

7 Health Services Research in Europe and its use to inform policy

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7.1 Introduction

Health services research is a “multidisciplinary field of scientific investigation that studies how social factors, financing systems, organizational structures and processes, health technologies, and personal behaviours affect access to health care, the quality and cost of health care, and ultimately our health and well-being” (Lohr and Steinwachs, 2002; p. 16). This chapter aims to describe the state of development of health services research in countries in Europe and the extent to which this research is used to inform policy-making.

Health services are an established area for research in some countries (e.g. the United States, Britain and the Netherlands). However, in other countries this field of research is still emerging, illustrated by the fact that the term “health services research” does not exist in some languages or has only recently been created (e.g. “Versorgungsforschung” in Germany). Nonetheless, there may well be research activities that would be classified as health services research, for example, under the banner of a discipline that contributes to health services research, such as clinical epidemiology, medical sociology or health economics.

There is a general perception that the potential of health services research is not sufficiently brought to bear on health care policy and practice (Ham, 1995). This “research-policy gap” is not unique to health services and health care policy, and is not surprising given the complexity and ‘messiness’ of the policy-making process, linked to its legitimate exposure to public pressure and political influence. Yet from a public policy perspective, this also constitutes an under-utilisation of public resources, as most health services research is publicly funded, as are most health services in high income countries (WHO, 2004). Assuming that evidence from research can contribute to improving the quality (including effectiveness, safety, humanity and equity) and efficiency of health services, not using this information constitutes a waste of resources.

However, the relationship between policy and research – as sometimes promoted by proponents of “evidence-based policy-making” – is not straight forward. There is a growing body of research on the relationship between health services research and health policy, mostly from Canada, England and Scotland. In addition, there is substantial activity in some fields of health services research that span the research-policy interface. At the micro-level, health technology assessment (HTA) has become increasingly influential in informing decisions on health services coverage in publicly financed health care systems (Velasco Garrido et al. 2008). However, in the other two areas of health services research, health systems (macro-level) and the organisation and delivery of health services (meso-level), the links between research and policy are often not well understood. This chapter aims to provide the first map of the capacity and institutional infrastructure of health services research in Europe and to examine the links between health services research and policy-making in European countries. The chapter largely focuses on the use of research at the level of national and systemic policy-making, although it is acknowledged that there is a much larger group of potential users of research than national policy-makers, such as clinical practitioners and health care managers.

7.1.1 Conceptualising the research-policy relationship

There have been a number of approaches to conceptualising the relationship between research and policy (Nutley et al., 2007). In sum, these fall into three broad categories:

Linear-rational approaches assume that the relationship between research and policy is relatively straight-forward, emphasising the possibility of “transferring” research evidence from researchers to policy-makers. Research and policy-making are typically seen as distinct processes, with researchers and policy-makers forming separate communities (e.g. Caplan, 1979). This model is often associated with a “traditional” model of the policy process, built on the assumption that policy-making follows a number of distinct stages: Problem identification; assessment of policy options and decision-making; policy implementation; and monitoring and evaluation (e.g. Stone, 2001). Research, it is argued, can influence policy at any of these stages. Further developments have been able to integrate other models of policy processes, focusing, for example, on networks of drivers of policy processes (Nutley and Webb, 2000). Linear-rational models share an assumption that research can translate into policy, by providing solutions for policy problems. However, this approach has been criticised as reductionist, oversimplifying the nature of the policy process, the limitations and potential ambiguity of research findings, as well as the complexity of many policy problems (e.g. Black, 2001).

Multidimensional approaches, in contrast, emphasise the complexity of the research and policy relationship. Proponents of these models argue that evidence is often contested and not easily applicable in practice. Policy processes are “messy” and often unpredictable, shaped by the practices and interests of multiple stakeholders, of which researchers are only one group among many that are competing for the attention of policy-makers. The process of developing policy is further complicated by the fact that many problems policy-makers face do not lend themselves to simple answers and thus demand complex interventions that often involve policy areas outside the reach of health ministries. Multidimensional models tend to emphasise the importance of the linkages and continuous exchange between researchers and policy-makers. Huberman (1994), for example, developed a “dissemination effort model”, outlining several factors that influence the use of research (in this case in education), including factors associated with the context of the producers and users of research, dissemination efforts of researchers, and linkage between researchers and policy-makers. Linkage and exchange have also been highlighted as the main factors in more recent work on knowledge transfer models (e.g. Mitton et al. 2007).

A third group of models emphasises *the role of context* in shaping the relationship of research and policy. In the extreme, contextual models question evidence from research as ‘socially constructed’, arguing that the meaning of research is contingent on its interpretation (e.g. Cousins and Simon, 1996), which is shaped by the local environment of the interpreter (i.e. the user of research). A model developed by Kitson et al. (1998) sees the use of research by clinical practitioners dependent on multiple contextual factors. Contextual factors may also be highly relevant in relation to health policy-making. Arguably, factors relating to the organisation and governance structure of the health care system, as well as to the institutions, rules, cultures and power dynamics within political systems strongly affect the behaviour and attitudes of policy-makers towards research. Therefore, one could expect that strategies that have helped to improve the uptake of research in policy in one country may not be equally successful in other countries, given the differences in national context.

7.1.2 The impact of research on policy

A further strand of research is concerned with conceptualising and studying the impact of research on policy. Weiss (1995) distinguished *instrumental*, *conceptual* and *strategic* uses of research in policy-making. “Instrumental” use largely assumes a linear relationship between research and policy, seeing policy-making as a rational activity in which evidence from research is a key factor. Although the idea of instrumental use rests on a range of assumptions, in practice, some types of

research may more easily lend themselves to application than others. Arguably, the growing utilisation of health technology assessments in informing coverage decisions provides an example of instrumental use, although some argue that decisions based on health technology assessments are as complex, context-dependent and multi-layered as other more macro policy decisions (Velasco Garrido et al., 2010). Concerns have also been voiced about the potential for researchers pursuing instrumental goals of research use to become too closely involved in policy at the expense of losing the distance required to comment critically on policy developments (Weiss 1995).

