



**NATIONAL INSTITUTE
OF CLINICAL STUDIES**

**Jean Slutsky – Getting Your Research Into Policy
Presentation Transcript**

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I gave a talk this morning about getting research into policy, but today, this afternoon, I'm going to talk about getting your research into policy, which is the converse of that. As researchers this is particularly important for you to make sure that the hard work that you're doing finds its way into policy, whether it's clinical, or policy writ large, which is regulatory policy or policy as it pertains to populations.

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So really it's like the blind man feeling the elephant. Everyone feels a different part of the structure. Whether you're a researcher, a regulator, or a policy maker, you all see the world quite differently, and that does end up to be quite a potential problem when you're looking at devising research programs that will be useful in policy making, as well as policy makers who are looking to find research that will help them make decisions on how they want to formulate policy for health care.

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There are many uses for evidence in policy making. Some of these may be more specific to the US, but I have a feeling that they cross boundaries between the US and other westernised countries, including Australia. Research is used in product approval in the US, when we approve devices, or drugs, pharmaceuticals. We use the best possible evidence for pharmaceuticals. There is a very tight policy for the types of randomized control trials that can be done. Also in the US we use research in terms of how we develop our formularies, how we make benefit and coverage decisions, so if you're an employee in the US on health care insurance, it's tied to your employee benefits. An employee benefit manager would look at what the evidence says about covering different procedures, or interventions, to decide whether or not that's part of your benefit package. We use evidence in developing clinical practice guidelines that often are translated into larger policy, as well as quality review and improvement on basing measurement on the best available evidence about what should be done, and measuring to see whether it in fact is done. Also when you're a patient, how do you choose a plan or a provider? Do you look and see whether that provider or plan has a good report card, do they provide high quality care? And finally organisational and management issues: in the US there's a fair amount of research going on right now on the best organisational and systems management to provide care in different health care settings. And finally, pay for performance has become a very attractive mechanism for improving quality of care, so paying a higher premium if you provide high quality care.

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These types of decisions fall into basically three categories. Public policy, which is do we fund heart transplants? Do we fund major costly procedures? Systems policy, where should these heart transplants take place? Should they be at centres of excellence? Should every facility have the ability to do heart transplant? In early years, in the 1980s when I was first studying health policy, one of the big issues in the States was who should have the ability to own a CT scan? Should every hospital have a CT scanning device, or should it only be a certain number of CT scans per population number? And clinical policy, who should receive heart transplants? What are the criteria for a patient to meet in order to have a heart transplant? So evidence can influence decision making at various levels, and these three levels are a good approach to see where your research can actually target a particular area.

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Having said that, there are lots of feelings that abound between researchers and policy makers, and policy makers generally don't have a lot of trust in researchers. They feel that they take forever to answer a question. They're extremely deliberative. You ask them a straight question, you know, what's the number of X in this setting, and you'll get a long convoluted answer, often that will include p values. It's very difficult to understand the research write-ups that they produce, very often not in lay language. They seem to work in a very rarefied air space, or ivory towers is something that's often talked about in the United States. Their ideas and their discussions seem irreverent to everyday real world decision making. You can never get a straight answer. I mean I don't know if this resonates with you, probably not, but I certainly sometimes feel uncomfortable when I read something like this, because you know in fact, I find myself saying to reporters often when they ask me questions, well you know, I wouldn't say that, because that's not exactly true, I'd like to put a qualifier there. Finally you know, if I ask you a question, do you answer it or do you answer a question that you feel like you want to answer. Oftentimes you will get a research finding that will have a huge impact on a policy or a community, and researchers may divorce themselves of those long term impacts of those research. One can say should a researcher be responsible for that?

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This just is a cartoon that many of us banty around the agency because when we tend to brief people – we call it the Hill, which is where Capitol Hill is in the US, where Congress is located, we're often hauled down there to speak to Congressional staffers which have an aggregate age of about 23. This 23 year old is sitting across from you, chewing gum, and their legs and crossed, and they're going okay, okay, okay, what's the bottom line, and you're just thinking God, is this how policy is made? I have so much to say! But it really is how policy is often made. It's – on certain levels, policy is made in a really fast paced, not very elegant way.

