Evidence-Informed Policymaking About Health Systems

5e symposium sur la recherche sur les services de santé

John N. Lavis, MD, PhD

Canada Research Chair in Evidence-Informed Health Systems
Professor, McMaster University
Director, McMaster Health Forum
Co-Director, WHO Collaborating Centre for Evidence-Informed Policy

Adjunct Professor of Global Health
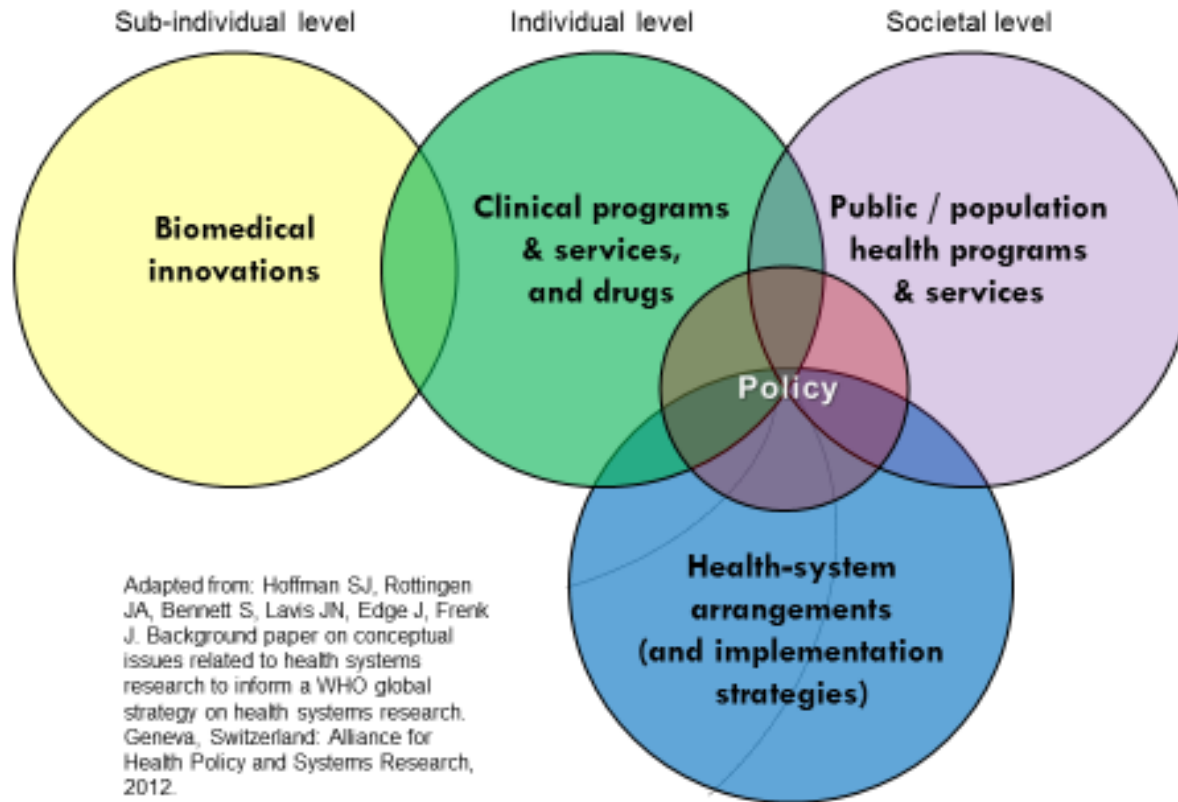Harvard T.H. Chan School of Public Health

