Theory, Like Mist on Spectacles, Obscures Vision

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This article reflects upon the choice of theory in theory-driven evaluation. While theory is helpful in focusing evaluators' attention and facilitating investigation, it also excludes evidence that does not fit within its framework. The argument is that evaluators need to be aware of all theories that may impinge upon a programme and to defend the theory of choice. They also need to be explicit about what may be excluded from their investigation. Governments aim at change at a macro-level, often using macro-theory, whereas evaluators often concerned with the implementation of programmes may use theory that is at a different, usually the micro-level. Theories at these two levels are not always compatible. The article briefly outlines the development of the theory-driven approach before focusing upon evaluation in health promotion as a case study to highlight the issues.

KEYWORDS: evaluation theory; health promotion; new public health; social order

Introduction

The use of theory in evaluations needs to be made more explicit. For a theory to contribute to understanding, and to be of use, it must contain the following features (Davies, 1989).

- It must present a model that explains, integrates and interprets facts.
- It must necessarily be prescriptive as well as descriptive, leading to conclusions about the proper or effective course for public policy.
- It will be normative insofar as it will raise moral and philosophical issues and must adopt clear positions on these. Thus meaningful and useful theory must contain, for example, notions of the nature of 'the good society', the nature and causes of human action and the differentiation of public and private.
- Finally any effective theory must be historically aware – institutions and activities can only be properly understood in a historical context.

The title of this article is a quote from the 1935 film *Charlie Chan in Egypt*. We have used it as a title because it illustrates that the adoption of a theory in an investigation (or evaluation) is not unproblematic. Theories, on the principles outlined above, are developed to help shape our view of the world and focus our attention on certain aspects of it in order to facilitate investigation. However, in choosing a theory we also exclude other theories *and* exclude areas of information that lie outside of the particular theoretical framework of choice. This is Charlie Chan's point; theory in illuminating some areas leaves others in darkness. In this respect the use of theory is like a double-edged sword – the trick is not to fall on it.

Theory-driven evaluation can only take place within the context of an adopted theoretical model or explanation of the state and condition of contemporary society (or some aspect of it) and with some prescription of how this can be improved. This article is based upon the conviction that a significant proportion of evaluations may actually be adopting theoretical models without a full explanation (or defence) of the moral and philosophical underpinnings of the theory and are not clear about the evidence that they are excluding. Theoretical notions of 'the good society' need to be critiqued to allow an examination of who benefits from the 'good society' that is being promoted and the implications of changing society in preferred directions. Our further argument is that those undertaking theory-driven evaluation need to be fully aware of (and report) all the theories and political issues that may be applicable to the programme and context under study before they can properly evaluate with a theory-driven approach.

In order to explore and illustrate these issues we will focus upon the use of theory in health promotion evaluation. The predominant theory adopted in health promotion evaluation is 'theories of change' (Connell et al., 1995; Connell and Kubisch, 1996; Judge et al., 1999; Wimbush and Watson, 2000). The 'theories of change' model is essentially a micro-level functionalist theory with normative roots. More specifically it refers to an approach which tests a programme's desired outcomes, according to the timescale by which they are achieved, together with the process through which the goals are fulfilled. In essence it refers to an evaluative process, which reconciles the process and outcome of change (Connell and Kubisch, 1996; Hughes and Traynor, 2000). There is nothing wrong with this in itself, but theories that may impinge upon the programme at other levels are often not considered in such evaluations. In particular, the social change sought by such approaches also has social order implications. We will first outline the development and key tenets of theory-driven evaluation before pointing to the implications of a wider theoretical discourse for the evaluation of programmes aimed at reducing 'at risk' behaviour in health.

The Theory-driven Approach

Theory-driven evaluation is a very important approach in the evaluation of public services and programmes. The basic concept is that a theory about, or underlying, a programme forms the basis of the evaluation. This could be a way of:

- substituting for the lack of clear organizational goals, which is often found in evaluations (Pawson and Tilley, 1997); and also
- avoiding the 'goal wars' that can often arise between the interests of different groups of stakeholders.

