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Le Réseau de liaison et d'application de l'information sur la santé

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Bridging the gaps: Improving interaction between researchers and decision makers

An example from the health care sector

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FOREWORD

HEALNet is a national network of researchers from disciplines throughout the health, social and applied sciences, focusing on decision making in health care. Its objective is to optimize the use of research information in decisions. The HEALNet Regionalization Research Centre, located in Saskatoon, is one of HEALNet's programs. The goal of the Centre is to provide an avenue for regional health authorities to meet their research needs in relevant and helpful ways. The Centre also promotes the study of regionalization as an innovation. The Centre's research program is designed in collaboration with decision makers in regional health authorities and other health care planners.

The Centre was established in July 1999, emerging from the former HEALNet Regional Health Planning theme. The Centre has a continuing commitment, begun in its first phase, to improving interaction between researchers and decision makers. This paper is a review and commentary on this aspect of the program's history. As former coordinator and current director, I believe it is important that we share and build on those experiences, in order to improve our practice.

I would like to thank the participants of HEALNet Regional Health Planning theme for their contributions to the program's development over the last three years — researchers, decision makers and others associated with the program. A specific note of appreciation is extended to Steven Lewis, former RHP theme leader, for his contributions to both the program and to this paper. I would also like to thank staff of the Health Services Utilization and Research Commission who provided comments on earlier drafts of this paper.

Interaction between researchers and decision-makers is an important topic for health care policy. We still have much to learn. I encourage readers to communicate to us your comments and opinions.

Denise Kouri
Director
HEALNet Regionalization Research Centre

HEALNet's aim is to better the health of Canadians by improving decision making at all levels in the health care system and in the workplace. The Network's research focuses on enhancing the use and utility of information in health care decision-making – from analyzing information needs to developing strategies and tools to facilitate effective information use and assess performance. HEALNet collaborates with health care decision-makers and other private and public sector partners to facilitate the transfer and uptake of its research.

HEALNet is a member of the federal Networks of Centres of Excellence (NCE) Program, a unique partnership among Canadian universities, Industry Canada and the federal research granting councils. The Network receives core funding from the Medical Research Council of Canada (MRC) and the Social Sciences and Humanities Research Council of Canada (SSHRC).

HEALNet's national administrative centre is at McMaster university in Hamilton. http://healnet.mcmaster.ca/nce

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INTRODUCTION

What is bridging? Why does it matter?

HEALNet's objective is to optimize the use of research information in health care decision making. Literature on research uptake informs us that one way to do this is to achieve closer interaction between decision makers and researchers (Webber, 1991-92). Decision makers do not generally seek research-based information to support every decision they make. However, the probability of use is increased if the information presented is coherent and clearly relevant to issues at hand. And the probability of research being relevant in both content and form is higher when decision makers and researchers understand a question in the same way.

We know there is a gap between the worlds of decision makers and researchers. There are different cultures. At times, the difference takes on an adversarial aspect — an *us vs. them* attitude. Bridging the gap requires knowing the terrain on either side. Researchers must come to understand the context in which decision makers operate and the pressures they face. How can decision makers be better served by what researchers have to offer? On the other hand, decision makers should be more aware of the support researchers require to carry out satisfactory work. Knowing the needs of each group contributes to developing effective interaction.

There is a widespread presumption that decision makers must become consumers of research findings in order to become better decision makers. However, our view is that we should avoid both marketing existing research products in a supply-sided fashion, on the one hand, and restricting research activities to marketable products on the other. It is preferable to improve understanding of the limits and potential of mutual environments, and thereby to create an agenda for research that will be relevant and used (Huberman, 1989).

Developing successful bridging strategies is an area of expertise in itself, which is increasingly the focus of research agencies who emphasize the *use* of research, as distinct from only its production and/or supply. This paper is intended to contribute to the knowledge in this area.

The three-year research project in which we were involved experimented with one method of bringing researchers and decision makers together. In this paper we describe and analyze that experience with the objective of identifying (1) the strengths and weaknesses of the method we used and (2) raising important additional questions about such collaboration.

Recommendations

Our paper concludes with these recommendations:

- Identify the conditions under which collaboration will be useful; and choose collaboration carefully.
- Build bridging expertise; and use this expertise to foster effective participation by both decision makers and researchers.
- Expect and plan for increased complexity and ambiguity introduced by collaboration
- Create several different mechanisms to enable decision makers to participate as their interests and resources allow.
- Counteract the structural disincentives to university-based researchers' participation in these kinds of collaborations.
- Reframe the research enterprise so that expectations about specificity and precision of results do not trump those about relevance and usefulness.

We elaborate on these recommendations in our discussion at the end of the paper, after describing the context and experiences that formed their basis. We first describe the HEALNet Regional Health Planning project, focusing on the aspect of decision-maker participation, and provide the views of the decision makers about the process. We then describe two examples of work in the field that relied heavily on researcher-decision-maker interaction. We augment our discussion with recent findings from a Canadian Health Services Research Foundation (CHSRF) workshop on researcher-decision-maker participation.

