

# Notes from the Editor-in-Chief

As I was reading and thinking about the contributions to this issue of *Healthcare Papers* focused on collaborative policy making, one of my favourite quotations kept coming to the forefront of my mind: “In the long history of humankind (and animal kind, too) those who learned to collaborate and improvise most effectively have prevailed.” If you do a quick search for this uplifting statement online, you will most likely be told that its author is none other than the renowned British scientist Charles Darwin. Alas, dig a little deeper, and you will learn that the attribution of this quotation to the father of evolutionary theory is almost certainly an error (Darwin Correspondence Project 2011). Nobody, it seems, actually has the foggiest who first uttered or inscribed this pithy observation!

*“In the long history of humankind (and animal kind, too) those who learned to collaborate and improvise most effectively have prevailed.”*

While I still quite like the quotation and believe it holds a lot of water, the facts of its murky origins and ubiquitous copycat attribution to Darwin also – in a pleasingly inverse sort of way – speak to collaboration’s deceptively simple appearance versus its much more complex actualization. That is to say, while just about everyone in healthcare, business, government and academia (and even your

local coffee shop) sings the praises of collaboration and urges lots more of it to take place, actually *making collaboration happen in practice* is a far from straightforward enterprise.

An exploration of the benefits and challenges facing collaboration in health policy making is the focus of this issue’s lead paper. Toward the end of their discussion, Ronald Lindstrom, Stuart MacLeod and Adrian Levy (2011) conclude that the “essence” of their argument is that “*research should inform practice and practice should inform research*” (emphasis theirs). Acknowledging that neither has happened on a consistent basis, the authors call for a “new strategy” that “encompasses the interdependence of research and practice and respects different kinds of knowledge and the needs and capacity of all stakeholders.”

The main stakeholders Lindstrom, MacLeod and Levy have in mind are government, academia and health authorities – these are the ones that must be able to collaborate in order to set priorities and coordinate health research, knowledge translation (KT) and policy making. Getting in the way of such collaboration, they argue, has been our emphasis on “structural change in health services delivery.” Rather, we ought to be attending to “the domains of people and process”; with regard to people, the authors stress the need to reconceptualize *relationships* – most importantly, between health services researchers and policy makers.

Lindstrom, MacLeod and Levy illustrate their contentions by via brief references to British Columbia’s Ministry of Health Services and Provincial Health Services Authority. In the former, greater coordination and collaboration between health authorities

and academic health sciences appears promising; in the latter, there has been increased emphasis on translating knowledge into practice. While these examples are thin on detail, they provide some real-world context for the more esoteric discussions that follow of such things as complexity science, participatory action research, KT and the study of “knowledge boundaries” and “boundary objects.”

Where I found some of the strongest traction was in the authors’ more extended discussion of efforts in British Columbia to lead and manage health system change by focusing on the boundaries – interfaces or borders – between “the myriad of stakeholders involved in the health system.” Specifically, the authors detail efforts by the province’s General Practice Services Committee “to bridge knowledge boundaries.” In plainer words, innovation is being driven by ensuring active engagement of multiple stakeholders early in the development of policy, service and system change.

The first commentary on this issue’s lead paper asks why, despite the “wealth of evidence and support for its use,” Canada is still beset by “poor translation of research evidence into policy”? In their quest to understand this paradox and to offer solutions, Adalsteinn Brown, G. Ross Baker, David Klein and Jeremy Veillard (2011) argue that new roles, structures, vehicles and behaviours are not required. Rather, they put forward two propositions.

First, the authors contend that the use of evidence ought itself to be made a policy, and that the focus should be on translating “collections of evidence” rather than from individual studies. In this regard, KT would become “part of a synthesis activity,” one that would involve “encouraging” researchers “to frame their findings around policy questions.” While I find this a tantalizing suggestion, I have to wonder how comfort-

able most academic researchers would be with such policy-oriented “framing.” I am rather more optimistic about the viability of the authors’ second suggestion: we should, they say, include in our policy-focused knowledge gathering and management evidence that is produced outside post-secondary institutions, hospitals and ministries.

Brown and his colleagues conclude by arguing for the measurement of “the proportion of policy with evidence and the proportion of evidence without policy.” Such analysis, the authors assert, would help to increase the value gained from investing in evidence creation. Again, though, my practical self wonders just how the “stronger hand” of management they envision could ever cohere such a large number of independent-minded individuals and organizations.