The concept of theory-driven evaluation is of course not new; e.g. Suchman (1967) in his book *Evaluation Research* refers to the importance of what he termed programme theories. However, it was Weiss (1972) who first seriously argued for the formation of an evaluation around the theories held about a programme. Although a number of authors subsequently explored the concept of evaluating on the basis of a programme's theories it was not until 1990 that another key work was to significantly develop thinking. This was the book by Huey-Tsyh Chen entitled *Theory Driven Evaluation*. Chen made a distinction between normative and causal theory and argued that evaluation should not be concerned with 'ad-hoc' functional hypotheses but with core social science theories. Chen argued that normative theory 'provides guidance on what goals and outcomes should be pursued or examined' (Chen, 1990: 43) whereas causal theory consisted of a set of assumptions about how the programme works. As Weiss argues:

If evaluation can show the series of micro-steps that lead from inputs to outcomes, then causal attribution *for all practical purposes* seems to be within reach. Although such an evaluation can not rule out all the threats to validity we have come to know and love, it has the advantage (if things go well) of showing what processes lead to the outcomes observed; if some of the posited steps are not borne out by the data, then the study can show where the expected sequence of steps breaks down. (Weiss, 1996: 3)

Weiss then goes on to argue that this would hold true in community-based programmes, when random assignment is impossible (as in the case of health promotion). There are a number of reported studies that have traced the emergence of steps in programme theory. These range from simple to more complex theories. In a survey by Weiss (1996) the conditions conducive to theory-based evaluation were explored. One of these was theory-based programme planning. Two areas that use this planning approach fairly extensively are risk prevention/management and health promotion (though these two are not discrete). For example, a fairly common theory underlying health promotion programmes is social learning theory (which is the basis of the theories of change model). The programme provides information (e.g. on how to stop smoking), which leads to a change in motivation and intention (e.g. willingness to reduce smoking) that in turn leads to change in practice (e.g. cessation of smoking). However:

If interventions are to change individual risk behaviours, they may also need to bring about changes in the social contexts that influence why and how people behave in certain ways. (Davey and Seale, 1996: 65)

This illustrates that health promotion strategies depend upon the active co-operation of social agents if they are to be successful.

Chen (1990) argued that both the experimental and the ethnographic approaches tend to treat programmes as having an independent existence. They look at what programmes do to the clients from different points of view – but

assume that the programmes are somehow given. The argument for theory-driven evaluation is that the research method used follows from the theory under test. What follows is that there is no prescribed method. Simple theories, like normative theory, produce a method that may be close to the standard quasi-experimental approach. However, the more composite the theories are, the less standard and more complex becomes the methodology. There is of course a debate over programme theory and implementation theory, and approaches such as theories of change attempt to reconcile these differences.

However, much of theory used in theory-driven evaluation is at the micro- or sometimes the meso-level, as is the case with much of health promotion evaluation, whereas government policy making is often a macro approach. Chen argued that wider social theories should also be utilized, or at least their contribution to understanding the programme under study should be acknowledged (Chen, 1990). To illustrate the importance of this we will focus upon the New Public Health (NPH) movement and the impact of this across the social system.

The New Public Health Movement

A key part of the Beveridge reforms in 1948, which formed the UK welfare state, was the notion that it was the duty of government to secure the well-being of the population. This has developed over the years to include the parallel idea that it is a civil right of the population to be provided with healthcare. It is this, it is argued, (together with an aging and increasingly dependant population) which has created increasing demands for health services. However, it is impossible to institute a 'right to health'. Health is a biological concept, outside of the remit of any direct health policy. In other words health could be said to be, in part, a matter of fate. As Foucault argues:

Health – good health – cannot derive from a right; good or bad health, however crude or subtle the criteria used, are facts – physical states and mental states. (Foucault, 1988)

This means that health cannot be a direct aspect of citizenship, only an indirect one. National governments can at best provide the conditions – such as medical staffing, hospital systems, sanitary infrastructure, etc. – that put different sections of the population on a more or less equal footing with regard to their chances for health. Governments can also provide and finance professionals to attempt to cure diseases after they have occurred. However, national governments cannot guarantee the health of the population.

