THE IMPACT OF SOCIAL SCIENCE RESEARCH ON
HEALTH POLICY

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Abstract—The relationship between research and health policy is discussed from a policy process
perspective, describing communication problems in the course of policy formulation, implementation and
evaluation. Policy process is often expected by researchers to be rational, having logical sequence of steps
and the objective evaluation of alternatives based on scientific knowledge. In fact, policies are often
formulated without clear problem identification or based on wrong assumption. The timing of research
and policy-making differs. Policy-makers need to respond quickly. Evaluations may be regarded by
politicians as embarrassing if they point to a need for significant change. It is not satisfactory to consider
only research and policy-making; their relationship is influenced by the media, different interest groups
and by the general public. Health policy formulation is embedded in the general policy environment of
particular societies. Some countries have a long tradition of consensus-building, while in others health
reforms have been formulated and introduced in a centralized way. Traditional bio-medical thinking
influences health policy-makers. The importance of social and political acceptability tends to be
overlooked. The paper emphasizes that we are experiencing an era of scarcity of resources and growing
tension concerning allocation decisions. Existing institutions provide insufficient incentives for policy-
makers and researchers to promote public dialogue about such issues. The paper concludes that there is
a need for new approaches to policy development and implementation, new structures in policy-making,
changes in research financing and co-operation between disciplines and new structures for public
participation in policy-making. Research should facilitate more open and democratic dialogue about
policy options and the consequences of alternative choices.

Key words—policy content, policy process, communication problems, public dialogue

INTRODUCTION

The aim of this paper is to provide a framework to advance discussion about the intricate, multi-faceted
relationship between social science research and health policy. Several approaches are possible. I
propose to distinguish between policy content, policy process and policy context, that is political, socio-
economic and cultural circumstances which give rise to (or inhibit) particular policy initiatives. There is no
need to stress that the content, process and context of any policy are inter-connected.

What knowledge social sciences have been able to provide about socio-economic and political factors
influencing health status, health care systems and health policy-making can be examined at the interna-
tional, national or local level. In other words, how social research has contributed to an understanding
of past and present health systems and how research can help achieve a vision for the future of health
systems embedded in a wider socio-economic context.

We are witnessing a transition to a new, unknown or only vaguely conceived economic and political era
not only in Eastern Europe but in Europe generally and on a worldwide scale. Health policies have to do
with changes of power-relations in world markets, the process of European unification, global problems of
population growth and environmental pollution, and other processes which generated widespread uncer-
tainty. There seems to be a lack of clear vision about impacts of global tendencies on health systems and
the future of health systems at the international, national and local levels.

Three questions should be discussed regarding the connections between research and health policy:

(i) How do different socio-economic and political circumstances influence the relationship
between research and health policy?

(ii) What are the main characteristics of research on determination of particular health
policies according to their socio-economic and political context? Are such research
results available at all?

(iii) What impact can the social sciences exert on the socio-economic and political context of
health policies? What has been the indirect impact of social science research exerted
through mediatory factors? How have research and researchers influenced public
opinion about general social policy goals which, in turn, influence health policy?

As to research on policy content this paper deals with two examples: the policy of allocation of health care resources and commitment to equity.

The main emphasis of the paper is on the impact of research on policy process. In most countries the direction of health policy is traditionally determined by the government with very little involvement from other actors in the health care arena, including the research community. A vital issue is whether or not fundamental change in our health care systems can be reached without changes in the policy process. Two sets of questions arise:

(i) the impact of research on elements of policy process, particularly on problem identification; and

(ii) the characteristics of research on policy process.

Examples are taken mainly from the Hungarian health care system, aimed to illuminate general problems of the policy process, not the Hungarian particulars.

Several difficulties should be taken into consideration. It is not satisfactory to view only research and policy making. A thorough analysis demands consideration of the part played by the general public, the media, and different interest groups in influencing the decision making process involving the relationship between research and policy-making. Furthermore, it would be an over-simplification to draw a demarcation line between researchers and policymakers, neither are homogeneous groups. Particular proposals and projects may have supporters and opponents in both circles. Nor is it enough to discuss only the impact of research on policy in the case of central governments: policies at international level—e.g. the policy of the WHO, the World Bank, etc.—or at local level have increasing importance and influence on national policies.

