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CITATION

Bruen, Carlos; Brugha, Ruairi (2020): “We’re not there to protect ourselves, we’re there to talk about workforce planning”: A qualitative study of policy dialogues as a mechanism to inform medical workforce planning. Royal College of Surgeons in Ireland. Journal contribution. https://hdl.handle.net/10779/rcsi.12350090.v1

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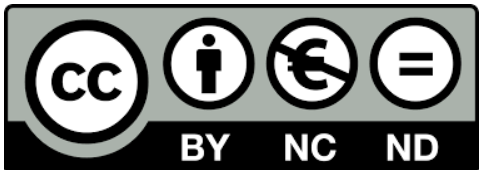
Bruen C, Brugha R. 2020. “We’re not there to protect ourselves, we’re there to talk about workforce planning”: A qualitative study of policy dialogues as a mechanism to inform medical workforce planning. *Health Policy*. DOI: https://doi.org/10.1016/j.healthpol.2020.04.001



"We're not there to protect ourselves, we're there to talk about workforce planning": A qualitative study of policy dialogues as a mechanism to inform medical workforce planning

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Acknowledgements:

This study was supported by the Health Research Board (HRB) Knowledge Exchange and Dissemination Scheme under Grant No. KEDS3085. The HRB had no involvement in the implementation of the study or its outputs. The authors thank Dr Niamh Humphries (RCPI) for her contributions to the early development of the study.

Conflict of Interest Statement:

The authors declare no conflict of interest.

Highlights

- We analyse policy dialogues as a formalised interactive mechanism for knowledge brokering.
- Policy dialogues can add value to both policy and research processes.
- Policy dialogues facilitate evidence-focused interaction between policy stakeholders beyond 'business-as-usual' relations.
- Policy dialogues strengthen the policy-relevance of research data collection, analysis, and dissemination.
- Contextual factors, e.g. competing policy priorities, limit dialogue impact on policy processes.

Abstract

Introduction

To address a disjuncture between medical workforce research and policy activities in Ireland, a series of national level policy dialogues were held between policy stakeholders and researchers to promote the use of research evidence in medical workforce planning. This article reports on findings from a qualitative study of four policy dialogues (2013-2016), the aim of which was to analyse policy dialogues as a mechanism for knowledge-sharing and interaction to support medical workforce planning.

Methods

Descriptive qualitative study design involving in-depth interviews with policy stakeholders and researchers (n=13) who participated in the policy dialogues; thematic analysis of interview transcripts.

Findings

Periodic policy dialogues, with discussion focused on research evidence, provided an enabling environment for exchange and interaction between policy stakeholders and researchers, and between policy stakeholders themselves. Findings foreground the significance of the policy-making context, in terms of how people interact during policy dialogues, and how research can potentially (or not) inform medical workforce planning.

Conclusion

Policy dialogues provide a mechanism for improving knowledge exchange and interaction between policy stakeholders and researchers. Situated within the policy context, policy dialogues also add value to: a) policy-making processes by facilitating interactions between policy stakeholders outside the day-to-day business of formal and sometimes adversarial

negotiation; b) research processes, including exposing researchers to the complexity of health workforce planning, and health policy more generally.

Keywords:

Policy dialogue; knowledge brokering; health policy; medical workforce planning; qualitative research

Main Manuscript:

Introduction

Accurately forecasting future medical workforce needs, and managing the complex dynamics of health worker supply and demand, is a challenge for all countries given the increasing complexity of health care, rising demand and expectations, and the portability of doctors' qualifications. In the case of Ireland, shortages of doctors, first identified in a series of key national level reports [1-3], was in part addressed through the development of new graduate entry medical training programmes introduced in 2007-11. Since then, however, high levels of emigration of Irish-trained doctors in 2008-14, coupled with large-scale recruitment of transient international medical graduates, has undermined Ireland's efforts to meet domestic medical workforce needs [4-7]. Research conducted since 2010 by the Royal College of Surgeons in Ireland (RCSI) Health Workforce Research Group [8] identified key reasons for this attrition, including: i) poorer working conditions, training and career opportunities than are available in other Anglophone countries [4, 9-11]; ii) a culture of emigration [7]; and underlying issues with medical workforce and hospital configuration [9]. Economic austerity in response to the onset of the financial crisis aggravated this, and continues to make itself felt across the health workforce and health system more generally [12-14].

