Sax Forum: Knowledge Mobilisation Symposium

22 March 2022

Organisational approaches to knowledge mobilisation

On 22 March 2022, the Sax Forum, in collaboration with the NHMRC and the NSW Ministry of Health, hosted an initial symposium on organisational mechanisms to enable the uptake of research in health policy.

Panel members were:

- Professor Nicholas Mays, Director of the Policy Innovation and Evaluation Research Unit (PIRU) of the UK National Institute for Health Research and Professor of Health Policy in the London School of Hygiene and Tropical Medicine
- Ms Liz Hay, Director of Economics and Analytics in the Strategic Reform and Planning Branch, NSW Ministry of Health
- Ms Anne Redman, Director of Evaluate in the Sax Institute
- Professor Luke Wolfenden, from the National Centre for Implementation Science in the University of Newcastle Australia.

The session was chaired by Professor Sally Redman, CEO of the Sax Institute.

Panel members' talks and the ensuing discussion examined four major themes:

1. Government frameworks for policy research and evaluation

The first theme was the effectiveness of a stable, government-endorsed framework to legitimise, normalise and support the interaction of research and policy on a sustained basis.

In the UK, formal relationships have existed for decades between the government and researchers in academic institutions. The UK Policy Research Programme is charged with providing policy analysis and evaluation for senior politicians and officials in health and social care, funding 15 Policy Research Units including PIRU. Their role includes to '…develop evidence on policy ideas that are being piloted or tested before becoming final policy'[1]. The agendas of the Policy Research Units deal with issues that concern government and are specified mainly by the Department of Health and Social Care.

In the UK, expectations and budgetary and organisational arrangements within government have sustained this policy development and evaluation enterprise throughout times of political and social change, highlighting the importance of solid commitment. A similar commitment has emerged more recently in the NSW Government, where Treasury has introduced widespread evaluation requirements and issued guidelines on how to formulate evidence for policy recommendations. Within the NSW Ministry of Health, the concept of value-based health care has become a strategic priority, and every significant initiative in the NSW health system must have a monitoring and evaluation plan.

In relation to health policy, value is defined as having four dimensions: health outcomes that matter to patients; patients' experiences of receiving care; health professionals' experiences of providing care; and the effectiveness and efficiency of care. Value-based health care programs are intended to promote consistency across a large health system that defaults towards heterogeneity, develop a

culture of evaluation and emphasise economic justification, drawing on access to necessary data on the four dimensions of value.

2. Relationships between policy and program agencies and researchers

The second theme was the capacity of academics and policy officials to understand each other's political, institutional and methodological imperatives, given the cultural divide between government and academia and the sensitivity of many of the policy issues to be considered.

The UK policy research model has addressed this clearly and comprehensively. On one side, the Department of Health and Social Care employs Liaison Officers who have an understanding of, and insight into, government policy. They form a strong but indirect link with researchers, referred to as 'close distance'[2]. On the other side, Policy Research Units, located in academic institutions, are staffed by teams of highly experienced researchers who are familiar with central government policy-making processes and have good political awareness. Initiatives to bring academia and government agencies together to deepen mutual understanding, such as staff exchanges, have tended not to be sustainable because the appetite for such arrangements across two complex bureaucracies inevitably wanes.

The highly developed structural relationships exemplified by the UK Policy Research Programme obviously cannot be applied for embedded evaluations. Rather, the relationships in the value-based health care programs of the NSW Ministry of Health and the suicide prevention trials in Victoria form through co-design and co-production involving researchers, clinicians, patients, and other community members.

In all types of systems, the nature of the relationships and the need for arm's-length separation are likely to vary through the life of a project. In the early stages, when evaluation parameters are being decided, no separation may be needed. But in the late stages, where independence is critical to preserve rigour and integrity, the separation is of primary importance.

3. Independence

The third theme was the was the independence of research and evaluation mechanisms from the policy agency or program under evaluation, and the meaning of 'independence'. Key questions were how much independence is sufficient, how can it be assured, what is the balance between pragmatism and research rigour, and how can it be maintained?

In the UK Policy Research Programme, the balance is achieved by the 'close distance' relationship. This provides a structured pathway for liaison without involving researchers in the policy development process within government. It also enables the government to assert policy legitimacy by referring to expert advice and emphasising 'objectivity', or to distance itself from findings that might cause political difficulty. For the NSW Ministry of Health initiatives under the value-based health care concept, the key mechanism lies in the consistent definition of data items for measuring and evaluating the impacts of health care in each of the four dimensions of value.

Where evaluation is embedded in the policy development or programs, arm's-length relationships between researchers and policy makers or program directors are mostly implausible, and other mechanisms have emerged. In the Victorian place-based suicide prevention trials, independence comes from a distributed governance structure, with an over-arching steering committee and 12 local governance groups. Measurements of impact are locally tailored but are cooordinated across the program. Evaluation processes have the status of a 'close friend' rather than the UK 'close distance' model. The embedded evaluation in the Hunter New England Population Health initiatives follows the principles of a learning health system with optimisation. These principles rely on sequential studies (including randomised controlled trials), with adaptation of services to incorporate indicated

improvements incrementally. Funding arrangements buttress the design, with both the policy or program agency (the Hunter New England Local Health District) and the research agency (the University of Newcastle, Australia) contributing.

All of the efforts to assure independence have drawbacks. Seemingly innocuous issues can suddenly become sensitive and place researchers under significant stress. Researchers need to be resilient to their peers' occasional perceptions that they are producing 'policy-based evidence'.[3] Negotiations to agree on processes for independence prolong evaluations and delay outcomes.

4. The timing of evaluations

The fourth theme was a consideration of the timing of interventions. Many evaluations are necessarily long-term, as the impacts of health policy may take years to become apparent. Advocacy for long-term evaluations is therefore important. However, evaluations that lead to incremental improvements in program delivery, such as the evaluations of the learning health organisation initiatives in the Hunter New England Local Health District, may have a short turnaround time.

Long-term evaluations are challenging. Attribution of change to the intervention being evaluated becomes increasingly difficult over the long term, and the context of the intervention invariably evolves over time. A high-profile intervention tends to be picked up and implemented widely even without evaluation, so the opportunities for comparisons are lost. The challenge of attributing change to an intervention can potentially be addressed by examining intensity-response relationships (i.e. intensity of the intervention, analogous to dose-response) but this can only be done if variations in the intensity of implementation have occurred and can be measured. The intensity of implementation can be affected by the presence of a powerful and influential implementation leader, and this also complicates interpretation of intensity-response relationships.

References

1. Department of Health & National Institute for Health Research. Policy Research Programme Call for Proposals, Policy Research Uniutrs, December 2017, p24.

2. van Egmond S, Bekker M, Bal R, van der Grinten T. Connecting evidence and policy: bringing researchers and policy makers together for effective evidence-based health policy in the Netherlands – a case study. Evidence and Policy, 2011; 7: 25-39.

3. Davey-Smith G, Ebrahim S, Frankel S. How policy informs the evidence. British Medical Journal, 2001; 322: 184.