratic, instrumental: knowledge is passed from researchers to policy makers and is facilitated by good connections between them. This is closely related to the 'rational' or 'stagist' model of policy making which describes a linear process from defining a policy problem to collecting information (including research evidence), deliberation and then implementing a course of action. Knowledge translation in public health often implicitly assumes the technocratic and rational models rather simplistically but empirical research indicates they have poor validity.⁵⁻⁷

2. Complex, messy: policy making is a complex, non-linear process driven by multiple elements of which research knowledge is only one. Other elements include: political values, organisational structures and cultures, lobbying and interest groups, media, public opinion, and budgets. Chance and making the most of 'policy windows' for adopting research knowledge are also important factors.
3. Normative, political: research is used selectively for political purposes such as supporting decisions that have already been made or using research where it fits with existing political ideas or values.
4. Democratic, conceptual: research shapes views over time at a societal level, including through concepts and theories becoming accepted, which eventually has an impact on policy. Weiss's 'enlightenment' model has been a significant influence on this perspective.⁸

The variety of conceptualisations of the relationship between research knowledge and policy making reflect the empirical complexity of this area, while the second and third models highlight the political nature of and competing interests inherent in policy making. They draw attention to policy making as 'the formal struggle over ideas and values' (p. 45)⁹ in which knowledge can be moulded and used strategically; research knowledge can for example be 'reworked' and some kinds of knowledge can be given greater legitimacy over others.¹⁰ Smith refers to 'the malleable nature of knowledge which is translated as it moves between actors and across contexts' (p. 213)⁶ and the bi-directionality of influence and ideas between research and policy. This perspective highlights the complex and political nature not only of policy but of knowledge too, where knowledge operates not as a stable 'thing' but as a more fluid and contingent phenomenon.

KNOWLEDGE IS POWER

The models and literature cited above indicate different ways in which research knowledge may operate in the policy making process. Interpretive perspectives explore in more depth how knowledge is

shaped in society,¹¹ and critical approaches emphasise how knowledge forms an interrelated system with policy and power.

Interpretive perspectives view knowledge as not directly transported from the empirical world to our brains, but as interpreted through individual minds which have formed in and therefore been shaped by a particular society and its institutions. This includes research knowledge: our understanding of health problems and solutions are not inevitable but are filtered by frameworks and concepts which vary over time and culture.¹² Current Western frameworks of 'health', in contrast to earlier models which defined health as 'being disease free', now encompass an individual's whole lifestyle in order to control risks of future disease.¹³⁻¹⁵ An uneven characterisation of risk is applied; for example, smoking is highlighted as producing risk more than issues such as pollution.¹⁶ Furthermore, there is an expectation that individuals will assume responsibility to promote their health through self-regulation of behaviours and that individuals will prioritise health; this underpins common health behaviour theories such as the Stages of Change model.¹⁷ Research knowledge is not neutral, therefore, but emerges from a social context.

Critical perspectives drawing on the work of Michel Foucault (1926-1984) go further and demonstrate how cognitive frameworks—including very broad ones concerning what is 'true' or 'rational'—are not only socially embedded but are exercises of power by implying (often moral) judgements about how institutions and individuals should behave.^{18,19} In Western societies, rational and acceptable behaviour is framed as reducing individual health risks, and therefore responsible (and virtuous) individuals will adopt healthy lifestyles. Institutions promote this, for example, through prescriptions for diet and exercise by general practitioners,¹⁴ or employee health programmes providing monitoring, advice and fitness interventions.¹³ Individuals may also regulate their own behaviour and adopt values such as 'responsibility': for example, smokers may try to quit but if they are unable to they may present themselves as responsible in other ways, such as not smoking around children.²⁰ Furthermore, some (usually lower socio-economic status) groups tend to be characterised as deviant because they do not adopt behaviours to maximise their health; they become subjects for monitoring, including through research studies, and are helped

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to behave more 'normally' by health professionals.¹⁷ These groups can be stigmatised as being irresponsible or flawed and as a result can incur harms such as stress.^{15 21} Dominant economic interests, such as ways in which employing organisations might cause ill-health, receive less attention.¹³

The overall argument from these perspectives is that our frameworks shape how we view and promote health, and often reflect power relations in society. Public health research and policy both tend to draw on and reproduce existing frameworks and concepts, and are therefore also part of this system of power and knowledge. However, critical perspectives, by illuminating underlying ideas, give us some measure of distance from them and make alternative ways of thinking more possible.

According to this type of analysis, knowledge translation and the role of the researcher in influencing policy become quite different issues:

- ▶ Knowledge is not a passive commodity but a productive force which shapes society. Researchers are caught up in systems of knowledge and power: the 'seemingly obvious assumptions—theoretical, simplistic, descriptive' (p. 981)¹⁴ adopted in research are an element of societal power and our dissemination of knowledge also has a socio-political effect. We should therefore be sensitive to the concepts in our fields and those underpinning policies, especially with respect to marginalised groups.^{15 17 21}
- ▶ With respect to knowledge translation itself there is a critical question to consider: why do we have such technocratic concepts as 'knowledge translation' and 'evidence-based policy' for what are essentially political processes; why are the political implications of this area of work obscured by our language? The concept of 'knowledge translation' is an exercise of power because it enables us to do some things (try to influence policy) but prevents us from doing other things

(engage in political analysis, which might make knowledge translation more effective).

In public health, knowledge translation has a tendency to be viewed simplistically as the transfer of scientific knowledge from researchers to policy makers in the hope that it will be taken on board. This political naivety means a challenging and complex area is uninformed by relevant theory which could support its effectiveness. The socio-political literature provides useful models to explain the relationship between research knowledge and the policy making process, and enables the research community to be more self-aware and proactive about the relationships among knowledge, policy and power. Even with a better understanding of the relationship between research knowledge and policy, influencing policy will always be challenging but this literature reminds us that policy making is not technical but social and political; therefore, our ideas about knowledge translation must be too.

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