Evidence-Informed Health Policymaking for Impact

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Disclosure of no conflict of interest

- I have no personal or financial interests to declare.
- I have no financial support for the current presentation.
THE ECOSYSTEM OF EVIDENCE

Global challenges for the future

9th International Conference for EBHC Teachers and Developers
8th Conference of the International Society for EBHC
Taormina, 6th-9th November 2019

#EBHC2019
Special thanks to this great audience …
Evidence-based medicine. A new approach to teaching the practice of medicine.
Evidence-Based Medicine Working Group.
PMID: 1404801
Similar articles
Evidence-based medicine. A new approach to teaching the practice of medicine.

Evidence-Based Medicine Working Group.

The EBM Approach ...

- Individual Clinical Expertise
- Best External Evidence
- Patient Values & Expectations

- Systematic Reviews
- Randomized Controlled Trials
- Non-randomized Controlled Trials
- Observational Studies with Comparison Groups
- Case Series & Case Reports
- Expert Opinion

Global Evidence Summit
Using evidence. Improving lives.

25 Years
Outline

- Introduction to evidence use in healthcare
- Health policymaking?
- EBM is different from evidence-informed policymaking
  - The nature of evidence needed
  - Facilitators and barriers to evidence use
- Does producing evidence-informed policies lead to impact?
- Encouraging and enabling evidence use in policymaking
  - WHO’s role
- Final words
The Use of Evidence in Healthcare ...

- Large and unjustified variation in clinical practice (Wennberg et al., 2016)
- Significant levels of inappropriate care (Brook, 1994)
- Evidence of overmedicalization and treatment-induced ill health (Illich, 1974)
The EBM Approach …

The 5 Steps of Evidence-Based Medicine

Step 1: Ask a clinical question
Step 2: Acquire the best evidence
Step 3: Appraise the evidence
Step 4: Apply the evidence
Step 5: Assess your performance
The EBM Approach / Movement …

- Can be regarded as a disruptive technology—a new way of doing things that sought to overturn previous practices.
- Was radical, in that it challenged standard practice or policy and, more fundamentally, the assumed authority of the clinical professional and the centralised policy-making apparatus.
- Had the potential to democratise decision-making by making research evidence available for everyone.

Common Criticisms of EBM

- Too many guidelines, unsuited for local application.
- Objectifies medicine: used as a control tool and erodes the professional role.
- Evidence base is overly influenced by commercial interests.
- Much research is of poor quality.
- Too many published findings turn out to be false or non-replicable.
- Remaining gains from forced implementation are now only marginal.
- Cannot deal adequately with complexity of comorbidities.
- Does not sufficiently incorporate patient preferences.

Evidence based medicine: a movement in crisis?

Trisha Greenhalgh and colleagues argue that, although evidence based medicine has had many benefits, it has also had some negative unintended consequences. They offer a preliminary agenda for the movement’s renaissance, refocusing on providing useable evidence that can be combined with context and professional expertise so that individual patients get optimal treatment.

Trisha Greenhalgh dean for research impact¹, Jeremy Howick senior research fellow², Neal Maskrey professor of evidence informed decision making³, for the Evidence Based Medicine Renaissance Group

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Evidence-based medicine has been hijacked: a report to David Sackett

John P.A. Ioannidis\textsuperscript{a,b,c,d,*}

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\textsuperscript{b}Department of Health Research and Policy, Stanford University School of Medicine, Stanford, CA 94305, USA
\textsuperscript{c}Department of Statistics, Stanford University School of Humanities and Sciences, Stanford, CA 94305, USA
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Accepted 18 February 2016; Published online 2 March 2016

Abstract

This is a confession building on a conversation with David Sackett in 2004 when I shared with him some personal adventures in evidence-based medicine (EBM), the movement that he had spearheaded. The narrative is expanded with what ensued in the subsequent 12 years. EBM has become far more recognized and adopted in many places, but not everywhere, for example, it never acquired much influence in the USA. As EBM became more influential, it was also hijacked to serve agendas different from what it originally aimed for. Influential randomized trials are largely done by and for the benefit of the industry. Meta-analyses and guidelines have become a factory, mostly also serving vested interests. National and federal research funds are funneled almost exclusively to research with little relevance to health outcomes.
Hijacked evidence-based medicine: stay the course and throw the pirates overboard

