Analysing evidence use in national health policy-making – an institutional approach

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Background

This outline describes a framework under development for analysing the role of research evidence in health policy-making. The framework will be used to explore how, why and when national ministries of health use research evidence in the process of health policy-making, which factors and conditions help or hinder evidence use, and how the role of evidence in health policy-making can be compared between countries.

We have chosen a theory-led approach to the international comparison of bureaucratic practices, to which this framework is expected to contribute. It also aims to help us better understand whether an institutional approach can be usefully applied to explore differences in policy processes in countries at central government level, and whether these differences in processes translate into differences in the use of research evidence in health policy-making. We focus here on evidence and policy in the field of public health – a policy area in which many expect that policy development should be fully informed by research evidence (Nutley et al., 2007, Lomas and Brown, 2009, Lavis et al., 2009). This framework is part of a larger programme of work that examines the relationship between evidence and policy in national health policy-making in six countries (high, middle, and low income).[2]

While well established in comparative public policy, institutions have been underutilised as an analytical lens to understand the institutional forces that influence whether, why and how research evidence is used in health policy-making. Research on evidence use in health policy suggests that how and the extent to which policy-makers draw on evidence varies between policies and settings, as well as a range of other factors associated with the context and politics of policy-making (Black, 2001, Mark and Henry, 2004, Weiss, 1979). Yet health policy researchers often find it difficult to conceptualise what they mean by ‘context’ or ‘politics’. This project therefore seeks to explore whether a better understanding of institutional forces can help shed light on the context and politics of evidence use.

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Contribution to the literature

The current reluctance to use institutional analysis to explain differences in practices of evidence use in a cross-country perspective may be explained by the divisions between academic disciplines and their different preferences in terms of both research foci and theoretical frameworks for examining these. Institutions are key concepts in political science and well established as a way of analysing political decision-making processes (Peters, 2010). Yet, the field is also diverse and riddled with complex debates about the precise meaning of institutions and the theoretical and empirical foundations of the various definitions (Ostrom, 1986, Schmidt, 2008, Radaelli et al., 2012, Greenwood et al., 2008).

Institutional analysis is also well established in the field of international public policy comparisons, including comparisons of health systems and reforms, the works of Immergut and Tuohy providing prominent examples (Immergut, 1992, Tuohy, 1999). Yet, these analyses do not specifically consider the role of evidence in health policy-making. Indeed, the specific focus of this comparative study – the use of particular knowledge sources as inputs to decision-making – is likely to pose challenges to an institutional approach, as the subject is complex, contextual and therefore dependent on many variables and differences. There is a risk that a definition of, and focus on, institutions that is too far removed from individual policy processes 'misses the point' of explaining the substantive differences between countries, processes, policy topics, timing, and policy outcomes (e.g. decisions), and therefore overestimates or underestimates the influence of certain institutions (Radaelli et al., 2012).

It seems that 'evidence use' has received less attention from political scientists than from researchers in the field of health policy. Unlike, health policy researchers, political scientists have been shielded from the paradigm of 'evidence based policy' which has grown out of the shadows of 'evidence based medicine' and developed its own powerful discourse, particularly in relation to health policy. In the UK, evidence use has become part of the official agenda for government policy (beginning with the 1999 White Paper 'Modernising Government'), although the impact and practical implications of this agenda are debatable (Parsons, 2002, Alvarez-Rosete and Mays, 2013).

It suffices to say that to date research into evidence use covers a vast spectrum of studies and conceptual approaches. For the purpose of this paper, we distinguish studies that have focused on the 'mechanisms' of evidence use and place them at one end of a spectrum of investigation of this issue. These include studies that aim to identify 'push' or 'pull' factors that influence evidence 'uptake', largely applying mechanistic models of supply and demand to explain the links between them (Ward et al., 2009). Implicitly, these studies suggest that there is a mechanism of evidence use that can to some extent be isolated from its context and reduced to a set of factors, which can then be manipulated and reproduced in other settings. On the other end of the spectrum are in-depth case studies that often provide detailed, well considered insights into evidence use in particular settings, relating to specific policies and specific points in time. However, these tend to be single case studies and may contribute little knowledge beyond their specific study site.