This paper is not a general description or evaluation of the project. We have chosen to sacrifice detail in the description presented here in the interests of focusing on and sharing what we learned about decision-maker involvement in research.

HEALNET REGIONAL HEALTH PLANNING

HEALNet Regional Health Planning (RHP) was a three-year research program studying regionalization and decision making in regional health authorities (RHAs). The program was located at the Health Services Utilization and Research Commission (HSURC) in Saskatoon, and focused on Saskatchewan RHAs. It was part of a national Network of Centres of Excellence project — HEAL*Net* — headquartered at McMaster University in Hamilton, Ontario.

The RHP focused on regionalization in order to increase understanding of its various dimensions. It also worked on developing decision tools for RHAs, as identified through consultation with six boards in Saskatchewan. The six RHAs were selected in the first year of the project (1996), to be representative of the 30 existing in the province at the time.

The RHP component was explicit from the beginning about its intentions to involve decision makers (Exhibit 1). The research design included collaboration with the six RHAs throughout the length of the program. The participatory approach enabled those who would potentially use the tools to inform their selection and development. It included RHA-level participants as key informants to the study of regionalization. The RHP also developed a relationship with Saskatchewan Health, a major actor in regionalization. A key question in regionalization is the degree of consensus among boards and the ministry on issues such as information requirements, the application of principles and tools to decisions, and the appropriate division of authority and responsibility.

The RHP's structure differed from that of a conventional research project. Several features were helpful in facilitating collaboration.

- It was structured as one program rather than a series of individual research projects. The program was funded and planned over three years. This created a more responsive and cohesive research team. They were not so committed to a specific, fragmented, preset agenda and could adapt the program to the decision-maker input.
- The program was hosted by an agency (HSURC), which had experience in establishing relationships with decision makers, and was already credible to Saskatchewan RHA decision makers. The HSURC Chief Executive Officer, Steven Lewis, was leader of the RHP program.
- In the beginning, the researchers built up general interest in the program with informational presentations and meetings.
- The program had fulltime research staff, with experience and expertise in collaboration and bridging.

Exhibit 1: Excerpt from the Regional Health Planning statement on culture, values and approaches, 1996

A participatory action research perspective

To a considerable extent the RHP program of research will be market-driven: the aim is to be useful to the participating boards (and eventually to all regional entities) by producing high quality, accessible research and decision aids. A key component of the research will be to get a full and profound understanding of board perspectives, priorities and dynamics. We will have to "get inside their heads, "both as individual board members and senior managers, and as collective decision-making entities.

In light of this, the program will succeed to the extent that we achieve a high level of participation and trust. The primary boards will not be just research sites responding from time to time to surveys and interviews. They will heavily influence the research agenda, select and prioritize decision-oriented items for testing and refinement, provide access to sometimes sensitive information, and evaluate the usefulness of both the program of research and the specific decision materials from the end-user perspective. If we are to meet these objectives, we will have to be responsive, sensitive, able to communicate clearly and adaptable to changing needs and priorities as the program unfolds.

We expect to conduct the research with methodological rigour, using both quantitative and qualitative approaches appropriate to the subject matter. Understanding the political and public policy dimensions of an evolving regionalization process will require observation, eclectic and creative data collection and both perceptual and objective information. This is not a program or research that will unfold algebraically. We cannot script all of the elements of the program in advance. Some data collection and analysis will have to be negotiated. We have built in mechanisms to ensure the smoothest possible unfolding of the research, but there will be unanticipated changes in direction and points of contention along the way.

The HEALNet Regional Health Planning Theme: Culture, Values and Approaches, 1996, pp. 2-3.

In addition to these structural features, the program had an advantage in being located in Saskatchewan. The province is known for its culture of cooperation. It is relatively small and people in the health field are more likely to be acquainted with each other. Another advantage for the program (though not for the province) is the relative lack of research resources in especially the rural regions. Participation in a research project is one way to gain access to such resources.

All of these factors likely encouraged all six RHAs to accept the invitation to participate. Five of the six accepted readily. One declined at first because the board felt it did not have the time or other resources to participate. However, it reconsidered within a month and eventually accepted.

Each invited RHA signed a memorandum of understanding that described the requirements of both parties. The process of agreeing to the MOU made the implications of the partnership more explicit for all parties. (See Appendix 1 for excerpts.)

The RHP researchers consisted of six initial principal investigators from academic and research institutions across Canada. One PI left the project after one year. Also associated with the program were the fulltime coordinator, a half-time research officer, and several academic researchers, graduate students and consultants working on different elements of the project over time. (See Appendix 2 for a list of participants.) Table 1 provides a list of the outcomes from the three-year project.

