

1 Introduction to the HSREPP project: concept, objectives and report overview

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1.1 Introduction

This final report, part of the FP-7 funded project Health Services Research into European Policy & Practice (HSREPP), addresses how health services research (HSR) can help decision-makers tackle the challenges they face and provide scientific evidence to inform policies and practices. Its aim is to contribute to a refinement of the European agenda of priorities in health services research, tuned to the information needs of health policy-makers. This can contribute to promoting effective interfaces between the research community and policy-makers for the benefit of scientific underpinning of health care policies. Better application of available and identification of new scientific evidence should result in more effective policy measures and health care systems that are both efficient and responsive to the needs of European citizens. For several reasons, policy decisions on the design of health services often lack an underpinning of scientific evidence. In part, communication channels between the research community and decision-makers may be poorly developed (Black, 2001; Innvaer et al., 2002). But it should also be admitted that the contributions that scientists can offer are incomplete. For instance, the insights in the transferability of evidence from one health care system to another are still limited. This should be understood, however, in a historical context. The incremental way in which health care systems have developed in many Member States, in particular those with 'Bismarckian' roots, has resulted in a collection of unique 'patchworks', in which health services research knowledge is highly context-dependent (Marrée and Groenewegen, 1997).

A main reason why optimizing health care systems and services has become a priority is because of the need to contain growing costs for health care and to be prepared for future challenges of demand. Another is because health systems are increasingly seen in the larger context of general societal values like solidarity and equity that should be reflected in good access for all and responsiveness of health care services to the population's needs. Although Member States retain sovereignty with respect to their health care systems, these efforts to optimize health care systems can be observed throughout the EU. The European Commission aims to actively support the optimization of Member States' health care by providing added value to national efforts (EC, 2006a). One of the target areas in its Seventh Framework Programme is the research area of health systems and services under Pillar 3, "*Optimising the delivery of health care to citizens*", aimed to provide the necessary evidence basis for informed policy decisions on health systems. Objective of this report is to provide inputs that can help achieve this aim, among others for the benefit of determining annual work programmes within the Seventh Framework Programme, as well as future Framework Programmes. However, the focus of the report is on other users as well, such as governments in Member States, national funding bodies, and international organisations including WHO and OECD, to contribute to ongoing dialogue and fine-tuning between initiatives in order to make effective use of (European) funded resources in the field of HSR.

1.1.1 Definition and approach of HSR

As the object of study of this report is on health services research, we start with a general step, namely defining what we consider as health services research and narrowing down which elements to include. For this purpose we adopt the definition used by AcademyHealth:

HSR is the multidisciplinary field of scientific investigation that studies how social factors, financial systems, organisational structures and processes, health technologies and personal behaviours affect access to health care, the quality and cost of health care and, ultimately, the health and wellbeing of citizens (Lohr and Steinwachs, 2002; AcademyHealth, 2007).

As this definition makes clear, health services research covers a broad field which requires more precise definition of the areas of HSR around which this report will be centred. We will address the level of analysis of HSR, its relationship with other fields of health research and its relationship with (health) policy.

1.1.2 Level of analysis

A major characteristic of HSR is its broad focus: phenomena can be investigated at macro-level, meso-level and micro-level of health care provision. The macro-level refers to the health care system at large, either at regional level, at national level, or even at supra-national level. The meso-level is the intermediate level of health care organisations and the services they provide, while the micro level includes physicians' use of medical devices and technologies. Increasingly, studies in the field of HSR take an international or European perspective, in part related to the growing interconnectedness of health systems and health policies across the EU. As the EC notes 'this increased interconnection raises many health policy issues, including quality and access in cross-border care; information requirements for patients, health professionals and policy-makers; scope for cooperation on health matters; and how to reconcile national policies with the obligations of the EU's internal market' (EC, 2006b: 1). The manners in which health services can be studied from a European perspective, while considering the diversity among European health care systems, is a key element of HSR to be addressed.

1.1.3 Relationship with other fields of health research

The definition presented above, implies a close relationship and partial overlap between HSR and (Public) Health Research, in which health or quality of life is the object of study. Similar to HSR, Health Research can be done at different levels. Among others, when focusing on groups or national settings it is often referred to as Public Health Research, studying a population's health, while at lower levels it includes clinical (intervention) research, studying the effect of treatment methods on health outcomes. The partially overlapping relationship between HSR and (Public) Health Research is depicted in the following Venn diagram (based on Van der Zee et al, 2004).

