

# **Politicising evidence for public health decision making – towards a ‘good governance of evidence’**

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**Improving health worldwide**

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# Lee Jong-Wook (2003)

“Scientifically excellent public health guidelines and other reliable information sit inert in journals and databases unless there is political commitment...to turning knowledge into action that will get results on the ground.”



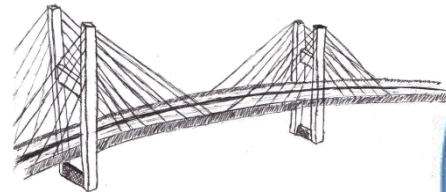
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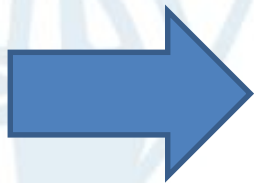
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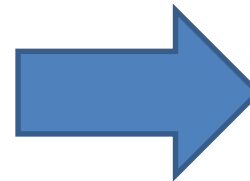
# 2 Worlds and bridging the gap



Bridging the gap  
-Linking  
-Joint planning  
-Networking



Research 'Push'  
-Synthesising work  
-Summarising results  
-Disseminating findings



Policy 'Pull'  
-Tools and guidance on how to use or rank evidence (e.g. Systematic reviews)

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# Common Responses

- Primary focus on knowledge transfer
  - Push factors; Pull factors; Bridging the gap (2 worlds)
- Little engagement with the politicisation of evidence, or the institutional structures in place which govern evidence usage.
- Key position of evidence advisory bodies:
  - To establish the institutional structures and norms for evidence use;
  - To respond to particular political realities and contestations.

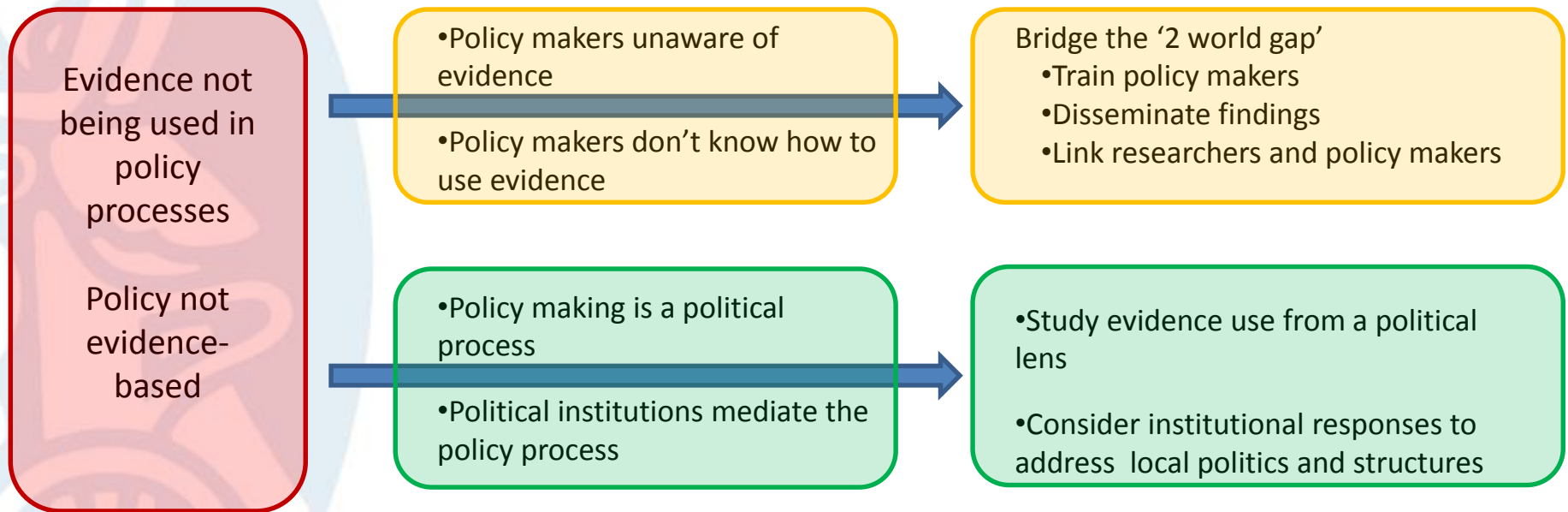
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# The GRIP-Health programme



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# Policy making is political...