Table 1: Regional Health Planning — Major Activities and Products 1996-1999

- *Strategies For Informed Democratic Decision Making*: Course developed for health board members and managers: topics include evaluation; population health; performance; information and decision making; and ethics.
- Survey of Saskatchewan health care decision makers: board members, managers and Saskatchewan Health managers and policy analysts; topics included regionalization and the use of information in decision making.
- Case studies of two RHAs focusing on their community context.
- Publications on various topics, including the decision-making needs of RHAs and regionalization issues.
- Facilitation and education work with RHAs on analysis of data and evaluation.
- Education, presentations, articles for the health policy community in Saskatchewan and Canada about HEALNet and the issues of regionalization and decision making.
- Support for graduate students doing work in the area of regionalization.

DECISION-MAKER INVOLVEMENT

Needs Assessment

The initial phase of the research was an assessment of the decision-making needs of the six participating RHAs. Three key informants from each of the six underwent a semi-structured personal interview. These findings were collated into a preliminary framework that was reviewed by each of the six boards, chief executive officers and in some cases, senior managers. The framework was then revised and prioritized by a group of representatives of all six RHAs and Saskatchewan Health. The assessment formed the basis for the project's tool development plan.

Operations Committee

Following the plan development, a process was implemented for ongoing collaboration with RHA partners. An Operations Committee (OC), composed of two members from each RHA, along with a representative from Saskatchewan Health, was established to oversee the work of the project (Appendix 2). The committee met on average three times per year.

The OC's purpose was to oversee the research agenda and provide suggestions and feedback. Each meeting began with a round-table where members provided a brief account of the relevant issues in their RHA. The objective of the round-table was partly group building and partly information-sharing. Certainly for the researchers, this was a way of becoming familiar with the events and issues in the regions. According to their evaluations of the OC process, decision makers identified the opportunity for networking as one of the best aspects of the meetings and one of the main benefits they derived from serving on the OC.

We structured the OC agendas to ensure that the members both benefited from and contributed with their participation. Therefore topics discussed at the OC meetings included both opportunities for learning and the provision of feedback by the OC members.

What we learned from this set of interactions is that a minority, but no more than that, of decision makers is very interested in those projects whose outcomes are less immediately concrete or visible. On the other hand, only a small minority of decision makers could be described as opposed to participating. The bulk of decision makers is somewhat interested but very pragmatic in orientation. They will participate in projects where the return is obviously high enough in the short term. This implies that to reach decision makers, researchers need to widen their range of options for interaction. A repertoire is required.

Decision-Maker Opinions about the Process

At the end of the project, we asked the decision makers on the OC to evaluate the process. Members generally expressed positive views of the experience. None were negative; however, two members, neither of whom had been strong participants, did not return the questionnaire, so their non-response could be taken as an indicator that their view was not all that favourable. In general, the stronger participants on the OC — those who attended more regularly, discussed more, piloted workshops and hosted case studies — had more positive views.

We asked members about the value of the OC, first as an experience for themselves, and then in terms of what the project was trying to achieve. Most noted the educational value of participating on the OC, either because of the information transmitted by researchers or by the contributions of other decision makers. Members also valued the opportunity provided by the OC to share their own concerns with others.

About the value of the OC for the research project, the dominant opinion was that having such a group makes research more relevant to the real world. In the words of one person, "the OC helps the research to stay grounded and focused on issues that matter." One member referred to this as different roles: "The OC put a certain amount of reality into the discussion while HEALNet people brought a broader vision." Several members pointed out that such committees make decision makers more committed, because through them decision makers develop a vested interest in cooperating with research. One person offered, "Involvement equals support and ownership." Several members emphasized that being closer to the research provided them with a vision and a larger perspective, a place to consider new concepts. Finally, two members reported that the OC had provided knowledge about research and the research process.

We asked OC members to suggest improvements. One member suggested that there be a more focused role for the OC, perhaps with job descriptions. This member expressed the view that the OC members should have had more influence on the direction of the work. Another felt that there should be more recapping and summarizing of discussions. A third member felt that it would be better if participants were fully committed and attended more consistently.

Researcher Participation

Saskatchewan researchers attended all OC meetings. In addition, all principal investigators and research associates, including those from outside the province, met about twice a year in *theme* meetings, to review the agenda and

distribute the workload. There was only one meeting where all researchers and OC members met together. This was unfortunate, because one of the main rationales for having the OC — for researchers to have direct experience about the realities of the RHAs — did not materialize for the out-of-province researchers. These researchers depended on the theme leader and coordinator to transmit the reactions and feedback of the OC members, and this was less than satisfactory.

These experiences, along with some of the reactions by decision makers, as noted above, led us to the conclusion that there needed to be changes to the way we had structured the interaction. We needed to have a format that encouraged better interaction between decision makers and researchers.

INTERACTION IN THE FIELD

In preceding sections, we explained some of the interaction issues that arose from the RHP structure and process. In this section, we describe work in the field that relied heavily on researcher-decision-maker interaction. We present one example that we consider to have been successful and another example that was not.

