Author’s response to reviews

Title: Utilization of Evidence from Thailand’s Health Examination Survey in Policy Development: Finding the Weakest Link

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Utilization of Evidence from Thailand’s Health Examination Survey in Policy Development: Finding the Weakest Link

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Health Research Policy and System

Responses to reviewers

Reviewer reports:

Reviewer #1: The manuscript draft is informative, organized, and very well-written. The discussion presents content strengths and limitations in an unbiased manner. Manuscript has logical flow, and uses appropriate headings. The conclusions are supported by information presented in the manuscript. My suggestions are as followed.

In-depth interviews and stakeholders are immensely impactful on the paper's results. Elucidating more details of the interviewees and stakeholders could give readers more insights and understanding of the context. For future research, I would like to suggest the authors to include broader scope of interviewees and stakeholders. Taking into account Thailand's regional diversity and inequality, hearing voices from the various regional locals, and the local authorities might benefit the conclusion.

Responses to reviewer:
The part of the study presented in this article focuses on NHES-policy linkage, relevant key informants included those who were working in health institutes, funding agencies and NHES managers at central level. However, we agree that the NHES may also be utilized by decision makers in regional health offices and local government organizations. As such, we would recommend including them as sources of information in future study.

While going through your manuscript, I found some suspected typographical errors. On page 5- line 50, after data into policies, "it explorers the NHES's policy". Correction: It explores the NHES's policy. On page 10- line 56, "there was a pan to transfer". Correction: there was a plan to transfer. On page11- line 16, "the NHES' notable strength". Correction: the NHES's notable strength, NHES is a singular proper noun. On page12- line 2, "collectively taken for different health surveys". Correction: collectively taken from different health surveys. Please take my suggestions into consideration, and kindly let me know if I was mistaken.

Responses to reviewer:

The corrections has been done as suggested:

On page 5- line 50, the phrase "it explorers the NHES's policy" was corrected to read "it explores the NHES's policy"

On page 10- line 56, the phrase "there was a pan to transfer" was corrected to read "there was a plan to transfer"

On page11- line 16, the phrase "the NHES' notable strength" was corrected to read "the NHES's notable strength"

On page12- line 2, the phrase "collectively taken for different health surveys" was corrected to read "collectively taken from different health surveys"

Reviewer #2: This is a qualitative study using an in-depth interviews and document review to investigate the obstacles in applying results from the National Health Examination Survey (NHES) into policies at country level. The manuscript is well written with important messages, the findings would benefit other low- and middle-income countries in designing population health surveys. I would like to accept this paper with minor revisions. Please see the list of points that needed to be clarified or fixed below.

1. P1, L16: Please be more specific about the method used in this study. In the abstract, the authors mention in-depth interviews and document review in the method section, however the majority of the results are from the interview.

Responses to reviewer:
We agree with your thorough observation and suggestions. The number of documents used as sources of information (in this article), especially in the Results section is quite small (reference #25 to #30), and the data collection mainly relied on interviews. As such, we removed ‘document review’ from the Abstract and Line 1 to 4, page 7.

2. P4, L55: missing reference in the NHANES application in raising awareness of public health institutes and concerned parties on the rising trends of NCDs.

Responses to reviewer:

Reference number 14 was added:


3. P8, L9: The authors use an establishment of a countrywide diabetes screening program as the successful example for the use of NHES data in policy making. The authors should discuss this success later in the Discussion.

Responses to reviewer:

We inserted one paragraph, as followed, on page 13 before the paragraph beginning with ‘As pointed out by public policy scholars, …’:

Although only one health officer explicitly mentioned in the interview about the use of NHES data to inform policy at country level, his arguments should be underpinned on some points. As prevalence of NCDs have been growing in Thailand and elsewhere, early detection and treatment together with enhancing healthy lifestyle among afflicted cases are important measures. NHES data had depicted silent diabetes attacks in different sub-populations and therefore, prompted attentions of responsible agencies to the diseases and proper interventions. By this, it means that this health examination survey could play a crucial part in agenda setting of not only diabetes but also other NCDs. Moreover, as can be learned from England’s HSE and the US NHANES (ref), data from the next cycles of the Thai survey will be helpful in monitoring and evaluation of the established programs for NCDs management.

4. In the conclusion, the authors seem to put more weight of evidence on the data governance issues in the shortcoming of NHES study. I would suggest that the nature of NHES survey itself is equally important because it prohibits the usage of this evidence in a policy cycle. The amount of time required to complete the survey does not allow the deliver of study results in the timely policy relevance. (see P9, L29: the section investigated why NHES data is rarely used in policy monitoring and evaluation). The manuscript convinced me that this is one of the major drivers for the development of alternative risk factor surveys. Similarly, another example is that the NHES appears to be
incapable of adapting its content to address the funding agencies' need (both MOPH and Thai Health). As a result, the use of NHES data in policy process is limited.

Responses to reviewer:

We agree with your suggestion. The mentioned problem concerning the use of time for delivering the survey results was mainly presented in result section II (page 10) but was not emphasised in the later section where we draw the conclusions on factors contributing to the weakest links of the survey in policy making process. We therefore added a sentence to emphasise the issue as suggested:

On page 11, under the topic ‘what are the weakest links of the NHES-policy connection?’ one sentence was added after the sentence beginning with ‘These problems may also result from the resource constraints …’ to read “Furthermore, the fact that the NHES could not deliver its results to policy makers in a timely manner is another factor that hinders the use of the survey data in policy-making process. As such, it could be argued that a critical shortfall involves the link between the policymaking community and institutes responsible for the survey in various interrelated aspects because inadequate resources and management may have adverse effects not only on NHES dissemination, but also on the performance of the entire program.”.

5. P14, L38: The conclusion in the final paragraph is vague. Please explain why you think the conceptual framework are not suitable for capturing the survey data in policy shift in this study.

Responses to reviewer:

Our conceptual framework assumes the utilization of NHES data in policy development is influenced by the users’ perceptions of the quality of the survey, the credibility of the survey practitioners and how the survey results are communicated, not plan to capture other aspects of research utilization such as interactions between researchers and users (as proposed by social interaction model)and range of ways in which research is seen to be utilised (in enlightenment model). Therefore, the conceptual framework is inadequate to capture complex pathways of NHES-policy nexus. Owing to this, we suggest application of specific theories and models such as those on policy transfer, policy networks and communities, and the policy advocacy coalition framework for future research to determine the implications of NHES data on specific policy decisions.

We agreed with you that the conclusion was unclear, and have this paragraph amended as followed:

An important limitation of this study is that, in large part, it relies on interview information based on key informants’ perspectives and experiences. Furthermore, the study’s conceptual framework was not designed to capture formal and informal interactions between NHES funding
agencies, survey practitioners and policy makers, as potential users of the survey data. Also, the framework does not address different ways of data utilization, as evidence obtained from the survey may be used straightforwardly to guide program development, while in some instances, the survey can raise awareness on certain health problems among decision makers and key stakeholders. Although the latter case may lead to policy change in later step, it is difficult to determine if such a development is attributed to the NHES or other factors. As such, this framework seems to be inadequate to explain policy shifts if the connection between evidence and policymaking is non-linear, such as those that fall into the social interaction model and enlightenment model as reviewed by Hanney and colleagues [6]. For future research to determine the implications of NHES data on specific policy decisions, public policy theories and models such as policy transfer [44], policy networks and communities [45], and the policy advocacy coalition framework [46] provide a more relevant basis to the study’s conceptual framework and data gathering tools.