- Political science/policy studies tenant: policy making is about choices between sets of competing outcomes and values:
  - ‘Who gets what, when and how’ (Lasswell 1936);
  - Policies pursue competing/contested ideas of a ‘good society’;
  - Science can explain how to do something, not whether it is the right thing to do (A. Brecht 1959).
- Contestation of ‘evidence based’ reductionism – shift to Evidence *Informed* Policy (EIP);
  - Recognition that research evidence is merely one of many concerns policy makers consider.

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# Decision criteria

- No health decisions without opportunity costs (improvement vs equity tradeoffs... among others);
- PH has accepted economic factors (at times) as valid decision criteria;
- PH has accepted ethical concerns as valid decision criteria;
- Others less established as valid to include, or inclusion depends on dominant discourse :
  - Human rights
  - Equity concerns
  - Moral implications
  - Other elements of the ‘good society’ we want to achieves
- Explicit listing of criteria and assignment of values (the grand goal of ‘rationalising’ decision making?).

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# Key questions

- What does it mean to improve the use of evidence in public health?
- Who should govern the use of evidence? (setting the institutional rules and processes on evidence use)
- What constitutes 'good' evidence for decision making?
- What constitutes 'good use' of evidence in policy?

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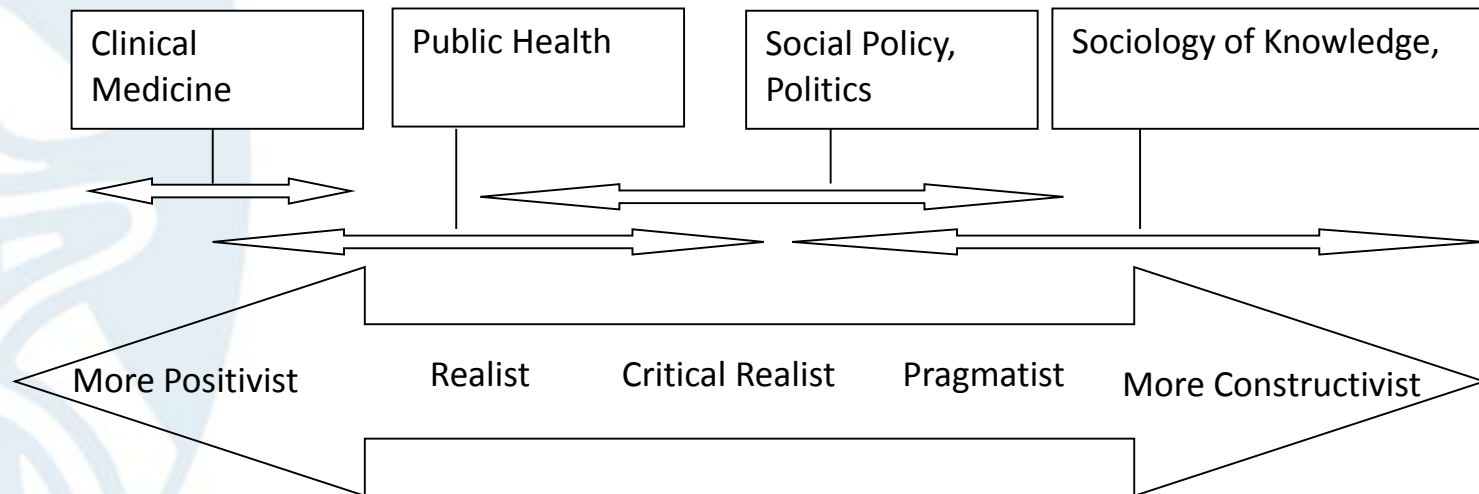
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# Improved use of evidence?

Ontological spectrum of approaches to evidence in Health policy



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# Improved use of evidence?

- PH actors are motivated by normative positions;
  - E.g. 'Improving health worldwide...'
- Improved evidence use would involve use of evidence that increases chances or ability to achieve those goals;
- Requires moving beyond purely positivistic notions of evidence in health, but retaining pragmatic goal orientation of the field;
- The political nature of (health) decision making requires consideration of consider other important principles of evidence use as well.

