

Whither evidence-based policy-making? Practices in the art of government

by

Catherine van Mossel
BA, University of Waterloo, 1988
MA, University of Victoria, 2005

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Supervisory Committee

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Susan Boyd, Faculty of Human and Social Development
Co-Supervisor

Donna Jeffery, School of Social Work
Outside Member

Abstract

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The term “evidence-based” is ubiquitous in practice and policy-making settings around the world; it is *de rigueur* to claim this approach. This dissertation is an inquiry into the *work* of evidence-based policy-making with a particular focus on the social practices of policy work/ers involved with developing policies relating to chronic disease at the Ministry of Health in British Columbia (B.C.), Canada. I begin with an examination of tensions in the policy-making literature germane to the relationship between knowledge, its production, and policy-making: the environment into which evidence-based policy-making emerged in the 1990s. Drawing on the theorising of knowledge, discourse, and power – particularly from Foucault’s work – for the analytic approach, I present the commitment to claims of “evidence-based” practices found in key government policy framework documents and policy workers’ accounts of their practices, gathered through interviews. I then show the unravelling of this commitment

in those accounts. This research reveals how the policy frameworks construct chronic disease as a financial burden on the health care system and direct policy workers to develop policies with this construction in mind. The discourses associated with evidence-based policy-making narrow how policy workers can think about evidence and its production to positivist, scientific methods and numerical measures that will provide proof of cost cutting.

Proponents of evidence-based policy-making laud it as keeping politics and ideology out of the policy-making process. However, the policy workers I interviewed reveal the power relations organising their deeply political work environment. Furthermore, the minutiae constituting policy-making practices produce a “managerialist approach to governance” (Edwards, Gillies, and Horsley, 2015, p. 1) in which people with chronic disease are noticeable by their near-absence. When they do appear, they are responsabilised to decrease the burden on the health/care system and the economy. I argue that as a governing project with an *appearance* of failure, given the many cracks in the commitment to the claim and the practices of being evidence-based, the discourse of evidence-based policy-making is actually quite *successful*. It has continuous effects: people are separated (so-called apolitical policy workers into imagined neutral space and decision-makers into political space), knowledge is divided, costs and responsibilities are downloaded to individuals, and evidence-based discourses appear in countless settings. The governing *works*.

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(almost!). I thank you.

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~*~

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Dedication

Caring for my mother, Lorna van Mossel (1923 – 2014), in the last years, months, days, and hours of her life were the most profound experiences of my life. I would not have exchanged that privilege and honour for anything, including meeting deadlines and an earlier completion of this dissertation. I finish this dissertation with the spirit of my mom by my side. Mom, you never let anyone's idea of the facts get in your way. Your effect on people's lives, mine included, eludes measure. This work is now done – finally. But the quest for peace and justice continues.

Thanks, Mom. I miss you more than words can say.

I also dedicate this dissertation to my dear friend Shirley Harrop, whose death two days before my defense has left me in shock and grieving. We met decades ago in stats class and the friendship we cemented in the pub discussing Plato's allegory of the cave lasted across many years and miles. Shirley loved all things academic and I know she would be pleased I finished this degree (and would likely call me Dr. Catherine with a twinkle in her eye).

Thanks, Shirley. I loved our friendship.

1. Introduction

What do we want?

Evidence-based research!

When do we want it?

After peer review!¹

Science speaks truth; Harper tells lies. Evidence not ideology. Evidence is too important to ignore. RIP Evidence. Canadians want science-based policy not ideology. Truth evidence science Harper's way. Death of science-based decision-making. Evidence speaks truth; Harper speaks lies. No science; no evidence; no truth; no democracy.

These messages appeared at a “Death of Evidence” rally in the summer of 2012 held by scientists working for the Canadian federal government, reportedly for the first time ever (Canadian Broadcasting Corporation, 2012). Viewing their work as apolitical, they had, until this rally, endeavoured to maintain their focus on science and keep out of politics, according to news reports. This rally coincided with 17 “Stand up for Science” rallies across Canada and the formation of a non-profit organisation “Evidence for Democracy” (Evidence for Democracy, n.d.). These actions were taken amidst the outrage, leading up to the recent (October, 2015) Canadian federal election, at the Conservative government’s alleged dismissal of science, evidence, and truth on matters of importance to many Canadians, not the least of which was the environment.

¹ Words on a backdrop slide, Congress 2013 of the Humanities and Social Sciences, Victoria, B.C.

Government libraries were closed and books burned. Statistics Canada was being muted. The long form census was cancelled. Research into long-standing world-renowned scientific studies – in the north, in the oceans and lakes – was cancelled. The protesting scientists were seen as taking a stand; things had gone too far down the anti-science/evidence/truth path and they abandoned their commitment to be apolitical and took to the streets, coffin with “evidence” written on the side in hand. Many citizens were also outraged and I was one of them. This contemporary moment in Canadian history is where I begin.

The term “evidence-based” began entering everyday lexicon in the 1990s and I started to hear it with frequency as I was writing my Master’s thesis (van Mossel, 2004). The research undertaken for that degree was an investigation into a public consultation process on the future of health care in British Columbia (B.C.) following the election of 2001, when the B.C. Liberals won a landslide victory, leaving the previous governing New Democratic Party with a rump caucus of two out of 79 seats in the legislature. I noted then, in my analysis of public hearing transcripts, that only certain “evidence” counted. I was also working at the policy headquarters of the B.C. Ministry of Children and Family Development when someone one day said: “we should be making sure our policies are evidence-based.” I was completely intrigued with this concept of ‘evidence-based.’ What did it mean and to whom? Who decided what counted as evidence? How did it work in the policy-making world? In the ensuing years, hardly a media report on

health care in B.C. went by without a reference to “evidence.” With my concern about who decided what counted as evidence in mind, and having done a lot of research into the standards I was writing at the Ministry, I wondered *how does one do evidence-based policy-making?* Captivated by the omnipresence of “evidence-based,” I focused my PhD studies on evidence-based policy-making, well aware that engaging in a critique of a concept at the very time people were taking to the streets to demand it seemed both risky and necessary.

Chronic disease: A (particular kind of) problem

When I first thought about pursuing this degree and wanted a site from which to investigate evidence-based policy-making, I asked a friend who worked for Health Canada, the Canadian federal government Ministry responsible for health, what health issue she thought was most pressing in Canada. She answered without hesitation: chronic disease. In her mind and in the view of her Ministry, it was the most significant challenge facing the health of Canadians and the health care system and was, thus, one in need of research. The issue resonated with me; I had several close friends and family members living with chronic disease, not the least of whom was my aging mother whose list of conditions was growing as she aged. I had participated in their seeking out (quality) care and was caught off guard upon discovering how unsatisfactory and limited in scope much of this care was. I was also intimately aware that each of their chronic diseases made their lives anything but straight forward, yet each system they

encountered seemed unable to deal with multifaceted features of their lives that intersected with their respective chronic diseases.

In the global north, in jurisdictions such as B.C., advances in medicine, including the proliferation of early and improved diagnoses and advances in treatment, are credited with increasing the number of people living longer. By living longer, many people live with chronic conditions that used to be fatal and/or left them in poor health, experiencing diseases and conditions that one typically gets in old age. The B.C. Ministry of Health defines chronic disease as “prolonged conditions such as diabetes, depression, hypertension, congestive heart failure, chronic obstructive pulmonary disease, arthritis, asthma and some cancers” (British Columbia, 2008). Not just a Canadian issue, chronic disease is also listed by the World Health Organisation (Chan, 2011) as one of the most significant issues facing health care systems around the world and is the focus of many policy strategies internationally. For example, the WHO (2012) switched its attention in 2011 from infectious diseases to chronic diseases.

The B.C. Ministry of Health reported that people with chronic conditions represented approximately 38 per cent of the B.C. population in 2012, up from 34 percent in 2005-2006 (British Columbia, 2012). Furthermore, correlating an aging population with an increase in incidences of chronic disease, in 2012 the Ministry projected that the prevalence of chronic conditions could increase 58 per cent over the next 25 years (British Columbia, 2012). Typical of the larger Canadian context, B.C.’s

health care system has excelled at delivering acute care and is now challenged by this supposed surge in chronic disease.

B.C.'s Ministry of Health's projection of an increase in the incidence of chronic disease is further articulated in budgetary terms: at the projected rate of increase, chronic disease will consume approximately 80 percent of the combined physician payment, PharmaCare and acute (hospital) care budgets (British Columbia, 2012). Both the *Ministry of Health 2008/09 - 2010/11 Service Plan* (British Columbia, 2008) and the *Ministry of Health 2012/13 – 2014/15 Service Plan* (British Columbia, 2012) reference the "rising burden of chronic disease" as one of the Ministry's strategic contexts. Significant not just because of its expected magnitude, the increasing numbers of people who will have one (or more) chronic disease is significant because the people are a "burden" on the health care system. A 2014 document that I analyse in further detail later in this dissertation, *Healthy Families B.C. Policy Framework: A Focused Approach to Chronic Disease and Injury Prevention* (British Columbia, 2014), states:

One in three British Columbians lives with at least one chronic condition, and the burden of preventable injury and disease in the province is significant. Continued and enhanced efforts in prevention are needed to further improve the health of British Columbians, reduce inequities in health and contribute to the financial sustainability of our health system. (p. 1) [...] By far the largest proportion of total health care costs is directly or indirectly attributable to chronic disease. (p. 4)

I examine this document more closely in chapter seven, but this excerpt is indicative of how this burden is perceived by the B.C. Ministry of Health: a significant driver of

demand for health services and a financial burden on the government's budget.

Amongst academics, there is plenty of agreement with governments' concern about this "burden" (Mirolla, 2004; Morgan, Zamoara, & Hindmarsh, 2007; Haydon, Roerecke, Giesbrecht, Rehm & Kobus-Matthews, 2006; Denton & Spencer 2010). In 2006, Health Council of Canada's website² (Health Council of Canada /Conseil canadien de la santé, 2006) articulates their concern, and in doing so, signals the hierarchy of their unease: "The burden of these long-term illnesses falls not just on individuals and their families. Chronic disease costs the Canadian economy an estimated \$80 billion annually through illness and disability." "Burden" is measured in financial cost to the economy, secondary to the burden on individuals and families. Their 2011 report titled *Self-Management Supports for Canadians with Chronic Health Conditions: A Focus for Primary Health Care* (Health Council of Canada/ Conseil canadien de la santé, 2012) states:

Chronic disease costs Canadian society more than \$90 billion a year in lost productivity and health care costs. Targeted investments to advance self-management hold potential to yield big wins on many levels—for individuals and their families (e.g., better quality of life); for health care providers (e.g., better outcomes for their patients); for the efficient, effective, and sustainable use of health care resources; and for a healthier, more productive Canada. (p. 4)

Chronic disease is linked with the use of health care resources in, and productivity of, the country. Collectively, these documents problematise chronic disease and those living with it as a financial liability in need of management.

² Stephen Harper's Conservative government closed the Health Council in the spring of 2013, allegedly to save money (McBane, 2013).

Prior to going to graduate school, I was on the Board of Directors of a local community health centre with a unique (in B.C.) approach to delivering health services that included community support programs and liaisons, a home care program, a family support program, child development workers, and a medical clinic. Staff in all those programs communicated with each other with the goal of ensuring that the health needs of those with whom they worked were understood and addressed holistically by this interdisciplinary team. This health care centre strove to deliver person-focused, team-based care that governments promote in positive, future-oriented statements (British Columbia, 2007b). Yet, I watched as the implementation of government policy resulted in the *dismantling* of our community health centre such that the clinic was reduced to traditional mainstream medical care delivered by physicians whilst other programs lost funding and/or were severed from the centre, including the individuals, families, and communities with whom they worked. Our funder, the provincial Ministry of Health, did not appear to recognise these integrated services as valuable *health* services (funding for the physicians in the medical clinic was maintained). At the time, the motivation for these policies was a mystery (though we suspected they were financial and we thought short-sighted) but the effect was clear: the implementation of Ministry policies collapsed our centre as well as other community health centres throughout the province and people's support was severely impacted. Concomitantly, Canadian media and academics alike have, for years, reported on issues relating to

chronic disease in Canada such as epidemics of obesity and diabetes, the latter most notably amongst Canada's First Nations, many of whom live in abominable living conditions: poverty, homes filled with mould, and communities without potable water. These are also issues of chronic disease.

Although the concern for chronic disease relating to an aging population seems important to governments, efforts to address it are hard to find; the approach to caring for my mother's chronic diseases as she aged appeared chaotic and peripheral. On a personal front, I had two bicycle accidents mid-way through this degree. Each left me experiencing more pain, having more trouble sitting at the computer – a modern day requirement of academic work, battling with institutions (insurance) we assume will support us when we need it, and wishing I had better medical coverage (because the kind of care I needed had long ago been privatised). While my experience hardly compares to others' I know, I was humbled enough to have just a hint of what it might be like to experience a chronic disease that is lived every day.

According to Bacchi (2012), "public policy and policy proposals contain implicit representations of what is considered to be the 'problem' ('problem representations')" p. 21. Furthermore, argues Bacchi (2012), "policy is not the government's best effort to solve 'problems'; rather, policies produce 'problems' with particular meanings that affect what gets done or not done, and how people live their lives" (p. 21). The problem constructed in government documents relating to chronic disease, and supported by

scholarly work, is that the surge of chronic disease is a health/care system and budget problem – indeed, *burden* – of significant magnitude. As such, chronic disease compels governments to respond – through programs, initiatives, budgetary allotments, and policies that govern these activities as well as define the problem. For the magnitude of concern to governments and for the influence on people’s lives, chronic disease is a good site to examine evidence-based policy-making. Furthermore, the rise in concerns about chronic disease is occurring in tandem with the increasing grip of the mantra of evidence-based policy-making.

Policies have material effects on actual people and, ultimately, how people experience policies is my main concern. However, rather than interview people with chronic disease to understand how they are affected by evidence-based policies, I wanted to take a step back and understand how those policies are developed in the first place. Coming at this research with a focus on policy work and policy workers is the preliminary work for understanding the effects of these policies.

Practising policy development

The literature on policy and policy development is vast. This study narrows in on the insufficiently studied practices of people involved in the development of policy. Adams, Colebatch, and Walker (2015) conclude that much of the academic literature on policy provides insight into the policy process by examining theories and frameworks for understanding. While this literature offers a view into the nature of policy and what

constitutes policy work, there is limited research into “what policy workers actually do” (Adams et al., 2015, p. 102). Freeman, Griggs, and Boaz (2011) concur, arguing that questions pertaining to activities that constitute policy-making and how accounts of researchers and the policy practitioners themselves represent what policy-makers do are neglected. This work has not received the attention it deserves in the academic literature (Page & Jenkins, 2005; Radin, 2000; Howlett & Newman, 2010; Howlett & Wellstead, 2012; Freeman et al., 2011; Adams et al., 2015). “We know surprisingly little of what those we call ‘policy makers’ actually do when they are doing their job” (Freeman et al., 2011, p. 128). Howlett and Newman (2010) argue for more “empirical research on the nature of policy work in specific contexts” (p. 125). Referring to Page and Jenkins (2005), Adams et al. (2015) note that “although policy is commonly seen as being made by authoritative leaders, it tends to be put together by a large array of middle rankers – a ‘cast of thousands’” (p. 102).

I take up the challenge put forward by these scholars. My research attempts to deal with their issues; it sheds light onto what policy workers say they actually do – with a primary focus on what they do amidst claims by their Ministry (via the Minister – and often the Premier, senior leadership, and public documents) of evidence-based policy-making. Much of the research on policy work has been quantitative in nature, mostly in the form of surveys (Newman & Head, 2015). On the contrary, my work sits squarely within a qualitative interpretive paradigm, in keeping with my interest in *how*

things work – the un-measurable, particularly how knowledge and evidence are understood and taken up, from a sociological perspective. My interest is in how evidence-based policy-making gets done. I examine this “doing” in the specific context of the B.C. Ministry of Health with policy workers working on developing policies relating to chronic disease. It is their *work*, their daily practices, that interest me. I am guided by the overarching question: how do policy workers do evidence-based policy-making in the context of chronic disease? I interviewed sixteen of the “cast of thousands” (Adams et al., 2015, p. 102), in a specific context; their interviews are the main focus of my analysis, as well as two government documents representing the Ministry’s strategic policy direction relating to chronic disease.

Policy work/ers

This dissertation is about the social practices associated with a particular approach to policy development – evidence-based policy-making – a dominating discourse at many, if not all, levels of government and many practice settings. Throughout this research, I have conceptualised the many activities inherent in policy development in the term used by Colebatch (2006a, 2006b): policy work. In his vast contribution to policy literature, Colebatch seeks to challenge mainstream approaches to policy work that dominate the literature, including the portrayal of those doing this work. He refers to these people as policy practitioners. Similarly, Freeman et al., (2011) theorise the practice of policy-making in the context of evidence in a manner that is

useful:

(B)oth evidence and policy – separately and together – derive meaning from an implied other, third term: that of ‘practice’. Evidence may be derived from practice or may be designed to inform it; it is often most significant when it contradicts it. The purpose of policy, similarly, is to shape and order practice, and evidence is one of the ways it finds of doing so. In this way, each term makes sense only in relation to a shared antonym, that of practice. And even when evidence and policy converge and coincide, there remains a residual order of practice, the unruly and elusive world in which things really happen, ordered but only partly so by evidence and policy. (p. 127-128)

While I have chosen to use the term policy workers for those I interviewed, I do so sharing these critical stances and see policy work – and its relationship to evidence – in terms of practice.

This dissertation is based on research at a particular site, the B.C. Ministry of Health, and those within that Ministry engaged in policy work at various bureaucratic levels. As a result, the empirical material at the centre of my analysis is accessed from these levels. The documents I analyse are official in that they are public and representative of the Ministry’s strategic position. The policy workers I interviewed in 2012 and 2013 range from junior level analysts to those in Executive Director level positions. Those at the junior levels, often referred to as policy analysts, do much of the ground or legwork of research that is intended to support the development of policy. Their work is assigned to them by, and channelled to, those in positions above them, unelected senior management. Depending on the policy, their work is eventually forwarded on to those elected officials who represent the public face of the Ministry

(who may also give direction to senior management). It is the work of evidence-based policy-making performed by multiple actors in the places of policy development that is at the centre of this dissertation.

Through this research, I have come to see the commonalities and discrepancies in the accounts of policy workers' practices and it is my intention to reveal these throughout this dissertation. I want to be clear that policy workers are not unified in their thinking, experiences, or practices; I cannot speak about "policy workers" as if they are one and speak with one voice. Similarly, I do not intend to reify the government and present it as one actor with unified agency. As one of the more experienced participants in my study notes, "The Ministry of Health is not a homogeneous organisation."

This research also serves to humanise the often demonised "government" or "the system" that is held responsible for the effects of policy on people's lives. I do not wish to deny these effects but rather to acknowledge that those working in government are "actual thinking and feeling people doing actual jobs" (Church, 1995, p. 8) with, arguably, good intentions and are, themselves, in a position of being governed by discourses and technologies. Individually, none can be held responsible for any government policy and its effects. Rather, my research reveals the challenges each confronts in her/his attempt to do good – even evidence-based – policy work. That said, I will trouble the taken for granted assumptions behind the oft-repeated claims made by the Ministry of Health (as well as many of those who work within it) and other

organisations as well as inherent in calls from the public – and sectors of the academy – for this approach to be taken by these organisations.

Locating/locations in this dissertation

My academic background is interdisciplinary; my undergraduate and masters degrees both crossed disciplines. Upon reflection, my life experiences and interests have also been interdisciplinary. Because the research at the centre of this dissertation arose from both academic and experiential learning and curiosities, my doctoral work, and this dissertation in particular, continue with an interdisciplinary approach. As a result, I draw from literatures in many disciplines rather than focus on any one alone, such as political science, public administration, sociology, or health care, for example. My worldview, interests, and research are informed by my travels into and across such disciplines and each contributes to an analytic breadth reflected herein. In this dissertation, I demonstrate the usefulness of sociological interpretations of knowledge and its production, particularly relating to understandings of truth, fact, and objectivity, as well as theories of power and power's relationship to knowledge. These are interdisciplinary concepts that surface as key tools underpinning my analysis.

That said, understanding the work of evidence-based policy-making requires some context from the literature on approaches to policy development. Thus, chapter two examines the understanding and use of knowledge, particularly in the rational approach to policy development, and touches on two alternative approaches that take

up knowledge in different ways from the rational approach. Chapter three provides a brief background to and summary of the evidence-based movement so as to contextualise evidence-based policy-making, which is the focus of chapter four. My problematisation of the evidence-based movement's inherent principles and epistemological assumptions contributes to my analysis of the practices of policy-making and claims that policy-making can be pure of ideology and politics, a carryover of the rationalist approach to policy-making. Chapter five is a discussion on methodological considerations, drawing on Foucault's theorising of discourse, knowledge, and power. I argue that "evidence-based" is a productive discourse, shaped by and shaping policy work. This chapter also discusses the social practices of policy work and reiterates the overarching question guiding my research: how do policy workers do evidence-based policy-making in the context of chronic disease? In chapter six, I describe my engagement with case study, using British Columbia's Ministry of Health as my "case." I also explain how I undertook the interviews with policy workers at the Ministry and the approach to my analysis of the government policy frameworks and interviews. In chapters seven and eight, I unravel the discourse of evidence-based policy-making in the context of chronic disease as seen in the policy frameworks and interviews. I begin by illustrating the commitment to the claim of being evidence-based and then show how this claim is undone in policy workers' accounts of the doing of policy work. In chapter nine, I name what I have shown in the previous two chapters. I

pay particular attention to relations of power and Foucault's concept of governmentality, arguing that it is in the mundane actions of policy work that the governing of the evidence-based discourse is revealed. Finally, in chapter ten, I return to those in whom my interest sparked this research: people with chronic disease. I revisit my claim in this introductory chapter that chronic disease and those living with it are constructed as a burden on budgets and the economy and reflect on the ways in which they are represented in the accounts of policy work.

2. Policy-making debates

In this chapter, I point to debates in the literature on policy development that take up and/or challenge assumptions associated with knowledge, science, objectivity, and purity. In particular, I begin by describing the rational approach and its reliance on positivism and claims of objectivity and follow up with two examples of alternative approaches that, in their respective ways, challenge rationalism's assumptions. These debates provide a context in which to understand the emergence of evidence-based policy-making.

The work of Harold Lasswell is often credited with founding the discipline of what he called "policy sciences" (Colebatch, 2006b) or the "science of policy" (Lerner and Lasswell, 1951). Lasswell argued that social sciences could produce knowledge useful for governments responsible for dealing with problems pertaining to the management of populations. In order for policy to serve this purpose, according to Lasswell, the production of useful knowledge required a scientific and impartial approach to political phenomena (Colebatch, 2006b; Farr, Hacker, & Kazzee 2006; Tao, 2006; deLeon, 1994b; Lerner & Lasswell 1951; Torgerson, 1985). Although some questioned that this was Lasswell's intention (deLeon, 1994a), what followed from Lasswell's efforts was a tradition of policy analysis that embraced the notion of so-called apolitical policy experts drawing on knowledge garnered through scientific inquiry to advise decision makers and politicians. These are features of what has developed and

taken broad hold over what can be described as the rational approach to policy-making. In the following section, I take up the concepts of scientific inquiry and apolitical policy-making because they are fundamental components of the rationalist approach advocated by Lasswell and his followers that has traditionally dominated policy-making environments and, I propose, makes assumptions to which evidence-based policy-making returns.

Claims of a rational approach

Advocates of a rational approach to policy-making claim it is a systematic approach with the ability to choose the best means to achieve a desired end for a defined policy problem (Stone, 2002; Howlett & Ramesh, 2003). The rationalist approach mirrors the positivist assumptions of science that were foundational to the most dominant branch of social science in that it relies upon scientific method or inquiry, a central tenet of science. Interpretivist approaches to social science have also existed but have been muted by more dominant, positivist approaches. The assumed goal of the positivist approaches is knowledge that produces generalisable 'truths' about phenomena generated by the hypothetico-deductive approach inherent in the scientific method (Garvin, 2001). Science is often considered a reductionist approach because individual variables are identified and studied in relation to others, leading to claims about cause and effect (Raphael, Curry-Stevens, & Bryant, 2008). Proponents of scientific inquiry allege it generates *factual* knowledge by gathering and analysing

observable data objectively and neutrally.

In the context of policy-making, those who adopt a rationalist perspective draw on scientific inquiry's claim of producing knowledge that is reliable, valid, objective, factual, irrefutable, rigorous, and can provide authority in the arbitration of issues of policy (Hajer & Wagenaar, 2003; Wharf, 1998; Tenbensen, 2004; Howlett & Ramesh, 2003). Quantification and standardized units of analysis are central (Tao, 2006). Rationalism is said to allow policy analysts to "deliver objective, certain knowledge to their political task masters" (Hajer & Wagenaar, 2003, p. 16). Accordingly, this knowledge is meant to offer assurance and confidence in the purity of the policy process, product, and, outcome. As noted in the introduction, calls for the makers of public policy to be accountable are not new and they continue to be articulated by the population, civil society, and opposition parties (regardless of political stripe) in parliaments across Canada (and likely elsewhere). Elections are frequently waged on issues of accountability including accountability for the process, product, and outcome of policy. Policy workers and politicians, by and large, want to be able to say they are basing policy on the facts – evidence, if you will. To follow a rationalist approach that (claims to) offer objective, factual knowledge means policy workers can offer assurances to people that a policy is the *right* one and people can have faith in the process – and product – and can have hope for the outcome. To claim a rationalist approach is a powerful assertion.

Alternatives to rationalism

Arguably, the rational approach dominates the mainstream policy-making literature as a normative model. But many who either study or practise policy-making say that in practice, things are much more nuanced than a strict adherence to the rational approach allows. Significant critique of the rational approach permeates the literature. Policy scholars such as Torgerson (1985), Fischer (1998), deLeon (1994a, 1994b), Stone (2002), Hajer and Wagenaar (2003) acknowledge that positivism and positivist epistemological perspectives and methodologies dominate policy-making literatures. However, they position positivist (or even neopositivist, according to Fischer, [1998]) approaches to policy-making as outmoded and inadequate. The commitment of positivist methods is to define “the knowable” and “the how it may come to be known” (Evans & Stoddart, 1994, p. 1348), maintaining an interest in “calculating solutions” for policy problems (Torgerson, 1985, p. 241). Positivism, Hajer and Wagenaar (2003) argue, “is not just a set of methodological principles but [...] above all an attitude towards knowledge [...] with deeply intertwined ramifications that range from a barely articulated ontological understanding of reality, via methodological principles of how to collect data in a proper way, to a rhetoric of accepted ways of talking about knowledge and policy” (p. 6). The belief in scientific rationality is “decaying” (Hoppe, 1999, p. 202) in part because of its association with human suffering (Hoppe offers the nuclear arms race as an example) and ecological degradation. The authority of positivist approaches

to policy has come into question, its critics describing it as inadequate (deLeon, 1994a) and unable to provide effective resolutions for policy problems (Fischer, 1998). These critics argue for post-positivist and post-empiricist approaches that expose the limitations and problematics of the “rationality project” (Stone, 2002). Hajer and Wagenaar (2003) argue: “post-positivist policy analysis displays much greater sociological validity than mainstream analysis” (p. 7). It challenges the foundations of certainty and the assumptions of scientific inquiry including the concepts of reality and fact (Fischer, 1998). It moves from “proof to interpretation,” argues Fischer (1998, p. 135), viewing politics, values, beliefs, history, traditions and attitudes as features of, not external to, policy (Howlett & Ramesh, 1998).

Everett (2003) proposes that the emphasis on positivism has been dismissed as out of date. According to Prince (2007, referencing Radin [2000] & Stone [2002]): “Certainly the literature has moved some distance from the positivist legacy of rationalist analysis to post-positivist perspectives on how we understand and research policy processes and systems” (p. 265). I do not doubt that movement has been made. Yet my reading of policy textbooks, as well as my conducting of this research, tells me that its main principles are still held by many academics and policy practitioners; positivism maintains a stronger hold than perhaps many of us care to admit.

Example of alternative approaches I: Acknowledging (some) politics

My interest is in policy as it relates to health/care where the relationship to

medicine – with its own ties to science – are strong and where the rational approach has dominated policy-making. Hankivsky and her colleagues (2004) examine health/care policy from a critical perspective. Seemingly uncomfortable with limiting health policy to a rationalist approach, they offer an example of research that challenges several tenets of the rationalist approach as they take up the concept of economics and efficiency. Claiming a feminist perspective in their work of undertaking economic evaluations to analyse “Canadian social values” (Hankivsky et al., 2004, p. 258), they dispute rationalism’s claim that economics is value-neutral. They propose that mainstream economic models (used within rational policy-making) do not typically attend to social values. In particular, they explore how the gendered and racialised nature of caring work is obfuscated in traditional cost-of-illness models producing, they argue, evidence that perpetuates inequities. Their solution is to offer an alternative cost-of-illness framework said to be informed by the values of social justice and equity that more accurately reflects the burden of disease and illness.

I read this work as, perhaps, an example of, or an attempt at, post-positivism. It appears as an attempt to appeal to adherence to the rationalist approach by using a framework acceptable to positivism (cost-of-illness) but introducing concepts (social values and equity, for example) that are deemed within the rationalist approach to be political and thus, contaminants. This move gives the *appearance* that their approach ameliorates negative effects of the rational model, softens its rigidity, and rounds its

harsh edges. Rather than leaving policy-making up to those who abide by a strictly rationalist approach, Hankivsky and her colleagues are working within that approach but with a twist, perhaps with the hopes that they can bring about the kind of policy not possible within a strict rationalist approach yet without moving so far out of it that their concerns are ignored.

Examining Hankivsky et al.'s (2004) efforts to work within the dominant framework of the rationalist approach *and* introduce the critical role of values, I am reminded of the debate: "you cannot use the master's tools to dismantle the master's house" (Lorde, 1984, p. 110) versus "every tool is a weapon if you hold it right" (DiFranco, 2002). These researchers are adopting DiFranco's position; they are using the master's tools to introduce important value commitments such as social justice to a framework in which they are largely considered absent. I applaud this effort and see that this approach could be viewed as resistance, a way to give voice to issues and values that would not be heard if one insisted on working only outside of the dominant framework. But I argue this effort also maintains the dominance of the rational model's essence. Hankivsky et al.'s (2004) approach, while laudable, allows the positivist assumptions of rationalism to maintain a stronghold in policy-making. Thus, excluded are features that are not quantifiable in terms of cost such as historical, social, and even economic contexts. Hankivsky et al. (2004) acknowledge that politics is innate to policy and its development but seem willing to introduce it only so far so as to maintain their

own position within a positivist framework, even while pushing its limits somewhat. The continued reliance on the methodologies of the dominant paradigm endorses and perpetuates the dominance of that paradigm and accepts claims that good health policy can be developed through the imposition of exclusions: features that are not measurable, particularly in terms of cost, are excluded from consideration.

Example of alternative approach II: Interpretivist approach

There are some critiques of the rational approach that provide alternative ways to think about the policy-making process. For instance, literature presenting an interpretive approach to policy-making rejects the rationalist claim that the only way to produce good policy is through a reliance on scientific inquiry. Rather, the interpretive approach is founded on very different assumptions that speak to the importance of attending to dimensions of policy-making that are not amenable to measurement but can be understood through interpretive inquiry. Interpretive policy analysis (or policy-making) emphasises subjective and human meaning-making and argues knowledge is attained through interpretation (Yanow, 2000; Bevir, Rhodes, & Weller, 2003; Fischer, 2003). If the world is understood through meaning that results from interpretation, mediation, and translation, as proponents of interpretivism claim (Yanow, 2000), it cannot be quantified. The objective quantification that is a cornerstone of the rationalist approach is challenged by an interpretive approach. Proponents of an interpretive approach claim their work is oriented towards the values, beliefs, feelings, and stories of

many people as the centrepieces of policy development (Fischer, 2003; Yanow, 1996; Yanow, 2000). They centre “the political” more fully than Hankivsky and her colleagues (2004). This approach assumes that the goal of policy work is to understand the meaning made by multiple policy actors in particular contexts, not to study facts or produce generalisable truths advanced by so-called policy experts.

According to Yanow (2000), the interpretivist approach values local knowledge and develops strategies to access and analyse it. This approach also “treat(s) policy, agency, and community members – the actors in the situation – as the substantive experts of their own domains” (Yanow, 2000, p. 19). Thus, people are considered active “constructors of meaning” (Yanow, 2000, p. 18) and policy workers seek out their interpretations of policy problems and solutions. This conceptualisation of experts, Yanow (2000) asserts, is more “democratic” than that held in traditional policy approaches, which “rests on the technocratic expertise of its practitioners” (p. 19). Yanow’s reference to what Lasswell (1951) valorises as the apolitical policy expert is revealed in interpretivist approaches to be anything but apolitical. Interpretive policy-making assumes a situated knower: “(n)either this person nor the knowledge he possesses is or can be objective: there is no point of view outside the matter being studied from which to observe it” (Yanow, 2000, p. 90).

Throughout this chapter are references to knowledge and how it is taken up in approaches to policy making. Inherent in these discussions, however, are also

perspectives on politics. Lasswell assumes the possibility of apolitical policy-making where politics appears aligned with elected politicians. Hankivsky (2004) and Yanow (2000) take quite a different perspective, assuming that politics is central to the work of policy development. To them, politics includes an analysis of gender, race, equity, relationships, and values, which collectively involve issues of power. I examine power elsewhere, particularly in chapters three and five, but it is useful to point to it now as a feature of politics, which is present throughout this dissertation. As I move forward, I draw on Mouffe's (2005) understanding of the political, which "takes issue" with rationalist, universalist, and individualist conceptions of politics: "The political cannot be restricted to a certain type of institution, or envisaged as constituting a specific sphere or level of society. It must be conceived as a dimension that is inherent to every human society and that determines our very ontological condition. Such a view of the political is profoundly at odds with liberal thought..." (p. 3).

I present these debates as a way to begin understanding the concepts and issues that are central to the evidence-based movement more generally and evidence-based policy-making specifically. I propose that rationalism's firm grip may have relaxed but those interested in alternative approaches must often justify their distinctively different worldview and claims against rationalism's assumptions of the production of knowledge. In the following chapter, I focus on the evidence-based movement to provide a context for situating evidence-based policy-making.

3. Enter the evidence-based movement: A modernist project

The previous chapter provides a view into some of the tensions evident in the literature on policy-making, particularly those relating to the relationship between knowledge and policy-making. It is into this environment that evidence-based policy-making emerged in the 1990s. This particular approach to policy-making captured my attention because of the vehemence and ubiquity with which it has been taken up in health/care and beyond, its influence on policy-making, and because of its effects – on policies and on people (in this instance, people with chronic disease but also policy workers). In this chapter, I provide a brief background on the evidence-based movement, particularly its inherent principles and epistemological assumptions that are inherited from rationalism, to contextualise evidence-based policy-making. I point to the fallacies in their claims and offer a critique of these assumptions that contribute to my analysis of how they are taken up in the practices of policy-making.

The concept “evidence-based” was coined in relation to practice in the discipline of medicine and it is there that it continues to have the most influence; in many instances, evidence-based practice means evidence-based medicine. “Evidence-based” appears frequently in general talk about the practice of medicine. However, the model of evidence-based practice has moved well beyond the bounds of medicine into other aspects of health care provision such as nursing, psychiatry, mental health, dentistry, health promotion, physiotherapy, complimentary and alternative medicine, and others.

Further still, its associated principles have been taken up and applied beyond health care to social work, child protection, criminology, and education, amongst other disciplines and practices, as well as in the acts and practices of policy-making within many disciplines. There are centres, networks, journals, conferences, institutes, and graduate degrees dedicated to evidence-based activities. Proponents of this approach argue vehemently for its value and necessity. I examine those arguments here.

The principles associated with evidence-based practices were developed in the 1970s³ by British epidemiologist Archie Cochrane. Based on his experience in World War II as a prisoner of war and senior medical officer in the prison camp, Cochrane was concerned that medical practice was too reliant on expert opinion and not sufficiently grounded on solid evidence of effectiveness using the principles of epidemiology (Cochrane, 1972). Thus, Cochrane alleged, medical practice was “causing more harm than good” (Chalmers, 2003, p. 22). He argued for randomised controlled trials and a synthesis of their findings as the best research methods – thus production of knowledge – to determine the most effective and efficient forms of health care, now often referred to as “best practices,” a term used well beyond health/care. The principles Cochrane espoused were subsequently adapted to patient care and physician training by David Sackett, a Canadian physician working out of McMaster University in Hamilton, ON who coined the term “evidence-based medicine.” Proponents of evidence-based medicine, and indeed the entire evidence-based movement (Sanderson, 2002; Pope, 2003),

³ Although some argue these principles were initiated much earlier but without the term “evidence-based practice.” See Cooper (2003) and Newnes (2001).

maintain that Cochrane's randomised controlled trials continue to be the "gold standard" today. Says Guyatt et al. (1992) of evidence-based medicine:

Evidence-based medicine de-emphasizes intuition, unsystematic clinical experience, and pathophysiologic rationale as sufficient grounds for clinical decision making and stresses the examination of evidence from clinical research. Evidence-based medicine requires new skills of the physician, including efficient literature searching and the application of formal rules of evidence evaluating the clinical literature. (p. 2420)

Named after Cochrane, The Cochrane Collaboration claims to make available up-to-date, accurate information about the effects of health care interventions, subtitling its website in 2008: "The reliable source of evidence in health care" (The Cochrane Collaboration, n.d.). Now called simply "Cochrane" (2016),⁴ its website's subtitle is "Trusted evidence. Informed decisions. Better health." In addition to promoting the method of randomised controlled trials to test interventions, The Cochrane Collaboration claims to systematically review trials to assess their outcomes. It draws conclusions and recommends the (alleged) best interventions on medical issues ranging from acute respiratory infections to tobacco addiction (The Cochrane Collaboration, n.d.). These systematic reviews and their distribution represent The Cochrane Collaboration's prized activity for which they are highly regarded by many healthcare practitioners and policy workers.

Understanding the principles guiding the decisions made by those contributing to The Cochrane Collaboration and evidence-based medicine is integral to

⁴ The Cochrane Collaboration recently changed its name to "Cochrane." However, the excerpts I present come from the website when it was called "The Cochrane Collaboration" and I speak to it in the present tense. I will continue to refer to this organisation as The Cochrane Collaboration; that is the name the media and policy workers tend to use.

understanding how this approach to practice and policy-making is adopted beyond medical practice. These principles have diffused into other locations and disciplines desiring to be seen to be evidence-based so as to have the authority and credibility that has accompanied evidence-based medicine, a process less documented in these disciplines than in medicine. The language, principles, and epistemological assumptions initiated and adhered to by evidence-based medicine are repeated in variable ways. According to their website, “The Cochrane Collaboration has a special organizational structure to meet the needs of producing high quality information” (The Cochrane Collaboration, n.d.). The main two “entities” are Cochrane Centres and Cochrane Review Groups, the latter of which are “composed of persons from around the world who share an interest in developing and maintaining systematic reviews relevant to a particular health area. Groups are coordinated by an editorial team who edit and assemble completed reviews into modules for inclusion in The Cochrane Library.” Other entities include: The Steering Group, The Secretariat, Methods Groups, Fields/Networks, The Consumer Network, The Ombudsmen and Public Arbiters, and the Funding Arbiter. Beyond staff members, these entities consist of volunteers who are located in the developed, largely English speaking, world in academic or health care settings.

