WHAT COUNTS?
Interpreting evidence-based
decision-making for management and policy

Report of the 6th CHSRF
Annual Invitational Workshop
Vancouver, British Columbia
March 11, 2004
Our Purpose

Vision
Our vision is a strong Canadian healthcare system that is guided by solid, research-based management and policy decisions.

Mission
Our mission is to support evidence-based decision-making in the organization, management and delivery of health services through funding research, building capacity and transferring knowledge.

Approach
Our focus is on the people who run the health system, as well as health services researchers. We help them get involved in research that makes a difference, help them produce, find and apply new knowledge to improve management and policy decisions, and bring the two groups together so they can each influence each other’s work and share ideas and experiences.
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Main Messages

CHSRF Workshop on Evidence-Based Decision-Making

- We have come a long way in increasing acceptance for evidence-based decision-making in healthcare management and policy. However, the terminology is being used differently between the communities of research and policy-making.

- There will probably never be total agreement between researchers and decision makers about what constitutes evidence. It may be more useful to look at evidence-based decision-making as a social process to develop a common understanding between the two communities.

- Participants at the foundation’s workshop did identify four characteristics of the decision process they felt were essential to evidence-based decision-making: transparency; reliability; inclusiveness; and explicitness.

- Evidence is a lot more than research, and it includes a lot of contextual information. We should not look at evidence as a way to end today’s healthcare debates, but rather as a way of raising the level of dialogue around important decisions. In this sense, evidence-informed decision-making may be a better term than evidence-based decision-making.

- Evidence-based decision-making is a value-laden process, as is the construction of the meaning of evidence. Recognizing the role that values play will lead to a greater level of transparency and understanding, helping to improve the quality of policy and management decisions.

- Proper evaluation is critical to evidence-based decision-making. We need to better evaluate today’s decisions to improve tomorrow’s decisions. Some workshop participants called for a national system for reporting the unintended effects of policies (“policy accidents”) — both good and bad — on the grounds that it could help collect wisdom and ensure policy makers do not act in isolation from each other and repeat the same mistakes.

- Methods of collecting evidence matter, but appropriate analysis of evidence from multiple viewpoints is perhaps at least as important if we want to improve evidence-based decision-making.
What is Evidence?

During the past decade, evidence-based decision-making has evolved from an appealing concept to a generally accepted principle by which we should operate our healthcare systems. Yet despite the current acceptance of these concepts, key questions remain largely unanswered: What is evidence, and evidence-based decision-making, in the context of health services management and policy?

To begin to answer the questions, the Canadian Health Services Research Foundation called together more than 150 health services researchers, managers, and policy makers in spring 2004 to discuss and debate the issues. Their discussions were informed and guided by some key individuals who have spent a lot of time thinking and writing about these issues. This report tries to capture the fruits of their discussions.

Numerous definitions are already available for evidence-based decision-making in the clinical realm, where the notion of evidence-based decisions has a much longer history. For example, evidence-based medicine has been succinctly defined as “the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients.”

Significant effort has been devoted to the creation of systematic reviews and clinical practice guidelines to ensure that clinical care is well evaluated, so practitioners can deliver the most informed and best quality care to patients. Much of this work has concentrated on the methods used to collect evidence and the quality of research findings, resulting in hierarchies of evidence where the randomized controlled trial is seen as the “gold standard of evidence.”

Some have suggested the guidance offered by evidence-based clinical practice can be extended to health services management and policy. After all, as one author recently argued, “Healthcare policies are interventions into people’s lives, and it is reasonable to require the same documentation of effects as one expects for healthcare interventions aimed at individuals.”

As a result, many organizations and individuals have devoted significant time and effort to translating systematic reviews for policy makers, with the logical assumption that the results of these reviews are just as applicable to decisions such as the availability and funding of healthcare. As the English government put it in a 1997 white paper on new directions for that country’s National Health Service, “What counts is what works.”
However, it is becoming apparent that this generalization may be faulty. Rudolf Klein, for one, has argued that while the notion that research evidence is a basis for management and policy decisions is “as seductive as it is simple,” it is ultimately unsatisfying. In his keynote address at the foundation’s workshop on evidence-based decision-making, Klein criticized what he calls “the privileging of research evidence over organizational evidence and political evidence.” There are weaknesses to research evidence, and other forms of evidence are often equally important in management and policy decisions, he argued.

“Most research is ambiguous when it comes to policy implications, and the notion that you can simply read off what ought to be done from the results of research is nonsense,” Klein told the workshop. Research evidence is a blueprint for policy and management decisions in some areas such as tobacco control, where a strong research base coincides with strong public support or the widely held beliefs of policy makers. However, it gets more difficult when it comes to system research, where a clear direction is almost never found, Klein said.

