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

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ABSTRACT

The knowledge-practice gap in public health is widely known. The importance of using different types of evidence for the development of effective health promotion has also been emphasized.

Nevertheless, in practice, intervention decisions are often based on perceived short-term opportunities, lacking the most effective approaches, thus limiting the impact of health promotion strategies. This article focuses on facilitators and barriers in the use of evidence in developing health enhancing physical activity policies.

Data was collected in 2012 by interviewing 86 key stakeholders from six EU countries (FI, DK, UK, NL, IT, RO) using a common topic guide. Content analysis and concept mapping was used to construct a map of facilitators and barriers.

Barriers and facilitators experienced by most stakeholders and policy context in each country are analysed. A lack of locally useful and concrete evidence, evidence on costs, and a lack of joint understanding were specific hindrances. Also 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.

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1. Introduction

It is well acknowledged that the use of robust evidence to inform public health policy is likely to ensure the greatest and most equitable population health gains [1,2]. Increasing focus on evidence-informed public health in which next to different sources of research evidence contextual factors also play a substantial role in the decision making process [3] and has numerous direct and indirect benefits. Among these are access to more and higher quality information on what works, a higher likelihood of successful programs and policies being implemented, greater workforce productivity, and more efficient use of resources [4]. Nevertheless, in practice, intervention decisions are often based on perceived short-term opportunities, lacking systematic planning and review of the best evidence regarding effective approaches [4] thus resulting in slow uptake of research evidence in practice. It has been estimated that it takes an average of 17 years for 14% of research to translate into practice [5]. More recent results show that even in clinical practice which is supposed to be more evidence oriented, the uptake of evidence has not changed substantially since then, indicating that the gap between evidence and practice has not diminished substantially [6]. Generally in public health policy making the use of research evidence is less than anticipated when considering the extensive availability of research evidence. While research evidence on effective health enhancing physical activity (HEPA) policies and interventions is available, it appears not to be optimally used to inform health related policy development [7–11]. A multitude of factors that impede (or facilitate) evidence-informed policy making exists resulting in below optimal health outcomes when implemented. Literature shows that specific contexts and traditions, political priorities, individual beliefs and preferences, social values, and available resources all play a major role [12,13]. Among these factors three main categories can be distinguished. Firstly, easy access to relevant and useful research [14] also entailing timely access to good quality and relevant research evidence [15]. Secondly, frequent opportunities to interact with researchers [7] including collaboration and networking with policymakers [15]. Thirdly, working in research receptive organizations [16,17] facilitates evidence-informed policy making.

The updated systematic review on barriers and facilitators of evidence use in policy making by Oliver et al. in 2014 [15] concluded that over the past 10 years these have basically remained the same and that it is difficult to find new perspectives. Some recent research however points in the direction of personal relationships and policy makers' networks as well as differences in contextual factors to be of utmost importance in relation to improving the uptake of evidence in policy. Policy makers appear to have a need for and also use a much wider range of information sources than research evidence and they access most of these through personal contacts [18]. In addition, policy makers' relationships within networks and characteristics of the organizational context such as the much neglected role of managers in policy decision making appears to be of great influence in evidence use [18–22]. Also studies with empirical data on interactions between stakeholders in policymaking report that the use of evidence in the policy process was difficult to trace or that the process itself appears to be rather closed [23–27].

Furthermore the literature shows that policymakers with respect to use of evidence need to pay attention to larger entities and multi-dimensional factors such as communities, municipalities, resources, politics and other factors as compared to for instance clinicians [21,28]. This makes use of evidence by policymakers much more complicated and may be the reason that the extent of evidence use by them is lower in comparison to clinicians who focus on one specific issue only, i.e. the physical condition of the individual patient.

Despite several decades of work on evidence informed policy, the goals to improve evidence uptake and promote greater use of evidence within policy making are still elusive. Recent literature warrants more research on evidence use by policy makers through interaction and personal contacts, relationships within networks and the complexity and varied context of policy making.

In 2011 the European Commission (EC) funded the Research into Policy to enhance Physical Activity (REPOPA) project. One of its aims was to study the extent to which EU member states use research evidence and other kinds of evidence in HEPA policies and what promotes or hinders the uptake of research evidence in the policy-making process of HEPA policies [25]. The general aim of the project was to facilitate the integration of research evidence to stimulate more evidence-informed physical activity policies. The aim, design, methods and preliminary baseline results of the overall REPOPA—(www.repopa.eu) project are described by Aro et al. [25]. Preliminary results show that supportive institutional resources, access to applicable context-relevant research evidence, media attention, good personal relationships and networks, joint language and collaboration between researchers and policy makers were found to facilitate the use of research evidence. Barriers identified were related to non-supportive institutional management, lack of easy access to best available evidence, limited contacts between administrative personnel, experts and researchers [25].

The aim of this article is to further explore barriers and facilitators in the use of research and other evidence in developing HEPA policies from six EU countries using semi-structured interviews conducted with key stakeholders as part of the REPOPA project. More specifically it focuses on aspects that (local, regional or national) policymakers and other stakeholders in different European contexts experience as most influencing in the uptake of evidence in real-life policymaking processes.

2. Methods and design

In the REPOPA project 21 HEPA policies were identified across six European countries (Finland, Italy, Romania, UK, The Netherlands and Denmark) (for details see Ref. [24]). They varied significantly across countries-. The policies were almost always part of a broader (public) health care or sports policy. In each country a national and a regional/local level policy was selected where available (not all countries had policies at both level). Semi-structured interviews