CSIRO PUBLISHING

HEALTH POLICY

Australian Health Review, 2021, 45, 74–76
https://doi.org/10.1071/AH21016

Perspective

A purple patch for evidence-based health policy?

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Abstract. The global focus on nation states' responses to the COVID-19 pandemic has rightly highlighted the importance of science and evidence as the basis for policy action. Those with a lifelong passion for evidence-based policy (EBP) have lauded Australia's and other nations' policy responses to COVID-19 as a breakthrough moment for the cause. This article reflects on the complexity of the public policy process, the perspectives of its various actors, and draws on Alford's work on the *Blue*, *Red* and *Purple* zones to propose a more nuanced approach to advocacy for EBP in health. We contend that the pathway for translation of research evidence into routine clinical practice is relatively linear, in contrast to the more complex course for translation of evidence to public policy – much to the frustration of health researchers and EBP advocates. Cairney's description of the characteristics of successful policy entrepreneurs offers useful guidance to advance EBP and we conclude with proposing some practical mechanisms to support it. Finally, we recommend that researchers and policy makers spend more time in the *Purple* zone to enable a deeper understanding of, and mutual respect for, the unique contributions made by research, policy and political actors to sound public policy.

Keywords: clinical practice, evidence-based medicine, evidence-based policy, health research, knowledge translation, policy makers, public policy, research evidence.

Received 12 January 2021, accepted 12 January 2021, published online 1 February 2021

The global focus on nation states' responses to the COVID-19 pandemic has rightly highlighted the importance of science and evidence as the basis for policy action. Actors with a lifelong passion for evidence-based medicine (EBM) and evidence-based policy (EBP) have lauded Australia's and other nations' policy responses to COVID-19 as a breakthrough moment for the cause.

This article reflects on the generalisability of EBM to EBP, the complexity of the public policy process, the perspectives of its various actors, and proposes some guidance for progressing a more nuanced approach to advocacy for EBP in health.

The impact of the EBM advances of the 1940s onwards and subsequent emergence of EBP in broader areas of public policy is well described by Baron.[1] EBM has progressed beyond its early focus on tiers of evidence, randomised control trials, systematic reviews etc., to extensive work in knowledge translation,[2,3] to institutional arrangements that enable it, and more recent applications in the form of value-based health care. A good exemplar of evolved EBM/EBP in health is Australia's Pharmaceutical Benefits Scheme.

So why can't we let the evidence and science speak for itself and similarly shape EBP in other areas of health, as EBM has shaped clinical practice? There is good reason to suggest that it is unlikely to be the case. We argue that although sound evidence is essential for EBP, it is but one element in the delivery of public policy.

The pathway for translation of research evidence into routine clinical practice is relatively linear. The Translational Cancer Research Network[4] outlines a pathway of three stages: T1 – developing treatments; T2 – testing efficacy/effectiveness; and finally, T3 – dissemination and implementation research. Although there are obstacles to progressing through these stages to T3, there are effective strategies to address them. The actors engaged in translation are typically clinicians and consumers, with both able to exercise significant degrees of agency in the process.

The pathway for translation of evidence to public policy follows a different, non-linear, more complex course – much to the frustration of health researchers and EBP advocates. While it draws strongly on T4 research, i.e. population level, real world evaluation and cost benefit analysis,[5,6] the engagement required for national public policy translation is via a different set of actors, with different considerations to address. The role and centrality of evidence and the weight applied to its economic aspects is one key area of difference. State governments' service delivery role versus the federal government's convening, international engagement and economic responsibilities is another differing perspective. The mechanisms for discourse and narrative among various actors required to bring it to life is yet another. The substantial literature base that explains the latter process lies more in political and social sciences, less in health and medicine.

Let us consider the actors in public policy at the national level. First, the Executive arm of federal government – Prime Minister, Ministers and Cabinet – consists of politicians who are ultimately accountable for public policy choice, design and execution. Second, the Administrative arm of government consists of the policy practitioners – i.e. public servants – whose role it is to provide advice, synthesise and contextualise evidence, and manage the essential administrative machinery to enable the elected government to deliver on its policy program.[7]

Those seeking to influence public policy may wish to consider the interplay between its principal actors. Alford *et al.*[8] describe their respective, distinct roles in terms of 'zones' in which they operate.