Overview

- Policymaking about health systems
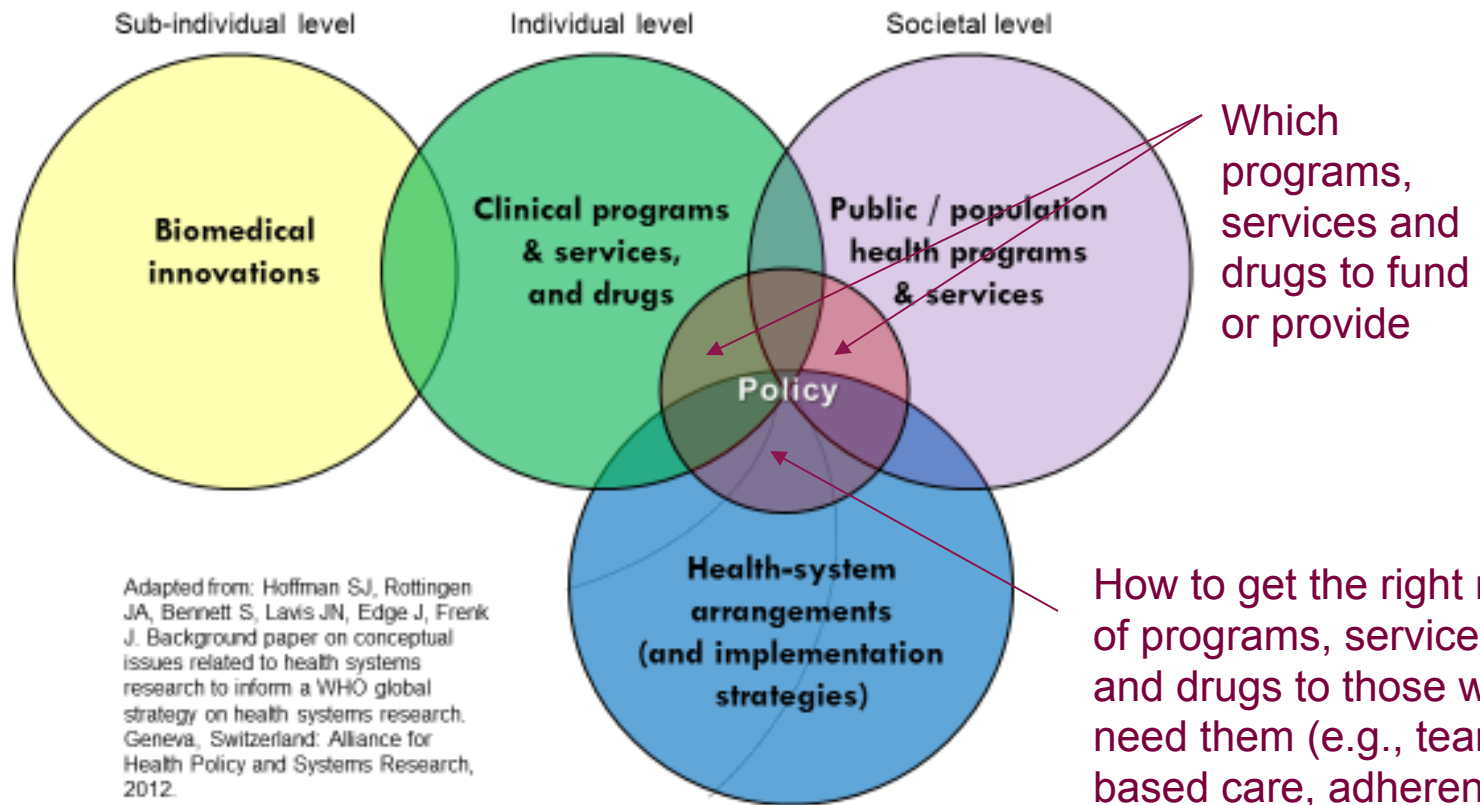- Supporting evidence-informed policymaking about health systems

Just Like There Are Different Types of Research, There Are Different Types of Policymaking

Sub-individual level

Individual level

Societal level

Biomedical innovations

Clinical programs & services, and drugs

Public / population health programs & services

Policy

Health-system arrangements (and implementation strategies)

Adapted from: Hoffman SJ, Rottingen JA, Bennett S, Lavis JN, Edge J, Frenk J. Background paper on conceptual issues related to health systems research to inform a WHO global strategy on health systems research. Geneva, Switzerland: Alliance for Health Policy and Systems Research, 2012.

Just Like There Are Different Types of Research, There Are Different Types of Policymaking

Sub-individual level

Individual level

Societal level

Biomedical innovations

Clinical programs & services, and drugs

Public / population health programs & services

Policy

Health-system arrangements (and implementation strategies)

Adapted from: Hoffman SJ, Rottingen JA, Bennett S, Lavis JN, Edge J, Frenk J. Background paper on conceptual issues related to health systems research to inform a WHO global strategy on health systems research. Geneva, Switzerland: Alliance for Health Policy and Systems Research, 2012.

