

Evidence-Based Policymaking

January 27, 2026

Evidence-Based Policymaking

- What is EBP and what are its defining principles/key steps?

The Pew-MacArthur Results First Initiative's Steps in Evidence-Based Policymaking

Steps in Evidence-Based Policymaking



Source: Pew-MacArthur Results First Initiative, *Evidence-Based Policymaking* (Washington, DC: Pew Charitable Trusts and the MacArthur Foundation, 2014). Reused with permission.

• EBP Collaborative “First Principles”

- 1 Building and compiling rigorous evidence about what works, including costs and benefits.
- 2 Monitoring program delivery and using impact evaluations to measure program effectiveness.
- 3 Using rigorous evidence to improve programs, scale what works, and redirect funds from ineffective programs.
- 4 Encouraging innovation and testing new approaches.

Evidence-Based Policymaking

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 - 1 Evaluating Existing Programs: focuses on assessing the effectiveness of current programs through systematic reviews and cost-benefit analyses.
 - 2 Generating New Evidence: involves creating new knowledge to design or refine programs and policy approaches.

Evidence-Based Policymaking

- RCTs for evidence generation. Limitations?

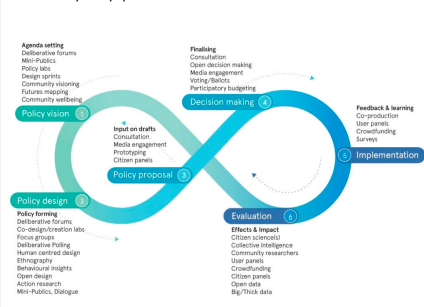
Policy Analysis - Policy Process

The Centers for Disease Control and Prevention's Policy Process



Source: "Policy Process," Centers for Disease Control and Prevention, last reviewed January 2, 2019, <https://www.cdc.gov/policy/polaris/policyprocess/index.html>. Reused with permission.

Simon O'Rafferty's Policy Cycle



Source: Simon O'Rafferty (@simonorafferty), diagram of the policy cycle, Twitter, June 27, 2019, <https://twitter.com/simonorafferty/status/1143979896835837952>. Reused with permission.

Evidence-Based Policymaking

- 6 approaches for broadening evidence types:
 - 1 Capture learnings beyond impacts.
 - 2 Evaluate indigenous interventions.
 - 3 Apply critical race theory.
 - 4 Engage practitioners in research design.
 - 5 Co-produce research with communities.
 - 6 Rethink the role of funders.

Bardach Technique for Policy Analysis

- Step 1: Define the Problem
- Step 2: Assemble Some Evidence
- Step 3: Construct the Alternatives
- Step 4: Select the Criteria
- Step 5: Project the Outcomes
- Step 6: Confront the Trade-Offs
- Step 7: Decide
- Step 8: Tell Your Story

- Bardach Step 2 - Assemble Some Evidence
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- How might we contribute to this evidence with our own policy evaluation (i.e., generate new evidence)?

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 - Does the evidence provide a causal interpretation?

Policy Analysis - Causal Interpretation?

- Bradbury et al. (2020) - Diet and Colorectal Cancer in UK Biobank: A Prospective Study

Methods

We used Cox-regression models to estimate adjusted hazard ratios for colorectal cancer by dietary factors in the UK Biobank study. Men and women aged 40–69 years at recruitment (2006–10) reported their diet on a short food-frequency questionnaire ($n = 475\,581$). Dietary intakes were re-measured in a large sub-sample ($n = 175\,402$) who completed an online 24-hour dietary assessment during follow-up. Trends in risk across the baseline categories were calculated by assigning re-measured intakes to allow for measurement error and changes in intake over time.

