

GETTING RESEARCH INTO POLICY AND PRACTICE

GUEST EDITORIAL

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Over the past decade or so there has been a growing interest in not only gathering the best available evidence on effective public health interventions, but also on how to use this evidence to make better policy and practice decisions. In 1993 Oxman and colleagues suggested that there are 'no magic bullets' for achieving effective dissemination and use of evidence, rather one must use a range of mechanisms in order to get evidence into practice.¹

Lomas has offered similar advice and suggested that 'multi-faceted activities' are required in order to 'retail' evidence and promote research utilisation.² Above all, for Lomas, getting evidence into policy and practice requires active management of the available evidence rather than passive diffusion. This requires 'product champions' who will take responsibility for promoting the use of available evidence, as well as evidence-based guidelines, the co-ordination of implementation activities, the involvement of relevant stakeholders (including patients and citizens), and incentives to use evidence (including financial incentives).

Stocking has suggested three requirements for getting evidence into practice—'observability' (or transparency) of the available evidence; 'trialability' of the available evidence (does it work in my context?); and 'demonstrable relative advantage' (will the use of the available evidence enhance the health care provided in some noticeable way, over and above doing something else or doing nothing at all?).³

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Davies has supported all of these ideas for getting evidence into practice and has also noted that open, democratic and non-hierarchical environments might be more conducive to research utilisation than those that are operated by rank, status or hierarchy.^{4,5} Davies has also suggested the importance of establishing ownership of a policy or practice issue, and of the available evidence on effective interventions, by the most senior decision makers in an organisation. Failure to do so can result in a lack of responsibility and accountability for the use of evidence, and a reliance on less robust influences. It is also important to recognise the many factors other than research evidence that influence policy making and practice, including experience, expertise, judgement, resources, habit and tradition; lobbyists and pressure groups; and contingencies.

Presentation and communication of the available evidence is also important. Too often research evidence is inaccessible to key decision makers either because it is published in journals that are not read by policy makers or practitioners, or is presented in ways that are dense, verbose, written in jargon or are otherwise impenetrable. Appropriate sources and formats for presenting evidence include user-friendly websites and printed documents that are clear, concise and coherent. The Canadian Health Services Research Foundation has proposed a 1:3:25 format for presenting research evidence. This consists of a one-page summary of key points and messages; a three-page executive summary that supports the one-page; and a full report of no more than 25 pages that provides substantiation of what is presented in the one-page and three-page documents.⁶

GETTING EVIDENCE INTO PUBLIC HEALTH IN NSW

The papers presented in this special edition of the *NSW Public Health Bulletin* allow many of these principles of getting research into policy and practice to be demonstrated empirically. Bowen, Zwi and Sainsbury in 'What evidence informs population health policy? Lessons from early childhood intervention policy in Australia' argue that the breadth and complexity of the public health field calls for a variety of types of evidence to be used to inform policy making and practice. This paper also makes the point that governments draw on a variety of types of evidence, other than research evidence, to inform decisions. Interviews with policy actors revealed that four types of evidence were required: evidence of the problem, evidence of effectiveness, evidence of effective implementation, and evidence of cost effectiveness.

Poulos and Zwi in 'Building capacity in injury research transfer' report on the role of translation task groups (TTGs) in getting research evidence into policy and practice. The principal role of TTGs is to 'enhance the linkage between researchers, policy makers and other stakeholders, and to foster the development of policy-sensitive researchers and evidence-sensitive policy makers'. Poulos and Zwi report

on two current TTGs in NSW, one focussing on road safety and the other on the prevention of falls in elderly people. Both TTGs identified personal contact with policy makers as the most critical factor in getting evidence into policy and practice. Poulos and Zwi note that 'two-way communication aids both the dissemination of emerging research, and the setting of the research agenda'. The authors also point out that 'research evidence requires active management, rather than the assumption that "the evidence would speak for itself"'.