It is evidence-based medicine and The Cochrane Collaboration to which other disciplines refer and upon which they are modelled. For example, a sister organisation, The Campbell Collaboration (Campbell Collaboration, n.d.), is focused on policy-making

in the disciplines of crime and justice, education, and social welfare. It follows a similar organisational structure and process of systematically reviewing randomised controlled trials. I provide this much detail of these organisations because of their undeniable significance in establishing a set of practices as well as an organizational structure against which other groups can develop their own evidence-based processes, including the practices of evidence-based policy-making in the context of chronic disease. In the following section, I explicate what I purport are its positivist and exclusive understandings of knowledge and knowledge production and counter that with a critique that draws on a sociology of knowledge perspective.

The allure of 'evidence'

The concept of knowledge within the evidence-based movement relies heavily on the scientific method of inquiry to produce empirical evidence with randomised controlled trials as the ultimate form of this method. According to Chalmers (2003), one of the founders of The Cochrane Collaboration, evidence produced by randomised controlled trials is the most sound; it is factual. Advocates of evidence-based medicine, such as Chalmers (2003) and Guyatt et al. (1992), position randomised controlled trials and the knowledge – evidence – they produce in opposition to guesswork, intuition, opinion, and claims of professional experience and expertise. The assumed value of randomised controlled trials is that they account for all variables except for the one under study, making their findings generalisable and the need for opinions and intuition

obsolete. Chalmers (2003) asserts that physicians who are certain about their opinions run the risk of doing harm to patients:

Those who reject randomization are implying they are sufficiently knowledgeable about the complexities of influences in the social world that they know how to take account of all potentially confounding factors of prognostic importance, including those they have not measured, when comparing groups to estimate intervention effects. (p. 30)

Objective, neutral facts – uncontaminated and unencumbered by any iteration of subjectivity, ideology, politics, opinions, or bias – are the cornerstones of external knowledge. They are deemed reliable, valid, and trustworthy and the basis of the evidence-based movement. Scientific inquiries, particularly randomised controlled trials, are alleged to be the producers of facts: proven findings. “What does the science say?” is a question often asked in the face of a dilemma. It is assumed that the facts produced by scientific inquiry and randomised controlled trials in particular, deemed to be evidence, are considered external to interference; they are pure, neutral, disinterested. Chalmer’s statement insists that the complexities of the social world are removed by the randomisation that accompanies randomised controlled trials. Within these claims are assumptions that scientifically produced knowledge remains complete, unquestionable, and unassailable.

Within these arguments for evidence-based practices, there appears little to dispute. At face value, the epistemological claims of evidence-based practice are seductive. How can one go wrong with the case for valid, reliable, and factual

knowledge over opinion; accuracy over error; objectivity over subjectivity; value neutrality over value laden-ness; order over unruliness; faith over mistrust? When presented in these binary terms, the arguments make for a compelling case, particularly in regard to one's health. Few people would want their medical (or health) care to be based on anything else, especially if the evidence is available for the knowing. In fact, it seems common sense, obvious. This notion of common sense is amongst the greatest attractions of the evidence-based movement and has, I would argue, contributed significantly to its success (ironically so, given that a reliance on 'common sense' is what the evidence-based movement seeks to remove from practice). Furthermore, "national evidence-based guidelines have the potential to end postcode lotteries in health-care, inform clinical decisions with the latest research evidence and ensure the provision of effective care" (Rogers, 2002, p. 95). According to these arguments, not only are there good reasons for evidence-based practices, but, as Chalmer's and Roger's respective statements above point out, there is an alleged injustice when *not* engaging in evidence-based practice; it democratises care. Goldenberg (2006) suggests that the appeal of this approach to practice rests with its intention to "rationalise this complex social process" (p. 2622) of health care decision – or policy-making.

Problematizing evidence and assumptions about knowledge

Despite its spread and acceptance across disciplines and practices, the principles of evidence-based practices are not without their critics. The arguments used to support

these principles are reflected in arguments to critique them, representing a very different perspective on knowledge. The perspectives on knowledge and knowledge production on which I draw are features of poststructuralism. Holmes, Murray, Perron, and Rail (2006a) argue that the hegemony of evidence-based practices results in the segmentation of knowledge where the empiricism found in science, observation, and justification is prioritised at the expense of other ways of knowing, thus marginalizing other sources of knowledge that they propose are as legitimate. This claim is reminiscent of Foucault's (1980) notion of subjugated forms of knowledge that are "particular, local, regional [...] incapable of unanimity" (p. 82), positioned low on a manufactured hierarchy of knowledge because they do not meet the requirements of science. Foucault argues that there can be no one, whole, complete, or even certain knowledge at the expense of all others. Concerned with the effects of power that accompany scientific discourse, Foucault (1980, p. 83) challenges attempts to "filter, hierarchize and order (these knowledges) in the name of some true knowledge and some arbitrary idea of what constitutes a science and its objects." In this statement, Foucault almost appears to predict the intent of evidence-based practice. Echoing Foucault, Kumashiro (2004) argues that hierarchies, subjugations, and, he adds, exclusions of knowledges result from a binary logic upon which the production of knowledge is often centred. These theorists, among others, challenge the epistemological claims of the evidence-based movement. The binaries that comprise

arguments supporting evidence-based practice assume a privileging of one knowledge (that produced by scientific inquiry) as superior, or even exclusive, over other knowledges. This assumption leads to hierarchies, subjugations, and exclusions in evidence-based practices that come to define it. Of concern is the who and the what that constitute the excluded.

Randomised controlled trials, the most highly valued scientific method within evidence-based movement, are the specific practice challenged by Weinstein in his dispute of their idealisation. Borrowing from Haraway (1988), he calls them “situated sites of knowledge,” or knowledge with limits. Weinstein (2004) wants to “blur those terms that clinical trials are supposed to secure: rigor, reliability, validity, and so on” (p. 247). The evidence-based movement further demands systematic analysis of these trials. These reviews are meant to catch research that is not rigorous or reliable, suggesting the possible fallibility of the scientific method, which puts the likelihood of absolute certainty in doubt. Those undertaking these reviews are steeped in the binaries central to evidence-based practices and will further the practice of exclusion in their analysis.

Although evidence-based practices are said to be based on “current best evidence in making decisions about the care of individual patients” (Sackett, 1997, p. 3), the implication is that current knowledge is complete, universal, certain, and factual in the moment. Weinstein says (2004): “(r)andomized experimental design as myth ceases

to be merely a particular strategy to answer specific kinds of questions about a limited range of issues and solve certain sorts of methodological problems; instead, it becomes emblematic of science, truth, and certainty ('reliable') as a whole" (p. 249). So, even though providing evidence that is only "current," as per Sackett, systematic reviews of randomised controlled trials produce knowledge that is considered whole. One of the powers of the evidence-based movement is this sense of totality. The entire model is totalising at the expense of other, apparently risky, ways of knowing.

Responding to critics: Nuances that expose fallacies

Examples of knowledges critics say are excluded are those of professional expertise and experience, clinical judgement, and patient (in the case of evidence-based medicine) experience (and expertise) that might be understood through qualitative, interpretivist research methodologies. Perhaps responding to these critiques, advocates of the evidence-based movement have become broader in their recommendations on what practitioners should base their practice. The Cochrane Collaboration and Sackett (1997) each, now, acknowledge that clinical expertise, experience, and judgement are important to good practice *alongside* the use of evidence. On The Cochrane Collaboration (n.d.) website, there is a disclaimer:

While 'evidence' can be essential in evaluating effectiveness of healthcare interventions, well-informed decisions also require information, and judgments about needs, resources and values; as well as judgments about the quality and applicability of evidence. Relying only on evidence about the effects of health care alone can be inappropriate. Care and compassion are vital, and understanding the nature and basis of disease and the way that interventions

work remains important.

And, according to Sackett (1997), who revised the definition of evidence-based medicine in response to growing criticism:

Good doctors use both individual clinical expertise and the best available external evidence, and neither alone is enough. Without clinical expertise, practice risks becoming tyrannised by evidence, for even excellent external evidence may be inapplicable to or inappropriate for an individual patient. Without current best evidence, practice risks becoming rapidly out of date, to the detriment of patients. (p. 3)

These words represent a marked shift from earlier rigid adherence to evidence produced by the systematic reviews of randomised controlled trials alone and acknowledge the value of clinical judgement and expertise. The Cochrane Collaboration even reminds practitioners to not neglect care while practicing medicine. But Sackett's (1997) statement "Without clinical expertise, practice risks becoming *tyrannised by evidence*," (p. 3, emphasis added) when juxtaposed to his earlier claims about the value of evidence-based medicine, is almost shocking. It is a remarkable caution coming from someone who not only coined the concept evidence-based medicine but for years sang its praises. Does this softening represent a fracture in the armour evidence-based practice purports to offer? Even with this (marginally) more balanced approach towards clinical practice, the knowledges gained from clinical experience or expertise are still excluded from the position of evidence, which remains the production (and property) of the scientific method. Sackett (1997) does not appear to acknowledge the division he has created between clinical expertise and evidence nor what to do when they

contradict one another.⁵ Furthermore, patient expertise, in the case of evidence-based medicine, or the voices of people at the focus of policy, remain excluded altogether in his schema. In this era of ‘patient-centred care,’ on which there is vast literature, the exclusion of patients’ voices in evidence-based practices stands out as a contradiction facing practitioners. That there is an acknowledgement of multiple, albeit limited, knowledges is small comfort given the strength of the hierarchy and the exclusions that remain. Evidence that is external (pure), not contaminated by knowledge lower on the hierarchy than scientific evidence (or not there at all), remains central and it alone guarantees certainty.

Sackett’s (1997) statement reveals clefs in the arguments for evidence-based practice and, I argue, insecurity in his confidence. Remarkable by its obviousness is the admission that “evidence may be inapplicable or inappropriate for an individual patient,” which is a direct contradiction to the definition of evidence-based practice: “current best evidence in making decisions about the care of individual patients” (p. 3). The veneer of certainty is beginning to unravel. Evidence that used to be reliable is now possibly inapplicable or inappropriate. Moreover, it seems that Sackett (1997) has actually reorganised the hierarchy; he clearly states that clinical expertise is required to make a judgement on evidence to determine its applicability and appropriateness for a patient. One might conclude that this expertise is, therefore, more important in the moment of making a medical decision than the evidence. These other features of good

⁵ Just as the current (2016) Canadian federal Minister of Environment and Climate Change, Catherine McKenna, has not said what she will do when Indigenous knowledge and scientific knowledge, both of which she wants to be part of a changed environmental assessment process, contradict one another.

practice, such as clinical expertise, cannot be tested scientifically and, therefore, cannot be allowed to have the influence scientifically produced evidence has, according to the principles of the evidence-based movement. They are, therefore, subjugated. Yet Sackett's (1997) comments suggest that external evidence alone, as it turns out, is not the final word but *depends* on clinical judgement. What was previously considered a contaminant is now a necessity. A further crack shows up in the last sentence of Sackett's quote: "Without current best evidence, practice risks becoming rapidly out of date, to the detriment of patients" (p. 3). Implicit is that evidence can 'go bad.' No evidence is really ever trustworthy because it may be refuted when the next evidence comes along and the basis for good practice will change. According to physicians grappling with evidence-based practice, you can never be really sure you are right (B. Marshall, personal communication, December 15, 2008).

I argue that collectively, the contradictions, exclusions, and ironies appearing in Sackett's attempt to assuage critics of evidence-based practices serve, instead, to highlight its fallacy. Yet the dominance of evidence-based practice has not seemed to diminish.

Objectivity and the false divide

Arguably, the most significant and productive arguments in support of evidence-based practices are the claims of objectivity, neutrality, and purity of factual, scientific evidence. One read of Latour (1987, 2013; Cayley 2007b) and the guarantee, or even the

possibility, of separation of the pure from the contaminated, the basis of the evidence-based movement, seems possible only in one's imagination. Haraway (1988) might call it a "deadly fantasy" (p. 580). The dichotomy set up by the evidence-based movement is a version of the science/social dichotomy Latour argues does not, and cannot, exist.

Latour asserts that the divide between science and the social is a modern divide, representing a political invention intended to free science from politics (Cayley, 2007b). In a similar vein, Said (1978) identifies the false binary of pure and political knowledge, arguing that in the contemporary west, "true" knowledge is seen as non-political, objective. " 'Political' as a label is used to discredit work that dares to violate the protocols of pretended suprapolitical objectivity" (Said, 1978, p. 76). Those who argue for this division, Latour contends, are arguing that the myth of science is pure reason (Cayley, 2007b). This myth, of course, stems from the Enlightenment's desire for reason, certainty, mastery and order: goals of modernity that are carried over into the goals of the evidence-based movement. Latour (1987, Cayley 2007b) is making not only an epistemological argument, but an ontological one as well. Science, he posits, is not separate from the social, and neither is the social separate from science. He is challenging us to question what we think science is and how we think it works. He argues that facts are never "just facts"; they are mediated or translated by something/one that/who influences how it is that we know them (Cayley, 2007b). They are not immediately available to people, Latour says. Rather, they must be mediated

and they are attached to practices. Latour (Cayley, 2007b) argues that it is the mediation that we can know; the mediation is what is knowable, not the “facts.” Thus separating science from the social is impossible yet it is fundamental to Sackett’s (1997), and the evidence-based movement’s, argument.

I propose that there are layers of mediation at play in evidence-based practices: the scientist who organises the randomised controlled trials; the practice of systematically reviewing those trials; and those at The Cochrane Collaboration or equivalent who make recommendations for practice-based on those reviews. Each of these plays a role in mediating “facts.” Rather than conducting their own research or even reading all available research findings, practitioners can read reviews of research findings, or, to be more efficient, refer to The Cochrane Collaboration for recommendations based on them, to learn about the evidence. Practitioners do not really even need to understand the specifics of the research since they can, apparently, rely on the systematic reviews. In the context of medical care, just as patients are excluded from knowledge production, we are also removed from the evaluation of evidence; we are meant to simply trust that our medical care professionals are paying attention and will translate the facts to us.

It matters how facts come to be known as facts, Latour says, but we can only know them through their mediation or translation, a process that taints any sense of purity. Proponents of evidence-based practices claim to be providing the facts yet the

layers of mediation of those “facts” are all we can really know. If, according to Latour (Cayley, 2007b), the social and science are inextricable, then the kind of objectivity and neutrality desired and claimed by evidence-based practices are impossible.

Knowledge/power

Foucault and others propose that knowledge is much more problematic than the promise of neutrality suggests. Foucault (1980) understood knowledge as interpenetrated by power so intricately that he coined the phrase “power/knowledge.” While often thought about from the perspective of power, I come at this concept with an initial interest in knowledge. Nelson (2008) understands power/knowledge to “describe how knowledge is always shaped and mediated by social forces – the power to dictate meaning, the assumptions (conscious or not) of the author, the social and political conditions in which it is produced, and the goals to which it might be applied” (p. 20). These comments mirror Latour’s insistence that facts are always mediated. Townley (1993) takes up this concept in the context of Human Resources Management and her interpretation is helpful:

Knowledge is not detached and independent; as a source of illumination, it is central to the operation of power. From this perspective, procedures for the formation and accumulation of knowledge, including the scientific method, are not, therefore, neutral instruments for the presentation of the real (Steffy & Grimes, 1992). Indeed, scientific discourse and the institutions that produce it are part of the taken-for-granted assumptions of knowledge that should be questioned (Knights, 1992). Procedures for investigation and research (e.g., the use of a classificatory table), although operating as a procedure of knowledge, can operate equally as a technique of power. Knowledge is the operation of discipline. It delineates an analytical space and in constituting an arena of

knowledge, provides the basis for action and intervention – the operation of power. (p. 521)

Townley's analysis makes several points that support my critique of evidence-based practices. I propose that randomised controlled trials and their systematic reviews operate as procedures of knowledge *and* techniques of power. They are neither "detached and independent" nor "neutral instruments for the presentation of the real." In staking a claim on knowledge as it relates to a particular discipline, evidence-based practices are operations of power.

Forcing a square peg in a round hole

As noted above, to assuage criticisms of rigidity, there have been nuances within the evidence-based movement that attempt to soften its appearance. A place has been made for qualitative research but with provisos. The movement's insistence on validity (a challengeable concept, says Lather [2015]), verifiability, rigour, and "quality and synthesis results" has resulted in these criteria – all positivist concepts – being applied to qualitative research. There also has been recognition of practitioner expertise and patient (in the case of evidence-based medicine and health/care policy-making) experience as useful knowledge alongside the scientifically-acquired evidence (Sackett, 1997). Denzin (2009) argues, however, that qualitative research is only given credibility when it is part of data gathering of an experimental or quasi-experimental study.

An example of the criteria used to judge quantitative research being applied to

qualitative studies can be seen with Canada's federal health research grant agency, Canadian Institutes of Health Research (CIHR), which has offered knowledge synthesis grant opportunities that stipulate methodologies such as meta-ethnography and meta-narrative. Ethnography and narrative are qualitative methodologies, but combined with "meta," in that there is (or can be) a synthesis done of their findings, represents the desire to judge findings from these methodologies using a quantitative methodological framework. According to CIHR's website, "a synthesis must be reproducible and transparent in its methods. [...] Science is a cumulative process that develops iteratively; few studies by themselves are sufficiently persuasive to change practice or policy. Individual studies may be misleading due to chance or bias" (Grimshaw, 2010). In this statement, research is, by definition, science and, whether qualitative or quantitative, considered as arising from the same paradigm. The website continues:

Knowledge syntheses are the cornerstone of knowledge translation. They transform vast libraries of scientific literature into knowledge that is reliable, relevant and readable for knowledge users. Syntheses are comprehensive and apply scientific methods to literature analysis which minimizes the risk of bias and error that may accompany single studies, so decisions are less likely to be based on insufficient or premature evidence. (Grimshaw, 2010)

This example demonstrates how the scientific paradigm is used to manage and judge knowledge produced through non-methodologies in order for them to be considered on the hierarchy of knowledge production. Although the evidence-based movement has granted qualitative inquiries a place on the knowledge production hierarchy, it has positioned them at the bottom and only then when they can meet the

standards of synthesis reviews that define the evidence-based movement. Elsewhere (Canadian Foundation for Healthcare Improvement/La Fondation canadienne pour l'amélioration des services de santé, n.d.), the language of "evidence-informed" (meaning there are more features to consider in decision-making than just evidence) has usurped "evidence-based," but fundamental concerns about the assumptions of knowledge and its production and applicability to policy-making are not resolved within this variation. Indigenous and decolonising methodologies do not register.

Denzin decries rationalism's claim about knowledge production and laments its (renewed) rise in the form of science- (or evidence-) based research. In a recent interview for a conference on *The Politics of Evidence*, Denzin (2015) discusses the paradigm wars of the 1960s to 1980s between qualitative and quantitative inquiry and the confidence he and his colleagues had that these wars were over. In retrospect, Denzin believes qualitative researchers developed a sense of complacency, believing there was a well-understood and shared belief that qualitative and quantitative research could (and would) not be measured against each other; that they had profoundly different methodological, epistemological, and ontological assumptions. Each needs to be allowed to speak to each other and maintain their own autonomy. But in the early 2000s, Denzin (2015) continues, there emerged pressure to "fold into the larger community of mixed methods which becomes handmaiden to science-based research evidence movement." Suddenly, the demand for science-based research from

the American federal government (and others, I propose) has reset the boundaries for what counts as valid knowledge and what research and services will receive funding. Denzin links this resurgence directly to the emergence of neoliberalism where market forces are inappropriately, he argues, applied to research that is “curiosity driven.”

Lather (2015), Strathern (2000), and St Pierre (2006) refer to the audit culture where everything needs to be represented by numbers, producing what Lather (2015) calls “measure-mania.” Numbers are valued above all else and they are “cloaked in objectivity.” Lather (2015), also interviewed for *The Politics of Evidence* conference, says “you cannot reduce some concepts to check marks.” The Cochrane and Campbell Collaborations are “institutional apparatuses” that perpetuate science-based research as the only valid form of knowledge production, argues Denzin (2015). The value of social justice and equity, legacy of the protest movements, and resistance to measuring outputs in positivist ways (numbers, dollars) as opposed to quality of life, for example, are initiatives that push against top down market managerial and measurement apparatuses, asking “how do they impact real people in real worlds who suffer from structures of oppression and inequity?” (Denzin, 2015). Denzin calls for a reframing of the debate as not just a qualitative versus quantitative paradigm war, but an examination of post-humanist critique, a recognition of multiple interpretive communities, the influence of critical qualitative research in the policy arena, and the rising influence of Indigenous scholarship. He is calling for a pushback against the

narrowed view of knowledge, the “colonial apparatus,” taken up by the evidence-based movement. In part, this dissertation aims to produce such a pushback.

A commandment of the evidence-based movement: Have faith

The scientific revolution was, in part, a response to the reliance of knowledge deriving from faith in metaphysical and religious foundations, yet ironically, science (and evidence-based practice in particular) relies on a kind of faith hitherto associated with religion. The faith we are to have in evidence-based practices and policies is hardly empirical, yet empiricism is a fundamental component of the evidence-based movement. “Evidence-based” is now doctrine in many disciplinary practice and policy-making settings. Based on its prevalence, this model commands and receives faith in its guarantee of producing knowledge that is pure of influence and errors and will result only in positive, measurable outcomes. But by challenging the model’s presentation as a straightforward and unproblematic approach to knowledge production and its essentialist knowledge claims, I want to shake the faith that evidence-based practice requires to be successful.

Schaffer (Cayley, 2007a) argues that one of western science’s greatest successes was, and continues to be, its ability to gain and maintain people’s trust. He offers an historical account of science’s dependency on trust. In the 17th century, when experimental knowledge was on the rise, the emerging notion was that private individual beliefs were not trust-worthy; they were based on blind faith and were a

threat to social order. Schaffer (Cayley, 2007a) presents Boyle's "solution to the problem of knowledge": if an experiment could prove a piece of fact, if that experiment could be replicated to reproduce that fact, and if there were witnesses to this production, a "matter of fact" was born that could not be denied and knowledge was produced. Furthermore, with enough of the right witnesses (in Boyle's case, fellow "gentlemen"), trust could be established and the knowledge produced could be counted on as truth. Boyle's arguments were amongst the first demonstrations of empiricism and, perhaps unwittingly, the dependency of science on trust.

Schaffer (Cayley, 2007a) proposes that there is a commonly held understanding that the hallmark of science in the 17th century, and its critical achievement, lies with its scepticism. Schaffer counters this assumption by arguing that science's greatest achievement lies in its ability to create and maintain trust with scientists as the craftspeople of this trust. Hardwig (2002) suggests that epistemologists have historically considered knowledge and trust to be antithetical, that trust has no place in knowledge. In this line of thinking, knowledge rests on empirical evidence and, therefore, cannot be blind. Conversely, trust must be at least partially blind – in the absence of the empirical, one must trust in the reports of the empirical. But, Hardwig argues, that knowledge is dependent on trust; it is knowledge, not trust, that is blind. "Modern knowers cannot be independent and self-reliant [...]. (T)rust is often epistemologically even more basic than that empirical data or logical arguments: data and the argument are available only

through trust” (Hardwig, 2002, p. 405). Rather than relying on evidence, Hardwig further argues, knowledge relies on trust. Hardwig’s and Schaeffer’s argument about the importance of trust is shared by Latour, whose research in laboratories concluded that the work of scientists is heavily dependent on trusting previous scientists who (using scientific methods with their own reliance on trust) created the methods, equations, and equipment, for example, on which work of subsequent scientists relies. Scientists, Hardwig says, are well aware that it is impossible for all scientific knowledge to be replicated. Trust in the source of knowledge is necessary to be able to move forward. Those generating knowledge, therefore, must gain the trust of others. Trust is often dependent on the status of the generator and witnesses of knowledge production. Boyle’s experiment with the air pump demonstrates this point, because of who he was (that is, the status he held) and who his witnesses were. “The experiments, which took place in the presence of other leisured gentlemen *like himself*, required the presence of labouring men to work the bellows; and they were purposefully carried out late at night to preclude the attendance of women” (Michelson, 1998, p. 217; emphasis added).⁶ Title, education, affiliation, reputation, and in Boyle’s experiments, class and gender, are amongst the characteristics that position particular people or institutions as authorities, indeed experts. We come to know things not because we produced the knowledge ourselves, but because those who translate the knowledge engender our trust.

⁶ Michelson (1998), drawing on Haraway, also argues that Boyle’s experiment with other gentlemen demonstrates “the forms of knowledge-production that erase both the marked bodies of participants and their own social location” (p. 217).

The “crisis of trust,” says Schaffer, is when you do not know whom to trust, thus, the need for an enterprise that can produce undeniable truth. By guaranteeing truth, there is no further reason to disagree, crisis is averted, and progress can continue. Science has, according to Schaffer, become this enterprise. Science organises trust very well and distributes it efficiently. It solves the problem of knowledge; recall Foucault’s (1980) reference to particular and local knowledges that are “incapable of unanimity” (p. 82), and, thus, surely in need of ordering. And it solves the problem of social dis/order caused by disagreement over truths. Social order, Schaffer says, is built on such mutual trust. And the distribution of trust is one of science’s most significant success stories.

Trust and its distribution are at the essence of the evidence-based movement. In the context of medicine, The Cochrane Collaboration seeks to command trust. “The Cochrane Collaboration is the largest organisation in the world engaged in the production and maintenance of systematic reviews. It has received worldwide support in its efforts to do something about the problems in health care” (The Cochrane Collaboration, n.d.). It prides itself on providing the best available evidence in which health care practitioners (and others) can trust. We should have this trust in part, one might assume, because of the certainty science claims to offer. But perhaps we are also meant to have this trust because of the authority assumed by those who distribute trust – like Boyle’s fellow gentleman who carried a certain respect because of who they were

(or how they were seen) in the community and, thus, were trusted witnesses to his experiment. The Cochrane Collaboration assumes a similar authority. What they say counts because of their epistemological assertions and the authority and expertise they assume. Members of their various entities are almost exclusively connected to academic institutions or health care teaching and/or research centres; they are scientists, “experts.” Using this authority, these experts undertake systematic reviews, which proponents claim offer an efficient and reliable way to know – even guarantee – what is the best, most up-to-date evidence, thus knowledge. These reviews are also, I contend, a tool used to distribute trust. In this model, knowledge production rests solely in the hands of those deemed fit by the likes of The Cochrane Collaboration. Neither practitioners, patients, citizens, nor anyone else needs to know the facts by conducting their own research – that would be impossible. The experts associated with The Cochrane Collaboration have done the work for them and they are the right witnesses in the same way Boyle organised the right witnesses: unmarked, objective, with “the gaze from nowhere,” in Haraway’s words (1988, p. 581). They get to be the knowers and we can rest assured in their knowledge.

Arbitration of evidence

Who are the final arbiters of evidence? In the previous sections, I have postulated that this act of mediation in evidence-based practices is neither neutral nor benign. In examining the scientific canon of objectivity, Haraway’s (1988) work sheds a

disturbing light on the practice of judging research and determining evidence. She argues that science is interested in something she calls reductionism. In seeking universality, the language of science is imposed as the standard for all translations, positioning science as the one equation of knowing (Haraway, 1988). This “doctrine of objectivity” (Haraway, 1988, p 579) is “in the service of hierarchical and positivist ordering of what can count as knowledge” (p. 580). The kind of objectivity claimed by scientific inquiry, according to Haraway, leaves everyone/everything unmarked, an allegation familiar to those interested in critical gender and race studies. Says Haraway (1988):

(The) gaze from nowhere [...] is the gaze that mythically inscribes all the marked bodies, that makes the unmarked category claim the power to see and not be seen, to represent while escaping representation. This gaze signifies the unmarked positions of Man and White, one of the many nasty tones of the word objectivity to feminist ears in scientific and technological, late industrial, militarized, racist and male dominant societies [...]. (p. 581)

The “gaze from nowhere” or the “god trick of seeing everything from nowhere” (Haraway, 1988, p. 581) is the gaze of the “objective” scientist who claims neutrality and, in doing so, removes the marks from marked bodies, rendering them neutral. The marked are those who are “other,” such as women, members of the LGBTQ community, ethnic, social, religious, economic and intellectual minorities, people with disabilities, and, in the context of this research, people living with chronic disease. Haraway theorises that the unmarked, universal, neutral subject is the modern subject. The subjectivities of the marked are discounted. Once rendered invisible, the marked are

excluded, silenced and the subject becomes one of the many since there are no longer marks to provide detail, nuance, or even contradiction to the dominant view. I see this same gaze producing the same effect in evidence-based practice in which the objective scientist is the arbiter who sees everything from nowhere. The objectivity and neutrality claimed by the evidence-based movement creates subjects who, by necessity, are unmarked. In the case of medicine, practitioners are encouraged to engage in evidence-based practice when dealing with individual patients, yet Sackett (1997) has acknowledged that evidence may not be applicable to individual patients. Because evidence-based practice is based on the general yet is to be applied to the individual, that individual becomes unmarked. Her particulars do not matter. This “god-trick” (Haraway, 1988, p. 581) cannot be done without material effects and so, too, the application of evidence-based practice, and its quest for objectivity, will have material effects on bodies (people governed by policy, for example).

Haraway (1988), however, is not interested in abandoning the concept of objectivity completely, but rather calls for a feminist version of objectivity. Feminists, she argues, “have to insist on a better account of the world. [...] Feminists don’t need a doctrine of objectivity that promises transcendence, a story that loses track of its mediations just where someone might be held responsible for something” (p. 579). Instead, Haraway (1988) calls for a feminist objectivity that means, in her words, “quite simply *situated knowledges*” (p. 581, italics in original). Objectivity, she posits, is about

those particular embodiments not seen in the traditional scientific objectivity that claims transcendence. Only knowledge that claims partial, situated knowledge can be objective (Haraway, 1988). Situated knowledge challenges the totalising and privileged knowledge claims of scientific inquiry and provides “intellectual and political space for hitherto silenced voices to be heard” (Merrifield, 1995, p. 51). The situated and embodied knowledge for which Haraway (1988) argues are set against the forms of “unlocatable, and so irresponsible, knowledge claims” (p. 583).

Earlier in this chapter, I quote Chalmers (2003), one of The Cochrane Collaboration’s founders:

Those who reject randomization are implying they are sufficiently knowledgeable about the complexities of influences in the social world that they know how to take account of all potentially confounding factors of prognostic importance, including those they have not measured, when comparing groups to estimate intervention effects. (p. 30)

A rebuttal might propose that it is the very complexity of the social world that is *not* taken into consideration with Chalmer’s rigid approach to evidence. He would have us believe that he is aware that the social world is important and understands all its nuances. But he positions its importance as an influence on people’s lives and health, apparently completely external to anything relevant to good medical practice.

Proponents of randomised controlled trials allege that because variances are accounted for under this scientific method of research, they do not interfere with the creation of evidence. The resulting evidence can then be broadly applied (although, not necessarily

to all individuals, according to Sackett's 1997 re-definition). The marked, one might assume, fits within the social world and are accounted for by randomisation, but only through a process of being transformed to be one of the many unmarked. Evidence-based practices rely on homogeneous evidence for homogeneous subjects – and neither exist. I argue that to pretend otherwise is a disservice for those who are the intended beneficiaries, especially the marked.

Finally, Cochrane (1972) posits two main arguments for evidence-based practices: effectiveness and efficiency. The latter claim of efficiency – that evidence-based practice will ensure that decisions are not only effective but also efficient – warrants a critique. The language of efficiency is embedded in business, corporate, and consumer discourses, insinuating cost effectiveness. Amidst “twin neoliberal pressures of privatization and cost-effectiveness” (Traynor, 2002), calls for efficiency are constant. In Canada's (and elsewhere) growing neoliberal ethos, there have been long standing debates on the privatisation of health care in tandem with (claims of) ever-expanding demands on public dollars and government (federal, provincial) coffers, creating an environment where guarantees of efficiencies would be welcome. The evidence-based movement is presented as one way to ensure that monies are spent efficiently – not wasted on ineffective practices. These arguments are used regardless of the site: medicine, health, criminology, and education, for example.

The claim of efficiency is countered by those who fear decisions will be made

with only financial cost in mind. Evidence-based policy is intricately connected to a broader political context “where efficiency becomes the primary political value, replacing discussions of justice and interest with discussions of what is possible and practical, with means rather than ends, with methods rather than truth,” argue Smith and Kulynych (2002, p. 163). They are less (than I am) troubled by notions of truth than notions of justice, a concern I share and that motivates my research. With chronic disease declared to be a financial burden on the budgets of health care systems, seeking efficiency is an attractive endeavour – but to what effect?

Mess

The attempt at organising and ordering is a modernist ambition that is costly. Walker (2003) suggests we consider the effects that modernism has produced, citing the current ecological crisis:

The history of modernity’s worst excesses conducted in the names of progress collectively scar the psyches of many across the globe. It is a central tenet of modernity’s critics that we must be ever mindful of the potential for every purportedly enlightening or empowering new idea to undermine its own potential. [...] (M)odernity’s obsession with progress and the activities it spawns (has) run horribly amuck. (p. 146-7)

Keeping in mind Foucault’s (1984) warning “it could be dangerous,” Walker (2003) is concerned about the unreflexive and dogmatic technologies of knowledge prioritised in evidence-based practices and suggests it could be dangerous to his profession of nursing:

Dangerous insofar as we lock ourselves into epistemic frames of reference that allow us only a limited (and limiting) view of health and health-care. Dangerous in that the established hierarchies of knowledge and power (in the form of bureaucratised medicine and an increasingly politicised healthcare system) are afforded the opportunity to reign unchallenged with the effect of marginalising and subordinating other, less authoritative knowledges and exercises of power (e.g. nursing's). (p. 153)

My concern for the material effects on material bodies, people living with chronic disease (the marked), has prompted me to explore this ubiquitous discourse. I have an interest in evidence-based policy-making in the very messy context of chronic disease where people are marked in multiple and unique ways – visible and not so visible or distinguishable from another with/out the same disease or through the effects chronic disease may have had on their bodies and lives. Throughout this chapter, I have tended to focus my comments on evidence-based practices generally. But, as I stated at the outset, the principles of evidence-based practice have been taken up in disciplines far beyond health care in locations where the value of a traditional understanding of science plays little, if any, role. It is hard to imagine how evidence-based policy-making would work in the contexts of child protection and criminology, for example. Yet the Campbell Collaboration sees no disconnect and distributes the results of systematic reviews on randomised controlled policy trials undertaken in these disciplines – a worrisome proposition. When evidence for the general is applied to the individual, both the intent and the tyranny of evidence-based practice, one must wonder: for whom, then, is the evidence appropriate? If “run horribly amuck,” as Walker (2003, p 147) ponders, to what effect? And while the focus of this study is the practices of policy

workers, I remain interested in the effects of evidence-based policy-making on people living with chronic disease. I argue that the two are inter-related in that how policy workers conceive of people with chronic disease, what knowledge they access, and how they assess it will affect their policy advice and, potentially, policies themselves.

One effect of this “obsession with progress” might be mess. Law (2003) asserts that the world is messy. Methodological attempts at “knowing mess” are looking for methodological hygiene and cleanliness, but mess is unknowable, making any search an exercise in frustration. Says Law (2003):

In practice research needs to be messy and heterogeneous. It needs to be messy and heterogeneous, because that is the way it, research, actually is. And also, and more importantly, it needs to be messy because that is the way the largest part of the world is. Messy, unknowable in a regular and routinised way. Unknowable, therefore, in ways that are definite or coherent. [...] Clarity doesn't help. Disciplined lack of clarity, that may be what we need. (p. 3)

That the world is messy and unknowable is in direct contradiction to the whole modernist agenda. It is also contrary to the evidence-based movement in which there appears to be no excuse for not knowing completely and with certainty. I am sure a “disciplined lack of clarity” would not be sufficient for the evidence-based practice faithful. Consider evidence-based policy-making (a purportedly neutral form of knowledge production combined with the purportedly neutral activity of policy analysis: the purest of the pure) in the context of something as messy as chronic disease: messy, indeed. Methodologies provide us the “routine” to grapple with the unknowable.

Latour (Cayley, 2007b) contends that in our attempts to create order and to reach purity, we only serve to complicate the mess; the more we try to become pure, the more we become entangled. Mess is something modernity aims to order, yet mess is the consequence of ordering. “The more science is absolutely pure, the more it is intimately bound up with the fabric of society” (Latour, 1993, p. 43). Evidence-based practice has as its goal to rid practice of errors and risk of harm and to establish standards and protocols that, if followed, will bring about the desired outcomes. Given Latour’s and Walker’s warnings, one is left curious about what kind of mess evidence-based practice might lead us to. The knowledge it claims to generate using only the alleged purest of methods – randomised controlled trials – is limited, exclusionary, totalising, and so questionable that purity seems not only unlikely but undesirable.

Given the number of calls for proposals from funding agencies to develop evidence-based research and claims of evidence-based practices by so many disciplines, the trust in evidence-based practice generally, and systematic reviews specifically, is pervasive. Throughout this chapter, I have identified tensions in the model’s assumptions by proposing a critique to its narrow epistemological standpoint. But I have also identified problems that appear in the model itself. With so many fissures in the foundation of this model, the trust factor is inevitably disrupted, the faith shaken, and the mess perpetuated. These critiques of this approach inform my analysis of the empirical material of my study. In the following chapter, I examine the claims of the

evidence-based movement and their critiques more specifically as they relate to policy-making.

4. Evidence-based policy-making

The previous chapter delves into the promise and critiques of evidence-based practices. This chapter examines evidence-based policy-making more closely from similar theoretical perspectives. I begin with a clear association between rationality and evidence-based practice made by Cronje and Fullan's (2003) who draw on Brown (1990):

The idea of 'rational' action exists because people find it useful to distinguish actions based on reason from actions based on emotions, impulses or random choice – 'rationality', then, is what protects our actions from arbitrariness, subjectivity, bias or error. The central idea of 'rationality' is that: 'we have reasons for our rational beliefs and can provide those reasons on request ... If we are to be rational, we must believe on the basis of relevant evidence, and be prepared to alter our beliefs if the weight of evidence changes. We also expect rational beliefs to be, on balance, more reliable than nonrational or irrational beliefs exactly because our rational beliefs are based on appropriate evidence' (Brown, 1990, p. 183). Rationality appeals because we believe that 'rational procedures provide reliable results'. EBM, because it focuses on integrating quantified scientific evidence into the decision-making process, thus promises to be a more reliable practice with better health outcomes for patients. (p. 354)

Cronje and Fullan argue for the legitimacy of the binary between rationality, reason, evidence and (or versus) subjectivity, bias, impulse, emotions, arbitrariness, irrationality, and, most notably, error; good versus bad. They set up this binary to establish quantified scientific evidence as the basis for "rational procedures," thus evidence-based practices, and make a direct link to evidence-based decision-making in the context of health (but really medical) practice.⁷ They have also established an argument for evidence-based policy-making.

⁷ Rationality, they propose "appeals" because "we believe." Perhaps, then, it is a belief system, but that would counter their own argument.

Evidence-based policy-making, an offshoot of evidence-based medicine and now a fundamental component of the evidence-based movement, is presented in the literature that promotes it as a 'modernising' project. Consider the following description of evidence-based policy-making, located in a UK background document relating to international development. I want to signal evidence-based policy-making's ubiquitousness in policy circles (that is, it is not limited to health/care/medicine) and, more noteworthy, draw attention to its internal contradictions:

Where does Evidence-based policymaking come from?