John P.A. Ioannidis

a, b, c, d, *

Abstract

The article discusses a number of criticisms that have been raised against evidence-based medicine, such as focusing on benefits and ignoring adverse events; being interested in averages and ignoring the wide variability in individual risks and responsiveness; ignoring clinician-patient interaction and clinical judgement; leading to some sort of reductionism; and falling prey to corruption from conflicts of interest. I argue that none of these deficiencies are necessarily inherent to evidence-based medicine. In fact, work in evidence-based medicine has contributed a lot towards minimizing these deficiencies in medical research and medical care. However, evidence-based medicine is paying the price of its success; having become more widely recognized, it is manipulated and misused to support subverted or perverted agendas.
“Renaissance” in EBM – Back to the Basics
THE ECOSYSTEM OF EVIDENCE

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#EBHC2019

Evidence Health Policymaking Impact
Moving toward UHC

“...all people receiving quality health services that meet their needs, without being exposed to financial hardship in paying for the services.”

Three dimensions to consider when moving towards universal coverage
## Annual Cost to US Health Care System in 2011

<table>
<thead>
<tr>
<th>Category</th>
<th>Low</th>
<th>Midpoint</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failures of care delivery</td>
<td>102</td>
<td>128</td>
<td>154</td>
</tr>
<tr>
<td>Failures of care coordination</td>
<td>25</td>
<td>35</td>
<td>45</td>
</tr>
<tr>
<td>Overtreatment</td>
<td>158</td>
<td>192</td>
<td>225</td>
</tr>
<tr>
<td>Administrative complexity</td>
<td>107</td>
<td>248</td>
<td>389</td>
</tr>
<tr>
<td>Pricing failures</td>
<td>34</td>
<td>131</td>
<td>178</td>
</tr>
<tr>
<td>Fraud and abuse</td>
<td>82</td>
<td>177</td>
<td>272</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>558</strong></td>
<td><strong>910</strong></td>
<td><strong>1263</strong></td>
</tr>
<tr>
<td>% of total Spending</td>
<td>21</td>
<td>34</td>
<td>47</td>
</tr>
</tbody>
</table>

(Berwick & Hack Barth 2012)
The Challenge of Sustainable Healthcare

- Sustainable healthcare (HC) is an emerging global challenge.
- The changing demographics, the surge of lifestyle-related chronic disease, technology advances, and increased expectations are all contributing to greater demand.
- To be sustainable, HC has to be:
  - value-driven,
  - effective,
  - affordable,
  - fit-for-the-future
  - leaving no one behind.
Health Policy is …

- A dynamic blend of social strategies, laws, regulations, and funding decisions, most often embodied in constitutions, legislative actions, rules, and judicial decisions.
- A nexus of policy, politics, procedure, and science, but not always in that order.
Health Policy is..

Chess while playing rugby on a speedy train.

Health Policy is …

Evidence base
Public policy
Political will
Social strategy
Health Policy

Social Strategy

Actual detailed *policy plan or approach* to address a problem along with the *social infrastructure (or systems)* in place to support the strategy.
Health Policy

Political Will

Public understanding and support for the resources needed to implement the strategy and achieve the solution.

1. Patients
2. Providers
3. Payers
4. Public entities
Evidence-Informed Policy Making (EIPM)

- Using the best available data and research evidence — systematically and transparently — in the time available in each of:
  - Prioritizing problems and understanding their causes (agenda setting)
  - Deciding which option to pursue (policy or program/service/product selection)
  - Ensuring that the chosen option makes an optimal impact at an acceptable cost (implementation)
  - Monitoring implementation and evaluating impact.

- Alongside the institutional constraints, interest group pressure, citizen values (and other sources of ideas) that influence the decision-making process (i.e., alongside political forces).

John Lavis in Cochrane Training Workshop (May 2019)
Evidence Needed

3D’s of Decision-Making

Decision
- Clearly defined legal mandate
- Citizens’ voice

Dialogue
- Legitimacy, Accountability, Transparency, Inclusiveness

Data
- Criteria for health priorities
- Burden
- Cost-effectiveness
- Budget impact
- Financial Risk Protection
- Fairness
- Acceptability

Actionable Governance

Resources

Cl. Knowledge (Outcomes)

HC Knowledge
EBM is Different from Evidence-Informed Policy Making (1)

HPM is never likely to be as open to the use of evidence as that seen in clinical practice.