It should be kept in mind that the RHP focus was on decision making at the governance and management levels. Decisions at this level are more complex and less technical. They are more likely to involve stakeholders outside the organization and be concerned with organizational accountability and legitimacy. Also the time that board members and senior managers have available for participating in research projects such as ours is less. These factors undoubtedly had an influence on the interactions.

Example One: Board-Management Workshops

One of the components of the original RHP plan called for the creation of workshops for board members and managers. RHP would develop and pilot workshops for RHA boards and managers based on their input and current research

The OC members were asked to check with their boards about their willingness to pilot such workshops. Four RHAs agreed, and a working group from each of them was formed to advise the RHP coordinator. There were several critical decisions to be made about how the courses should be delivered. The principles the working group formulated for the course, with their justifications, were:

- That both the whole board and the whole senior management team should attend. This would provide a team-building component.
- That the workshops should take place over a two-day period, preferably in a retreat setting, to contribute to team building and to have a better learning environment.
- That the workshops should be delivered in the RHA, to maximize the attendance of board members. The idea is that those who need it the most would be those least likely to attend such a workshop.

This delivery model differs from one generally used in the province, where a workshop is held centrally, in one of the urban centres, and individual participants attend. The HEALNet model promotes whole board and management participation, as described above, and the participation is exclusive to that RHA, so region-specific issues can be discussed. The workshop is developmental for the board and management as organizational entities as well as for individuals.

In the end, four workshops were developed dealing with the topics of decision making for RHAs in the context of their population health and community-oriented mandate. The courses were designed to build on decision-maker experience, as well as add new knowledge.

Ongoing participant feedback was incorporated into the workshop content. The workshop interaction was successful both as a way to pilot-test the workshop material and format, and as a way to involve decision makers. Using the working group in the early stages was a good example of how important it is to involve participants in the planning.

As the workshops were being piloted, and decision makers were being asked for reactions and ideas, there developed varying levels of interest among the participants. For decision makers, time is always at a premium, and the ability to participate in projects is therefore low, even when interest is high. Inevitably, interest varies within groups. Most participants, however, were quite positive about the process.

Although we consider the pilots to be a successful experience, they are limited as an example of researcher-decision-maker interaction. After all, this was overall an educational interaction. The *research* aspect of the pilot took second place to the *developmental* aspect. For example, in the early stages of the project some of the RHP researchers expressed the idea that it would be important to have a control or comparison group of RHAs who did not take the course, in order to be able to evaluate the effect of the course on decision makers and their decisions. However, as the project developed, the idea was abandoned in favour of a formative evaluation process — and improving the course as it was delivered, from one pilot RHA to another.

The workshops are an example of how producing something for decision makers can take researchers far away from the classical research mode. The needs and circumstances of decision makers do not easily lend themselves to controlled experiments. Research methods have to be more formative and naturalistic, and therefore, some degree of rigour is traded.

Example Two: Informed Consensus

In the fall of 1998, we asked the OC whether any RHA would be interested in piloting a tool being developed by a HEALNet researcher from the University of Montreal. The tool, called Informed Consensus, is a process for a local authority (any local board, not only a health board) to obtain recommendations from its *citizenry*. The process calls for the authority to formulate a question to which it would genuinely wish to be guided by the opinions of the citizens. The question is well documented to facilitate informed discussion, and a group of 15 citizens is selected to discuss it. The citizens are selected formally at random, and none must have direct material interest in the issue. The citizens are linked to a group of experts to answer any information questions they might have, and then are asked to formulate recommendations. There are guidelines as to how the citizen process should unfold, and the researchers, to ensure that the essential elements of the process are followed, facilitate the project. It remains the authority's right to accept or reject the citizen recommendations.

One RHA agreed to pilot the tool. There was a contentious resource allocation issue in one location in the region and the board thought the process of citizen engagement would assist it. RHP initiated the project, hired a facilitator, and arranged discussions and interviews. However, after a few months, it became clear that the informed consensus process was inappropriate for the needs and intention of the authority, and the researchers withdrew.

The experience, however, shed light on some of the issues regarding the difficulties of researcher-decision-maker interaction. First there were some logistical issues. The head office of the RHA piloting the tool was a three-hour drive away from Saskatoon (the RHP headquarters). The location in question was another hour away from the RHA head office. The main Principal Investigator for this project was from Montreal. So distance was a factor (and climate as well — the first two trips made by the Montreal PI happened to coincide with a blizzard, causing delays, meeting cancellations, etc.)

In addition to geographic distance, barriers related to culture and language arose. A rural Saskatchewan board member was cautious about how a francophone academic would be received in the community. Whether or not the caution was warranted, the board member's anxiety was a factor to be dealt with. Language was also an issue with respect to communication — most of the documents describing the process were in French. We describe these

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Exhibit 2: Excerpt from correspondence between HEALNet RHP coordinator and the piloting RHA board, explaining the RHP decision to withdraw from the informed consensus project.

In the meantime, however, the situation in the district has changed. While the facilities question has not been definitively decided, it now appears as if the course is relatively clear and there is little likelihood that citizen discussion would influence the outcome.