[...] The term EBP gained political currency under the Blair administrations since 1997. It was intended to signify the entry of a government with a modernising mandate, committed to replacing ideologically-driven politics with rational decision making. EBP has now become a focus for a range of policy communities, whether government departments, research organisations or think-tanks.

What is EBP?

EBP is a discourse or set of methods which informs the policy process, rather than aiming to directly affect the eventual goals of the policy. It advocates a more rational, rigorous and systematic approach. The pursuit of EBP is based on the premise that policy decisions should be better informed by available evidence and should include rational analysis. This is because policy which is based on systematic evidence is seen to produce better outcomes. The approach has also come to incorporate evidence-based practices. (Sutcliffe & Court, 2005, p. iii)

This definition presents evidence-based policy-making as a normative approach with considerable appeal because it is new, different, modern, effective, and reliable – and results in “better” outcomes (contradicting the assertion that it does not attempt to directly affect the goals of policy). By positioning evidence-based policy-making as a

rationalist approach and in contrast to “ideologically-driven politics,” Sutcliffe and Court demonstrate their conviction that the political is problematic and should not (and cannot) contaminate policy-making. Other proponents believe evidence-based policy-making answers the call for a rational approach to policy-making that seeks to utilise research evidence for policy-making (Sanderson, 2009) just as it should for practice, according to Cronje and Fullan (2003). Nutley and Webb contend: “society appears to be guided more by politics than by science, and politics is more about the art of the possible or generally acceptable than what is rational or might *work best*” (Nutley & Webb, 2000, p. 14, emphasis added). Collectively, these assertions suggest evidence-based policy-making allows policy workers the opportunity to determine what will “work best” and avoid politics and the effects of ideology that allegedly have interfered with earlier policy-making processes. These arguments, as already noted, are *appealing*; they come across as common sense. Who would argue for decisions to be made on *less* evidence (Tenbenschel, 2004) or that evidence be ignored?

One of the most interesting features of the preceding quote is the way in which evidence-based policy-making enables the extension of the rationalist approach through the use of the language of “evidence,” which Cronje and Fullan link with rationality. The discourse of evidence signals an assurance of *truth* upon which we can confidently rely to generate the best policy. This (new-ish) language, in conjunction with arguments that this approach is modernising (Sutcliffe and Court, 2005), ground-breaking, even a

paradigm shift (Guyatt et al., 1992), are attempts to position evidence-based policy-making as a brand new model. These understandings deny any history, including the tradition of rationality in policy-making that has been proposed as the ideal approach for decades as I outlined earlier.

I argue that in the face of an increasingly discredited positivist framework, claims of evidence-based policy-making represent an effort to promote a new and modern approach to the work of maintaining the principles of rationalism (in new clothing), give rationalism renewed credibility, and signal the ability to purify policy-making processes from politics and ideology through the language of evidence. On close inspection, however, to the extent that the principles of rationalism are still firmly in place, the criticisms of both rationalism and evidence-based policy-making continue to be relevant. Rather than being an approach “whose time has come” (Young, Ashby, Boaz, & Grayson, 2002, p. 215), I argue that evidence-based policy-making promotes a continuation of rationalism’s positivist approach to both knowledge production and policy-making as well as an overarching scientisation of policy-making, which I discuss in the next section.

The insistence on rationality inherent in evidence-based policy-making assumes the epistemology of the larger evidence-based movement, which defines what counts as knowledge, as discussed in the previous chapter, and by default what does not, and how what counts can be known (Pal, 2006). Aligned with its rationalist precursors, evidence-

based policy-making's principles maintain the hierarchy of research methodologies and knowledge production of the entire evidence-based movement that prioritises the scientific method, particularly randomised controlled trials, as *the* way to produce knowledge (Asthana & Halliday, 2006).

Pure of politics and ideology: An impossible dream?

A rational approach to policy-making is mirrored in an evidence-based approach to policy-making in that it accepts facts as neutral and that an objective stance toward them can be achieved. It accepts these claims not only as unproblematic, but as essential to good policy-making. Central to this position is that scientific inquiry offers measures to eliminate that which contaminates objectivity and neutrality, particularly bias, subjectivity, politics, and ideology. Assumed, then, is a distinction between an apolitical approach to policy-making and political interference.

When she first began teaching in the field of policy sciences, Stone (2002) discovered this distinction when noting the ways in which her profession of policy studies viewed politics with disdain, as something that gets in the way of the good form of policy-making arising out of rational analysis. Rationality is seen as an answer to the problems of politics. Says Stone (2002):

From inside the rationality project, politics looks messy, foolish, erratic, and inexplicable. Events, action, and ideas in the political world seem to leap outside the categories that logic and rationality offer. In the rationality project, the categories of analysis are somehow above politics or outside it. Rationality purports to offer a correct vantage point, from which we can judge the goodness

of the real world. (p. 7)

Stone also provides an excerpt from Lindblom (1980) that provides a useful way to see the relationship between policy and politics:

When we say that policies are decided by analysis, we mean that an investigation of the merits of various possible actions has disclosed reasons for choosing one policy over others. When we say that politics rather than analysis determines policy, we mean that policy is set by the various ways in which people exert control, influence, or power over each other. (p. 26)

Like its rational approach kin, arguments for evidence-based policy-making claim it provides policy workers the mechanism to avoid political and ideological interference. Packwood (2002) suggests that within the evidence-based movement, researchers are similarly tasked to “put their ideological, methodological, and disciplinary ‘posturing’ on the side to produce valid and reliable knowledge” that can inform policy and guide practice (p. 269).

There are interrelated assumptions characterising the literature advocating a rational approach to policy-making. First: values, subjectivity, politics, and ideology are inherently bad; second: it is possible to approach policy-making outside of politics, ideology, objectivity, and bias; and third: that generalisable truths claimed by scientific inquiry are both possible and desirable. To those who accept these assumptions as legitimate, the claims of the rationality literature – the ability to follow a logical, linear rationality to produce apolitical, thus credible, policies – are enticing as the basis for good, reliable policy-making. However, it is a model that is based on highly restrictive,

some would even say fallible, epistemological assumptions. The rational approach to policy-making relies on principles inherent to scientific inquiry that are made manifest in the kind of research that can be drawn upon to inform the policy-making process, as well as in a similar set of assumptions that guides activities in the world of policy-making. This limiting of knowledge production for policy-making to scientific inquiry is important. It results in what some scholars describe as the scientisation of policy (Hoppe, 1999; Lather 2004; St Pierre 2006). The scientisation of policy binds policy workers to using research characterised by quantitative data collecting, counting, measuring, and predicting: features of scientific inquiry. As well, it requires defining policy problems and solutions using principles of science. If the solution must be found in scientific research, the problem must be framed in similar terms. As a result, when policy is scientised, it is limited in what it can attend to (that which is collectable, predictable, measurable, quantifiable) and how it can attend to those things, so as to 'ensure' policy can be said to be based on fact – without political interference.

Furthermore, Stone (2002) argues that instead of being outside politics, rational analysis itself is a "creature of politics" (p. 8) creating its own ambiguities and paradoxes to resolve. She challenges the belief that politics is fundamentally wrong and problematic, arguing that it is a "creative and valuable feature of social existence" (Stone, 2002, p. 8). Packwood (2002) also challenges the assertion that evidence-based policy-making is counter to, or outside of, ideology when she theorises this approach in

the context of education:

An evidence-based approach to policy is ideological in that it supports particular beliefs and values compatible with the dominant cultural paradigms that define how people and society function. At present these are determined by definitions of effectiveness as a quantitative measure, professionalism as performativity, teaching as technicist delivery, research as randomized clinical trials, and 'credible' evidence as statistical meta-analysis. (p. 267)

My study is focused on policy workers developing policies relating to chronic disease, therefore, I keep chronic disease in mind when reflecting on knowledge and its use in policy making. When policy workers rely on knowledge produced through scientific inquiry, particularly when addressing complexities associated with chronic disease, the aspects of life that rationalism deems not knowable are rendered invisible. Such invisibility does not protect the resulting policy from political interference, the alleged goal. Instead, such efforts to disregard particular issues as legitimate topics for health/care policy workers to consider shape and influence the ways in which matters of health/care and illness can be conceived of and addressed by policy. While the precepts of rigour, precision, and predictability may have served the natural sciences well, their application to social sciences and policy-making has deleterious effects (Wagle, 2000; Raphael et al., 2008). The messy stuff that cannot be studied using scientific inquiry is removed from consideration of policy workers when adherence to rationality is a goal. And living with chronic disease, I propose, involves much more than "natural science."

Limiting knowledge to scientific inquiry subjugates not only qualitative research methodologies but other forms of knowledge and knowledge production: post-

humanist critique (Denzin, 2015), the influence of critical qualitative research in the policy arena, and perhaps most importantly, Indigenous and ecological scholarship that is gaining increasing attention. Million (2013) offers the example of diabetes, a disease that has recently become rampant and is seen as part of the “crisis of chronic disease” (Reading, 2009; British Columbia, 2007a) amongst Indigenous communities across North America. Says Million (2013):

(D) diabetes prevention is certainly becoming an important focus in community health education. In positing that traditional foods take their place in preventative health strategies, Indigenous peoples also assert their epistemological frames on what those foods mean and a whole world of differently theorized practices. ‘Food’ profoundly organizes a sense of Indigenous polity; thus, any discussion of food is always a profoundly political one. (p. 171)

While there is no one “Indigenous way of knowing,” Million is proposing that Indigenous people have an “epistemological frame” that may differ from mainstream (health) research and must be considered as valid as scientific inquiry. Smith (2001) argues that Indigenous methodologies view cultural protocols, values, and behaviours as an

...integral part of methodology. They are ‘factors’ to be built in to research explicitly, to be thought about reflexively, to be declared openly as part of the research design, to be discussed as part of the final results of a study and to be disseminated back to the people in culturally appropriate ways and in a language that can be understood. This [...] is simply part of an ethical and respectful approach.” (p. 15)

The knowledges these approaches can bring to the policy development table are absent in the hierarchy of knowledge within the evidence-based movement. Furthermore, knowledge is equated with evidence is equated with science; these terms are used

interchangeably, perpetuating science's priority position.

I argue that rationalism and its current iteration in the form of evidence-based policy-making assumes an understanding of knowledge that is too narrowly understood. It limits what can be understood as policy problems and policy solutions. It ignores the politics inherent in policy-making and knowledge production. It leads to the scientisation of policy. Evidence-based policy-making not only is what it claims to oppose (an ideology), it venerates its own ideology. Evidence-based policy-making is a modernist project and its claim to distinguish facts and scientific inquiry on one hand from values and the political on the other does not, and cannot, exist and neither can the 'truth' claimed in literatures promoting rationalism. It is to this argument that I turn in the next section.

The effects of evidence-based policy-making – for policy workers

My reading of the vast policy-making literature suggests that an increasing amount of interest is paid to policy-making approaches other than rationalism. The burgeoning amount of literature advocating evidence-based policy-making alongside its influence as a normative model in policy-making settings, however, suggests that rationality and positivism continue to dominate. In my experience, the term "evidence-based" rolls off people's tongues with ease, as though they know what it is and how it should be practised. Holmes, Perron, and O'Bryne (2006b) call the evidence-based movement "dogma." As a normative model, rationality in its new identity of evidence-

based policy-making has come to re/occupy policy-making rhetoric; it is *de rigueur*. The claims of evidence-based policy-making – to newness, truth, and the rejection of political interference – are, indeed, powerful.

I am interested in how policy workers, particularly those who contribute to the development of policies relating to chronic disease, experience the effectiveness of efforts to purify knowledge they access in performing their work. Is their day-to-day work challenged by dominating discourses? How do the assumptions of rationalism, particularly evidence-based policy-making, influence their practice of policy work? Do policy workers recognise the efforts to keep rationality central and depoliticise their work? Do they experience these efforts as problematic? If so, how do they resolve these challenges? How might they resist? Are there alternative ways to imagine policy work that shift the focus away from the risk and individual behaviour and consider issues of social, economic, and cultural inequities and the effects of racist, sexist, homophobic, and ableist discourses, for example? What can I gather of policy workers' understanding of power – in relation to their work and the policies they produce? These are some of the questions that launched me into this study of the practice of evidence-based policy-making.

5. Evidence-base policy-making: An inquiry into discourses

The theoretical perspectives on epistemology discussed in the previous chapters converge with method to form the methodological approach to my study. Methodology is a statement on how researchers view the world and privilege particular ways of knowing. As such, choosing a methodology is a political action. This study (also a political action) is situated in a particular site in which policy is developed. It examines social (and political) practices and their contexts within (and without) this site. Central to these practices are practices of knowledge work: how knowledge is conceived of and how its production is understood, evaluated, and, over time, actively developed and incorporated, through policy work, into policy artefacts (e.g. advice, attitudes, guidelines, statements, documents, advertisements, and budgets etc.). Artefacts such as these are typically shared with and/or taken up by senior management in the bureaucracy and/or elected politicians, and eventually, practitioners and people governed by these policies. Policy workers are active agents in a process that they also, at the same time, are subject to: a discursive process. I argue that inherent in their practices are contested knowledges, power relations, politics, and the effects of discourse: the discourses of evidence-based policy-making. The conceptual and theoretical influences within my methodology are discussed in the previous chapters. This chapter goes further, presenting theories of discourse, power, and power relations

that are inherent to Foucault's theorising of knowledge and providing a way in to interpret the empirical material of this study.

Foucault, discourse, truth, knowledge, and power

In the previous chapters, I argued for critical perspectives on knowledge and knowledge production that are features of poststructuralism, which is at the foundation of my theoretical and methodological approach. Poststructuralism is often pitted against humanism, something St Pierre (2010) warns against. Rather, she suggests we think about what a poststructuralist analysis can do. For instance, Gottweis (2003) argues that poststructuralism "offers a number of well-defined epistemological points of departure to develop a distinct set of conceptual tools which lead to a new understanding of the policy process" (p. 247). It brings attention to "the concept of uncontrollability," a challenge for structuralism and its search for "general ordering principles and universal regularities, which make the world capable of technological and scientific mastery, which give clear orientation in a world which otherwise would seem to be out of control" (Gottweis, 2003, p. 247). Examining how language and discourse operate and carry meaning that shape our understanding of ourselves and the world in which we live, particularly through Derrida's concept of deconstruction – "looking at how a structure has been constructed, what holds it together, and what it produces" (St Pierre, 2010, p. 48) – are examples of poststructuralist perspectives useful to this study.

A fundamental feature of knowledge and knowledge production, particularly as

it relates to science and “technological and scientific mastery” is the concept of ‘truth.’ Truth is a problematic concept for Foucault (1980), who is interested in how “effects of truth are produced within discourses which in themselves are neither true or false” (p.118). Foucault theorises discourse as constituting truth, but truth in a moment of time. Discourses do not appear one day as if out of nowhere; rather, they have a history. And they are not static. New discourses will emerge to displace current ones, producing new conceptions and new subject positions. As it gains authority, each new discourse will become the truth in its moment of time, regulating practice in a new way, creating discursive shifts (Hall, 2001). There are official and unofficial discourses (Kingfisher, 2007), each contested and challenged (Carabine, 2001). These reminders of the fluidity of discourse show up in Foucault’s (1978) words:

(I)t is in discourse that power and knowledge are joined together. We must conceive discourse as a series of discontinuous segments whose tactical function is neither uniform nor stable. To be more precise, we must not imagine a world of discourse divided between accepted discourse and excluded discourse, or between the dominant discourse and the dominated one, but as a multiplicity of discursive elements that can come into play in various strategies. It is this distribution that we must reconstruct, with the things said and those concealed, the enunciations required and those forbidden, that it comprises; with the variants and different effects – according to who is speaking, his position of power, the institutional context in which he happens to be situated – that it implies; and with the shifts and reutilizations of identical formulas for contrary objectives that it also includes. (p. 100)

Here, Foucault offers suggestions as to how to understand some of the complexities of discourses, their contexts, and their production. But most importantly, he highlights the significance of power.

Power is essential and central to a Foucauldian analysis; it is what makes such an analysis inherently political. In Foucault's thinking, power is not an entity that can be possessed, wielded over another, or given away (as in empowerment). It is "not something that is acquired, seized or shared, something one holds on to or allows to slip away" (Foucault, 1978, p. 94). Rather, it is relational, evident when it is exercised or "put into action," and through its effects (Foucault, 1982, p. 788). Power does not exist in isolation but is always in relation; power relations re/produce discourse (Parker, 1992). Furthermore, Foucault (1984) links power to discourse and truth: truth can be thought of as being in relation to systems of power that, when exercised or enacted, produce and sustain truth. For Foucault (1984), power is productive:

If power were never anything but repressive, if it never did anything but to say no, do you really think one would be brought to obey it? What makes power hold good, what makes it accepted, is simply the fact that it doesn't only weigh on us as a force that says no, but that it traverses and produces things, it induces pleasure, forms knowledge, produces discourse. It needs to be considered as a productive network which runs through the whole social body, much more than as a negative instance whose function is repression. (p. 61)

And just as power is productive, so is discourse. Weedon (1987) captures many elements of Foucault's theorising of discourse and power:

Discourses, in Foucault's work, are ways of constituting knowledge, together with the social practices, forms of subjectivity and power relations which inhere in such knowledge and the relations between them. Discourses are more than ways of thinking and producing meaning. They constitute the 'nature' of the body, unconscious and conscious mind and emotional life of the subjects which they seek to govern. (p. 108)

This understanding of discourse offers insight into its productive nature. That discourses

have force, are active and productive, and have effects are central to Foucault. Foucault is concerned, according to Hall (2001), with the production of knowledge not just through language, but through discourse. Discourse produces knowledge, the objects of our knowledge, and the meaning we give to those objects. It governs how a topic can be meaningfully talked and reasoned about, and influences how ideas are acted upon and people are regulated.

Power is not *simply* repressive; people are not *only* either obedient or wielders of power over those who then obey. According to Foucault (1980), “there are no relations of power without resistances” (p. 142). As discursive strategies are productive of power, they are also productive of resistance; that resistance necessarily exists within power relations is fundamental to any Foucauldian analysis of power and discourse. In Foucault’s (1978) own words, “(d)iscourse transmits and produces power; it reinforces it, but it also undermines and exposes it, renders it fragile and makes it possible to thwart it” (p. 101).

We ‘know’ the ‘burden’ of chronic disease through discourse. We understand that this burden ‘exists,’ in part, through depictions of the percentage of the health care budget allocated for chronic disease, a percentage that grows when spending on other services is reduced. The discourse of ‘evidence’ takes on a very particular meaning in the literature promoting evidence-based practices. It is through the practices of scientific inquiry that a particular kind of ‘evidence’ takes on, or is produced as, the essence of

truth. However, if one believes that stories offer insight into people's lives, 'evidence' has a very different meaning. Similarly, we understand the 'burden' of chronic disease other than in economic terms when we witness people struggling to live well in the face of decreasing support services. Each set of discourses produces a 'reality.' Simply put, understanding the productivity of discourse is to understand its capacity to 'bring into being and effect' what is being talked about, the objects (chronic disease as burden, evidence as the result of randomised controlled trials) that are constituted through discursive practices (Jones, Lee, & Poynton, 1998).

Mills (1997) and Carabine (2001) argue that many dominant and official discourses "'hook' into normative ideas and common-sense notions" to produce "shortcut paths into ideas which convey messages about [...] acceptable and inappropriate behaviours" (Carabine, 2001, p.269). In doing so, they construct and maintain social norms and define and order thoughts and actions. Established norms, then, become instruments of judgement of conformity; we should all seek to achieve them and we will be measured against them (Carabine, 2001). People come to know what is un/acceptable and what is expected, and thus power is exercised through processes of establishing norms.

Through rules, discourse accomplishes effects. "(J)ust as discourse 'rules in' certain ways of talking about a topic, defining an acceptable and intelligible way to talk, write, or conduct oneself, so, also, by definition, it 'rules out', limits, restricts other ways

of talking, or conducting ourselves in relation to the topic or constructing knowledge about it” (Hall, 2001). Through discourse, people come to know the rules that govern them. For example, through the discourses of chronic disease and, particularly, self-management, we come to know how people with chronic disease ‘should’ act, what is expected, when it comes to managing their own health. Mills (1997) suggests that discourses are organised around practices of exclusion, thus the unsayables. In this manner, discourse is disciplinary in nature in that it governs what is thinkable and sayable and, thus, prescribes and penalises what is unthinkable and unsayable.

... In practices

Practice is a key feature of a Foucauldian interpretation of discourse. Discourse does not mean language understood merely as words to be dissected – or even as words held together under the umbrella of a “theme.” Rather, discourse implies that power inheres in language and can be understood as action and practice in sites for analysis (Sharp & Richardson, 2001; Hall, 2001). The term ‘text’ is often identified as the location where discourse is evident, where it does its work. Text often refers to spoken or written words. According to Carabine (2001), discourses are evident in the ways an issue or topic is “spoken of” through language, in speech and writing, but also through practice. One could argue that “speaking of” is not purely literal but also metaphorical, that text is not limited to words but extends to meanings and even implications. Parker (1992) offers a useful definition of text: “delimited tissues of meaning reproduced in *any*

form that can be given an interpretative gloss. [...] All of the world, when it has become a world understood by us and so given meaning by us, can be described as being textual" (p. 6).

Howarth and Stavrakakis (2000) argue that "discourses are concrete systems of social relations and practices that are intrinsically *political*, as their formation is an act of radical institution [...]. They always involve an exercise of *power*, as their constitution involves the exclusion of certain possibilities and a consequent structuring of the relations between different social agents" (p. 4 italics in original). Hook (2001) offers a comprehensive evaluation of the differences between a Foucauldian perspective of discourse that speaks of practice and what he calls "erroneous applications" (p. 522) of Foucault's concept of discourse, particularly found in the work of Potter and Wetherell (1987) as well as Parker (1992). Hook (2001) proposes that these authors do not sufficiently take up truth as a discursive *effect*, attained in discourse, nor the bases of power and forms of knowledge underlying truth claims. He argues that in order to centre analysis in political action, Foucault intends to "restore materiality and power" to what had been mainly a linguistic conceptualisation of discourse where analysis is limited to language and text (Hook, 2001 p. 523). "One should approach discourse less as a language, or as textuality, than as an active 'occurring', as something that implements power and action, and that also *is* power and action. [...] (D)iscourse *is* the thing that is done" (Hook, 2001, p. 532). Hooks' description of discourse perhaps is the

most informative to how I approached my analysis.

... In institutions

The ways in which discourses come to constitute – minds, bodies, subject positions, beliefs, issues, topics – are often through institutions. Foucault, says Hall (2001), was interested in how knowledge is put to work through discursive practices in specific institutional settings to regulate the conduct of others (Hall, 2001). According to Traynor (2004), discourses and discursive practices are reflected in, supported by, and serve to reproduce institutions. Institutions impose and reproduce what Foucault (1981) calls the ‘will to truth’ through practices, power relations, and how knowledge is put to work. Parker (1992) proposes that “the most interesting” discourses are the ones involved with the organisation of institutions. For Foucault, those institutions were prisons, asylums, and hospitals: institutions that regulated people as prisoners and patients. In the context of my interests in this study, similarly interesting institutions are universities (conducting research and systematic analysis of research and producing ‘evidence’), government ministries (analysing research to consider for policy), health care settings (treating patients with evidence-based medicine), and science (and the methods informing it).

Triantafillou (2012) argues that Foucault is interested in the “effects or political costs of producing knowledge in particular ways” (p. 12). As knowledge is re/produced through discourse, it gains authority and constructs or produces ‘truth’ (Hall, 2001).

Scientifically produced knowledge (as in randomised controlled trials) gains authority because of the authority claimed by discourses of scientific inquiry. This knowledge influences the way people understand, think about, experience, and respond to a particular issue (Carabine, 2001). Hook (2001) asserts that “the strongest discourses are those that have attempted to ground themselves on the natural, the sincere, the scientific – in short, on the level of various correlates of the ‘true’ and reasonable” (Hook, 2001, p. 524). I argue that evidence-based policy-making is one of these strong discourses. In his critique of evidence-based medicine, Murray illustrates the power of scientific authority that has led to the ascendancy of evidence-based discourses: “evidence-based practitioners, much like Milgram’s subjects,⁸ reap institutional rewards and the pleasure of ‘a job well done,’ dutifully capitulating to a scientific authority that is authoritative merely because it has the institutional imprimatur of Science” (Murray, 2009, p. 101). Chapter three presents a fuller discussion of the theoretical considerations of the evidence-based movement. But it is clear that the assumptions inherent in the evidence-based movement about knowledge, truth, and science situate it as an approach to policy-making for which discourse is an entirely appropriate tool of analysis.

The ‘how’ of discourse

In the process of constituting subjects, entities, and relations, according to Foucault (1979), discourse also “conceals their own invention” (p. 27). It is the process

⁸ A reference to Stanley Milgram, a psychologist at Yale University who, in the 1960s, conducted a series of experiments examining the willingness of participants to obey authority figures

of discourse analysis that can excavate the mechanisms through which discourse works. Indeed, it is with questions of “how” that Foucault (1982) recommends one begin an investigation where power and knowledge are central. A Foucauldian-inspired analysis emphasises identifying and analysing discursive practices that produce and reinforce power relations and claims to truth. Rather than asking about the truth of an argument, it encourages researchers to ask “how, why and by whom truth is attributed to particular arguments and not to others” (Sharp & Richardson, 2001, p. 197). Barrett (1991) proposes “The word *how* is the key to Foucault’s concept of power” (p. 136). *Who* questions associated with power must be examined in conjunction with *how* questions – “the how of power,” changing the object of analysis to power relations (Barrett 1991, p. 136). Thus, I have phrased my overarching research inquiry with *how*: *How do policy workers do evidence-based policy-making in the context of chronic disease?* This question has stayed with me since the beginning of my doctoral program and has been instructive in how I proceeded with my research and writing.

Above, I present an interpretation of discourse that offers me a framework for an analytic approach that proves most useful in my research. There is no one method necessarily associated with this approach to analysis, a feature that some find frustrating. Parker (1992) and Potter and Wetherell (1987) attempt to offer steps in undertaking a discourse analysis, perhaps in an effort to assist people to get beyond feeling immobilised by “no method.” After arguing that “to prescribe a methodology

would be “un-Foucauldian [...] (T)o do so would afford a particular position the status of truth in a perspective where truth is always conditional,” Hewitt (2009, p. 3) presents an adapted, and ordered, version of Hajer’s ten steps of “doing discourse analysis” in public policy research.

In my study, I did not take an approach whereby it was necessary to follow particular steps. In some sense, I hesitate to formalise the term “discourse analysis” as the methodology underpinning my research. Rather, when embarking on my analysis, I read proposed steps as suggestions of the kinds of specific steps and analyses I, as a researcher, might (and eventually did) undertake: collection of documents for analysis, engagement in interviews with key participants, analysis of power and practices, and, more broadly, interpretation of those actions that produce particular effects.

Discourse, analysis, and the policy-making process

Marston (2000) sees policy-making as a “communicative event structured by a range of competing discourses, in which there are unequal outcomes for different policy participants” (p. 349). This interpretation of policy, one that recognises the political nature of policy-making and the centrality of discourse as a theoretical and methodological category for understanding how the process of policy-making works (Marston, 2000), presents a scenario suitable for discourse analysis. According to Howarth and Stavrakakis (2000), discourse analysis allows for a political analysis of the formulation and implementation of public policy. Such an analysis acknowledges that

policy work is neither neutral nor without effects. Foucault's thinking about the production of discourse, suggests Hewitt (2009), raises questions about the practices of government and how public policy is formed, shaped, and reshaped. According to Howarth and Stavrakakis (2000): "Analysis of discourses has the potential to show the link between political rhetoric and how discourses are created and maintained. Foucault's concept of power acknowledges the diverse influences of social and political relations on policy, beyond the immediate political arena" (p. 5). The relevance of this statement became apparent as my analysis proceeded.

As I argued earlier, a key debate in the policy literature is the role of rationality in policy work. This debate is central in discussions about the scientisation of policy-making and the epistemological assumptions of scientism (Torgerson, 2003), particularly evidence-based policy-making. I have argued that the discourses of evidence-based policy-making perpetuates a rational approach to generating 'truths' upon which policy workers (and those who are governed by policy such as practitioners, people with chronic disease) can confidently rely. According to Sharp and Richardson (1996), Foucault does not condemn rationality outright. Rather he is interested in "how rational and/or irrational arguments may be appropriated as 'truth' through the exercise of power" (p. 197). Richardson (1996) argues:

(T)his obsession with establishing or disproving the credentials of rationality blinds us to the simple fact that policy is shaped by arguments, or discourses, based on knowledge claims which may be rational or irrational, reasonable or unreasonable. The shaping of policy, however depends ultimately not on these 'surface' characteristics of rationality, but on a deeper dynamics of power and

knowledge within and between discourses. (p. 279)

Discourse analysis's focus on knowledge, power, and discourse, or as Richardson (1996) puts it, "the way in which power appropriates knowledge, and weaves it into discourses," (p. 280) makes it a useful approach to investigate policy work, particularly to investigate an approach to policy-making advanced because of its claim to rationality and truth-seeking. Furthermore, my approach to analysis was influenced by Richardson's argument that policy is shaped by "dynamics of power and knowledge within and between discourses." Looking for these dynamics became my approach to the doing of discourse analysis.

Foucault (1981) posits that the 'will to truth' is exclusionary and "rests on an institutional support: it is both reinforced and renewed by whole strata of practices [...]. But it is renewed, no doubt more profoundly, by the way in which knowledge is put to work, valorised, distributed, and in a sense attributed, in a society" (p. 55). These notions are central to my research interests and to how I approached my analysis. I advance the claim that knowledge is "put to work" in particular ways – ways that can be excavated through an analysis of discourses constituting policy work; a particular knowledge – indeed, truth – is certainly "valorised" in the claims made by proponents of evidence-based policy-making and "attributed" to a scientific method. Discourse analysis challenges the very notion of truth. It is not a methodology that seeks to produce, speak, or locate (Carabine, 2001) a truth but seeks to understand how truth is

produced (Hook, 2001). Says Hook (2001):

The methodological imperative (of discourse theory) stemming from these formulations (in the 'will to truth') is an unrelenting scepticism towards all those rationales, explanation and statements that would validate themselves on the grounds of their proximity to a supposed truthfulness. The methodological injunction here is to replace these 'true' explanations with some other form of answer that is more conditional, that can demonstrate that what counts as 'the truth' is a product of discourse and power: a displacement of the will to truth by the will to power. This is a methodological tactic that will not only make overt certain conditions of possibility (certain contingencies underlying 'the truth'), but that will likewise prove a vital means of sensitizing the analyst to the pervasiveness of the power-knowledge complex. (p. 524)

"Policies enable this (process of dominance and exclusion) to happen by setting a political agenda and giving institutional authority to one or a number of overlapping discourses" (Shore & Wright, 1997, 14). What, then, are the competing or overlapping discourses? How do they reveal political agendas? How do they 'speak' about and produce objects (chronic disease or evidence, for example)? Where are examples of power in action and resistance? How do current institutional arrangements operate to promote particular forms of policy practices? These are questions I asked of my empirical material.

A discourse analytic approach enabled me to examine the places in policy work where meaning-making occurs and analyse the (discursive) implications of those meanings and their implementation through policy. I also looked for strategies in which discursive elements came into play. Jones et al. (1998) propose the following:

(A)s analysts, we are concerned, not so much with negative critique of the undesirable effects of the exercise of power through policy, though contestation

of particular policy effects is sometimes necessary, but rather, with the conditions of possibility of policy meanings and policy effects, and with the positions made available for individuals and institutions within those meanings. (p. 149)

This quote is a reminder that alongside my interest in how particular discourses work, I am also interested in how things might work differently – how policy workers do things and (might) do things differently. As noted earlier, discourses are found in and are formed by words and texts, as well as actions and practices. Words show how we understand the world. And, says Gill (2012), “the way that the policy workers talk about policy reflects how policy is done. And looking at what they say tells us something about policy practice” (p. 85). The talk gathered through my interviews do tell quite a bit about policy practice and are the focus of chapters seven and eight.

A Foucauldian-inspired understanding of discourse offers a strong theoretical foundation for a methodological approach that is not focused just on the spoken/written wor(l)d, but also on the social world of everyday practices as well as the specific professional world of policy development. Compelled by Foucault’s assertion that discourses are historically and socio-politically situated, I am interested in the (shifting) contexts of policy relating to chronic disease. Given the current prominence of and credibility attributed to evidence-based everything, in this dissertation, I examine discursive strategies and practices in policy-making processes and the contexts in which they occur. I analyse what is said and what is left unsaid; how particular discourses operate in order to enable those things to be said and to sequester other forms of

speaking and engaging in action in relation to health practices (and policy-making); how particular discourses come to dominate while others are marginalised or excluded; and how particular discourses are practiced.

Research inquiry

Throughout the previous sections and chapters, I have placed my interest in the forefront. I resist maintaining the scholarly tradition of posing *a* research question; it is not just one question that is the focus of my inquiry. So I pose the large, overarching interest and argue it is about this interest that I seek to learn – and to share: *how do policy workers do evidence-based policy-making in the context of chronic disease?* An analysis of discourse, power, and governing became the analytic process I undertook.

The social practice of policy work

Academic accounts portray policy-making in distant and abstract terms. They make the process appear orderly, rational and linear; if they are peopled at all it is by cognitive beings only. Academic accounts do not describe the dynamic interactions [...]. They do not reflect what I know about how people actually live 'policy-making.' Lived policy-making is characterized by serendipity, by sudden, irrational changes and unexpected, unpredictable events. It is full of actual thinking and feeling people doing actual jobs... (Church, 1995, p. 8)

While the intent of Church's work is not to critique the vast body of academic literature on policy-making, she notes her recognition of "lived policy-making" as a place of contention, arguing that it is far less orderly, rational, and linear than some of the academic literature would suggest. Church draws attention to a place where actual work

is done: the world of policy-making where “thinking and feeling people (are) doing actual jobs.” It is this world that I situate my inquiry. And I share Church’s stance. In part, this dissertation is an attempt to expose the “actual work” done and humanise the “thinking and feeling people” who are doing this work and are often relegated to the category of “the government” or the system” in critiques of policy and its development.

Church’s observations point to two features of policy-making that interest me in relation to this study. First, she signals the mainstream literature that frequently presents a rational approach to policy-making, to which I referred earlier and I argue that the rational approach’s current iteration is evidence-based policy-making. Second, Church opens a window on the policy-making process that has remained largely shut in mainstream literatures. Policy-making is a practical endeavour. It involves, as Church notes, actual people doing actual work. There are scholars who endeavour to shine a light beyond actor-less discussions and on workers engaged in policy-making activities, connecting the work, those who do the work, and the context in which they do this work (Yeatman, 1998; Colebatch, 2006a and 2006b; Petticrew, Whitehead, Macintyre, Graham, & Egan, 2004; Maybin, 2013). In my research, I have opened this window further by examining and developing an understanding of the policy-making environment and space (theoretical, epistemological), and everyday work policy workers undertake when they engage in the processes of doing the practical endeavour of evidence-based policy-making. As noted in the introduction, the daily work of policy

workers has not received the attention it deserves in the academic literature (Radin, 2000; Howlett & Wellstead, 2012; Tenbenschel, 2006; Freeman et al., 2011) and little research has examined in depth the effects of evidence-based policy-making on this daily work, particularly from a critical perspective. It is by following the “actual” work of policy workers that I will understand how they make sense of the knowledges that come their way and either incorporate it into their work or, equally important, set it aside and how they account for this “sorting” of knowledge and evidence.

Chambon likens the examination of practice to an “unearthing of daily details” that are often neglected or treated as though they “don’t matter” (Chambon, 1999, p. 60). Kingfisher (2007) would likely agree:

The literature on those who construct and make policy decisions regarding minorities of various sorts is not nearly as comprehensive, despite calls to *study up* [...] and to interrogate the cultural systems of those whose categories are dominant [...]. Although information on policy makers and/or dominant frameworks is often provided as context [...] it is not nearly as often foregrounded. (p. 93, italics added)

In her research, Kingfisher’s “study up” – studying from the ground up – is taking as her “object of study those whose object of study and interest is the homeless” (Kingfisher, 2007, p 93). Similarly, this dissertation is based on a “study up,” taking as the object of my study those whose object of study is (allegedly) chronic disease, foregrounding the daily details of policy workers working within the dominant framework of evidence-based policy-making.

I argue that evidence-based policy-making represents a re/surgence of the principles of the rational approach and has the potential to scientise policy. With a heavy reliance on research findings that are measurable and causal, by default, it must assume policy issues are understood in similar epistemological ways, limiting what issues can be considered health and, thus, addressed to those that can be quantified, measured, and described in terms of cause and effect relationships. A narrow approach to knowledge production and a narrowed conceptualisation of health sets the stage for an equally narrow approach to policy-making that insists on scientifically produced knowledge, which serves to limit what is knowable and how it can be known. With this epistemological and ontological stance, the many features of life that have a profound effect on health are disregarded and left unattended yet continue to effect people's health. These arguments are important because they demonstrate how evidence-based policy-making defines that which is the purview of health/care policy workers. Health, understood in narrow technical terms because of the dominance of scientific inquiry, translates into how policy is developed and implemented but particularly, what is deemed to be ir/relevant for health policy development. In this model, is it in the purview of health policy workers to attend to the potability of water or the prevalence of mould in houses on First Nations' reserves? Does it make room for linking these conditions with the "crisis of chronic disease" amongst First Nations in Canada (Reading, 2009)? Policies that manage individual bodies by attending to the biomedical or disease

and the delivery of care for disease are health care policies rather than health policies (thus my reference to health/care throughout this paper). As either a normative or descriptive model, evidence-based policy-making gives precedence to the biomedical and the technical; it is both individualist and individualising and the conditions of daily life are off the radar.

My commitment to social justice informs my interest. The principles of evidence-based policy-making represent an effort to de-politicise health/care policies and health itself. But I believe that health is deeply political; any attempt to suggest otherwise is unjust. And as Latour suggests, removing the political, by which he means the social, the biased, the contingent, is impossible. A guise of purity cannot be sustained; I imagine that these efforts break down *eventually* in the day-to-day work of policy workers and, perhaps even sooner in the lives of people with chronic disease governed by policies.

What might an approach guided by principles of social justice look like? There is literature that calls for attention to dimensions of difference that contribute to health disparities and people experiencing policy differentially such as race, gender, income, sexual orientation, and the availability of services (Weber, 2006; Raphael & Bryant, 2006; Raphael et al., 2008; Coburn, 2000; Coburn, 2004). Much of this literature seeks to incorporate the social determinants of health in policy work, often attending to political contexts (Raphael & Bryant, 2006, for example). Weber (2006) considers social inequalities as power relations, not resource (income, education) differences between

people. Her alternative to positivist epistemologies that come with a biomedical paradigm is a feminist intersectionality where researchers are engaged subjectively, reflexively, and critically, paying attention to social location (theirs and others). Weber does not recommend abandoning the dominant discourses but seeks to engage with them on a more equal footing. While this sounds like the politicising work of Hankivsky et al. (2004), the questions Weber asks and her claims of working toward social justice appear quite different. Rather than policy being guided by research evidence (through what is called knowledge translation or iterations thereof), Weber calls for a social change agenda where a bridge is built between academic theory and social action. Although Weber (2006) theorises in the American context, her examples are relevant in Canada.