- Research is only one of several knowledge sources
- Policy makers have goals other than effectiveness and efficiency
- Driven by ideology, political motives and other (short term factors)
- Medical care is thus no more the only policy goal; it extends beyond that to include interventions that could mitigate the underlying causes of the low levels of population health such as poor sanitation, environmental pollution, certain lifestyles and behaviours.
EBM is Different from Evidence-Informed Policy Making (2)

The healthcare ecosystem includes multiple stakeholders.
EBM is Different from Evidence-Informed Policy Making (3)

Lebanon Experience in Evidence-Informed Policy Making

Source: Dr Walid Ammar, MD, PhD 2019
EBM is Different from Evidence-Informed Policy Making (4)

New insights from policy studies raise new advice and dilemmas

<table>
<thead>
<tr>
<th>How to maximise the use of evidence in policy</th>
<th>New insight from policy studies</th>
<th>New advice based on such insights</th>
<th>New dilemmas arising from such advice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Too many studies focus on supplying scientific evidence to reduce uncertainty; focus instead on increasing demand for evidence by reducing ambiguity</td>
<td>Successful actors reduce ambiguity by, for example, framing issues in manipulative ways, using emotional language</td>
<td>How far should scientists go to persuade policymakers to act on their evidence? Should they be manipulative? This strategy may be effective, but it presents moral dilemmas and challenges a politically effective image of science as objective. We identify several current responses to this dilemma</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How best to understand and act effectively within the policy process</th>
<th>New insight from policy studies</th>
<th>New advice based on such insights</th>
<th>New dilemmas arising from such advice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Too many studies assume that there is a policymaking ‘centre’, making policy via linear stages in a cycle; focus instead on a complex multi-level system or environment</td>
<td>Successful actors take the time to identify which responsibilities are delegated, ‘where the action is’ and the ‘rules of the game’ in each policymaking venue</td>
<td>How far should you go to defend a hierarchy of evidence to deliver policy solutions? Should scientists object to ‘localism’ if it undermines policies based on RCTs? Or, should they embrace the ‘co-production’ of policy with actors who reject their ‘hierarchy’ of evidential methods? We identify three main responses to this dilemma</td>
<td></td>
</tr>
</tbody>
</table>

Evidence-based policymaking is not like evidence-based medicine, so how far should you go to bridge the divide between evidence and policy? Paul Cairney and Kathryn Oliver. *Health Research Policy and Systems* volume 15, Article number: 35 (2017)
A systematic review of barriers to and facilitators of the use of evidence by policymakers

Kathryn Oliver¹, Simon Innvar², Theo Lorenc³, Jenny Woodman⁴ and James Thomas⁵
What Determines Evidence Use by Policy Makers?

A systematic review of barriers to and facilitators of the use of evidence by policymakers

Kathryn Oliver¹, Simon Innvar², Theo Lorenc³, Jenny Woodman⁴, and James Thomas⁵

*BMC Health Services Research* volume 14, Article number: 2 (2014)

- Draws insights from 145 studies
- Published from 2000–12
  - (including 13 other systematic reviews going back further).
- About three-quarters are studies of the UK, Canada, the USA, and Australia.
### Most frequently reported barriers and facilitators of the use of evidence (n = # studies in which factor reported)

<table>
<thead>
<tr>
<th>Top 5 barriers to use of evidence</th>
<th>Top 5 facilitators of evidence use</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Availability and access to research / improved dissemination (n = 63)</td>
<td></td>
</tr>
<tr>
<td>• Clarity/relevance/reliability of research findings (n = 54)</td>
<td></td>
</tr>
<tr>
<td>• Timing/opportunity (n = 42)</td>
<td></td>
</tr>
<tr>
<td>• Policymaker research skills (n = 26)</td>
<td></td>
</tr>
<tr>
<td>• Costs (n = 25)</td>
<td></td>
</tr>
</tbody>
</table>
What Determines Evidence Use by Policy Makers?