Which programs, services and drugs to fund or provide

How to get the right mix of programs, services and drugs to those who need them (e.g., team-based care, adherence supports)

EVIDENCE >> INSIGHT >> ACTION

Policymaking About Systems Looks Different Than Policymaking About Programs, Services & Drugs

- Decisions about starting/stopping, accelerating/decelerating or consolidating a move towards a new health-system arrangement (while juggling a range of interlinked changes) are typically
  - A number of heterogeneous decisions (small & big, visible & traceable or not)
  - Made over a long period of time
  - By a broad range of different decision-making bodies
  - With little to no routinization possible
- Evidence informing these decisions is typically context-dependent (so local applicability questions are asked), local tacit knowledge and views and experiences matter, and democratic accountability typically overshadows methodological expertise in making judgements about the pros and cons

McMaster
HEALTH FORUM

EVIDENCE >> INSIGHT >> ACTION

Policymaking About Systems Looks Different Than Policymaking About Programs, Services & Drugs (2)

- Decisions about health-system arrangements and implementation strategies are usually made by or in large groups working under many <u>institutional</u> constraints, require negotiation / compromise in the face of <u>interest</u> group pressure, and influenced by many types of <u>ideas</u> (e.g., research evidence, values) and external events (e.g., recession, debt)

- Decision support is typically provided by large, hierarchical civil services with other providers of decision support sometimes seen as interest groups

- Civil servants often come from diverse backgrounds, change portfolios frequently, and are rewarded for general management skills not content-specific knowledge and skills

EVIDENCE >> INSIGHT >> ACTION

Need Many Types of Research Evidence

1) Prioritizing <u>problems</u> and understanding their causes (agenda setting)
   - ❑ Comparisons – administrative database studies or community surveys
   - ❑ Framing – qualitative studies
2) Deciding which <u>option</u> to pursue (policy development)
   - ❑ Benefits – effectiveness studies
   - ❑ Harms – effectiveness or observational studies
   - ❑ Cost-effectiveness – cost-effectiveness evaluations
   - ❑ Adaptations – qualitative (process) evaluations
   - ❑ Stakeholders' views and experiences – qualitative (acceptability) studies
3) Ensuring the chosen option makes an optimal impact at acceptable cost (<u>implementation</u>)
   - ❑ Barriers and facilitators – qualitative studies
   - ❑ Benefits, harms, cost-effectiveness, etc. of implementation strategies
   - 4) Monitoring implementation and <u>evaluating</u> impact (bringing us back to 1)

Need Many Types of Research Evidence (2)

1) Prioritizing <u>problems</u> and understanding their causes (agenda setting)
   - ❑ Assessing the state of preventive care in family medicine in Switzerland
   - ❑ Variations in preference-sensitive care in Switzerland
   - ❑ Variations in hospitalization rates in Switzerland (Swiss Health Atlas)
2) Deciding which <u>option</u> to pursue (policy development)
   - ❑ Benefits (and harms) of team-based care for hypertension management
3) Ensuring the chosen option makes an optimal impact at acceptable cost (<u>implementation</u>)
   - ❑ Benefits (and harms) of an intervention to improve adherence to inhaled medication in asthma/COPD patients
4) Monitoring policy implementation and <u>evaluating</u> policy impact (bringing us back to 1)

Much health services/systems research (HSR) is about problems, and no health system can rely only on local/national HSR to inform decision-making

Health Services/Systems Research

- "We need to fund research that compares the effectiveness of different <u>systems of care</u> – to reduce our uncertainty about which systems work best for communities. These are empirical, not ideological questions."
  - Atul Gawande, *The New Yorker*, 1 June 2009, p. 44

- "We need to fund research [and research syntheses] that compare the effectiveness of [and answer a range of other questions about] different systems of care – to reduce our uncertainty about which systems work best for communities. These are empirical, not [just] ideological questions."
- We also need to systematically support the use of this research

