

Policy Advocacy to Promote Healthy Aging

The Time to Engage Is Now

Several arguments can be made for encouraging health researchers to engage in the policy arena to promote healthy aging. Health researchers bring experience and expertise that are critical to ensuring that rigorous evidence is used to develop the most effective and equitable policies/programs that improve care environments and outcomes for older adults.

Most professional ethical codes recognize a commitment to engage in policy practice to “support access to medical care for all people” (American Medical Association, 2001, p. 1), “provide leadership in the development and implementation of changes in public and health policy” (American Nurses Association, 2015, p. 1), and “improve social conditions in order to meet basic human needs and promote social justice” (National Association of Social Workers, 2008, p. 18). Thus, working to effectuate change to improve fairness and equitable access in the health care system is a fundamental obligation grounded in professional ethics codes.

Using research is also an ethical obligation derived from human subjects’ protections, as researchers are expected to maximize research benefits (U.S. Department of Health and Human Services, 1979). By proactively disseminating research evidence to policymakers and practitioners, we ensure that research generates benefits to society, rather than merely generating knowledge for knowledge’s sake. Why then is there ongoing reticence on the part of researchers to engage in policy practice?

Several challenges deter health researchers from engaging in policy practice. Some in academic circles argue that advocacy is biased and therefore not appropriate activity for the “objective” research enterprise. However, simply by asking a particular research question we begin at an already biased position. The focus should be on disseminating research evidence to the policy arena, while accepting

that all evidence is tentative and incomplete (Lincoln & Guba, 1985).

A second challenge relates to time and competing demands. For researchers, such challenges include fitting the research process to real-world timeframes, establishing relationships with policymakers, and justifying pursuits that fit poorly with traditional academic performance measures (Mitton, Adair, McKenzie, Patten, & Wayne Perry, 2007). Even for researchers on soft funding, the continual need to seek research funding to support staff salaries leaves little time for knowledge exchange or policy advocacy. Similarly, health practitioners contend there is little time to engage in advocacy with such a packed clinical care load. Finally, many argue that their lone voice will never have an impact in the policy realm.

Furthermore, policymakers have identified several barriers to using research in policy decisions. “A perceived lack of knowledge of the research process, the traditional academic format of communication, research that is not relevant to practice-based issues, and a lack of timely results are often cited by” policymakers as barriers to using research findings (Mitton et al., 2007, p. 730).

With ever increasing pressure on health care resources, the transfer of evidence to policymakers and practitioners is even more critical. “The primary purposes of knowledge transfer and exchange (KTE) are to increase the likelihood that research evidence will be used in policy and practice decisions and to enable researchers to identify practice and policy-relevant research questions” (Mitton et al., 2007, p. 729). Relationship building is fundamental to knowledge exchange. Research and practice experts can collaborate with advocacy coalitions and community-based agencies to increase the impact of their combined knowledge and skills. Many universities have internal grants that focus on community engagement and reciprocity.

Recent national initiatives have focused on collaboration between community-based agencies, decision makers, and researchers to promote knowledge exchange. These collaborative efforts can expedite reciprocal information sharing and translation of effective interventions.

KTE is also about communication. Publishing an article in a peer-reviewed journal even with a press release may simply be too little, too late. KTE requires a two-way interactive communication channel from researchers to policymakers/practitioners and vice versa. Researchers need guidance on policy/practice relevant questions to study. Likewise, dissemination must be intentional, considering the specific target audience(s), the message, how to communicate, and an appropriate messenger. Resources are available to train researchers in communication and policy practice (e.g., The Health & Aging Policy Fellows program). Also, most universities have internal staff to help communicate research results through social or traditional media.

Regardless of how you engage, be aware of the political environment on the given issue. Consider: Where is the policy conversation on this issue? Who is engaged in the discourse, and how are they defining the problem? How can you build trusting relationships with practitioners and policymakers and include them in the research planning stage? What message needs to be communicated, to whom and how? To ensure that the best evidence is used in policy/practice, we also need to change academic and health systems, to incentivize investments in relationship building and intentional dissemination efforts. Although we may not always succeed in changing policy outcomes, we can inform the debate by using strategic methods of KTE. Otherwise, our clients may suffer.

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