Within this context, members of the RCSI Health Workforce Research Group engaged with national-level policy-makers and stakeholders with a remit for medical workforce planning,

policy and strategy implementation, through organising formal health workforce policy dialogues. Beginning in 2013, the policy dialogues ran concurrent to the programme of research being conducted by the Research Group. The dialogues were organised as a response to a perceived disjuncture between health workforce research and planning in Ireland; and the limited opportunities for policy-makers, stakeholders, and researchers to discuss systems challenges.

Policy dialogues have been described generally as a form of consensus building, a process of communicating and negotiating priorities and values among different stakeholders to agree a common programme of action [15]. Focusing less on consensus-building and more on interactions, policy dialogues have also been defined as a means of closing the gap between research evidence and practice to address health challenges [16]. This includes facilitating learning between stakeholders to support the integration and interpretation of research evidence and contextual information to support health policymaking [17-20]. Specifically defined, policy dialogues facilitate knowledge-sharing when conducted as part of broader knowledge brokering activities, where knowledge brokering is defined as "the use of information-packing and/or interactive knowledge-sharing mechanisms to bridge policy-makers' (and stakeholders') contexts and researchers' contexts" to address the disjuncture between information and action [21].

This article reports on findings from a qualitative study evaluating medical workforce policy dialogues held between 2013-2016. Drawing on interviews with policy dialogue participants, the aim of the study was to analyse policy dialogues as a mechanism for facilitating knowledge-sharing and interaction in support of medical workforce planning. Findings focus on the key design features of the policy dialogues; interactions between participants outside

of their day-to-day business of formal and sometimes adversarial negotiation; and the contextual factors influencing policy dialogues specifically, and medical workforce planning more broadly.

Methods

We employed a descriptive qualitative study design comprising in-depth semi-structured interviews with key stakeholders that had participated in the policy dialogues, followed by thematic analysis of interview transcripts. Ethical approval for the study was granted by the RCSI Research Ethics Committee (REC1434).

People interviewed for the study included policy-makers, stakeholders, and researchers. In line with definitions of knowledge brokering actors provided by the European Observatory on Health Systems and Policies BRIDGE Study [22], we refer to policy-makers as those working in government departments directly involved in decision-making for policy, or those with an advisory role working in close proximity to such decision-makers. We use the term stakeholder to refer to those with an interest in medical workforce planning, but who are not directly involved in decision-making as part of policy processes. For ease of reference, we collectively refer to health workforce policy-makers and stakeholders as policy stakeholders. In the context of this study, interviewed policy stakeholders included senior decision-makers and advisors in relevant divisions of the Department of Health and Ireland's national Health Service Executive (HSE), as well as senior personnel based in national training bodies, regulatory agencies, and junior doctor and professional association representatives.

Data Collection

Using purposive sampling [23, 24], the primary criteria for participant selection was their involvement in the medical workforce policy dialogues in a capacity not limited to attending one policy dialogue, e.g. the invitee provided advice during the planning of policy dialogues,

including identifying other potential key stakeholders to be invited, or who should be informed about the dialogue process and knowledge exchange; the invitee was the key person in their organisation leading on medical workforce planning; or the invitee was a key person in their organisation who had already attended a policy dialogue, suggested a substitute when unavailable, and attended later policy dialogues. We did not include in our purposive sample the substitute attendees or one-off participants that did not have involvement beyond attending one policy dialogue event. Of the 25 people that attended one or more policy dialogues, we identified 15 people that met the criteria above. Invitations and an information sheet were emailed to identified participants, explaining the study objectives, data collection methods, what their participation involved, and their right to withdraw at any point. Of the fifteen people invited for interview, 13 accepted. Interviewees were comprised of national-level policy stakeholders (n=9) and researchers (n=4). Interview participants confirmed their consent in writing.