So far, only a small number of studies have examined institutions in relation to evidence use. These focus on organisational arrangements that facilitate or hinder the uptake of evidence, for example, in drug policy in England and Scotland (Nutley et al., 2002), in routine nursing practice in US hospital (Stetler et al., 2009) or in health inequality policy in England (Smith, 2013). However, while such papers use the general terminology of 'institutions', their interest is mostly in specific organisational structures, and thus employ a definition of institutions as formal organisations. This research interest is also reflected in current work on organisational 'embeddedness' (Gonzales-Block, 2013). In fact, some of the problems these papers raise are discussed elsewhere in the literature, without reference to institutions (e.g. how clinical guidelines influence nursing practice). However, what is absent is a broader conception of institutions that captures the diversity of contexts and structures as they relate to administrative, political and cultural factors that influence whether and how evidence is used in policy processes.

An institutional approach to analysing evidence use in health policy processes

To develop a broader approach to analysing the role of institutions in relation to evidence use in policy-making, we first have to define what we mean by 'institutions' and specify which type of institutions we are particularly interested in and for which purpose. There are a plethora of competing definitions of institutions (March and Olsen, 1984, Ostrom, 1986, Peters et al., 2005, Tsebelis, 2011).

We choose to use a broad definition of 'institutions' that denotes the forces that influence policy decision-making, especially those rules, norms and procedures that shape policy decision-making in government bureaucracies (i.e. ministries of health), which will be the main level of analysis (the unit of analysis being different policy processes). For the purpose of this comparative research, we stipulate that the focus of the analysis will be on ministries of health and, where appropriate, agencies, autonomous and semi-autonomous bodies and/or other subsidiary organisations involved in the execution of its responsibilities. Previous work has highlighted the substantial organisational differences between ministries of health and related agencies in a number of (European / high income) countries and the different roles ministries of health and related agencies exercise in relation to key health policy decisions, such as public coverage of health services (Ettelt et al., 2007, Ettelt et al., 2010). Institutions relating to this level of analysis will be referred to as *administrative institutions*.

In addition, two further levels of analysis will be relevant: *political institutions* and *cultural institutions*. The former refers to institutions relating to the political system, in which government bureaucracy is embedded and which to a large extent provides the regulatory framework in which the bureaucracy operates. The latter, meanwhile, refers to institutions that relate to wider societal influences that impact on the attitudes, perceptions and preferences of policy-makers in government bureaucracies. This broad definition of institutions, therefore, cuts across these different levels of analysis and, to some extent, links

between the different domains, even though they do not necessarily relate to each level in the same way and may refer to different norms, rules or procedures (Figure 1).

