**Title**

What makes evidence-based policy making such a useful myth? The case of NICE guidance on bariatric surgery in the UK[[1]](#footnote-1)

**Author**

John Boswell, [j.c.boswell@soton.ac.uk](mailto:j.c.boswell@soton.ac.uk)

**Abstract**

There is widespread scepticism among policy scholars and practitioners about the move to rationalise policy making: the naive vision of ‘evidence-based policy’ is often contrasted with the reality of ‘policy-based evidence’. Yet the language of evidence-based policy making (EBPM) continues to dominate policy debate about complex and contested issues. In this paper, I explore this apparent paradox by looking at what makes EBPM such a useful myth for all sorts of policy actors. I do so with reference to the pioneering work of the National Institute for Health and Care Excellence (NICE), focusing specifically on its work in relation to bariatric surgery, a suite of controversial and drastic weight loss procedures. I show that the myth of EBPM has political, pragmatic and procedural utility in practice, allowing the organisation to set and administer guidelines on this uncertain, complex and contested treatment in ways which sustain buy-in and enable ongoing contestation.

**Key Words**

Evidence-based policy making; rationality; policy practice; obesity; NICE

**Introduction**

The What Works agenda in Britain is credited with breathing new life into the project to make policy making rational. New Labour’s commitment to implementing ‘what works’ is typically seen to have kick-started renewed interest among policy scholars about the potential and use of scientific expertise in political decision-making. The mantra of evidence-based policy making (EBPM) has become commonplace in policy practice across Britain and elsewhere (see Legrand 2012). But if anyone truly believed in the rationality project at the outset of this brief renaissance, they certainly do not seem to now. Policy scholars now almost uniformly express cynicism about the notion of EBPM, deriding it as a naive and even dangerous pursuit doomed to failure (see Parsons 2002; Pawson 2006; Hammersley 2013). Policy practitioners in Britain and elsewhere are, when asked to reflect on the idea, even more disparaging—they are sceptical about the prospect of EBPM solving the complex, uncertain and contested issues that they deal with (eg. LSE GV314 2014; Blomkamp 2014; Boswell 2014). Moreover, in the broader political sphere, it is said that we are witnessing the emergence of a ‘post-truth’ era in contemporary democratic governance. Though most notable in the US, this is also apparent in EBPM’s birthplace the UK, where the rhetoric of the recent Brexit campaign held that “people in this country have had enough of experts”. Far from the warm embrace of EBPM—or even the ambivalence to science that What Works was meant to replace—there is a growing popular and political *hostility* towards expertise in Britain and beyond. The very ideological dogmatism that New Labour sought to stamp out appears to be experiencing a resurgence in political rhetoric.

The rationality project, then, seems to be dead again: its resurrection short-lived. So why does the EBPM movement seemingly persist, in Britain and beyond? Why are so many government departments still formally committed to EBPM? Why does the language of EBPM still seep so deeply into policy advocacy, even on apparently contentious issues of conflicting values? In this paper, I consider not ‘what works’ but *what’s working*: I look at why EBPM retains such prominence at the coalface of policymaking despite clear misgivings among the actors who practice there. I want to explain its strange persistence in policy work amid an unfavourable political climate in which seemingly no one really believes in it. I look at what makes EBPM, discredited as it is in theory, such a useful myth in practice.

My analysis speaks to policy work more broadly but zeroes in especially on health policymaking in Britain, and in particular the work of the National Institute for Health and Care Excellence (NICE)—the original What Works Centre and perceived paragon of all things evidence-based. It is in this sector, in this country, that the paradox of EBPM is most acute: British health policy actors universally recognise the limitations of EBPM in practice, yet virtually all remain zealous proponents of the ideal publicly, and committed to justifying their claims with reference to the evidence base. Through an examination of the politics surrounding NICE’s history of guidance on a paradigmatically uncertain, complex and contested issue within its remit—the use of bariatric surgery to stave off the ill-effects of obesity—I seek to unpack ‘what’s working’ for the EBPM movement.

From this analysis, I identify three kinds of utility that EBPM entails in the practice of policy work. The first is an epistemic function: EBPM works as *a shifting fix* for uncertain policy problems like bariatric surgery. The fall-back claim to EBPM allows policy actors to get on with the business of governing in the absence of truly clear evidence about ‘what works’ on this issue. It enables policy actors to successfully justify action, and inaction, in both the short- and long-term. The second is a pragmatic function: EBPM appeals as *a principled instrument* for highly complex policy problems. The regular refrain to EBPM justifies action to address pressing problems that demand a visible political response. It provides an avowedly principled means for instrumental ends. The third, and most fundamental, is a procedural function: EBPM is *a secular faith* amid political contestation. The universal commitment to EBPM helps assure ongoing buy-in from stakeholders with very different views. It provides a mode of coordination for even the most contentious policy problems.

I advance these claims over five sections. In the first, I re-examine the emergence of What Works and trace the scholarly and political history of this agenda in brief. In the second, I outline and justify the case selection and my approach to analysis, highlighting the importance of NICE in this field and the manner in which its production of guidelines around bariatric surgery throws into sharp relief both the limitations, and the uses, of EBPM. In the third, I begin examining ‘what’s working’ by outlining the epistemic utility of EBPM as a shifting fix that allows NICE officials, and those seeking to influence them, ‘wriggle room’ to adapt as received wisdom about the evidence changes. In the fourth, I outline the pragmatic utility of EBPM as a principled instrument that enables NICE officials, and those seeking to influence them, to promote (or push back against) the use of bariatric surgery while appearing principled and detached. In the fifth, I outline the procedural utility of EBP as a secular faith that all actors can hold onto despite clashing values and incommensurable ideas about what counts as knowledge in relation to this issue. I conclude by considering the implications of this analysis for the practice and scholarship of EBPM in policy work.

**Tracing the What Works agenda**

In the UK, the incoming New Labour government in 1997 famously promised to ‘modernise’ government (White Paper 1999). A key plank of this programme was to make a break with the past—both the previous Conservative government’s devotion to neoliberal reform and to Labour’s long association with socialism—by promising a rational approach to policymaking. Theirs would not be a programme based on ideological commitments or leaps of faith. They would look to the best scientific evidence on how to deal with problems effectively. They would implement What Works (see Davies et al. 2000). The EBPM movement was, in these early days, greeted with much enthusiasm both in academia and in practice, spreading across Britain and well beyond. Many scholars across the social sciences were buoyed by the prospect of their research having a genuine impact on policy work.