**RESEARCH AND POLICY PROCESS**

Hann and Hill [1] distinguish seven varieties of policy analysis:

--- *studies of policy content* aim to explain how a particular policy emerges and how it is implemented;

--- *studies of policy process* analyze the influence of different factors on policy formulation and implementation;

--- *studies of policy outputs* take policies as dependent variables and understand them in terms of social, economic and other factors;

--- *evaluation studies* analyze the impact that particular policies have on the population.

The further three types of policy analysis seek to help and improve policy-making in more direct ways:

--- *information for policy-making* marshals a variety of data from various sources in order to assist policy-makers;

--- *process advocacy* aims to improve the nature of the policy making system;

--- *policy advocacy* provides pressing specific options and ideas in a given policy process.

It could be a useful starting point to describe the characteristics of these different approaches in the case of health policy. In this section of the paper, however, I shall limit discussion to some typical problems of the relationships between research and policy process.

**Communication problems between research and policy-making**

Types of communication problems are numerous, starting at the very onset of the policy process, *problem identification*. There are often discrepancies between issues identified by researchers and issues identified by health policy-makers as problems; research proposals are often ignored. There is a Hungarian saying: "dialogue of the deaf"—communication between policy-makers and researchers often seems to be such a dialogue.

When, why and how does a problem revealed by research become or does not become identified also by health policy as one which needed policy responses? The question can be put in reverse: when, why and how does a problem identified by health policy become or does not become also a research topic? How does the process of problem identification take place in reality? Does the policy process start with a clear revelation of the situation and unambiguous formulation of the problems? In fact, policies are often formulated without clear problem identification or are based on wrong assumptions. "Serious diagnostic distortions are very hard to repair once accepted as postulated reality, as policy assumptions and as policy-making starting lines" [2, p. 148]. Politicians tend to like catchwords which, however, can dominate and distort or mislead policy formulation.

The *timing* of research and policy-making differ. Policy-makers need to respond quickly, decisions have to be taken within a brief time scale. Consequently government wants research results quickly and in brief form. In other cases, however, -- in the interests of budgets or other government commitments — decision-makers may delay making decisions, even in the case of an unambiguous need for change [3]. Research studies may take several years to complete. Research results are presented in the form of detailed analysis in a language which is often unintelligible to bureaucrats. Proposals may be too radical or their timing too early for administrators. How can problems stemming from discrepancy between the timing of research and that of policy-making be overcome? Hailey emphasizes the need for mutual education: "There is a major need for methods that are quick enough to inform the
decision-making process adequately, in addition to longer term research. In turn, policy areas need to develop approaches to be able to take on board results of longer term studies” [3].

Communication problems arise in the course of policy implementation and evaluation. Evaluations may be regarded by politicians as embarrassing if they point to a need for significant change. Processes—after a policy decision is taken—may be difficult to reverse or adjust. Evaluation has inherent problems [4, 5]. For example, benefits are less easy to quantify than costs; costs mean policy problems in the present while benefits may take a long time to emerge, and therefore can have less impact in the present. Benefits often arise in different areas than those budgets who pay for the costs. These problems are characteristics of the curative care also, but particularly apparent in the case of health promotion and preventive measures.

Evaluation can be carried out easier concerning a process, but it can be impossible to predict impact on outcome of the particular program. For example, in Hungary an important goal of the health policy has been the privatization of general practitioners (so called family doctors). There is data concerning the number of general practitioners who become self-employed. The outcome of the impact of privatization on the quality of services, however, has not been evaluated.

Political interests may lead to premature evaluation looking for effects before the programme is functioning properly or in ignorance of results. For example, in Hungary in the late 1980s, experiments with the DRGs financing method started in 10 hospitals but proper evaluation of these experiments has still not taken place. Despite that, a new financing method based on DRGs was introduced in July 1993. It should be stressed that the absence of other, competing experiments has a lot to do with political processes. Particular groups of researchers and policy-makers may have common interests in monopolizing experiments—and consequently information—commissioned by policy-makers.

In many Western and Eastern European countries health care reforms have been taking place. Systematic evaluations of ongoing reforms are very rare—if they exist at all. Lack of evaluation can allow governments to declare their measures successful. How can this problem be overcome? What are the preconditions for the incorporation of systematic and continuous evaluation into the policy-making process?