'Conceptual' use refers to situations in which research is used to shape policy-makers' perceptions of a policy problem, without necessarily providing a solution. Weiss argued (1979) that such 'enlightenment' was one of the key functions of research. However, she also warned that improper use of research can have the opposite effect, hence the risk of diffusing 'endarkenment' as well as 'enlightenment' (Weiss, 1979).

'Strategic' use of research occurs when findings are used as political ammunition or in support of decisions that have been taken before the research was being considered. There is debate whether strategic or selective uses of research always constitute misuse of research, with some arguing that the difference is situational and not clear-cut (e.g. Patton, 1996). This type of use is likely to resonate with the experience of many researchers. It also draws attention to the imbalance of power that often characterises the relationship between policy-makers and researchers. While researchers may see themselves as the ones that 'speak truth to power' their influence on policy is often limited if not marginal. Still, it may be essential for researchers to understand the political context of decision-making if research is to have a role in policy-making. There are efforts in some countries, notably Canada, to strengthen the uptake of research in policy by changing the policy process in ways that may give researchers greater opportunities to have influence. Research utilisation checklists for policy officials are an example of a tool developed to facilitate the integration of research in the policy process (Lomas and Brown 2009).

Measuring the impact of health research on policy-making is a further focus. Lavis and colleagues, for example, have developed a framework for assessing the outcomes of activities that aim to support the dissemination of research (research push), uptake of research by policy-makers (user pull), as well as linkage and exchange efforts (Lavis et al. 2003).

A growing body of research examines the factors that shape, enable and hinder the use of research in policy-making. Based on interview studies of policy-makers' perceptions, Innvær et al. (2002) identified a number of barriers (and corresponding facilitators, see Oxman et al., 2009), including the absence of personal contacts and mutual distrust between researchers and policy-makers, insufficient timeliness of research, doubts about the quality or relevance of research, power and budget struggles within policy organisations and high staff turnover among policy-makers. Similar barriers were identified by Brownson et al. (2006), who added the problem that policy-makers often have to manage vast amounts of information, the lack of data relevant to many policy questions and the frequent ambiguity of research findings. Although these factors play out differently in different health care and political systems, and in relation to different research or policy topics, they are likely to shape the relationships between research and policy to some extent in any given country.

Despite the extensive analytical literature, there are few studies in European countries on the relationship between health services research and policy making, and the use made of health services research. Most research on health (services) research utilisation originates in English

speaking countries, notably Canada. Even descriptive information on activities and institutional arrangements is lacking. For these reasons, there is value in undertaking a first survey of the field. In what follows, a conceptual framework of knowledge transfer processes was used to inform collection and analysis of data from countries in Europe. This framework is based on recent work by Ward et al (2009a) that identified five broad components that shape the use of research and/or knowledge in policy-making: a recognition of a (policy) problem; the knowledge and research available relevant to the problem; contextual factors relating to barriers to and support of research utilisation; the use of research in the policy process; and interventions and mechanisms to support the use of research. Based on the review of 28 models which explain all or part of the process of research utilisation, this framework is 'empty', in the sense as is not associated with a particular context. The framework does not make assumptions about the type of knowledge transfer process, which the authors concede can be 'linear', 'cyclical' or 'dynamic/multidirectional'. The framework is thus generic enough to allow for the application to a variety of different situations and national settings, without making assumptions about policy processes and processes relating to the use of research, which lie beyond the scope of this study.

7.2 Aims and objectives

This chapter is part of the project "Health Services Research into European Policy and Practice", funded by the European Commission (EU-FP7 HSREPP). The project aims to identify, evaluate and improve the contribution of health services research to health policy-making in countries in Europe. The project involves the organisation of a conference, held in April 2010 in The Hague, with the purpose of this chapter being to provide an overview of health services research in Europe and its use in policy.

The specific aims of this chapter are:

- To examine the sources and scope of funding available for health services research and the extent to which research funding reflects the priorities and/or strategies of policy-makers and policy agencies in countries in Europe.
- To describe the landscape of health services research, including the types of organisations undertaking research, the type and level of training available for health services researchers, the journals that publish health services research, the existence of conferences, associations and networks, and the balance of domestically produced versus externally produced research available in European countries.
- To identify the main users of health services research for policy and to describe the mechanisms which support the dissemination of research findings, facilitate the use of research by policy-makers and promote 'linkage and exchange' between researchers and policy-makers in these countries.
- To analyse the barriers to using health services research evidence in policy-making and to examine the incentives and disincentives facing both researchers and policy-makers to produce and apply research findings to policy, and to outline how the relationship between health services research and health policy-making can be strengthened in future.

7.3 Methods

This chapter is based on a survey of health policy experts recruited specifically to act as informants in the 34 countries participating in this project. Countries are the member states of the European Union as well as Croatia, Iceland, Macedonia, Norway, Switzerland and Turkey. As this is a preliminary mapping exercise of activities in 34 countries we decided to use a broad framework as an initial analytical tool to guide questionnaire development and subsequent analysis of country responses. The framework takes a knowledge transfer perspective, based on the recent review by Ward et al. (2009a), mentioned above.

A brief review of the literature was also undertaken to inform the design of the survey questionnaire and the framework of analysis. Given the wealth of studies on research utilisation, knowledge transfer and evidence-based policy-making, we focused on reviews that bring together existing knowledge about the research and policy interface. Country informants were selected based on reputation and expertise, using the professional networks of the EU-FP7 HSREPP project consortium. Most country informants are members of the academic community involved in health services, health systems or health policy research. As a consequence, the views of policy-makers are likely to be underrepresented.