Yet many specialist policy scholars were rather less enthusiastic. What Works or EBPM, to these scholars, appeared to just be new labels for the ill-judged project to rationalise policymaking. For some of these critics, the What Works agenda was dangerous. These scholars saw the EBPM movement as part of a broader effort to ‘depoliticise’ public problems, promoting a form of technocratic domination that might sideline legitimate democratic contestation (see especially Schwandt 1997; Parsons 2002; Roberts 2010; Papadopoulos 2013). For the bulk of critics, however, the view was that moves towards EBPM were naive (see especially Pawson 2006). The harsh practicalities of *realpolitik*, they argued, would never allow for a rational policymaking process. Over time, this latter stance has hardened as the orthodoxy. It has become common to refer cynically to ‘policy-based evidence’ instead as a way of deriding the manipulation of science for political ends (eg. Marmot 2004).

In the face of these criticisms, even those who initially embraced EBPM have softened their stance. They instead promote a form of evidence-inspired or evidence-informed policymaking (see Duncan 2005; Nutley et al. 2007; Head 2010). In doing so, they accept that a few pervasive features of policy work mitigate the prospect of EBPM, which I foreground in some detail below.

First, there is widespread acknowledgment that the focus of much policy work is not on What Works (based on the past) but on *what will happen* in the future. This introduces a great deal of scientific *uncertainty* into the process. The evidence, in this sense, is not always very clear. It can contain ambiguities that leave space for politicised interpretation (see Cairney 2016). And, of course, policymakers and anyone engaged in policy work can tell many stories about the political use and abuse of evidence in such circumstances. How can policymakers implement What Works when no clear evidence-based solutions exist?

Second, there is a growing awareness of the practical and political limitations to pursuing EBPM in the context of issue *complexity*. Governments face increasingly complex or ‘wicked’ policy problems—these are multifaceted issues which take in a wide range and level of contributing factors, and into which the effect of policy interventions is very difficult to determine (see Rittel and Webber 1973; Head and Alford 2015). Yet, in practice, policymakers still need to respond urgently to these highly complex problems. More fundamentally, then, how can policymakers implement What Works when they can’t even get a grip on the animating problem in the first place?

Third, a lot of policy work also confronts significant *conflict*, where political contestation is underpinned by clashing values and incommensurable claims about what counts as knowledge (see especially Fischer 2009). In such circumstances, it is not possible to simply solve problems with greater scientific knowledge. Indeed, at times, scientific knowledge itself can be beset by conflicts which reflect these differences. Most fundamentally of all, then, how can policymakers implement What Works when there is no agreement as to what ‘working’ might even mean?

Given these inherent difficulties, proponents of pure EBPM in policy scholarship have become thin on the ground. The normative battle lines have been redrawn around whether EBPM represents an appropriate regulatory ideal. The analytical focus has gone towards understanding the processes of policy learning in practice, and understanding the roles that scientific evidence can play in such learning across different policy contexts (see Sanderson 2009; Dunlop and Radaelli 2013). This is a rich and important literature that looks to go ‘beyond EBPM’ in order to understand what forms of knowledge underpin the practice of policy work (see eg. Smith 2013; Voss and Freeman 2016; Cairney et al. 2016).

Yet the risk in skipping beyond EBPM is that we might miss a key paradox at the heart of this movement—that many of its apparent proponents do not believe in it, and have never believed in it, either. The problems that scholars identify are not new to practitioners (see House of Commons 2006). Indeed, when asked, policy practitioners have proven highly reflexive about the limitations of EBPM. They feel the pressure to act despite their strictly bounded knowledge (Gains and Stoker 2011). They see the manipulation of science up close (LSE GV114 Group 2013). They know that contentious problems cannot be ‘solved’ with evidence (Richardson 2011). And so they typically share, privately, in the knowing cynicism towards What Works (see Blomkamp 2014; Boswell 2014). But publicly they continue to engage in the pursuit of EBPM. The language persists. In Britain especially, it still pervades government documents (eg. HM Government 2012, p 17), and remains at the centre of official rhetoric (eg. Hunt 2014). It is central to modern political advocacy. In the rush to dismiss EBPM, what is missing is detailed scrutiny of this apparent paradox. Why do policy actors cling so tightly to something they don’t actually believe in? What makes EBPM such an enduringly useful myth?

**Case Selection: The importance of NICE and the difficulties of bariatric surgical procedures**

To unpack the persistence of the EBPM myth in this unfavourable climate, it is useful to draw on a critical case that exemplifies the paradox of the EBPM movement (see Flyvbjerg 2006). And no field more acutely exemplifies the paradox than British health policy, embodied most notably in the founding ‘What Works Centre’, the then National Institute for Clinical Excellence (NICE). To be clear, my interest in NICE is not as an ‘evidence-based policymaker’—NICE performs an advisory function, and can only be seen as making policy in concert with other institutions and actors. Instead, the case focuses on the politics surrounding the production and communication of NICE’s evidence-based guidelines in this context.

NICE would seem to represent a best-case scenario for the prospect of enabling and promoting EBPM. It is an organisation whose very *raison d’etre* is to examine, synthesise and translate scientific evidence about technologies and treatments so as to render them amenable for advice to policymakers and practitioners. The body of scientific evidence on which it relies is the deepest, broadest and most rigorous among any of the key sectors that confront governments.[[2]](#footnote-2) The broader health sector is itself steeped in an evidence-based tradition – indeed evidence-based policy making represents a crossover from the prevailing culture of evidence-based medicine (see Milewa and Barry 2005). The stakeholders surrounding health policy such as professional groups, patient groups, and the pharmaceutical, medical technology and insurance industries all express deep commitment to evidence-based principles. All the ingredients for rational policymaking would seem to be in place.

Yet two decades of scholarship on or surrounding the politics of NICE have highlighted the limitations and obstacles that inevitably thwart the rationality project. Indeed, this field has produced some of the most important insights into the reflexive nature of practitioners, and their personal reservations about the pursuit of EBPM (see Sheldon et al. 2004; Brown and Calnan 2011; Landwehr and Bohm 2011). The aforementioned complexity, uncertainty and contestation that pervade policy making come flooding back, and disrupt the work that NICE is supposed to carry out.