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# What is 'good evidence' for decision making?

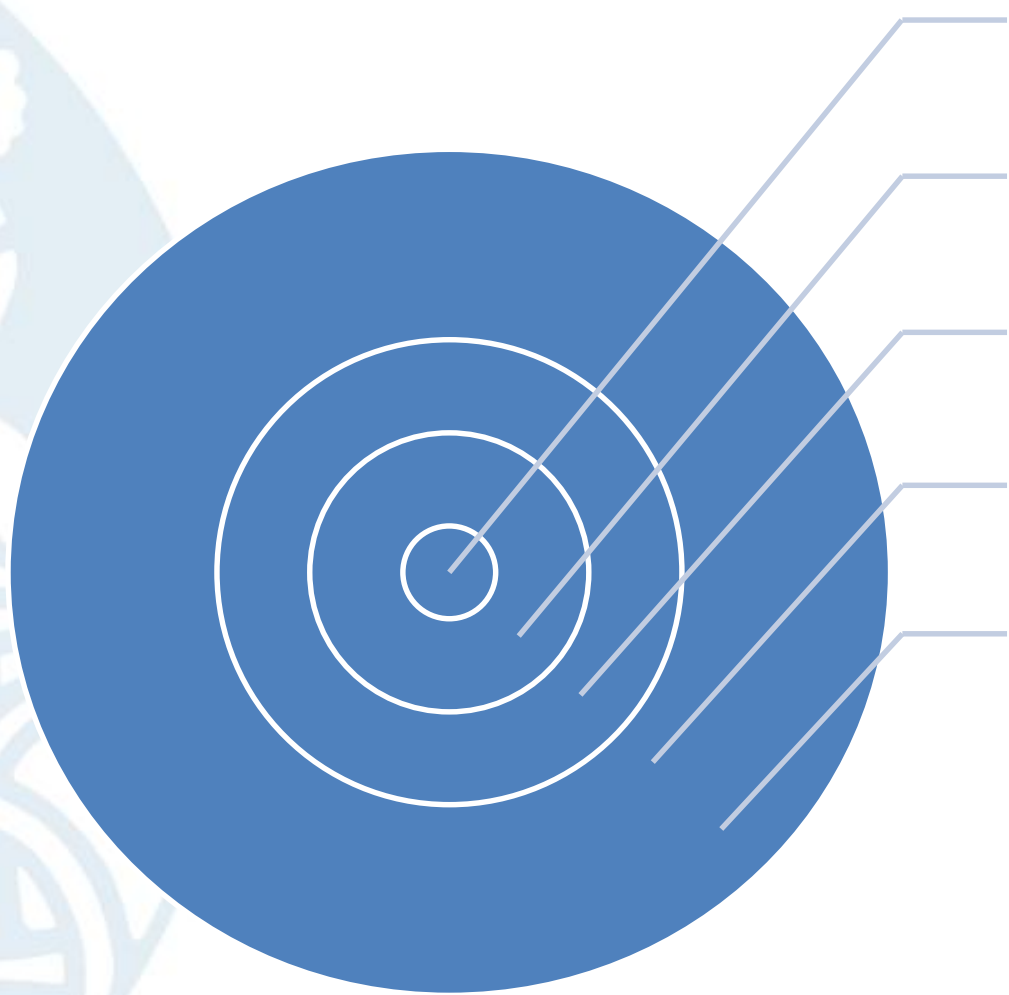
- Multiple competing concerns in decisions means multiple evidence sources;
- Moving beyond a simple hierarchy of evidence of causal effect;
  - Some valued outcomes are evidenced by experimental trials of effect, others are not;
  - Acknowledge external validity problems in many public health interventions.
- Social determinants of health and social construction of illness concepts;
  - Improving population health or reducing health inequalities may be more effectively achieved by challenging existing social constructions shaping medical and public health interventions.

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- Aetiological
- Biological/  
Physiological
- Individual  
Behaviours
- Micro-Social  
Mechanisms
- Macro-Social  
Mechanisms

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# What is 'good evidence' – cont.