Further, it would appear that with budget constraints, there will in all likelihood not be much latitude for enhanced services or programming in Central Butte.

Given these two changed circumstances, we believe it is no longer advisable to carry on with the project the way it was originally designed. The informed consensus project should be built around a relevant question which the board is truly interested in exploring with its constituents, and to which the board has the latitude to respond. I think you will agree that the latitude is not there in this case. The exercise will therefore not be very meaningful, and has the possibility of wasting citizens' and others' energy and time, raising expectations that cannot be met and fueling cynicism about participatory process. From a purely research point of view as well, using the tool in inappropriate circumstances reduces the potential success of the pilot.

RHP correspondence, 1999

problems not because we think they were unique to the project, or insurmountable. We describe them to make the simple point that there is always extra planning and resources required when dealing with a relatively more uncontrolled environment.

The more problematic issue was the difference in goals between the researchers and decision makers. The RHP selected the informed consensus process for piloting because of the nature of the interaction among experts, citizens, and board. They felt that the process had potential for enhancing the use of information in decision making where citizen and community engagement were important factors. In such situations, keeping constituents satisfied is often perceived as an *exchange* for judicious and informed decisions. Informed consensus attempts to make this less of an exchange by simultaneously educating the citizenry and educating the board about the citizenry.

Because of its potential, researchers believed this process to be important to develop and study. For the RHA, however, it was more important to resolve the issue at hand. Timing was critical — the RHA had provincial government deadlines to meet. RHA members were therefore not always patient with the process. They were patient with it to the extent that they recognized that time is required to achieve good citizen participation. However, they were less patient with time required to meet research needs. In the end, the timeline issues won out.

Evaluation was a related issue. From the researchers' point of view, it was very important to evaluate and document the process. That is, after all, the *research* part, the part that would generate new and generalizable knowledge. This was less important from the RHA's point of view, in which there was more interest in the service that could be obtained in this particular case.

In the end, HEALNet withdrew from the project because the environment was not conducive to proper testing of the tool. The excerpt presented in Exhibit 2 (facing page) from correspondence between the project coordinator and the piloting board explains the decision to withdraw.

The example shows how this kind of work requires negotiation. Researchers give up some control of the agenda. From the researchers' point of view, the pilot represented an opportunity but also demanded additional resources and skills. They needed to adapt to and adjust for the RHA's needs as much as possible to make the project function, while retaining those principles of the process, the loss of which would make the project useless from a research point of view. In the end, the balance could not be achieved, from our point of view, so we withdrew.

COMPARATIVE EXPERIENCES

Researcher-decision-maker interaction is a current topic of analysis in the health policy field. In February 1999 the Canadian Health Services Research Foundation (CHSRF) convened a national workshop to explore issues in linkage and exchange between researchers and decision makers. It brought together over 100 researchers, research funders and decision makers from across Canada. Many of the issues they identified are similar to those we have identified here. The left side of Table 2 presents a series of challenges to linkage and exchange as identified by the workshop participants (CHSRF, 1999). The right side of the table shows where the experience of RHP corroborates the items on the list.

Table 2: Challenges to Linkage and Exchange — Comparative Experiences

ISSUES IDENTIFIED BY CHSRF WORKSHOP PARTICIPANTS	RHP EXPERIENCE
FOR RESEARCH ENVIRONMENTS	
Time and Timelines	
• not enough time given current workloads; finding commonly available time to meet	This is especially true for an interprovincial collaborative project, when travel requirements make meeting arrangements more time-consuming, costly and inflexible.
• not enough lead time from funding agency for development of linkage	The program design of the RHP project allowed for the development of the linkage. It has become more of a problem in the renewal phase, where the program approach in HEALNet is less supported.
• decision makers often need results faster than the research process can produce them	This was true in several instances. We should not conclude from this, however, that the difficult time-consuming projects should not be worked on. On the other hand, working on them without working within decision-makers' timelines and/or negotiating a compromise would be useless.
Multiple decision maker partners	
• resource intensive to tailor a single project to the (sometimes competing) needs and agendas of multiple decision maker partners	The RHP OC served as a way to mediate interests among decision-makers, and this needed to be resourced. There were also other costs of interaction between researchers and decision-makers.
Finding decision makers	
• no obvious or single "point of entry" into decision maker organization	This was less of a problem in Saskatchewan where relationships had already been established between HSURC and the RHAs. It will be more of a problem in the next phase when we invite RHAs from other provinces.
• broad array of potential partners, with no way of knowing which ones are influential	
Moving target	
• frequent personnel changes discourage investment of time to establish linkage	
• frequent restructuring makes it difficult to find stable areas for evaluation	
Interaction structures	
• no established structure sensitive to the particular needs of the research interaction	HSURC, an agency with a mission to influence decision-makers through research, was sensitive to these needs.
FOR DECISION-MAKING ORGANIZATIONS	
Time	
• linkage with researchers not usually rewarded (financially or otherwise)	The participation of OC members was time consuming and not financially rewarded. However, built into the meetings were opportunities for networking that the decision-makers found positive.
• easier to justify commitment for ongoing programs of research than for single projects	The issue seemed to be the concreteness and visibility of the payoff for participating in research.
Understanding the research process	
• poor understanding of what is involved in doing research, and few opportunities to learn	For the most part decision-makers will find the processes of research cumbersome, sometime incomprehensible, and time-consuming. Explaining why the process is valuable requires clarity and the ability to relate research to the needs of the sceptical. The OC and workshops provide opportunities to learn and were partly successful in transmitting the essence of research, but the frustrations remained.
Format of communications/presentations	
• often hard to understand researchers' presentation of ideas or findings	Especially in the workshops, efforts were made to present and educate in learner-friendly ways.
Potential volatility of findings	
• the control over release of findings for "political " reasons is not always compatible with researchers' needs.	This was certainly an issue in the Informed Consensus Project, and a factor in its not going ahead.