If NICE is an emblem of EBPM, then the issue of bariatric surgery represents an especially crucial case about the limitations and challenges confronting the rationality project in practice. Bariatric surgery has risen to prominence in the last two decades at the same time as the widespread rise in rates of obesity across the Anglo world especially. The term refers to a suite of radical and invasive procedures that work to physically restrict a patient’s stomach size so as to reduce their feasible calorific intake. The core question for NICE (and bodies like NICE elsewhere in the world) has been to ascertain the cost-effectiveness of surgical interventions for the health service—whether, in essence, the long-term savings made from reducing the ill-effects of associated with obesity (diabetes, heart disease and so on) outweigh the immediate cost of funding the procedure and its follow-up. As critics of EBPM would suggest, though, making such a calculation is far from a simple or value-free exercise. Assessing the cost-effectiveness of bariatric surgery brings into sharp relief the concerns about uncertainty, complexity and conflict outlined above. Indeed, a NICE official interviewed for the project set the scene with this remarkably reflexive insight:

*To imagine you can have a sort of aseptic environment in which only the evidence counts is utterly unrealistic. We live in a democracy. Politics plays in, whether that's in the form of ideology, naked self-interest, sectional interest, or simply the ebb and flow or give and take of the political process, these are dynamics into which evidence is but one component part. And I suppose, although I'm an evidence practitioner—it's what I do—whatever the faults of a system which sometimes is driven by ideology, sometimes by vested interests, sometimes by sectional interests, and so on, democratic politics are probably preferable to all of that than to another narrow sectional interest, which is evidence. (Interview with NICE official, June 2012).*

There is much work on the disputed evidence surrounding the broader issue of obesity (see e.g. Oliver 2005; Lupton 2013). This scholarship questions many of the fundamental assumptions that underpin most of the more concentrated policy work and public debate around bariatric surgery—whether prevailing measurements (predominantly the Body Mass Index) adequately capture population rates of obesity, whether obesity is conclusively linked to ill-effects such as diabetes, and so on. In fact, the analysis that follows represents a tangent to a comparative project that explores the knowledge politics of obesity at this broader level (Boswell 2016). What I do here instead is narrowly focus on the way NICE, and those seeking to influence NICE guidelines, deal with and respond to the uncertainty, complexity and conflict that surround bariatric surgery specifically. The fact that these same limitations recur at a more fundamental level—the fact that key contentions about the reliability of the evidence on the prevalence of obesity and its consequences for ill-health need to be bracketed even for such debate to proceed—only serves to reinforce the puzzling nature of the persistent emphasis on EBPM and the need to unpack the dynamics driving it.

**Approach: Tracing the Practices of EBPM**

The broader project on which the paper builds is an interpretive account of the beliefs of policy actors who seek to influence policy on obesity. But in recognition that interpretive approaches focused on discourse can neglect the important praxis through which beliefs are actually enacted (see Wagenaar 2012), the narrower scope here enables a sustained focus on the practices of embedded policy actors as they seek to shape and respond to unfolding events. To examine the ways through which situated actors have made use of evidence, and claims to EBPM, in their policy work and political advocacy, I adopt a ‘practice tracing’ approach (see Pouliot 2014 for a detailed account: for other applications, see Visoka 2016; Corbett and Howard 2017).

Practice tracing represents an interpretive twist on the increasingly popular ‘process tracing’ approach to single case work (see Bennett and Checkel 2014). Practice tracing shares with process tracing a focus on understanding how chains of events unfold so as to shed light on causal dynamics. Like process tracing, practice tracing involves a rigorous, theoretically-informed analysis of the sequence of events that lead to particular outcomes and create particular effects, which draws on careful consideration of alternatives and regular reference to like cases. However, consistent with an interpretive orientation, this approach is abductive, moving between theory and practice in ways that do not just test theory, but build and augment it as part of an ongoing dialectic (see Schwartz-Shea and Yanow 2012). Moreover, it also eschews ‘mechanisms’ as external structuring forces. For interpretivists, such mechanisms only gain causal power from their meaning in context (Corbett and Howard 2017). Instead this approach emphasises ‘practices’ as socially embedded ways of doing things that have causal influence on the world.

The strength of practice tracing is its capacity to develop fine-grained analyses of meaning in action that speak explicitly to broader theoretical concerns. The focus on practices is key to making “small facts speak to large issues” because, though practices are always embedded in the particular, they can also represent more general patterns of action: “patterns of meaningful action may be abstracted away from local contexts in the form of social mechanisms that can travel across cases” (Pouliot 2014, 238). By tracing the practices that reproduce the myth of EBPM with respect to NICE guidance on bariatric surgery, I can develop and extend ideas about how similar outcomes occur across other policy settings and sectors.

Because such practices are often tacit, practice tracing necessarily relies on a multiplicity of data sources that can shed light on their aspects or features. This analysis draws on a broad qualitative dataset compiled between 2011 and 2016. The dataset includes 12 semi-structured interviews with key informants in British public health policy, in which actors reflect expressly on their practices of policy work and political advocacy. But it combines this reflective material with analysis of extensive documentary sources, focused on those that occupy and record sites of practice. This documentary record includes newspaper coverage over the course of NICE’s lifetime[[3]](#footnote-3); NICE documents (inclusive of formal guidelines, publicity surrounding the production of guidelines, and records of stakeholder and expert engagement exercises); and Parliamentary Hansard of relevant committee reports and hearings.

**The Epistemic Function: EBPM as a Shifting Fix**

There is lingering uncertainty about the efficacy and cost-effectiveness of bariatric surgical interventions. For some, especially firm proponents of such procedures, the evidence is very clear, and very supportive. They point to systematic reviews of evidence collected across medical trials—the ‘gold standard’ in EBPM—that indicate marked patient weight loss and concomitant drops in rates of chronic disease. Yet nagging questions remain about the long-term sustainability of these benefits. The concern is both that individuals cannot continue to tolerate the unpleasant physiological, social and psychological side-effects of the procedure—reversing or circumventing the treatment to restore their normal eating habits—and that the intervention may inadvertently become a cause of new, complex and expensive health problems. One physician opposed to the procedure explained his scepticism about the ‘industry’ surrounding the evidence on bariatric surgery:

*Clinician: In my experience there are two main groups of surgeons. One group of surgeons believe they're doing a helpful thing by putting a band around a person's stomach. And there's another group of surgeons who see this as a very good business model, and they're happy to take on anyone who falls into a criteria that someone has decided is an okay criteria to put a band around someone's stomach. The results that I've seen are very poor.*