Considering the relatively small number of people working at senior levels in this field in Ireland, a breakdown of individual interviewee organisational affiliations is omitted, to ensure anonymity. Furthermore, the dialogues were conducted under the Chatham House Rule, whereby participants were free to use the information received, but neither the identity nor organisational affiliation of participants should be revealed in dialogue outputs [25].

Interviews took place August to December 2017, face-to-face (10) or by telephone (3), as proposed by participants, with no discernible difference in quality by interview method. Interviews were conducted by [author 1], using a semi-structured topic guide addressing: a) interviewee's background in medical workforce planning; b) their views of the policy dialogue design and processes; c) the range of, and interactions between, participants; d) and

the enablers and constraints to using research evidence in health workforce planning. Interviews lasted between 27 and 66 minutes. All participants consented to audio-recording, were informed of their right to review transcripts for accuracy and to correct factual errors. Five requested a review of their transcripts, with one identifying text for redaction from any published outputs. All identifiable data (names, organisations, professional roles) were removed from transcripts. Interviewees were assigned and are identified in this manuscript by an anonymised number, followed by a Policy Stakeholder (PS) or Researcher (Rr) designation to provide further context for the reader, e.g. I01-PS.

Data analysis

Transcripts were thematically analysed in NVivo (Version 12), which involved identifying, coding, categorising, analysing and reporting patterns or themes across the data [26-30]. Inductive thematic analysis focused on participants' experience and perceptions of policy dialogues with respect to facilitating knowledge-sharing and interaction in support of medical workforce planning. Analysis was conducted by [author 1], with key results and interpretation discussed with [author 2] during the analysis. Queries and discrepancies regarding theme development and interpretation were resolved through further transcript checking, theme refinement, and co-author discussion. Summary draft findings were presented to selected interviewees for feedback on the accuracy of analysis and reporting. Feedback has been incorporated into this paper.

Results

We begin this section with a description of the health workforce policy dialogues to contextualise the study findings. We then go on to describe interviewee experiences and perceptions of policy dialogues with respect to knowledge-sharing and interaction.

The health workforce policy dialogues were established to: i) disseminate and discuss research findings on medical workforce planning with key policy stakeholders in Ireland; ii) support policy stakeholders in utilising the research findings in their organisational responses; iii) promote an on-going dialogue between policy stakeholders and researchers, and between policy stakeholders from different organisations. The RCSI Health Workforce Research Group served as a knowledge brokering organisation [31].

Research evidence was packaged into information products (research summaries and reports) that were circulated to policy dialogue participants. Slide decks were presented at the policy dialogue meetings to summarise issues arising from the research and to inform discussion, with printed copies made available to participants. The information products primarily presented locally-specific findings from the RCSI Health Workforce Research Group programme of research, contextualised by other Ireland-specific research evidence, organisational data, and international research. In a smaller number of instances, information products focused on international comparisons. This included, for example, a request by policy stakeholders to the researchers to conduct a narrative review of peer-reviewed research studies, reports and policy documents to better understand how other countries addressed the retention of health workers, their working conditions, and their career progression and development. This was packaged as a report and summarised to policy stakeholders at a later policy dialogue meeting.

Four policy dialogue meetings were held between 2013 and 2016. While these were initiated by the research team, the planning and focus of meetings was informed by consultation with a small number of senior-level policy stakeholders working in organisations responsible for medical workforce policy and implementation. The purpose of the consultation was to ensure

that the focus of the policy dialogues was relevant to and involved key policy stakeholders, and to achieve their buy-in for the initiative. The structure of each dialogue involved a presentation of research evidence summarised by the researchers, followed by facilitated discussion bringing the research together with the experience and knowledge of policy stakeholders. Application of the Chatham House Rule [25] was used to encourage open discussion around reasons for doctor emigration and potential policy responses to address this. A summary of the key points and next steps was documented and circulated to participants after the meeting. Informal interactions also took place between dialogue meetings, most commonly via email or telephone exchanges between researchers and policy stakeholders, such as in advance of publications that might be of interest or to collaborate on related research activities.