Determinants of evidence use in public health policy making: Results from a study across six EU countries

Ien van de Goor\textsuperscript{a,*}, Riitta–Maija Hämäläinen\textsuperscript{b}, Ahmed Syed\textsuperscript{c}, Cathrine Juel Lau\textsuperscript{d}, Petru Sandu\textsuperscript{e}, Hilde Spitters\textsuperscript{a}, Leena Eklund Karlsson\textsuperscript{f}, Diana Dulf\textsuperscript{e}, Adriana Valente\textsuperscript{g}, Tommaso Castellani\textsuperscript{g}, Arja R. Aro\textsuperscript{f}, on behalf of the REPOPA consortium\textsuperscript{1}

\textsuperscript{a} Tranzo, Tilburg School of Social and Behavioral Sciences, Tilburg University, Tilburg, The Netherlands
\textsuperscript{b} Welfare: Equality and Inclusion, National Institute for Health and Welfare, Helsinki, Finland
\textsuperscript{c} Specialised Services, NHS England, London, UK
\textsuperscript{d} Prevention and Health Promotion Research Centre for Prevention and Health, Capital Region of Denmark, Glostrup, Denmark
\textsuperscript{e} Center for Health Policy and Public Health, Babeş-Bolyai University, Cluj-Napoca, Romania
\textsuperscript{f} Unit for Health Promotion, Institute of Public Health, University of Southern Denmark, Esbjerg, Denmark
\textsuperscript{g} Institute of Researches on Population and Social Policies, National Research Council, Rome, Italy
Determinants of Evidence Use in Public Health Policy in 6 EU Countries

- A lack of locally useful and concrete evidence, evidence on costs, and a lack of joint understanding were specific hindrances.

- Users’ characteristics and the role media play were identified as factors of influence.

- Attention for individual and social factors within the policy context might provide the key to enhance more sustainable evidence use.

- Developing and evaluating tailored approaches impacting on networking, personal relationships, collaboration and evidence coproduction is recommended.
Effects of a demand-led evidence briefing service on the uptake and use of research evidence by commissioners of health services: a controlled before-and-after study

Paul M Wilson,1* Kate Farley,2 Liz Bickerdike,3 Alison Booth,4 Duncan Chambers,5 Mark Lambert,6 Carl Thompson,2 Rhiannon Turner7 and Ian S Watt8

1Alliance M

Access to a demand-led evidence briefing service did not improve the uptake and use of research evidence by NHS commissioners compared with less intensive and less targeted alternatives. Commissioners appear to be well intentioned but ad hoc users of research.
Scientists Produce Evidence But…

- Not in a **form** or **quality** that is known about, read, or understood by (or persuasive to) policymakers.
  - Quality can refer to the format of the information, the extent to which any recommendations are seen as non-partisan/unbiased, their source (trusted experts), and informed by knowledge of political and policy process constraints.
  - Effective ‘dissemination’ is about more than plain or ‘punchy’ language or shorter reports across many formats.

Cairney, Paul: The Politics of Evidence-Based Policy Making Palgrave Macmillan 2016
What Information/Evidence Policy Makers Need?

- Relevant
- Timely
- Robust (and the methodology is relatively uncontested)
- Applicable to the issue of concern
- Accessible to wider audiences
- Brings together relevant expertise from a number of disciplines
- Has champions and advocates
- Involves the users of research in the research project from the outset - the ‘co-production model’
- Supports existing ideologies and are uncontroversial.
The traditional metric (cost/QALY) is seen as “abstract” and does not resonate to their local needs.

Return on Investment (ROI) could help real-world decision making by offering information on the costs and benefits of alternative policy actions.

Should usually be presented as a single, simplified metric making it easy to relate to their local context.
Popular Recommendations Focusing on Increasing Research Use by Policymakers

- Develop ongoing, collaborative relationships between researchers and potential users:
  - increase levels of trust and the likelihood of shared opinions about the definition of policy problems, the importance of particular policy issues and the criteria against which potential solutions should be assessed.