DISCUSSION AND RECOMMENDATIONS

HEALNet RHP was in a sense experimental in its attempt to bridge the academic and health communities. There are different cultures at work, with inherently different perspectives. For example, is it reasonable to expect the academic community to be principally interested in developing *tools*? There are different conceptions about what composes *research* and *knowledge*. There is a difference between analyzing issues and developing means to resolve them. In the same vein, there is a difference between acquiring deeper understandings of regionalization and providing a useful service to RHAs.

We want more than researcher-decision-maker interaction. We want *good* interaction. What is realistic? What commitment is required to make this work?

There are limits on time and energy, on the part of the researchers and also the boards and managers. Decision makers are problem focused and service oriented. Their time and interest in developing new knowledge for its own sake is a lower priority. They may *use* research as a political tool, to justify decisions rather than to inform them.

However, participation in research also represents an opportunity for decision makers. It brings exposure to new ideas and discussion with others. And not all decision makers are alike. For example, although the OC decision makers were mainly positive about their participation in HEALNet, we note that they are among the leadership of the RHAs. They may be more visionary and more patient with long term projects than other decision makers. In addition, personal attitudes and histories come into play. In the field, some decision makers brought an anti-intellectual element to the interaction, while others went to the opposite extreme and were uncritical of research.

Researchers also bring a corresponding mix to the interaction. Some see decision makers as subjects of study, or as needing education, while still others see them in a more interactive capacity. The traditional ethos of research is that it should be driven by the curiosity of the investigator. The RHP intention was that the research be more *market-driven*, but often the market is imprecise and difficult to articulate. Researchers are unlikely to yield the agenda entirely to the decision makers in any event. There are differences between decision-maker needs in the short run and researchable issues for the longer term.

For researchers in HEALNet, beyond the logistical issues of overcoming time and distance problems associated with *fieldwork*, the main difficulty is that it is harder to see this kind of work as *research*. The closest it comes to being seen as research is when it is considered development, as in *Research and Development*. More often, such activity is seen as *service* and less desirable from a research point of view. There is an inherent tension between providing a service to decision makers and producing original research on researcher/decision-maker interactions. There is the further issue of generalizability: researchers more often want an experimental design to find generally applicable truths, while one might serve best by being more of a consultant, tailoring products to specific individuals or groups rather than the general RHA or research community.

The academic research community has a supply side orientation. Researchers have their own agenda. They have a product in mind that they are interested in having marketed or published. This places constraints on their ability to respond to needs in a flexible way. Even when the researchers' agenda is derived from their own curiosity and intellectual interests, it is tinged with survival and advancement issues, arising from the imperatives of the academic incentive structure.

Part of the issue has to do with the nature of research. Academic research is embedded in the problems and framework of a discipline, which makes it less adaptive to the needs of decision makers, whose questions are not framed along the same disciplinary line. The nature of research often makes researchers reticent advisors to decision makers. They are (justifiably) uncomfortable with predictions and with generalizing from too little data. Yet that is often what the decision-making world demands.

Similarly researchers are ambivalent about the role of experience. Most researchers are trained to suspend their own experience in making judgments and drawing conclusions. Yet for decision makers, experience is a valuable resource.

Finally, we know that much research is analytical and diagnostic. It can critique a problem far more readily than it can solve it. Academic research is less likely to be helpful in creating new alternatives. The research enterprise as a whole needs to ask itself, therefore, in the terms of the classical analogy, are we looking for lost keys only under the lamp post where the light is brightest, or are we looking where we are most likely to find them. Does the research enterprise inform the most important decisions?

We conclude that what is required is a balance. One needs to serve immediate needs while at the same time ask the important long-term questions. Consideration must be given to both agendas. Being helpful will imply an agenda that somehow includes the significant and meaningful issues even if current research does not have immediate answers. In order to succeed on this more ambiguous terrain, we will no doubt require a wider repertoire of research methods, including inferential approaches as well as experimental ones.