Whereas Brown and his co-commentators propose policy making itself as a way to engender better policies, Carol Herbert and Allan Best (2011) say that fruitful collaboration of the kind the lead authors encourage “must begin with the convergence of two driving imperatives: the need to ground partnership in shared values and the need for systems thinking.” Focusing on what they label the “necessary partnership” among academia, government and health services, Herbert and Best devised a six-point framework that sets out the six principles for action they believe are essential for implementing a beneficial “value chain.” There is much to admire in the authors’ value-driven approach – in particular, their emphasis on “social responsibility.” I am not always clear, however, on the actual processes they imagine would be involved in the “centrepiece” of their model: implementation. I am sure that Herbert and Best are right that values matter, but more needs to be done to understand their role in the “boundary” transactions Lindstrom, MacLeod and Levy address.

The next few commentaries step away from theoretical considerations. Instead, they present views anchored in personal experiences with policy making. Renaldo Battista (2011) argues that “a central piece of the therapeutic puzzle is missing that would ensure the cohesiveness of the initiatives” Lindstrom, MacLeod and Levy advance: that is, an “intermediate” health technology assessment (HTA) organization that would “generate scientifically valid evidence in response to specific questions.” There might be a kinship here with Brown and his colleagues’ recommendation that researchers frame their findings around policy questions; however, Battista goes a bit further into the realm of praxis by suggesting that “greater forums for exchange” (e.g., a pan-Canadian network) and more powerful channels of KT communication are required.

For her part, Patricia Martens (2011) draws on lessons from the Manitoba Centre for Health Policy to point out that the kinds of relationships advocated by Lindstrom, MacLeod and Levy require significant time, money and institutional commitment. Thinking largely of the role of universities in collaborative research and KT networks, Martens argues that “integrated” KT “implies user involvement in research from start to finish” (a proposition, incidentally, that is quite familiar in the HTA world). But Martens also adds the caveat that while boundary crossing is a noble objective, we must be cautious not to erase the borders that distinguish researchers from policy makers. Not unlike the lead authors, though, Martens asserts that “relationship building” is essential for positive collaboration; however, unless universities value and reward those sorts of relationships, not much will be accomplished.

For the sake of clarity and persuasion, most of the contributors to this issue presented approaches that are broadly

prescriptive. I therefore found valuable Diane Watson’s caution that no one strategy will ever suffice for every project – or even for every part of a single project (Watson 2011). Advancing collaborative policy making, she says, requires clarifying roles, responsibilities and “rules of engagement” at the individual project level. Not unlike Martens, Watson concludes that the “different kinds of knowledge” and roles of policy makers and researchers require us to “be clear about and respectful of the boundaries” between them, thus acknowledging that “interdependence, dependence and independence” can all factor in to these complex relationships.

While Martens and Watson see value in maintaining boundaries, Hugh MacLeod (2011) takes a rather contrary view. Arguing that the boundaries spoken of by the lead authors are in fact “the silos of research, policy and operations,” MacLeod proposes that it is only by asking “wicked questions” – ones that unearth the “embedded and often contradictory assumptions” in policies and systems – that we will succeed in bringing about the necessary “horizontal connectivity and integration between the silos.”

Perhaps it is in Duncan Sinclair’s commentary that we find a productive middle ground on the boundary dispute: “make the boundaries thinner and more permeable” so as to engender “mutual respect, co-operation and collaboration” (Sinclair 2011). Easier said than done, of course, as Sinclair admits. For him, the lead authors miss an opportunity to go beyond theory and to explain how real change can occur, and one of the related shortcomings in their argument, he remarks, is the absence of patients in the picture. Where Sinclair does concur, however, is in the role values – especially as they are manifested in politics/Politics – play in inhibiting change and reinforcing boundaries’ “relative impermeability.” In this respect, I would be

deeply intrigued to listen in on a conversation among Sinclair, Herbert and Best as they puzzle out the mechanics of operationalizing values in collaborative policy making.

One of the recommendations that Lindstrom, MacLeod and Levy made that really hit home for me was their advice that successful transformation will occur when we link strategies to people to operations. The final piece in this issue of *Healthcare Papers* is less of a formal commentary and more of a case study, casting light on the merits of that insight. Joanna Nemis-White and seven colleagues explain a recent initiative at the Cape Breton District Health Authority, whereby that organization surveyed primary care providers in order to gain information that would contribute to developing evidence-based strategies that support practitioners and patients (Nemis-White et al. 2011). While it uses language that is far removed from the theoretical discourse of Lindstrom, MacLeod and Levy, the “collaborative” and “inclusive” approach documented here leads me to believe that, in fact, research-informed policy making can – with the right time, methodologies, funding and attitudes – be more than a fond aspiration.

Peggy Leatt, PhD  
Editor-in-Chief

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