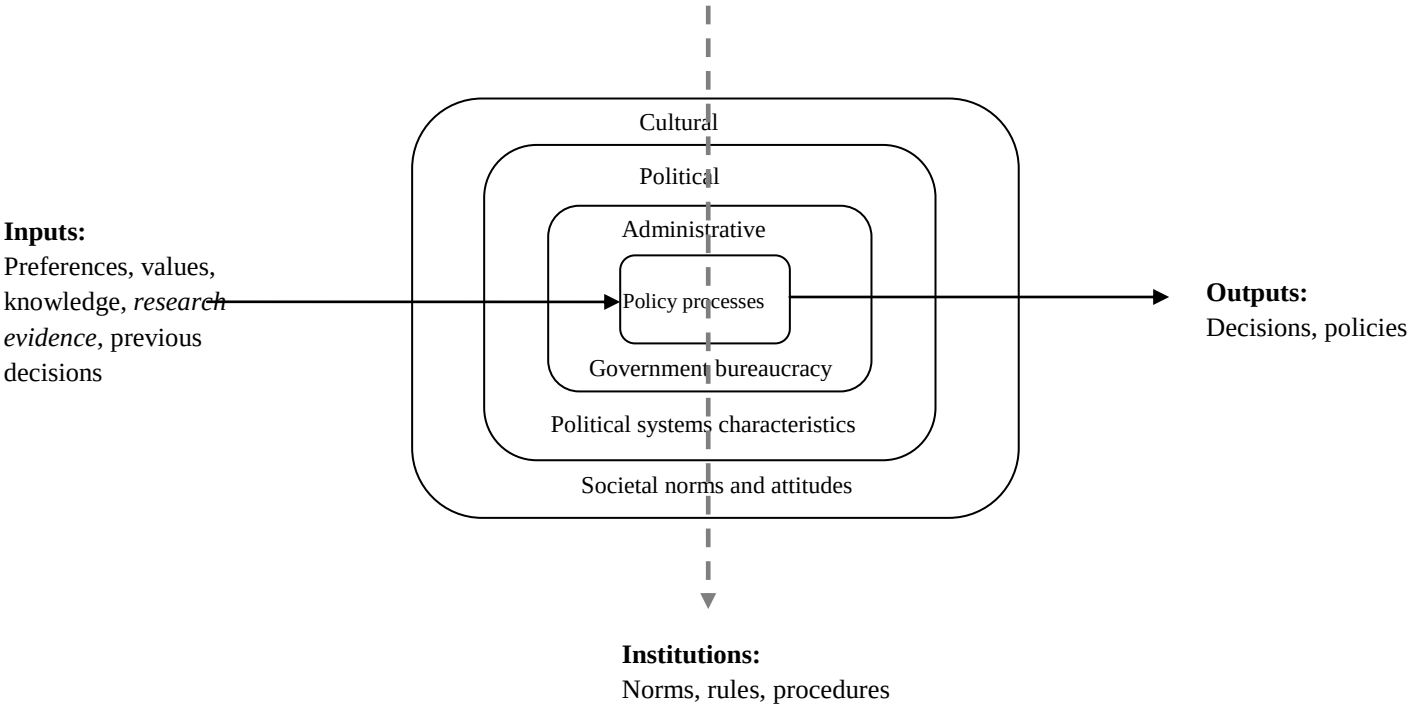

Figure 1: *Framework for an institutional analysis of policy processes at national government level*

We recognise that within this definition, different types of institution lie on a spectrum between the formal and the informal, that is to say between those that have brought about or are represented by specific structures and organisational arrangements, and those that are largely invisible, tacit, and intangible (Douglas, 1986, DiMaggio and Powell, 1991). We expect that relevant institutions will not exist in isolation, but will form clusters and patterns that are both complex and dynamic (Ostrom, 1986). The second category of institutions; i.e. those rules and norms that are invisible and tacit, will be the more difficult to capture, although they may be particularly pertinent to the study of policy-making.

There has been debate about the role of actors and stakeholders in institutional analysis (Radaelli et al., 2012). Sahlin and Wedlin (2008) stipulate that institutions cannot be thought of in isolation from actors and the interaction between them (Sahlin and Wedlin, 2008). We argue that, after all, policy processes are organised, and driven, by people who discuss, negotiate, disagree, co-operate and, at times, come to decisions. The institutional perspective, therefore, provides a focus for analysis, even though it is acknowledged that the policy making process cannot be fully conceptualised in terms of institutions alone. However, it is likely that the institutional approach to analysing evidence use will bring the role of some actors to the fore while de-emphasising others.

A related concern is recognising the dimension of power and relative weight of actors in decision-making processes and the role of institutions in defining this weight. This issue will be relevant in the context of government bureaucracies, given that they form the interface between political decision-making (involving elected politicians) and administrative decision-making (involving government officials).