- Improve structural communication channels, for example, by investing in ‘knowledge brokers’ and/or knowledge-transfer training
Knowledge Brokerage

- Societal systems ...
  - Codes
- Institutions ...
  - Missions
- Professional roles ...
  - Expectations
- Individuals ...
  - Socialization
- Settings ...
  - Design
Popular Recommendations Focusing on Increasing Research Use by Policymakers

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- Improve structural communication channels, for example, by investing in ‘knowledge brokers’ and/or knowledge-transfer training

- Ensure there are sufficiently high incentives among researchers and research users to engage in knowledge exchange.
Review

The effectiveness of payment for performance in health care: A meta-analysis and exploration of variation in outcomes

Yewande Kofoworola Ogundeleja, John Martin Bland, Trevor Andrew Sheldon

\(^a\) Department of Health Sciences, University of York, York, YO10 5DD, UK

\(^b\) Health Strategy and Delivery Foundation (HSDF), 1980 Wikki Spring Street, Maitama, Abuja, Nigeria

\(^c\) Hull York Medical School, University of York, York, YO10 5DD, UK
The effectiveness of payment for performance in health care: A meta-analysis and exploration of variation in outcomes

- Estimates of the effectiveness of incentive schemes on health outcomes are probably inflated due to poorly designed evaluations and a focus on process measures rather than health outcomes.

- Larger incentives and reducing the perceived risk of non-payment may increase the effect of these schemes on provider behavior.

Ogujindeji YK, Bland JM, Sheldon TA in Health Policy 120 (2016) 1141–1150
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Evidence → Health Policymaking → Impact
Do Health Impact Assessments Promote Healthier Decision-Making?

- Health Impact Project 2016
- A collaboration of the Robert Wood Johnson Foundation and The Pew Charitable Trusts
- Contracted with Harder+Company Community Research to study a sample of HIAs.
Do Health Impact Assessments Promote Healthier Decision-Making?

- Findings from a national study of the perspectives of HIA stakeholders

- **Health Impact Assessments:**
  - Build trust and strengthen relationships between decision-makers and community residents.
  - Contribute to more equitable access to health-promoting resources such as healthy foods, safe places for physical activity, transit, and health care.
  - Protect vulnerable communities from disproportionate exposure to environmental hazards
Effective measurement of impact requires **DATA** from a variety of sources:
- traditional public health surveillance, observational studies, surveys, health information and other administrative systems, and more.

To ensure maximal utility, desired uses for information should be considered when **designing systems** so that the proper data are collected and analyzed.

Data collection and analysis must also be thought of as a **continual process**, ideally with feedback loops to enable refining of program efforts to improve results, as one-off efforts are generally ineffective for long-term assessment of impact.
Addressing overuse and underuse around the world

Vikas Saini • Shannon Brownlee • Adam G Elshaug • Paul Glasziou • Iona Heath

Published: January 08, 2017 • DOI: https://doi.org/10.1016/S0140-6736(16)32573-9

The benefits of modern medical care have advanced the health of populations around the world, but with better health has come rising health-care spending. Not surprisingly, there is global interest in optimising the delivery of health services, exemplified by the universal health coverage (UHC) and waste in research campaigns.¹ ² Comparatively neglected is a central paradox that afflicts high-income countries (HICs) and low-income and middle-income countries (LMICs) alike: the failure to deliver needed services alongside the continuing delivery of unnecessary services. The Lancet Series on right care³ ⁴ ⁵ ⁶ aims to bring these two issues—overuse and underuse—to the centre of global health strategies (panel).

Panel

Key messages in Right Care Series
Sustainability in Health care by Allocating Resources Effectively (SHARE) 11: reporting outcomes of an evidence-driven approach to disinvestment in a local healthcare setting

Claire Harris¹,²*, Kelly Allen¹,², Wayne Ramsey³, Richard King⁴ and Sally Green¹

Abstract

Background: This is the final paper in a thematic series reporting a program of Sustainability in Health care by Allocating Resources Effectively (SHARE) in a local healthcare setting. The SHARE Program was established to explore a systematic, integrated, evidence-based organisation-wide approach to disinvestment in a large Australian health service network. This paper summarises the findings, discusses the contribution of the SHARE Program to the body of knowledge and understanding of disinvestment in the local healthcare setting, and considers implications for policy, practice and research.