Politicians inhabit a *Red* zone, focused on the authorising environment of its election policy platform, licenced by public mood; an endless, competing list of societal problems to respond to (or not); timeframes for policy action and outcomes that extend beyond their approved terms; and a normative and narrative role to publicly and instantaneously explain and enact highly complex solutions within the context of interests of parties affected by them and prevailing societal values.

Public servants inhabit a *Blue* zone, a more neutral world; performing a cognitive role of assembly, synthesis and distillation of complex evidence; preparation of options and proposals for decision and implementation; the management of risk; adherence to lawful practice; and of course the smooth operation of government services.[9]

Both the *Red* and *Blue* zones are real, and we argue equally valid and important spheres of activity and influence in the public policy process. In reality, actors work across both zones and Alford *et al.*[8] describe a *Purple* zone where the *Red* and *Blue* zones of the respective public policy actors' interface. It's a shared space where the different perspectives of actors must align and combine to deliver the policy outcome.

The Australian COVID-19 response at critical times displayed this *Purple* zone on an almost daily basis. Australian policy (*Blue*) actors' perspectives of evidence, and political (*Red*) actors' perspective of narrative morphed to deliver essential, sometimes unpalatable but successful prescriptions for action.

Other nation states' *Purple* zones were arguably less effective, some with catastrophic results. Mintrom and O'Connor's[10] timely case study of four US states' responses to COVID-19 underscores the critical importance of combining evidence with consistent narrative.

Advocates of EBM and its prized variant, EBP, may wish to draw guidance from the *Blue–Red–Purple* zones analogy. We argue that the world of evidence production in health and medicine is another type of *Blue* zone, with its unique operating environment and norms, and society is well served by it. However, its ideas do not always easily speak for themselves, and even when they do, can be insufficient for pragmatic public policy application. Evidence does not trump its extrinsic explanation and multiple perspectives must be reconciled. The narrative required to birth ideas into action requires the researcher to enter, engage, understand and acknowledge the *Purple* zone of the policy makers.

Kingdon[11] espoused the Multiple Streams Approach (MSA) to public policy, which consists of Problem (definition), Policy (solution), and Politics (motive and opportunity) streams. In MSA, each stream can (and frequently does) operate in isolation from the other streams. Policy action is not affected until alignment across the three streams occurs, no matter how well or longstanding the problem and its solutions are established in evidence. Mandating hand hygiene and mask wearing in the COVID-19 context is a current exemplar of MSA alignment.

Cairney[12] delivers a masterclass on the 'successful policy entrepreneur' which we recommend for all health EBP advocates. We paraphrase here:

1. *Make the time and effort to understand how policy agendas are set* – the story and framing of the problem are as important as its underpinning evidence;
2. *The policy solution needs to be ready (and explicable) well before the policy makers even turn their minds to it* – the researcher's solution must have been socialised, networked, war-gamed and simply explained across multiple actors' perspectives;
3. *The* '*window of opportunity*' *or timing for policy attention can be both unpredictable* [think COVID-19] *or predictable* [think electoral cycle] – there is both a long game and short game to be played to respond to the necessary timing for policy action.

Finally, we recommend spending more time in the *Purple* zone to make it all happen. Enduring mechanisms for systematic *Blue–Red* engagement through formal organisational partnerships, ongoing staff secondments, multidisciplinary learning opportunities, mature citizen engagement approaches, and career paths that straddle the research and policy spheres can help make this happen. A deeper understanding of and mutual respect for the unique contributions made by research, policy

and political actors to develop, implement and explain sound public policy will be its essential underpinning.

Competing interests

No competing interests declared.

Acknowledgements

This manuscript benefitted from discussion at an Australian Harkness Alumni Forum on 29 September 2020. This research did not receive any specific funding.

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