Understanding the role of power relationships enables us to shape interventions that differ from approaches emerging from a biomedical paradigm where the focus would more likely be on changing the values, behaviours, cognitions, or even biochemical processes of individual(s). [...] When social inequalities are viewed as power relationships, the ways in which dominant groups benefit from denying others adequate child care and medical access, for example, become a focus of attention. So changes that might alter the balance of power – a living wage; shifts in workplace control; universal, affordable, quality child care; accessible public transportation; safe and affordable housing; equal access to quality education; and universal prevention-focused health care – become the preferred interventions. While the former may change the lives of those involved in targeted programs, the latter is more likely to effect change that would significantly reduce health disparities. (p. 39)

Might viewing all public policies through a social justice/health lens make visible the connection between health and policies not typically seen as health related? Rather

than focusing on individual behaviour such as smoking as causes of ill health, perhaps social, economic, and political conditions could be examined for their relationship to health. Whose questions define health research and policy agendas? How possible is it to move beyond individualistic and individualising approaches to policy that minimise the opportunity for critical thinking?

This chapter took the theoretical concepts of previous chapters and situated them in the context of an analytic framework for my study. I presented concepts of knowledge, power, and discourse – largely from a Foucauldian perspective – to illustrate how I will approach my analysis of the empirical material. I also examined social practices of policy work, particularly in the context of health/care. The next chapter speaks to the practical considerations of my study as it explains how I conducted this research.

6. Methods

A reflection of research

“Simplicity, I’m asking you to say, won’t help us to understand mess” (Law, 2003, p. 2). I find some comfort in this statement. Previously, I explained how evidence-based policy-making is something whose goal is to bring clarity and certainty but is, as a set of practices, actually quite messy. In this chapter, I describe, in an orderly fashion, how I might go about this task, in an orderly fashion – but one capable of understanding the messiness of everyday practices of policy-making. The research conducted for this study required a plan. I needed to substantiate, outline, and follow up on this plan with some kind of justifiable method, and, after a while, write the whole thing up in the form of this dissertation – this writing. The very act of writing requires me to make an argument and to order ideas. I have drawn on theorists whom I trust because their arguments appear logical and rational to me and I have applied their argument to my area of interest to make a point. My writing appears in a linear fashion as if the order in which it appears is how it should be read and how I got to the end of the argument and the end of the dissertation. I have made headings to order (even hierarchise) my thoughts and yours. I am trying to be logical and to point out the illogical aspects of “other” arguments. I aim to contribute to knowledge, a concept I am problematising, and in the following pages, I attempting to rationalise (!) my analysis. Thankfully, I know full well that simplicity is nowhere in sight. But I am very conscious in this study that I

am engaging in the acts that I am examining and problematising: ordering, clarifying, generating knowledge, rationalising, trusting and asking for trust, and making sense of mess. What a modernist endeavour! The irony is not lost on me and it keeps me not only grounded but also humoured.

My point in this dissertation is not an attempt to dismiss science; I am grateful for the science behind medication that can save lives, for example (and yet I am aware of the impurities of this science). And I trust that they will work even though I have no idea how. But I wish the attention given to developing pharmaceuticals would similarly be given to examining the pollutants that may contribute to chronic disease in the first place. And I wish for an acknowledgement of the role science played in the creation of those pollutants – in the name of progress. Surely, there is evidence, if you will, connecting pollutants to ill health. Yet I wonder how *that* evidence is taken into account and if it is deemed too political. Just as surely, since science can create pollutants, it can create a way for us to survive without them – in the name of progress, for we may not survive with them – and that is a very material effect. This dissertation is about the politics of evidence, knowledge, and knowledge production – all evidence, all knowledge, all knowledge production. Rather than dismissing science completely, I want to shake up the ground upon which the evidence-based movement rests so comfortably. I have attempted to read against the compelling arguments in favour of evidence-based practices that abound, to problematise their simplistic presentation.

That the canonical nature of evidence-based practice plays out on bodies and lives compels such a critical examination.

Methods serve an inquiry; they do not drive it. Researchers choose methods that will allow them to collect material relevant to their inquiry; methods are practical activities supported theoretically to align with methodology. In this chapter, I describe the methods I undertook in my study to understand how policy workers do evidence-based policy-making.

To facilitate my inquiry, I engaged in a case (or field) study, borrowing elements of ethnographic and organisational studies. A case study allows researchers to study in detail the particularities and complexities of a single “case” (Stake, 1995, p. xi), preserving the “holistic and meaningful characteristics of real-life events” (Yin, 2009, p. 4). Each case shares similarities with other cases but also offers uniqueness worthy of study. Ethnographies examine patterns, relationships, understandings, and meanings. Ethnographers “read” these meanings to make sense of a place in relation to social settings, relationships, and other contexts (Parthasarathy, 2008). The “place” in an ethnographic case study is the “case” – or site or location – at the focus of the inquiry. Case and ethnographic studies share a requirement of the researcher to enter into the world of people in the site – “*in situ*, finding them where they are” (Scott, 1965/2013 p. 261) – what Latour (1987) might call their laboratory.

In choosing case or field study of a particular site, the insight I gain about a

particular site (in my study, evidence-based policy-making at the B.C. Ministry of Health relating to chronic disease) can be considered in understanding other sites. I am not suggesting generalisability but my findings can shed light on evidence-based policy-making practices that could then be explored as to similarities and differences in other settings. I chose a provincial ministry because governments are places where policy-making happens, especially policy relating to health/care. Furthermore, governments are places where people claim to be “doing” evidence-based policy-making. It is also a place that is public: it is not a private industry that is unaccountable to the public. Within current conceptualisations of neoliberalism, which emphasise accountability and transparency, telling how things work may be something governments are accustomed to or feel an obligation to do. My theoretical interest in knowledge can be well examined in a location where (multiple) knowledge(s) is/are taken up (or not) and reflected (in myriad ways) (or not) in policies.

Site (case) selection

I chose the British Columbia (B.C.) Ministry of Health because I live in B.C., in the capital city of Victoria where the Ministry headquarters are located. I am familiar with it; I have paid attention to public presentations of the Ministry (media, documents) for many years. I know the British Columbian context – socially and politically. Proximity and relevance are important. And, most importantly, I know this Ministry makes claims of evidence-based policy-making. Chapter one explains why chronic disease is an

important and timely context in which to examine evidence-based policy-making. Chronic disease puts a boundary on my inquiry; it serves a purpose in the design of the research in that it helps me to situate the interviews in a context rather than asking broadly about evidence-based policy-making. Focusing on one site allows me to dig deep and broad, be more thorough than had I accessed more 'cases,' and to gather an expansive picture of how people in this site 'work up their work.' The Ministry of Health is akin to Latour's idea of a laboratory into which I would glimpse to understand this work.

Stake (1995) proposes an approach to case study that involves informal "backgrounding": making early observations and impressions as one gets to know the case prior to formally undertaking the study (p. 49). For years, I have been interested in aspects of health, health care, and health systems. As a result, I paid close attention to media reports on this ministry (and other ministries in B.C. and elsewhere) and stories of people I knew who worked within this ministry or Minister's office (and elsewhere in the B.C. government bureaucracy). Thus, long before I translated my interest into the focus of this study, I was "backgrounding" and collecting informal empirical material that informed my research. Prior to approaching the Ministry of Health to begin the formal study, I spent time exploring the Ministry website and documents, familiarising myself with its organisation and mandate. Drawing on Sharpe and Richardson (2001) and Parker (1992), who argue for the importance of looking beyond the written text, I

consider as part of the empirical material of my study the socio/political context of B.C., particularly in the last 15 plus years of the current provincial right-wing B.C. Liberal government. Teghtsoonian (2009) suggests B.C. is oriented toward neoliberal policy orientations, having “vigorously pursued neoliberal reforms in several policy arenas, including health, education, social assistance and labour relations” (p. 29). This context (and having experienced the effects of this orientation personally) became part of the backgrounding and informs my analysis here.

Entering the site

I entered the site of my study – branches of the B.C. Ministry of Health in which policies relating to chronic disease are developed – through two entry points: i) the Ministry of Health website, where I located the two government documents on which I focused my attention and ii) a senior manager at the Ministry, through whom I accessed policy workers to interview.

Discourses are manifested in the public representations of the Ministry and its workings, making websites and public documents appropriate material to investigate. I had monitored the Ministry’s website for a while before I officially began this study. I bookmarked relevant pages,⁹ noting issues, language, priorities, and people who appeared on those pages as well as changes over time. I also searched the on-line B.C. government directory for names of divisions and branches (and the people positioned therein) as well as their hierarchy, seeing these hierarchies as signalling priorities and

⁹ Retrospectively, I wished I had the technical know-how to capture those websites because they changed frequently and were often no longer available.

language used within the ministry. Time spent looking through the website was part of my backgrounding work and offered a context in which to analyse the government documents and interviews. The two policy framework documents with which I spent the most time and take up in this study were published and distributed by the Province of British Columbia. They are: i) *Promote, Protect, Prevent: Our Health Begins Here, B.C.'s Guiding Framework for Public Health* (British Columbia, 2013) and ii) *The Healthy B.C. Families Policy Framework: A Focused Approach to Chronic Disease and Injury Prevention* (British Columbia, 2014).

Most of my analysis, however, is of interviews with policy workers. A colleague had introduced me to a woman she knew who had years of experience working within the Ministry and who, until just prior to my receiving ethics approval and formally beginning this study, was an executive director in a branch that had as part of its mandate aspects of chronic disease. I discussed with her my research interests; she offered her support. Following her invitation, I went to a team meeting in 2012 and met most of her team members who she thought were potential participants. She made further suggestions of people who, because of their position at the Ministry, would be appropriate for my study. All these names and positions are available on the B.C. government directory website (British Columbia, n.d.) along with the contact information for most of them. Following my receipt of ethics approval, I sent *Invitations to Participate* (see Appendix 1) to people whose name and contact information I had

and interviewed those who expressed interest. I met all but two in their offices or an office in their building. I met the other two in a coffee shop near their office. At each interview, I inquired of the participant who else they thought might be helpful for me to interview. By using this purposeful snowball method of recruiting participants (Miles & Huberman, 1994; Noy, 2008) – inviting to participate those who were identified by their colleagues as dealing with some aspect of chronic disease or considered the area in which they worked relevant or relating to chronic disease – I was able to ensure that I was inviting as many appropriate policy workers as possible. In keeping with research ethics and my commitment to participants as outlined in consent forms (Appendix 2), to maintain their confidentiality and anonymity, I do not identify the names of specific branches, divisions, programs, or focus of their work. Surprisingly, no branch or division is very big and to identify a person's branch or area of focus would compromise her/his anonymity. I can say here that I contacted policy workers in every branch that was recommended to me and met people in all but one of them (the person I contacted in the remaining one said they were understaffed and too busy to meet with me). I interviewed 16 policy workers including entry-level policy analysts (all who had, however, worked for government in either the Ministry of Health, another ministry, or in another jurisdiction for at least several years), senior analysts, managers, and executive directors or equivalent level.

Approach to interviews

It was during the interviews that I could inquire into how evidence-based policy-making is done. I have done a lot of interviewing for research projects since I entered graduate studies (and a lot of interviewing for my paid work prior), and have used different technologies as they became available, beginning with the use of cassette recorders and graduating to digital recorders. I have noted a marked difference in the atmosphere of interviews that were recorded digitally. Digital recorders are small devices with no (or very small) blinking lights. Because they have good quality recording capabilities, they can sit to the side and be out of the way. They also can record for hours at a time with no need for me to stop and turn over a cassette during the interview. Thus, the interview is not interrupted by technology. I am convinced this quiet, unobtrusive technology results in people being at ease, almost forgetting they are being recorded.

My interview style is one of a conversation, and it remained so in these interviews. While I had a paper in front of me with a list of questions I wanted to cover before ending the interview, I was not glued to it. Rather, I began with a first question and launched into a conversation based on their responses. So, rather than a question/answer encounter, we had a discussion, what Kvale and Brinkmann (2009) calls an inter action. Usually, they were relaxed discussions. Several people expressed pleasure in being asked thought provoking questions, telling me “I have never thought

of that before; it is interesting to think about.” I was genuinely interested in what they were saying and for the most part, I thought they were happy to be able to talk about their work. The friendly, almost casual, nature of the discussion put them at ease, I think – or at least hope. And I believe the discreetness of the recording technology added to this feeling. As a result, I had the sense that many people were being very frank with me. On a few occasions, it felt almost like a confessional – like they were telling me something they had not told anyone before: “I hate to admit it but...” or “confidentially.” This honesty is the gift of anonymity and confidentiality, which I take very seriously. People can say things they want others to know without feeling like they are “talking out of school” or risking their job. I believe that happened in many of these interviews. And because of this honesty, our interaction tells quite a bit about how evidence-based policy-making works.

I know from my own practice experience and through my reading of the literature and documents of the Ministry that “evidence-based policy-making” dominates. However, in presenting my research interests to policy workers I wanted to interview, I did not want to use the language of “evidence.” I did not wish to suggest to participants the concept (evidence-based) I wish to examine, thus leading them in a particular direction or to frame their responses accordingly. If I introduced the language of “evidence,” I could be limiting their responses to my interest; I wanted them to tell me the framework in which they operate. I presented my interests in broader terms,

using language such as knowledge, knowledge production, research, and the relationship between these concepts and policy work. My goal was to leave it open to discover what language and concepts they use to describe their work. If the language of “evidence” really did not come up, I intended to ask about it in the interview, pointing out that I read on the government website references to evidence-based policy- and decision-making and solicit their views. As it happens, I only had to bring it up a few times as “evidence” was at the top of their mind during our discussion.

I conducted semi-structured interviews in order to draw out, hear about, and understand the daily practices of policy workers – in their own words. (See Appendix 3 for interview guide.) Policy workers’ accounts became the main empirical material for interpretation. My initial interview questions were broad because it is the full picture of their work that provided me with the context of their understanding and use of this approach, which I focused in on as the interview progressed. The interview questions continually built upon each other, allowing me to delve more deeply into what participants said.

The digital MP3 recordings of the interviews were transcribed – some by myself, some by a transcriptionist. I listened to the recordings of interviews done by the transcriptionist to guarantee accuracy. Each MP3 was a password-protected file, as were each *Word* document of the transcript. Transcript word documents were then given names of the pseudonyms I gave each participant. Throughout the rest of the

dissertation, I refer to participants by their pseudonyms. I chose to use pseudonyms rather than numbers to contribute to my attempt to humanise the policy workers; while I cannot put a face to them in this dissertation, I can put a name to them to help the reader to think of them as 'real' people.

Analytic approach

In keeping with the earlier discussion on Foucault and drawing on the work of Bacchi (1999, 2000, 2009), I read the government policy framework documents for how they re/produce the discourse of evidence and evidence-based, how they represent chronic disease, giving shape to it as a problem, and their strategic approach to future policy development undertaken by policy workers. As I analysed the interview transcripts, I often referred back to the policy framework documents. In my approach to analysis, I was seeking to make connections between how the documents instruct policy workers to think about both their work and chronic disease, and then how policy workers actually did talk about them.

I approached my reading of the interviews cognisant of Gill's (2012) claim that policy workers' talk will tell me something about policy practice. Kvale and Brinkmann's (2009) proposal that "with the loss of faith in an objective reality that can be mirrored and mapped in scientific models, attention must be paid to discourse and negotiation about the meaning of the lived world" (p. 54) is consistent with my theoretical perspective in this study. It is in interviews with people in the midst of this lived world

where conversations about daily life can be had. I embrace Kvale and Brinkmann's (2009) thinking that an "inter view" is an "inter action" between the interviewer and interviewee in which there is an "inter change" of ideas. Kvale (1996) also notes an interview is a conversation or dialogue between two people about a topic of shared interest. The inter action I had with participants, then, were conversations in which ideas were exchanged and concepts and theories were discussed (and revealed) under the broad focus of "how do you do your work here (when you do evidence-based policy-making)?"

Language is the medium through which the inter action – the interview – is rendered active. Interview talk is "*interpretation work*" (Talja, 1999, p. 464) about a topic – in this study: policy-making. I would argue there was interpretation work during the interview by both me and by the people I was interviewing. This (shared) work is available for further interpretation (analysis) (by me) because it leaves behind traces – texts, constituted by words and language (and observation) – and by following the conversation as it evolves in particular ways – and not other ways, meaning is being made. The meaning represents ways in which knowledge is conceived of, mobilised, and/or challenged and power is enacted in order to accomplish particular work – policy work. In the language, there is action. There is a recursive process: knowledge informs action, which informs knowledge. As a qualitative, interpretivist researcher drawing on poststructuralist ideas, I come to my analysis well aware I do not have a "value neutral"

stance. I am not a detached observer; I am a participant in the interaction. For each transcript, I created a table of two columns and put the transcript text into the column on the left leaving the column on the right for my analytical comments. The policy frameworks and the interview transcripts became the texts constituting my empirical material with which I engaged in interpretative readings.

With each text, I began by using the search function in the Word program for the word “evidence,” highlighting each usage. This gave me a visual representation of where in the discussion the concept appeared – the first line or ten minutes in, for example, and who raised it – and how. I read the text around this word just to see how it was being used. Then I started from the beginning and read each transcript slowly, to get the picture each participant painted for me. I read each transcript through and made notes on the right column on what stuck out as relating to evidence, knowledge, truth – either through precise words or description and how they understood the concept and worked with its material representation. I asked questions of each text in order to reveal: how chronic disease and people living with chronic disease were constructed; discourses, including how they work, what (knowledge) they produce, and how they shift, contradict, are shared, and are resisted; what discursive strategies are at play; examples of power in action and in relation and how discourse is re/produced in these power relations; and how concepts of truth and knowledge are taken up, produced, sustained, and/or challenged. With each reading, my analysis deepened until I could

almost visualise an unravelling of discourse. I present this unravelling, based on an interpretive read of the two sets of empirical material read against each other: government policy framework documents and my interviews with policy workers. As noted earlier, as I read the interviews, I referred to the policy frameworks to see if/how they were reflected in the interviews.

I recall reading the first chapter, *The body of the condemned*, in Foucault's *Discipline and punish: The birth of the prison* (1979). Foucault begins with a story that provides the reader with a starting place to understand (to varying degrees) his analysis and argument. I am going to borrow this page from Foucault in that I write from/about accounts I read in the texts and my writing reads almost like a story. The following presents verbatim accounts to show how evidence-based policy-making works.

7. Claiming a solid ground of evidence

We always do evidence-based practice. As an underlying principle, it is evidence-based. (Hal)

In this chapter, I show how the B.C. Ministry of Health claims to be committed to (or is committed to the claim of) grounding their policies on evidence. This commitment can be found in the two government policy framework documents I analysed and my interviews with policy workers. Prior to my study, this claim appeared in print and radio media over many years as the Premier(s), Minister(s) of Health, Provincial Health officer, and others have appeared in media clips asserting the Ministry of Health makes evidence-based decisions. In the chapter that follows this one, I problematise both this claim and the commitment.

Commitment to concrete

The two government documents on which I draw (collectively referred to hereafter as the policy frameworks) include: i) *Promote, Protect, Prevent: Our Health Begins Here – B.C.'s Guiding Framework for Public Health* (British Columbia, 2013) and ii) *Healthy Families B.C. Policy Framework: A Focused Approach to Chronic Disease and Injury Prevention* (British Columbia, 2014). In this section, I spend some time with each to unveil how they signal the importance of the concept of evidence-based and how this

concept appears to frame their approach to policy-making, in other words, to show the commitment to the claim of being evidence-based at a Ministry organisational level that I problematise in this dissertation. These two frameworks represent the authorised, public version of policy-making work against which I read the transcripts of interviews with policy workers carrying out the Ministry's mandate.

Promote, Protect, Prevent: Our Health Begins Here – B.C.'s Guiding Framework for Public Health

Promote, Protect, Prevent: Our Health Begins Here – B.C.'s Guiding Framework for Public Health (hereafter referred to as the Guiding Framework) has a publication date of March 2013. It is “a guiding document for the public health system” that “unifies resources and strategies” (p. 4). In the document that came out the following year, *Healthy Families B.C. Policy Framework: A Focused Approach to Chronic Disease and Injury Prevention* (British Columbia, 2014), the Guiding Framework is described as a “directional document for the public health system with long-term goals and targets to drive system-wide action and improve health outcomes” (p. 1). The Guiding Framework presents five “values/guiding principles for the public health system” (p. 1). The first value/principle is:

HEALTH SURVEILLANCE

We will provide quantitative health information, advice and support that are scientifically accurate, useful, timely and relevant. We will share health data in a format and manner that helps respond to and address real issues, while ensuring ethical data usage.

The second is:

**EVIDENCE,
EVALUATION &
INNOVATION**

We will ensure that decisions are informed by the best available evidence and are monitored, measured and evaluated for success. We will continuously look for innovative ways of bridging research and practice, science and context. We will seek opportunities to create better or more effective programs, processes, policies, services and technologies.

These are followed by: equity, working together, across the lifespan, and multiple settings and supportive environments. Health surveillance is interesting as a *value/principle* and prioritised as a *first* value. One does not typically think of surveillance as a value or principle but rather, perhaps, as an action or mechanism to achieve a desired outcome. Surveillance does have a very particular, technical meaning within public health discourse. According to *Health Assessment Disease Surveillance Evidence Review* (British Columbia, 2006a), a B.C. Ministry of Health document, “Disease surveillance is the ongoing, systematic collection, analysis, interpretation and timely dissemination of data to the appropriate audiences for public health action, including disease prevention, health promotion, program planning and evaluation” (p. 2). Omitted are details of data and “appropriate audiences.” This definition or one like it, however, does not show up in the Guiding Framework, leaving those unfamiliar with its use to imagine its relevance. Amidst current public debate about – and arguably discomfort with – the legitimacy of increasing and/or proposed government surveillance of our lives through the monitoring of our technical devices – thus emails, social media involvement, and phone calls à la Edward Snowden (and one might add in the context of health, electronic health records), surveillance seems an unusual, almost socially

disconnected value or principle.

While the Guiding Framework does not say so outright, perhaps one might assume this surveillance will be of people, perhaps measuring their use of health services and maintenance of good health, producing “data.” How advice and, particularly, support can be scientifically accurate is left unsaid (and is somewhat of a mystery). Information that is accurate, useful, timely, and relevant will be, according to this stated value/principle, quantitative and scientific. Other kinds of information and other ways of knowing appear to be eliminated as a consideration. The data collected through this surveillance will be shared – but shared with whom is not stated. That data usage will be ethical is, perhaps, an attempt to assuage any concerns that it might be otherwise. The B.C. Ministry of Health has been under scrutiny for the last four years for how it handled its own allegations of misuse of data relating to British Columbians by its own staff and contractors such as university researchers (see MacLeod, 2015). Privacy concerns and how government data is mis/used, particularly by those *within* government, has hit the media. As a result, perhaps prioritising “ethical data usage” is a reasonable value. But the value as stated is surveillance.

This first value/principle takes an ontological (quantitative information, advice, and support, and accuracy) and epistemological (science as the way of knowing) stance in relation to what matters and counts – and how it will be counted. It also provides the first suggestion of a commitment to a discourse of truth – the reliability of scientific

accuracy. I propose that this stance feeds into the second value, which takes up evidence. This second value/principle establishes *evidence* that can be measured as primary to bridging research and practice – and science and context – for the entire public health system. That it follows the value placed on quantitative information and science and prioritises a positivist approach to knowledge production inherent in measurement, indicating the kind of evidence that will be considered legitimate. Science is, again, important. I draw attention to these first two stated values/principles to show that, together, they establish evidence-based policy-making as guiding (even directing) the actions of the Ministry – that is, the people who constitute the Ministry and those funded to do the work under the Ministry’s mandate – prioritising quantitative scientific evidence. These values/principles lay the groundwork and provide the evidence, if you will, for a stated commitment to evidence-based policy-making that continues throughout the Guiding Framework document, which addresses the public health system more generally; the Ministry’s *Healthy Families B.C. Policy Framework*, which deals specifically with chronic disease, and my discussions with policy workers. Next, I examine the *Healthy Families B.C. Policy Framework*.

The Healthy Families B.C. Policy Framework: A Focused Approach to Chronic Disease and Injury Prevention

The Healthy Families B.C. Policy Framework: A Focused Approach to Chronic Disease and Injury Prevention (British Columbia, 2014) (hereafter called Healthy Families

Framework or HFBC) has a published date of March 2014. The Healthy Families Framework claims to be built on an earlier Healthy Families BC (HFBC) platform, introduced in May, 2011, to operationalise four of the goals of the Guiding Framework (discussed above): Healthy Living and Healthy Communities, Maternal Child and Family Health, Positive Mental Health and Prevention of Substance Harms, and Injury Prevention. It highlights seven focused intervention streams that were to be the focus of work for the following three years as well as approaches to guide the implementation of these interventions.¹⁰ The Healthy Families Framework, then, is the Ministry of Health's main document dealing with chronic disease. Just like the Guiding Framework, the Healthy Families Framework also serves as a directive document. For instance, under the title *The Direction* in the *Introduction*, "The Minister of Health's Mandate Letter includes a requirement to work with health authorities to develop a 'preventative health plan' for the province" (British Columbia, 2014, p. 1). Later in the document, under the title *The Approach*, the notion of directive is clearer: "The HFBC Policy framework directs health authorities to use a combination of levers across each focused intervention stream in order to most effectively shape behaviour and influence outcomes" (British Columbia, 2014, p. 8). I argue that it is not only the health authorities that are being directed, but the Ministry staff – policy workers – as well. It is policy workers who do this work with health authorities; both are guided – or directed – by this Healthy Families Framework. Policy workers are subject to the directives within these texts. As I will make clear in my forthcoming interpretative reading of my

¹⁰ The dates of the documents and claims of their order do not add up chronologically. However, I am following the claims rather than the dates.

discussions with policy workers, policy workers engage closely with health authorities in establishing policy and guidelines that fit within the intervention streams. As one participant makes apparent, the Ministry no longer provides direct service delivery; it (service delivery) is now done at arms length through health authorities, which receive their funding from the Ministry, tied to mandate letters requiring alignment with these government-level policy directives. No longer delivering care or service itself, the Ministry still spells out goals for this care and plans, through surveillance techniques, to monitor its success – from a distance: conduct of conduct (Foucault, 1991). I point here to the directive nature of these both policy framework documents to establish their role in guiding the practice of policy workers. And while no policy workers refer to these documents directly (the latter was made public after the interviews but was being developed well before it was made public), I argue that these documents set the tone for planning for the management of chronic disease and people who live with/at risk of chronic disease within B.C.

As in the Guiding Framework, the concept of evidence appears central in the Health Policy Framework. The first sentence of the first section of the document, the *Executive Summary*, states, “a number of evidence-based public health initiatives have been launched in B.C.” (British Columbia, 2014, p. 1) From the outset, the Ministry of Health makes a claim about being evidence-based, stating that “over the past few decades” (meaning, perhaps, the last 30 years), it has established its initiatives for

chronic disease based on evidence. At the bottom of the one page Executive Summary, the document identifies how it will proceed: “the HFBC Policy Framework provides the rationale for each focused intervention stream, sets the foundation of effective evidence-based work in each and identifies the policy direction” (British Columbia, 2014, p. 1). Of the four paragraphs that constitute the Executive Summary, the first and last make claims about being “evidence-based.”

The following appears within the *Introduction*, under the heading *Scope* (British Columbia, 2014):

(T)his policy framework sets out a focused approach to chronic disease and injury prevention for the province that uses evidence to design interventions that address the major risk and protective factors over the life course and in key settings. The new HFBC Policy Framework more explicitly applies behavioural and public health science to promote health and shift behaviours in order to improve outcomes, reduce the demand for care and treatment, and improve overall health system sustainability.” (p. 2)

Again, the claim is clear. Evidence and science are introduced as serving a fundamental function in planning interventions relating to chronic disease at the beginning of the body of the document, linking them with desired outcomes. The concept of evidence is given prominence throughout the document. *Evidence/Rationale* appears as the first heading under each of the seven intervention streams laid out in the Health Policy Framework and is followed by, presumably, the evidence and rationale for each intervention. Notable is that by putting a “/” between evidence and rationale, they are equating – or at least linking – the two concepts, that the rationale for the intervention

stream is (based on the) evidence alone and for no other reason. The introductory paragraph to the Executive Summary states: “Continued and enhanced efforts in prevention are needed to further improve the health of British Columbians, reduce inequities in health and contribute to the financial sustainability of our health care system.” The first two needs are laudable. The latter part of this statement, however, has the potential to contradict the notion that evidence is the sole rationale of intervention streams; it does not relate to the health of British Columbians but rather to the financial sustainability of the health care system. They are making a direct (even causal) link between policy development, health of citizens, and fiscal sustainability of the health care system. The message is: policies relating to chronic disease must make a financial contribution. And given earlier claims by governments in Canada that chronic disease is a substantial burden on budgets as well as claims of proponents of evidence-based policy-making of efficiency, this desire to contribute to the sustainability of the health care system is not a surprise. Furthermore, evidence’s earlier link with quantitative information and scientific accuracy suggests that the evidence/rationale for each intervention contains these ingredients, that is, the information under this title is scientifically accurate, again prioritising a positivist approach. Finally is the notion that interventions that will shift behaviour are needed by the Ministry to meet its (fiscal) priorities. The emphasis on individuals changing their behaviour will, accordingly, be supported by behavioural and public health science.

Message to policy workers

In positioning the words “evidence” and “evidence-based” front and centre, these documents are signalling to the public of B.C. that, because evidence has been used to determine direction, focus, and approach, the policies generated are evidence-based and, by definition, the best and can be trusted as reliable to achieve their desired outcomes. People can have confidence. Important to the focus of this study, however, is the message signalled to the people working on creating these evidence-based policies: policy workers. The prevalence and convincingness of these claims motion to policy workers guided by this Health Policy Framework that “evidence-based” is a key message and the way to frame their thinking and talking about their work, that what they are doing is “evidence-based.” They, too, can have confidence. The glossy and pleasant presentation of these policy frameworks lends credibility to the claim of being evidence-based.

Being evidence-based is, apparently, the first priority for dealing with chronic disease in B.C. Designing evidence-based interventions that will promote health and shift the behaviour of British Columbians with the goal of improving outcomes, reducing the demand for care and treatment, and improving overall health system sustainability, is the task of policy workers. The specifics of what the concept means or how it works or is achieved, however, do not appear in these official texts.

Interviews

As noted in the methods section, when presenting my inquiry in the invitation to participate (Appendix 1), the consent forms (Appendix 2), and initial questions to participants (Interview Guide is Appendix 3), I did not use the term “evidence.” Rather than leading participants in a particular direction or limiting their responses to a particular concept or framework, I presented my interests in broader terms such as knowledge, knowledge production, research, overarching principles that guide their work, and the relationship of these to their policy work. I used this approach to give people the latitude to speak about the framework in which they operate including if, and how, they referred to evidence. When the subject of evidence came up either directly or indirectly (in that they talked about it without using that specific word,) I dug deeper. And when it did not come up, I referred to publically available documents and audio texts that speak to the Ministry’s commitment to being “evidence-based” (such as the Ministry’s website and news reports). I then inquired about their understanding of this concept and its bearing on their work.

The varying accounts I heard in interviews with the participants reveal similarities, contradictions, and tensions around the nature of policy-making. It became clear there is not one way of thinking about or doing policy-making and thinking about evidence. Rather, it is in the multi-layered, varied, shared, opposing, and contradictory accounts that, together, paint a picture of what doing evidence-based policy-making

involves. No one account is more – or less – accurate, “truthful,” or valid than another. But together, the accounts illustrate that the Ministry’s claim that it produces evidence-based policies is not as clear, obvious, nor singular as the directional policy frameworks reviewed above suggest. The layers in the accounts mirror the layers involved in the practices of evidence-based policy-making – and demonstrate that “what works” and putting “what works” (Davies, Nutley, & Smith, 2000) into policy-making practice is not as straightforward or simplistic as it sounds.

Pouring the foundation of evidence

In the beginning of this chapter, I showed how the concepts of “evidence” and “evidence-based” were central in government documents. This next section shows the prominence of these concepts in the policy workers’ accounts of their work. These concepts often emerge as key – and early – as the workers describe the principles that guide their work or even their job title. Typically taking only a few minutes to say either “evidence” or “evidence-based,” many policy workers identify these concepts as the normative approach to policy-making within their Ministry. It seems important for them to tell me, an outside researcher, that their job is to develop policies (or guidelines) according to the evidence; it is how things ought to be. In doing so, those who claim this approach to practice are in line with their Ministry’s key messaging.

In response to my first question “What is your exact title?” to Debra, a junior-level policy analyst, she tells me “I mainly work on clinical care management, which is

establishing evidence-based guidelines to clinical care in some specific health areas.”

Evan works on a prevention program aimed at primary care physicians that encourages people to “make the right lifestyle choices.” He responds to my interest in the use of knowledge in policy-making:

The (name of¹¹) program is a major research piece that says what prevention manoeuvres should happen for British Columbians at certain times in their life, right, so [...] in terms of sort of knowledge and research and evidence, [...] that's very much driven by knowledge and research. And that's kind of what prevention is supposed to be, prevention is mainly built around [...] around pretty solid evidence a lot of the time. Lots of research.

Similarly, Cassie tells me about initiatives that could be put in place “to get rid of the variation in service and to really focus on the initiatives or the interventions that actually work. [...] (W)hat we’re looking for is evidence-based or evidence-informed.” Diane says she leads a team that has the responsibility of “ensuring that the (program area) criteria is up to date, reflects scientific evidence, reflects the current marketplace, all that kind of stuff. So that's done from policy.” In explaining some recent organisational changes at the beginning of our conversation, Sally describes the function of a particular unit that was under her management: “to synthesise evidence of disease and that was generally looking at systematic reviews and summarising the findings of systematic reviews. And it was ... there are a variety of formats they used to present information. But it was an evidence syntheses.” Belinda describes her team: “Our team is in a supportive role for policy development [...] so if it’s around access to (program names) services, we would do a bunch of analysis to look at the patterns of use of those things. So we help try and

¹¹ To protect the confidentiality and anonymity of participants, I have left out particular terms that may identify in what department they work and who they are.

provide evidence-based support for decisions around policy development.” Belinda is likely referring to the ‘surveillance’ that appears prominently in the Guiding Framework – patterns measured through a numerical monitoring. “It's evidence-based and we don't make any recommendations that we can't show in the evidence section” offers Yvan. Hal captures the overall sentiment: “from a knowledge generation/knowledge translation perspective, we always do evidence-based practice. As an underlying principle, it is evidence-based.” And finally, in response to my question about how knowledge fits into their work, Patty offers a useful summary when describing what she and her colleagues are looking for: “So much of it (knowledge) is that we want evidence. (C: And what does that mean?) We want someone to have researched the issue to say this works better than this.”

In response to my question “what is your role here,” Oren tells me he is at an executive level of leadership and offers a high level description of policy work at the Ministry, which leads to his reference to evidence. The work of his branch in relation to policy, he says, is that of i) formulating and proposing policy options for decision-makers in government and ii) where decisions are made to proceed with particular policy, to oversee the policy’s implementation. But, says Oren,

(T)he role of a Ministry of Health anywhere is stewardship and a health system is comprised, any health system, no matter how it's funded and all the rest of it, is comprised of three big, I dislike the word, but buckets of stuff. So there's financing, there's resource generation, which is a little different from financing, and there's service delivery. And so the stewardship piece kind of has that overarching view of the system that is about formulating policy, setting direction

for the overall system, and ensuring the elements all work together.”

The order of these three “buckets” under stewardship – financing and resource generation followed by service delivery – highlights the dominance of cost, noteworthy as a follow up to one of the Healthy Families Framework’s key outcomes: increasing or contributing to the sustainability of the health system, a discussion I take up later in the dissertation. But stewardship is important for another reason. Oren identifies the first of the six functions or domains of stewardship, intelligence generation, because it is “probably of interest to you,” likely in reference to my inquiry into the use of knowledge and research in policy-making. It includes: “evidence, amongst many other things, relationship building, health system structure, and culture.” In Oren’s orderly listing of the layers of the Ministry’s responsibilities, evidence is positioned as important – the first of six domains of stewardship. Intelligence generation, according to Oren, “inform(s) strategic policy development and ultimately accountability for results.” So, rather than just saying “everything we do is evidence-based,” like his colleagues do, Oren paints a picture of the Ministry’s overarching role, beginning with stewardship and what falls under that, clearly linking evidence, as part of intelligence generation, directly to policy direction and results.

Each of these excerpts illustrates how these participants introduce the concepts of evidence or evidence-based. With no prompting from me, these comments tend to come early in our conversations. In responses to questions, “What is your job title?”,

“What role do you play within the Ministry?”, and/or “What principles guide your work?”, evidence and the discourses of evidence-based appear prominently in many policy workers’ account of how they think about their work, if not the work itself. These excerpts also point to features that I take up later in this chapter: where policy workers locate evidence and why it is important.

The “legwork” of evidence-based policy-making

Oren’s description of the strategic role of the Ministry of Health omits the day-to-day aspects of work that contribute to intelligence generation and ultimately a policy recommendation. Tacit in his description are tasks that require executing: searching out, locating, determining, and evaluating/assessing what counts as, in Oren’s terms, “compelling evidence.” Those doing what Debra calls “legwork” offer a hands-on explanation of how they understand knowledge and/or evidence and how they work with it. Kara provides a general description of policy analysts’ work:

...reading journal articles and interpreting how that's (an initiative) going in other jurisdictions and then writing a briefing for the ADM (Assistant Deputy Minister) to go up to the deputy. So that would be kind of a standard policy analyst process – to be really given an assignment to research a specific area within a certain area of time, and, you know, summarize that material as best you can into two pages or whatever.

After making the link between research, knowledge, and evidence that supports his policy focus, Evan explains how he understands the concept of evidence:

A lot of it's just lit reviews. You look at the bulk of papers. Where do the bulk of papers land in terms of their results and conclusions on things. [...] We'll do lit

reviews ourselves and pull out papers on various prevention topics to see, hey, what are the papers saying out there in terms of is this worthwhile doing. [...] We'll pull all the papers together and sort of read them all. See where the evidence is, you know.

Others think of evidence in a similar way: literature, research, studies, and papers. Studies are a particular kind of research, the testing of an initiative, intervention, or strategy; papers are reports on studies. This understanding of evidence as testing an intervention, common amongst those I interviewed, is in line with the Healthy Families Framework's claim that the Ministry "uses evidence to design interventions that address the major risk and protective factors over the life course and in key settings." The sources referenced are fairly consistent: reputable, recognised academic journals that are peer reviewed. Kara cites the *B.C. Medical Journal*, which she describes as "a recognised academic journal," although how widely it is recognised or how academic it is, I am unsure; it certainly is a local example. What evidence is and where it might be found are often conflated: evidence "is just lit reviews" or can be found in journal articles. Nevertheless, a decision is required: how do policy workers know a journal, paper, or study and the evidence it presents is reputable? They know because "we have it in the library;" it is recommended by their librarian, their director, or someone in the working group (usually a physician); or it is found in trusted databases. "I stay on top of the literature," says Patty; "I'm on list serves and I'm forever reading at least the abstracts of articles and strategies that come out from other jurisdictions. And discussions around some new controversial policy."

Patty has spent years “immersed” in the topic at the centre of her work, “having spent so many years in it, [...] I can just filter the junk out now. If it doesn't ring true on the basis of all the other things I've read, then, you know. [...] I guess because I've done a heck of a lot of reading and it's kind of just piling up: oh yes here's another one that says a similar kind of thing,” says Patty. First, she relies on her own expertise. Second, she looks for the frequency of a finding, as does Evan, as seen in his comments “Where do the bulk of papers land in terms of their results and conclusions on things” or, later, “say the same thing.” The more a particular finding appears in literature, the more it can be assumed to be evidence; repetition equals evidence. Belinda concurs: “(Y)ou'd make sure that it wasn't a goofy thing that just one (person had said); you'd say yes, the rest of the professionals in this area agree, they would review it, we would have our policy analysts and other ministry staff look at it in some detail, and examine it critically. So it's not just that we [...] grab one and run.” “The easy part (of assessing research) is definitely trying not to be too wowed by any single study,” says Sally.