*Interviewer: Really? Advocates tend to trumpet the evidence as being very strong…*

*Clinician: No, they don't [tell you the whole story]. At 6, 7, 8 years there's a gradual rate that people gain weight again. Some of the researchers who've looked at a run of lap band patients—I think they were from the Netherlands or something like that—their comment is that we don't see the positive outweighing the negatives for these people because there's so much risk along the way … And one endocronologist said to me that he thought that lap band surgeons should at the same time as putting a lap band around their stomach, put a television down their toilet so that every time they vomit at least they've got something to do when they're vomiting! (Interview with physician, July 2011)*

There have also been persistent uncertainties about which groups the surgical intervention is suitable for. These questions surround degree of obesity (whether it works for obese patients or just morbidly obese patients), age (whether it works for adolescents, the elderly) and health condition (whether it works for patients with existing co-morbidities). For example, the Association for the Study of Obesity’s (2014) submission to the stakeholder engagement exercise in the 2014 reassessment explicitly urged caution on the grounds of these limited insights:

*The suggestion that recently diagnosed diabetics (10 years) ought to be assessed and offered bariatric surgery is a new one. Could the rationale be justified, especially as new research recommendations suggest insufficient monitoring data are available to determine long term effects? BMI 30-34.9 should not be accepted into clinical practice without good quality evidence on what the longer term benefits really are. We consider this may be premature.*

As this might indicate, NICE’s response to these epistemic challenges has been a policy of incremental expansion. Initially tentative support for bariatric procedures in limited groups has firmed, with each revisitation of guidelines more strongly endorsing evidence of efficacy and cost-effectiveness and expanding the range of the population deemed suitable and eligible for treatment. The very first guidelines were developed in 2002 under the auspices of the NHS Research and Development Health Technologies Assessment Programme - a programme with the authority to set mandatory rules on new technologies and procedures. The HTA panel issued guidance supportive of surgical interventions as ‘a last resort’, though only for a small subset of the population for whom the evidence of efficacy and cost-effectiveness was deemed to be sufficiently strong. This included those meeting certain criteria with a BMI of over 40, or over 35 in the presence of type-2 diabetes. When revisited in 2006, however, the issue had been subsumed within the remit of the Guideline Development Group (GDG) on the broader issue of obesity, and thus with a reduced authority only to set guidelines for commissioning and practice. It is this shift in setting that has been crucial in setting in motion a practice of stronger NICE advocacy on the issue. The sacrifice in capacity to enforce compliance is what has freed these actors up to develop more definitive assessments and employ stronger rhetoric in their communication of those assessments. Certainly, later guidance has expressed a greater degree of confidence about the evidence of efficacy and cost-effectiveness cost effective. It has also expanded the range of the population for whom such procedures are recommended to include potentially adolescents and those with other co-morbidities. The latest reassessment, in 2014, has made stronger claims still about efficacy and cost-effectiveness, with a further lowering of the threshold for eligibility to include individuals with type-2 diabetes who have a BMI over 30.

The refrain to EBPM—in spite of persistent and well-documented uncertainty—works as a kind of *shifting fix* for the epistemic challenges surrounding the relevant evidence on this issue. It allows NICE officials to forge short-term compromise, producing guidelines that suitably reflect the evidence-based arguments of proponents of bariatric surgery, while also leaving sufficient ‘wriggle room’ for service providers, commissioners and clinicians less swayed by the weight of evidence. In particular, a key function of the shift away from the HTA Programme and into the GDG for the broader obesity guidelines has been to embolden the rhetoric while actually making greater space for non-compliance. But the emphasis on EBPM also reflects a long-term commitment, best epitomised in NICE’s support for the National Bariatric Surgery Register – a regular audit set up by ‘the bariatric community’ to monitor (and, for those involved, mainly to suppress) any lingering uncertainty. The practice is a promise to continually revisit the guidelines, to wait for new evidence to come in about its long-term efficacy and cost–effectiveness and its impact across different demographics.[[4]](#footnote-4)

NICE officials, and all those who seek to influence their guidelines on this issue, are willing to accept the reliance on EBPM, even in the absence of reliable and conclusive evidence. They do so on the basis that the ‘truth will out’ eventually.

**The Pragmatic Function: EBPM as a Principled Instrument**

More central to the challenges associated with setting guidelines on bariatric surgery is the overwhelming complexity that characterises the issue it is meant to treat. Indeed, perhaps the chief objection from those sceptical about the value of bariatric procedures is that it represents a naive ‘magic bullet’ for obesity, when in reality this is a condition associated with a vast range of intricately entwined contributory factors (see Foresight 2007).

This complexity is compounded by the realities of the service delivery environment ‘on the ground’. Assessments of cost-effectiveness parsimoniously presume capacity to deliver services upfront in order to make savings later. But the managers charged with commissioning are faced with a range of immediate pressures over health spending priorities, in the context of ever-tightening budgets (Rawlinson and Johnson 2016). There is also limited capacity to deliver even if upfront funding were available, due to an ongoing lack of specialists with the requisite skills (Donnelly 2014). The result has been exceptionally low rates of referral for bariatric surgery across the NHS in spite of NICE’s evidence-based guidelines. In a recent analysis – one drawn on extensively in the 2014 reassessment—Owen-Smith et al. (2013) show that only 0.6% of those eligible on the formal criteria were actually referred up the clinical pathway for surgical intervention.

In the face of this confounding complexity, NICE and NHS officials—and those actors seeking to promote the use of bariatric surgery—have voiced their concerns about the lack of uptake. Indeed, NICE began employing an implementation director in the mid-2000s in response to stinging criticism in the *BMJ* about the ongoing ‘postcode lottery’ with respect to bariatric surgery. But several years later little had changed when Medical Director of the NHS Sir Bruce Keogh vented his frustration in a Public Accounts Committee hearing. In response to a question prompted by a Royal College of Surgeons submission about continuing low rates of referral for the surgery, he replied:

*I think this is something that we will have to take to the new clinical leaders and the Commissioning Board because one of our problems with NICE guidance is that although it is significantly evidence-based and is excellent, we have no way of enforcing adherence. We can enforce things that go through its technology appraisals guidance, but not its regular guidance* (Committee of Public Accounts 2013, p 26)*.*

The response, in the absence of the authority to formally ensure compliance, has been to cling firmer still to the tenets of EBPM in the effort to encourage wider uptake of their guidance. EBPM, in this sense, acts as something of a disciplinary tool in the absence of the capacity to enforce guidelines. Refrain to the evidence allows these actors to rhetorically push for greater compliance. In 2010, for instance, the Royal College of Surgeons seized on an audit of referrals across England and Wales to reassert the purpose of NICE and the authority of its evidence-based guidelines in a concentrated media campaign. A spokesperson was quoted in the *Telegraph*:

*[NICE] guidelines are meant to signal the end of postcode lotteries, yet local commissioning groups are choosing not to deliver on obesity surgery. In many regions the threshold criteria are being raised to save money in the short term meaning patients are being denied life-saving and cost effective treatments and effectively encouraged to eat more in order to gain a more risky operation further down the line* (in Dickinson 2010).