Discussion: The SHARE program was conducted in three phases. Phase One was undertaken to understand the current position of the health service in relation to disinvestment. Phase Two involved the development and implementation of strategies to support the disinvestment process. Phase Three was focused on evaluating the outcomes of the program. This paper provides insights into the effectiveness of the SHARE approach and highlights areas for further research and policy development.
Sustainability in Health care by Allocating Resources Effectively (SHARE) 5: developing a model for evidence-driven resource allocation in a local healthcare setting

Claire Harris1,2*, Kelly Allen1,2, Cara Waller2, Sally Green1, Richard King3, Wayne Ramsey4, Cate Kelly5 and Malar Thiagarajan6

Abstract

Background: This is the fifth in a series of papers reporting Sustainability in Health care by Allocating Resources Effectively (SHARE) in a local healthcare setting. This paper synthesises the findings from Phase One of the SHARE Program and presents a model to be implemented and evaluated in Phase Two. Monash Health, a large healthcare network in Melbourne Australia, sought to establish an organisation-wide systematic evidence-based program for disinvestment. In the absence of guidance from the literature, the Centre for Clinical Effectiveness, an in-house ‘Evidence Based Practice Support Unit’, was asked to explore concepts and practices related to disinvestment, consider the implications for a local health service and identify potential settings and methods for decision-making.

Methods: Mixed methods were used to capture the relevant information. These included literature reviews; online
Sustainability in Healthcare by Allocating Resources Effectively

**AIM 1: Systems and Processes**
- Develop, implement and evaluate organisation-wide systematic, transparent, accountable and evidence-based decision-making systems and processes for resource allocation related to health technologies and clinical practices.
- Explore six decision-making mechanisms:
  - Purchasing and procurement
  - Guideline and protocol development
  - Proactive use of published research
  - Proactive use of local data
  - Economic approaches to priority setting
  - System redesign

**PRINCIPLES**
Focus on ‘effective application of health resources’
- Consider ‘resource allocation’ rather than ‘investment’ or ‘disinvestment’ in isolation
- Introduce ‘proactive’ use of information to drive decisions and build on existing ‘routine and reactive’ processes
- Use evidence from research and local data rather than economic factors to drive decisions
- Implement both ‘top down’ and ‘bottom up’ strategies
- Take evidence-based approach to development, implementation and evaluation of all program components and include action research to investigate the process of change
- Ensure alignment with Monash Health Strategic Goals and Integration into Business Plan

**AIM 3: Support Services**
- Develop, implement and evaluate services to provide expertise and facilitate action.
- Explore support in four settings:
  - Providing expertise to deliver research evidence to decision-makers
  - Providing expertise to deliver local data to decision-makers
  - Building capacity in the health service workforce to use research evidence and local data in decision-making and to implement and evaluate change based on these decisions
  - Providing expertise in project methods and tools and providing assistance in data collection, analysis, project administration

**RELATIONSHIPS**

1. **Systems and Processes**
   - Making systematic, transparent, accountable, evidence-based decisions

2. **Disinvestment Projects**
   - Identifying, prioritising and implementing change

3. **Support Services**
   - Providing expertise and facilitating action

4. **Program Evaluation and Research**
   - Learning and sharing

**PRECONDITIONS**

**Strategic Direction, Influence, Support and Endorsement**
- Executive Directors (3)
- Program Directors
  - Medical
  - Nursing
  - Allied Health
  - Pharmacy
  - Diagnostic services
- Committee representatives
  - Technology/Clinical Practice
  - Therapeutics
  - Research Ethics
  - Clinical Ethics
- Legal counsel
- Information Services
- Procurement
- Biomedical Engineering
- Consumer representatives (2)

**Funding**
- Project costs
- Establishment costs
- Ongoing costs

**Expertise**
- Evidence-based practice
- Knowledge brokerage
- Health service data analysis
- Health program evaluation
- Health economics

**Stakeholder Engagement**
- Managers
- Clinicians
- Consumers
- Funders

**Fig. 4 Revised draft of SHARE framework**
Ten Years of Supporting Evidence-Informed Policymaking

Over the past 10 years, the McMaster Health Forum has harnessed research evidence, citizen values and stakeholder insights to help strengthen health systems and get the right programs, services and products to the people who need them. Through Forum+ we’re now broadening our work to include social systems and the Sustainable Development Goals.
Recent Books

What Works Now: Evidence-informed policy

Beyond Evidence-based Policy in Public Health: The Interplay of Ideas

The Politics of Evidence: From evidence-based policy to the good governance of evidence

Evidence Use in Health Policy Making: An International Policy Perspective

The Politics of Evidence-based Policy Making

Paul Cairney
What’s next?