The inclusion of policy options in information products and interactive exchanges is advised in the knowledge brokering literature [21, 32]; however, researcher-identified policy options for policy stakeholders to consider were not provided in the health workforce policy dialogues. While originally intended, the advice from some of the policy stakeholders was that any explicit deliberation on policy options risked being perceived as encroaching on the Department of Health's area of responsibility. To reassure the policy stakeholders, group discussion instead considered the implications of research findings for national medical workforce planning and doctor retention generally. This provided the opportunity for participating organisations to discuss retention strategies that might be applicable in Ireland.

Characteristics of the Policy Dialogue

In general, interviewees spoke positively about their participation in the policy dialogues. For some, the fast turnaround of credible research provided a mechanism for learning about and discussing findings sooner than would be the case through normal academic dissemination

activities. For others, the policy dialogues provided a safe space for a range of different stakeholders to discuss and interact, a space with a dynamic different to – and outside of – the day-to-day processes of negotiation and influence in which policy stakeholders often engaged. While mostly positive, interviewees also highlighted inherent limitations of policy dialogue processes, and the non-linear nature of policy processes that such dialogues or events seek to inform.

The policy dialogues were described by interviewees as being researcher-led with respect to the timing, structure, and content. This was viewed positively by those in non-academic organisations, freeing them up to participate and engage in discussion on a range of issues that were not seen as reflecting the agenda of any particular organisation. Policy dialogues created a different dynamic to that experienced in other settings:

> *I think sometimes the form and function of our organisations that we represent …can restrict how we share information, and I think any way that gets around that is a good thing…[in the policy dialogues] we're not there to protect ourselves, we're there to talk about workforce planning…so let's focus and drop our baggage. (I05-PS)*

One interviewee questioned however why there was not wider input from participants into the structure and content of the dialogues. For this person, it was about making the process more inclusive, of allowing others to input into the agenda or for them to present other sources of information relevant to the findings. The intent, for this person, was to promote ownership and shared responsibility, recognising that other organisations and not just the researchers were producing research evidence and data intelligence. Another interviewee suggested there should be wider input from policy stakeholders from an even earlier stage, in that policy dialogues were viewed as a midway point whereas earlier engagement with policy

stakeholders in the research design could have pre-empted some of the issues arising at policy dialogues:

> *If you're dropping midway through the research, you're almost coming in I think, some stakeholders are coming in and saying "okay, I'm going to have to go in here and spend twenty minutes talking about the kind of, you know, walking back some of these assumptions", and if you come in at the research design level, you've sorted that all out from the start. (I08-PS)*

Facilitation of the meetings was described as playing an important role for encouraging discussion between people that in other contexts sometimes engaged with each other more strategically or on a bilateral basis, rather than collaboratively. Three of the four meetings were facilitated by people associated with the research, with one meeting facilitated by an independent international health workforce researcher and expert. Most participants considered that meetings were facilitated well, discussions were open, and that the policy dialogues provided a neutral venue with facilitators viewed as arbitrators independent of health workforce decision-making processes.

While perceived as being independent of these policy processes, other interviewees suggested that, where possible, future dialogue facilitators should also not be connected to the research being discussed. Contrasting between their experience of facilitators associated with, and independent of, the research and policy issues under discussion, one interviewee described how power dynamics are inevitable in policy dialogues, suggesting that having a neutral and trusted facilitator independent of policy and research processes can help to navigate these power dynamics:

> *If there's a power dynamic going on, if some people are more senior than others, even the gender dynamic too, all kinds of dynamics in there, which you have to be aware of, which means you probably won't get as free as a discussion as you would*

like - unless you have a really good facilitator and someone who is very trusted. (I10-Rr)

The application of the Chatham House Rule during policy dialogue meetings was a specific design feature aimed at supporting more open discussion. For some, it was considered helpful for supporting people to speak from a personal rather than an organisational perspective, in that they could be less diplomatic and freer to discuss issues or express positions that they might not be as open to talking about in other contexts:

Definitely I think the Chatham House Rule helped. I think we were clear that we were in a sort of safe space. I think that was a factor in terms of my experience at those meetings and the difference in dynamic and content versus the business bilaterals [negotiation meetings] with some of the stakeholders that were there. (I02-PS)

For others however, particularly those holding more senior positions in policy and research organisations, the Chatham House Rule was described as less useful, in that they were often saying the same things in their workplace or in the public domain as in the policy dialogue settings. A key and more general limitation of the Chatham House Rule identified by several policy stakeholder interviewees was the fact that dialogue participants came from a small circle of people that met each other frequently in other fora, which in turn placed limits and constraints on what could be said.