Through the years, Patty says, she has generated a lot of knowledge and she knows a lot of people. She has confidence in the work when she knows the researchers (scientists) and believes they have experience in the field.

P: It helps if I know the scientists who are generating them (the evidence). In some cases I do. It helps if it's in a reputable journal.

C: So peer reviewed?

P: Yup. It helps if somebody I respect is using the information. I will pay more attention if it's somebody I respect who I know has some credibility. So, those

are some of the things. And that would have impact on the public too. You'd be more inclined to listen to me talking about (her program) because you know I have a background in it, than if I was talking about picking out running shoes for running. I don't know much about that. So, yea, the credibility of the person.

Aside from trusting a source of knowledge to provide evidence, policy workers often must assess the strength or promise of evidence. Criteria used to determine usefulness of research include date and size of the study; context, such as whether the jurisdiction and study group are comparable to the individuals, community, province under consideration; study design (but not methodology – that is not a term most people I interviewed use or understand in terms of research they are reading; they use it in reference to their own job of research); and effectiveness. “I would say guidelines that are in place in other jurisdictions are probably a little bit more valued than some random study in the *British Medical Journal*,” offers Debra. This dismissal of the *British Medical Journal* is almost ironic given the trust many policy workers with whom I talked have in lauded journals such as the *British Medical Journal*. But Debra’s point is that the evidence needs to be practical, to be proven to be effective in practice, particularly in a practice setting (program area? Canada?) for which she needs evidence. Evan lists several criteria for judging:

If you read a paper and there's ... some papers will say the sample size is really small or things like that, or maybe it doesn't fit in the Canadian context because it's maybe a US study or different things like that, and you might say, often the papers highlight if there's any kind of shortcomings, sort of the limitations if you're reading them and you think they're pretty significant. You never want to say, hey let's go forward with this one policy based on this one paper which has a really small sample size. Are 30 or 40 papers saying this? Or 20 papers sort of

saying the same thing? And that's kind of what it's about.

Evan is aware of the criteria to which he needs to pay attention, such as sample size, geographical context, and how many papers “say the same thing,” for example. He also relies on the authors of a paper telling him what its limitations are. Kara has a similar list:

C: You talked (about) making the decision about how good the study is and prioritizing them. How do you make that determination?

K: Well, a number of criteria, but I don't have like a set checklist. How recent it is? Is it a jurisdiction that's relatively comparable to B.C.? Who is the study group? Is it the right study group compared to what we're trying to look at? And how large is that study group? And how was the study conducted? Is it a random controlled trial? Or is it just a systematic review or that kind of thing?

For Debra, assessing the value of a study because of features like sample size is taking, as she says, a “critical” or “rigorous approach:” “I'm assuming my director would want me to be able to look at that critically and be like, okay, this is a really small sample size, and who was in it, it's a completely different healthcare system, or they're using three different drugs (and) we're only focusing on one.”

Ministry policy workers are not the only ones doing the work of researching the literature and finding and judging evidence; there is heavy reliance on others. When I ask Seline “How do you know when evidence is reliable or how do you judge the reliability of it?” she says they “hire individuals to look at it in terms of grading it and judging it.” Says Belinda: “we are highly dependent on external content expertise.” Trust in the expertise of others is key. Patty references her “bible”: “In my case, there's a book

that's our bible for (her area of focus) policy. It's put out by the WHO (World Health Organisation) and it's got 16 world-renowned scientists on it. Four of them are Canadian." She points to the aspects that give her bible credibility: a world renowned organization (World Health Organisation) that she believes is reliable and whose work is produced by scientists (even Canadian scientists) – these matter to Patty and indicate her preferred form of knowledge production. "Because we don't have a lot of money to go out and do our own reviews, typically we rely more on what are accepted syntheses of the knowledge, or of the evidence, and the knowledge that can be learned from that. [...] We hire individuals to look at it in terms of grading it and judging it," says Seline. There are "independent bodies [...] that gather all these papers around each of these different sort of prevention manoeuvres," according to Evan, who knows there is one in the UK but does not name it. Perhaps he is referring to The Cochrane Collaboration, which, says Seline, has "more reliable evidence." Other sources such as the Canadian task force on prevention, CIHI (Canadian Institute of Health Information), or websites such as Health Evidence¹² are also named as sources relied and drawn upon. These organisations provide systematic reviews of many studies on a particular issue so people can feel confident in the evidence to which these organisations point, knowing they are not the result of just one study.

Evan makes a comment that captures his impression – and being impressed – with the Ministry of Health's commitment to evidence-based policy-making:

¹² This website (<http://www.healthevidence.org/>) is based out of McMaster University in Hamilton, Ontario, Canada – the home of the evidence-based medicine.

The physicians, they kind of like to see the evidence, right. I mean the ministry works on a lot of committees with physicians, you know, (names three committees), and you know, the physicians are very much, they like to see, you know, they like to see evidence and some papers before they're sort of willing to jump into things too quickly. They like to be guided by that [...]. I find coming here at the Ministry of Health, compared to where I've been before, is, you know, a lot more driven by what are the papers saying; what are the conclusions and the results in the papers. Whereas compared to where I was before, it was a lot more, I don't know, I guess you could say politically driven.

Throughout the interviews, knowledge is evidence when it appears in trusted journals, is found repeatedly, is written and/or assessed by known or trusted people (particularly scientists), or is recommended by trusted sources. And the more often a particular result appears, the more likely it represents the evidence. In the following chapter, I describe how discourses of evidence-based meets with contradictory discourses and resistance and show how the commitment to it unravels as my conversations with policy workers deepens.

8. The “reality”: And so the fissures begin

C: Can you tell me what evidence-based is?

(No hesitation)

P: No, I can't actually.

C: Do you have a sense of what other people think it is?

(14 seconds of thinking)

P: I would bet you that would be another thing that is defined differently

C: What are some of the ways people understand that (concept)?

P: I'd have to think about that (Paige)

As the previous section illustrates, the concept of evidence-based is established as fundamental in the government policy frameworks and runs prominently through my conversations with policy workers at multiple levels. However, the commitment to these concepts begins to unravel as I probe participants about the workings of evidence-based policy-making. This chapter, based on the interviews, reveals this undoing, as policy workers roll out exactly what kind of evidence counts, even if implicitly. The policy workers I interviewed often conflate the terms knowledge, evidence, science, and even information. For instance, I ask Patty about knowledge and she answers referring to evidence. Kara prefers to think in terms of information: “I think it's more about information, you know. I mean I've always enjoyed sharing information with people and having information is really important to me to be able to, you know, make an informed decision about something. So I guess I think of it more in that term.” However, there was a general agreement that there are different levels of knowledge, evidence, or information. This chapter begins with descriptions of these levels.

Storeys of evidence

“When I am talking about evidence, I am thinking about scientific evidence.

Yeah, that’s what I’m thinking about.” This sentiment of Sally’s is not unique. Scientific knowledge and evidence is given a privileged position in descriptions of policy work. And while scientific evidence is not the only evidence policy workers encounter and draw upon, its importance cannot be disputed. I ask Evan how he recognises evidence when he sees it.

E: You mean study design?

C: Yes. How do you determine from reading an article that this has evidence that is either, that it's a good idea, or it's not a good idea; what about this tells you this is a piece of evidence? Are there study designs that are more ...?

E: The doctors like the double-blind studies.

C: Randomised controlled trials?

E: Yes. So that's what I think our area has pushed more towards. You know, we do a lot of things with physicians. They like to see their studies kind of like that.

This excerpt identifies a feature that runs throughout our entire conversation: evidence is recognizable because it is a study of a medical intervention. And not only must the study be scientific, it is preferable when it is a double blind randomised controlled trial.

Kara presents a completely different point of view. As noted earlier, Kara offers a general description of policy analysts’ work and lists the criteria she uses to assess research studies. In doing so, she acknowledges there are different levels of research. The following lengthy excerpt offers a fuller explanation of how she understands these

levels. Kara explains her process of literature reviews and criteria for judging studies:

C: You talked (about) making the decision about how good the study is, and prioritizing them. How do you make that determination?

K: Well, a number of criteria, but I don't have like a set checklist. How recent it is? Is it a jurisdiction that's relatively comparable to B.C.? Who is the study group? Is it the right study group compared to what we're trying to look at? And how large is that study group? And how was the study conducted? Is it a random controlled trial? Or is it just a systematic review or that kind of thing?

C: [...] So what [...] (are) the more valued kinds of studies?

K: Certainly a systematic review would be up there, in terms of sort of like gold standard.

C: A systematic review of randomised control trials, mostly?

K: Well, if you could find it (laughter).

C: So, that's ideal?

K: Yes, (but) certainly (it) isn't always the case, depending on the topic.

C: And what if it isn't the case? What if you can't find those? What's kind of second best? [...]

K: Well, using the other criteria that you're left with. I mean often you know, you have a research question and it's pretty narrow and so many studies, [...] they're in that area, but they're really looking at another angle. You know, I often find that. You can't find just the exact thing that you're looking for, so you certainly have to interpret some of that stuff (and) have some cautions about it.

C: And when you say study, what do you mean by that term?

K: A journal. You know, I mean it would be published in a journal [...] a recognized academic journal, *B.C. Medical Journal*, you know, just as an example. [...] (O)ften you're looking at a whole mix of stuff. [...] (S)o I mean you have that hierarchy down. Certainly with the report on (a topic) brought in a lot of gray literature sources there and books and things because you know there were some studies but definitely they weren't random controlled trials, you know.

C: So that's the ideal study, a randomised controlled trial?

K: Yes

C: What would you define as gray literature?

K: Well, with (program area), because they wanted examples of resources as well for instance, I looked to organizations that publish materials for seniors in that area, could be Canada Mortgage and Housing, or it could be ...

C: Seniors' magazines like CARP (Canadian Association of Retired Persons) or whatever?

K: Ya, a little bit of that. What else. It could be financial institutions that have planning tools, you know. So we looked at all the different tools. Like housing and financial and social and [...], I found several books that were on that topic. So it was quite a mix. And reports and things would be included.

C: And you just mentioned this hierarchy. [...] What are the various positions on that hierarchy? [...]

K: Well you've got your systematic review and you've got individual random control trials and then you've got other studies, it may be different types of studies that look at a population, and it might be over a period of time, and they're measuring some things, and you're observing some things, or it might be qualitative interviews with some people and you get into the qualitative stuff, there's reports, you know, from government, and organizations that have been published, you know, specialists in certain fields and things like that. And then you get more into gray lit, which could be a matter of books and other types of publications.

Kara's description of policy work and assessment of research is rich. She confirms the criteria for judging a study beginning with systematic reviews of randomised controlled trials as the gold standard. "Study," a term others use along with "papers," implies something published in a recognised academic journal – this, she has in common with Evan. She also identifies a hierarchy and lists the levels within this

hierarchy, with randomised controlled trials at the top and “other criteria *you are left with*” ranked below, with gray literature at the bottom. This description of ranking is textbook. Yet, while Kara identifies key components of policy work that are fundamental to descriptors of evidence-based policy-making, she does not mention “evidence” or “evidence-based.” These concepts do not exist as words front and centre in her description of her work. However, since much of her explanation reiterates how others, including organisations such as Cochrane and Campbell Collaborations, describe the hierarchy of knowledge associated with evidence-based policy-making, I ask her about it:

C: So here's a term that I've heard of a lot for a long time and that's the concept of evidence and evidence-based

K: oh, yea (laughter)

C: So what's your thought about that?

K: Well, I think that language has been used here, well, I think since I started here¹³ for sure. It's when it's been a focus to try and use evidence certainly as part of mere policy planning process. And there was a course that was government-wide as well on, what's it called, one sec, (she searches for and locates a binder, and gives me a document with a visual of the structure of the hierarchy) but they had a nice policy analysis wheel with this part of that whole course. It was a course you took in modules, like you went to another location and took, you know, a half day or a day's worth of the module stuff.

C: [...] (W)hat do people understand evidence to be?

K: Oh, the evidence thing, right. I think there's different levels of evidence and you always try and find the gold standard out there.

C: And that's the systematic review?

K: Yea, that whole hierarchy again, but if not, then a lot of people will look to

¹³ Earlier, Kara told me she has worked at the Ministry of Health for seven years.

what they call best practices in other jurisdictions, other areas, so that's become quite a common thing, too, if you can't get any really hard evidence about something [...].

C: And you would know that based on what other people are saying that that's their work, that that's their best practice, that you would consider that as part of determining what's a best practice here? Or that would sort of feed your . . .

K: Yes, that would be part of the picture, like there's guidelines, for some divisions, like the pharmaceuticals area, on medical services, they may have protocols. So again there's sort of different levels within that. There's like protocols, and it would be something that would be more mandatory, guidelines are more general, and then there's best practices which are even a bit more vague possibly so not necessarily all written down that sort of thing, so those are different categories as well in that area.

Kara identifies, both in her own words and in the visual of the hierarchy she sends home with me, the preferred order of knowledge production; most notably, the gold standard is systematic reviews of randomised controlled trials. She calls them “hard evidence.” If they are unavailable, there is an array of other steps on the hierarchy down to gray literature. She confirms this approach is a priority of the Ministry – they have held courses on it to teach their policy workers how it is done. Hard evidence, notes Kara, is necessary for health policy areas such as pharmaceuticals. In other policy areas, she suggests, the evidence that is closest to the top of the hierarchy is “best practices,” often from other jurisdictions, which, when not written down, are vague. One might ask: how is evidence located further down the hierarchy, away from *hard* evidence, characterised: *soft* evidence?

Diane has only a slightly different view. She could not think “off the top of (her) head” of an instance where evidence from randomised controlled trials would not be

available. However:

D: I'm sure there's been certainly times when the evidence isn't great, you know, like the evidence is consistent, there's not necessarily intervention trials or randomised control trials, like the evidence is kind of weak.

C: So what do you do then?

D: We build a case as best we can, and use what we've got. We would acknowledge the lack of evidence.

C: So really the evidence is pretty much strictly attached to the scientific method and then if there isn't that, then what do you call this other stuff?

D: Kind of gray evidence or gray literature. And acknowledge that it's gray literature and that there is a paucity of strong evidence, but (we) just use what we can.

C: And does that work? Is it convincing?

D: [...] Depends on what the issue is.

C: [...] (Is) this kind of approach [...] (workable for all) the issues on your plate [...]?

D: I don't know how else you can do it. I don't think you can generate knowledge without it. I absolutely think that being able to say it's based on best practice is just kind of, you gotta have it.

C: And that's completely linked to the scientific method?

D: Well, I think in best-case scenario, yes. I mean, when you talk about best practice, how do you know it's best practice? Well, you know there's been really strong, the best is randomised control trial. There's been really strong valid research that's been done on it that's consistently shown

For Diane as well as Kara, evidence other than randomised controlled trials is second rate, certainly not strong. Randomised controlled trials are the most quantitative, positivist method of knowledge production and not without critique, as I

will discuss in the next chapter. But that critique does not blunt the value of such studies for these folks; randomised controlled trials are the most valued. While Kara suggests a few categories between randomised controlled trials and gray literature, Diane positions everything *but* randomised controlled trials as gray – and weak – evidence. For Kara, gray literature appears to be non-academic and not peer reviewed; perhaps published as a magazine but not in an academic journal; and brochures, manuals, and reports from organizations or governments. Furthermore, for Kara, “best practices” is often “vague,” and for Diane, best practices appear to be equivalent with evidence-based. “Best practice” is a term used often by those I interviewed, often interchangeably with evidence-based. When I ask Nora about the term evidence-based, she says: “Well for me I flip it and say best practices. So how is it that you can take a program or an initiative that was successful and use that as your sort of example, starting block or how do we morph that.” I am not clear how that is a “flip.” But at this point, she does seem to want to distinguish it from the evidence-based.

Oren prioritises evidence this way:

So there's sort of two layers. This is actually always a challenge when talking with ... it's actually a challenge internally and it's something I'm still working on. And the challenge is that there is the classic, well, you know, randomised control trial comes in ahead of a time series, da da da – that's expert opinion, that's (that explanation of evidence is) sort of the bottom of the pile if it even makes it in the door, which in my case it probably shouldn't and most of this kind of stuff. So there's that thing, which I presume you are very familiar with.

Oren takes the classic hierarchy of evidence articulated by Kara and lumps it together

into the one “layer” of evidence. It is a really a process of ranking he is talking about – and showing disdain for. He continues:

Then there’s another thing [...] (Y)ou then take the things that have come out sort of higher on the list, you then say: ‘so in reality where is this at in terms of implementation in other parts of the world, or other parts of Canada or whatever.’ Is it something that has been already implemented and evaluated in a real world setting, as opposed to a research university trial, and is it established? Has it generated outcomes in multiple language or culture or geographical kinds of settings? Or is it limited but all the road signs are great, or is it just sort of out the door in three places and we don't really have any real world, real live people who aren't employed by research teams but are employed by your garden variety health service health authority in Brandon Manitoba or wherever it is. Are they actually generating outcomes that are in some ways reflective of what the evidence suggests that they should if they are you know fidelity in the implementation of whatever it is, or is this sort of one step below that where we've got five research teams all over the place who've generated some incredibly promising result and da da. So it's a sort of a parallel or an additional lens. Now you see that in places. But that is, it's that dual kind of piece that is really really really important.

[...]

(I)f you don't have those two layers that I've just described, and generally you don't, what you get is sometimes, is staff saying: ‘well gee whiz, we've got three randomised control trials and three different settings . . . on and on and on . . . this is a gold star five whatever.’ And my question is, ‘so who's implemented it?’ And if you quiz, sometimes you get [...] all this sort of stuff, well *that's* what I need. The next step is to move it out of academia. And maybe no one's implemented it, in which case that doesn't mean you don't do it, it just means that it's really really important information and it's evident, quite frankly.

Oren is making the case for the layers or steps of research on which he must make judgement; most particularly he distinguishes research that has occurred only at the academy vs. research that has been implemented and produced the kind of outcomes expected by the researchers. “Real world, real live people” moves the

evidence up the ladder to be useful – and it appears as if he needs to “quiz” his staff to get at that information, as if it is not a distinction or “lens” they automatically have. Putting research through randomised controlled trials in real settings provides him with evidence he needs to consider an initiative.

Oren gives an example of a program out of the United States that was run through three randomised controlled trials in different states and is being adapted in B.C. so they can collect local evidence.

The follow-up continues in all three RCTs. There's also a whole lot of qualitative stuff, like a ton of qualitative stuff attached to it, and this is where I'm trying to sort of move you – it isn't because the RCT in and of itself has done all this. It's because it's a complete package of research that is very well thought out on multiple levels (examples of these levels) [...] But multiple multiple layers of research associated, so that allowed us to be briefing decision makers at actually great length about the detail, [...] it captured attention for a whole lot of reasons, and it's generated multiple positive outcomes across different domains, well beyond health.

[...]

So what we've ended up with is a package of research that's absolutely applied stuff that's going to add globally to the scientific knowledge base, but that's going to inform the delivery of this particular program in a way that, assumingly generate acceptably good results in that first little while, that will then allow us to adjust where we need to adjust, to tinker where we need to tinker, to have the evidence to support that tinkering with a model with which we need to remain, we've got to sort of respect the fidelity of the model, but make it work for here and then we'll go forward. [...] (Y)ou get some information out of a randomised control trial, but you get a whole lot of other really important information through a different approach to research and you kind of need to do both and if you're going to get there.

Oren touches on many facets here. He reiterates what others to whom I have

referred earlier speak about: the judging of evidence against the “real world.” The most interesting point (and unique amongst those I interviewed) is that it is not randomised controlled trials alone but the “complete package of research” that gives him the kind of detail he needs to be convincing when making a recommendation to decision makers. In this example, he needs both the randomised controlled trials and the qualitative research to recommend moving forward. The idea that an initiative has been tested elsewhere (ideally in several places) is really the clinching piece of evidence. But unlike his colleagues I interviewed who report to him or someone at his level of management, he argues for a whole package of research across (methodological) domains and *beyond* health that makes for useful evidence. Randomised controlled trials remain important, however; they are a necessary part of the package, particularly if undertaken in multiple locations. Adding globally to “the scientific knowledge base” with applied research is also important. The example he gives is one Oren has convinced decision makers to try in B.C., using a randomised controlled trial, and he is very pleased with this opportunity to test (and hopefully prove) the initiative will provide positive outcomes in B.C. But Oren seems to understand the value of other research methodologies (he mentions qualitative research) and argues for it to complement randomised controlled trials. Furthermore, generating and having available local evidence is an important device to convince decision-makers of the validity of a program and the value of funding it.

Oren is savvy enough to know that randomised controlled trials alone are not

the only kind of useful evidence and while they are important (even imperative), he does not refer to them as “hard” evidence. As noted above, Kara did reference hard evidence, the gold standard, and a hierarchy, but she is certainly not the only one, even if others do not use that term. Seline acknowledges that randomised controlled trials are the gold standard for clinical practice guidelines, and when randomised controlled trials are not appropriate, “you are going to have to take whatever evidence, level of evidence you can get.” They need *something*, some thing they can call evidence to go along with an idea or recommendation. Locating randomised controlled trials is their first goal but they do not stop looking if one is not available. Hal says something similar: “From a research perspective, you go from Cochrane reviews as sort of gold standard.” Hal admits that there are areas of health policy where randomised controlled trials will be helpful. However, he describes “Grade A” and “Grade B” evidence. I ask what he means by these terms.

H: So if you actually look at the rigour, so randomised controlled trials or (findings) based on systematic reviews

C: makes for A?

H: Yes, and if you’ve got good studies, you might have good systematic reviews, just one systematic review that shows positive outcomes, that might be a Grade B. [...] In a way, it’s based on reality, but it is also based on what’s been published. And where people have got the funding to make their case.

C: [...] If I’ve understood you correctly, there’s a particular kind of research approach that will make it into a Grade A?

H: Yeah, for sure. But that’s very costly. [...] yeah, and sometimes it’s more easier to do with cardiology because they are more in a clinical setting rather than... When you are working on capacity building for communities. So the values, and I

mentioned the Cochrane review on healthy communities, healthy improvement between local government and health authorities. So, the question of putting evidence into place, into practice, for chronic disease prevention, I wouldn't say is a mute point. But it is not as easy as our clinical interventions.

Hal acknowledges that while Grade A is what they prefer ("clinical guidelines Canada [stipulate] that you just look at Grade A evidence"), for a variety of reasons, it is not always possible. Then they use Grade B evidence. Offers Hal:

Most of us will usually, you know, I'll say this and I'll contradict myself. We'll usually class a bar as systematic reviews and meta analysis. The meta analysis is basically the systematic review of systematic review. So you're pretty much... high power, that those things make a difference.

Hal also describes situations when the kind of evidence they would like is unavailable but there are opportunities to learn from others who have put a program or response in place in another context.

So we tend to do a lot of taking from others or designing our programs based on those lessons learned from all those practices. It may not have been fully evaluated. They are not necessarily evidence from publications or journals. It's more from the community of practice of response. And that's where we get most of our guidance. It's not from the published research.

After several people, including Hal earlier, tell me they go looking for some kind, any kind, of evidence, it turns out that most of their evidence is not from publications; rather it is from people in practice, a more local kind of evidence, according to Hal. I ask if that is considered evidence. "We class it as learning from practice; we say best or promising practices. That's where that term comes from." Hal's take on "best practices" differs from both Kara's and Diane's. But Hal, Oren, and others are making a useful

distinction when they talk about the importance of knowing that an initiative or policy has been tried in “real life” or “reality.” That it has been shown to work (in particular ways) in practice is what adds credibility to/as evidence. They need to know it has been implemented and evaluated at a local level, past the randomised controlled trials. This desire for local evidence seems to outweigh, or at least is necessary to balance, the more distant, narrow findings of randomised controlled trials. Even though randomised controlled trials are given a lot of credence, perhaps it is how something works *in a local reality* that matters most.

Excerpts from these interviews exemplify features of policy work that others also raise, particularly the practice of grading or ranking research evidence: hard versus a paucity of strong evidence, i.e. soft or weak evidence. These discussions are important in that they speak to the privileging of particular methods of knowledge production – randomised controlled trials and their systematic reviews – or at the least, scientific studies that measure or test – words that come up often. Sally has a desire to:

rais(e) the level of discourse in the Ministry about research. One of the things that we don't have so much that we used to have was more critical questioning about methodology. (B)ecause there's lots you can start poking at so that ... maybe nicely and some of it not nicely ... but some of it like legitimately, questions about methodology [...] because I think that that's the other thing, you've got hard-core RCTs; you've got really loose qualitative over here. But in all of it you've got some good research and some bad research. And a lot of 'who cares research' in every single category.

Sally is either convinced that (most) randomised controlled trials are “hard core” (which fits with some of her colleagues I interviewed) and qualitative research is “loose”

– or she is being somewhat sarcastic. She seemed to be drawing some comparisons: hard-core randomised controlled trials on one hand and loose research on the other; good research on one hand and bad research on the other. Hard-core randomised controlled trials are positioned as good and loose, qualitative as bad (a contradiction to Oren’s valuing of qualitative research, even if just alongside randomised controlled trials). But “And a lot of ‘who cares research’ in every single category” leans toward sarcasm. Even though earlier in our conversation she expounds the virtues of evidence-based policy-making, in this excerpt, she does not sound convinced there is sufficient critical thinking amongst her colleagues to successfully accomplish it.

Early in my conversation with Patty, she tells me of an academic whose work she admires. From him, she has learned “that we have relied too much on knowledge [...] in most cases, information alone just does not change behaviour.” When I ask her to clarify how she defines knowledge or how she sees it being produced, she tells me “scientific knowledge” but follows up by saying “you have to take into account other kinds of knowledge.” She prioritises scientific knowledge, in keeping with her earlier reference to scientists. But Patty also acknowledges there are other kinds of knowledge: priorities of the government, political climate, economic arguments. Noteworthy here is that Patty thinks of these things as *knowledge*. Sally, on the other hand, offers a different perspective on what counts as evidence, which she distinguishes from inputs:

(W)ell I've been at conferences where the discussion about the definition of evidence has been hotly debated and I would say that for the purposes of the work that I do here, when I'm talking about evidence, I am thinking about

scientific evidence. Yeah, that's what I'm thinking. It is not exclusively university-based research. And that doesn't mean that it precludes other kinds of inputs to planning and policy that need to be done like public values and ethical analyses and those sorts of things that are also part of good thoughtful policy development. But I would tend to keep things clear in my own mind - not to call that evidence. But I see those as valid inputs.

While some clearly identify the privilege given to scientific studies as the priority way to produce knowledge and evidence, it seems apparent that many cannot hold firm to this stance. Many concomitantly argue that randomised controlled trials are the gold standard *and* put forward examples where such a method will not work; many issues confronting them for which randomised controlled trials are simply impossible. Several mention population health, public health, and chronic disease prevention programs. For these, says Kara, “you do the best with what else you can get.” According to Seline, “(I)n the typical clinical setting, it's randomised control trials (that are valued) but in public health you don't always have that luxury. You're never going to get a randomised control trial in food security. [...] (B)ecause population health approaches do not lend themselves to randomised control trials.” Seline is making a distinction on the kinds of knowledge produced by randomised controlled trials that may be useful in clinical settings but cannot be produced on another issue that she associates with chronic disease: food security. Seline argues there are occasions when randomised controlled trials are not appropriate and qualitative research is required, typically in issues of public health, to “mobilise communities to take on policy and move issues forward.” Oren, in a previous excerpt, proposes that qualitative research may need to be seen as

part of the “package of research.”

From Paige’s perspective, however, qualitative research is “usually backed up with....” She searches for the right word but does not find it. I offer “quantifiable, measureable?”

P: Yes, so for the things I am thinking of [...] I’d say that they have the qualitative and the quantitative and I don’t know if that’s because they’re taking into consideration the different people who might be looking at it.

C: Do some take priority? Does quantitative take priority over the qualitative or the other way around or does it not work that way?

P: I don’t know. I would have to think about that because I know we are so patient centred if the qualitative did but I cannot say yes, that happens. I just wouldn’t be surprised because, now we are told we are patient-centred.

Paige does not sound convinced that qualitative research is valued for its own merit, like Oren and Belinda, for example, do. It is hard to miss her cynicism, however, in her comment: “now we are told we are patient-centred.” Paige seems to be alleging that claims such as evidence-based and patient-centred are just that: claims – or phases – that have time limits on them. Sooner or later, they will go out of fashion.

The issue of Aboriginal health came up with only three people. Nora has had experience in policy relating to Aboriginal health and appears to acknowledge that mainstream evidence-based policy-making is an inappropriate approach for many aspects of Aboriginal health, noting how the Ministry’s “policy lens has changed here over the years for sure.” With the Tripartite First Nations Health Plan and the devolution of services, staff, and money to the First Nations Health Authority, “we’re really setting

precedents across the country here in B.C.” Cultural competency, cultural sensitivities, as well as providing an Aboriginal lens to other Ministries: it sounds as if the Ministry’s approach to Aboriginal health had dodged the evidence-based bullet. As I noted earlier, when I ask her directly about the phrase “evidence-based,” Nora says “I flip it and say best practices.” And while initially appearing to be supportive of that phrase, she then acknowledges “I’ve struggled with that term [...] evidence-based or best practice now from a First Nations perspective because of the diversity” in the province. She is also aware that spirituality is one of four directions, important to “the making a whole human, of being a human in [...] development over (ones) lifespan.” “Let’s take a look at spirituality,” Nora says. “Evidence-based? Best practice? Yikes.”

Further into our conversation, however, Nora seems to make an about face, asserting that “we (the Ministry of Health) are trying to give them (the First Nations partner) the evidence-based information, like (Nora’s colleague) will provide (it), and they just don’t agree with it. And it’s like, well you can’t not agree with the evidence.” I inquired of this change in her view on evidence several times to ensure I was understanding her correctly and left satisfied that I had. Throughout our conversation about Aboriginal Health, Nora fluctuates between seeing the benefits of evidence-based practices and challenging it. And I understand that balancing the requirements of evidence-based policy-making and thinking about/through an Indigenous lens is a monumental task.

Advocating for stories as evidence, Nora offers a critique on how political motivation plays out on health programs:

The story must be told. So with (a program First Nations advocated for), you're going to get data, yes, we're going to have some numbers again, even for this year. What's the story behind that? How did we affect somebody's life? The problem with *ActNow*¹⁴ was our premier wanted to see results in three years or else. He's not going to see that, and that's how they failed [...] Not going to happen. We're talking 10/20 years, because it took us how long to get here, to the problems we're having now. It doesn't happen in two or three years, premier, and he wanted to see results and action instantly, before the Olympics, because that only all happened in 2007/2008, the Olympics were in 2010, and then it died. And then it was dead, gone. And now it's morphed, it's changed obviously. But that's the thing that we're struggling with in government as well. We're our own worst enemy. In that we say we want to see results and yet we also know prevention-wise, chronic disease-wise, it takes years to heal and/or see results/change.

Another participant speaks about the Provincial Health Officer's Annual Report:

Pathways to Health and Healing: 2nd Report on the Health and Well-being of Aboriginal People in British Columbia.

If you look at our Aboriginal report, there was a lot of qualitative stuff in there, stories by persons who'd gone through certain things, persons who had diabetes, persons who'd been in residential schools, those kinds of things. I think (the Provincial Health Officer's office) tr(ies) to put stories into (their) reports,

¹⁴ The initiative *ActNow* BC was the precursor to *Health Families BC*. Now history, *ActNow* is described in an archived government document (British Columbia 2006b) as

... a cross-government health promotion initiative that seeks to improve the health of British Columbians by taking steps to address common risk factors and reduce chronic disease. Research has shown that inactivity, poor nutrition, overweight and obesity, tobacco use and unhealthy choices in pregnancy are the key risk factors contributing to the main chronic disease categories in B.C. *ActNow* BC's goals by 2010 are to:

- increase the percentage of the B.C. population that is physically active by 20 per cent;
- increase the percentage of B.C. adults who eat at least five servings of fruits and vegetables daily by 20 per cent;
- reduce the percentage of B.C. adults who are overweight or obese by 20 per cent;
- reduce tobacco use by 10 per cent; and
- increase the number of women who receive counselling about the dangers of alcohol and tobacco use during pregnancy by 50 per cent.

because it's pretty invaluable, it actually makes the numbers mean something to individuals and to the community.

Stories provide meaning to the numbers – to individuals and communities. Numbers provide meaning to the decision-makers.

Tim concurs on the value of numbers. His critique of science and the peer review research process provides him with a perspective unique amongst those I interviewed. He acknowledges that aside from academic research as evidence, there is clinical evidence or practice-based evidence and traditional Indigenous knowledge, which he says is informing some of the work on setting up the Aboriginal Health Authority. But there is a tension:

T: (C)ertainly what we've heard from the contributions of the Aboriginal partners [...] is that they (First Nations Health Authority and B.C. Association of Aboriginal Friendship Centres) expect to see Indigenous knowledge recognised as valid and incorporated. [...] I think there are lots of people who are very much steeped in the positivist tradition who would just say that is just mumbo jumbo. [...] They'll have to swallow it and accept it because, you know, we've seen a real shift, I think in the past decade or so to embracing, even if not fully respecting, at least tolerating, that kind of input. [...] Textual knowledge, numerical knowledge, I mean, right away, those two things dominate everything we do. Probably in the other order, numerical order then textual order. So traditional Indigenous knowledge which is typically oral based...

C: Bottom of the totem pole?

T: Yeah, and it's hard to argue for it. And, you know, one of the questions is: why can't traditional Indigenous knowledge, (be accepted) just by itself on its own terms, then why is scientific knowledge... So to the degree that we do accept input from traditional Indigenous practices, we will accept it only if it is validated by scientific studies. It's like 'OK, let's do research on this Indigenous practice and if it meets (our scientific standards)'... Or traditional Chinese medicine is another example, acupuncture. If it is validated by positivist science then we'll accept it. But we can't accept it on its own terms. Because there's been

thousands of years of Indigenous knowledge saying that this is true, that's not enough, right? We are the ones who hold the judgement power about what's admitted or not.

That the storeys that go into building an evidence-based policy are many, yet not always agreed upon, further demonstrates that if not everyone agrees on what counts for what in evidence-based policy-making, the doing of it might be just as confusing, with each person making assessments based on her/his own understanding.

Thinking about methodologies

Until this point, I have shown that randomised controlled trials (or at least some kind of scientific evidence) carry significant weight as evidence. Yet some policy workers are well aware that there are ethical and practical considerations that challenge their usefulness. Ruth describes the difficulty of relying solely on randomised controlled trials even in clinical work:

R: Randomised controlled trials are the gold standards for clinical work. There has been well-funded research in (a clinical area) so if any field of research could tell you what should happen and what shouldn't happen, you'd think this would be a slam dunk. And it's not. If you really dig into the epidemiology and the studies, we actually have very little evidence to go on. Most of the studies that were randomised were done on technology we never use. You cannot get ethics on randomised controlled trial on technology we do use.

C: How come?

R: [...] What ethics board is going to let you take thousands and thousands of (a population) and not give them the standard of care today? So we have no research really on the current technology, on the current cohort. On all that kind of stuff. And so, what you'd think would be one of the most easy evidence-rich decisions about (clinical program area) isn't that easy. [...] And then, when both the US and Canadian task forces look at that with all the resources they can bear,

and say ‘you should not regularly (follow the policy)’ all hell breaks loose in two countries.

Ruth’s example is of a standard clinical guideline that is well known amongst both clinicians and the general public and taken for granted as being based in evidence, thus the correct way to proceed. Yet she clearly says that not only is this guideline *not* based on evidence, but there is no way it could be as it would be unethical not to provide (that is, to deny) this standard care to the large segment of the population for whom it is applicable. This example demonstrates how readily people assume particular policies are evidence-based because of how often we hear this claim. More importantly, however, it illustrates how difficult it is to be evidence-based even on clinical issues that appear to be so appropriate for randomised controlled trials. This same example of standard care is also given by another person, in a director position, as an example where there *is* good evidence, directly contradicting Ruth. Ruth continues:

The more that someone has been trained as a clinician, the harder it is to let go of that (randomised controlled trials). The more it has been drummed into to you. But [...] there aren’t randomised controlled trials for everything, they are expensive. And randomised controlled trials don’t do health systems. You don’t do randomised controlled trials on health systems or policy work, right? So, um, if you think about the clinical practice guidelines folks, they are heavy, heavily weighted into the idea of randomised controlled trials being the gold standard, right? [...] Writing a clinical practice guideline is not the same as writing a policy. It might be a form of policy writing. But you know what I mean.

I want to point to two contradictions. The example Ruth provides is a clinical practice guideline and she argues it is not possible for it to be evidence-based.

Furthermore, the two policy framework documents discussed in chapter seven do not

make the distinction between guideline and policy. *And* they list many aspects of policy that are not clinical but, instead, relate to individual behaviour – and claim they are evidence-based. Ruth contradicts the policy frameworks, her colleagues, and herself, illustrating the confusion of some of the divisions and restricted understandings of knowledge production.

Belinda also details the challenges with assuming the value of randomised controlled trials:

We're in a particular bio-medical kind of area. You say, well, double-blind, randomised control trial, gold standard, but in much of our work, there's nothing like that because we're talking frequently about evidence around implementation research or evaluation, or things that are not as hard and fast. And there's huge methodological issues frequently, with how those are done. So I think we really struggle, because much of the evidence we're looking for is from qualitative evaluation, so I don't know that we really have great tools for assessing the rigor of that. It requires individuals who have experience in those areas, or an expertise and they are scattered around. We do try and hire people with that kind of background and knowledge. But you know it is a murky and difficult area. So people tend to highly value peer-reviewed published literature [...] so that puts a certain filter. It puts almost a veneer of respectability on things that sometimes don't bear (out). When you actually dig down into the methods or look at what they have done, you may not be as convinced that it's appropriate to be using it. So it is an ongoing challenge for us. It's a very interesting world. But frequently people will pull a paper and say look, this was in JAMA (Journal of American Medical Association), this is the real deal, and they've said this, and let's all go down that road. And sometimes it's not applicable to us, or the methodology is not strong, so there are certain assumptions around, oh, if it's in the published realm there's that quality assurance and a rigor, but we know it's not necessarily the case.

Belinda could be talking about several of the other policy workers I interviewed: people who attach this (veneer of) respectability to peer-reviewed published literature

and see it as appropriate in clinical policy areas. And while her critique is different from Ruth's, she also challenges common (but different) assumptions. Although some policy workers may have assumptions of what kind of policy work is appropriate for randomised controlled trials, Ruth and Belinda both trouble those assumptions and complicate the benign tone in which evidence-based is usually referenced – including by their Ministry.

The more junior level policy workers appear less clear on the existence and value of qualitative research than those with more experience. My conversation with Evan is almost over when I ask him if some study designs (Evan and Kara have consistently used the term “studies” and “papers”; Evan asks if I mean study design in response to my question about how he recognises evidence) are seen as more valuable than others. He acknowledges:

E: I think policy is driven by a wide range of different types of research. You can have your perfect, your more perfect studies on that end, and sort of ones that are a little more in the middle, your just pure administrative databases. I don't think there is one exact type of study the ministry makes decisions on.