Country informants were asked to complete a detailed questionnaire, which they received in September 2009. Twenty-nine questions covered the following areas: funding and prioritising health services research; production and producers of health services research; health policy users of health services research; activities to promote the use of health services research; and barriers and facilitators to using health services research in policy-making (see appendix 1).

The questionnaire used a broad definition of health services research as a “multidisciplinary field of scientific investigation that studies how social factors, financing systems, organizational structures and processes, health technologies, and personal behaviours affect access to health care, the quality and cost of health care, and ultimately our health and well-being” (Lohr and Steinwachs, 2002; p. 16). We did not provide a definition of the term “use” in relation to policy-making. However, most questions included a number of detailed prompts to guide responses.

The analysis of responses was guided by the framework of the knowledge transfer process developed by Ward et al (2009a), which we have adjusted for the purpose of this chapter in several ways. As the scope of this mapping exercise does not allow an in-depth analysis of the problems and issues policy-makers face in individual countries, we decided to omit the dimension “Problem” suggested by Ward et al. (2009a). Likewise, we did not attempt to describe the extent and activities of health services research in Europe, which will be undertaken by other contributions to this project (see previous chapters). Instead, we describe the type of actors involved in producing health services research and the organisations using this research to inform policy-making. Finally, we have added the funding of health services research and approaches to priority setting as separate dimensions to highlight the importance of these influences on the links between all dimensions of this framework (Figure 7.1).

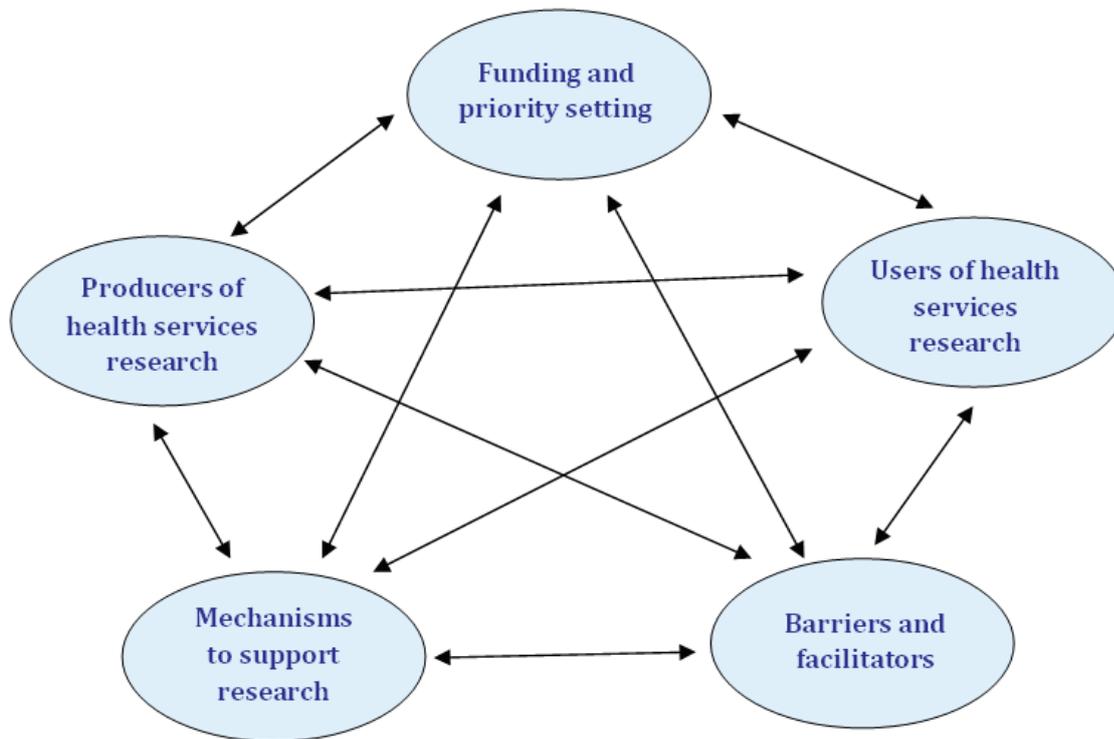


Figure 7.1 Framework for the analysis of the use of health services research to inform policy

7.4 Results

Information was returned by informants in 30 of the 34 countries approached (as of December 2010): Austria, Belgium, Bulgaria, Croatia, Cyprus, the Czech Republic, Denmark, England, Estonia, Finland, France, Germany, Greece, Ireland, Italy, Latvia, Lithuania, Macedonia, Malta, the Netherlands, Norway, Poland, Portugal, Romania, Scotland¹, Slovakia, Slovenia, Spain, Switzerland and Turkey. Information was unavailable (or substantially incomplete) from Hungary, Iceland, Luxembourg and Sweden.

7.4.1 Funding of health services research

We begin to assess the scope and scale of health services research in Europe by describing the sources and level of funding available for research. The second part of this section examines the extent to which decisions to fund health services research are determined through strategic priority-setting.

The following main sources of funding were identified: (1) governments, (2) health system organisations, (3) the independent sector, and (4) international organisations. Health services research in Europe is predominantly publicly funded. However, the sources and level of funding varies substantially among countries.

- 1 In most countries, governments play a key role in providing funding for health services research. This role is typically exercised at central government level, although regional or local governments may also fund research in some countries (see below). There are generally two

¹ We here count Scotland and England as two separate countries, with two separate health systems and health policy mechanisms.

channels for government funding (a) through dedicated research funding bodies, and (b) through government ministries or agencies. Research funding organisations typically fund health services research as one area of research among others.