First of all, managers and policy makers will view different types of research evidence differently, depending on their values. For policy makers, even the most solid research evidence can be rejected as “dense” or “academic” when it challenges strongly held beliefs or goals. Less reliable or “soft” research results are often embraced by decision makers when they support the value system in place.

That’s where organizational and political evidence come in. According to Klein, when designing public policies, one of the first questions you must ask yourself is, “is it feasible?” The material used to answer this question is organizational evidence, and it includes considerations such as human resources requirements, the availability of appropriate managerial expertise, and the reality of limited budgets.

Political evidence, on the other hand, includes information about what the public attitudes are toward proposed policies, or how the media will react. “Very often, when people use the term political, there is a slight sneer in their voice, as though this weren’t legitimate,” Klein said. “I think it is highly legitimate to ask whether policies will be politically acceptable, or whether the media will start arguing against a particular policy — because if they are, it may be a warning signal to think again.”
Rudolf Klein’s three types of evidence

- **Research evidence** is produced by scientists, in accordance with accepted research methodologies.
- **Organizational evidence** is information about an organization’s capacity to complete the tasks being approached. It can also be characterized by the question “The last time we tried this, why did we fall flat on our faces?”
- **Political evidence** includes information about how the public, politicians, and other players will react to policies under consideration, helping or hindering the success of the policy decision.

Health system decision makers operate in an environment of scarcity, where decisions must be made in the context of limited resources. As a result, there is a strong performance focus on evidence, often related to economic demands.

Vicki Kaminski, CEO of Sudbury Regional Hospital, said she considers evidence to include such things as financial statements, utilization data, and best practice benchmarking. In addition, she says that report cards, environmental scans, discussion forums, and expert panels are useful evidence that help managers and policy makers to compare where they are, versus where they want or need to go.

**Vicki Kaminski’s three steps to making good decisions in health services organizations**

1. Make decisions.
2. Evaluate, determine where and when you went wrong.
3. Use corporate storytelling to share experiences and lessons to improve decisions.

While many researchers understand and appreciate that these other forms of information may need to play a role, many are concerned that considering “everything to be evidence” will result in watering down research results.
“As a researcher, I sincerely believe that research evidence should be privileged, and that’s because methods matter,” said Andy Oxman, an active member of the Cochrane Collaboration and director of health services research at the Norwegian Directorate for Health and Social Affairs.

Methods matter not only in randomized control trials, but for any type of information to be used as an input to a decision, Oxman said. For example, you would not accept the results of an opinion poll of three people who all happened to be friends of the person conducting the poll.

“In the clinical setting the problems with doing things by trial and error are obvious. I think some of the same problems carry over to the policy situation and the management situation,” said Oxman. “If we do things by trial and error, it’s not good information, it’s not reliable information upon which to base decisions — and it does indeed sometimes kill people, as well as waste resources.”
What is Evidence-Based Decision-Making?

Prior to the workshop, we asked the researchers, managers, and policy makers attending to tell us what “evidence” meant to them in their daily work — either conducting research or making management and policy decisions.

It was encouraging that there were a number of similarities in the responses between the groups — in general, both groups recognized the importance of research findings and that there were levels of quality in evidence. In addition, many individuals in both groups recognized that a lot more than research evidence is required to make good decisions and that context is important.

At the same time, there were some key differences in the responses between the groups. For example, researchers pointed out that evidence was actually seen to be a well-established, if not passé, term, while decision makers felt it was a term that was growing in use.

In their responses to us, researchers were more likely to equate evidence with research. “To me, evidence is synonymous with assertions that are supported by results observed as a result of sound and rigorous research design,” said one researcher. According to another, “Like best practices, the term evidence has been degraded by misuse. Properly, it refers to the results of good scientific research.”

Researchers tended to stress the relative strength of different forms of evidence, often pointing out accepted hierarchies of evidence based on study design. They looked at evidence as data, and they mentioned the importance of how it was collected and who it was collected by. “Evidence is knowledge that is based on credible investigation, calculation, or analysis. The key is that it must have been collected in a manner that is as free as possible from personal interest, vested interest, or belief,” one researcher told us.

On the other hand, managers and policy makers said that in making management and policy decisions, evidence was much broader than just research findings and could also include information sources as diverse as statistics, trend analyses, environmental scans, and costing and polling data.
“My one-minute response to the question would be that evidence is a combination of synthesis of research with expert (broadly speaking) opinion,” said one policy maker. One manager was even blunter: “From a management point of view, evidence is proxy for ‘most up-to-date information’ on a subject — nothing more, nothing less.”

The results of this exercise highlight the importance of developing a common language, because if researchers and decision makers have different understandings of evidence, there are profound implications for decisions in health services management and policy.