The conceptualization of health is also problematic. Knowles argues that health is not an absolute or determinate concept but is essentially indeterminate, relative and elastic (Crawford, 1997). As a consequence, even if all known disease were to be eradicated, one would still not have achieved an absolute concept of health. The reason for this is that with every new service provision, technological advance or development in medical knowledge the very concept of health widens and extends. For example, one could argue that the concept of health has recently expanded to include the right of women to have children (IVF and advances in reproductive technologies) (Davies, 1989); the right of men to have an erection

(Viagra); and the right not to be unhappy (Prozac) (Shaw and Middleton, 2001). Even death is becoming perceived as a form of pathology rather than a natural event (Beck and Beck-Gernsheim, 2001).

As a consequence health policy will always fail to meet public expectations of it (Osborne, 1997: 198). This is not a new phenomenon. It became evident to liberal thinkers of the 19th century that the actions of the state could actually serve to frustrate the ends of the state itself – as intervention led to a distortion of the territory to be governed (Foucault, 1989; Barry et al., 1996). This is politically very frustrating because it is clear that ‘ill health’ is becoming an indicator of bad government (Osborne, 1997).

The NPH movement has adapted itself to address this phenomenon. The approach focuses upon identifying and tackling factors that underlie the causes of illness – the upstream factors. This is an important part of any public health model, but the upstream factors being identified are less the structural inequalities of society and more the actions of individuals. In an increasing number of UK Government initiatives, concerns about the structural causes of ill health have been replaced by a focus upon individual action and upon individuals’ social capital (see Social Action Research Project [SARP], Health Action Zones [HAZ]). People are being encouraged to rely more upon themselves. A key feature of this argument is that the NPH movement (including health promotion) is adopting a neo-liberal approach to achieve its *own* objectives, particularly when faced with the fiscal concerns of increasing demands upon health services (Petersen and Lupton, 1996). This ideology is trying to break the link in public perception between provision of services and demands for health improvement. The value of access to services is being replaced with a new preoccupation with controlling ‘at risk’ behaviours. Despite the language of empowerment, the agenda of the NPH movement still reflects government objectives, laid out by professional experts (Petersen and Lupton, 1996). The NPH movement can be regarded as a moral enterprise, promoting prescriptions for how we should live our lives. This is politicization of the self, through discourses of empowerment (Rose, 1993; Petersen and Lupton, 1996). To fail to recognize this is to fail to understand the significance of the NPH movement.

The role of health promotion is therefore at the epicentre of the NPH movement. It is the vehicle by which government concerns are transported throughout the social network to arrive at the level of agency. By defining risks and consequent strategies for risk avoidance, health promotion attempts to change the behaviour of individuals as it is assumed that when presented with the ‘facts’, social agents will become active participants in the process of risk prevention (Petersen and Lupton, 1996).

At a time of financial constraints, self-discipline has emerged as a popular theme. Instead of rights and entitlements, individual responsibility and self-help have moved to the centre of political discussion. This is particularly evident in the USA. Victor Fuchs, a noted US health economist, commented:

Some future historian, in reviewing mid twentieth century social reform literature will note . . . a ‘resolute refusal’ to admit that individuals have responsibility for their own stress. (Fuchs, 1974: 27)

By normalizing certain patterns of behaviour, health achieved through self-control and good citizenship is assumed to be a priority for all (Crawford, 1984). The *New York Times* reported Robert Whalen of the US Department of Health as stating:

Unless we assume individual and moral responsibility for our own health, we will soon learn what a cruel and expensive hoax we have worked upon ourselves through our belief that more money spent on health care is the way to better health. (Whalen, 1977)

This is a view supported by Knowles, who argues that the primary critical choice facing the individual is to:

change his personal habits or stop complaining. He can either remain the problem or become the solution to it: beneficent government cannot and should not do it for him. (Knowles, 1977)

Knowles later went on to say:

The idea of individual responsibility has been submerged in individual rights to be guaranteed by the state and delivered by public institutions. The cost of sloth, gluttony, alcohol, intemperance, reckless driving, sexual frenzy and smoking have now become a national not an individual responsibility and all justified as individual freedom. But one man or woman's freedom is another's shackles in taxes and insurance premiums. (Crawford, 1997: 396)

Although the politicization of the NPH movement has not been as strong or as extreme within the European context as it is within the USA, there are still political implications (Beck and Beck-Gernsheim, 2001). The politicization of the NPH movement within Europe is signalling a new politics of citizenship, with greater emphasis upon the duties, which are implied by rights (Davies, 1989). One concern could be the extent to which the NPH movement may provide a bridgehead for a wider application of the concept of personal responsibility. Weingart suggests that the introduction of major change requires a kind of bridgehead within the social system from which it can then spread out.