Another public health issue that requires effective knowledge transfer is the prevention of HIV. Salter in 'HIV prevention and community engagement: 15 years on' presents an overview of the National Centre in HIV Social Research's (NCHSR) work in this area. He also notes the importance of collaboration between health care providers and researchers, and argues that 'health providers are being encouraged to turn to research to both inform and justify their service delivery decisions, and researchers are increasingly expected to engage policy makers and research consumers in both the construction and dissemination of research'. Salter adds that this involves integrating knowledge transfer with community engagement, and the work of many health and community agencies. Integrated and strategic planning of both research and service responses is also seen as being very important to successful knowledge transfer and effective prevention.

Jones et al offer the important message that in order to get best evidence into policy and practice we need to find effective ways of changing behaviour. The authors propose social marketing as one way of doing this. They note that despite the use of social marketing techniques in the areas of smoking cessation, healthy eating, drug use and physical activity they have been under-used in preventing skin cancer (a major public health challenge for Australia). Drawing on systematic review evidence the authors suggest ways in which social marketing might be used to change Australians' behaviour so as to reduce exposure to the sun and prevent skin cancer.

Another substantive area in which research has influenced effective practice is the prevention of smoking. Oakes and Edwards in 'Building evidence and support for a strategy to counter smoking images in movies' report on counter advertising in cinemas. This provides health promotion messages to cinema-goers to counterbalance the encouragement of smoking by the tobacco industry. Oakes and Edwards join other authors in this special issue of the *Bulletin* in highlighting the importance of collaboration across a number of sectors. This is particularly important in areas where there are powerful vested interests—in this case the tobacco industry and the mass communications industry—against which the health promotion sector has to compete. Oakes and Edwards conclude their case study by suggesting that 'by working collaboratively, public health research, health promotion and advocacy groups

can combine their respective strengths to present a feasible solution that is not only based on sound evidence but will also satisfy the many technical and practical issues involved in implementing the strategy’.

Harris and Powell Davies in ‘SNAP: A journey from research to policy to implementation and back’ present an account of the SNAP (Smoking, Nutrition, Alcohol, Physical activity) prevention program and the actions needed to enhance greater systematic implementation of effective primary care interventions. The SNAP program involves actions at the levels of clinical consultations, the general practitioner practice, the Division of General Practice, and state and national levels against seven broad outcome areas (organisational structures and roles; financing systems; workforce planning, education and training; information management and information technology; communication, community awareness and patient education; partnerships and referral mechanisms; and research and evaluation). NSW Health has funded an implementation trial of the SNAP framework, the main results of which are presented in Harris and Powell Davies’s paper. The authors report that ‘a number of the tools and guidelines developed in the trial have been widely disseminated across Australia—notably the SNAP guide, which was published by the Royal Australian College of General Practitioners and distributed to all general practitioners, with funding from the Australian Government Department of Health and Ageing’. By integrating primary care services with other community agencies, as well as state and national bodies, the SNAP program has achieved some success in linking policy, practice and research and improving the risk management of these major public health challenges.

Campbell and Rubin in ‘An “Evidence Check” system for facilitating evidence-informed health policy’ present a tool, called Evidence Check, ‘to facilitate access to high quality research reviews that could inform policy development across NSW Health’. Evidence Check has been produced for the Sax Institute to provide NSW Health users with a commissioning tool, a directory of experts who can undertake reviews, and a team of knowledge brokers who

can liaise between policy makers and researchers and advise appropriately. This tool will help enhance the development of ‘intelligent customers’ of evidence (the demand side) as well as the provision of ‘intelligent providers’ (the supply side).

The paper by Tang and Penman reminds us of the potentially important contribution of economic analysis to the evidence to inform policy and practice. It also demonstrates the cost and benefits to NSW of reducing smoking. There are two clear messages from this study: reducing smoking would benefit the economy of NSW and will, in particular, be of greatest benefit to the poorest households in NSW. Tobacco control is a case example that demonstrates that research evidence faces many challenges in the decision-making process and, on its own, is usually not enough to bring about change. Empirical evidence is but one factor influencing decision-making. It must compete at times with stronger political and economic influences, and vested interests, in the shaping of policy. As noted by the authors, doing this relies on much more than just producing good research and calls for research design that considers the impact of broader factors in decision-making.