C: What about qualitative research? Is that valued at all? Or do you even encounter it?

E: I don't encounter it as much – I guess, surveys and stuff. Maybe not so much. I don't know. We look at survey data sometimes. Physicians are sometimes surveyed about this or that and they include that in papers and we read those.

Evan is unusual amongst those I interview in that he appears to have no experience with qualitative research (or is not aware of having any) and thinks of it in terms of “survey

data.” When I ask him about the production of knowledge in relation to research, he asks me: “do you mean like an original thought?” This comment is from a master’s prepared policy worker who identifies as a mid-level policy analyst.

Sally is one participant who appears most open to methodologies other than randomised controlled trials and systematic reviews. However, she is clear: “When I am talking about evidence, I am thinking about scientific evidence. Yeah, that’s what I’m thinking about.” She continues:

There have been occasions when, for reasons that, whether it’s because elected officials have a particular belief about the efficacy of something. And I mean with people moving through the portfolio at elected levels and people always think, they come in thinking, ‘I am going to solve the problems and I know the answer and it’s got to be this, this, and this.’ And so the policy development on-the-fly. [...] We probably don’t see it in the same degree (now) but when money was flowing more, that there would be a 50 million or 90 million or whatever tens and tens of millions of dollars investment into something that the calculations were done (on) the back of an envelope or napkin kind of thing. That... And the environment that people are working in where the public reacts strongly around issues related to health care elected officials and want to try to figure out solutions and they want to try things want to be responsive.

In this excerpt, Sally argues the most classic case for ensuring policy is evidence-based: to save us from on-the-fly (thus irresponsible) policy-making with insufficient rationale but sufficient cost. She follows this argument for scientific research with a lengthy reflection on her time working on a participatory action research project with the Ministry and members of a particular community whose voices were (and remain) largely unheard. “We were like delving deep and it was really a fine heady time,” she says with enthusiasm and more than a hint of nostalgia in her voice. “I know very

intimately about what it is like to try to assemble, to produce knowledge, to make change, to bring it forward and to hear from people who have been very much without voices, to hear it in their own voices.” Since then, she has been more ensconced in health policy areas drawing on scientific research, but admits there are times when it is necessary to be “creative”: policy delayed trials where randomisation is not possible, then post-market surveillance when the policy problem calls for it, the uptake of new devices such as titanium hips, and even ethnography. But, Sally adds, “if you are trying to talk to (medical specialist), and you're trying to talk to different people whose support is absolutely critical, you need to have it (high quality research and the quantitative stuff).” Ruth shares a similar sentiment:

S: Well you don't want to go back to the time where a bunch of people would sit on the 5th floor of a building and say 'let's just do this, it sounds like a good idea.' And if that is the antithesis of evidence-based practice, we don't want that to happen anymore as an exclusive way to create policy. Now, sometimes people have to brainstorm and blue sky and actually really think out of the box. And just doing evidence-based practice is not helpful because you are building on something you know, not creating something new. But the time when people sit in a back room and say 'I think every kid in B.C. should do X' you don't want to do that.

C: how long ago was that do you think?

S: I don't know. But know evidence-based practice/evidence-based policy-making happened about the same time population health promotion was created. Probably it's been 15-20 years. You know this... there is some discipline that comes with that that is good.

Tim is more frank with me than his colleagues. You can hear the cynicism in the following excerpt.

T: (W)hen I first started working here, about a decade ago, the big buzz word was evidence-based policy and you know we had to make evidence-based policy. Even though [...] I understand that policy is rarely about just evidence. Hopefully, some evidence. And evidence as it is defined in the circles that we move in here at the Ministry, means basically peer reviewed academic journal articles.

C: Would you say it is still a buzz word – maybe not so buzzy because it is not so new, but is it still something that guides what people are supposed to be doing around here?

T: Absolutely. No, it is the be all and end all. And sorry, I should say peer reviewed academic journal articles with quantitative methodology. [...] It has to be numbers-based because anything else is touchy feely.

C: So is that something that circulates around you – you are meant to be producing evidence-based policies?

T: Any policy recommendations we make have to be supported by evidence. I wouldn't ever put forward something that I couldn't justify with peer reviewed academic literature with quantitative analysis.

Tim is clear that evidence is only understood in quantitative terms from peer review literature. He has come to accept that is what is needed so that is what he goes looking for. He continues:

Science itself is a monolith, it is a bunch of competing – people working with their own hypothesis, and funding sources. So the politicisation of science – so the other piece around evidence-based policy is what I call policy-based evidence, which is where the evidence-base that we have to draw on is actually very much constrained. And I like to use a funnel metaphor. At every level of research, there is a narrowing between what is possible to be investigated – I call this top level the research imagination, like for a researcher to even conceive of a question to investigate scientifically requires a certain kind of imaginative capacity. But that's constrained right away by the social forces around us where certain kind of questions just don't even come into someone's mind.

Referring to an issue he is interested in, Tim describes the difficulty encountered in research:

Most research would never even think of that (particular approach)! Even if they did imagine it, to put forward a grant application, you know they are going to self censor – even if they had the idea, like oh now, that’s such a crazy idea, no one would ever go for it so I’m not even going to put in the grant application. Even if they went over that and said ‘I’ll put in the grant application.’ Next level, no, the grant application adjudication process is like: who is this crazy researcher saying this crazy stuff. That will get weeded out there. Even if they were to get the grant and go through with the research, submitting it to a peer review journal, it’s going to be narrowed – the peer reviewed process is very conservative. So peer reviewers will say: ‘this is preposterous, it doesn’t fit with my ideology.’ And so what you get is this kind of tiny drop of authorised knowledge or evidence that is very much distilled out of what is possible. And it’s not the be-all-and-end-all of that kind of possible capital T Truth that could be found.

Tim concedes: “We live in a very constrained environment with respect to what we can put forward as policy options based on the evidence that’s available to us because evidence itself is very much constrained by the broader ideological apparatuses of the state. [...] Science does not have all the answers.” I ask him how it is to work in an environment that places so much value on scientific and quantitative evidence when he has a critical perspective. “Sometimes I feel like I am spinning my wheels here. It’s like digging the hole and knowing it is being filled – as you take a scoop out, two more are being added. [...] But recognising the bigger picture; it’s like not expecting to see any change anytime soon.” Tim’s critical analysis on knowledge production and the entire evidence-based policy-making process is remarkably different from all the others I interviewed. He knows what the acceptable (to the Ministry) answer is when I asking him if any knowledge has more value than another.

You know, if I was being asked by a Minister or one of my superiors here, I’d say methodology, looking at the rigour with which things were done. Was it a randomised controlled trial? Was it just a review? Is it qualitative? In reality, it is

ideology. I think in the end, well, I shouldn't say that with everything. But in my area, [...] so much of it is ideology. Because again, the research that's commissioned [...] is funded, commissioned by the US government. [...] Where the US government doesn't commission research on prevention that doesn't align ideologically with its (position).

The expanding cracks in the commitment

One might assume from the policy framework documents and other government texts that the Ministry of Health is committed to the idea of evidence-based policy-making and actually follows through with the commitment. Most of the policy workers I interviewed articulate this shared commitment – initially. But not everyone. And for those who do, as our conversations continue and they talk about the specifics of their practice, the idea that they do – or even *can* do – evidence-based policy-making begins to erode. “One of my staff thought that if we just took a report to the board of health it would happen [...] just the fact that it was a report and laid out the evidence. [...] if the evidence says you should [initiate a policy related to her area], that was sufficient in her mind to convince all the powers that be.” In this excerpt, Patty acknowledges that evidence of any description alone is insufficient as the basis for policy, a sentiment many others I interviewed share. In so doing, they are troubling either the ease at which the ideal of evidence-based policy-making can be done or the concept itself. I heard myriad descriptions of what many refer to as their “reality” in which evidence is one component. Says Kara:

K: (T)he knowledge, the information we synthesize from all that is also only one piece of the policy-planning picture.

C: So I've heard lots about the others, but can you tell me what you think some of those other pieces are?

K: Well, I mean, it depends on, sometimes the timing when things occur, and what's going on politically, what's going on with maybe some lobby groups, you know, that external environment certainly influences what we work on here in kind of, you know. Sometimes it's more reactive more than proactive types of research that we would do on topics. Trends in the external environment, you know, if it was something to do with obesity in school children, we might be doing a paper on that because it's a really big issue, or salt reduction, or something like that. What's happening in other jurisdictions influences what we might work on, if Ontario has decided to change a policy on something, we'll think oh, maybe we should be looking at that, you know. Or, it's so varied, it can be the deputy minister read an article on the helijet coming back from Vancouver and wants to look at it [C: his crank got turned?]. Yea, that's as varied as it can get.

Kara succinctly lists the many influences policy workers face daily. Patty adds something Kara does not mention: emotion. Patty describes an encounter she had with a federal Minister of Health in the previous Conservative government under Stephen Harper (a government Patty believes “doesn't pay any attention to science in particular, that their ideology is what drives them”). Patty was representing the B.C. Ministry of Health when working with the federal Minister, who Patty believed was resistant to the advice Patty and her colleagues were giving her. Her comments are aligned with Lasswell’s desire, discussed in chapter two, for impartial and apolitical advice to decision-makers:

Our role is to give the best advice possible. Our role is not to make the decisions and so that's how you can work with any government. [...] And so what drives policy often is emotion, not knowledge. And we said there is no evidence on which we can base a statement like that (policy example). [...] (E)motion and people's preconceived and people's firmly-held beliefs on a topic get in the way of both policy development and behaviour change.

According to Tim, some initiatives for which they have had evidence have only been implemented once it became “politically possible [...] So, I feel kind of fortunate that the kinds of things that we’ve been directed to do politically are also supported by solid research evidence.” He runs into conflicts, however, when different levels of government working on the same issue have different points of view – and evidence. Referring to another jurisdiction: “they’re commissioning their own evidence. They hire researchers to produce evidence papers to support their position.”

Oren’s initial, almost straightforward, description of how evidence leads to a recommendation turns into a convoluted picture of the myriad considerations alongside evidence that needs to be considered before a recommendation can be acted upon.

So our recommendation is the government consider adding this (intervention) to the publicly-funded schedule. So we take all of that and that becomes a component of an even bigger decision, which is, what funds are available, is this a priority, are there other priorities, what in fact are the qualities, what is that all about, [...] we're hearing it's feasible to deliver, but the feasibility is, you know, there's another money piece to that...

So while policy workers may want to start with sound evidence, they do not end there.

Patty understands what “gets in the way” but also positions these interferences as a feature of, not external to, policy development.

Winding up her story about when, earlier in her career, she participated in a debate about the merits of creating a policy agenda on a particular health issue that leaves many people marginalised, Sally says “it (this experience) strengthened my

understanding about the need to figure out and get some high quality research and get the quantitative stuff. Because if you are trying to talk to (a medical specialist), and you're trying to talk to different people whose support is absolutely critical, you need to have it." Similarly, as I noted earlier, Evan says:

E: The doctors like the double-blind [RCTs] studies. So that's what I think our area has pushed more towards. You know, we do a lot of things with physicians. They like to see their studies kind of like that.

C: So you're guiding your knowledge to fit the population that you're working with, which is physicians [...]?

E: A lot of the, yea, the physicians, they kind of like to see the evidence right. I mean the Ministry works on a lot of committees with physicians, you know, (names of committees) and you know, the physicians are very much, they like to see, you know, they like to see evidence and some papers before they're sort of willing to jump into things too quickly. They like to be guided by that.

Evan introduces the concept of evidence and talks about studies and papers, but not evidence-based policy-making so I ask him about it.

E: I don't hear the term thrown around a tonne. I mean it's used at the committee meetings, you know, and I think it's kind of, I don't know, I almost [...] think it's done more so in health. It's kind of understood that if you're going to be doing anything, do a little research first, you know

C: and pull out some stats and some numbers?

E: We're encouraged to build it into everything, but also you're supposed to kind of keep up on those papers, read them, so we can have an informed . . . because when you're dealing with physicians, they're very smart guys, they're very knowledgeable and they know what's going on and stuff and a lot of them are familiar with what's going on on the ground and it's . . . if you're going to have a useful discussion with physicians you kind of have to be, you know, have that stuff in your head, you have to sort of know where . . . not necessarily to quote off each paper, but sort of know what some of the research says, right, because you know, you're dealing with a very informed group of people, right.

One's audience matters; the audience often determine what counts as quality evidence, what evidence is needed and so must be kept in mind. Required, then, is a managing of evidence and an understanding of one's audience to ensure the desired kind of evidence is provided for each audience.

Several people nuance the phrase "evidence-based" to "evidence-informed." After repeated references to "evidence" and an acknowledgement that she wants "to ensure her practice is based on the best available evidence," Seline corrects my question about evidence-based policy-making, saying it is "evidence-informed." I ask if that is the term she prefers. "Well I do, because it's not just the evidence." She expands:

(T)he fact is, is that you can take the synthesis of the evidence and so, to varying degrees people will uptake on that or they won't. So first of all, you have the leadership within the Ministry or you may have outside leaders with influence, or the public, so it is something within the public realm, seemed to be important at that point in time. [...] (W)e do our best at working within the Ministry to inform our elected officials and those that are officially, even more directly, it's those that are appointed in terms of the leadership within the Ministry, you attempt to inform them, but at the end of the day we also work for an elected body. [...] and it's the community, it's everything. I mean what does the population want at that point in time? There has to be a readiness factor, whether it's local government, whether it's your partners, or whatever.

Furthermore, the effectiveness of evidence alone is insufficient or too narrow a basis for assessment. Seline has a range of people to consider, whose voices weigh in on what initiative should be implemented and her evidence will only go so far. For evidence to be useful within B.C., as noted by several others, *applicability* is important:

(Y)ou need to move beyond that (effectiveness) to say when you actually implement it in real-life experience versus in the research situation, can, is it

actually effective in the community or with individuals and, you had to know the context where in which it was initially done, and the context of where you're attempting to implement it are similar enough that in fact you may get similar results. And so looking at it, does the evidence seem strong enough or promising enough because there's so many similarities to what's worked with other types of programs or something that you would actually look at implementing it across the province or in a larger setting.

Seline provides many considerations to which policy workers need to pay attention outside of evidence. Belinda's take on "evidence-informed" differs from Seline's: "(T)o me it's just sanitizing. People are doing exactly the same thing." Evidence-informed is "the same thing" as evidence-based, just "sanitized" with a different, perhaps more palatable, name to make it seem more acceptable.

Hal explains his shift to evidence-informed immediately after claiming to do evidence-based practice:

H: For sure, from a knowledge generation/knowledge translation perspective, we always do evidence-based practice. As an underlying principle, it is evidence-based.

C: And what does that mean?

H: So it's either based on best practices, so we go to the literature either in house or work with partners or contract literature searches and we use Cochrane reviews. Most of us have collaborators on research as well. So it is evidence-informed practice. So we're developing evidence-informed practice while we are developing programs and policy. So it's implementing research in practice.

C: OK so can you distinguish for me evidence-based and evidence-informed?

H: It's interesting, we tend to be doing some sort of evidence-based decision making or decision-based evidence-making.

C: What does that mean?

H: Decision-based evidence-making, which is a term that's been around for a couple of years now. So decision-based evidence-making. We work in a political framework. So our political framework – we often get, sort of, I won't say direction but good ideas that are generated through MLAs, which would often come from the community. And uh, sometimes those things are brought to our attention and we will do the appropriate review and make recommendations but it's not our decision on where those recommendations go. I mean it's political systems. So, cabinet will make the decisions on which way to go. So we - everything we put forward is based on the evidence and if it is not based on the evidence, we will say so. We will say there is evidence contrary to this. And we have the ability to put that forward. But decisions are based on many, many factors of course. But when we are generating everything, we [...] use multiple approaches.

Hal begins first, by asserting that they always do evidence-based practice. He then identifies evidence-based policy-making as the underlying principle to policy workers' practice, which is somewhat nuanced from something "we always do." However, he is holding firm. Asked to explain the meaning of evidence-based practice, his answer is typical of that given by others: literature searches, Cochrane reviews, and collaborators conducting research for the Ministry. Then Hal takes a slippery step, saying that what they do is evidence-informed practice. He gives this term a definition common to that of evidence-based policy-making or knowledge translation: implementing research in practice. I am familiar with the phrase evidence-informed and it is not the first I have heard of it in these interviews. But I want to know how Hal understands it in relation to evidence-based policy-making. It is at this point that Hal, without missing a beat, turns the evidence-based decision- (or policy-) making concept on its head and says they do *decision-based evidence-making*. And with that new and completely different phrase that implies a meaning exactly opposite of evidence-based

policy-making, Hal describes the political context in which he and his colleagues practice and how this context *works* to influence the policy-making process. Evidence-based policy-making and decision-based evidence-making are two very different entities. Evidence-informed may be a nuanced version of the evidence-based, meant to soften the strict reliance on scientific method by acknowledging the value of experience and judgement. But “decision-based evidence-making” (two others call it “policy-based evidence”) introduces not just a nuance, but an entirely new twist that suggests *evidence must be found or created to support decisions already made* rather than using evidence in order to come to decisions about how to proceed. In other words, rather than developing decisions based on available evidence, they search for evidence that supports a decision. While acknowledging he works in a political environment, Hal seems unperturbed that the result is decision-based evidence-making; he provides no hint, indication, or demonstrable acknowledgement of the irony of this about-face. By introducing this different concept, Hal is not only saying there is more to policy-making than relying on the evidence. He is confirming Seline’s point that politics plays a major role. He references elected politicians as not just making the final decision but also bringing “good ideas” forward to be reviewed. Hal and his colleagues do their best to bring evidence to the fore and even note when the evidence is contrary to the idea, but that is as far as policy workers can go. After that, a decision is no longer theirs; it is a political decision made by elected politicians, even if the evidence recommends against

the decision. One of the key tenets of evidence-based policy-making, removing the politics from the policy-making process, is now pushed to the side in Hal's description of exactly how politics is integral to the policy-making process. Hal points to a significant crack in his own claim of evidence-based policy-making.

Yvan talks at length about the "big picture." I ask him:

C: So does all of this big picture you've just described, does it feed into what you referred at the very beginning as evidence-based? Is all of this evidence?

Y: Yes

C: No matter how it comes to be?

Y: Unfortunately, sometimes there's – oh what's that little line – evidence, or – research to produce evidence to support the policy that you've already made, right."

Perhaps this little line is Hal's "decision-based evidence-making" or others' "policy-based evidence-making." This concept is not just a one off; multiple people give it to me, but mostly sort of parenthetically, apologetically – perhaps because it contradicts everything they have told me about evidence-based policy-making until that point in our conversation and certainly, what is proclaimed by the Ministry.

Paige works as a policy analyst, at a more junior level than Hal and Yvan. She takes much more time to think about her answers, several times pausing for up to 14 seconds – which is a significant period of time in everyday conversation – before speaking. She conveys more emotion and judgement in her account, and in doing so, adds an insight missing from Hal's account. In the following excerpt, Paige describes her

work with committees and working groups of which the majority of members are physicians.

P: They decide on what is going to be the best initiative to implement. So they decided on (an intervention). They go away and think about it for a while and come back together and...so that's where we would come in, is to do the research for finding out where (the intervention is) being implemented around the world or in Canada.

C: How do you come to the place of 'this is the idea that we're going to do?'

P: (It) is kind of a 'thou shalt' right now. Which it was never, from our perspective ... the people who are doing the work have never felt like it should be that way. [...] And then all of a sudden, we'll be working towards something and looking into things and saying this is an area and this is an area we need to look and see if we can find something. But I think the reality is that it's someone somewhere saying [...] because sometimes this is *big in the news right now* [...] so we need to do something about that (emphasis added).

[...]

C: Who decides that it is (an particular intervention) that is going to be the solution?

P: We have a steering committee so that it's VPs within the health authorities so I don't believe that that's necessarily the right people to make the final decisions. [...] they don't necessarily have a good feel of what is happening in the health authorities on the ground. They are too far removed. [...] I think (it) is just the reality of how health works, certainly with the health authorities.

[...]

P: I really feel like it was whoever had the decision makers' ears. So you've got Dr. Whoever in (a health authority) who has done tonnes of work around (an intervention) and he wants his stuff done; he's good, he's in tight with so and so and sits on the steering committee or whomever. Each one of those people believe very strongly that what they are working on is really important and very beneficial. So, um, we did at one point try within our group to kind of pick the top 100 (interventions) and then put (them) through some criteria to see what would kind of come out. We ended up having to just make it come up with those people's answers anyway, which was very frustrating. We might be the people

who should be kind of looking into those things because we can get the data, we can get a lot of the data. And so I do feel like that is our role. It's just not really our role.

Paige's detailed excerpt offers a rich description of what it is like for someone in her position of policy analyst, who sits on a lot of working groups and committees, to try to fulfil her role. While, like Seline, Hal points to elected politicians as the ones generating "I won't say direction but good ideas," Paige points to people in the health authorities, particularly those with the "decision makers' ears" such as Vice Presidents of medicine within the health authority, for example, "the big wigs in the health authorities" who have influence over what the Ministry pays attention to, and other physicians as deciding which intervention will be implemented. Paige also refers to Accreditation Canada, a body that sets "ROPs" (she thinks that stands for required organisational practices) health authorities must meet. "So I think it was maybe thought of as the quick win, like we need to implement this by March 31. We need to jump on initiatives that are already out there and showing promise or whatever and also we have these ROPs that health authorities have to ... that's my suspicion." So, once the working group decides on an intervention, Paige is tasked with finding the evidence to support it – or, "they are giving us the evidence and we're working on it." The significant point here is that the decision to adopt a particular intervention *precedes* the uncovering of evidence as opposed to looking at the evidence and determining which decision to make. And while she does not use Hal's language – decision-based evidence-making, she certainly describes it, naming physicians. Ruth confirms Paige's experience: "Physicians

(are) a tremendous powerhouse in the politics of health care.” Cassie takes it up a notch: “there's so many power drivers in the system. Like in the health care system it's all driven by male physician politics.”

Unlike Hal or Seline, Paige expresses her discomfort and frustration with the process. “Health authorities see us as the big brother. One of our biggest battles is trying to get them to understand we are not the ... we really want the good for the people.” On committees and working groups, Paige works a lot with physicians from the health authorities and physicians in practice. She believes they, particularly those from health authorities, see the Ministry as getting in the way, “telling them what to do.” While each of Seline, Paige, and Hal use very different tones while telling me these accounts, they articulate the same point: despite the heavy emphasis on “evidence” within the Ministry, policy-making is anything but separate from political influence. Political influence, wearing a variety of hats, appears to be front and central.

In her first comment to me, Debra says she works on establishing evidence-based guidelines.¹⁵ I ask her later in our discussion what the evidence-based approach means to her.

D: Well that's something that we really struggled with because a lot of the original (guideline) areas they have one or two champions who pushed us towards certain guidelines.

C: Champions, being people?

D: Yes, people actually within the health authorities, who sort of had maybe a bias towards a specific guideline and now we're looking at them and being like –

¹⁵ This example is why I am looking at policies and guidelines – Debra offers an example of how evidence-based guidelines are also fraught with politics.

maybe that's not the best, maybe the evidence doesn't support that kind of approach. So we are looking at maybe creating some more rigorous approach to the collection and a review of evidence.

Debra uses the term evidence-based at the outset of our conversation; Paige does not use it until I bring it up. Yet both describe the same scenario, when sometimes a guideline or policy is implemented just because a particular person or two wants it to be implemented. Says Debra: “(T)his might not sound good, but in a lot of cases there is a direction that we’re being pushed from senior executive so if you can find things that are pointing in that direction that might get a little bit more weight added to them.”

Debra then assumes a place of deference to explain. “It might just be my lack of knowledge of their decision making process. [...] (I)t sort of feels like it was randomly pulled out of the air, but it could have had more substance behind it. [...] They might have had more fulsome discussions than I'm aware of, (but) when it filters down to me, it's just ‘hey, we’re doing this now’.” However, given she is not the only one who mentions this pressure related to those in authority, I doubt she misunderstands the decision making process. She takes on a subservient role, downplays her analysis of how things work, dismisses her own assessment, and questions her own knowledge and in so doing, gives the committee credit. With less confidence, Debra’s account corroborates Paige’s.

I ask Paige about evidence-based policy-making because, even after her description of her struggles with the process, she has not yet referenced it. “I would say that is our

goal. But I don't ... I could just be being, I don't know, I don't feel that that is... I think they label it as that but I don't believe that that is true, which is why I haven't been saying it. [...] that is what they keep saying that is what we are going." "They" are the premier and deputy premiers – the executives of the government. I then ask Paige if the term evidence-based disappears somewhere down the bureaucratic hierarchy.

"Probably, because the people who are doing the work you know realize ... well, that's not true because I think that the people who do a lot of the work are, you know, they have been given this and they trust that ... and that's not to say that a lot of it isn't evidence-based. I just ...there is no framework to be able to say so." Debra also questions that what they do is evidence-based.

We've been calling it evidence-based because we have a couple of studies or another jurisdiction has been doing it. But I think most people would argue that's probably not the proper use of evidence-based. [...] It sounds like we've done the legwork and it wasn't done. [...] I think it (the term evidence-based) is becoming more and more used. I do an 'ow' when I hear it; I wonder if it is being properly used, and whose determining that.

Kara shares a similar sentiment. As I noted earlier, I introduced the concept of evidence to her after she offered a textbook description but not the label. I follow up with a question about evidence-based policy-making, to which she replies:

K: There's a lot of terms that get kicked around, and I don't think everybody's using the same definition definitely, depending on their background, the program area [...] certainly the pharmaceutical services division would be more, you know, a research-based area, because drugs is more an area where there is controlled trials and all that sort of stuff compared to in population health, it's a much more difficult area to find hard evidence about the results of a prevention program you know over time and stuff like that so you do your best with what

else you can get.

C: And that people, politicians and bureaucrats say, we do evidence-based policy-making.

K: It's not always true. I mean they'll say it (evidence-based). I think some people say it just because it sounds good, they think that's what people expect, that's what people want to hear. They're aware of evidence, but they don't always, certainly there's no guarantee, you know, when you've done all the research with the highest level of evidence you can find about a topic and you make your recommendations and it goes up the line, that the minister is going to follow that recommendation.

To Kara, the term evidence-based has become suspect; people use it because it “sounds good.” It makes people feel better. But, she suggests, it is not what happens. Cassie adds: “You hear more and more people now talking about evidence-informed. [...] But to me, it's just sanitizing. People are doing exactly the same thing. [...] I think it's kind of ‘the emperor has no clothes.’ That's the long and the short of it. [...] Somehow that gives us both individually and us professionally a sense of security that we're doing the right thing. And I'm not sure we know that.”

Speaking truth to power: The job of an analyst

As noted earlier, many policy workers see their job as providing advice or recommendations on issues of guidelines or policy, regardless of their level. A few frame their understanding of their responsibility in terms of “speaking truth.” For these policy workers, searching for truth and ensuring it is central in their recommendations is at the core of their work. Says Patty: “So it's important for us to be speaking the truth and saying this is what we know about this particular situation and this is what we know has

the potential to impact the situation and this is how we might situate it in B.C. because of x, y, z.” Cassie talks about one of the few people with clinical experience or providing clinical advice: “(S)he's incredibly knowledgeable about the administrative systems within government and she uses that knowledge to be able to direct practice in what I would say was a very progressive way. [...] She's very interesting. So she'll go in and she'll say, that's not true what they're saying. [...] She's rare, and she speaks truth to power.” Cassie adds more detail to her thinking about speaking truth, furthering what I noted she said in relation to power in the system:

I sometimes think it is, too, that senior executives go up with this briefing note and they watch eyes and reaction. And my experience is there's not many that will argue for the science. They're more concerned about managing up, doing what [...] saying yes to power. [...] (T)here's so many power drivers in the system. Like in the health care system it's all driven by male physician politics. So somebody at some point has to say this is not true. Call it.

Kara agrees, but acknowledges a tension when describing her role of policy analyst, her professional obligation, and her “reality”:

The role of the analyst and the job of the analyst, and I remember this line that [my university professor] said in our masters program, was speak truth to power, you know, and that was our job. And so to speak the truth of the evidence up the line as best you can, even knowing probably at the time that there may be all these other influences and factors going on but that's your job. And at some point it's up to the deputy, who knows, it's beyond your control. It's the reality of the situation.

This term, “speaking truth to power,” used by all three, is loaded with assumptions: that truth is out there in the world to be found and spoken and that power is central to their work. I expand on these points in the next chapter.

Evan talks in terms of the balance of evidence and will:

E: (I)s there evidence out there (for an intervention)? [...] (D)o we have that many papers? And we'll talk about that and say that, and that kind of guides where you might go to a certain extent. I mean some of it's still, you know, I think it's a balance, you know, I mean, you know, you use evidence, but some of it is also, you know, will.

C: OK, say a little bit about that.

E: Well, in some areas you might have some evidence, but at the same time it's sort of, in areas where it still might be a good idea, but maybe you don't have a tonne of evidence, some of it comes down to will. Does whatever committee or whatever executive, do they want to push that, do that want to move that forward? It's kind of, you know, sort of, you know, a lot of government and bureaucracy. You should have your evidence there but in terms of when things get done, a lot of that's sort of, you know, things flare up there, when there's an appetite for that when there's an appetite to push that policy of whatever, you know, you sort of have to take advantage of that timing, and have your research and have some research there, just kind of like a backup and have something to say in terms of the research, and you plug your research into those specific points in time when there's a lot of will and there a lot of desire to do, if you don't take advantage of that opportunity, you know, it might not come along again for quite a while. Maybe there is evidence just for that.

C: It's not just about the evidence, then, is it?

E: Yea. It's evidence working in the reality of a political structure. It's not this system where every single thing, where there's clear evidence that there's a good idea that we're doing to do. Government doesn't, you know. Maybe in a perfect world it would work like that where every perfect idea, let's do (it). Other people might disagree with me, but I think that you've got to pick your point in time. It's sort of the flavour, you know, that's what the politicians or the higher executives want at that time you know, you push that, you get your evidence behind it, you try to get your evidence behind it as much as possible, as you put it, and then move that forward, right. I mean we've done a lot of research and looked at a lot of papers on different things, but it's kind of just so we know what some of the papers are saying on certain things.

[...]

E: I think most decisions or actions on things come from the deputy minister or

assistant deputy minister and up. [...] I think it's quite top driven. I don't think in general the government is good at grabbing on to good ideas. I don't think they're good at innovating from the bottom up. You know, there's tonnes of people working in all these ministries that are highly educated and you know, they don't have good ways of generating ideas and generating good ideas and you know somehow picking those out.

C: It's more top down?

E: Yea, I think it's pretty top down, like any large organization maybe, but for good or bad.

Paige, Kara, and Evan, all policy analysts (vs. management), each point to the layers – or storeys – of people and considerations that epitomise their work. That the details each offer corroborates the others' accounts shows their experience is not likely unique. They hold evidence-based policy-making as an ideal, yet so clearly point out that it is cracked, interfered with by their "reality," which they critique. Ruth, who works at a director level, is critical of the concept itself, proposing an analysis of the practicalities of "what really happens when people are trying to make policies. It is not a straight-line thing. (A) much, much more sophisticated analysis of power and political science is required than this recipe of you know: I'll give them the right research study and they'll make the right decision." Ruth continues:

(Policy-making) is not linear at all. (Evidence-based policy-making is) like a kindergarten (understanding) of what policy-making is about. And it ... when I left my (undergraduate) degree [...], we all believed that information-liness was next to god-liness. Build the system and great decisions will come. And it is just not that simple. It was the great disillusionment of my first career. It's not that good information shouldn't help and support good decisions; it's true. It is an essential element. The better the information we have, the better we can manage. But it's not the only element. It is a much more sophisticated analysis of force fields or something that you have to do. Like, what you don't want to do is

to do policy that has no evidence unless you know that you are making it up. I cannot help but wonder if “making it up” has happened (and still does?) but is not acknowledged. Ruth offers a pragmatic perspective of policy-making. She is one of only two participants who offers an outright critique of the concept of evidence-based policy-making as the idyllic policy-making model to work toward and the claim that it is the essence of good policy-making. “(O)ne of the things that I think is a problem (is) with the arrogance with the evidence-based policy argument from academia is: policy-making is not like a recipe. [...] They don’t understand our reality.” There is an entire set of literature aimed at people such as Ruth that focuses on how to generate research more applicable to, and improve the uptake of evidence in, policy settings. Ruth adds to the list of other considerations and influences on policy workers’ practice:

(O)ne has to know the politics of the organisation and the big P politics out of government, right? You have to know who is pushing what, what the funding implications are, what the do-ability, the skill level of the people implementing the policy or writing the policy or writing the legislation would be. Like how it could fit. And evidence is only one part of that. So, it is like a litmus test, practical reality. And the competing interests which are not bad ideas competing with one good idea. They are all good ideas.

The necessary rebar

Throughout the interviews, people offered examples of considerations they needed to pay attention to alongside evidence and the previous sections dealt with many. The most consistent, however, was cost. As noted in my discussion about the policy frameworks, increasing or contributing to the sustainability of the health care

system is a responsibility of policy. Oren reiterates this position, saying financing and resource generation are the first of three “buckets” under stewardship, before service delivery. I asked people what they thought was necessary, to be convincing, to include in a two-page briefing note seeking support from a cabinet minister or the treasury board for an initiative or policy direction. Says Diane:

D: Definitely evidence. You definitely have to put in the evidence, what the impact is going to be to the province, maybe what another jurisdiction is doing.

C: So a comparison?

D: Comparison and of course the bottom line. What is this going to cost us, and for how long, what's the sustainability [...] and that will all be in the cost-benefit analysis. But certainly evidence comes in quite heavily.

Evidence, yes. But the bottom line, the rebar that must hold up a policy, even in the absence any (other) evidence is (of course) cost, linked with politics. Diane uses the language in the Healthy Families Framework: sustainability. She knows this is required of her; it must be factored into any policy recommendation. Debra weighs various factors and cost wins:

I would think that it would [...] (be) that costs would have a larger impact than evidence so that if we could demonstrate that this is going to save money through this, I think that would hold more weight. [...] I think the financial piece always comes into play; I'm not totally sure what the degree is, if it's the number one consideration or if it's... I mean patient care is always on the forefront but I could see certain projects being picked over others because there is a cost savings, and a really tangible cost savings it seems.

Patient care appears just short of an afterthought; Debra sounds as if she is reminded that they must be considered “on the forefront.” But she also says cost is often the

criteria for decision-making. She, too, references sustainability, although indirectly; she needs to demonstrate that her recommendation would save money. Kara also links costs with benefits: “You're looking at both sides of an issue, and then trying to see if the benefits outweigh the cost, or whatever, in terms of B.C.'s situation.”

Hal answers my question about a briefing note: “We always put the evidence in there, we don't often cite the evidence because there's no need because there's an understanding that we've gone through an evidence-based decision making and thought process to formulate a budget ask.[...] In those (briefing notes for decisions) are options for pros and cons and budgets associated with them.” Evidence and budgets go hand in hand.

Evan brings up cost in response to my question about research methodologies: “What kinds of research do they (researchers) do that's considered valuable by you, because you're having to make an assessment of all the literature that you read?” Evan replies: “They'll say if it's worthwhile doing in terms of cost-effectiveness and other things like that, sort of general, you know, worthwhile doing in terms of population.” To my probing questions about methodologies, he answered: “I'm not really too sure.” He does not think in terms of methodologies but what a “study” will tell him about cost effectiveness; that is what determines whether something is “worthwhile going.” Evan's understanding of how a policy is determined to be worthwhile is narrowed to cost effectiveness: cost effectiveness as evidence.

Seline links the need for budget consideration to the reality that she works in a political environment:

(A)t the end of the day, we also work for an elected body. And so, you know you have to (say), what's the budgets that are available, are there opportunities to produce new things because there's sufficient funding, are you in a period of cutback where you may have to look at different approaches or amending approaches so that you can actually move forward.

Again, available budgets determine policy choices.

Ruth references the Institute for Health Care Improvement's triple aim, which B.C. has modified.

(T)hey show it is as a triangle where if you improve population health and outcomes, reduce costs, and improve patient experience – we call it patient and provider experience because we don't think it is any good to improve the patient's experience and not improve the provider's experience because it is not sustainable. And that some of the evidence will show you that in doing all three, you can do all three. It is not like a project management triangle where you can only do two of the lengths. Lots of things that are good for patients actually cost less. Right? And lots of things that are good for patients' experience actually result in good outcomes. So, you don't necessarily have to trade the three off against each other. You know what I mean? What you are looking for is a sweet spot where you are hitting them all.

Ruth wants to make sure I understand her when she argues that cost considerations do not have to come at the expense of what is good for patients. Unlike her colleagues who believe costs are the most important consideration, Ruth says you can have it all – and there is evidence to prove it.

In Oren's mix of listing the features of "strategic policy direction" (relationship building, setting goals, accountability, population and system outcomes) are "tools for

implementation.” “Rewards and sanctions to be honest. So the tools for implementation is the more polite way of putting (rewards and sanctions). So how do you work with dollars and cents, with public understanding, with public accountability.” Budgetary considerations are as, or more, important than other strategic planning.

Patty also talks about the importance of an economic argument but she spins it as a positive; that putting money up front will save money in the future:

P: And the economic arguments seem to be more critical now as in, more important than they were before. All governments are seeing health costs going up exponentially, and they're just very gradually beginning to recognize that we really do need prevention and health promotion and so on, not that anybody understands health promotion, but that's it's going to cost us some money up front

C: to see a decrease on the other side?

P: Yea, and we are in the fortunate position now that we have a Deputy that was the Deputy of Finance. He knows figures and costs and he is willing to listen, which is really nice

C: and rare?

P: yes, from my limited experience.

Subtly, Patty is linking “putting money out front” with evidence that health will be improved in the long run. Hal has a slightly different take: “There is never an approach from the health system to save money because we don’t have enough money. There’s been a strong evidence on cost avoidance so that cost can be reinvested in another area. It rarely gets reinvested in the prevention piece, though.” Sally spins cost positively:

That said, a lot of the research and the evidence that we collect is not of that nature (post market surveillance). It may be cost effectiveness. And cost effectiveness not just looking at the dollars but trying to understand what the benefits to people are. And well designed so that it is not necessarily just our own system measures but at other levels in metrics that are meaningful for people.

Cost effectiveness for Sally is both dollars and cents and human benefit. But she also indicates that the value of evidence is whether or not it demonstrates its cost effectiveness.

Shifting ground

The previous sections relate specifically to my interest in the practices of evidence-based policy-making: what it is, how it *works*. Standing out, however, is a feature of many interviews that does not, at first blush, appear to be related to understanding the practices associated evidence-based policy-making. It appears so often and usually very early in the interviews (a few times in the answer to my first question and sometimes in the same sentence as “evidence”) that I began to see it as more than just a descriptor of work context. I will let Paige, a junior level analyst, introduce it:

I don't even know the name of the branch right now because it's ah, it's changed again. [...] I think our branch name has changed about six times in the last three years. [...] At one point, it was only me. And then I spoke to the HR (human resources) person and going 'you know there's only me, right?' She was like 'nooo' (laughter) but that was during the big transition to the new ADM (Assistant Deputy Minister) and we had no director. And we had no executive director at that point, that kind of re-org. Debra¹⁶ was on a TA (temporary assignment) in a different division. And I was like 'ok, it's just me. I am going to go for coffee now.' (laughter) [...] We weren't able to get any of the work done

¹⁶ pseudonym for another policy workers participating in this study

really. It was really not a, well ... it wasn't the way to go. Then, of course, we started losing employees and we aren't able to replace them."