Results

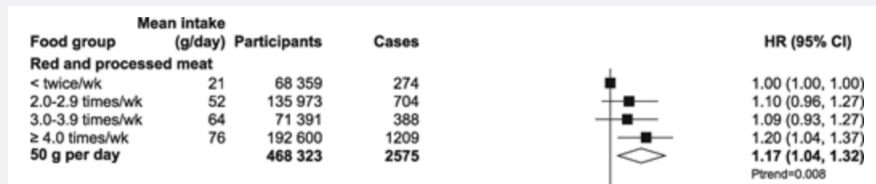
During an average of 5.7 years of follow-up, 2609 cases of colorectal cancer occurred. Participants who reported consuming an average of 76 g/day of red and processed meat compared with 21 g/day had a 20% [95% confidence interval (CI): 4–37] higher risk of colorectal cancer. Participants in the highest fifth of intake of fibre from bread and breakfast cereals had a 14% (95% CI: 2–24) lower risk of colorectal cancer. Alcohol was associated with an 8% (95% CI: 4–12) higher risk per 10 g/day higher intake. Fish, poultry, cheese, fruit, vegetables, tea and coffee were not associated with colorectal-cancer risk.

Conclusions

Consumption of red and processed meat at an average level of 76 g/d that meets the current UK government recommendation (≤ 90 g/day) was associated with an increased risk of colorectal cancer. Alcohol was also associated with an increased risk of colorectal cancer, whereas fibre from bread and breakfast cereals was associated with a reduced risk.

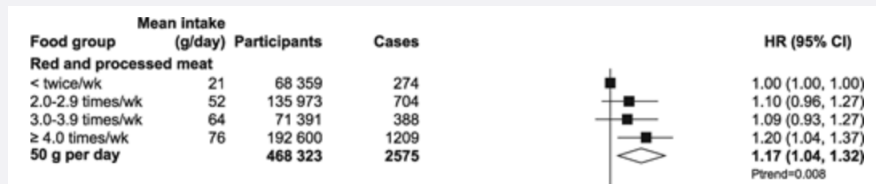
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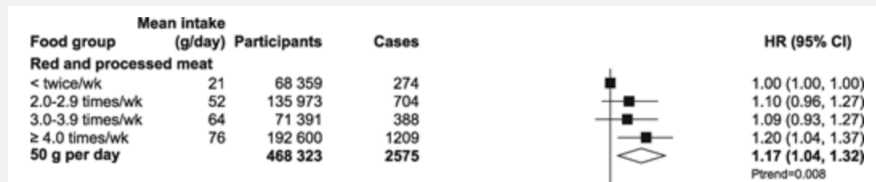
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- Always consider effect magnitudes!

Policy Analysis - Causal Interpretation?

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- Always consider effect magnitudes!
 - 20% increase off of a base of 0.40% $[(274/68,359)*100] = 0.48\%$

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 - Does the evidence provide a causal interpretation?
 - Is the evidence rooted in the appropriate historical context?



Contents lists available at [ScienceDirect](https://www.sciencedirect.com)

Economics and Human Biology

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The long-run effects of adolescent athletic participation on women's health

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^a Tulane University, Department of Health Policy and Management, School of Public Health and Tropical Medicine, 1440 Canal St., New Orleans, LA 70112, USA

^b Grand Valley State University, Department of Economics, 3027 L.W. Seidman Center, 50 Front Ave. SW, Grand Rapids, MI 49504, USA

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I12
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Title IX

ABSTRACT

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Race and Gender Equity in Sports: Have White and African American Females Benefited Equally From Title IX?

Moneque Walker Pickett, Marvin P. Dawkins, Jomills Henry Braddock

First Published October 10, 2012 | Research Article



<https://doi.org/10.1177/0002764212458282>

[Article information](#) ▼

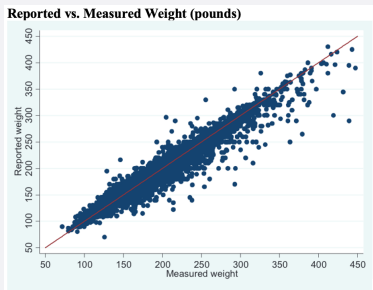


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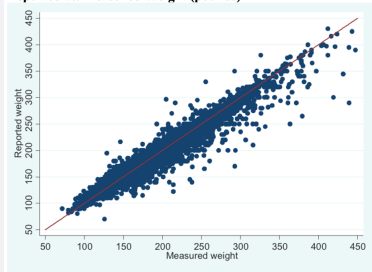
Policy Analysis - Data Quality

- Cawley et al. (2015) - Reporting Error in Weight and its Implications for Bias in Economic Models



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Reported vs. Measured Weight (pounds)



Highlights

- Reporting error in weight is substantial; its absolute value averages 6 pounds or 3.3%.
- Reporting error in weight is not classical; the extent of underreporting increases with measured weight.
- Roughly 1 in 7 individuals obese according to measurements are misclassified as non-obese by their reported weights.
- Better educated individuals tend to report their weight more accurately.
- Reporting error in weight can lead to upward bias in estimates of the healthcare consequences of obesity.