For researchers in the field of policy and decision making analysis, there are many advantages to interaction with decision makers. Often, the real world site is the only or best way to test certain ideas. Interaction with decision makers is a way to inform about the context and needs, and to provide the researcher with new ideas and ways of thinking about the world. Finally, there is the opportunity to serve the public; many researchers are also public servants, in a formal or informal sense.

In closing, we draw together these reflections on our experience into these few recommendations about researcher-decision-maker interaction. Our experience and the recommendations are consistent with that of others in this field (CHSRF, 1998 and 1999)

- **Identify the conditions under which collaboration will be useful; and choose collaboration carefully.**

Among the acknowledged benefits of collaboration are the pooling of resources and the increased *buy-in* of participants. In some circumstances, collaboration is not only beneficial it is essential. Conversely, collaboration is not always required. Sometimes it brings no appreciable benefits, or the costs outweigh the benefits. In some cases, straightforward one-way strategies may be optimal. Ineffective collaboration has negative future consequences in that it may create cynicism about the method. When considering partnerships between researchers and decision makers, we should identify the reasons for collaboration and plan accordingly.

- **Build bridging expertise; and use this expertise to foster effective participation by both decision makers and researchers**

Fostering effective participation requires purposive, skilled behaviour. Identifying and valuing the required skills, and generally building a body of knowledge in this area is important. One of the primary features of a bridging strategy is to build an atmosphere of mutual respect between decision makers and researchers and to create an expectation of participation by both groups. A sense of co-ownership can be achieved by involving decision makers early in the process so that researchers and decision makers can address the issues together. Tough research problems and topics should be made common knowledge and discussed so that ownership of the problems and consequences is shared.

- **Expect and plan for increased complexity and ambiguity introduced by collaboration**

When collaboration is judged to be required or helpful, it is important to plan and budget for the efforts required. We must expect to negotiate and this will often make the process more complex and ambiguous than it would otherwise have been. Participants must commit to the process over time, to resolve the inevitable additional problems that will arise. It is important to build structures for ongoing participation, and to make explicit goals and expectations of researchers and decision makers. There should be interim checks on process and outcomes.

- **Create several different mechanisms to enable decision makers to participate as their interests and resources allow**

It will help to widen the range of ways by which decision makers can participate, attending to different needs and incentives. Some, and only some, decision makers are more like co-researchers. For these people, we can and should plan for longer-term commitment and deeper engagement with the subject matter. We can pose questions at an earlier and more ambiguous stage. These decision makers would participate in think tanks or planning groups. Other decision makers, the majority, are more service-oriented. For them, more focused participation in more clearly defined projects would be preferable.

- **Counteract the structural disincentives to university-based researchers' participation in these kinds of collaborations**

Just as we must diversify our repertoire of strategies for decision-maker participation, we must also augment our strategies for enabling researcher participation. We will need to address those features of the academic structure which are disincentives to this kind of collaboration.

- **Reframe the research enterprise so that expectations about specificity and precision of results do not trump those about relevance and usefulness**

The more important problem may be a still too prevalent view of the *best* science as being limited to controlled experimentation. A more far-reaching impact will be achieved by expanding our repertoire of research methods to include those that allow us to analyze, infer, and generalize from real-world activity and intervention as they unfold.

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APPENDICES

Appendix 1

Excerpts from the Regional Health Planning Memorandum of Agreement

The following are excerpts and summarized points from the Memorandum of Agreement signed in 1996 by HEALNet Regional Health Planning and the six participating health boards. The agreement lasted 3 years.

PURPOSE OF AGREEMENT

"This memorandum of agreement outlines the commitments, terms and conditions for the RHP project, in its relationship with the six participating district health boards (DHBs)."

GENERAL PRINCIPLES

"The project is designed to be useful to district (and in other provinces, regional) health boards. The content and form of the decision tools will be developed in cooperation with health boards and senior management. Interactive processes and collegial working relationships will be established to encourage participation by the districts. A spirit of openness among the participants will assist the project to develop more successfully.

"Participants will take into account the time and resource constraints of district boards and of the project itself. The research team will make known the research agenda and project expectations in advance, allowing sufficient time on the participants' part to plan for, respond to, and meet, project requirements. Districts will make known their expectations of the project, participate in project planning and priority-setting, and will work with other participants to establish a consensus around the work and expected outcomes of the project."

NATURE AND SCOPE OF ACTIVITIES

"The basic approach is for the RHP research team to work interactively with DHB members and their senior managers (defined initially as the CEO and the level reporting directly to the CEO) throughout the life of the project."

Provided in the agreement was a list of what project activities involving DHB participation or requiring their support may include: i.e. discussion sessions and workshops with board members and managers; presentation and discussion of survey and senior management processes and decisions.

OBLIGATIONS OF RESEARCH TEAM TO DHBs (Summarized)

1. Opening workshop to explain HEALNet.
2. The research team to explain the rationale behind all data gathering activities to the boards.
3. The research team to provide boards with a reasonable amount of time to participate.
4. The research team to present work in progress to participating boards.
5. DHB representatives invited to participate in the planning of conferences and seminars on regional health governance and activities .