Paige paints a picture of mayhem resulting from the perpetual shuffling, restructuring, and downsizing. She laughs at how ridiculous it sounds. Kara, a senior policy analyst, works in a completely different branch and even though she is a more seasoned policy worker, she shares a similar story. She makes her point when answering my first question to her "what is your role in this branch." She responds not with her job title or description, but by explaining that the role of her branch has changed four times in the past few years. She follows up:

We've also, in the last three years now, had a total division kind of change with the assistant deputy minister retiring and then a new person coming in with a whole different vision for our group and then another re-org just this past fall with another new ADM and an ED retiring and not being replaced and our branch split, literally, into two bits.

Debra, to whom Paige refers, answers my first question to her "what is your exact title" by saying: "I am analyst in (name of) branch but the branch has changed names numerous times. I mainly work on (program area) which is establishing evidence-based guidelines to clinical care in some specific health areas." Debra's first response in our conversation references confusion about the name of her branch as well as her focus on establishing evidence-based guidelines.

The recounting of these "reorgs" includes tales of turmoil and commotion that define the work place such that these policy workers tell me about them often at the outset of our conversations. These accounts signal that a key piece of policy work

includes negotiating with/in this constant shuffling in order to find one's footing. Stories about new ministers, deputy and assistant deputy ministers, managers, and directors, each bringing new visions, ways of working, and priorities are common – and frustrating. Says Evan: "I'll be working on something and I'll say 'well this is sort of the direction I am going in.' But you don't often have time to finish it because quite often they'll...the next meeting comes around and you'll change direction."

Several junior-level policy analysts talk about the number of committees on which they sit: functional, data, and communication working groups and steering committees, for example. For a couple of policy workers, these various committees exist for each of the 11 care areas of their branch and they have, on occasion, been required to attend all committee meetings. Each committee has representatives from organisations outside the Ministry: clinical leads, support leads, "bigwigs of the health authorities" – usually physicians, and often community members with whom they must liaise and provide support as well as do the work requested of them. Several policy workers confessed there is hardly time to do their work with so many meetings to attend and people with whom they must communicate.

These comments are often (but not solely) made by junior level analysts who are trying to find their feet at the Ministry and/or in their role as a policy worker in a Ministry of Health – with often little or no training or experience relating to health. They are also the ones with the least control over their work; it is given to them by managers,

directors, and sometimes committee members. A few take their time in answering questions, often saying they have never thought about the kinds of things I ask them – knowledge and research methodology, for example. “I've never really thought about methodology before” and “a lot of the things you are asking me, I haven't considered before. And I don't know why that is.” says Debra.

Debra describes the bureaucratic hierarchy: “My level is sort of 4 stages down from the decision, like the decision is made and then to the executive directors and directors and then down to me.” Those at a management level are not entirely exempt, however. They speak of the political influence over the policies and programs on which they work and about needing to respond to a new idea coming from a MLA, for example. But they do so in quite a different tone than the more junior policy workers. They do not make a list of the interruptions; they do not hint at any sense of frustration or bemusement. Those in management positions also speak more matter-of-factly about their work – with confidence: this is how things are.

I had personal experience with the problematic of these reorganisations several times, beginning with my own entry into the Ministry as a researcher. I had established a relationship with a director who supported my research and had already introduced me to her team. By the time I got ethics approval and started to set up meeting times, however, my contact person had left the Ministry, the team was dismantled, and the community of practice meetings to which I had been invited had ceased to exist. And

later, between the time I set up a meeting time with a participant and the meeting itself (no more than two weeks), the programs and people in her branch had changed. This institutional instability is not unique to this Ministry or even to government and is not necessarily causally linked to evidence-based policy-making. As those I interviewed continually volunteered information of these disruptions without my prompting, however, I realised it was a significant component of the context within which this work takes place and needed to be accounted for in my analysis.

These workers are positioned to offer some insights into at least this one aspect of organisational practicalities, contributing to an authentic view from the inside about how doing evidence-based policy-making works in their (and likely other) setting(s). Their descriptions of their working world that appear in both this and previous sections illustrate the challenges faced daily. This constant shifting, the "minutiae of changing institutional structures and practices" (Sharp & Richardson, 2001, p. 198), helps to explain why, when the ground underneath them is in perpetual motion, policy workers search for something concrete on which to ground their work, such as evidence and the promise of evidence-based. Evidence-based policy-making offers a way to create order out of disorder. Just like science's experiments offered not only a solution to the "problem of knowledge" but also a solution to the "problem of social order" (Cayley, 2007a), evidence-based policy-making provides a structure to manage the population of policy workers as well as the public.

Several junior (and senior) level policy analysts use the word methodology only as it relates to the process they use in their work. According to Kara, “our branch would always attempt to start at the top (of the knowledge production hierarchy) and work down, so that was the start, our methodology.” Evidence-based policy-making acts as a framework that is meant to define how they go about their research. Debra makes the link between the shifting nature of her work and evidence-based policy-making:

D: (W)e have had a lot of staff turnover and there's been a lot of changes of direction within the branches and within the division, the Ministry, it sort of changed, changed paths a number of times, and I don't really think you have a solid foundation to begin with, to keep it on sort of a solid methodology where this is clearly defined. [...] Yeah, previously in (branch name) we've been relying on what other people have been telling us is evidence.

C: Other people meaning...

D: Usually physicians and in most cases there's sort of a bias toward a certain guideline, you know they've developed a computer system that's going to track a certain thing, so they want us to put this in provincially and all the other health authorities will buy it, or whatever it is.

[...]

D: (W)henever there is a shift within our branch or if I change roles, having new colleagues is always something that really changes how I think about things just because you get exposed to people doing things a different way, and if you're in the same group you can get into a bit of a rut in terms of how you do your work. So moving over to (new supervisor's) area, she's much more – she wants everything documented and everything laid out really clearly so that if our branch changes or this project gets moved to another area of the ministries, it's easy for somebody else to pick it up, which isn't how I worked in the past, so that's been interesting.

C: [...] Is there a lot of shifting around?

D: Yeah, there's been quite a lot, yeah.

C: Is that typical?

D: Yeah from my experience in health, anyway.

I ask Debra how the claim of evidence-based policy-making is possible with all these shifts.

D: I'm sure that everyone would say 'yes of course it's evidence-based.'

C: So that's why I say right off the top, 'what does that mean to you.' I'm wondering if the constant shifting also impacts how evidence gets or can be used, because if your version is different from the person who takes over your file when it gets shifted over there, or the fact that you've only had it for six months before it got moved from you, taken away from you – what happens then to the grounding they or you were trying to bring to it?

D: Yeah and I think that's sort of what my executive is really pushing for now, it's because of those changes and things can get lost, and people can view things in different ways. Having a really clearly defined documented approach – hopefully that won't happen, things won't get lost.

Debra's director is pushing for her to take a more documented approach so things will not get lost in the inevitable shuffling around. So the "shifting ground" is yet one more feature of their work that affects policy workers' ability to do evidence-based policy-making. And given the multiple ways people understand evidence-based policy-making, its accomplishment is debatable.

I argue that taking account of this shifting work space – both literal and theoretical – is an important component to understanding how policy workers perform the work associated with evidence-based policy-making because it complicates any simple understanding of the concept as merely doing "what works" (Davies et al., 2000) and how "what works" can be put into practice. Scholars and the policy workers I

interviewed alike agree that “what works” is far more than facts and scientific evidence and demands problematisation (Marston & Watts, 2003; Sanderson 2009; Fafard, 2008, for example). However, there remains a dominant literature, both scholarly and practice-based, advocating for strategies to determine and implement pure, objective politically-neutral policies that will implement “what works.” The challenges my participants describe sifting through layers of evidence to determine what will be convincing and managing political influence are likely magnified when the issues for which they seek evidence are frequently changing. If the job of policy workers is to ground their work on the firm foundation of evidence, doing so in an environment that is itself groundless is somewhat ironic and prompts one to question the possibilities of staying focused and developing the knowledge base and confidence on any subject matter. But exemplifying the shifting context in this way sheds a new light on “evidence,” challenging its status as a solid reliable ground and underlining its own shifting nature.

This chapter unravels the claims made in the previous chapter. It illustrates how, through policy workers’ talk about the “reality” of the working environment, there is an undoing of the commitment and a troubling of the possibility of doing evidence-based policy-making. Beginning with uncertainty about what evidence-based means, through descriptions of people’s understanding of what constitutes the layers of evidence, the “reality” of their working environment becomes clear. Contrary to Lasswell’s view of

apolitical policy analysis, most of the policy workers I interviewed make very clear their awareness of the political nature of their work and show how their policy work is influenced by their political environment. In these two chapters, policy workers have described the minutiae that constitutes policy work in the kind of detail most outsiders rarely hear. What I make of this work and its implications are taken up in the following final two chapters.

9. The emperor has no clothes

We are the ones who hold the judgement power about what's admitted or not. (Tim)

It's all in the power dynamic of controlling information, and that's at the practitioner level, at all kinds of levels in the system. It is really fascinating. (Belinda)

I think it's kind of 'the emperor has no clothes.' That's the kind of long and short of it. (Cassie)

I am writing this dissertation in the lead up to and the aftermath of arguably the most important Canadian federal election of my time (over half a century), when the “unmuzzling of scientists” has been raised as a significant issue by opposition parties, community members, current and former government scientists, academics, and the media. For the last four-year term prior to the election, the Conservative Party of Canada held a majority government led by Stephen Harper. His nine-year run as Prime Minister (five years with a minority government prior to winning a majority) was fraught with accusations that he ran a tight ship, limited cabinet ministers' and bureaucrats' ability to speak to publically, and controlled every government message. Germane to this dissertation, however, is the accusation that Harper disregarded science and the value of data for public policy as well as advanced policies for which there was counter evidence, such as a “tough on crime” agenda that included minimum term sentences for certain criminal convictions and a complete opposition to safe injection sites. Read one newspaper editorial headline in May of 2015: “Let federal scientists speak freely: The

Harper government's controls on scientific debate and research are growing tighter, undermining the basis for sound public policy" (Toronto Star, 2015). The October 2015 election saw the Conservative Party replaced as government by the Liberal Party, which won a majority. Amongst the many Canadians who lobbied hard to vote the Conservatives out (including their push for strategic voting, the likes of which Canada had not seen before), this election generated a collective sigh of relief over the change in leadership.

Inherent in this relief was the belief that the Canadian government would renew its respect for science and return to the reliance on evidence for the making of public policy (assuming these were in place prior to the Conservatives winning power). Days after the election, on November 10, 2015, Scott Brison, newly named to the cabinet as President of the Treasury Board, said: "We will bring back evidence-based decision-making to replace decision-based evidence-making" (Canadian Broadcasting Corporation, 2015). His overt statement points to a level of cynicism regarding policy-making at the federal level, consistent with the comments made by my participants at a provincial level, underlying the complicated relationships between political ideology, science, objectivity, and policy-making.

At about the same time, a Facebook post by a fisheries biologist with the federal Department of Fisheries and Oceans expressed gratitude that the department sent a message to their scientists saying they were now permitted to talk freely about their

work, including to the media. This post was reposted by his mother, Jody Patterson, a well-known former journalist from Victoria B.C., and it went viral (Silverman, 2015).

Patterson adds in her own post:

I feel like I'm in one of those post-apocalyptic movies where there's nothing but darkness and sorrow and hard times, and then right at the end of the movie there's a scene of the sun rising over a new world and it's like everything just might turn out OK. People, we must never again let our government plunge us into such a fearful, secretive, divisive state.

Recall the slogans chanted at the "Death of Evidence" rally in the summer of 2012 noted at the beginning of this dissertation: *Science speaks truth; Evidence not ideology; Canadians want science-based policy not ideology; No science, no evidence, no truth, no democracy*. The sought after "unmuzzling" of scientists is portrayed in these statements as meaning an unmuzzling of the *truth* of science and *freedom* from ideology: "It was like the fall of our own little Berlin Wall," says Patterson in her letter of thanks to Canada's new Prime Minister. The relief is that palpable.

Members of the academic community are also relieved at this apparent return to the reliance on evidence as a way of developing policy that avoids ideology. In a January 27, 2016 winter bulletin email from the Canadian Sociological Association, the President of the Association notes: "The recent change in government at the federal level is accompanied by a renewed tone of openness to scientific pursuits, accompanied by promising actions such as the reinstatement of mandatory long-form census, that are welcome measures for social science inquiry and evidence-based decision-making." We

see that this approach is not limited to the “hard” sciences and issues such as climate change or testing of pharmaceuticals; it is extolled across disciplines and issues. The Conservatives were alleged to have run the government based on ideology and “decision-based evidence-making” and the Liberals are applauded for their (claimed) rejection of this approach in favour of a return to a kind of evidence that these messages suggest is apolitical and non-ideological. Given what I have demonstrated in this dissertation, *is this claim possible or valid? Arguably, not.*

Regardless of the significant amount of literature on “the problematic nature of evidence, the uncertain status of policy and the difficulty of establishing any coherent and consistent relationship between the two” (Freeman et al., 2011, p. 127), the discourse of evidence-based in relation to practice and policy-making continues to be strong and is intimately tied to the discourse of science. When science is invoked, it is a thoroughly positivist notion that maintains strong allegiance to the claim that evidence can be produced in a pure, apolitical manner. These stories that followed the Canadian federal election, along with the dominance of evidence-based discourse in both the government policy frameworks and policy workers’ accounts in my study, convince me that we continue to exist in a particular socio-political-economic moment at a time when politics and ideology are seen as both *distinct* from good policy-making and the *driver* of policy. And the contradiction of this position is not acknowledged. Evidence-based policy-making is seen as a way out; it is viewed as *the way policy-making and*

practice ought to be: objective, neutral, apolitical, disinterested, truthful, and pure – necessary for policy-making (and resulting policies) to be considered reliable. My study reveals, however, that “decision-based evidence-making” is alive and well and not likely to be so easily replaced as Brison seems to suggest. I propose that the Berlin wall is not as far down as people believe it to be, *nor can it be*.

To many, science is a welcome relief to political ideology that they believe directs too many policies. Tied to this relief of welcoming (back) science is the belief (one could say faith) that knowledge is possible without politics and ideology and, when produced through the very particular processes of science, generates useful evidence. It is understandable, then, that knowledge is conflated with science, which, in turn, is conflated with evidence. And it is understandable why B.C.’s Ministry of Health and (many) policy workers alike want to claim to be developing policies based on the evidence. To say anything else is akin to admitting to being ideologically driven. Evidence-based policy-making is normative. When I told a friend recently I was engaged in a critique of evidence-based policy-making, he responded: “as opposed to using a Ouija board?” I have heard responses to this effect many times over the years. The assumption is that if not from a Ouija board, policy must be evidence-based. This binary perspective is not uncommon. However, many policy workers in my study told me that the Ministry says it does evidence-based policy-making because it “sounds good,”¹⁷ but

¹⁷ I have earlier quoted Kara, who says “I think some people say it [evidence-based] just because it sounds good, they think that’s what people expect, that’s what people want to hear.”

it is not really what happens; the “reality” is quite different – as it will be, given their political environment, they say. And not one said anything about a Ouija board.

Bevir (1999) posits that for Foucault, “the study of political institutions became a study of processes or activities. The focus is on the devices or policies that give effect to a regime of power and the ways in which these devices and policies define, control, and regulate the individuals who are subject to that regime of power” (p. 352). My interest is in the practices, the devices, associated with policy-making and the evidence-based movement. It is also in how policy workers use knowledge. But most importantly, my primary interest is in how policy workers enact their work in the face of the discursive mantra of evidence-based policy-making and to what effect. I was once one of those policy workers and I wanted to know others’ experience of *how evidence-based policy-making works*. In learning about their daily practices, I also learned how policy workers problematise their Ministry’s claims of being evidence-based, which I propose can be understood as acts of resistance to the regime of power that is evidence-based discourse.

In this chapter, I want to argue three basic points. First, on the basis of my analysis of interviews with policy workers, the promise of evidence-based policy making has the appearance of failing: evidence is not pure, the policy-making process is influenced by political “realities,” and individual policy workers are well intentioned but many have little, if any, influence over final policy. Second, despite the *appearance* of

failure, evidence-based policy-making is a governing project that is succeeding based on its ubiquitous invocation. Third, in the midst of (claims of) doing evidence-based policy-making are techniques of Foucault's concept of governmentality— and it is the unique operations of governmentality that both constructs this apparent contradiction of a program failing yet succeeding and enables policy makers' conduct to proceed smoothly despite that contradiction. It is this last point where I start.

Governmentality in action

This study began with an interest in people with chronic disease and the (alleged evidence-based) policies that govern them. And while this interest remains, I decided, for this study, to take a step back and try to understand what goes into the development of those policies, leading me to the question at the centre of this research: *how do policy workers do evidence-based policy-making in the context of chronic disease?* I did not enter this study as a neutral researcher; I brought to it an explicit analysis of power, drawing on the work of Foucault. One critique of evidence-based policy-making suggests that its “exclusive focus on building up scientific knowledge about the effects of various policy mechanisms has the effect, deliberately or not, of sidestepping political and moral questions important to the functioning of any liberal democracy” (Triantifillou, 2015, p. 168). Furthermore, Edwards, Gillies, and Horsley (2015) argue that the assumption that

... every problem in society has an evidence-based solution is part of a normalizing, new managerialist approach to governance in which social values

and moral issues are reduced to technical rationality, cut adrift from political debate involving interests and power, while social justice, material conditions and social inequalities are obscured from view.” (p. 1)

While I brought an analysis of power to my study, it is only upon reflection, as I see the picture unfold, that I can understand the broader picture, the “managerialist approach to governance” revealed in the details. Thus, I now also view my case study through the lens of governmentality and it is this lens that frames my final analysis.

The previous two chapters presented an analysis of discourse in action in which I revealed how the discourses of evidence and evidence-based policy-making operate, as seen in government policy frameworks and policy workers’ accounts of their work. I began by showing the commitment to the claim of evidence-based policy-making as the foundation of Ministry policy relating to chronic disease as well as policy workers’ practice. I then showed the many cracks in this foundation and examples of the unravelling of commitment to it.

In reading the two Ministry of Health policy frameworks, I was struck by how people with/at risk of chronic disease are constructed and problematised. I read in these texts language that is action; these documents are productive. They are written to policy workers and the public (since I am reading them), including people with chronic disease. They instruct us how to understand chronic disease and people who live with/at risk of chronic disease (which appears to be all of us). In doing so, I propose, these documents act as a tool, a technology; they are a *device of governing*. Furthermore, as the previous

two chapters illustrate, policy workers face multiple constraints in doing their job. Revealed in the descriptions of these constraints and “realities” are the minutiae that are inherent to their day-to-day work and where relations of power run deep. It is through the lens of Foucault’s concept of governmentality that I have come to see how power is enacted *through* the minute qualities and the small details (such as responding to physicians, accessing trusted sources of knowledge, locating studies that provide hard evidence with the right sample size) of policy work that have the appearance of common sense. I propose that the documents and the described activities of policy work are, at the same time, both mundane *and* powerful. Evidence-based policy-making is a regime of power that makes governmental power possible. And this power has material effects, effects that I take up in the last chapter.

Governmentality is an analytical approach developed by Foucault in the 1970s as a way to understand how humans (individuals, populations, souls, bodies) and their everyday activities are shaped and governed; how individuals engage in self-regulation; and how “the state, market, and the population (are) constituted and entwined in/through particular arts of government” (Nadesan, 2008, p. 2). Governmentality describes the “art of government” in tackling the “problem of personal conduct” (Foucault, 1991, p. 87): the activities and practices that aim to shape, guide, or affect the possible field of actions – or conduct – of self and others (Gordon, 1991; Li, 2007; Chambon, 1999). Foucault (1991) argues:

Government has as its purpose not the act of government itself, but the welfare

of the population, the improvement of its condition, the increase of its wealth, longevity, health, etc.; and the means that the government uses to attain these ends are themselves all in some sense immanent to the population; it is the population itself on which government will act either directly through large-scale campaigns, or indirectly through techniques that will make possible, without the full awareness of the people, the stimulation of birth rates, the directing of the flow of population into certain regions or activities. (p. 100)

Of significance to me in this study's final analysis is Foucault's interest in how governmental power is exercised through an array of techniques, procedures, targets, and levels of applications, that is the means, strategies, and technologies that guide behaviour and practice (Foucault, 1979), as well the rationalities that make these practices seem 'normal' (Christie, 2006). What I saw in the interviews is policy workers talking about these practices and activities: Sally's desire for scientific knowledge, Kara's reference to the hierarchy of knowledge, Evan's understanding that randomised controlled trials are the most effective and desired study, Diane's distinction between hard and soft evidence. These statements delimit what they can value as evidence and, I argue, serve as advanced liberal technologies of rule that facilitate "governing at a distance." In so doing, they govern economic activity, social life, and individual conduct (Rose and Miller 1992) of both self and others as conducted through the policy frameworks. This conduct of conduct, however, presupposes and is reliant on our freedom (Burchell, 1991): making the healthy choice the easy choice. Foucault's concept of governmentality provides ways to think not only about the art of government but also activities of politics (Rose, 1993), particularly how rule is exercised in advanced liberal democracies (Rose & Miller, 1992), and is useful in understanding what is going

on in my study. According to Lemke (2007):

(G)overnment defines a discursive field in which exercising power is 'rationalized'. Ways in which this occurs include the delineation of concepts, the specification of objects and borders, and the provision of arguments and justifications. In this manner, government makes it possible to address a problem and offers certain strategies for managing or solving the problem. (p. 44)

Recall Bacchi's (2009) argument: "The ways in which issues are problematised – how they are thought about as 'problems' – are central to governing processes. [...] In effect, we are governed through problematisations rather than through policies" (p. xi). The policy frameworks clearly problematise chronic disease as a particular kind of problem: most particularly, a financial burden, but also a *potential* financial burden in that we all appear to be at risk of chronic disease. It is a problem that (apparently) requires solving and people with/at risk of chronic disease (also, apparently) require managing. Because the policy work described by those I interviewed seems so mundane, the tasks go without notice, they are not objectionable; they seem, as noted above, so normal. Yet together, the many activities that constitute policy-making, in a context where being evidence-based is claimed loud and clear, also constitute *governmentality in action*. Rose and Miller (1992) propose that the "problematics of government should also be analyzed in terms of their governmental technologies, the complex of mundane programmes, calculations, techniques, apparatuses, documents and procedures through which authorities seek to embody and give effect to governmental ambitions" (p. 175). Evident, if you will, are techniques that guide the

individual behaviour – *conduct* – of people with chronic disease that are rationalised not only to (apparently) assist people with chronic disease and prevent incidents of chronic disease, but, most importantly, contribute to the sustainability of the health/care system and the economy.

Evidence-based policy-making has an ontological effect, that of narrowing how chronic disease is to be understood (by policy workers, by the public) as a financial burden and solved through individual, measureable, ‘surveill-able’ actions of people with chronic disease as well as those at risk of chronic disease.

In keeping with the narrowing of how to understand chronic disease, we also see an epistemological effect, that of narrowing how policy workers (and really the rest of us) can understand what counts as knowledge and evidence, which in my study, is to the place where cost effectiveness can be “proven” through scientific means of measurable, numerical knowledge. Together, these characteristics underscore the framework for developing policy relating to chronic disease and, when combined with appropriate evidence, serve to solve the “problem of government” (Lemke, 2002, p. 50) posed by chronic disease. These acts of narrowing are techniques of governmentality in action. Lemke offers a way to see how governmental power is rationalised and justified through claims of being evidence-based and the activities of policy-making. Lemke (2001) argues:

The neo-liberal forms of government feature not only direct intervention by means of empowered and specialized state apparatuses, but also characteristically develop indirect techniques for leading and controlling individuals without at the same time being responsible for them. The strategy of

rendering individual subjects 'responsible' (and also collectives, such as families, associations, etc.) entails shifting the responsibility for social risks such as illness, unemployment, poverty, etc., and for life in society into the domain for which the individual is responsible and transforming it into a problem of 'self-care'. The key feature of the neo-liberal rationality is the congruence it endeavours to achieve between a responsible and moral individual and an economic-rational actor. It aspires to construct prudent subjects whose moral quality is based on the fact that they rationally assess the costs and benefits of a certain act as opposed to other alternative acts. (p. 201)

Power is circulating throughout the policy-making environment and operates through the policy workers who become the vehicle for the conduct of conduct; their work conducts the conduct of people with/at risk of chronic disease, responsabilising them. Burchell (1993, p. 276) describes responsabilisation this way:

... 'offering' individuals and collectivities active involvement in action to resolve the kind of issues hitherto held to be the responsibility of authorized governmental agencies. However, the price of this involvement is that they must assume active responsibility for these activities, both for carrying them out and, of course, for their outcomes, and in so doing they are required to conduct themselves in accordance with the appropriate (or approved) model of action. This might be described as a new form of 'responsibilization' corresponding to the new forms in which the governed are encouraged, freely and rationally, to conduct themselves.

Evidence-based policy-making is invoked widely in the government documents and policy workers' accounts and it is through the details of these texts that the governed are responsabilised. The policy frameworks not only problematise chronic disease as a burden, they also act to direct policies (and those who contribute to their development) to conduct "lifestyle" behaviours, responsabilising and individualising people with/at risk of chronic disease. One technology to accomplish this conduct is the surveillance that

leads the values/principles of the Guiding Framework. This concern for costs to the economy and the sustainability of the health/care system is primary. It is seen in the policy frameworks and reiterated by policy workers, who state clearly how important providing the evidence of cost reduction is to their work. This primary concern reveals the neoliberal rationality of their work. “Neoliberalism highly values the individuated citizen working on ‘oneself’ to become more effective, vital, or productive” (Million 2013, p. 149). The narrowing described above is a technique of governmentality and its effect is a service to neoliberal capitalism working at the level of responsabilising individuals with chronic disease (to work on themselves) and of policy workers, to know what counts as evidence and what does not and to facilitate the work of individuals with chronic disease – in the name of protecting the economy.

Foucault (1980) argues:

It is a question of what *governs* statements, and the way in which they *govern* each other so as to constitute a set of propositions which are scientifically acceptable, and hence capable of being verified or falsified procedures. In short, there is a problem of the regime, the politics of the scientific statement. At this level it’s not so much a matter of knowing what external power imposes itself on science, as of what effects of power circulate among scientific statements, what constitutes, as it were, their internal regime of power, and how and why at certain moments that regime undergoes a global modification. [...] this problem of the ‘discursive regime’, of the effects of power peculiar to the play of statements. (p. 112-113, italics in original)

As just noted, the policy frameworks are governing statements with an ontological effect: they narrow and delimit (how to think about) chronic disease. They lend authority and display trust in relation to particular methodologies of producing

knowledge (randomised controlled trials, systematic reviews, positivist methods); particular journals; particular organisations that review scientific studies (such as The Cochrane Collaboration); and particular scientists. Most policy workers I interviewed accept that knowledge is articulated through the power of scientific statements. Scientific statements are the hallmark of the evidence-based movement and are exercised throughout the policy frameworks and policy workers' accounts. I propose that evidence is dependent on these relationships of trust and power which is "circulat(ing) among scientific statements" to produce statements that are taken as truthful and reliable. It is common sense to trust these statements. They represent "discursive regimes." "Gold standard" is like "best practices," which, Walters (2004, p. 34) says, is an example of the talk in which "governance [...] operates not as a site of politics but as a space of technocratic management." It promotes good governance while declaring to be above politics. And in so doing, "governance is not really about the expansion of democracy but the search for more effective and efficient forms of problem management" (Walters, 2004, p. 34).

The belief in scientific methods in particular, and positivist methods in general, has authority and is made evident in claims that these methods are disinterested and outside of politics and ideology. But as Latour (2013; Cayley, 2007b) and Stone (2002) articulate, this claim is impossible. In every aspect of policy-making, there is politics. "Facts" are produced in social processes (Latour, 2013; Cayley, 2007b). They do not exist

outside of their interpretation and mediation; they come “clothed in words and numbers” (Stone, 2002, p. 309). Says Stone (2002): “Naming, like counting and rule-making, is classification, and thus a political act” (p. 309). The words used to describe the problem (and solution) of chronic disease and those living with/at risk of chronic disease – burden, choice, linking it with injury prevention, and naming “risk factors” that responsabilise people with/at risk of chronic disease – are political acts with political effects, not the least of which is that they tell policy workers to think of chronic disease in those terms *and* to lay responsibility for the sustainability of the health/care system on the shoulders of those with/at risk of chronic disease. The same is true of the language used to describe the Ministry’s approach to policy-making: evidence-based, behavioural science, improve health system sustainability. “(T)o name is to take a stand. And if naming is political, there can be no neutral facts, no pure description to convey to others as neutral information” (Stone, 2002, p. 310). Stone (2002) argues that the inherent political nature of policy work does not infer there are no standards for making judgements; “every name is a symbol, not the thing itself, and in the choice of names lies judgement, comparison, evaluation, and above all the potential for disagreement. The problem of neutrality and objectivity begins with naming” (p. 310). Each of the two policy framework documents (*Promote, Protect, Prevent: Our Health Begins Here – B.C.’s Guiding Framework for Public Health* and *The Healthy Families B.C. Policy Framework: A Focused Approach to Chronic Disease and Injury Prevention*) names

“evidence-based” as the approach guiding policy development. What follows in those frameworks names what matters: details that, when examined closely, expose their political, governing nature that is belied in the assumption of neutrality associated with the language of evidence-based; details that will be measured, judged, compared, and for which people with/at risk of chronic disease will be held accountable. Policy workers name scientific evidence as their priority knowledge. These are strong stands and appear neutral, which is a goal of all things evidence-based.

I have argued in this dissertation that “facts” are always in dispute and I do not believe scientific facts garnered from the “gold standard” – randomised controlled trials – are an exception. The concerns with randomised controlled trials are many and include such things as informed consent, decisions on what gets studied and what findings are not/published, commercial rationale for findings, the payment of participants, funding (from corporate health care organisations to study care delivery models for example), choosing of study participants, and study participants influence over their lives. These decisions are political and moral acts of power. Stone (2002) gives the example of people enrolled in trials examining the efficacy of AZT. Many study participants were able to determine that they were taking AZT rather than the placebo and some of those who were on AZT shared it with those taking the placebo so they, too, would have the chance of experiencing its benefits – if there were any.¹⁸ These processes involved in the generation of “facts,” objectivity, and disinterested research

¹⁸ One policy worker in my study offered an example from this person’s work but referring to it in this dissertation would risk identifying the participant.

findings are social processes. *All* research is political. It is shaped by funding; researchers' career interests and goals; the "political tendencies of research institutions"; government funding and involvement; peer pressure; and class, racial and gender bias (Boyd & NAOMI Patients, 2013, p. 4).

Randomised controlled trials remain the most prized technique for the generation of reliable evidence, by participants in my study, many others in diverse practice and policy-making settings, and academic institutions. According to several policy workers, this evidence increases in value when a randomised controlled trial can be done in B.C. (even when they have already been done elsewhere). Local evidence seems to add credibility to an argument made by policy workers to a decision maker.

I return to an excerpt from my discussion with Ruth, quoted earlier:

It is not a straight line thing. (A) much, much more sophisticated analysis of power and political science is required than this recipe of you know: "I'll give them the right research study and they'll make the right decision." [...] We are all great apes and therefore we are all programmed to exist in social hierarchy and manage that social hierarchy. And what is politics if it's not that? Right, so, it is in our DNA.

Throughout my conversation with Ruth, who has many years of experience in upper management at the Ministry of Health, she challenges the "we do evidence-based" discourse that runs through this Ministry and so many other practice and policy settings. She left her undergraduate program, where "information-liness was next to god-liness" to find out that, in the "reality" of policy-making, she had to learn how to do a "sophisticated analysis of force fields" or, as in the excerpt above, a "sophisticated

analysis of power.” Learning that *she had to do this kind of analysis, then how to do it*, appears to be a requirement to survive working in the “reality” of political environments such as the Ministry of Health. Like Ruth, Kara and others describe coming up against the “political reality,” where politics is at play. Policy workers give advice; they do not, typically, make decisions. The discourse of evidence produces a sequestered space where politics is deemed external. While several other policy workers with whom I talked begin their conversations with me aligned very closely to the claim of being evidence-based, they eventually move away from this commitment and explain (without using the language Ruth uses, for the most part) their own analysis of and negotiation with power or “force fields.” Relations of power are a feature of their work and they have learned how to work with and respond to them in order to get their work done.

My interviews with policy workers illustrate that, for the most part, they initially adhere quite closely to the claim of doing evidence-based policy-making. However, when faced with inquiries about what that means and what is involved, their commitment to it is chipped away until it breaks down, and what it – evidence-based policy-making – even means begins to crumble. Furthermore, the link to people with chronic disease is weak, at best. As we have just seen, however, the discourse of evidence-based policy making creates a separate space where policy workers can talk about being free from political influence, even though they recognise how deeply political their work environment is. All their talk seems to have the effect of creating a

separate space where they can do their work (seemingly) free of politics, generating knowledge that can be passed on to the decision makers. Even though this space is elusive (and illusive), it is valued. Actual people with chronic disease, however, barely appear other than in a somewhat generic form and as a collective that is positioned as posing a risk to the fiscal sustainability of the health care system. This near-absence is the most astonishing finding of this study and I will return to it in the next chapter. But first, I want to confront in more detail the conundrum of how the governing project appears to fail yet, I would argue, succeeds.

The (explicit) governing project's failure

I propose that the explicit governing project at the centre of this research is the development of policies that are evidence-based – generating or accessing pure knowledge and unassailable evidence – which in this research is to solve the problem of chronic disease, most notably, its actual and potential cost to the health/care system and economy. This is the project I examine through a lens of governmentality. The previous chapters show that as my discussions with policy workers deepened, it became clear that the practices of evidence-based policy-making turn out to be fraught with contradictions and power relations that constitute the “reality” of their work environment with which policy workers must negotiate: senior management, elected politicians, physicians, budgets, knowledge, and evidence.

The most literal talk of power in policy workers' accounts – “speaking truth to

power” – assumes the traditional understanding of power as an entity wielded by those in positions of authority. The phrase “speaking truth to power” originates with Quakers in their arguments against war and militarisation. It continues to be equated with activism, speaking against the influence of the powerful, and is often considered a potentially risky yet ethically progressive action. It is also a term that has been used in the policy-making world, from Wildavsky (1979) to Hoppe (1999), but with a more nuanced intent than its Quaker origin and before the rise and influence of the evidence-based movement. The desire to “speak truth to power” is in keeping with the mainstream tradition of policy analysis and policy sciences whereby apolitical policy experts are to draw on social science’s (apolitical) knowledge to deal with political problems – including the management of populations. These apolitical policy analysts are tasked with offering impartial advice, garnered through neutral scientific approaches to knowledge generation, to those in political power (Colebatch, 2006a; Colebatch, 2006b; Farr et al., 2006; Tao, 2006; Torgerson, 1985). For the policy workers I interviewed who used this phrase (and perhaps others), this mandate holds true. They understand that their job is to offer pure, apolitical advice, often to those in elected political positions and who may not want to hear their advice. Oren recalls a previous Minister telling him that it is Oren’s job to speak truth to power and he must never apologise for doing so. Says Kara: “And so to speak the truth of the evidence up the line as best you can, even knowing probably at the time that there may be all these other

influences and factors going on but that's your job." Those using this phrase believe speaking truth to power is their responsibility and how they perform their work; it is also how they *want* to perform their work. They are mobilised to perform the work of the evidence-based policy-making discourses in the interests of creating "good" policy. It becomes a moral obligation, even an act of resistance or activism against attempts to politicise the policy-making process.

In deploying this phrase "speaking truth to power," policy workers have identified a key relationship in which power is most obviously exercised: their relationships with the elected officials and senior bureaucrats with/for whom they work. It is in these power relations, however, that the governing project of evidence-based policy-making begins to break down. In their accounts, policy workers make it clear that they are well aware that their advice takes on a life of its own after their involvement is over and those with (or exercising) "the power" get their hands on it. Their profound recognition of the political environment of their work, where elected officials matter, surfaced as I delved deeper into how they went about doing their work in relation to the Ministry's claim of being evidence-based. Speaking "truth" – impartial neutral advice based on evidence that, having been "purified" through some form of scientific methodology, is taken by these policy workers as neutral and true – to the elected officials may be risky but it is their job. This message is taught in mainstream graduate university programs that produce many government workers; Kara even names the (still

practising) professor who taught her this way of thinking about her practice. Hoppe (1999) harkens back to Lasswell's definition of "the policy scientist's operational task as eliciting the maximum rational judgement of all those involved in policy-making" and that includes "speaking truth to power" (p. 201). Hoppe (1999) argues that policy analysis has moved beyond its "positivist beginnings" and places his "bets on an argumentative turn [...] within post-positivist constraints" (p. 209). But as Denzin (2015) notes, and the post-election "unmuzzling" within which my research is situated is revealing, the resurgence of science-based research and normative policy-making and positivism is back playing a central role, at least in rhetoric, and this is where the failure is evident. The evidence-based argument falls apart.

As noted by those I interviewed, policy workers give advice; they do not, typically, make policy decisions. But they are in relationship with those who do and they claim to know the kind of evidence that is needed/wanted to constitute that advice, i.e. numbers, facts, dollars, with a story thrown in to support the effectiveness or expected outcome of those numbers. But the "reality" of their work is such that certain numbers matter, particularly those numbers that demonstrate an outcome they are looking for, such as the reduction in burden. There is power in the use of numbers; they *work*. Furthermore, demonstration (proof?) that particular evidence will work locally is highly valued. The Ministry is conducting a randomised controlled trial on a program they believe will prove effective. Their randomised controlled trial, which will provide local

knowledge, is a source of great pride. The irony of valuing particular numbers and/or location is that the desire for specifics is opposed to the generalising aim of the scientific, and the evidence-based, endeavour.

The numbers of interest to the Ministry are those specifically related to their responsibilities, responsibilities that are reducing in number as they are increasingly downloaded to individuals. Cost and burden are only measured in terms of their relationship to government, not to individuals living with chronic disease. There is evidence, if you will, of a relationship – even a causal relationship – between poverty/low income and chronic disease. Geneau et al. (2010) argue that the “chronic disease pandemic originates from poverty and disproportionately affects the poor” and that “chronic disease also causes poverty” (p. 1693). Kimpson’s (2015) recent work makes a very clear connection between women living with chronic disease/disability and their experience of structural poverty, to which government policy is a contributing factor. Not one of the policy workers I interviewed raised this issue. I asked them all if they could think of any policy issues relating to chronic disease that might not be amenable to the kinds of methodologies prioritised in evidence-based policy-making. Tim is the only person who had any thoughts on this question and he talks about his critical perspective on the workings of Government and politics. Tim laments: “the inequitable distribution of wealth [...] there’s nothing I can do about that.” I raise the issue with others and several acknowledge that while they often work collaboratively

with other ministries, it is not possible for them, at the Ministry of Health, to deal with issues such as the distribution of wealth and ensuring a liveable income. So while the alleged financial burden of people living with chronic disease is the primary concern for government, the financial burden on those same people is beyond their purview.