The papers presented in this special issue of the *NSW Public Health Bulletin* provide both evidence and encouragement to those eager to link research evidence to policy and practice. It is also encouraging to learn that the substantive public health issues covered in this issue are common to other countries as well as Australia, and there is a growing body of evidence from around the world on how to respond to them effectively.

Since guest editing this issue of the *Bulletin*, Shelley Bowen has left the Sax Institute to pursue full time study for a doctorate.

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See the Sax Institute’s website, www.saxinstitute.org.au, for:

- information about the Institute, its governance and members
- information about the 45 and Up Study, a long-term study of ageing. The study will recruit 250,000 people aged 45 and over in NSW and follow them for many years
- Evidence Check, a new system to facilitate the commissioning of research reviews relevant to policy
- the Coalition for Research to Improve Aboriginal Health (CRIA), a partnership between the Aboriginal Health and Medical Research Council and the Sax Institute. CRIA develops research partnerships to address priority issues for Aboriginal communities and build capacity among Aboriginal health researchers
- up and coming events such as the Second Health Policy and Research Exchange in October 2006
- links to public health and health services research centres in NSW
- significant new research projects and findings from researchers in NSW.

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WHAT EVIDENCE INFORMS GOVERNMENT POPULATION HEALTH POLICY? LESSONS FROM EARLY CHILDHOOD INTERVENTION POLICY IN AUSTRALIA

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Given that we know that policy making is ‘iterative, continuous, incremental, subject to review and inherently political’, how does evidence feed into policy?

The term ‘evidence-based policy’ has become routinely used in government policy deliberations, but the rhetoric is often not matched by the reality. The systematic integration of evidence into policy and practice is rare. There is also ongoing debate on what constitutes evidence for policy. This paper proposes a way of categorizing, according to source, the evidence used for policy making. We draw on the literature and on the ideas and experiences of the key people (referred to here as policy ‘actors’) involved in the development of policies that support families and the early years of life in NSW and South Australia. The findings from this study suggest that a variety of types of evidence inform health policy making. This challenges the public health community to broaden its ideas on what constitutes evidence for policy and to recognize the validity of different types of evidence in better informing the policy process.

Policy making is complex; appreciating the interplay of people, processes and politics is critical if such processes are to be understood. While policy actors are constantly encouraged to base their policy making on evidence, this is extremely difficult given the limited quality of available policy-relevant research to inform the breadth

of public health issues. One response to navigating the use of evidence in policy making is to adopt an ‘evidence-informed’ approach² that considers how different types of information may be transformed into evidence for policy making. We seek not to detract from the value of high quality research evidence, but rather to recognize that even when such evidence is available, governments still draw on a variety of other forms of evidence to more comprehensively inform their decisions.

HOW ARE EVIDENCE AND POLICY MAKING LINKED?

The evidence movement has its origins in evidence-based medicine, ‘the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients’.³ However, the public health community has been struggling with attempts to transfer the concept of evidence-based medicine to policy and practice.^{4,5} Recent literature has transformed the notion of evidence from clinical interventions and direct pathways to practice to evidence in complex policy settings in which people, processes and politics need be considered.^{2,6-9} The term ‘evidence-based decision making’ has emerged to describe the use of the best possible evidence when dealing with real life circumstances.^{3,10-12}

Rychetnik and colleagues (2004) encourage the judicious use of a range of research and evaluation evidence.^{9,13} There is increasing recognition of complementary and competing evidence in the policy process, building on scientific research^{3,10,14-18}, although health policy decisions remain primarily based on experience and opinion, with little use of available research evidence.¹⁸⁻²³ Davies et al²⁴ describe the ‘hot debate’ raging around definition and propose that the term ‘evidence influenced practice’ would emphasise the need to be context sensitive, examining what works and in what context.