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So researchers on policy makers, we can kind of know where this is going, right? They don't ask intelligent questions. They don't – can't deal with uncertainty, they want the bottom line, I want to know exactly what the research says. They don't appreciate what influence this has on my "publish or perish". Most researchers in the US, and I suspect it's quite true here, that you're promoted on the number of publications that you produce. They want results now, they can't wait for the peer reviewed journals to publish the results, which can be six to nine months, sometimes longer, depending on the periodicity the journal publishes. And they expect me to drop everything to give

them the results. I mean they want me to stop whatever research I'm doing, and research what they want, and they want me to do it now. They want my results to tell them what they want to hear. They don't trust my results if they say something that they don't believe.

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So look at it from this point of view. If researchers ruled the world, you can kind of see where this is going, food in grocery stores would be alphabetised, so cornflakes would be next to croutons. Holiday sales would be advertised in peer reviewed journals, so you'd pick up your Journal of the American Medical Association and see that Kmart is having a blue light special. School room size would be directly related to numbers needed to learn. I say this kind of jokingly, but it's really two cultures that are completely different.

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So in search of well developed systematic review, enjoys good health, doing the right thing, and in search of a perfect partner to make things happen and enjoy life. And this is – I say this kind of jokingly, but one of the things I find most frustrating, and I have a lot of responsibility over development of systematic reviews, is how terribly difficult they are to interpret.

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So this is just a couple of sentences from a systematic review that we recently published, and it took me a while to get through this and see what is this saying. You can imagine if you're a clinician in a busy practice, and you want to interpret this quickly, or if you're even a public health person who has to make a broader, community-based decision, I mean this is almost incomprehensible. I mean it's very difficult to interpret. And that's one of the problems with systematic review, is it's a wholesale product. When I say wholesale, it's not in a position to be applied directly, unless you're very familiar with systematic reviews.

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So it's a challenge. Developing systematic reviews for people who don't do systematic reviews. We have this debate around my office all the time. About half of the people who work in my centre do systematic reviews. They are some of the best folks in the US who are doing systematic reviews, and then we say okay, you get with the public affairs folks, and you create a fact sheet, what does this review say? And it's the most painful process. It's painful for them intellectually to devolve these statements into meaningful sentences that have something that can be used by either a policy maker or a clinical decision maker, or even a patient when trying to determine what works and what doesn't.

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And for researchers it presents an even bigger problem, because there's not a lot of value in translating your research. I don't know how many of you are familiar with Carl Sagan, but there was a review done on the impact of his life, and particularly his popularisation of his science, and he was criticised most of his professional career because he popularised his science. It created something that was called the Carl Sagan Effect. I actually didn't even know what the Carl Sagan Effect was, I don't know if any of you do, but it actually was coined, this term, because he spent so much time on the Johnny Carson Show, the Tonight Show in the US, which is a late evening talk show,

talking about astronomy, and he became quite ubiquitous in American popular press as one of the scientists you would know if you were not a scientist yourself. People felt that he was failed, and that in fact you could be tarnished with the Carl Sagan Effect if you did similar things, where you talked to the press, or you talked about your science in lay terms.

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In fact Carl Sagan was anything but a defunct scientist. He actually published one scientific peer reviewed article a month throughout his career, and that's pretty phenomenal. I don't know about any of you, but that's pretty prolific to be able to publish in a peer reviewed journal one article per month. So this clearly had no impact on his ability to produce scientific evidence in scientific, respected journals.

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So this sociology of systematic review goes on to say:

Popularisation is traditionally seen as a low status activity, unrelated to research work, which scientists are often unwilling to do and for which they are ill-equipped. Essentially, popularisation is not viewed as part of the knowledge production and validation process, but as something external to research which can be left to non-scientists, failed scientists or ex-scientists.

Well that pretty much says it all. And then when you look at the academic research enterprise, and we know how you get ahead from being an Assistant Professor to an Associate Professor to being a full Professor, it has a lot more to do with how you publish and how many grant dollars you get, than actually how you popularise your science.