DHB OBLIGATIONS TO THE PROJECT (Summarized)

1. Make known their information and other decision tool requirements to the researchers so that the work responds to their circumstances and needs.
2. Make available to the project on a confidential basis all minutes of the board and its committees.
3. Make available to the research team documents deemed essential to an understanding of board decision-making processes, use of and need for decision tools, etc.
4. Test decision tools, information formats, and other products they have determined to have potential to assist them in their work, and to facilitate the evaluation of their usefulness and impact.
5. Respond to interviews.
6. Review and provide comments and suggestions on reports and other work in progress.
7. Supply members of the Operations Committee, and other committees.
8. Name a formal contact person through whom day-to-day communications with the project coordinator and research staff will normally flow.
9. Agree to collectively reach a consensus on priorities, and to participate in the group-generated activities.

DISSEMINATION OF FINDINGS (Summarized)

1. Agreement that HEALNet has both the goal and obligation to publish high quality research findings.
2. Researchers report to the boards and other relevant constituencies in a clear and easily understood fashion.
3. Participating districts have the right to review documents intended for publication and/or wider dissemination for accuracy and confidentiality and to provide coments.

Appendix 2

List of Regional Health Planning Participants

Researchers

Steven Lewis, *RHP Theme Leader, CEO Health Services Utilization and Research Commission, Saskatoon*
Denise Kouri*, RHP Coordinator, Saskatoon*
Harley Dickinson, *Department of Sociology, University of Saskatchewan, Saskatoon*
Jeremiah Hurley, *Centre for Health Economics and Policy Analysis, McMaster University, Hamilton*
Cam Mustard, *Manitoba Centre for Health Policy and Evaluation, Winnipeg*
Jack Williams, *Institute for Clinical Evaluative Sciences, Toronto*

Operations Committee

Margaret Meckleborg, *Board Member, Central Plains District, Res. Muenster*
Karen McClelland, *CEO, Central Plains District, Res. Humboldt*
Sandra Fowler, *Board Member, Moose Jaw-Thunder Creek District, Res. Eyebrow*
Dale Holmberg, *Board Member, Moose Jaw-Thunder Creek District, Res. Moose Jaw*
Karen Gelowitz, *Board Member, Northwest District, Res. Pierceland*
Irene Denis, *CEO, Northwest District, Res. Meadow Lake*
Don Kent, *Board Member, Pipestone District, Res. Grenfell*
Alvin Gallinger, *CEO, Pipestone District, Res. Grenfell*
Eric Braun, *Board Member, Saskatoon District, Res. Saskatoon*
Cory Neudorf, *Director of Research and Utilization Management, Saskatoon District, Res. Saskatoon*
Dolores Tumbach, *Board Chair, Southwest District, Res. Leader*
Alan Ruetz, *CEO, Southwest District, Res. Shaunavon*
Lois Borden *Saskatchewan Health, Regina*

Associates

Research and Contract Staff: Jackie Dutchak, Joanne Barry, Meredith Moore, Len Usiskin and Lori Hanson, Saskatoon
Graduate Students: Julia Abelson and Gerry Veenstra, McMaster; Renee Torgerson and Jennifer Poudrier, University of Saskatchewan
Office Manager: Barbara Crockford, Saskatoon

Note: The positions listed here are those held at the time of participation.

Appendix 3

Regional Health Planning Operations Committee Activities 1996-1999

November 1996	■ Tool Proposal: Detailed Critique of Each Topic Area ■ Synthesis of Decisions and Plans
January 1997	■ Role and Participation of Operations Committee Members ■ Progress and Issues - Tool Development ■ Survey pretest
March 1997	■ Outcomes and Evaluation Methods for Tool Areas A and B ■ Board/Manager Workshop
April 1997	■ Community Profile Proposal ■ Population health data: The National Population Health Survey and other options: presentation by Saskatchewan Health
September 1997	■ Board/manager survey: preliminary findings; feedback ■ Board/manager workshops: review of revised plan ■ Other information and updates (Community Profile, case study research; HEALNet national–AGM, preAGM workshop, etc.) ■ Resource Allocation: Presentation of proposal ■ Indicator Framework: Presentation of options
November 1997	■ RHP Plan Update ■ OC interim self evaluation ■ HEALNet AGM Report ■ Presentation by HEALNet exchange student from McMaster
February 1998	■ Feedback on Survey Report: *Regionalization at Age Five.* ■ Board Management Workshops ■ Review of 1998 Planned Activities
September 1998	■ Current Research Program: Review and Plan to March 1999 ■ Implications of HEALNet renewal: New plans and ideas for 1999-2002 e.g. Regionalization Research Centre ■ Possible new projects for discussion: Evidence Module; Deliberative Polling; Heart Health work
April 1999	■ Attendance at HEALNet AGM
September 1999	■ Closure of OC and Evaluation