[The Chatham House rule is] all very fine, but the next time I meet [participant] at something, what's said was said, and in that sense it's a little bit constrained by that. (I01-PS)

No one can divorce themselves from the organisational positions and organisational imperatives that they have back at their home place, and that other web of relationships [between policy actors in their formal roles]. (I07-PS)

Several interviewees said that trust was necessary for the Chatham House Rule to be effective, noting that trust takes time to establish and is dependent on the quality of the relationships between participants. Consequently, while the Chatham House Rule sought to encourage more open discussion, this discussion was for some interviewees inevitably constrained by the organisational and political contexts within which they worked and interacted with others.

Participant Range and Interactions

Participation in the policy dialogues was by invitation, and where a person was unable to attend they could suggest a colleague to attend in their place. Identification of invitees for policy dialogues was through personal knowledge and snowball recruitment. Participants from previous dialogues were invited to later dialogues, with the range of people invited expanding over time. While invitations were sent months in advance, often some participants were unable to attend, sometimes due to last minute work demands from senior colleagues, clinical site demands or the necessity to appear at short notice at a parliamentary committee, as I09-Rr noted: "*these are busy people, you get who you can*". However, interviewees reported that there was generally good participation by the key individuals from the relevant organisations instrumental in medical workforce planning, policy, strategy, and implementation.

Several interviewees highlighted other groups that might usefully have participated, including senior health service and hospital managers, other cadres of health workers, and others from statutory bodies. They also acknowledged the size and complexity of organisations like the Department of Health, the HSE, and other governmental agencies and departments, their fragmented and siloed structures, and the regular turnover of personnel within these organisations. This at times made identification and participation of the right people difficult,

and limited the potential for establishing longer term working relations to support trust building.

For I08-PS, the dialogues were described as "*good at bringing together people who are engaged in making decisions and shaping policy, and less so in bringing together people who are affected by them*". Similarly for I10-Rr, it meant that the dialogues became narrowly focused on particular aspects of medical workforce rather than broader health workforce planning:

> *If you're going to do realistic workforce planning you have to go across cadre, you have to go across professions. But then you really do get into a bunfight if you try and do a policy dialogue, because people will just automatically go for their rifles. Think of all the, the pharmacists, GPs [general practitioners], consultants, nurses, social support staff workers…You can imagine! (I10-Rr)*

While circumscribing the range of participants inevitably placed limits on the range of perspectives, this was viewed by I10-Rr as a necessary trade-off, of "*biting off less*" and making the process more manageable, while recognising that it limited the range of participants and issues discussed. Other interviewees expressed a contrasting view, in that they were less concerned about having broad representation and participation at the dialogues, suggesting that the purpose of the policy dialogues was scientific rather than political, and could therefore be more selective regarding who to involve. Interviewee I01-PS, for example, described it as "*the difference between politics and research"*, contrasting research against political processes, with the latter more focused on building consensus for change:

> *It's as important how we, who we include; how we engage with them; how they feel about how they've been engaged with, than it is what they actually say…producing a report that all those who have been asked about it will feel that they were involved*

> *in this conclusion…so that in the end everybody feels an ownership of this process. You don't really need to do that with the research (I01-PS).*

For this and several other interviewees, at issue was not representation but roles, functions, and responsibilities in relation to research and policy processes. For some, the role and function of research and researchers was to inform but not to make policy decisions; while for others, policy stakeholder input into research processes should be managed to avoid conflicts of interest that potentially influence the research process and outputs. That said, most recognised the value of interaction, while at the same time, as I07-PS added, "*respecting our functions and domains, while finding that space in the middle to collaborate appropriately".*