NICE officials have been reticent to engage in such antagonistic terms, but they have still drawn on appeals to EBPM to assert their authority. Take, for example, the press release that accompanied the announcement of the revised guidelines in 2014. This included not just details about changes in the guidelines but renewed pleas from experts engaged in the reassessment process for widespread implementation, trumpeting the strength of the evidence base behind their claims. A physician on the GDG was quoted as enthusiastically endorsing the assessment:

*[If] someone is diagnosed with type 2 diabetes and their BMI is 35 or over then they should be offered an early, rapid assessment for weight loss surgery…. There is an initial cost of around £6,000 in the short term, but preventing the long-term complications of diabetes is great for the individual and will save the NHS money.* (NICE 2014)

Yet EBPM, for those more sceptical or concerned about bariatric surgery, also offers the main means by which they can push back against these disciplining efforts. The key here is that evidence does not always point in one direction in relation to such a complex issue—there are different bodies of criss-crossing evidence that can be used to justify quite different courses of action. For example, in explaining the lack of concerted follow-up and action, one clinical researcher complained that the focus on minor silos like the cost-effectiveness of bariatric surgery came at the expense of comprehensive evidence-based policy to tackle obesity:

*Within the field of obesity there are people who concentrate on genetics of obesity, there are others that concentrate on bariatric surgery, there are others that concentrate on the neuro-endocrinology of obesity, and then there are others who do cost-benefit analysis on different treatments but actually there is no joined up thinking (Interview with physician, June 2012).*

A public health researcher made a similar comment in an *Observer* story about the roll-out of the 2006 guidelines:

*We are medicalising something that is actually to do with how we live as a society. People become overweight because of their environment - because we take a car rather than walk - because we spend hours in front of the TV and because we are saturated by a junk food industry. If you take a purely medical approach to this, you start to normalise what is a deeply abnormal state.* (Dr Geof Rayner in Revill 2006).

But reference to EBPM is not just a resource for scientific experts hoping to influence debate. It is also a resource for practitioners at the frontline of service delivery. For General Practitioners, for instance, the question is about what evidence is relevant in the context of clinical practice where patients present with a complex range of conditions. There is the evidence against which NICE guidelines are directed but also the separate body of evidence against which their own practice is benchmarked – the Quality and Outcomes Framework or QOF. The point is that, because of the familiar barriers to joined-up thinking in implementation and service delivery, the incentives promoted by the QOF and the details of NICE’s guidance worked at cross-purposes. One physician, exasperated by this conflict, explained it thus:

*The QOF at the moment for me as a GP is that I'm incentivized to manage my patients extremely well. I get paid based on the evidence, on the statistics, on how well I'm managing my patients' blood pressure. For obesity, I'm given an incentive to count the number of fat people on my list, and then do absolutely nothing with that list of fat people, except a year later I weigh them again to make sure they're still fat enough to stay on my list so I keep getting paid for it (Interview with physician, March 2012)*

But it is not just that claims to or efforts towards EBPM work at cross purposes in the practice of policy actors. At times, they can be directly conflicting. Indeed, sceptics of bariatric surgery typically make claims to EBPM in order to promote alternative courses of action. In one rather strange twist, for instance, a report of the Select Committee on Health—persuaded by advocacy from leading public health experts—invoked NICE as an evidence-based authority in order to actually *criticise* existing NHS expenditure on bariatric surgery. One of its key recommendations explained:

*According to Public Health England, there is an unmet population need for support for weight loss and sustaining a healthier weight. NICE have recommended cost-effective interventions in this area and we recommend that these are funded and implemented as a matter of urgency. The Committee regards it as inexplicable and unacceptable that the NHS is now spending more on bariatric surgery for obesity than on a national roll-out of intensive lifestyle intervention programmes that were first shown to cut obesity and prevent diabetes over a decade ago. (House of Commons 2015).*

The effect is that EBPM—within a context of overwhelming complexity that would thwart any course of truly evidence-based action—provides a *principled instrument* both for NICE, and for the other actors that interact with NICE in this area. It allows all these actors to pursue instrumental ends to promote a pragmatic course of action, albeit via avowedly principled means.

**The Procedural Function: EBPM as a Secular Faith**

The last point is that bariatric surgery entails contestation over values and over what counts as knowledge. It is an invasive and radical procedure that fundamentally alters the way in which individuals experience eating and interact with food. This necessarily invokes value judgments about the appropriateness of the intervention, particularly in the case of adolescents. Claims about the evidence cannot be so easily disentangled from these value judgments. Take, for example, the controversy surrounding the 2006 NICE reassessment which left open the prospect of extending bariatric surgery to children and adolescents (with “psychological maturity”). Those opposed to the notion responded aggressively in their advocacy, discounting any evidentiary basis behind the claims as wishful thinking:

*These proposals come out of desperation from the medical community because they find it difficult to treat these children. My main concern is that these children will have this procedure done without trying out more natural treatments* (dietician Paul Sacher quoted in Fricker 2006)

Indeed, a principle claim among sceptics of bariatric surgery is that the supposed evidence base in this case is one rather manufactured by the powerful and well-resourced interests in the medical industry. Some critics have argued that the supposedly neutral GDG is in fact riddled with conflicts of interest:

*[S]ix out of 14 members of this latest panel have conflicts of interest. Four are bariatric surgeons and two are happy customers of bariatric surgery. One of them is Ken, the nice chap I met at the obesity conference, or should that be the Nice chap representing the bariatric surgery industry.* (Harcombe, 2014)

Likewise, while reflecting in an interview, a prominent public health advocate was dismissive of the ‘gold standard’ in EBPM precisely because it required a golden budget to produce such a degree of confidence:

*Randomised controlled trials…who can afford to pay for them? Only the medical and pharmaceutical industries! (Interview with health NGO representative, March 2012).*

Perhaps more fundamentally still, bariatric surgery generates a form of experiential knowledge (from patients and their carers) and professional expertise (from frontline practitioners) that is notoriously difficult to capture in EBPM (see Spyridionidis and Calnan 2011). This practical wisdom associated with experience of the intervention often contradicts the scientific evidence. This knowledge comes in the form of highly emotive narratives about the difficulties and indignities associated with the intervention, particularly the intensity of the physical, social and psychological side effects (see eg. Goodchild 2015).

