

EVIDENCE-INFORMED DECISION MAKING: BREAKING DOWN THE WALLS BETWEEN RESEARCHERS AND POLICY MAKERS

Anyone who has worked closely with government, be it local, national or international, will know the frustrations of trying to influence policy and decision makers. The ‘dark arts’ of the political analyst and the political lobbyist, particularly those that seem to succeed in having influence, remain a mystery to many. **Dr Logan M. Lawrence** at Dalhousie University, Nova Scotia, explores the concept of ‘policy capacity’ to try and understand, measure and operationalise the best approaches to assist and support policy makers to make ‘the right decisions’.

Health Policy: Research into Practice

Like many working in health policy, particularly those in preventive or public health, Dr Logan M. Lawrence at Dalhousie University, Nova Scotia, understands that there is an enormous chasm between the production of academic, evidence-based research, and the implementation of the findings from that work to become adopted policy in the ‘real world’. He acknowledges that early in his training, like many, he held the common misconception that to influence policy makers, we must simply provide them with the ‘right’ information. It can be tempting to believe that if only academics could better present and translate their findings, then decision makers would introduce the logical improvements that have been recommended.

The field of public health presents significant challenges. The determinants of health and the prevention of ill-health are multi-layered and complex, and next to impossible to summarise succinctly. Traditional health prevention interventions, such as tobacco control and physical activity, focused primarily on individual behaviours, can take decades to produce health gain in the population and may come at a high economic cost or societal change. More recent topics, such as health equity, acknowledge the roles of structures and systems which contribute to health, but changing these systems requires more than making a case for their flaws. Finally, health policy can be highly politicised, making it even more challenging to interact in the political world of policy makers.



When preventative public health is competing for scarce health resources, it is often easier for policy makers to grasp the immediate benefits and short-term outcomes of hospital and secondary care. Policies of more doctors and nurses, cheaper drugs and more specialist equipment are quick headline grabbers, and can appease the strong and powerful lobbying from the medical professions, even when the evidence on long-term effects and cost savings favour other options.



Dr Lawrence studies the complex factors that influence policy decision making through two synergistic approaches. The first is through knowledge translation and evidence-informed decision making; understanding how knowledge is created and shared to support decision making processes. The second is through studying 'policy capacity', which in its simplest form, refers to the ingredients which help policies succeed. Underlying the concept is a focus on identifying the individual, organisational, and system-level abilities required to best inform and implement policy decisions. With the combination of these two areas, Dr Lawrence hopes to better understand and assist the passage of research into policy and practice.

Policy Capacity

Dr Lawrence and colleagues examined studies of policy capacity over the past two decades. Through this, they identified a broad range of definitions. The concept of policy capacity was generally described in one of three ways. The first was related to improving the likelihood of helping policy makers arrive at a successful policy decision or solution. The second considered the need to adapt existing policies to improve societal outcomes even in the face of challenges. The third description was related to policy capacity being a tool to measure government performance.

Dr Lawrence and his colleagues identified a conceptual framework developed by researchers in 2015, which provided a 'comprehensive and multifaceted conceptualisation of policy capacity'. The framework consisted of nine interrelated elements (sub-capacities) that reflect the components of policy capacity at a resource level (i.e., individual, organisational and system levels) and through the competency areas of those involved (i.e., analytical, managerial/operational and political). However, the team identified gaps in the framework's operability, noting that 'further work was required to determine its usefulness in assessing policy capacity across policy areas, particularly as a practical tool for policy makers and scholars to assess and compare policy capacity in different cases'.

The Dalhousie University team then developed a tool for systematically and transparently assessing policy capacity. By drawing on the input of health policy experts in academia and the health system, they generated 40 factors and 131 indicators for assessing the nine sub-capacities. The adapted tool could, for the first time, be used for assessing policy capacity across several resource levels and competency areas by those working close to government, to measure their ability to produce successful policies. Dr Lawrence and his colleagues believe the tool will be

improved through use by experienced policy practitioners, and state that 'users are encouraged to use their judgement to determine which items are most relevant for their purposes, and [to] identify and test new factors and indicators that suit their needs and context'.

Dr Lawrence and colleagues hope that future testing of the tool, across a variety of policy areas and changing the weighting or prioritisation of different elements, will enable the tool to 'craft a narrative around policy capacity ... (i.e., whether indicators denote factors, which denote sub-capacities, which denotes policy capacity, which leads to policy success)'. The team hopes that knowledge and insights obtained from the tool will provide direction for future efforts requiring a large degree of policy capacity.