The policy workers' accounts are riddled with power relations of another (political) kind and that is with physicians, most of whom are working with the Ministry of Health on behalf of the health authorities. Physicians play a *powerful* role in their everyday work in that they introduce ideas arising from their own practice that they encourage policy makers to pay attention to. They wield significant influence over which initiatives will be implemented and what evidence is required to support such decisions. They are said to prefer randomised controlled trials, are "smart, informed, knowledgeable, familiar with the ground, and know what is going on": all language used by Evan when describing how he goes about his work finding evidence to satisfy the physicians. Physicians encounter people with/at risk of chronic disease to change their behaviour, facilitate the use of assessment tools, monitor (surveil) risk factors, and prescribe other services – and are paid for these activities through a financial incentive package negotiated for them by their association with the Ministry. That the overall goal of reducing costs to the health/care system is challenged by the perpetual need for people to return to their physicians to be surveilled, visits which cost the system significant dollars, is yet another irony.

Described this way, physicians appear as the *source* of power but that analysis is inconsistent with Foucault's conception of power. Rather, using Foucault's stance, physicians must be understood as exercising power in relation to narrowing the spaces within which policy workers can engage in their work and the ways in which people with/at risk of chronic disease are positioned to be supported.

Underscoring these relations of power are actions in language inherent in evidence-based discourses. Discourses of evidence and evidence-based policy-making produce and shape (and are produced and shaped by) talk about policy directives and policy work in relation to knowledge(s) and its production, evidence, science, and studies. Policy workers I interviewed often use this language interchangeably: questions about knowledge are often answered in the language of evidence and science. It is useful to draw distinctions between these terms.

I understand knowledge to be historically, regionally, and socially contextual; a cultural product (Epstein, 2008); temporary; and, above and through all, constituted through relations of power. It is created through exercises of power and brings about the effects of power: "It is not possible for power to be exercised without knowledge, it is impossible for knowledge not to engender power" (Foucault, 1980, p. 52). It is *not* permanent, fact, or truth. By contrast, and in the specific context of evidence-based policy-making that I studied, evidence is viewed as a sign of something existing, proof. It derives from (particular kinds of) research and should be reproducible, verifiable, and

generalisable. It is outside opinion, experience, expertise, or values. But in the context of the policy frameworks in this study, *particular* evidence is required to support *particular* policy outcomes, most notably, the overarching goal of reducing the (financial) burden of chronic disease on the health/care system.

Scientific knowledge is equated with evidence by most of the policy-makers I interviewed. Even when an issue is inappropriate for a randomised controlled trial, policy workers still want (or know they need) something that looks like science i.e. surveys, statistics, or other traditional social science methods associated with positivism. This point illustrates the reliance on technique (vs. knowledge) referenced earlier in the quote by Foucault.

“Studies” is an interesting term. I refer to the research I did for this dissertation as a study. However, I am quite sure research of this nature would not be considered a study in the eyes of the policy workers I interviewed. And even for those for whom it might, they would expect concrete findings they could translate into practice. I think my research may be helpful for people to understand their practice in a new light or confirm what they already suspect. But I am not dictating anything or even making recommendations. I suppose the previous chapters present a kind of evidence and others who share my worldview and draw on similar theoretical tools might agree with and/or share my interpretation. But not for a moment would I suggest that I am drawing cause and effect relationships, measuring or quantifying, or stating truths or facts. And I

am entirely aware of the political nature of my words/actions/interests. I think policy workers say “studies,” they mean scientific studies, preferably randomised controlled trials, which they know as “the gold standard.”

Throughout my conduct of this research, policy analysts use terms such as knowledge, evidence, science, scientific knowledge, and scientific studies to point to particular things and thus these are *actions* that institute a hierarchy by delineating what is excluded. The actions narrow what knowledge is acceptable (thereby marginalising other knowledges) in understanding policy problems and possible policy solutions. Furthermore, many policy workers, when conflating evidence and science, reproduce a false dichotomy of science and ideology or politics, particularly as these relate to evidence. This dichotomy is also reproduced in the hierarchy of evidence Kara refers to explicitly (and others implicitly). It is in their attempt to reproduce this dichotomy that policy workers demonstrate their desire to sequester space for their particular knowledge work. In his interview with Crawford (1993, p. 257) and commenting on the work of Shapin and Schaffer (1985), Latour argues:

(W)e should not believe in the existence of inside and outside. We should sit exactly at the place where the inside and the outside of the network are defined. So the point is exactly the same: we have to see inside-and-outside as an active category, created by the actors themselves, and it has to be studied as such.

Perhaps this statement explains the conundrum of failure/success of evidence-based policy-making. My analysis shows that the policy workers want to make (and uphold) the distinction of/between inside knowledge (pure, factual) and outside knowledge

(political, soft). They are committed to the sequestration of their space. Some can see the challenge, such as Ruth and Tim. Eventually most of the other policy-workers come close to acknowledging the impossibility of this separation in that politics invades the possibility of reliance on scientific knowledge and evidence. But this understanding of impossibility is quite different from what Latour intends. I also use the inside/outside as an analytic approach; it speaks to my role as a researcher – sitting “at the place where the inside and the outside [...] are defined” (Crawford, 1993, p. 257). The line is an easier place for me to be; I can see the inside/outside separation does not exist, that the barriers to the success of evidence-based policy-making are false. The policy workers are creating this separation with their language and talk. They come up against forms of power, they recognise power, and they use the language of “evidence-based” to mark their separation from the political world.

According to high level claims within the Ministry of Health, evidence – and a particular evidence in the form of randomised controlled trials – is essential for the delivery of reputable, reliable health care. However, the overriding commitment to the fiscal project of system sustainability produces, in part, a need for local evidence: practical solutions that can be proven to work at a local level. As a result, efforts are all about narrowing their field of vision to individual practices (of people with chronic disease) that can be dictated, measured, and surveilled. Attached to policies that accomplish these efforts are value divisions: the choice is yours and if things do not

work out for you (the way we think they should), you are responsible.

In trying to maintain the separation of the purity of their evidence-producing knowledge work and the world of politics that policy workers inhabit, language and action are at odds. If it is too difficult (and I imagine it would be) for people to live their lives in such a contradiction, or sustain the contradiction over time and context, they have to resolve it. Policy workers repeat the mantra of evidence-based and, when they come up to the line where the political space starts, they go back to their more familiar, preferred space of believing in science. They try to hold on to a language that explains that they use evidence-based policy-making; doing so reinforces the security of the place where they are or want to be. The policy worker who bucks it the most, Ruth, appears the most stressed yet resigned to the political nature of her work. She knows evidence-based policy making is almost impossible. The claim of evidence is trumped by the need for fiscal restraint; the claim of ideology-free policy-making is trumped by the reality of the political environment in which health/care policy-making occurs. Policy-making is a thoroughly political endeavour. The apparent failure of evidence-based policy-making is seen in the minutiae of powerful policy-making activities. Evidence-based policy-making as a governing project is failing.

The governing project's success

I have shown how, as a governing project, evidence-based policy-making is a failure. Policy workers come to understand and accommodate the built-in failure. Cassie

articulates the failure clearly. At the beginning of our interview, she is very committed to evidence-based policy making. By the end, however, she has talked herself right out of it: “(I)t's kind of ‘the emperor has no clothes.’ That's the kind of long and short of it.”

And yet, I want to argue, the discourse of evidence-based policy-making is remarkably *successful*. Despite the fact this project appears to fail, we cannot take that appearance of failure as given, because the project continues to have effects: people are separated (policy workers in their imagined neutral space from their political colleagues), knowledge is divided, costs and responsibilities are downloaded to individuals, and evidence-based discourses appear in countless settings. The governing *works*.

The talk of evidence-based dominates the Ministry's policy frameworks. It shows up often, with varying amounts of commitment, in the talk of the policy workers with whom I interviewed. How does the successful penetration of the phrase “evidence-based” into everyday accounts operate as a practice? What does the saying do? This talk of evidence is seen to be creating a space distinct from the political world within which policy workers operate, where policy workers can “do their job” of finding knowledge (even truth) to hand over to decision makers (those in power). The details they describe are examples of Foucault's techniques to separate space for particular evidence. Policy workers see the edge, past the point of which politics interferes, and most try to stay away from it, with varying degrees of success. In this separate space, policy workers can

feel they are helping people (recall Foucault's [1991] assertion that the purpose of government is the welfare of the population) using appropriate evidence. And who wants to argue with that? They need the language of evidence-based to instantiate and create that space; this is the doing that the saying of evidence-based does. That the language of evidence-based is invoked with such frequency and rarely questioned until pushed to describe how it works, underscores its success.

Representing a key component of the argument for evidence-based policy-making, as I noted earlier, Nutley and Webb (2000) say that "society appears to be guided more by politics than by science, and politics is more about the art of the possible or generally acceptable than what is rational or might work best" (p. 14). Describing their "reality," policy workers frequently point to the many instances and ways that politics and power relations guide – or interfere with – their work. Their reality requires them to negotiate "the art of the possible." Inherent in Nutley and Webb's argument, however, is "its separation and contradistinction of 'politics' and 'rationality'" (Tenbenschel, 2004, p. 189). This distinction is born out in the words of many of the policy-makers who speak about their reality as being one of a political environment, where what is going on politically is an important piece of the policy-making picture – and one that must be attended to in order for them to be successful in their work. These policy workers know how to conduct themselves both in relation to those they advise and the discourses that dominates their work place. It is a double-

edged sword: while the governing project *appears* to fail, that appearance is contradicted by its constant invocation. The discourse *is doing something*; it is important. Its invocation allows them to do the tasks they are given – as mundane as they appear to be.

The neoliberal project of reducing health/care budgets, maintaining the sustainability of the health/care system, gaining efficiencies, and protecting productivity and the economy is legitimised by the claim of being evidence-based. At the same time, it is impossible to know what “evidence” exists to support any initiatives, guidelines, or legislation that supports people living with/at risk of chronic disease, regardless of the claim. How do we know if so-called “evidence” may or may not substantiate the claim of sustainability? Neoliberalism, on the surface, appears to have nothing to do with evidence-based policy-making, yet my study shows it has everything to do with it.

This study matters

This study matters. It matters because claims that practices, including policy-making practices, are evidence-based are ubiquitous. It matters because the practices of policy workers and the context in which they do their work are not well understood and yet often maligned. We so often critique “the government” or “the system” in problematic terms with little, if any, thought about the actual people doing the work. This study has shown how their lives are governed.

This study also matters because policy-making practices play out in a multitude of ways in people's lives, whether, for example, they have chronic disease or mental illness, are in the education or criminal justice system, or experience other contexts where "evidence-based" discourses govern. Bodies will live the effects of these practices. What I have shown in the study is not unique to the site of the Ministry of Health; I propose similar practices occur anywhere that "evidence-based" is being claimed. My goal is not to decry that things are not right as they are but to show that claims such as evidence-based policy-making are not doing what, on the surface, they claim – and this not doing is not benign. This dissertation has revealed what these claims *are doing*. "Evidence-based" is what Weaver (1953/1985; Roderick, 2016) would call a "god-term": a vague term that has inherent potency. It is the potency that matters and to let these claims remain unexamined and unassailable is to endorse their effects on people's lives – your life, my life, our lives.

10. Returning to chronic disease

Most of it can be prevented if people have the right lifestyle,
sort of make the right lifestyle choices. (Evan)

All our work around chronic disease prevention was branded and called *ActNow*. (Hal)

People with chronic disease and the material effects of policies on their bodies and lives spawned this research and so it is to these people I return to finish this dissertation. Chronic disease figures centrally in government documents – the two policy frameworks I analysed in this study but also in those at other provincial, federal, international levels – as well as Canadian funding agencies, media reports, and academic circles. I am struck at how chronic disease is so readily discussed in terms of its relationship to the cost to the economy. However, as my research evolved and I analysed my interviews with policy workers, my concern deepened as the prominence of the evidence of cost savings emerged in their accounts at the same time that people with chronic disease were largely absent. Thus, my focus became almost entirely on the evidence-based policy-making practices of policy workers. I cannot help but wonder, however, if chronic disease is such a significant issue to the Ministry of Health, why did it and the people who live with it not show up more in my interviews? This question remains a curiosity. In the following, I take up the presence and absence of chronic

disease and people living with/at risk of chronic disease in my study.

I chose to examine evidence-based policy-making in the context of chronic disease because various governments in Canada and health researchers (Mirolla, 2004; Morgan et al., 2007; Haydon et al., 2006; Reading, 2009, & Denton & Spencer, 2010) report it to be an enormous issue that requires attention, something I discuss in the introductory chapter. The government policy frameworks I examined make clear how the B.C. Ministry of Health constructs and represents the problem (Bacchi, 1999) of chronic disease to be a financial burden that individuals must bare. In chapter one, I illustrate this construction. But let me elaborate. Goal one of the Guiding Framework is “Healthy living and healthy communities: Supporting communities that make it easier for people to make choices at every stage of life” (British Columbia, 2013, p. 19). Under this goal is a list of “performance measures” to reach that goal, including:

... the proportion of British Columbians (age 12+) who consume at least 5 servings of fruit and vegetables per day; the percentage of British Columbians who are meeting the guidelines for physical activity; the percentage of British Columbians (age 15+) who smoke; and the percentage of BC students in grades 3, 4, 7, 10 and 12 who report that at school, they are learning how to stay healthy. (British Columbia, 2013, p 20)

Each of these are individualising and responsabilising measures: what individuals can do to reach the goal of healthy living and healthy communities. There are, in a text box, “examples of what other health care partners can do” but many of those are how to encourage individuals to act. The second (and last) text box provides “examples of what partners in other sectors can do” (British Columbia, 2013, p. 21). In this list are actions

that are not placed on the shoulders of individuals such as land use, neighbourhood design, and child-care settings.

The Ministry's 2014, *Health Families B.C. Policy Framework: A Focused Approach to Chronic Disease and Injury Prevention* (British Columbia, 2014) provides readers insight into the Ministry's positioning of chronic disease as burden:

Over the past few decades, a number of evidence-based public health initiatives have been launched in B.C. These initiatives have been instrumental in decreasing the incidence of chronic disease, as well as in reducing premature mortality rates. However, one in three British Columbians is still living with at least one chronic condition, and the burden of preventable injury and disease in the province is significant. Continued and enhanced efforts in prevention are needed to further improve the health of British Columbians, reduce inequities in health and contribute to the financial sustainability of our health system. (British Columbia, 2014, under heading Executive Summary)

The document points to the Ministry of Health's mandate to develop a "preventative health plan" for the province:

... that will result in reductions in both chronic disease and injuries; [...] reduce the growth of health care costs. [...] (S)ustained efforts are required, and a more focused approach needs to be taken in order to further prevent and reduce avoidable illness, injury and the associated care and treatment costs. Unhealthy eating, physical inactivity, tobacco use and risky alcohol use are all significant risk factors for chronic disease [...] help make the healthy choice the easier choice, prevent disease and injury, support healthy growth and development and foster positive mental health across all stages of life. (British Columbia, 2014, under heading Defining Direction)

[...]

By far the largest proportion of total health care costs is directly or indirectly attributable to chronic disease. (British Columbia, 2014, under heading Burden of Disease)

This Health Families Framework notes the percentage of British Columbians who live with chronic disease as well as the percentage of the working population who experience mental health challenges

... which can directly affect the contribution they are able to make to their job – this costs the B.C. economy an estimated \$6.6 billion in lost productivity each year (not including patient care, insurance for employers, community services, and the many intangible costs for affected individuals and their families). (British Columbia, 2014, under heading Burden of Disease)

These two policy frameworks point to responsibility placed on individuals and the costs that those living with chronic disease incur on the health/care system and economy. People with chronic disease are viewed in economic terms, responsible for the sustainability of – and for the impending failure to sustain – the health/care system. Everyone else is at risk of adding to this burden and must take personal responsibility to prevent the failure of the system from occurring. And goals that are more oriented to social determinants of health still frame chronic disease as burden. Furthermore, I propose these documents lay responsibility on individuals for disease prevention and the reduction of health inequities. Each of the risk factors is laid on the shoulders of individuals who are responsabilised to make the right choices. And, of course, the right choice must be the easy choice; that is where the policy workers come in. It is their mandate to both keep this construction of people-with-chronic-disease-as-burden in mind (the quote from Evan at the beginning of the chapter demonstrates he has done so) and endeavour to contribute to policies that facilitate making the right choice the

easy choice. The priorities in the policy frameworks convey the narrowed focus on personal, individual behaviour that can be monitored and surveilled. Issues beyond the control of individuals that are the responsibility of the state, such as availability of good drinking water and the chemicals put on crops and in meat, are secondary, if mentioned at all.

In my interviews with policy workers, the circumstances that people living with chronic disease face everyday were notable by their near-absence. However, on occasion, language of the two strategic policy frameworks emerged. For example, Patty tells me she wants to make the “healthy choice the easy choice,” almost verbatim wording of the policy frameworks. Evan offers another example, describing his keenness for a program with which he is involved. I include the following lengthy excerpt from my interview with Evan because it captures how chronic disease is constructed as being the fault of individuals and the responsibility of individuals to solve – so simply, by getting a “rec pass”:

The (name of program) is only a couple of years old, I think, but basically the concept is that most of it (chronic disease) can be prevented if people have the right lifestyle, sort of make the right lifestyle choices. (The program is) intended for the primary care physician and sort of aimed at the patient having a conversation with them about certain lifestyle risk factors. So, it's aimed at medical obesity, unhealthy eating, inactivity, smoking. There's even a portion of it for mild mental health issues, but a lot of it's aimed at getting in front of the unhealthy eating stuff and the inactivity. So basically the patient goes to their family physician and they can ask about it or the physician sort of brings up the topic and they go through what's called a [assessment tool] and that is basically, goes through the person's immunizations, looks at all their risk factors, or baseline, all that stuff, recommends any tests and whatnot so they kind of go through this elaborate sort of assessment of the person. (details of payment) So

the primary care physician sets a goal with the patient and then after that there's what's called a prescription pad, which is attached to that and it's a list of five service providers, And one's [...] a smoking cessation program. There's a physical activity line, there's dietician services, and basically the physician hands them this piece of paper with check marks on it, saying, you should go to this, you should go to these people to help you out, right. And the last end of that program there's a subsidy end of it. So if the person goes to say a rec (recreation) centre, they want to sign up for a rec pass for three months, the Ministry will give them 50 bucks back on that, or whatever they spend, right. So they put in an application for that.

This program continues the responsabilising found in the policy frameworks. Its focus is narrow. It sets individuals up for taking care of their own (physical – mental health is almost sidelined) health, again removing responsibility from the state. Noticeable, however, is that the “preventative health plan” that appears in the Healthy Families Framework as the goal of the Ministry now appears to be the responsibility of individuals; it is *their* job to fulfil the mandate of the Ministry with no apparent recognition of people’s differential ability to meet those demands. The program is set up such that individuals’ behaviour can be measured (how many times did he go to the rec centre?) and monitored (did she return to his GP for test results and did his test results improve?). As noted in chapter seven, surveillance is the first value/principle of the Guiding Framework. This policy on which Evan is working has achieved the directions set out in the policy frameworks.

Dianne’s understanding of people with chronic disease as responsible is seen as she confirms that *shifting behaviour* is important: “But we do know, again through the evidence, that shifting people's behaviour, just through information and education, is

very difficult. So, we don't do a lot that focuses specifically on the home setting. That's more difficult." Policies can attempt to solve the problem of chronic disease at a high, ideological level but cannot so easily deal with actual people's genuine issues as they are lived everyday. Patty also articulates her need for behaviour change and the challenge in achieving it and in so doing, she assumes an objective stance aligned with Lasswell's interest in apolitical policy analysis. Says Patti: "(E)motion and people's preconceived and people's firmly-held beliefs on a topic get in the way of both policy development and behaviour change."

People with chronic disease: Missing in action

Alongside the construction of people with/at risk of chronic disease as a burden on the health/care system and economy, for which they must take responsibility, perhaps the most shocking discovery to me throughout this study was the near-absence of people with chronic disease in the policy workers' accounts. Eton et al. (2012) write about the work of having a chronic disease and the burden placed on people not only by their disease but also by the "ever-expanding health care regimens that can include medication-taking, keeping medical appointments, monitoring health, diet, and exercise" (p. 39), the very things that can be surveilled and measured by the Ministry. Yet people with chronic disease barely register when policy workers describe their work. Even though everyone I interviewed was referred to me because she/he worked in an area relating to chronic disease and each read that chronic disease was my area of

interest in the Letter of Invitation to Participate and the Consent Form (Appendices 1 and 2), many told me they did not really see their work as relating to chronic disease, or at best, in peripheral ways only. There was one branch I could not access because they were short staffed (another example of shifting ground). But since I had only interviewed people who were identified as relevant, I am not convinced anyone in that branch would necessarily have had more to say about chronic disease. People living with chronic disease are central to the policy frameworks, but, it would appear, are less central to actual policy work. An effect of governmental power is the responsabilisation of people with/at risk of chronic disease and then their removal as a focus of attention, beyond making them a vehicle of a sustainable health/care system. And all this is done with the alleged support of “evidence.”

Within policy workers’ accounts are very few examples of policy workers *knowing* anything about chronic disease or people with/risk of it. Many could barely see a direct connection with their work and people – except perhaps health care workers. People with/at risk of chronic disease are at a distance, in front of policy workers is the minutiae of policy work. At a general level, the entire Ministry of Health is, ostensibly about people but in the particular, as Diane noted above, their individual concerns are too unique to really attend to. Diane’s acknowledgement is akin to Haraway’s (1988) theorising that marked bodies are discounted and rendered invisible and neutral to be alongside, or amidst, the more general *unmarked* subjects, removed of marks that

provide detail, nuance, or contradiction to the dominant general view – or policy.

Ruth, who has had a long career mainly in senior management, discusses collaborative work where:

... you bring the problem not the solution to the table because it gives people a way in to being part of the partnership. ‘Nothing about me without me’ is a basic principle of the patients and partners agenda. So trying to involve patients, people affected by decisions in making decision. [...] We have a program where we are trying to build up a cadre of patients who have the skills to participate in the health systems work as well as in their own care. Um (pause) We try to use quality improvement principles more than performance measurements and accountability and evaluation principles.

Ruth’s claims resemble an interpretivist approach to policy-making, which values and seeks out “community members – actors in the situation” (Yanow, 2000, p. 19) for knowledge and expertise during the policy-making process. Given how infrequently I had heard policy workers talk about people with chronic disease in my interviews, by the time I interviewed Ruth I was anxious to hear about this practice of partnering with patients. So I asked her to tell me more about the involvement of patients. Her answer, however, has to do with establishing a fee structure for particular health care providers and looking for the upsides and the downsides of a policy proposal. For example, she says, when putting money toward one initiative, you take money away from another.

You push on a balloon, you know, there is an impact. [...] What you are trying to do in your analysis of a new initiative is challenge each other to say OK, kind of what, what could go wrong here? What could be the perversity? [...] One of the other things that works with that is really understanding what your agenda is, being able to articulate it. Sometimes, you know, some of the agendas people have are not all that pretty.

Ruth talks about a particular health improvement strategy that B.C. has modified.

It is as a triangle where if you improve population health and outcomes, reduce costs, and improve patient experience – we call it patient and provider experience because we don't think it is any good to improve the patient's experience and not improve the provider's experience because it is not sustainable. And that some of the evidence will show you that in doing all three, you can do all three. [...] Lots of things that are good for patients actually cost less, right? And lots of things that are good for patients' experience actually result in good outcomes. You don't necessarily have to trade the three off against each other. You know what I mean? What you are looking for is a sweet spot where you are hitting them all.

During this account, Ruth does not give me an example where patients are involved in a partnership. But what she does tell me is that with every policy, the key component has to be the reduction of costs. This message fits with the policy frameworks' priorities. And there is "evidence (that) will show you that in doing all three you can do all three." Ruth has successfully linked evidence-based policy-making with the goal of reducing costs. And people with chronic disease remain largely missing.

Debra works at a more junior level than Ruth. Her talk of "patients" is quite different. Her example of the impact on patients is through the health care providers, a group that is one step removed.

D: And when we talk about the patient, it's always at very sort of high-level terms. We talk about high-quality patient care and improving patient outcomes.

C: So the idea of patients as people – (is it) harder (to put) your finger on?

D: Yes, I mean it comes up as: of course patients and family should be involved in the decision-making process but it's not sort of directly applicable to what I've been working on.

C: That's what it kind of sounds like. Do you think there are others who do? Not

so much that they're relating to patients but that they see their work as having direct implications on people's lives?

D: Yeah I mean there has been times in my career that I've felt like the work I am doing it's going to directly impact patients.

C: Can you give me an example?

[...] (her example is about legislative and regulatory changes for a particular group of service providers)

D: Something like that really does feel like it's impacting people. But the work that I do now doesn't really feel – it feels like I'm impacting healthcare providers more than patients.

In her example, Debra describes having to negotiate with another set of service providers who have “put up roadblocks” to the changes she is working on. Even when a policy is meant to benefit patients in the long term, Debra is manoeuvring between various relations of power to accomplish the goal. She is cognisant of the political manoeuvrings inherent in her work.

During the time I was doing background work and collecting the empirical material for this research, I paid attention to the B.C. Government Directory website (British Columbia, n.d.) and the changes made to it – representing changes made to the names and responsibilities of divisions, branches, and program areas (collectively called Organizational Units), and thus priorities over time. At the start, chronic disease was prominent on the Ministry of Health's website and in the titles of organisational units. However, over time, “chronic disease” appeared less in titles and “injury prevention” appeared alongside chronic disease and was progressively given more prominence. I ask

Hal about the rise in attention to injury prevention and he tells me:

If you actually look at the slice of who is coming through the doors in the health system, chronic disease is by the far of the biggest slice. But the second biggest is those with injuries. [...] It's not as if it (injury prevention) is not a priority issue from a population perspective. But everyone gets from a health system perspective, chronic disease prevention. So it's far easier to understand that we have the main lead for chronic disease prevention and its impact on the system. [...] We know injuries impact on the system. But in terms of policy decisions up the upper echelons, they don't quite get why we are leading certain injury responses.

Despite Hal's claim, however, injury prevention appeared more often (in the titles of several organisational units) than chronic disease (reduced to one title). As I complete this dissertation, chronic disease is now absent in any branch or division title but there is a Chronic Disease Epidemiologist listed in the Primary Health Care Services

Organisational Unit. Injury prevention is in the names of two organisational units:

Healthy Settings and Physical Activity as well as Tobacco Control and Injury Prevention. I describe these changes to show the active disappearance of chronic disease in the face of on-going allegations that it consumes so much of the health/care system budget.

I do not want to leave the impression that people with chronic disease are never on the minds of policy workers. But there is so much else for policy workers to be considering, negotiating, and calculating, that people living with chronic disease become/are peripheral to their work. Often, when it looked like people with chronic disease might come up or did enter into a conversation, it was often overshadowed by discussions of the how the system works and the background bureaucratic negotiations

necessary to move on any idea. These discussions crowded the space available to talk about people with chronic disease. As Debra notes, “there's not a lot of discussion about how what we were proposing [...] might, you know, impact patients.”

I did hear talk of nutrition in schools; the value of green space, bike paths, local agricultural land, and food access; and the need to reduce second hand smoke. These were often discussed in relation to the “built environment” – a term several policy workers use often. One policy worker acknowledges the importance of paying attention to food and access: “Access to food. Absolutely, like in Haida Gwaii [...] they line up hours and hours, like they'll get up at three o'clock in the morning and line up for the sale day at the grocery store.” This person also acknowledges that priority and “what can we really do, what can we really commit to, oh yea, there's even more tension now that we're under fiscal restraint. It ebbs and flows as you can imagine depending on the government or the election time. Oh yea, no, there is tension for sure.” Another policy worker offers a very frank assessment of the government’s approach:

Can they sustain the fruit and vegetable program at the school? Oh I know. We've had those tough discussions over the years, absolutely. Talk about *ActNow*, God kill me. (laughter) Fucking millions of dollars on that goddamn program and it doesn't even exist now. That stuff dives me nuts.

This person is very frustrated, alleging that a program initiated under the auspices of making healthy food available to children was only a political manoeuvre associated with the Olympic games held in Vancouver in 2010 and disappeared when the games were over. This person has similar concerns regarding the “privatisation” of programs

such as “Community Living B.C.” (programs to support children and adults with disabilities that was carved off the Ministry for Children and Family Development into a stand alone agency) “because ultimately government is responsible for the citizens of this province.” Then this policy worker lists the programs that were cancelled or privatised, illustrating how the government is not taking this responsibility and people live the effects.

A couple of policy workers talk about the work they do across Ministries within the B.C. Government, such as with the Ministry of Transportation, and with committees representing government, academic institutions, and community groups. All these, says Hal “(are) chronic disease prevention. [...] (L)ike I said, we’ve mainly been focused on a lifestyle approach which is really around smoking, healthy eating, being physically active. But also [...] like I said, underpinning of healthy communities and that encapsulates our chronic disease prevention approach.” Amidst all the interesting things said about a broader understanding of chronic disease prevention, Hal describes how the Ministry has branded it: “All our work around chronic disease prevention was branded and called *ActNow*.” Hal insists that the Ministry has “always looked at the built environment piece, the transportation and all that sort of stuff, and the individual behaviour piece and health promoting environment.” *ActNow* morphed into a new brand *Healthy Families B.C.* (described in the second of the two government policy frameworks), which carried on with *ActNow*’s goals that are both individualising and

responsibilising (see British Columbia 2004b). “Our prevention and health improvement strategy has a focus on chronic disease prevention and healthy weights based on that review of who is using the system.” The claim to focus on the built environment, health promotion, and disease prevention cannot escape a focus on individual lifestyle behaviour; it appears it is these individuals (“who use the system”) who are called upon to *act now*.

I entered this research expecting that people with chronic disease to appear prominently. Policies are ostensibly meant to benefit people – in this instance, those living with chronic disease. Throughout the descriptions of policy-making offered by policy workers, however, people with chronic disease materialise on the sidelines, barely present, and quickly slip away, replaced in favour of other priorities. The effects of evidence-based policy-making are political as evidence is marshalled to enhance the confidence of residents of B.C. while meeting the goal of reducing costs. That British Columbians will be positioned to be responsible, under the guise of evidence-based policies, raises the question of whether the challenges of living with chronic disease will be mitigated in any specific – or useful – ways.

Afterword

I met one of the policy workers I had interviewed out in the community shortly

after I completed my interviews. She worked for many in a senior management position in the Ministry. She inquired how my study was going. I expressed surprise to her that hardly anyone talked about chronic disease. *She* was not surprised. "That's because no one is doing it," she replied.

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Appendix 1: Invitation to Participate in a Research Project

The relationship between knowledge production and policy development in the context of chronic disease

I invite you to participate in a research study entitled: The relationship between knowledge production and policy development in the context of chronic disease. I am undertaking this research as part of my Interdisciplinary PhD in the Faculty of Human and Social Development (Nursing and Studies in Policy and Practice) at the University of Victoria.

Purpose and Objectives

The purpose of this research project is to examine the principles that guide the day-to-day work of policy-makers. In particular, the purpose is to understand how policy-makers make use of knowledge generated through research in the creation of policy. I am interested in the relationship between knowledge, knowledge production, the policy-making process, and resulting policies. The focus is on policy-making as it relates to chronic disease, considered one of the most significant burdens on the health care system in BC specifically and Canada more generally.

Importance of this Research

Research of this type is important because while there is much literature on the importance of knowledge translation between research and policy and practice, there is not a lot of literature available or very little research being done on how it actually works by those engaged in the work of policy-development. This research goes behind language of knowledge translation to the practice of how it is done at the level of policy-makers. The focus of this project on policy-making relating to chronic disease is important because chronic disease is one of the biggest health care issues facing governments today and much of work by health policy-makers attends to chronic disease.

Participants Selection

You are being invited to participate in this study because you work in a branch of the ministry that is engaged in policy-development as it relates to chronic disease or you work in knowledge translation supporting the policy-development process. Your name was given to me by your colleague as someone who might be able and willing to offer valuable contribution to this study.

What is involved

If you agree to voluntarily participate in this research, I will seek your consent to be interviewed at a time and location of your convenience. The interview will take approximately 1-1½ hour, as your time permits. With your permission, the interview will

be digitally recorded and transcribed. I will also take written notes during our conversation. All identifying information will be removed from the transcripts to protect your identity.

If you are working on a policy project that might be useful for me to understand more fully, I will invite you to participate further by allowing me to observe your work at a community of practice meeting and have a second interview/discussion with me, if I think I need more information.

Risks

There are no known or anticipated risks to you by participating in this research.

Benefits

The potential benefits of your participation in this research include contributing to research that examines the day-to-day work of those involved with policy development. This research will provide policy-makers an opportunity to reflect on their daily practice, contribute to the literature that explores how knowledge and knowledge production contributes to policy and practice, and inform policy-makers how their work is influenced by frameworks that guide their practice.

Voluntary Participation

Your participation in this research must be completely voluntary. You may choose not to answer any question during the interview. If you do decide to participate, you may withdraw at any time without any consequences or any explanation.

If you are interested in participating in this study or would like to inquiry about it, please contact me: Catherine van Mossel (contact information removed).

If you have any inquiries about this research, you are welcome to contact the research (contact information above) or her supervisors Dr Mary Ellen Purkis (contact information removed) or Dr. Michael Prince (contact information removed).

Thank you for your consideration.

Catherine van Mossel

Appendix 2: Consent Form

The relationship of knowledge production and policy development in the context of chronic disease

You are invited to participate in a research study entitled *The relationship of knowledge production and policy development in the context of chronic disease* that is being conducted by Catherine van Mossel.

Ms. van Mossel is a PhD Candidate in the Faculty of Human and Social Development at the University of Victoria and you may contact her if you have further questions by emailing her at (contact information removed).

As a graduate student, Ms. van Mossel is required to conduct research as part of the requirements for an Interdisciplinary PhD degree in The Faculty of Human and Social Development (Nursing and Studies in Policy and Practice) at the University of Victoria. It is being conducted under the supervision of Dr. Mary Ellen Purkis and Dr. Michael Prince. You may contact my supervisors at (contact information removed).

Purpose and Objectives

The purpose of this research project is to understand and examine the principles that guide the day-to-day work of policy-makers. In particular, the purpose is to understand how policy-makers make use of knowledge generated through research in the creation of policy. I am interested in the relationship between knowledge, knowledge production, the policy-making process, and resulting policies. The focus is on policy-making as it relates to chronic disease, considered one of the most significant burdens on the health care system in BC specifically and Canada more generally.

Importance of this Research

Research of this type is important because while there is much literature on the importance of knowledge translation between research and policy and practice, there is not a lot of literature available or very little research being done on how it actually works by those engaged in the work of policy-development. This research goes behind language of knowledge translation to the practice of how it is done and enacted at the level of policy-workers. The focus of this project on policy-making relating to chronic disease is important because chronic disease is often identified as having the most significant burden on our health care system today and much of work by health policy-makers attends to chronic disease.

Participants Selection

You are being asked to participate in this study because you work in a branch of the ministry that is engaged in policy-making as it relates to chronic disease or you work in knowledge translation supporting the policy-making process. Your name was given to me by your colleague as someone who might be able and willing to offer valuable

contribution to this study.

What is involved

If you agree to voluntarily participate in this research, I will seek your consent to be interviewed at a time and location of your convenience. The interview will take approximately 1-1½ hours, as your time permits. With your permission, the interview will be digitally recorded and transcribed. I will also take written notes during our conversation. All identifying information will be removed from the transcripts to protect your identity.

Risks

There are no known or anticipated risks to you by participating in this research.

Benefits

The potential benefits of your participation in this research include contributing to research that examines the day-to-day work of those involved with policy development. This research will provide policy-makers an opportunity to reflect on their daily practice, contribute to the literature that explores how knowledge and knowledge production contributes to policy and practice, and inform policy-makers how their work is influenced by frameworks that guide their practice.

Voluntary Participation

Your participation in this research must be completely voluntary. You may choose not to answer any question during the interview. If you do decide to participate, you may withdraw at any time without any consequences or any explanation. If you do withdraw from the study, I will ask your permission to include the content of our interview in my analysis. If you do not agree, I will immediately destroy the data.

On-going Consent I may wish to contact you for a follow-up interview. If you agree to meet with me for a second interview, I will provide you with a new consent form.

Anonymity

Any identifying information will be removed from transcripts. All presentations or papers produced from this study will not reveal any identifying information of participants.

Confidentiality

Any identifying information will be removed from transcripts and will be kept strictly confidential. Because I may be meeting you in your office or because a colleague has referred you to me, there may be limits to your confidentiality in that your colleagues may know you are participating in this research. Only the interviewer will have access to the transcripts of the interview. All participants will be anonymous and be identified by a code number in the transcripts. There will be no names or any identifying information

about you in any final research presentations, reports, or publications. If, in the writing of the analysis, I am concerned that readers may be able to identify you as a participant, I will bring that section of the analysis to you and seek your agreement on the manner in which I have attempted to protect your identity. Data obtained in this study will be retained for eight to ten years by the researcher of this project to be used for educational purposes and writing articles post dissertation.

Dissemination of Results

It is anticipated that the results of this study will be shared with others in the following ways: PhD Dissertation, published articles, and presentations to scholarly and practice meetings.

Disposal of Data

The digital recordings of interviews will be kept on a password-protected computer and transcripts will be kept in a locked filing cabinet. All digital recordings will be deleted from the digital recorder once they have been transcribed. All electronic transcripts on computer hard drives will be deleted and paper transcripts will be shredded in fifteen years or at such time they are no longer being used for research purposes.

Contacts

You may contact the following individuals if you have questions regarding any aspects of this study: the researcher (Catherine van Mossel, PhD Candidate, University of Victoria (contact information removed) or her supervisors (Dr Mary Ellen Purkis at [contact information removed] or Dr Michael Prince at [contact information removed])

In addition, you may verify the ethical approval of this study, or raise any concerns you might have, by contacting the Human Research Ethics Office at the University of Victoria (250-472-4545 or ethics@uvic.ca).

Your signature below indicates that you understand the above conditions of participation in this study, that you have had the opportunity to have your questions answered by the researchers, and that you agree to participate in this research project.

Name of Participant

Signature

Date

I consent to be interviewed for future phases of this research project for e.g. observation at a policy of practice meeting and/or another interview. (I will explain what I hope to do in the second phase of the research and seek their permission to be in touch with them again if necessary.)

A copy of this consent will be left with you, and a copy will be taken by the researcher.

Appendix 3: Interview Guide

The Relationship between knowledge production and policy development in the context of chronic disease

Draft questions guiding interviews with policy workers may include: (I will not necessarily ask all of these questions but will use them to guide my conversation with secondary questions to probe further if necessary.)

1. What is your job title? What do you do here at the Ministry?
2. Can you tell me about a project you are working on right now? How do you come to be working on this project? What are some of the steps you engage(d) in with this project?
3. Are there principles you are supposed to follow in your work? If so, what are they? How do these influence your work? What else influences your work?
4. What kinds of expectations are put on you? Where do they come from? What limits you? (the broader context in which they work)
5. How does your work relate to chronic disease? How do you understand chronic disease?
6. Do the influences you mentioned earlier affect how you understand the “problems” of chronic disease that you are supposed to deal with in your work?
7. How do you gain knowledge to support you in your work? What sort of knowledge is most useful to you in your work?
8. What role does research play in your tasks of developing policy? What kinds of research do you look at in the course of your work? Can you tell me how you access research? Assess research? How do you decide which research will inform your work?
9. Referring to the principles/approaches that guide your work and the research you access: how do these relate to your approach to chronic disease? What aspects of people’s lives are you able to deal with in your policy-making? What are you not able to deal with? What limits your ability to deal with particular aspects?
10. How does the approach you use affect how you or your colleagues understand problems and potential solutions?
11. If you had to write a two page briefing note to convince someone to consider

funding a policy proposal, what would you include in it?