Developing hypothesis for mid-level theory

As outlined above, three levels of analysis will be distinguished, each providing a different institutional perspective and each associated with a different set of questions. The following presents some preliminary thoughts about the type of questions that could be asked at each level (depending on country, type of process and policy content):

a) *Administrative:* Are some administrative practices more likely to be amenable to evidence use in policy processes? How does the role of civil servants, and the decision space they enjoy in relation to their political leaders, affect the likelihood of evidence use? To what extent is evidence use required by (or at least compatible with) the rules of procedure? Does it matter whether these requirements are formal or informal?

b) *Political:* Do different political systems provide different opportunities for and constraints on evidence use? For example, are decentralised (e.g. federalist, regionalised) political systems more or less likely to use research evidence in policy processes than centralised systems? Are single-party governments more or less likely to use evidence than coalition governments (and does this matter at all)?

c) *Cultural:* Is there an expectation in society that policy-making is a (more or less) evidence informed process? Is there an expectation that policy-makers can and should justify and thus be held accountable for their actions and decisions? Is there an expectation that science and research should contribute to improved policy outcomes (in this case improved health and wellbeing) and thus policy?

We in we will attempt to answer these questions through in-depth, multiple case study analysis, using semi-structured interviews and documentary analysis. As noted above, the focus of this research is on administrative practices in ministries of health and related agencies, which provide the setting for these case studies and, as the political-administrative interface, the arena in which health policy processes take place. Institutions relating to the political and cultural domains will therefore be considered selectively only, to the extent that they matter in relation to administrative processes involving research evidence in health policy-making.

We recognise that mid-level theory is required to explain (or at least provide hypotheses for) how particular institutions or institutional patterns bring about processes which benefit or hinder evidence use for the purpose of informing policy. Due to the complexity of the topic, it is difficult to set out what these hypotheses might consist of beyond the most rudimentary

conditions of possibility for evidence use (e.g. if there is no functional administration there can be no evidence use in policy processes). In addition, it is difficult to generate specific insights (e.g. there is a better chance of [instrumental] evidence use if the government bureaucracy is less politicised and is governed by a code of neutrality). We therefore treat these hypotheses as an (interim) outcome of this research, to which the empirical work aims to contribute.

It is often difficult to establish whether, why and to what effect evidence has been used. Some uses may be symbolic or tactical and/or for the purpose of making policies appear 'evidence based' (Weiss, 1979, Klein, 2000). For the purpose of this work we will apply a broad definition of evidence use that accommodates a wide range of uses and purposes as long as these can be reasonably seen as contributing to a policy decision.

Study design

Country case selection is currently in progress and will be using a number of variables, which aim to capture the three dimensions, i.e. differences in government bureaucracy, political system characteristics, and societal attitudes and norms. To avoid relying solely on indicators relating to differences in political systems (e.g. whether a country is federalist or not; whether it tends to have coalition or unitary governments), we are trying to construct variables that could inform our choices with regard to government bureaucracy and societal norms. For example, we are thinking of choosing 'government effectiveness' as a proxy indicator relating to the administrative domain, although arguably there is no simple link between measures of effectiveness and the assumption of evidence use, and this variable veils substantial differences in approaches to administration. Level of income will be another variable informing country selection; this largely reflects the scope of the project rather than any specific assumption with regard to government organisation (although donor dependency may become relevant in relation to health policy-making).

Policy processes will be the unit of analysis and will be selected purposively to illustrate the interplay of selected institutional forces, which can then be compared across the selected case-study countries. For this purpose, comparators will be selected, probably on a one-to-one basis, to either compare particular processes or particular policies to be developed. It is possible to pair countries to be able to compare specific processes and/or policies to allow for in-depth analysis of variables and 'context'. This means that the selection process for the comparison will happen at two levels, i.e. the level of the country (providing the political system setting) and the level of the process or policy (the 'tracer'). As a result, there will be a combination of 'most different' and 'most similar' designs, for example, by comparing policy-making practices in the Department of Health in England with those in the Federal Ministry of Health in Germany. However, these decisions should reflect the existence of previous hypotheses about variables that influence such processes and will have to be taken on a case by case basis. Given the complexity of the subject we expect that these choices will

be made selectively, with due consideration of the limits to generalisation and potential learning.

Having elaborated on case selection, the focus of this paper is on the rationale for developing the analytical framework rather than on specific decision about individual comparisons.

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