Integrated Knowledge Translation

A second strand of work has been undertaken by Dr Lawrence and his colleagues to understand how knowledge is created and shared to support decision-making processes.

Policy makers working in complex fields such as public health are often faced with 'wicked problems': multi-dimensional and dynamic issues which can cross social and political contexts, and where positive effects need to be balanced against simultaneous negative consequences. For example, to fund a new service may require the decommissioning of an existing service, with all the human and social costs that may entail. Yet wicked problems have no single solution, so the creation of a new service at the cost of an old one will be insufficient to resolve the problem. Rather, multiple strategies need to be pursued, collectively adding to the possibility that the problem will be meaningfully diminished.

To formulate and justify their recommendations, public health practitioners rely heavily on evidence-



based decision making, which has been defined as the synthesis, interpretation, translation and utilisation of large quantities of evidence in order to arrive at the best possible solutions. A perceived flaw in evidence-based practice is perhaps that it can be perceived as 'expert driven' and not always reflective of political realities; a factor which may deter policy makers. Therefore, Dr Lawrence and colleagues have investigated the concept of integrated knowledge translation (iKT), as a mechanism to engage users (e.g., clinicians and patients, but particularly policy makers, the intended recipients of the research evidence), as active participants in the research process. These participants are known as 'knowledge users' (KUs).

For the approach to generate meaningful research that can be used by KUs, the KUs need to be included in the research process from the very beginning; establishing and refining research questions, developing research methods and participating in analysis and dissemination of results. Equally, researchers will be encouraged to think about how their research can be conducted in order to maximise its benefit to others in society. It is often challenging for academics and specialists to work with people who may have no scientific training, but iKT is a process that facilitates these relationships to be built to achieve a common goal.

The idea of engaging KUs to help shape research has its roots in participatory action research. Participatory approaches are often used to create a sense of 'community ownership' and to build partnerships when attempting to deliver social change. The process has been shown to add value to research projects and increases engagement and sustainability of new projects, with the notable benefit of improving community capacity. iKT has gained popularity in Canada for its potential to co-create research-based solutions with those that will have ultimate authority in the decision-making process, but research conducted by Dr Lawrence and his colleagues notes a lack of meaningful engagement which is the hallmark of participatory research. The conditions required for effective iKT with policy and decision makers include flexibility of contributions and building longstanding relationships that extend beyond one-off research projects.



iKT in Practice

To explore how researchers and policy makers can work better together, Dr Lawrence was awarded a Health System Impact Fellowship from the Canadian Institutes of Health Research (CIHR) to work with the Government of Nova Scotia. The aim of this project was for Dr Lawrence to bring his research ability to support the development of new policies to improve the population's access to primary health care (PHC) while also giving policy makers an idea of how researchers can support their work.

As a frontline healthcare service, PHC is responsible for routine community based medical care and disease prevention and management, usually delivered by a general practitioner or 'family doctor'. The Nova Scotian government has committed to improving access to local health care providers, and particularly interprofessional 'collaborative family practice teams'. However, the reorganisation of existing complex services needs to account for differences in population need, while balancing patient preferences, evidence-based options and financial constraints.

Above and beyond his current work at the interface with local government, Dr Lawrence has expressed his general belief that knowledge translation also has a greater role in beginning to address the public's growing distrust in experts and science in the new 'age of ignorance' and fake news. He states that knowledge translation 'is a plan for getting your research out into the world'. Beyond publication in academic journals, he encourages researchers to look for wider opportunities for sharing their research with non-scientists, through blogs, podcasts, articles and discussion forums like Science cafes and TED talks, to open up awareness and conversations with a broader audience.

Through early and meaningful collaboration with others that have access to different social groups across different settings and contexts, such as policy makers, editors, journalists, comedians, graphic designers and celebrities, the research community can break down barriers between 'the experts' and general public, and encourage a wider understanding and appreciation of both the complexity and nuance of research and its relevance in everyone's daily lives.



Meet the researcher

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Dr Logan M. Lawrence completed a Bachelor of Science in Kinesiology at the University of Alberta in Canada, in 2012. He then completed a Master of Science in Kinesiology, at Dalhousie University, graduating in 2015. In 2020, he was awarded a doctorate in Health at the same university. Dr Lawrence has an overarching commitment to improving health policies and systems, working at the interface of health services and policy research, knowledge translation, and political science.

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FURTHER READING

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