In the context of clashing values and incommensurable understandings about what constitutes knowledge, NICE officials have sought further refuge in EBPM to develop guidelines amid this conflict. Notably, however, this has involved a clear expansion or re-imagination of what constitutes the evidence base. It frequently involves extrapolation on the basis of existing studies, or on transposing ideas from one existing area of scientific knowledge to the specific area of focus. Nowhere is this better exemplified than in the 2014 update to the guidelines on follow-up care. The issue here is that there are severely limited studies on which to draw – indeed, the first three recommendations in the report for further research all revolve around building the evidence base about follow-up (indicative again of the *shifting fix* for uncertainty discussed earlier). But in the meantime a clanging disclaimer in respect to the most potent justification for the reinforced guidelines was buried in the ‘Other Considerations’ section of the report:

*Current practice is variable and the GDG felt that, while research into different care packages for a longer period of follow up would be valuable, it was important to provide advice for the NHS now to mitigate against poor care and to encourage long-term sustainable positive outcomes. Consequently, the GDG chose to make a number of consensus recommendations. The GDG noted the limited poor-quality evidence and therefore the recommendations were drafted based on the experience and opinion of the GDG (National Clinical Guideline Centre, 2014).*

Crucially, this sleight of hand does nothing to impugn NICE’s EBPM credentials. ‘Experience’ and ‘opinion’, in this context, are not referents to the experiential knowledge of patients or the professional opinions of practitioners or patients. They are the experience and opinion of the GDG members and their accumulated wisdom as ‘evidence-based practitioners’, to recall the term used by the NICE official quoted at the outset. Their authoritative knowledge of existing evidence is what provides them with authoritative knowledge of limited or absent evidence, too. But, of course, the justification remains evidence and the evidence-base, and not the values, experiences or assumptions that we might equally see as inflecting their policy work and political advocacy.

Just as importantly, those seeking to influence NICE guidelines— even if, when asked to reflect, they are happy to accept that their claims are inflected by values, assumptions and experiences (see Boswell 2016)—also make their appeals through reference to EBPM. The artefacts of their practice are testament to this privileging of evidence in advocacy efforts. Take, for example, the document circulated and collated as part of the stakeholder consultation exercise in the latest round of NICE reassessment. The consultation involved circulation of a pro forma that tightly circumscribed and channelled stakeholder input. The box-filling exercise required that actors support any claim with reference to scientific evidence. The manner in which these inputs were collated, translated and formatted served to make the presence of evidentiary claims integral to any recommendation or criticism. Notably, though, this was a rule of engagement that all participants willingly complied with, and again, one they are happy to accept as part and parcel of the advocacy ‘game’ (again, see Boswell 2016). There was tacit acceptance, in practice, that no claim could make the grade unless it was tightly backed up by accompanying reference to scientific evidence.

This emphasis on evidence in advocacy extends beyond the current evidence-base. It shapes the production of research, too. Just as proponents of bariatric surgery have sought to prove the efficacy and cost-effectiveness of surgical interventions (through measures like the National Bariatric Surgery Registry), so too have actors sceptical about or opposed to widespread funding of these procedures seek to build and promote a body of evidence that records and systematises the sort of experiential knowledge underpinning their beliefs and claims. The aim is to transform this knowledge into a form of scientific evidence that can be more convincing and effectual (see eg. Ogden et al. 2011; Ogden et al. 2015).

The point is that, in spite of different ideas about what counts as knowledge and the clashing values underpinning them, EBPM has provided a shared value which everyone seemingly holds. EBPM is in this sense a *secular faith* for which there is universal devotion. EBPM underpins a process that everyone can believe in, and thus an outcome that everyone can accept the legitimacy of, whether they win or lose personally.[[5]](#footnote-5) It provides a mode of coordination in the face of widespread conflict and contestation.

**Conclusion**

To recap, my focus has been on why the myth of EBPM persists—how actors continue to make ‘evidence-based’ claims and promote ‘evidence-based’ practices despite deep misgivings about the fundamentally political nature of policy work. My analysis outlines first an epistemic utility to this practice, in that it enables short and long-term resolution in spite of strictly bounded rationality; second a pragmatic utility, in that it enables actors to promote courses of action in the face of overwhelming complexity; and third a procedural utility, in that it provides the shared norms of engagement that can assure continued engagement amid political conflict. This analysis begs two key questions—one of generalizibility; the other about normative implications. The conclusion addresses each in turn.

First, in line with my interpretive preference for ‘plausible conjecture’ rather than generalization (see Rhodes 2014), there are grounds for assuming broader resonance across sectors and settings. The key findings align with rich contemporary scholarship on the use of evidence across policy contexts. My account of the epistemic utility of EBPM echoes Stevens’ (2011) study of how British civil servants used snippets of evidence to build persuasive narratives on criminal justice policy, or Knaggard’s (2014) study of how actors leveraged limited evidence in the development of climate change policy in Sweden. My account of the pragmatic utility of EBPM echoes Dunlop’s (2016) study of how actors interpreted RCT’s from badger culling in southeast England to ‘clinch’ their preferred policy outcomes, or Blomkamp’s (2014) study of how simplistic indicators underpin political claims about cultural policy in New Zealand. My account of the procedural utility of EBPM echoes Boswell’s (2008) account of how actors in the European Commission relied on science to generate buy-in for asylum policies.