One may evoke the image of colonization: the triumphant march of the colonizers, even overcoming the superior strength of the 'old cultures', can be explained only by the fact that these are internally divided and ambivalent in the face of the intruders. (Weingart, 1989: 190)

To this end there is a social dimension to the notion of personal responsibility as looking after one's health has developed into a social value. It could be argued that this may create a bridgehead from which the expansion of a culture of personal responsibility (for poverty, ignorance, unemployment, etc.) may follow. This has particular significance because 'the individual has become the basic unit of social reproduction' (Beck and Beck-Gernsheim, 2001: xxiii):

... in the land of individual freedom of choice, the option to escape individualization and refuse participation in the individualizing game is emphatically *not* on the agenda. That men and women have no one to blame for their frustrations and troubles does not mean, any more than it did in the past, that they can pull themselves out of trouble by their bootstraps. If they fall ill, it is because they were not resolute or industrious enough in following a health regime. If they stay unemployed, it is because they failed

to learn the skills of winning an interview or because they did not try hard enough to get a job. As Beck aptly and poignantly puts it 'How one lives becomes a *biographical solution to systemic contradictions*'. Risks and contradictions go on being socially produced; it is just the duty and the necessity to cope with them that is being individualized. (emphasis in original) (Bauman, 2001: xvi)

This highlights that a focus upon the individual and their responsibility draws attention away from the structural causes of ill health.

Individual Agency and the New Public Health Movement

The relationship between individuals (and their agency) and social structures has long been of interest to social science. Individuals create social institutions and reform social movements. However, once created these exert power over individuals, following a logic that cannot be understood as simply the sum of the desires of the individuals within those institutions. Such institutions are wholly dependent upon individual choices. However, those choices are in turn influenced by collective structures and representations and while they can be seen as having their own 'needs' (equilibrium, adaptation, preservation, reproduction) their legitimacy and survival lie in the choices of individuals (McGubbin, 2001).

Although individualism has long been a feature of Western societies, the 'rise' of individualism as a social theme has been linked to the weakening of occupational structures and the 'rolling back of the state' since the late 1960s (Callinicos, 1999). In response to this the notions of individual autonomy and rationality have risen to the forefront of the social agenda. An example of this can be found in the NPH movement, which has been developed to encourage positive lifestyle choices through health promotion (Turner, 1988; Petersen and Lupton, 1996; Higgs, 1998). Individuals are no longer regarded as 'docile bodies' to be regulated by the disciplinary power of the medical professions (Foucault, 1973); the attention has changed direction from direct medical control towards health risk prevention at the level of individuals. We are now in a situation where we, as social citizens, are expected to be self-regulators of our actions and bodies (Miller and Rose, 1990; Castel, 1991; Higgs, 1998). As a part of this process collective rights to welfare are being replaced by individual obligations (Higgs, 1998).

The calculation of risk by social agents is a central tenet of the NPH movement. In other words individuals are being increasingly regarded as 'masters of our own fate' (Petersen and Bunton, 1997). In this sense the onset of preventable disease or illness can be regarded as a personal failure (Beck, 1992; Greco, 1993). This notion of the 'Individual as Enterprise' (Petersen and Bunton, 1997) also has the implication that the body is becoming a site of moral worth and that illness may bring with it the potentiality for blame (Greco, 1993; Davey and Seale, 1996).

Individuals whose conduct is deemed contrary to the pursuit of a 'risk-free' existence are likely to be seen, and to see themselves, as lacking self-control, and therefore not fulfilling their duties as fully autonomous, responsible citizens. (Petersen and Bunton, 1997: 198)

Beck and Beck-Gernsheim link the shift towards personal responsibility with changes in employment.