It would be misleading to conceive researchers and policy-makers as two homogeneous groups, with a demarcation line between researchers and policy-makers. There can often be different and even totally opposite views on a given issue within both the research community and political circles. In Hungary, for example, since the mid-1980s one of the most disputed issues has been free health care. According to many politicians and researchers universal entitlement and free care were the main causes of the failure of the state-socialist health care system. Others have stressed the monolithic power structure and consequent incapability of the health care system for adaptation. They regard entitlement for health care as a basic right. In 1990 and 1991 the main slogan of the new conservative government’s health policy was “Health care will no longer be a citizen’s right, it will be based on the insurance principle”. Leading health policy-makers kept using the slogan without adding further explanation, as if it should have been obvious to the public that this was the solution for the crisis of the state-socialist health care system and even a key to the best ever health care system. Those who insisted on universal entitlement to health insurance were often accused of wanting to conserve the state-socialist system. It was a ‘blasphemy’ to point out that policy-makers had misconceptions about the ‘insurance-principle’ and the “solidarity principle”.

A fundamental question is how different and conflicting views are treated within the research community, by the media and by policy-makers. In Hungary, policy-makers tend to be automatically hostile to the proposals of researchers who have a different ideology. Researchers, in turn, tend to be automatically hostile to measures of the policy-makers. Furthermore, in Hungary a hostile political climate has made the dialogue between scientists standing to the governing parties and those who are associated with opposition parties more difficult than a few years ago. Are these phenomena specific to Eastern Europe—because of their political transition—or are they more general?

The sensitivity and receptivity of the public and politicians toward particular research results depend on several factors, including the wider social and political context, and also the timing and way of presentation of the issues. Take as an example the changing attention of the policy-makers and the public to the dramatic deterioration of the health status of the Hungarian population. In the late 80s great political and public attention was paid to the deteriorating trend of the health status of the Hungarian population. In 1990, the election program of every party declared their commitment to change. The government elected in 1990, however, has not given priority to the issue of health status. During the last three years political and public attention to the deteriorating health status have disappeared. A recent study by the Central Statistical Office presents new shocking data concerning mortality and life expectancy [8]. This study has been given attention neither by the media nor by the policy-makers. Journalists—with few exceptions—have only limited knowledge of health and social issues. It is a telling example that when parliament discusses the social security budget, usually only short articles on the third or fourth page of the dailies cover the topic.
Journalists are not able to demonstrate the effects of macro level health policy decisions on the everyday life of the individuals. The main fount of information concerning health issues are official sources, mainly the Ministry of Welfare. There is no independent institute in the field of health care to provide regular systematic analysis and evaluation about the most important processes and data. In economics, for example, there are three independent institutes which forecast and evaluate the state of the Hungarian economy every year. In the case of health and social policy there is none.

The expectations of policy-makers toward research tend to be to receive quick (and magical) solutions for their problems and praise for their actual measures. This attitude may influence the conditions, first of all the financing of the research. Research results criticizing the activity of government are likely to be refused—and often regarded as a hostile act—by government, whereas research results showing success tend to be viewed with suspicion by the research community. The expectations of researchers toward policy-making might be unrealistic. Researchers tend to expect that scientific and reasonable arguments should be enough to make their proposals accepted. Policy process is often conceived as a rational process having a "logical sequence of steps and the objective evaluation of alternatives making full use of available scientific knowledge" [7]. In fact, ideas which had been regarded as 'utopian' for ages can become suddenly accepted. It might need a special situation when there is a widespread expectation for change and pressure on policy-makers to bring about changes—but they do not have new ideas.

Communication problems are stemmed partly from the professional backgrounds of policy-makers and the hierarchical, traditional, semi-feudal organization of the medical profession. In Hungary medical doctors tend to consider representatives of other disciplines incapable of understanding problems of the health care system. In turn, sociologists and economists tend to have the opinion that policy-makers, most of whom are physicians, are unable or unwilling to disregard the vested interests of their own profession.

There is medical dominance at every level of policymaking. Top positions in the Ministry of Welfare, on the health committees of local self-government, and hospital directors are almost always doctors. Traditional bio-medical thinking influences their political view leading to a failure to appreciate the importance of social and economic implications of their proposals.

RESEARCH ON THE CONTENT AND CONTEXT OF HEALTH POLICY

Major factors influencing: (i) processes of change in the health sector; (ii) health policy; and (iii) social research are:
---dominant values and assumptions (e.g. dominance of neo-liberal economic and neo-conservative political thinking in the 1980s, the public perception of equity in health care and the actual problems of a given health care system);
---economic circumstances;
---political institutions (e.g. traditions, party policies);
---overall social policy (changing role of the public and private sectors, privatization);
---the development of medical technology;
---power relations between the main actors in the health care system; and
---existing characteristics of a particular health care system (e.g. forms of service provision, ways of financing).