While similarly expressing the need to respect roles and functions, some interviewed researchers described how their experience of policy dialogues highlighted the importance of collaboration with policy stakeholders, including early in the research process. For some, policy dialogue deliberations led them to re-examine conclusions drawn from the data, recognising that involvement of policy stakeholders earlier in the research process could help to identify gaps or issues sooner. For others, observing and engaging in deliberations with policy stakeholders provided them with a deeper insight into the complexity of policy processes, particularly with regard to their understanding of the take-up, integration, and interpretation of research into the policy setting:

> *They're saying, as they're absorbing the information, debating the information, they're foreseeing obstacles…To be observing, to be present while they tried to translate it into practice, and in doing that saying 'oh that would clash with this' or 'this lot will never go for that'…[the policy dialogues] gave me an insight into that, the messiness of policy. (I09-Rr)*

Policy Dialogues in Context

Interviewees were cognisant of the context within which the research and policy dialogues were situated. For instance, I02-PS described policy dialogues and stakeholder interaction as "*a continuation of what was already happening*" in the wider policy context; but that these had "*an added value*" because of the focus on research evidence as opposed to inter-organisational negotiation. For others however, it was not clear how the research was brought forward beyond the policy dialogue meetings into the policy arena, who held responsibility for doing this, or indeed how it could be done in a complex policymaking environment. Underpinning it was the perception that coordination between organisations impacting medical workforce planning was lacking, and a recognition of adversarial positions, as well as competing interests and evidence, that shape health workforce planning.

Interviewees identified some of the wider contextual factors that impacted on medical workforce planning, and consequently the take-up and use of research in the policy arena. Firstly, for instance, participants provided examples of how shorter-term resource-intensive priorities frequently took precedence, the main example being the need to fill hospital posts to meet the immediate needs of the service, through providing temporary contracts in non-training positions, recruiting agency staff and recruiting international medical graduates. Such fire-fighting drew resources from the longer term needs to train and retain specialist staff, which participants all recognised was the priority for the wellbeing of the health service:

> *Short term requirements will always trump longer term strategic planning, and that's the reality…it's a reality at service delivery level; it's a reality for all of the officials at all the levels of the system…Ensuring that those posts are filled on a short-term basis will always trump everything else, even when issues around quality and safety are or may be raised. (I07-PS)*

> *Where's the future planning? I guess it's in the health workforce planning section, [they] are the only people looking forward. Everybody else is looking to this winter and seeing if the system collapses or not, which is also important…[But] its either/or, its not both. (I09-Rr)*

Secondly, some interviewees described how a narrow, siloed-sectoral focus, limited to specific cadres, undermined broader health workforce planning. A small number suggested that this lack of inter-sectoral planning meant opportunities were missed to involve other governmental departments, organisations, and agencies that could either place obstacles or could enable some of the medical workforce changes required, i.e. other policy venues or arenas in which authoritative decisions take place. The Irish government Department of Finance, and Department of Public Expenditure & Reform were specifically identified as being critical to health workforce planning:

> *These are the guys and girls behind I guess a lot of the decision-making in government that's linked to finances, that's linked to value for money. (I09-Rr)*

> *If you're going to effectively address some of the workforce policies, you need to involve other government departments that have an influence…[Departments of Finance and Public Expenditure & Reform] have a big say in the levels of workforce, remuneration terms, and conditions under which people are employed, and would tend to be, would tend to put, kind of I suppose, barriers in place trying to implement some of the changes you might, within the health sector, think are good to do. (I04-PS)*

Thirdly, some interviewees referred to global factors influencing domestic medical workforce policy and practice. Central to this was Ireland's ongoing dependency on recruiting international medical graduates to fill gaps left by large scale emigration of Irish trained doctors. Some interviewees noted how adherence to the principles set out in the 2010 WHO Global Code of Practice on the International Recruitment of Health Personnel (the Code) could have a positive effect [33]. Others however expressed scepticism on the impact of the Code, pointing out that there was no counterfactual to test claims that recruitment practices

had improved since Code endorsement, and that the Code has no enforcement or redress mechanism. As one sceptical voice suggested: "*when you play hardball, it's in high-income countries' interests to take medical graduates off other countries – is and always has been*" [I10-Rr]. These national and global contextual factors serve to illustrate how research is only one of a number of factors influencing medical workforce planning, and highlights the difficulty in determining the discrete effect of knowledge brokering in a complex policymaking environment.