Overview

- Policymaking about health systems
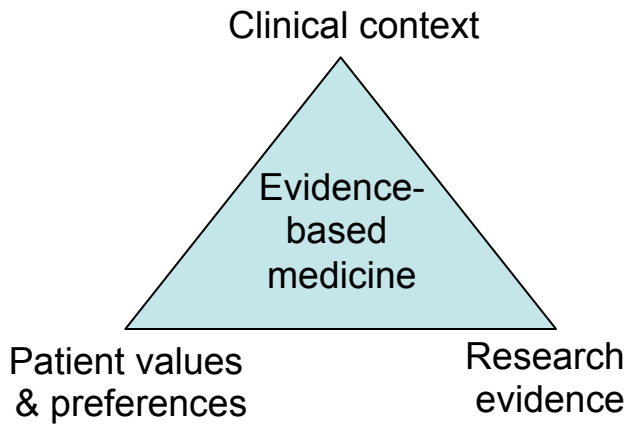- Supporting evidence-informed policymaking about health systems

What Does Evidence-informed Policymaking Mean?

- Evidence-informed policymaking means using the best available data and research evidence – systematically and transparently – in the time available in each of
  - Prioritizing <u>problems</u> and understanding their causes (agenda setting)
  - Deciding which <u>option</u> to pursue (policy development)
  - Ensuring that the chosen option makes an optimal impact at acceptable cost (policy <u>implementation</u>)
  - Monitoring policy implementation and <u>evaluating</u> policy impact
- … alongside the institutional constraints, interest-group pressure, values and other sources of ideas that influence the policy process
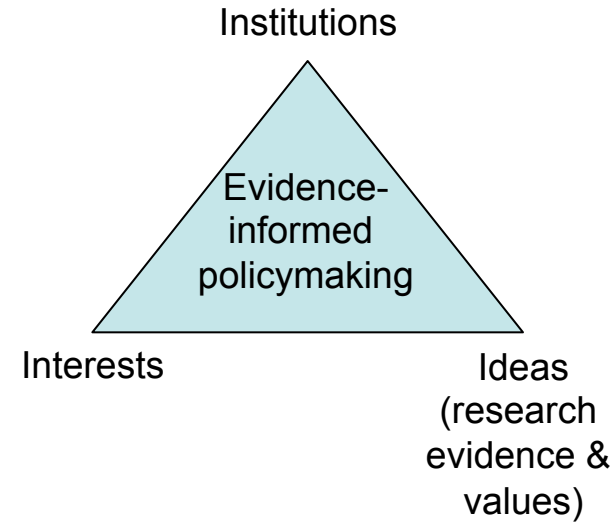
As With Evidence-Based Medicine, Research Evidence is Just One Factor in the Decision

Clinical level

Policy level

Clinical context

Evidence-based medicine

Patient values & preferences

Research evidence

Institutions

Evidence-informed policymaking

Interests

Ideas (research evidence & values)

We Don't Know How Best to Support Evidence-Informed Policymaking

- (Nearly) empty systematic reviews of effects
- Two factors emerged with some consistency in a systematic review of 124 observational studies (case studies, interview studies, documentary analyses) of the factors that increased the prospects for research use in policymaking
  - <u>Interactions between researchers and policymakers</u>
    - Engage policymakers in priority-setting, research (including systematic reviews) and deliberative dialogues
  - <u>Timing / timeliness</u>
    - Facilitate retrieval of optimally packaged, high-quality and high-relevance systematic reviews, etc. (e.g., one-stop shopping, rapid-response units)

Supporting Evidence-informed Policymaking Involves Five Types of Activities

- Prioritization and co-production
- Packaging and push
- Facilitating pull
- Exchange
- Improving climate / building demand

McMaster
HEALTH FORUM

EVIDENCE >> INSIGHT >> ACTION

Prioritization and Co-Production

- E.g., Applicants for research funding have to respond to government-articulated priorities and a share of programmatic research budgets need to be 'held back' for responsive research

- E.g., Systematic and transparent processes for eliciting the short-, medium- and long-term priorities of policymakers (that can be addressed in weeks, months and years by evidence briefs, systematic reviews, and primary research, respectively)

- E.g., Researchers involve policymakers in all steps of the research (synthesis) process (i.e., what some call 'integrated knowledge translation'), from articulating the question to designing the approach to merit review to end-of-project knowledge translation

Packaging and Push

- E.g., Policymaker-targeted summaries of systematic reviews
- E.g., Evidence briefs that provide a context-specific summary of systematic reviews and local data/studies about
    - A problem and its causes
    - Options to address the problem and its causes
    - Key implementation considerations

- E.g., Proactive KT plans that address five questions
    - What's the message?
    - To whom should it be directed?
    - By whom should it be delivered?
    - How should it be delivered?
    - With what effect (or goal) should it be delivered?