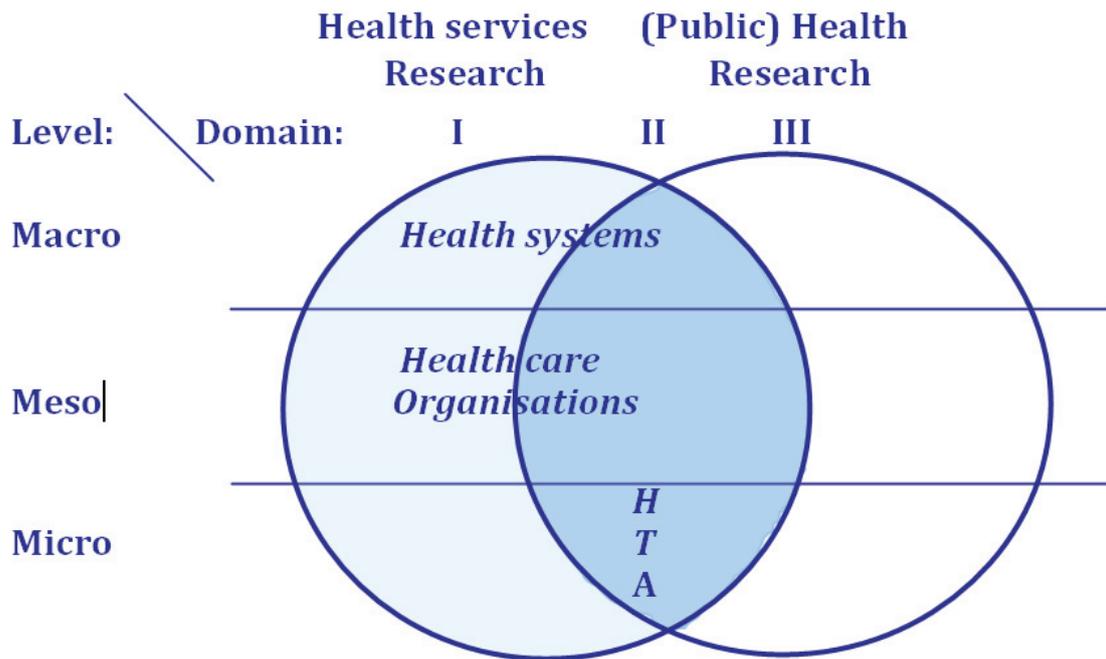


Figure 1.1 Relationship between Health Services Research and (Public) Health Research

Explanation of figure 1:

- Domain I has no overlap with (Public) Health Research. This domain is the utilisation of health services without taking individual health as an outcome or specific clinical interventions into consideration. Examples are determinants of doctors' incomes; teamwork and division of tasks between health care providers; and studies on health care expenditure.
- Domain III is the exclusive domain of (Public) Health Research. It includes research on health status or clinical interventions without taking into account the influence of the organisation or type of health services. Examples in the field of public health are studies about smoking behaviour or population-based epidemiological studies; examples in the field of clinical research are studies on the influence of specific medical interventions or pharmaceuticals on health outcomes.
- Domain II refers to the overlap between both adjacent research domains, relating the organisation of health care with health outcomes. For instance, health systems or health service facilities may be compared in terms of health outcomes. Or, features of the health care system or the organisation of facilities may be considered as a determinant of health or an influencing factor for the implementation of clinical interventions. Health Technology Assessment (HTA) takes up a special place within this domain. HTA entails the overlapping field between HSR and Health Research at different levels, as it not only covers topics such as medical devices, screening programmes or diagnostic technologies, but also concerns 'the organisation and delivery of care, since assessments, by definition, include issues about the use and diffusion of technology' (Jonsson et al., 2002). This especially applies to studies concerning the long-term effects of health technologies and their applicability and transferability to different (national) settings.

Health Services Research consists of both domains I and II and consequently both are addressed in this report.

1.1.4 The relationship between HSR and policy-making

As HSR is typically applied research, it is vital that an overview of HSR not only aims at research activities in themselves, but also addresses the manner in which these activities are being funded and used, as it helps understand and enhance an effective relationship between decision-makers, other stakeholders and researchers. In practice, the relationship and communication between the health services research community and decision-makers has been structured differently across Europe, varying from formal councils and other bodies to more informal connections. Reinforcement of this relationship, whatever its shape, is indispensable for at least two reasons. Firstly, in this relationship the policy problems to be studied need to be identified and clarified. Secondly, researchers and the users of study results together play a role in formulating lessons and recommendations as inputs to new policy. Without effective communication channels between researchers and the users of their results, the available HSR potential may not be focussed on the priorities of policy-makers, and policy-makers may not be effectively provided with available evidence from HSR studies (Mays et al., 2005). Therefore, we aim to contribute to future dialogue by clarifying possible contributions of HSR to policy-makers in order for gaps that deserve to be prioritised to be filled (Tennison, 1996).