By Angshuman Gooptu, Asako S. Moriya, Kosali I. Simon, and Benjamin D. Sommers

Medicaid Expansion Did Not Result In Significant Employment Changes Or Job Reductions In 2014

ABSTRACT Medicaid expansion undertaken through the Affordable Care Act (ACA) is already producing major changes in insurance coverage and access to care, but its potential impacts on the labor market are also important policy considerations. Economic theory suggests that receipt of Medicaid might benefit workers who would no longer be tied to specific jobs to receive health insurance (known as job lock), giving them more flexibility in their choice of employment, or might encourage low-income workers to reduce their hours or stop working if they no longer need employment-based insurance. Evidence on labor changes after previous Medicaid expansions is mixed. To view the impact of the ACA on current labor market participation, we analyzed labor-market participation among adults with incomes below 138 percent of the federal poverty level, comparing Medicaid expansion and nonexpansion states and Medicaid-eligible and -ineligible groups, for the pre-ACA period (2005–13) and the first fifteen months of the expansion (January 2014–March 2015). Medicaid expansion did not result in significant changes in employment, job switching, or full- versus part-time status. While we cannot exclude the possibility of small changes in these outcomes, our findings rule out the large change found in one influential pre-ACA study; furthermore, they suggest that the Medicaid expansion has had limited impact on labor-market outcomes thus far.

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 - ▶ External validity

By Sayeh Nikpay, Thomas Buchmueller, and Helen Levy

Early Medicaid Expansion In Connecticut Stemmed The Growth In Hospital Uncompensated Care

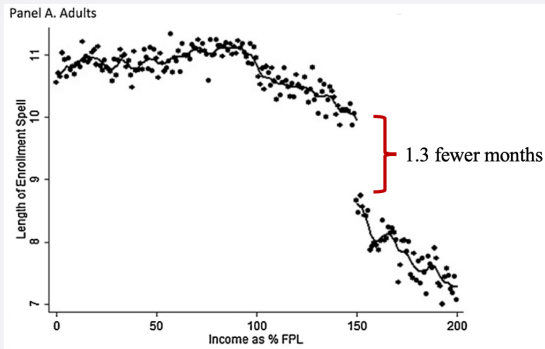
ABSTRACT As states continue to debate whether or not to expand Medicaid under the Affordable Care Act (ACA), a key consideration is the impact of expansion on the financial position of hospitals, including their burden of uncompensated care. Conclusive evidence from coverage expansions that occurred in 2014 is several years away. In the meantime, we analyzed the experience of hospitals in Connecticut, which expanded Medicaid coverage to a large number of childless adults in April 2010 under the ACA. Using hospital-level panel data from Medicare cost reports, we performed difference-in-differences analyses to compare the change in Medicaid volume and uncompensated care in the period 2007–13 in Connecticut to changes in other Northeastern states. We found that early Medicaid expansion in Connecticut was associated with an increase in Medicaid discharges of 7–9 percentage points, relative to a baseline rate of 11 percent, and an increase of 7–8 percentage points in Medicaid revenue as a share of total revenue, relative to a baseline share of 10 percent. Also, in contrast to the national and regional trends of increasing uncompensated care during this period, hospitals in Connecticut experienced no increase in uncompensated care. We conclude that uncompensated care in Connecticut was roughly one-third lower than what it would have been without early Medicaid expansion. The results suggest that ACA Medicaid expansions could reduce hospitals' uncompensated care burden.

Policy Analysis - External Validity (Method)

- Dague (2014) - The Effect of Medicaid Premiums on Enrollment
 - ▶ Beginning in 2008, Wisconsin charged a monthly premium for Medicaid coverage for non-elderly, non-disabled, childless adults at 150% FPL and above.

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