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So some tips for getting research into policy. These come from a health services researcher in the US named Mitch Greenlick, and he was a health services researcher for 30 years before he ran for State Senator in Oregon, so his tips I think are well taken. He says to start asking the questions – or the answer years before being asked the question. So really what this says is do horizon scanning. Look to the future, try to find out what those big policy questions will be three or four years from now, so when you're asked the question, you're almost there to getting the answer. And it's really phenomenal, but public policy is driven in a way that we can pretty much chart. I mean the things that we are dealing with now, if we look ahead, probably weren't that much of a surprise, but oftentimes we don't take the opportunity to research things that are just on the cusp, or before they penetrate the system. So it's good advice to be on that edge, to be on that precipice, and to look forward to what those important questions will be from policy makers, so you can be there when they ask the questions.

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And remember the difference between being an advocate and a policy expert. No one wants – I mean policy makers are inundated by lobbyists, and I don't know, I can't speak to Australia, but oftentimes policy makers in the US hear more from lobbyists because they make it an art to come to a policy maker, they drill down, they get the information in very useable bites, they're very, very good at making sure that the information they want the policy maker to get is easily digestible. And it's very important that scientists don't lose – and again I don't mean to prejudice us – but don't lose the battle with people who

are not using the best available evidence to get to policy makers. So I think it's very important that we learn how to communicate science and our research to people who can only take it in certain ways. We can't expect more of policy makers than they can give. I mean they're confronted with such a heterogeneous group of decisions over a very short period of time, that how they take in information is just the way it is. Trying to change how they take information in is probably a lot less valuable than how – our changing how we give them information.

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And I like this one a lot. Remember the difference between a point estimate and a confidence interval. And this is – let's say a policy maker says Jean, what's the number of uninsured in the US. Well, it's 36 million give or take 12 million, depending on if you're doing it in June or July when employee benefits seem to change. Mitch says, it's 43 million. At any given time, it probably is 43 million, and it's not going to matter if you're off by 12 million and then the next month it's up by 12 million, and the next month it's down by 12 million. He's really talking about giving a number that is workable for policy makers. It's fine enough for them to make decisions, but isn't equivocated by the uncertainty that it is at any point in time. So I think that's really an important take home message.

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This last one is do not show off, and I say that a bit tongue in cheek, but I know that I've been kind of an idiot giving briefings before, and my guess is that some of you, and I don't want to say all of you or one of you, but some of you have probably been idiots talking to a policy maker thinking that they're stupid and dumb. We talk to them in a way that we don't appreciate their needs and their understanding. So one of the things that I think is important is to be humble. Humble pie is difficult to eat and difficult to swallow, but I think it's a very good thing to do, and he felt very strongly about this. This is a Health Services Research article, and if you ever get a chance to read the article, it's actually quite interesting as he describes young researchers oftentimes who go before policy makers and try to get them to understand, and their voices raise, and they shout, and then they leave the room talking about how stupid these people are, when in fact they're quite smart, they just live in a different world.

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This is a quote from the same article. This gentleman, Bruce Goldberg, actually worked in a State Senator's office. His take was he's gotten lots of calls from health services researchers, and they want two things: data and money. But he has – he's only gotten calls from two researchers who asked what they can do to inform state health policy. In the US that's pretty remarkable, because all of our universities are funded by State dollars. So it's pretty amazing that we have 50 states, all of which have huge, giant health policy problems, and they don't turn to their universities for help. In some studies I've seen it's ranked 15 out of other sources of information, none of which are as credible as universities. So – and again, I don't know if that situation is similar here in Australia, but tying that link between you as researchers and policy makers at the Government level or the community level is critically important, because I bet you've got the best information. It's certainly the less biased, and it's better for them to get the information from you than from pharmaceutical companies, which may have good information, but it's probably biased toward their product.

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So just a diagram to illustrate what I'm talking about. Research has generally been what I call supply side. Somebody comes up with a question, you develop a hypothesis, you try to get funding, you do a study, and you know, there might be someone waiting to get that answer, there might be a receptor site, but it may never happen at all. It just might go away, it's a nice citation in Pub Med, it may help you get another research grant.

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So my plea is to make sure that the work that we do in health policy, and that we do in generating evidence for good decisions, doesn't get lost in translation. I thank you for allowing me the chance to give you some of the benefit of what we've done in the United States to try to bridge the gap between health services researchers and clinical researchers and policy makers and other decision makers, and I'd be happy to answer some questions before your plenary starts at 1.