Discussion

This study examined knowledge brokering activities in the context of medical workforce planning in Ireland. Policy dialogues provide a means for synthesising research and contextual knowledge, and can bring key stakeholder groups together to bridge the worlds of research and policy [17, 20, 21, 34]. Frequently supported by the packaging of research evidence [35], policy dialogues offer opportunities to mediate interactions around research evidence in support of policy making [32]. The key features of policy dialogues are appropriate meeting environments, mix of participants, and use of research evidence [20].

Emerging in response to a disjuncture between health workforce research and planning, and the limited opportunities for exchange between policy-making and research communities, findings from this study describe how the health workforce policy dialogues helped bridge this gap. This was achieved through: i) the provision of a conducive environment for discussion of timely and relevant summarised evidence; ii) personal contact and ongoing interaction between a range of participants central to health workforce planning in Ireland, while recognising differences in research and policy priorities, and the form and function of the organisations that people represent; and iii) evidence-focused discussion that facilitated a

bypassing, at least temporarily, of the day-to-day business of negotiation and influence in which policy stakeholders across different organisations often engage. Consistent with other studies [16, 18, 19], our findings suggest that policy dialogues provide a promising strategy for bridging research and policy contexts.

An intended effect of policy dialogues is to inform policy processes and, as recent studies have shown, face-to-face dialogues, when combined with other knowledge brokering strategies, can and do influence these processes [36-38]. While the intended effect of the policy dialogues examined in this study was to have the research evidence inform future medical workforce planning, our study was not able to determine how (or if) the research-informed dialogues had longer term or system-level effects on medical workforce planning. As our findings describe, the decision-making context on doctor retention in Ireland is influenced by a range of factors other than research evidence or research-informed policy dialogues. This in turn makes it difficult to identify the discrete effect of policy dialogue interactions and knowledge-exchanges at a systems level.

As Boyko and colleagues [20] have described, however, policy dialogues can also have shorter term individual-level effects, as well as medium term organisational/community level effects. At the individual level, this includes learning new information or developing alternative perspectives about an issue, along with enhancing mutual understanding among individuals affiliated with different organisations and with different positions on a given policy issue. At the organisational/community level, this can include solidifying pre-existing relationships or cultivating relationships established at the dialogues, with positive spin-offs in other areas of mutual interest. In the case of the medical workforce policy dialogues, and as described in the findings, short term individual-level effects included learning,

information-sharing and research-informed deliberation among policy stakeholders outside of, and different to, day-to-day interactions. Interacting with policy stakeholders has also been shown to have positive individual level effects on researchers [39]; and, in the case of our study, researchers described this as having strengthened their capacity to understand their research from a policy perspective, and to develop a deeper insight into the complexity of medical workforce planning.

Medium term community or organisational-level effects were also observable. Building on the policy dialogues, research and policy spinoff activities included: i) collaborations that led to new data collection tools, further data gathering, and data sharing to address a range of medical workforce research issues of relevance to researchers, regulators, and public agency organisations [e.g. 4]; and ii) opportunities that emerged for researchers (author 2) to engage in national policy processes, such as participating in the national Strategic Review implementation monitoring group, during the five years since its inception in January 2015 [40, 41]; and inputting into the drafting of a national health workforce strategic framework [42]. Together, these shorter- and medium-term effects suggest that the medical workforce policy dialogues have gone some way towards strengthening the capacity of the medical workforce "community" to collaborate beyond the dialogue meetings, to further explore issues related to medical and broader health workforce planning, and to participate in policy processes aimed at finding ways to address them.