1.1.5 Position of HSR in Europe

By a number of activities we aim to map and promote effective HSR contributions that can enhance the information base of health policy. However, there is not much to promote or to coordinate in this respect in the absence of HSR capacity. The level of development and the volume of health services research is quite diverse across European Member States (Gonzales-Block, 2006; Delnoij and Groenewegen, 2007). In particular in most of the newest EU Member States, HSR has very little tradition and has only developed slowly since the mid 1990s. Researchers in these countries learn from joint international projects and exchanges, but their numbers remain modest, mainly because funds for health services research are scarce. This situation is highly relevant and it gives a considerable European added value to this overview. Our exploration of the European 'HSR landscape' explicitly pays attention to the diversity in the position of health services research in Member States. This may also contribute in reducing the gap in research capacity among Member States. If the information base of health policy is to be strengthened, at national and European level, HSR capacity in individual Member States needs to be further developed. It is not sufficient for policy-makers to rely on international comparative studies alone. These are useful to compare general indicators, but are usually not detailed enough for balanced policy-making in the national 'patchwork situations' of health care. Moreover, for most relevant policy issues no results from international studies are available. Information-based national health policy cannot do without its own HSR inputs. As copying service arrangements from other (different) health care systems is not always justified (Øvretveit, 2003; Ros et al., 2000), national HSR is indispensable for the monitoring and evaluation of newly implemented health policy measures. We will address this problem by mapping the HSR potential in Member States, by employing strategies to involve researchers and policy-makers from countries that are developing their HSR capacity and by discussing a HSR agenda that is also aimed at such countries.

1.2 Objective

The overarching aim of this report is:

“ to identify, evaluate and improve the contribution of health services research to the health policy process at the level of Member States and the European Union, and thus to help optimizing the delivery of health care services to European citizens.”

This general objective can be broken down to the following specific objectives:

a. To identify the state-of-the-art of HSR in Europe.

Explanation: An identification of the current state-of-the-art of HSR clarifies the areas that are currently well-defined and the outcomes of which can be used for policy-making purposes to improve health services. At the same time, this mapping results in an inventory of research areas that are currently under-researched from a policy perspective. Identified gaps are possible priorities for new research and a future HSR research agenda.

b. To identify at European and Member State level current and upcoming priorities in HSR for addressing policy needs.

Explanation: In order to create and support a market place for health services research, the needs and demands of policy-makers for HSR inputs need to be clarified. Health services research priorities may concern either the specific topics of studies, the methods used or the timeliness of research. Priorities vary because of the differences in the body of knowledge in research areas and how these relate to the policy agenda (Bensing et al., 2003). The linkage to the policy agenda illustrates the importance of health services research being aimed at asking the right questions, in the right manner and at the right time. This refers to mapping research topics and priorities as well as to the methodological issues involved, e.g. for improving comparability in studies between Member States (Dash et al., 2003). Another aspect is the timeliness of research, in order to meet “real time” needs of policy-makers (AcademyHealth, 2006), but also in terms of distinguishing short- versus long-term priorities (Dault et al. 2003). As such, this objective requires a picture of the current state-of-the-art in HSR (objective a), as well as identification of what the needs of policy-makers are.

c. To assess at Member State and European level current infrastructures for the translation of HSR into the policy and practice.

Explanation: This assessment and evaluation relates to research practice (for instance, the exchange of methods and data availability) as well as to the use of research networks and scientific and advisory bodies, and how these contribute to effectively disseminating HSR results to policy-makers. Promoting the “linkage and exchange” between health services researchers and the users of their products is crucial in ensuring an effective use of HSR (Lomas et al., 2003). This evaluation includes opinions and experiences of policy-makers, other stakeholders and researchers as to the role of HSR in health policy development. This to determine whether current infrastructures are sufficient to meet the needs of health policy-makers and to recommend how possible shortcomings can be removed.

d. To contribute to agenda setting on HSR at European and Member States’ level.

Explanation: This objective relates to the intended outcomes of the report and therefore, its main focus. On the basis of the state-of-the-art of HSR, consultations among decision-makers and researchers and presentations of innovative research across the European Research Area, a dialogue will be established in order to determine and refine HSR priorities at European level. These priorities will help EC Directorates-General to further develop their research programmes.