Yet, turning towards the second question about normative implications, it is equally apparent that not every policy context entails such a resilient commitment to EBPM: that there are instances where the secular faith of EBPM has failed to take root or lost support. Do these repudiations of EBPM really promote the deeper democratic deliberation that critics desire? The chief concern has been that moves towards EBPM threaten to undermine fair processes of democratic contestation; that the avowedly value-free pragmatism of What Works’ simply sneaks ideology in the back door (eg. Wesselink et al. 2014). But understanding EBPM as itself ideological—as a set of ideas that shape norms of engagement and generate intersubjectively shared criteria for making and judging claims—reveals its key role in *underpinning* and *enabling* democratic contestation. The persistent myth of EBPM helps governing institutions build and perform the authority upon which their legitimacy rests, but in doing so it also provides a crucial resource by which that authority can be questioned and challenged.

This conclusion points in two directions for future research. One is for studies to further flesh out, augment and challenge the findings contained here about how and why the myth of EBPM persists. Perhaps the more pressing need, though, is for scholarship that examines why faith in EBPM lapses, and assesses what happens when the shared commitments and standards underpinned by EBPM ebb away.

**References**

Bennett, A and Checkel, JT 2014, *Process Tracing: From metaphor to analytic tool*, Cambridge University Press, Cambridge.

Bevir, M and Rhodes, RAW 2006, *Governance Stories*. Routledge, London.

Blomkamp, E 2014, ‘Uses of evidence in local cultural policy: performance, legitimation, problem representation, and learning in two Australian municipalities.’ *Evidence & Policy.* vol. 10, no. 2, pp. 223-241.

Boswell, C. 2008. ‘The political functions of expert knowledge: knowledge and legitimation in European Union immigration policy’. *Journal of European Public Policy*, 15(4): 471–88.

Boswell, J. 2014, ‘‘Hoisted with our own petard’: evidence and democratic deliberation on obesity’. *Policy Sciences*, vol. 47, no. 4, pp. 345-365.

Boswell, J. 2016. *The Real War on Obesity: Contesting knowledge and meaning in a public health crisis*. Basingstoke: Palgrave Macmillan.

Brown, P. and Calnan, M. 2011, ‘The civilizing process of trust: Developing quality mechanisms which are local, professional-led and thus legitimate.’ *Social Policy & Administration* vol. 45, no. 1, pp. 19-34.

Cairney, P (2016) *The Politics of Evidence-based Policy Making*, Basingstoke: Palgrave Macmillan.

Cairney, P, Oliver, K and Wellstead, A 2016, ‘To Bridge the Divide between Evidence and Policy: Reduce Ambiguity as Much as Uncertainty’, *Public Administration Review*, Early view, DOI:10.1111/puar.12555

Corbett, J and Howard, C forthcoming, ‘Too big to fail? Rethinking the relationships between agency termination and size’, *Public Administration*.

Davies, HTO , Nutley, SM and Smith, PC 2000, 'Introducing Evidence-Based Policy and Practice in Public Services', in Davies , Nutley and Smith (eds), *What Works? Evidence-Based Policy and Practice in Public Services*, Bristol: Policy Press.

Dickinson, M 2010, ‘NHS 'inconsistent' on weight-loss surgery’, *The Independent*, January 21.

Donnelly, L 2014, ‘Obesity surgery could be offered to a million more people on NHS’, *The Telegraph*, July 11.

Duncan, S 2005, ‘Towards Evidence-Inspired Policy Making’, *Social Sciences*, vol. 61, no. 1, pp. 10–11.

Dunlop, CA and Radaelli, CM 2013, ‘Systematizing Policy Learning: From Monolith to Dimensions’, *Political Studies*, vol. 61, no. 3, 599-619.

Dunlop, CA 2016, ‘Contestation and Contingency in Advisory Governance’, in Bevir M, Rhodes RAW (eds) *Rethinking Governance: Rules, Rationalities and Resistance*, London: Routledge.

Fischer, F. 2009, *Democracy and expertise: reorienting policy inquiry*, Oxford University Press, Oxford.

Flyvbjerg, B. 2006, ‘Five misunderstandings about case-study research’, *Qualitative Inquiry*, vol. 12, no. 2, pp. 219-245.

Foresight 2007, *Tackling obesities: future choices—project report (The Foresight Report)*, The Stationery Office, London.

Gains, F and Stoker, G 2011, ‘Special advisers and the transmission of ideas from the policy primeval soup’, *Policy & Politics* vol. 39, no. 4, pp. 485–498.

Goodchild, S 2015, ‘Weight-loss surgery can 'ruin patients' quality of life', warns leading doctor’, *Independent*, July 5.

Hajer, M.A. 2006, ‘Doing discourse analysis: coalitions, practices, meaning’, in M van den Brink and T Metze (eds.), *Words matter in policy and planning: discourse theory and method in the social sciences*, KNAG/Nethur, Utrecht, ND, pp.65-74.

Hammersley M 2013, *The Myth of Research-based Policy and Practice*. Thousand Oaks, CA: SAGE

Harcombe, Z 2014, ‘Gastric bands are as useful as a plaster on a severed artery’, *The Independent*, July 12.

Head, B 2010, ‘Three lenses of evidence-based policy’, *Australian Journal of Public Administration*, vol. 67, no. 1, pp. 1-11.

Head, B.W. and J. Alford. 2015. ‘Wicked Problems: Implications for Public Policy and Management’, *Administration & Society*, vol. 47, no. 6, pp. 711-739.

HM Government 2012, *Civil Service Reform Plan*. Cabinet Office, London.

House of Commons 2006, ‘Scientific Advice, Risk and Evidence Based Policy Making’. *Seventh Report of the House of Commons Science and Technology Committee, Session 2005-06*. HC 900-1. The Stationery Office, London.

House of Commons 2015, ‘Impact of physical activity and diet on health’. *Sixth Report of the House of Commons Health Committee, Session 2014-15.* HC 845. The Stationery Office, London.

Hunt, J 2014, ‘Keynote Address’, *Health Policy Summit 2014*, Nuffield Trust, March 6.

Knaggård, Å. 2014. ‘What do policy-makers do with scientific uncertainty? The incremental character of Swedish climate change policy-making’. *Policy Studies,* vol. 35, pp. 22–39.

Landwehr, C and Bohm, K 2011, ‘Delegation and institutional design in healthcare rationing’, *Governance*, vol. 24, pp. 665–688

Legrand, T. 2012, ‘Overseas and over here: policy transfer and evidence-based policy-making’. *Policy Studies*, vol. 33, no. 4, pp. 329–348.

LSE GV314 Group 2014, Evaluation under Contract: Government Pressure and the Production of Policy Research. *Public Administration* 92(1): 224–39.