However, existing definitions of evidence-based decision-making instead tend to highlight the differences between these two communities. They often look at decision-making as a process involving people and organizations actively consulting research findings in the process of making discrete decisions. Thus, they lean on definitions such as those offered by evidence-based medicine (that is, “the conscientious, explicit, and judicious use of current best evidence.”)

However, if we accept that connecting these cultures of researchers and decision makers is perhaps the most critical element of the process, it becomes more useful to look at evidence-based decision-making as a social process and an ongoing dialogue between the two communities.

In his presentation, Andy Oxman outlined a useful accountability framework for this collaboration. Policy makers have multiple accountabilities — senior officials, voters, the media — but they are fundamentally accountable for making evidence-based decisions (which Oxman called evidence-informed judgments). Researchers are accountable to both their scientific colleagues and to their policy-making collaborators, and their overriding responsibility is to provide the best available evidence. Both sides are accountable for ensuring mutually agreed-upon rules regarding collaboration and communication, for making the process as explicit as possible, and for continuing to struggle to ensure that judgments are well informed.
Andy Oxman’s six lessons for evidence-informed collaborations between researchers and policy makers

1. Policy makers alone are accountable for decisions about policy — They are accountable to multiple sources, such as senior officials, voters, and the media. They make judgments using a variety of information such as financial feasibility, voters’ preferences, and the positions of interest groups. Both policy makers and researchers need to appreciate these different types of information and the role each plays in informing judgments about health policies.

2. Researchers are accountable in different ways than policy makers — They are accountable both to scientific colleagues and to policy-making collaborators, and for providing the best available evidence.

3. Researchers can help inform the judgments of policy makers — It is important to be explicit about distinct roles for the two. It may be useful to regulate the process by contracts, rules, and procedures (especially regarding confidentiality and communication). At the same time, both sides must feel they can be frank and candid with each other.

4. Even institutionalized decision-making processes can be endangered — Changes in government or the presence of groups with vested interests can threaten or even dismantle processes of evidence-informed decision-making, even those that have been established by legislation.

5. It will always be easier to say yes than no — There are many examples of technologies that have been funded by public payers when evidence is shaky, because of a natural reluctance to make unpopular decisions.

6. The best policy makers are rarely in place for long periods of time — Policy makers who strive to promote better decision-making, including better use of research evidence, are likely to move on sooner rather than later.

To begin to develop a shared understanding of evidence-based decision-making, we asked the more than 150 researchers, managers, and policy makers at the foundation’s workshop to form small discussion groups, analyse various decision-making scenarios, and provide us with feedback on what are some of the key processes and characteristics of evidence-based decision-making. Their feedback can be grouped under four key areas: transparency; reliability; inclusiveness; and explicitness.
Evidence-based decision-making has a high level of transparency

Workshop participants stressed that evidence-based decision-making does not use evidence to justify or bolster decisions that have already been made. Instead, it is an honest attempt to verify the range of evidence that is available in an area of policy or management, and to adjust decision-making accordingly if the evidence proves to be suitable.

Several participants went to great lengths to point out that evidence-based decision-making does not mean that evidence is used to force particular decisions, but rather that it is a transparent part of the process of decision-making. In addition, they noted that decision-making can be evidence-based even if research evidence is not found — many times, it is enough that attempts were made to verify whether there is evidence.

Finally, the fact that evidence-based decision-making is free of pretence does not mean that values and opinions are not involved. In fact, both play a central and valid role in evidence-based decision-making, although this is often not acknowledged. Both decision makers and researchers have cultural and other biases, and this must be recognized and accepted. If we do this, we avoid “groupthink” and allow unorthodox yet important ideas to have an impact.

Evidence-based decision-making is a reliable process and can be used in many situations

For the workshop participants, reliability implied that the process is somewhat replicable — in other words, evidence-based decision-making will have similar results in different situations, not in the particular decisions that are made, but rather in improvements to the quality of, and satisfaction with, decision-making.

Reliability implies that evidence-based decision-making is a sustained way of addressing long-term challenges, rather than a knee-jerk reaction to short-term problems. For the workshop participants, it also meant that evidence is only the information that is systematically collected and analysed.
Workshop participants stressed that even when decisions are made in haste, it can be evidence-based decision-making. In these cases, evaluation is critical, including monitoring and processes for proper follow-up of decisions. Some workshop participants even called for a national system for reporting the unintended effects of policies (“policy accidents”) — both good and bad — believing that it could help collect wisdom and ensure that policy makers do not act in isolation from each other and repeat the same mistakes.