For example, in England, the National Institute for Health Research (NIHR) funds health services research through several programmes, in addition to funding clinical research. In Scotland, this role is exercised by the Chief Scientist Office that is part of the Scottish Government Health Directorates. In Denmark, the Danish Council for Independent Research (Det Frie Forskningsråd) and the Danish Council for Strategic Research (Det Strategiske Forskningsråd), both under the umbrella of the Danish Agency for Science, Technology and Innovation, are key funders of health services research. The Czech Science Foundation (Grantová agentura České republiky, GACR), the Swiss National Fund (Schweizer Nationalfonds) and the German Research Foundation (Deutsche Forschungsgemeinschaft, DFG) provide funding for a wide spectrum of research in science and humanities, including some limited funds for health services research (DFG, 2010; GACR, 2010)². The Research Council of Norway (Forskningsrådet) has set up a funding programme for health and health care systems research (2006-2010, now extended to 2015) which includes funding for health services research.

In most countries, the ministry of health is directly involved in providing funding for health services research, as well as ministries of science or research (where they exist). In Spain, the Institute of Health Carlos III (Instituto de Salud Carlos III, ISCIII) is a major funder of health research. In France, the Institute of Public Health Research (Institute de Recherche en Santé Publique, IReSP) was formed in 2004, bringing together 24 public organisations involved in public health research (including health services research). The aim of the institute is to pool expertise and to co-ordinate funding for public health research. In Croatia, the Ministry of Education and Science is the largest funder of health services research. In some countries, typically those in which political decision-making is in part decentralised, regional or local governments provide some funding of health services research (e.g. Austria, Belgium, Finland, Slovenia and Spain, but not, for example, in England). In Norway, regional health authorities fund research into secondary health care, including funding for research positions at universities and hospitals. In Poland, in contrast, the ministry of health is prevented by law to directly fund research activities.

- 2 In a number of countries, health system organisations at national, regional and/or local level fund health services research, such as sickness funds in Austria, the Federal Chamber of Physicians (Bundesärztekammer, BAK) and sickness fund associations in Germany, the Norwegian Medical Association, the administration of the social security (Direction de la sécurité sociale) or the regional unions of self-employed doctors (Union régionale des médecins libéraux, URML) in France. Funding is often for single projects and small scale programmes only.
- 3 In a number of countries, the independent sector funds health services research, although mostly single, small-scale projects. These organisations are typically charitable and not-for-profit health or social research bodies. In England, for example, the King's Fund and the Nuffield Trust fund projects in this field, as do private foundations, research charities and patient-support organisations in Denmark, Ireland, Norway, Portugal, Romania, Scotland and Spain.

² Not all of these research funding bodies are government organisations, as some of them are accountable directly to parliament. The Czech Science Foundation, for example, is monitored by a supervisory board appointed by the Czech Parliament. Likewise, the Finnish Innovation Fund (SITRA) is overseen by the parliament.

- 4 Funding provided by international organisations supports health services research in a number of countries, for example, Croatia, Cyprus, Greece, Lithuania, Macedonia and Malta, and Turkey. International organisations in this field include the World Health Organisation, the World Bank and the Open Society Institute. The European Commission is a key funder of health services research projects in many countries of the European Union (Box 7.1). Some governments or research councils actively promote applications for funding through the European Commission, such as the Research Council of Norway.

Box 7.1 Role of the European Commission in funding health services research

The European Commission (EC) funds health services research through its frameworks for research funding, such as at present FP 7.

Between 2007 and 2010, the EC, through its Seventh Framework Programme, spent € 275 million on research aimed at “Optimising the delivery of healthcare”, of which € 67.5 million was spent on translating clinical research outcomes into clinical practice (supporting 28 projects), € 63.5 million on health systems research (63.5 million), € 47 million on health promotion and disease prevention (20 projects), and € 97 million on international public health and health systems research (35 projects). This compares to a total budget for health and life science research of € 2.5 billion (EC, 2010).

Themes of the work programme are informed through an internal and external consultation process. Internally, the Directorate General for Research liaisons with other directorates of the Commission, especially the Directorate General for Health and Consumer Affairs (DG Sanco) to identify priorities. Externally, the Commission invites inputs from a wide range of actors through formal and more informal channels (e.g. strategic research agendas of European Technology Platforms, as well as position papers from organisations and other interested parties).

A recent study by Ernst and colleagues (2010) found that the Community Research and Dissemination Services (CORDIS) of the European Commission does not provide complete and up-to-date information to facilitate access to all EC funded health research. The authors recommended that the European Commission could strengthen its efforts to improve the accessibility of EC funded health research.

Information about the level of funding available for health services research is poor and not available for most countries. Available data usually do not distinguish between funding for health services research and other health-related research. With the exception of England, no overview of the total funding for health services research could be identified. Even in England, provided data on funding was largely based on estimates (UK Clinical Research Collaboration 2006, 2007).

Data suggest that the level of funding varies dramatically among countries, with England likely to be the largest spender in absolute terms at £156 million in 2004/5 (€174 million; as of April 2004). Annual spending in Switzerland was estimated at SFr5 million (€3.4 million; as of January 2009); €6-8 million in Ireland (2008); over £15 million (€15.5 million; as of January 2009) in Scotland; €60 million in the Netherlands (2006) (RGO, 2008). Total funding for health services research in France is unknown; however, the IReSP made available €1.35 million for a call for health services research proposals in 2009. Data on total spending on health services research mostly does not provide

details about funding for different disciplines or areas of research.

Information about funding trends is also scarce and mainly based on personal reports. In a number of countries, spending on health services research appears to have increased in recent years (e.g. Cyprus, England, Germany, Ireland, Malta, Spain, Portugal, Turkey), with substantial growth reported from England. However, in other countries funding seems to have been stagnant (Croatia, Slovenia), fluctuated (Italy) or even decreased (Switzerland). In Latvia, health services research does not receive any funding, either public or private.