What are the main reasons why research has been missing or very scarce on the joint, inter-related impact of the above factors on ongoing changes in health care systems and changes in health policies?

In the mid-1970s changes in these major factors, especially radical changes in the economy, rearranged the agenda for both health policy and research. Cost containment became the dominant if not the only concern of health policy. Health reform has been taking place in almost every developed country. There has been much about cost-containment policies and health care reform. But, with a very few exceptions, the studies have not analyzed the wider socio-economic and political context of health care reform.

Health policy formulation is embedded in the general policy environment. Some countries have a long tradition of consensus-building, while in other countries, including Hungary, health reforms were formulated and introduced in a centralized way only in the early 1990s. In Hungary changes in the political system as a whole have not entailed changes in policy-making processes in health care, there is an institutional vacuum. Decision-makers do not seem aware that a necessary (but not sufficient) precondition for the success of any reform is to involve all the main actors—that is, to reform the process of reform itself, including honest information to the public about the difficulties and possible options. This has produced widespread dissatisfaction at all levels. We are experiencing a time of scarce resources, an era of growing tension between fiscal constraints and the pressures created by new technology, a growing tension between the 'economically attainable' and the 'medically possible'.

Jennings has emphasized three types of allocation decisions:
'1 (i) setting limits to the routine utilization of expensive new medical procedures of uncertain efficacy, (ii) setting priorities among currently recognized health care needs and health goals, and (3) determining how access to medical resources should be distributed—how equitable should access be, and what should everyone be entitled to have access to' [8, p. 174].
what are the just priorities. Consequently the 'how' is as important as the 'what'—policy-makers need to establish a set of priorities as openly and fairly as possible. We know that different forms of rationing do take place—but they are not transparent allocation decisions. These questions of rationing and priority-setting have not been publicly debated, inadequate information is available even for professionals and research. The desirable roles of policy makers, experts and the civil organizations in these processes need to be identified. How can research contribute to the answer? What is acceptable to respectively patients, health care providers and the general public? What are society's value of priorities and goals for health care?

What can and should researchers do to make optional priority settings more readily understandable to the public, facilitating a more open, democratic dialogue about policy options and the likely consequences of alternative choices?

How can public debate be developed? "The ability to communicate a message is as important as generating it. If the message does not reach the public and those involved in policy development, it cannot make a difference" [9, p. 22]. In fact, existing institutions do not give sufficient incentives for policy-makers and researchers to promote public dialogue about allocation issues.

Public and individual access to information is a key issue. Adequate information is often lacking when consumers make decisions. "Consumers need more information on how they can stay healthy, recognize their own illness and take a more active part in their own treatment. Good consumer information should also instruct patients on the most effective way to communicate with their health care providers..." [9, p. 348]. Research on the use of medical technology has provided increasing evidence about the unnecessary use and sometimes harmful effects of medical technology. Research results can affect public expectations but consumer organizations are either absent or weak in Eastern Europe where there is a tradition of socialism and semi-feudalism in the first half of the century. This makes the dissemination of knowledge difficult to accomplish. One task of research might therefore be to contribute to efforts to make consumer voices stronger? This would be helped if the public were organized to speak up for their own needs and priorities.

But there are many impediments, cultural, psychological, political. "Few people want to discuss medication and health care options when they are healthy; and once they are sick, consumers may find it difficult to argue effectively for their own interests. Instead, because they need a drug or service, consumers become highly dependent upon their health care providers" [10, p. 345].

Equity is low on the agenda of health policy in most countries. There have been contrary forces. WHO's Health-For-All policy placed a strong emphasis on equity, the first of 38 HFA targets. WHO has supported research on inequalities, series of conferences have been organized and projects prepared under the auspices of WHO. Special issues of Social Science & Medicine have provided detailed information about inequalities in health and health care in Eastern Europe. What impact has WHO's equity concern had on health policies of individual countries? In the case of Hungary, it has had little, if any, impact. Although the government programme of 1990 repeats—almost word for word—sentences from the HFA WHO document, the government has in fact paid only lip-service to equity goals.