Evidence → Health Policymaking → Impact
What was Happening in WHO in 2017/2018?
53 WHO Member States calling for enhanced action to use evidence for policy: Regional Committee 2016

Adoption of Action Plan and Resolution on evidence-informed policy making
1. Strengthening health information systems, harmonizing health indicators and establishing an integrated health information system for the European Region;

2. Establishing and promoting health research systems to support the setting of public health priorities;

3. Increasing country capacities for the development of evidence-informed policies (knowledge translation);

4. Mainstreaming the use of evidence, information and research in the implementation of Health 2020 and other major regional policy frameworks.

Concrete actions for Member States and WHO

Adopted by 53 Member States through resolution
The European Health Information Initiative is committed to improving the evidence on which policy is based.
Current situation of health reporting in Europe
The future: Integration of health information

Interoperability
Ability to exchange and make use of information

Harmonization
Definition, classification and interpretation of data indicators

World Health Organization
Regional Office for Europe
Evidence-Informed Policy for Impact Meeting
Nov 22 – 23, 2018 WHO HQ (Geneva)
Developing national institutional capacity for evidence-informed policy-making for health

Executive summary

1. To ensure that health policies are appropriate, effective and cost-effective, they need to be based on sound evidence. Evidence-based policy-making is therefore essential to achieve the Sustainable Development Goals and universal health coverage, and its importance is emphasized repeatedly in WHO’s Thirteenth General Programme of Work 2019–2023 (GPW 13). However, it can be challenging for countries to obtain and use high-quality evidence.

2. This paper is the latest step in a long-standing programme of work by WHO to foster evidence-based policy-making in countries of the Eastern Mediterranean Region. It was developed in response to a request by the Regional Committee for the Eastern Mediterranean, and proposes a framework to help countries improve their national institutional capacity for evidence-informed policy-making. The framework provides practical actions that Member States can take to build their national institutional capacity and outlines the support WHO can provide to facilitate this process.

3. Countries’ needs, priorities and capacities vary, and the proposed framework is designed to be flexible to accommodate such variations. Furthermore, the paper sets out a five-dimensional analytical approach to help countries assess their needs and capacities and formulate a suitable strategy, and includes real-world examples of different possible actions from countries. The proposed framework is presented for consideration and possible endorsement by the Regional Committee.

Introduction

4. This technical paper was developed in response to a 2017 Regional Committee resolution requesting the Regional Director to “establish regional mechanisms to support the bridging of gaps between relevant
Limited Capacity to Generate and Use Evidence for Decision Making

- **Capacity**: Comparatively limited health research conducted in EMR
- **Standards**: Research designs not conducive to produce robust evidence for decision making
- **Priorities**: Research studies often not focused on national or regional challenges

- Few national health observatories or survey plans
- Health policies often not supported by policy briefs
- Few national programs for clinical and public health guidelines
- Health Technology Assessment structures are limited in EMR

1. Minimum institutional capacity requirements for all countries

2. Country specific requirements and options
   - Countries with limited academic resources
   - Countries in emergencies
   - Smaller countries with strong academic capacity
   - Larger countries with strong academic capacity

3. WHO support and required actions for each category of countries

- Institutional capacity building for evidence-informed policy-making
- Develop policy briefs on topics of regional importance
- Adapt WHO guidelines for areas of high priority
- Develop multi-country or regional guidelines for high priority topics
- Establish a regional network of support institutions

WHO Support for the Member States

- Support development of policy briefs/ adapt WHO guidelines

Countries with limited academic resources

- Support rapid processes for policy synthesis products

Countries affected by emergencies
What is Happening in WHO now?

World Health Organization
A New Sicily Statement?

Evidence -> Health Policymaking -> Impact
Debate

Sicily statement on evidence-based practice

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Published: 05 January 2005


Received: 03 October 2004
Accepted: 05 January 2005
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Sicily statement on classification and development of evidence-based practice learning assessment tools

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Abstract

Background: Teaching the steps of evidence-based practice (EBP) has become standard curriculum for health professions at both student and professional levels. Determining the best methods for evaluating EBP learning is hampered by a dearth of valid and practical assessment tools and by the absence of guidelines for classifying the purpose of those that exist. Conceived and developed by delegates of the Fifth International Conference of Evidence-Based Health Care Teachers and Developers, the aim of this statement is to provide guidance for purposeful classification and development of tools to assess EBP learning.

Discussion: This paper identifies key principles for designing EBP learning assessment tools, recommends a
Thanks you ...