7.4.2 Strategic priority-setting for health services research

With few exceptions, countries do not appear to have developed a comprehensive national strategy for funding and developing health services research. In England, the government published “Best Research for Best Health” in 2006 setting out the strategic aims of government in funding health research, including health services research (Box 7.2) (DH, 2006). Likewise, the Scottish Chief Scientist Office, in 2009, published a comprehensive strategy for health research (CSO, 2009). Arguably, both countries share a long tradition of health services research, supported by government funding.

In some countries, funding for health services research is embedded in a funding strategy for science and research in general or health research in particular, with a (typically smaller) section devoted to health services research. In Ireland, for example, the strategic business plan 2010-2014 of the Health Research Board sets out four strategic goals of the Board, one of which is to build capacity to conduct population health sciences research and health services research (HRB, 2009). A review of government funding for health services research is currently underway. In France, the IReSP aims to co-ordinate funding activities of a range of public organisations, organised as a partnership. In Norway, a consortium of universities, regional health authorities and the Research Council have begun a process that aims to develop a strategy for the future of health services research in Norway. In Romania, a National Plan for Research 2007-2013 exists, which also covers health research and some aspects of health services research. A National Plan for Development (2007-2013) has been developed in Greece, which includes health services research as well as capacity building.

Box 7.2 Best research for best health – England’s national health research strategy

In January 2006, the Department of Health in England published its new national health research strategy “Best research for best health”. The strategy outlines the government’s objectives for its research funding and describes how it intends to achieve them. Objectives are as follows: (1) to establish the National Health Service as an internationally recognised centre of research excellence, (2) to attract, develop and retain the best research professionals to conduct health research, (3) to commission research focused on improving health and social care (e.g. through several research programmes), (4) to manage knowledge resources (e.g. through an IT based management system), and (5) to ensure that public money is used for public good (DH, 2006).

Based on these objectives, the government, in March 2006, commissioned a comprehensive review of the use of government funding for health-related research in the UK, the so-called Cooksey Review, named after the chairman of the review team Sir David Cooksey (HM Treasury, 2006). The review concluded that progress had been made to spend public funding for health-related research more effectively, but also made a number of recommendations to improve the strategic direction and co-ordination of existing funding arrangements, for example, by establishing an Office for Strategic Coordination of Health Research (OSCHR). The role of the office is to co-ordinate the activities of the government’s two main funding streams for health research, the National Institute for Health Research and the Medical Research Council, but also to communicate health research priorities to the health industries, such as for the development of new pharmaceuticals (HM Treasury, 2006).

In most countries, no structured process of identifying priorities for health services research was reported, mirroring the absence of a comprehensive strategic approach in these countries. In Belgium, the Court of Auditors (Rekenhof), in January 2010, published a report criticising the fragmentation of policy advice to government and parliament in relation to health policy. The Court recommended introducing a more strategic approach to research funding, more stringent project management and better communication on the part of research institutes, but also demanded more transparency of decision-making from health policy-makers (Rekenhof, 2010).

However, priorities may be set for specific research programmes or streams of research funding. In the Netherlands, for example, the Ministry of Health, Welfare and Sport defines the priorities for health (and health services) research for the ZonMW (Netherlands Organisation for Health Research and Development). These priority setting procedures are often indirect or ex post, for example through the selection, review and approval of research proposals after scientific review by members of the research community. These decisions are typically taken by committees or panels of senior researchers in a particular field of expertise.

Health technology assessment appears to be an exception in some countries, with processes of priority-setting often being more explicit and more clearly attuned to the preferences and interests of health system decision-makers.

7.4.3 Producers of health services research

The following section examines the production of health services research in countries in Europe, focusing on the type of organisations that undertake health services research, the associations and networks that represent and link health services researchers, the training available, and the opportunities for disseminating research through scientific journals and conferences.

Four groups of research producers have been distinguished: (1) institutions of higher education and research (i.e. universities), (2) government organisations, including research departments at ministries and governmental research institutes, (3) health systems organisations at national or regional level (such as sickness funds and professional bodies), and (4) independent sector organisations, including for-profit and not-for-profit organisations, such as consulting firms, charities, think tanks and foundations.

- 1 In almost all countries, researchers based at universities play a key role in conducting health services research. However, the number of organisations involved varies greatly among countries, ranging from one research unit at the University of Malta (the Health Services Management Division at the Institute of Health Care) to over 30 at universities in England and Germany, many of which are departments or large research units. For example, in England, the Department of Health Services Research and Policy at the London School of Hygiene and Tropical Medicine has about 60 academic members of staff (of whom 15 are senior staff); the Centre for Health Economics at the University of York comprises about 40 academic staff (14 senior). In addition, numerous research teams have received funding from the National Institute of Health Research to undertake health services research, despite the fact that they are not based within a dedicated unit. In other countries, research activities in health services research may be less organisationally formalised, with research conducted by individual researchers or smaller research teams. Health services research may also be embedded in multidisciplinary units, in which public health and health services research co-exist and collaborate (e.g. at the University of Tartu in Estonia). While the number of universities active in this field is potentially indicative of the scale of research activities undertaken, it does not allow conclusions to be drawn about the number of researchers or the quantity (or quality) of research produced (for which we would have had to analyse and compare, for example, papers published in scientific journals and reports in the 'grey' literature by researchers based in these organisations). No activities in health services research have been documented for Latvia.
- 2 In many countries, governmental research bodies play an important role in producing health services research; they also provide a direct link between the research community and policy-makers. Governmental research bodies include, for example, the National Institute for Health and Welfare (Terveyden Ja Hyvinvoinnin Laitos, THL) in Finland, the Health Research Board in Ireland, the National Institute for Public Health and the Environment (Rijksinstituut voor Volksgezondheid en Milieu, RIVM) in the Netherlands, Institutes for Health Research in the regions in Spain (e.g. Institut d'Estudis de la Salut in Catalonia), and the Norwegian Knowledge Centre for the Health Services (Nasjonalt kunnskapssenter for helsetjenesten). Many of these institutes undertake health services research as one of several research activities. The Belgian Health Care Knowledge Centre (KCE) is an independent organisation, established in 2003, that conducts studies and analyses to advice the Belgian government on decisions relating to public health and health care insurance. The Danish Institute for Health Services Research (Dansk Sundhedsinstitut, DSI) and the Danish Institute for Governmental Research (Anvendt KommunalForskning, AKF) are independent research organisations at arm's length from central government, which provides basic funding beyond which both institutes have to apply for