This study should also provide major information for Member States to set their own HSR agenda and create structures to enable to improve the information base of their health care policy.

1.3 Overview of the report

This report and its mapping activities on the state-of-the-art and future priorities is structured around a number of sub-areas in HSR, broken down into different chapters, 3 to 7. First, chapter 2 will shortly describe the research activities that were carried out for the production of this report. Although the exact activities differ somewhat between HSR areas and chapters, there are three key elements that all chapters make use of: literature searches, country consultation forms, and an online stakeholder survey. The following chapters then focus on each of the main HSR areas: chapter 3 deals with HSR at macro level, focusing on health care systems; chapter 4 with HSR at the level of organisations and professional practices; chapter 5 will focus on HSR at micro level: the effects of interventions and services; chapter 6 and 7 apply to all these levels and address the relatively new field of benchmarking studies, and the HSR research-policy interface, respectively. The five chapters are briefly explained below.

- **Chapter 3** will address the available knowledge of HSR at the level of health care systems, being national or sometimes regional entities, influenced by European institutional forces. As health care systems may contribute to the realisation of general values of universality, access to good health care, equity and solidarity, attention is being paid to understanding and improving health systems performance. Many topics that are currently high on the European research agenda are linked to the arrangements of the health system as a whole (for instance, cross-border healthcare purchasing and provision, migration of health care professionals, and patient safety).
- **Chapter 4** will focus on health care organisation and service provision. Health care organisations and the services they provide form an intermediate level between the health care system at large and service provision in the interaction between patients and providers. Their systematic coherence can be evaluated (in terms of interactions and interconnections between organisational structures) (Sibthorpe et al. 2004), as well as their contribution to optimal and sustainable health care delivery. As such, the functioning of organisations is influenced by the system at large, for instance by prevailing regulation that may affect their degree of autonomy and market exposure.
- **Chapter 5** will address health care interventions, by specifically looking at the field of Health Technology Assessment (HTA). HTA is a multidisciplinary field of policy analysis that systematically assesses the medical, social, ethical, and economic implications of the development, diffusion, and use of health technology (INAHTA, 2007). HTA addresses a wide range of interventions used in health care and health promotion. It studies the effectiveness of methods for prevention, diagnosis, treatment and rehabilitation and the systems in which health is protected and maintained. Compared to other areas of HSR, HTA is a field in which most experience is available concerning the transferability of research to (evidence-based) health policy and the various forms in which research and policy meet structurally (councils, by means of national expert centres, chief scientists, conferences, seminars). As such, HTA can provide valuable lessons for other fields of HSR for refining the research agenda and strengthening the linkages between research and policy.

- **Chapter 6** will be devoted to benchmarking and performance indicators. An issue relevant to all areas of HSR is the collection and dissemination of information on 'good practice'. Benchmarking is increasingly important in the light of 'responsive health care systems' with a growing emphasis on the needs of users (and choosers) of health care services. This activity entails monitoring health services within and across Member States over time, pooling valuable health services initiatives and setting up (European) mechanisms to exchange best practice. A crucial step in this process is to develop and refine criteria for benchmarking health services by using comparable performance indicators (Arah et al., 2003). A growing number of studies has shown concern about the quality of indicators used (WHO, 2000; Wait and Nolte, 2005; De Koning et al., 2007). This chapter will address these issues by identifying main themes and opportunities to improve the HSR evidence base behind policy developments and to identify priorities and recommendations for setting the research agenda in the field of performance indicators and benchmarking.
- **Chapter 7** will focus on the relationship between the HSR community and the health policy process at the various subsystems and levels of the health care system (regionally, nationally and at European level). Its focus will be on modes of commissioning research by policy-makers as well as on how results of research are fed into the policy process. This includes structures and conditions for the effective transfer of knowledge as well as feedback structures between decision-makers and researchers. This information will be considered in the context of the organisation of the policy cycle and the general political structure (e.g. coalition governments versus two party systems) and general health care system structure (social security health care systems versus National Health Services). The question of how research is (and should be) linked to policy is applicable to all of the areas within HSR. Lessons from HTA, for instance, may also apply to other areas. On the other hand, linkages between research and policy may well vary between HSR topics and between Member States, depending on the overall structuring of the national (health care) system.

Given the European perspective of this report, each of the chapters 3-7 will put special emphasis on evaluating research across the European Research Area, including Eastern and Central European countries that may up to now be underexposed. As such, the combined efforts of these chapters will help build on *past* European HSR, evaluate *current* HSR and help develop *future* research initiatives based on the past and current state of research as well as policy information needs, which can be used in current as well as future research programmes.

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