**Evidence-based decision-making includes many voices and many types of information**

Evidence-based decision-making involves as many of those who will be affected by decisions as possible. This includes not only researchers, policy makers, and managers, but also patients, the public, and health services providers. Building trust between these different groups is critical, and it is important that multiple opinions and perspectives are included.

According to the workshop participants, an evidence-based process carefully weighs the strengths and weaknesses of many approaches and acknowledges that there is no singular truth. It assesses the impact of many options and values thinking “outside the box.” In fact, the quality of the analysis may ultimately be more important than the quality of the evidence available.

Finally, evidence-based decision-making acknowledges that decision-making is a web, and decisions are interrelated. For example, the results of budget cuts made in one area will be felt in other areas.

**Evidence-based decision-making must be explicit**

A process of evidence-based decision-making is clear about who is making decisions, what evidence is being used, and how it is weighted. Clarity must be not only in the quality of design of the studies that are used, but also the range of inputs involved and how much credence they are given. There are always judgments involved, regardless of the quality and quantity of evidence that is available.
Evidence-based decision-making is open about the judgments that are made throughout the process — from evaluating the evidence and other inputs that will be used to the courses of action chosen. It is also explicit about the relative roles of researchers and decision makers in collaborations between the two communities.

Clarity is required not only in the consideration of evidence but in the understanding of problems as well. We have a strong basis for evidence-based decision-making when we have clarity about what we know, as well as what we need to know.
Conclusion

The quality of the discussions at the 2004 workshop on evidence-based decision-making demonstrated how far we have come in accepting the concept of evidence-based decision-making. In particular, there appears to be a lot of common ground between researchers, policy makers, and managers.

When discussions in this area take the nature of a “What’s In, What’s Out?” discussion about the nature of evidence and decision-making, and dialogue between members of these communities, differences between these two communities are highlighted and exacerbated. Accordingly, moving toward a framework of evidence-informed decision-making may help remove some roadblocks to collaborations between researchers and decision makers.

Regardless of the terminology used, when we look at the road ahead as a social process and an ongoing dialogue between these two communities, it is clear that there is a mutual desire to work together to better understand and also to improve the process.

Of course, mistakes will be made along the way. As keynote speaker Rudolf Klein put it: “It is not only scientists who experiment — policy-making is an experiment as well.” Our shared challenge is to learn from these successes and mistakes and continue to improve and advance evidence-based decision-making in our healthcare systems.
Endnotes


Appendix

AGENDA

REGISTRATION & BREAKFAST ~ 7:30 – 8:30

WELCOME AND ORIENTATION ~ 8:30 – 8:45
David Clements, Senior Program Officer, CHSRF

PART I: OPENING ARGUMENTS
(Plenary Session) ~ 8:45 – 10:15

Rudolf Klein (England)
Emeritus Professor of Social Policy, University of Bath; Visiting Professor, London School of Economics and London School of Hygiene and Tropical Medicine

Vicki Kaminski (Canada)
President & Chief Executive Officer, Sudbury Regional Hospital

Andy Oxman (Norway)
Director, Department of Health Services Research, Norwegian Directorate for Health and Social Welfare

BREAK ~ 10:15 – 10:45

RECONCILING OUR DIFFERENCES (Small-group exercise) ~ 10:45 – 12:15
Researchers and decision makers will gather in groups of 15 to 20 to share different understandings of what constitutes evidence and evidence-based decision-making and attempt to find common ground on the issues.

LUNCH ~ 12:15 – 13:45
PART II: EVIDENCE IN ACTION

EVIDENCE AND …
(Afternoon sessions) ~ 13:45 – 15:15
On site, participants will choose from five small-group sessions, profiling collaborations between researchers and decision makers to bring about evidence-based decision-making. For more details, please refer to the attachments, “Descriptions of Afternoon Sessions” and “Speaker and Presenter Biographies.”

… System Change (Session A)
Luc Boileau, Jean-Louis Denis and David Levine (Quebec)

… Mental Health (Session B)
Charlotte Waddell and Jayne Barker (British Columbia)

… Palliative Care (Session C)
Deborah Dudgeon and Anne Smith (Ontario)

… Provincial Waiting Lists (Session D)
John McGurran and Doug Calder (Saskatchewan)

… Primary Healthcare (Session E)
Margaret Dykeman and John Campbell (New Brunswick)

… Hospital Waiting Lists (Session F)
Lynn Molloy and Allan Hennigar (Nova Scotia)

BREAK ~ 15:15 – 15:45

CLOSING ARGUMENTS
(Plenary Session) ~ 15:45 – 16:45
This session will build on the morning plenary session and the work done in the small groups, allowing participants to take away concrete lessons and practical skills.

CONCLUDING REMARKS ~16:45 – 17:00
Pierre Sauvé, Director, Knowledge Transfer, CHSRF