competitive project funding. In several countries, the ministries of health host research departments or teams that undertake health services research on behalf of government. Examples are the Directorate for Research, Evaluation, Studies and Statistics (Direction de la recherche, de l'évaluation, des études and des statistiques, DREES) at the Ministry of Health in France, the Health Analytical Services Division of the Scottish Government, the National Centre of Public Health Protection at the Ministry of Health in Bulgaria as well as ministries in Ireland, Italy, Macedonia and Slovenia.

- 3 In some countries, health systems organisations, usually those involved in steering functions, undertake health services research to some extent. This particularly applies to countries, in which some core steering functions are executed through corporatist actors, such as in France, Germany and the Netherlands. In Germany, the Scientific Institute of the General Regional Sickness Funds (Wissenschaftliches Institut der AOK, WIdo) funds and conducts health services and health systems research.
- 4 In several countries, the independent sector (i.e. non-governmental and not university related) also plays a role in health services research, both in form of commercial organisations (e.g. consulting firms) and not-for-profit organisations (e.g. charities, think tanks and foundations). In the Netherlands, NIVEL, the Netherlands Institute for Health Services Research is an independent research organisation, partly subsidised by the Ministry of Health. In England, a range of not-for-profit organisations contribute to the various branches of health services research, such as the Office for Health Economics, the King's Fund, the Nuffield Trust, Picker Institute Europe and RAND Europe, some of which have substantial own resources, while others entirely depend on project funding. Other examples include the Ludwig Boltzmann Institute (not-for-profit) in Austria, the International Healthcare and Health Insurance Institute (IHII) in Bulgaria, the Praxis Centre for Policy Studies in Estonia, the Economic and Social Research Institute (ESRI) in Ireland, the Centre for Efficiency Evaluation of Health Services (Centro per la Valutazione dell'Efficacia Dell' Assistenza Sanitaria, CeVEAS) in Italy, the Lithuanian Free Market Institute, the Health Policy Institute in Slovakia and the Institute for Economic Research in Health Care (INERHC) in Slovenia.
- 5 In a few European countries, international organisations such as the World Health Organisation or the Open Society Institute are actively involved in undertaking health services research (Bulgaria, Macedonia).

7.4.3.1 Training

Universities in most countries in Europe offer some form of training in health services research and related disciplines, however, there are marked differences with regard to the comprehensiveness of training and the range of training options. It is not possible to enumerate all the training available, merely to indicate the range and types of activity.

Only a few countries offer bespoke multi-disciplinary training in health services research (Table 7.1). In England, several universities and (post-) graduate schools offer programmes that provide specialist training for future health services researchers. The University of York, for example, offers a one-year Master's programme in Health Sciences covering multidisciplinary research methods, applied biostatistics, epidemiology, health economics, randomised controlled trials and systematic reviews (University of York, 2010). The University of Newcastle runs a one-year programme in public health and health services research at Master's, diploma or postgraduate certificate level. The programme includes training in research methods, health statistics, health economics, applied

epidemiology and project management (University of Newcastle, 2010). The University of Malta offers an MSc in Health Services Management, with almost half of the course modules being dedicated to health services research (University of Malta, 2010).

In Finland, the Ministry of Education and the Academy of Finland jointly fund scholarships for postgraduate students at the National Postgraduate School in Social and Health Policy, Management and Economics. The school is a partnership of educational or development organisations in the field of social and health policy, management and economics (UKU, 2010). In the Netherlands, NIHES, a collaboration between the academic medical centres in Rotterdam and Amsterdam, the Netherlands Cancer Institute and the National Institute for Public Health and the Environment (RIVM), offers a number of Master's and doctoral programmes, as well as short courses and professional training courses, in health services research and its sub-disciplines (NIHES, 2010). Students at the University of Maastricht can take a two-year course leading to a Research Master's in Health Sciences.

Taught components include health measurement, health technology assessment, applied epidemiology, process evaluation and qualitative research methods (University of Maastricht, 2010). In Ireland, senior academics at the Royal College of Surgeons, Trinity College Dublin and University College Cork jointly offer a structured PhD programme in health services research, funded by the Health Research Board. The four-year programme includes several relevant taught components, ten weeks of specialist rotation in Irish health-related data collection agencies, a placement at an agency overseas and a PhD thesis (RCSI, 2010). In 2005, a School of Public Health was established in Switzerland by forming a partnership of six universities offering Master's and doctoral programmes, for example, in health economics, including modules on health services research and related disciplines.

The absence of bespoke specialist training in some countries, however, does not mean that there is no training available at all. Programmes in public health, for example, often include a health services research component or may integrate training in some of the skills required by health services researchers. Such programmes, both at Master's and/or doctoral level, exist, for example, in Austria, Belgium, the Czech Republic, Denmark, Estonia, Germany, Greece, Norway, Portugal, Romania, Slovakia, Slovenia and Spain.