To keep one's head above the water in a competitive labour market it is necessary to be fit, healthy and capable. Now health is not so much a gift from God as a task and achievement of the responsible citizen, who must protect and look after it or face the consequences . . . health used to be something given to us that only required repair in an emergency, now it has to be constantly produced. (Beck and Beck-Gernsheim, 2001: 140)

This notion of good citizenship incorporates the concept of 'fluid subjectivity' where power and knowledge are internalized through a process of self-surveillance (Armstrong, 1995). This adherence to changing social norms creates a form of ontological security. More specifically, the concept of risk prevention is constructed as 'real' (Sachs, 1996). In part this may become manifest through the use of stigma to reinforce the 'anti-risk' social norms in those not conforming to them. Health promotion can play a part in this by defining moral principles for 'healthy' behaviour, the deviation from which may lead to moral judgements (and stigma) (Davey and Seale, 1996).

Responsibility is presented as meaning greater autonomy, however . . . anyone who does not take responsibility is counted as irresponsible . . . The health system would increasingly assume the role of institutionalised monitor of people's lifestyles. (Beck and Beck-Gernsheim, 2001: 147)

The phenomenon of 'healthism' basically refers to the pursuit of being healthy and succinctly illustrates the impact of health promotion in the defining of moral values. Health promotion strategies provide social agents with information regarding what constitutes healthy behaviour. It then becomes the individuals' choice as to whether they prevent disease or not. The consequence of this is that when people do not conform to regulating their behaviour it will be viewed as 'a failure of the self to take care of itself' (Greco, 1993: 361).

New Public Health and Social Order

The rise of individualization linked to the politicization of the NPH movement illustrates the changing relationship of health, and the role of health promotion, in the social order. The UK policy document *Our Healthier Nation* (Department of Health, 1998) stated that health was dependent upon 'a new three-way partnership, comprising individuals, communities and government' (pp. 6–7). It is interesting to note that the subtitle of *Our Healthier Nation* is *A Contract For Health*. Contracts place mutual obligations upon the parties involved. This is indicative of the principle of responsibility, which works as an increasing force throughout the healthcare system. This illustrates an example in the UK where the NPH movement is operating at the level of both structure and individual agency. By offering advice (risk discourse) to the population at large, health promotion is defining (and promoting) a set of social values regarding health and well-being (Crawford, 1984; Petersen and Lupton, 1996). Strategies of risk management are distributed throughout society by a process known as intersectoral collaboration.

This process does not involve direct coercion, intervention or punishment by health promoters or policy makers. It refers to 'a multi-levelled and multi-organizational network of surveillance and regulatory practices' (Petersen and Bunton, 1997: 197). With specific reference to health promotion strategies, it illustrates the way in which they operate at a distance by encouraging the co-operation of various social groups and individuals (Ashton and Seymour, 1988; Petersen and Lupton, 1996).

This is linked to changing notions of citizenship, which emphasizes personal responsibilities and promotes risk prevention as an active challenge for individuals (Davies, 1989). Governmentality is at work here as moral components of social life (in this case health policy and service access) are dependent upon the active participation of individuals (Nettleton, 1997). One consequence is that people may be refused NHS operations because they are engaging in at-risk behaviour, i.e. they are overweight, smoke, etc.

The new citizen learns to engage with risks constructively because if he or she doesn't there is no collective security net waiting to make good the damage. (Higgs, 1998: 193)

Health has therefore become conceptualized as a core social value within society (Crawford, 1984) where the individual's relationship with health is becoming governed by notions of social duty (Herzlich and Pierret, 1987). Public health, and government, in seeking to change individual risk behaviours may also need to bring about changes in the social contexts that influence why and how people behave in certain ways (Davey and Seale, 1996). Preventing the spread of infectious disease is known to involve the power of government and community in ordering and controlling the lives of individuals for the public good. In a similar way health promotion seeks to control individual behaviour for the good of the individual and to benefit society. When individuals resist public health campaigns, as was the case in wearing crash helmets on motorbikes, the state steps in with legislation. The state also intervenes by means of financial disincentives to action, such as the taxation regime on alcohol and tobacco. However, such control is always a mutual affair (Scott and Scott, 1971). Thus the NPH movement can be regarded as a mechanism for social order as it depends upon social as well as individual action. Suppressing undesirable individual behaviour, such as unhealthy lifestyle choices, and replacing them with desirable behaviour is largely an issue of social control (Scott and Scott, 1971). An example of this can be found in the UK Government document *Our Healthier Nation* which states:

everyone in the country is affected by this programme and we have to do our best to make sure that everyone is committed to it. That's the only way we can get things done – saving lives, improving health and reducing inequalities. (Department of Health, 1998: 1–2)