There are a lot of barriers to a policy toward the attainment of equity [10]; a lack of co-operation among those with competing interests; lack of co-operation by different ministries and jurisdictional levels; difficulties in mobilizing public support; an adequate knowledge base; ideological differences between advocates of different approaches. Greenberg has emphasized impediments related to the individuals, government and science. As to government: "a preference for technological solutions rather than primary prevention, opposition by commercial interests, and the bureaucratic struggles have been impediments to introducing and implementing science-based health policies" [11, p. 533].

In Hungary a national health promotion programme has been elaborated by only one or two people in public health administration. The research community (except for a few pro-government researchers), local government, the medical profession, civil organizations and the health insurance companies have not been involved. The programme seems to have been forgotten.

PROBLEMS OF RESEARCH

Communication problems exist not only between research and policy-makers but between different disciplines and between the proponents of quantitative and qualitative methods. Health problems need interdisciplinary, problem-oriented approaches, cooperation between disciplines and methods. But opposite tendencies have been prevailing: those of disciplinary fragmentation and specialization. Yach identifies the main reasons for the split between qualitative and quantitative methods by being the growth in the number of disciplines, increasingly impenetrable walls separating disciplines which now tend to use separate jargon, while funding agencies have placed pressure on researchers to produce rapid results; alas the dominance of the medical profession in many aspects of public health [12, p. 604]. Traditional disciplines such as descriptive sociology often do not consider scientific what is done by more applied research.
A recognition of the need for integration between qualitative and quantitative methods and different disciplines has re-emerged:

... why do we remain at war with each other across the disciplines of social science when their boundaries are of no more significance than the demarcations made by any other classification scheme? Sociology, economics, history, anthropology and the rest are mere points on a continuum" [13, p. 173].

What are the preconditions for interdisciplinary, problem oriented research?

The funding of research is a crucial element. Should public money be provided for research, and, if so, should it be in the hands of government or independent, non-governmental bodies? Even in the case of a seemingly independent organization, members might be government nominees.

Managerial and market-style methods and incentives in research and education have been introduced in several Western European countries. How have they influenced the character of research and education? According to Jefferys, until the early 1980s health care researchers still had some latitude and, more important, some resources to initiate and pursue issues which they considered researchable. She points out that "opportunities for social scientists to obtain funding to undertake research on matters which they see as sociologically relevant have been eroded. The major 'client' for health-care research—the Department of Health—has set its research priorities more rigidly on short—rather than intermediate—or long-term policy issues. The Department no longer set aside funds to finance small scale, non-priority projects for which researchers used to apply" [14, p. 228].

In Hungary, continuing cuts in the state budget for the Hungarian Academy of Sciences during the last three years have occurred not only—and perhaps not mainly—because of economic difficulties, but because of the tense relationship between the Academy (the research community) and the government. Tension has also emerged concerning the Academy's autonomy. It is shocking that many researchers, lawyers, poets and teachers who have become MPs in the first freely elected parliament have developed a similar bias (the so-called 'old reflex') against researchers as the socialist politicians of the past. It is going to take a long time to develop a normal division of labour and co-operation between researchers and policy-makers.

Researchers have different views about social responsibility, the political role of researchers, the desirable or harmful effects of political involvement of researchers. The contributions of social science to health policy are by no means always obvious, direct or visible... one should remember that with regard to health policy, as with any other policy area, much of the contribution of sociology comes through the way in which its researchers lead to the reconceptualization of everyday thinking, so that the origins are obscured" [15]. Education is also an important mediating factor. The social sciences have become part of the medical universities, sociology and economics part of the curriculum.

Common problems in the developed countries encourage comparative research. There is "frustration about lack of comparative information of all kinds. This included lack of information about mortality, and morbidity, effective and safe medicines, nutrition and food distribution, the use of illicit substances, evaluation of technologies, the differing roles of nurses and doctors and other health professionals and about the consumption of health services" [16, p. 362].

CONCLUSIONS

"Social research is a pre-condition of modern democracy. It is only by the systematic study of our social existence... that we can make available to all citizens, directly or indirectly, the knowledge that makes informed choices in social or economic policy possible" [17, p. 172]. Conflicts, stemming from the different nature of research and policy-making, communication problems between them in the course of policy-making, impede effective co-operation between researchers and policy-makers. Changes in the ways of co-operation between research and policy-making demand new approaches to policy development and implementation, new structures in policy-making, changes in research financing and co-operation between disciplines, and last but not least new structures for public participation in policy-making.

REFERENCES