Training in relevant disciplines is also available in most countries, such as Master's programmes in health economics, medical sociology or health (services) management (e.g. Belgium, Cyprus, Czech Republic, Denmark, England, Estonia, Germany, Greece, Ireland, Italy, Lithuania, Malta, Norway, Romania, Slovenia, Switzerland).

Training in health services research or relevant disciplines for health care professionals (e.g. doctors, hospital managers) is also available in some countries, including short courses in research skills, health technology assessment or training in hospital benchmarking (e.g. Belgium, Bulgaria, Cyprus, Germany, Italy and Romania).

Table 7.1 Training, associations, journals and conferences in health services research (HSR)³

Country	Academic training		National associations		Scientific journals		Conferences	
	HSR training	Related subjects and sub-disciplines	HSR association	Related subjects and sub-disciplines	HSR journals	Related subjects and sub-disciplines	HSR conferences	Related subjects and sub-disciplines
Austria	No	Yes	No	Yes	No	Yes	No	Yes
Belgium	No	Yes	No	Yes	No	Yes	No	Yes
Bulgaria	No	Yes	No	Yes	No	Yes	No	Yes
Croatia	No	Yes	No	Yes	No	Yes	No	Yes
Cyprus	No	Yes	No	No	No	No	No	No
Czech Republic	No	Yes	No	Yes	No	Yes	No	Yes
Denmark	No	Yes	No	Yes	No	Yes	No	Yes
England	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Estonia	No	Yes	No	Yes	No	Yes	No	Yes
Finland	No	Yes	No	Yes	No	Yes	Yes	Yes
France	No	Yes	No	Yes	No	Yes	Yes	Yes
Germany	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Greece	No	Yes	No	Yes	No	Yes	Yes	Yes
Ireland	No	Yes	No	No	No	No	No	Yes
Italy	No	Yes	No	Yes	No	Yes	No	Yes
Latvia	No	Yes	No	Yes	No	No	No	No
Lithuania	No	Yes	No	Yes	No	Yes	No	Yes
Macedonia	No	No	No	Yes	No	Yes	No	Yes
Malta	Yes	Yes	No	Yes	No	Yes	No	Yes
Netherlands	Yes	Yes	No	Yes	No	Yes	No	Yes
Norway	No	Yes	Yes	Yes	No	Yes	No	Yes
Poland	No	Yes	No	Yes	No	Yes	Yes	Yes
Portugal	No	Yes	No	Yes	No	Yes	No	Yes
Romania	No	Yes	No	Yes	No	Yes	No	Yes
Scotland	Yes	Yes	Yes*	Yes*	Yes*	Yes*	Yes	Yes
Slovakia	No	Yes	No	Yes	No	Yes	No	Yes
Slovenia	No	Yes	No	Yes	No	Yes	No	Yes
Spain	No	Yes	No	Yes	No	Yes	No	Yes
Switzerland	No	Yes	No	Yes	No	Yes	No	Yes
Turkey	No	Yes	No	Yes	No	Yes	No	Yes

³ This table distinguishes training, associations, journals and conferences that are bespoke and involve all the disciplines contributing to health services research, as opposed to training, associations, journals and conferences relating to either related subjects (such as public health research, biomedical research) that may include health services research as one area of research among others or disciplines that contribute to health services research (such as health economics, epidemiology, medical sociology).

7.4.3.2 National associations and networks

Professional associations, societies or networks devoted specifically to the promotion of health services research were only reported in a few countries (Table 7.1). The German Network for Health Services Research (Deutsches Netzwerk Versorgungsforschung e.V.) was founded in 2006 as a charitable organisation. The inter-disciplinary network comprises over 40 associations of health care professionals and other relevant disciplines, and aims to bring together researchers and practitioners, to promote health services research and to build capacity by supporting young researchers. The network was preceded by the Permanent Congress Commission for Health Services Research (Ständige Kongresskommission für Versorgungsforschung, DNVF), a committee formed at the first German congress on health services research in 2002 (DNVF, 2010).

In the UK, a Health Services Research Network was established as late as 2005, though the UK Society for Social Medicine founded in the mid-1950s has included health services researchers for many years. The HSR Network aims to bring together organisations with an interest in health services research, to promote and support the use of research in policy and practice, and to enhance the voice of health services research in health policy debates in the UK (NHS Confederation, 2010). The network is financially supported by the National Institute of Health Research (the government funding body for health research), the Nuffield Trust (a not-for-profit research institute) and institutional membership subscriptions. It currently has about 100 member organisations, predominantly universities, but also NHS bodies, professional and commercial organisations, charities and other not-for-profit organisations.

The Health Research Board in Ireland is planning to establish a network for health services research as part of its activities set out in its strategic business plan 2010-2014 (HRB, 2009). In France, no association or network specifically devoted to health services research has been established. However, some of its functions are carried out by the Institute for Public Health Research (l'Institut de Recherche en Santé Publique, IReSP). The Institute was established in 2007 and is based on a partnership of 24 public organisations involved in public health research (IReSP, 2010). Although the Institute only deals with health services research as a subset of public health research, it actively promotes collaboration and co-ordination in this field.

In Denmark, the Danish Forum for Health Services Research (Forum for Sundhedstjenesteforskning) is a (relatively loose) network formed by university researchers involved in health services research. The Forum conducts an annual meeting, which in the past has focused on various aspects of health services research. Health Services Researchers in Norway can participate in the Nordic Network for Healthcare Management Research (NOHR), which also involves researchers from Denmark and Sweden.

Despite the paucity of HSR associations or networks, most countries in Europe have long established professional associations of researchers or research organisations in disciplines contributing to health services research, such as medical sociologists, health economists, health management, health policy or epidemiologists. Societies of social medicine or medical sociology, for example, are involved in promoting health services research in Austria, Bulgaria, the Czech Republic, Finland, Germany and Macedonia. In addition, associations for health technology assessment, a major category of health services research, exist in Finland, Germany, Italy and Switzerland.