Lupton, D 2013, *Fat*, Routledge, London.

Marmot, MG 2004, ‘Evidence-based policy or policy-based evidence?’, *British Medical Journal*, vol. 328, pp. 906–907.

Milewa, T and Barry, C 2005, Health policy and the politics of evidence, *Social Policy and Administration*, 39(5): 498-512.

National Clinical Guideline Centre, 2014, *Obesity: Identification, Assessment and Management of Overweight and Obesity in Children, Young People and Adults: Partial Update of CG43,* London: National Institute for Health and Care Excellence (UK); 2014 Nov. (NICE Clinical Guidelines, No. 189.) 8, Follow-up care packages. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK311345/>.

NICE 2014, ‘Offer weight loss surgery to obese people with diabetes’, NICE News and Features, November 27 (available at: <https://www.nice.org.uk/news/article/offer-weight-loss-surgery-to-diabetics>).

Nutley S. M., Walter I., Davies H. T. O. 2007, *Using Evidence: How Research Can Inform Public Services*. Bristol: Policy Press.

Ogden J, Avenell S, Ellis G. 2011, ‘Negotiating control: patients’ experiences of unsuccessful weight-loss surgery’. *Psychological Health*, Vol. 26, pp. 949–964.

Ogden, J., Hollywood, A., and Pring, C. 2015, The impact of psychological support on weight loss post weight loss surgery: a randomized control trial. *Obesity Surgery*, vol. 25, pp. 500-505.

Oliver, JE 2005, *Fat Politics: The Real Story Behind America’s Obesity Epidemic*. Oxford University Press, New York.

Owen-Smith A, Kipping R, Donovan J, Hine C, Maslen C, Coast J. 2013, ‘A NICE example? Variation in provision of bariatric surgery in England.’ *BMJ* 346, p.2453

Papadopoulos, Y 2013, *Democracy in Crisis? Politics, Governance and Policy*. Palgrave Macmillan, Basingstoke.

Parsons, W 2002, ‘From muddling through to muddling up: Evidence based policy making and the modernization of British government’, *Public Policy and Administration*, 17(3): 43-60.

Pawson, R 2006, *Evidence-based policymaking: A realist critique*, London, Sage.

Pouliot 2014, ‘Practice tracing’ in Bennett and Checkel (eds.) *Process Tracing: From metaphor to analytic process,* Cambridge University Press, Cambridge.

Rawlinson, K and Johnson, C 2016, ‘Decision to deny surgery to obese patients is like 'racial discrimination', *The Guardian*, September 3.

Revil, J. 2006. ‘NHS must pay for fat children to get surgery’, *The Observer*, November 19.

Rhodes, R. A. W. 2014. “Genre Blurring’ and Public Administration: What Can We Learn from Ethnography?’” *Australian Journal of Public Administration* vol. 73, no. 3, pp. 317–330.

Richardson, L. 2011. ‘Cross-Fertilisation of Governance and Governmentality in Practical Policy Making on Behaviour Change.’ *Policy and Politics* vol. 39, no. 4, pp. 433–446.

Rittel, HWJ and Webber, M 1973, ‘Dilemmas in a general theory of planning’, *Policy Sciences*, vol. 4, pp. 155-169.

Roberts, A 2010, *The Logic of Discipline, Global Capitalism and the Architecture of Governance*, Oxford University Press, Oxford.

Sanderson, I 2009, ‘Intelligent policy making for a complex world: pragmatism, evidence and learning’, *Political Studies*, vol. 57, no. 4, pp. 699-719.

Schwandt, T 1997, ‘Evaluation as practical hermeneutics’, *Evaluation* 3: 69-83.

Schwartz-Shea, P. and Yanow, D. 2012, *Interpretive research design: concepts and processes*, Routledge, New York.

Sheldon, TA, Cullum, N, Dawson, D et al. 2004, ‘What's the evidence that NICE guidance has been implemented? Results from a national evaluation using time series analysis, audit of patients' notes, and interviews’, *BMJ*, 329, 999.

Smith, K 2013, *Beyond Evidence-Based Policymaking in Public Health: The Interplay of Ideas*. Palgrave Macmillan, Basingstoke.

Spyridonidis, D. and Calnan, M. 2011, ‘Opening the black box: A study of the process of NICE guideline implementation.’ *Health Policy* vol. 102, pp.117-125.

Stevens, A 2011, ‘Telling policy stories: an ethnographic study of the use of evidence in policy-making in the UK’. *Journal of Social Policy*, vol. 40, pp. 237-255.

Visoka, G 2016, *Peace Figuration after International Intervention: Intentions, Events and Consequences of Liberal Peacebuilding*. Abington, Routledge.

Voss, J and Freeman, R 2016, *Knowing Governance*, Palgrave Macmillan, Basingstoke.

Wagenaar, H. 2012. ‘Dwellers on the threshold of practice: the interpretivism of Bevir and Rhodes’. *Critical Policy Studies*, vol. 6, no.1, pp. 85–99.

White Paper 1999, *Modernising Government*. HMSO, London.

Wood, M 2015, 'Holding Back the Tide: Depoliticisation, Resilience and the Herceptin Post-code Lottery Crisis', *British Journal of Politics and International Relations*, 17, 644-64.

1. A slightly adapted versión of this paper is forthcoming in *Governance*. [↑](#footnote-ref-1)
2. This is best exemplified by the Cochrane and Campbell Collaborations that collate and systematically review medical and public health research. [↑](#footnote-ref-2)
3. N=384, recovered from across leading British newspaper publications on the Lexus Nexis database. [↑](#footnote-ref-3)
4. There are important parallels to be drawn here with other prominent controversies in NICE’s history, especially NICE guidelines surrounding drug treatments for Multiple Sclerosis. The relevant GDG’s negative assessment of cost effectiveness met with opposition from MS patient groups and medical professionals, on the basis that the evidence was sufficiently promising. Eventually a deal was struck to approve the treatments with the emerging evidence to be carefully monitored by a specially convened ‘working group’ – who would initiate and feed into a revised assessment after collecting a solid evidence base. [↑](#footnote-ref-4)
5. There are clear parallels here to the handling of the controversy surrounding the breast cancer drug Herceptin in the mid-2000s, where NICE’s resilient institutional processes (underpinned by a commitment to EBPM) shored up its legitimacy in the face of intense political debate (see Wood 2015). [↑](#footnote-ref-5)