ing has many irrational inputs and may not be particularly open to evidence. One need look no farther than my own country, the United States, for some recent, major (and somehow shocking, even to this jaded observer) examples of the willful neglect and manipulation of scientific evidence to fit policy agendas rather than to shape them. These range from *ignoring* evidence for policies the Bush administration opposes (recommendations that emergency contraception be made readily available, or that greenhouse gases are an important cause of global warming); to *refusing to collect* scientific evidence for policies Bush promotes (abstinence-only interventions for reproductive health are funded without evidence of their effectiveness); to *willfully manipulating* scientific evidence to reframe issues in the Bush administration's favor (a national report on health disparities is censored so thoroughly that instead of calling such disparities a national problem it emphasizes ways that ethnic minorities are healthier than the general U.S. population; and government websites are altered to contradict accepted scientific data reviewing condom effectiveness or abortion risks). (Many of these abuses and others are documented at: http://www.democrats.reform.house.gov/index.asp.) One wonders at times whether theorizing about improving the use of research in policy is even useful in the absence of political change.

If it is true, as the authors suggest, that there is "a certain consensus" among analysts with respect to the barriers that impede use of research in decision-making, how do they explain this consensus given the many competing theoretical formulations of the research to policy process? That is, if a theorist like Patton thinks more about use *processes* than products, but a theorist like Kirkhart talks more about *influence* than use, why wouldn't these different formulations lead to the identification of quite different types of barriers and a consequent lack of consensus?

I would have liked to see the authors pay more attention to, and review more of, the empirical research they call for in their last paragraph. This attention would have been of benefit to those considering designing such research. Nonetheless, I think this summary piece provides a good introduction to a broad array of important theories and concepts and definitions related to research and policy-making, and I will look forward to the authors' eventual review of the empirical research they urge.

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## "Talk of bulls": a comment on Almeida & Báscolo

The question of how health systems research is and may be used in policy decision-making has been the subject of numerous learned articles and international workshops. The ways in which the so-called research-to-policy transfer is viewed or modeled often reflects the academic discipline and ideological background of the authors. The most obvious differences exist between the rational or linear models of the relation between research and policy on the one hand, and the complex, indirect and not necessarily logical models on the other. The paper by Almeida & Báscolo provides an excellent overview of different approaches and analytical frameworks to describe and learn from the interactions of research and policy. Almeida & Báscolo do not conceal the fact that they are dissatisfied with what they have found. In their conclusion, they complain about the "*excessive formalization of instruments and pragmatic simplification*".

Obviously the boundaries between research and policy are not clear-cut and can therefore not be managed easily. It has become obvious that the "two-communities" perspective may be deceiving [1]. After all, neither the research nor the policy community is homogenous and there may even be overlaps in how the world is viewed from each side. Interestingly enough, however, all models relate to a phenomenon that, albeit being paraphrased on a couple of occasions, is not once mentioned explicitly in the review paper: communication. This is particularly surprising as quite a few of the models draw on institutionalism, be it from a sociological or a rational choice perspective. Even if the latter approach frequently neglects communication, institutionalism and communication are conceptually closely linked.

The analysis of communicative processes, taking into account the lessons of social science in terms of organizational relationships as well as the functions of language, promises to point towards a model of effective communicative interaction between researchers and policy-makers. Even if researchers and policy-makers can possibly rely on a culturally ingrained "pre-understanding", effective communication, i.e. an effective research-to-policy transfer, requires a mutual understanding based on the intent on both sides to engage in a communicative process, which again to a certain degree necessitates the willingness to relativize one's position in the light of the other's perspective. In this sense,

communication means more than the mere transfer of information. The ideal process, which is socially superior to other forms of human action, is what Habermas termed "*communicative action*" [2]. While the analysis of communicative processes means leaving behind linear models, the goal to derive strategies to improve the use of research results in health policy decision-making may not be as distant as under the application of a more remote paradigm. After all, the research-to-policy transfer can even be interpreted as communication in its most basic sense, namely as a process of conveying information. Effective communication is what we would like to see as a result: an impact on policy formulation and implementation.

When policy research is perceived as threatening by policy-makers, when researchers do not get their messages across to policy-makers, and when basic research is not considered relevant by policy-makers, then communication is not effective. The underlying communicative processes need to be analyzed. Recommendations from the research-to-policy literature on the right format of easily digestible research findings or on engaging with advocacy coalitions only tackle the symptoms, not the root causes for the failure to communicate effectively between the two spheres.

The commodification of internationally streamlined research and the standardization of tools and output formats in the interest of supposed quality management do not necessarily contribute to developing an atmosphere conducive to effective communication between policymakers and researchers at a national level. An increasing amount of research commissioned by health authorities and international organizations may affect the self-image of the researcher and thereby jeopardize effective communication from the outset.

Almeida & Báscolo spark off a cascade of insights into the reasons of successes and failures of the use of research results in health policy decision-making. Ultimately, the degree to which research will be considered in health policy depends on researchers being able to effectively provide counter-evidence to the widespread proverbial belief that it is not the same to talk of bulls as to be in the bullring.

1. Gibson B. Beyond "two communities". In: Lin V, Gibson B, editors. Evidence-based health policy: problems and possibilities. Melbourne: Oxford University Press; 2003. p. 18-32.
2. Habermas J. The theory of communicative action. Volume one: reason and the rationalization of society. Boston: Beacon Press; 1984.

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In a study carried out in eight Latin-American and three European countries, the NEVALAT Project group showed that the decision-making process for different issues in the health system (reimbursement for new drugs, resource allocation, provision of public health interventions, inclusion of services in health insurance packages, adoption of new technologies) is based not on research, but primarily on political criteria, historical records, geographical areas, and specific groups of patients and diseases [1]. The authors emphasize the need for a clear understanding of the research-to-policy process. The paper by Almeida & Báscolo provides a critical update of the literature on this process, and the authors highlight the complexity and non-linearity of research use for decision-making and policy formulation processes in the health sector.

The authors have tackled numerous relevant issues that deserve academic and theoretical analysis, but I will limit my comments to just a few. As the paper states, there are several barriers preventing research results from influencing decision-making and policy formulation. One is the chasm between scientists and policy-makers, due both to "mutual intellectual disdain" (science is sometimes viewed as authoritarian and triumphalist [2]) and a lack of reciprocal knowledge and understanding. Policy-makers have rarely related to science: according to Carl Sagan, less than 1% of Members of the U.S. Congress have any scientific background [3]. Meanwhile, researchers are unfamiliar with the political world, where research is merely "another view" according to politicians, who must also take social, economic, and political factors into account during policy-making, an attitude that is not always understood or accepted by scientists. In addition, as the authors state, the timing of the two processes (research and decision-making) may not coincide, and research results are not immediately available on request by policy-makers. Scientists should also