As a periodic interactive forum, policy dialogues can go some way towards tackling the (albeit simplified) "two communities" problem, i.e. researchers and policy stakeholders existing in different worlds, with different goals, expectations, and incentives [43, 44]. Findings from this study reinforce the value of formalising ongoing interactive and

collaborative processes between policy stakeholders and researchers for brokering between the interconnected, though not always compatible, contexts of research and policy [18-20, 44]. Policy dialogues can add value to policy-making processes through the provision of a research-focused forum that brings together a relatively diverse set of policy stakeholders; is not perceived as reflecting the agenda of any one policy stakeholder organisation; and seeks to circumvent the limitations of the day-to-day business of negotiation and influence that policy stakeholders ordinarily engage in. Policy dialogues can also add value to research processes by improving the policy-relevance of research data collection, analysis, and dissemination, as well as the capacity of researchers to better understand policy processes.

While this study did not analyse how (or if) the health workforce policy dialogues contributed to building an informal network of allies operating within the health system, future research on policy dialogues can move beyond a narrow focus on research/policy stakeholder interactions to include analysis of interactions and spinoff collaborations between policy stakeholders themselves. This will necessitate a shift from analysing the role of policy dialogues for promoting the use of research in policy, to analysing the role policy dialogues may play in informing the coordination of political behaviour among a small set of actors from research and policy contexts, i.e. the potential for medical workforce advocacy coalitions to form, mobilise resources, and coordinate strategies in support of their policy goals [45].

Strengths & Limitations

By focusing on the perspectives of policy stakeholders and researchers that participated in the health workforce policy dialogues, a strength of the study is the empirical contribution it makes to the growing knowledge brokering literature on bridging research and policy contexts [19-21, 44, 46, 47]. Of more local relevance, findings from this study have informed

the organisation of subsequent policy dialogues. This has included, for example, an expansion of invited stakeholders to include specifically affected groups - non-consultant hospital doctor and nurse representatives in particular - at a November 2017 event focused on a facilitated discussion of six years of synthesised research evidence. This was followed by drafting of a 'challenges and responses' document, based on the discussion, which was placed in the public domain [9].

There are limitations to this study. Firstly, rather than being conducted after each policy dialogue occurred, this study was conducted after a series of policy dialogues had taken place. Consequently, interviewees were asked to reflect on and recall specific details from events that had taken place potentially up to four years previously. Steps were taken during the interview process to aid memory, such as presenting an interview prompt, detailing a timeline of key national policy events and providing summary information on issues arising in each policy dialogue. While this aided recall, there were instances where interviewees described a degree of uncertainty regarding when particular issues arose in relation to particular policy dialogues. Secondly, while published evidence from the research was referenced in national reports, a further limitation of the study relates to the lack of evidence on the impact that the research evidence discussed in policy dialogues had on national decision-making and policy processes.

Recognising that research rarely translates directly into policy [46], knowledge brokering aims to increase the likelihood that health systems information will be utilised in decision-making. In this context, and to address these limitations, future policy dialogues should be designed and assessed against empirically informed information-packaging [35] and/or knowledge-sharing [32] criteria, as well as incorporating formative and summative

evaluations into the design [e.g. 18, 19]. Held immediately after individual policy dialogues and again at a later time interval, this can aid a better understanding of how research is used and how (or if) knowledge brokering mechanisms like policy dialogues facilitate this.

Conclusion

This study explored stakeholder perspectives on key design features, the range and interactions of participants, and the policy context of a series of health workforce policy dialogues held between 2013 and 2016. Findings underscore the potential of policy dialogues as a knowledge brokering strategy to inform policy processes. This potential is however shaped by wider contextual factors and policy tensions, which can in turn limit or create opportunities for research evidence to have an impact on policy processes. The study also highlights how periodic policy dialogues can provide a highly acceptable mechanism for increasing engagement between researchers and policy stakeholders, and between policy stakeholders themselves. Findings presented in this article are informing on-going health workforce researcher/policy stakeholder collaborations in Ireland, and will contribute more generally to future research on the role of policy dialogues in promoting the use of research evidence and facilitating coordinated action in health policy processes.

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