Facilitating Pull

- E.g., One-stop shops for pre-appraised research evidence that provide user-friendly summaries and free monthly evidence services
  - ACCESSSS for clinical evidence (e.g., EvidenceAlerts)
  - Health Evidence for public health evidence
  - Health Systems Evidence for evidence about how we organize ourselves to get the rights programs, services and drugs to those who need them
- E.g., Rapid-response service that provides a summary of the best available research evidence
- E.g., Building capacity among policymakers to find and use research evidence as part of their policy analysis work

Exchange

- E.g., Stakeholder dialogues where health policy challenges can be discussed with those who will be involved in or affected by decisions, all of whom are supported by

  - Best available research evidence (in the form of an evidence brief)

  - Systematically and transparently elicited values and preferences of citizens (through excerpts from a citizen panel summary that are included in the evidence brief)

  - Facilitation that draws out the full range of factors that will influence decision-making

Improving Climate / Building Demand

- E.g., Strong messages from all levels of government that research evidence is a key input to the policymaking process

- E.g., Performance criteria for government staff related to their use of research evidence

- E.g., Research evidence checklist that must be completed before briefing materials are submitted to Ministers or cabinet

- E.g., External audits of government reports and the expert advice that informed them

- E.g., Journalists that highlight when government statements aren't supported by research evidence

EVIDENCE >> INSIGHT >> ACTION

First of Two Examples from Canada

- McMaster Health Forum (www.mcmasterhealthforum.org)
  1) Health Systems Evidence (5,800+ systematic reviews; 11,000+ registered users, half receiving a monthly evidence service)
  2) Rapid response in 3, 10 and 30 business days (21)
  3) Stakeholder dialogues (46), informed by evidence briefs (46)
  4) Citizen panels (32), informed by citizen briefs (20)
  5) Health Systems Learning (>60 capacity building workshops)
- These programs address prioritization (2-4), packaging and push (1), facilitating pull (1, 2, 5) and exchange (3, 4); many of them address contextualization
- What programmatic efforts to support evidence-informed policymaking are being undertaken on the 'evidence supply' side in Switzerland?

Second Example from Canada

- Ontario Ministry of Health and Long-Term Care
  1) Strong messages from all levels of the ministry
  2) Health System Research Fund awards (all of which have to respond to ministry-articulated priorities, and 25% of budgets held back for 'Applied Health Research Questions')
  3) Rapid responses and literature reviews
  4) Research Evidence Tool
  5) Capacity-building workshops (delivered by the Forum)
  6) Next step… expert advisory groups (no evidence in or out)
- These efforts address climate (1, 5), prioritization (2), and facilitating pull (2, 3, 4, 6)
- What programmatic efforts to support evidence-informed policymaking are being undertaken on the 'evidence demand' side in Switzerland?

EVIDENCE >> INSIGHT >> ACTION

Some Lessons Learned from These Examples

- We can point to <u>many</u> examples of direct impact on the policy process
    - E.g., six weeks from the 'call' to a cabinet decision (with six Steering Committee calls, 26 key informant interviews, a synthesis of what the research tells us and a framing of the policy issues, a stakeholder dialogue, and a briefing about what was learned)
- We see a <u>virtuous</u> cycle of more evidence-informed policymaking leading to
    - More evidence-informed interest-group pressure
    - More policy-relevant research
- Our biggest challenge remains how to <u>institutionalize</u> these processes (and reduce our dependence on a small number of charismatic leaders)

EVIDENCE >> INSIGHT >> ACTION

Conclusion

- We don't know how best to support evidence-informed policymaking about health systems, but we know that
    - Timeliness and interactions are important
    - It likely needs to look different depending on the type of policy
    - It typically involves five types of activities (and we have many examples of each, which need to be tested across issues/contexts)
        - Prioritization and co-production
        - Packaging and push
        - Facilitating pull
        - Exchange
        - Improving climate / building demand

McMaster
HEALTH FORUM

EVIDENCE >> INSIGHT >> ACTION