- Problems with current calls for methodological pluralism;
  - Research questions address different problems;
  - Research questions are embedded with ontological positions.
- Requires a lens of *appropriateness* which can identify the relevant concerns and appropriate evidence to achieve (normative) goals.
  - Led by pragmatic goals – what strategies most likely/effective to achieve goals;
  - Requires consideration of which evidence talks to broader health determinants or inequalities, and how to act on complex causal situations;
  - Can critically look at categories and classifications to question if most useful to achieve normative goals.
- Requires broadening view away from overly-reductionist positivism, yet for pragmatic purposes;

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# Still need rigour (babies and bathwater...)

- A critical perspective or the critique of a single hierarchy does not mean that evidence itself is arbitrary ;
- Still important to judge the quality of evidence, ensure rigour and minimise bias:
  - Standards of quality and rigour will depend on the nature of the evidence , not a single hierarchy;
  - Rigour judged against the methodological norms and standards for the appropriate evidence type;
  - Systematic and comprehensive reviews of bodies of evidence are a ‘better’ use of evidence than selective/strategic picking of pieces of evidence from a larger body.
- ‘Good evidence’ for PH conceptualised as both appropriate to the goals of the actor, and rigorous according to disciplinary standards of best practice.

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# Who should govern evidence use?

- Broader debate of the change from *government* to *governance*.
- WHO 2000 World Health Report – Identifies Ministries of health as *stewards* of health system;
  - Provides mandate to oversee the health system – the ultimate authority on health matters, regardless of governance arrangements
  - Incorporates an ‘intelligence’ function in most conceptualisations of stewardship – enables conceptualisation of stewardship of evidence:
- Can be tasked with setting the institutional forms and rules of evidence advisory bodies;
- Inter-sectoral planning (a.k.a horizontal governance, or ‘health-in-all-policies in health sector) requires collaborative effort
  - Ministries of health can remain the legitimate *stewards of health evidence* used to inform other sectoral policies with a health aspect

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# What is the 'good use' of evidence?

- Evidence advisory bodies can consider *appropriate* evidence only if the multiple social outcomes of value are made explicit in the decision making process;
  - Need for transparency around values brought to bear and outcomes against which decisions are based.
- Evidence advisory bodies can be institutionally structured to ensure 'good evidence' (appropriate and unbiased) informs decision making processes;
  - 'Good practice' in evidence synthesis commonly seen to encompass particular principles:
    - Rigour and systematic review
    - Unbiased review
    - Transparency in review
    - Contestability of review

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# ‘good use’ of evidence cont.

- Rigorous and systematic evidence *still* does not answer the core political question of what a ‘good society’ looks like;
  - Decisions are made by those representative of, and accountable to, local populations.
- Principles of transparency, independent review, contestability, accountability and representativeness are core principles of ‘good governance’
- Requires Public Health actors to shift discourse from ‘evidence based’ (or even evidence informed?) policy to one of the good governance of evidence for health.

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**Stewardship** – setting the rules for evidence use

Institutions

**Competing outcomes:** health issues involve contested values

Politics

Public Health:  
Not enough  
evidence use

Public Health:  
Better 'use' of  
evidence

Critical Realist  
and normative  
analysis

**Better  
governance  
of evidence**

What is (good)  
evidence?

What is (good)  
evidence use?

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# Future Research

- A set of comparative case studies in low, middle, and high income countries
  - Principally institutionally oriented;
- Map the official health evidence advisory bodies (can compare descriptively);
- Process trace multiple decision making experiences:
  - Evidence used 'well'
  - Evidence used 'poorly'
  - Tracer issue
- Analyse functioning and importance of different national bodies in the use of evidence. In terms of:
  - National (context specific) principles of good evidence use.
  - Conceptual/normative construction of good governance of evidence.

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# Remaining questions

- What institutional features or structures should be investigated
- What analytical lenses should be applied to this work
- How much can we say there is a 'better' (or best) use of evidence?
- Can we *evaluate* health evidence advisory bodies from a normative position?
  - A universal idea of 'good evidence' or 'good use of evidence?'
  - Locally identified norms and principles of evidence use?
- *Or* can we merely undertake analysis of how normative positions and institutions shape the use of evidence?

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