Social roles and expectations combine to effectively make up the social system (Parsons, 1951). Social roles can be interpreted as social duties, which are for the benefit of the wider society. 'Social control involves both the maintenance of moral community and the collective initiation of intentional, purposeful change' (Scott and Scott, 1971: 103). To be effective social roles also require 'a

high degree of correspondence between personal motives and group goals' (Scott and Scott, 1971: 104).

However, this approach threatens the earlier aim of health policy, which was trying to equalize health chances (Townsend and Davidson, 1982). The 'risk management' model of health provision is fundamentally not redistributive, in the sense that redistribution is seen as overly deterministic. Giarni and Stahel (1989) argue that modern societal and economic development depends not so much on achieving perfect objectives but rather upon developing creative activities in a world where uncertainty and risk are given conditions. The implication is that individual creativity in the provision of personal welfare (including health) is the ideal form of social insurance. This is an underlying tenet of the UK Government's 'middle way' policy programmes (Sevenhuijsen, 1999). Their postulation for a welfare system based upon the recognition and management of risk carries the subtext that risk, in some sense, can still be known. However, we can not predict what will be risky in the future (as eating beef would not have been considered in any degree 'risky' 10 years ago) and thus people can not design their own risk-aware 'life politics' to a sufficient degree. It is here, it is argued, that the State sees its prime role for the future (Etzioni, 1996).

The concept of sickness does not exist in a vacuum; it must be compared to and found to be deviant from some concept of what constitutes being healthy – and we have seen that what is regarded as 'healthy' is not fixed but has changed and is changing. Furthermore, what is regarded as deviant has also changed and is changing. As the NPH movement develops, what is considered 'at risk' behaviour is also likely to change. As campaigns against smoking (which are reinforced by workplace and legislative pressures as well as tax regimes) succeed the NPH movement will move on to other areas of perceived health risk in its task of reshaping society. Today it is smoking and drinking, tomorrow it could include *not* jogging or otherwise exercising.

Our present concept of health will disappear . . . medicine will change its focus from treatment to enhancement, from repair to improvement, from diminished sickness to increased performance. (Crichton, 1990: 5)

Implications for Theory-driven Evaluation

The key implication of this article for theory-driven evaluation is that the application of theory in evaluations without acknowledgement of alternative or wider theories is not only problematic, but may serve to decontextualize and depoliticize both services *and* evaluations. As previously discussed, theory-driven evaluation was promoted as a solution to 'goal wars'. This article suggests that choice of theory may be just as relevant and problematic to evaluation. In particular, failure to acknowledge wider theoretical or political agendas serves to remove such services *and evaluations* from political and critical analysis. As a consequence, arguments about the degree of freedom an individual should have over their own body is pushed aside in the quest for 'better health'.

In this respect health evaluations, which adopt an undefended theories of change approach, do not fully take account of the context in which they operate.

Services, and evaluations, are constructed within legislative, policy and funding processes and are shaped by considerations of inequality. To suggest that health promotion may exist outside of these processes usually means the acceptance of a 'taken for granted' view about the services' aims and benefits.

... the political relationship between taken for granted understandings and dominant ways of seeing things in a society divided by gender, race, class, sexuality, disability and age should make us extremely wary of evaluations that focus only on the practice as though it existed uncontentiously within a policy and social vacuum. (Everitt, 1996)

Health evaluators run this risk if they ignore the political context of the NPH movement and its contribution to changing the social order.

Health, and welfare, agendas are changing at a fundamental level across Europe. Evaluators need to be aware of these changes and to be able to defend their choice of theory by illustrating how the adoption of various alternative theories may alter the direction, methodology and possibly even the findings of their evaluations. This article has focused its arguments upon health promotion by way of illustration. However, these arguments have implications not only for evaluators in health but for all that use theory-driven evaluation.

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