Professional associations and networks typically provide opportunities for researchers to exchange ideas, share information, identify collaborators and present research at conferences and meetings. It is not clear from the data collected to what extent these organisations contribute to the future development of health services research. The presence or absence of a dedicated association or network is indicative of the state and level of development of this field of research. However, this can be misleading insofar as longer established, non-HSR-specific associations could be more active and thus more relevant than a HSR-specific organisation that is less active and less recognised. However, it seems that health services research networks, in those few countries where they exist, have been established in addition to a range of existing societies and associations covering a spectrum of disciplines relevant to health services research.

7.4.3.3 Journals

The publication of scientific journals is another potential indicator for the state of development of health services research in countries in Europe.

Scientific journals entirely dedicated to health services research are published in England (Health Services Management and Research and Journal of Health Services Research and Policy, both quarterly) and Germany (Das Gesundheitswesen, monthly).

Also, scientific journals in related disciplines may, routinely or occasionally, publish health services research papers, such as medical journals, journals of public health and of social policy. Examples are, among many others, the Bulgarian Journal of Public Health (Българско списание за обществено здраве), the Italian Journal of Public Health (published in English), the Portuguese Review of Public Health (Revista Portuguesa de Saúde Pública), the Dutch Journal for Health Sciences (Tijdschrift voor gezondheidswetenschappen), the International Journal of Public Health in Switzerland or the Journal of the Norwegian Medical Association (Tidsskrift for Den norske legeförening).

Countries have also reported a number of journals in disciplines that contribute to health services research, such as the Journal of Clinical Evaluation and Practice and the Journal of Health Economics in England, Health Economics and Quality Management (Gesundheitsökonomie und Qualitätsmanagement) and The Health Care System (Das Gesundheitswesen) in Germany, Society, Economy and Health (Κοινωνία, Οικονομία και Υγεία) in Greece, Management in Health (Management în Sănătate) in Romania, the Bulletin on Health Economics, Organisation and Informatics (Bilten Ekonomika, Organizacija, Informatika) in Slovenia, the Review of Quality in Health Care (Revista de Calidad Asistencial) in Spain and the Hacettepe Journal of Health Administration (Hacettepe Sağlık İdaresi Dergisi) in Turkey.

Health services research is also published in general medical and nursing journals, such as the British Medical Journal, the Archives of Hellenic Medicine or the Journal of the Finnish Medical Association, or in grey publications produced by universities or research institutes. There are also a number of periodic publications issued by health system organisations, such as Health System Watch published by the central association of sickness funds in Austria or Practices and Health Care Organisation (Pratiques et organisation des soins) published by the social health insurance fund for employees (La Caisse nationale de l'assurance maladie des travailleurs salariés, CNAMTS) in France.

7.4.3.4 Conferences

If it is difficult to map the existence of professional associations and networks, the opportunities for training and education, or the publication of scientific journals on health services research in Europe, it is almost impossible to describe activities with regard to conferences, workshops, seminars or meetings accurately or comprehensively.

A few countries host regular health services research conferences, such as the annual joint conference of the Health Services Research Network and the NIHR Service Delivery and Organisation Programme in England, the Health Services Research Meeting (Terveydenhuoltotutkimuksen päivät) of the Society of Social Medicine in Finland and the annual German Congress on Health Services Research (Deutscher Kongress für Versorgungsforschung). In France, the High Authority for Health (Haute Autorité de Santé, HAS), since 2007, organises an annual conference (Premières Journées des rencontres de la HAS), which provides a forum for both researchers and representatives of the health system. In Denmark, as mentioned above, the Danish Forum for Health Services Research holds an annual meeting, covering a range of themes of health services research.

Health services research may also be a sub-section of conferences, for example, on public health or medicine (e.g. Austria, Czech Republic, England, Estonia, Greece, Italy, Malta, Portugal, Slovenia, Spain, Switzerland). At European level, the health services research section of the annual conference of the European Public Health Association (EUPHA), the annual conference of the European Health Management Association (EHMA), the European Conference on Health Economics (ECHE; every two years) and the annually organised European Health Forum Gastein are further examples for conferences that are, in part, devoted to health services research. International meetings include the annual conference of the International Society for Quality in Health Care (ISQUA) and the annual meeting of the International Society for the Promotion of Health Technology Assessment (HTAi).

In addition, countries reported a wide range of conferences, workshops and meetings on selected health services research topics. To some extent, the topics of these events tend to reflect specific national interests or priorities, often related to health system reforms or policy developments. For example, Bulgaria has hosted a number of conferences, meetings and round tables on health system financing, health insurance and hospital reform in recent years. Workshops and meetings have also been reported in the context of the final stages of research projects. These may be ad hoc and small scale, but they can provide a valuable opportunity for policy-makers and researchers alike. In Italy, a number of conferences in recent years have been devoted to health technology assessment. Health economics appears to be a particular focus in many countries (e.g. Bulgaria, Czech Republic, Denmark, England, Finland, France, Germany, Italy, Norway, Slovenia, Spain, Switzerland). There are few regular conferences that directly address policy-makers internationally, with the WHO/European Ministerial Conference on Health Systems, held in June 2008 in Tallinn, Estonia, being one example.

A number of countries reported hosting no conferences (e.g. Cyprus, Czech Republic, Ireland, Portugal, Slovakia). However, the data collected do not allow firm conclusions about the absence or precise number of activities. Rather, they provide an impression of the scale of activities in countries in Europe.

7.4.3.5 National and international health services research

Most countries report that health services research produced in other countries (in Europe) is of relevance to their policy-makers, such as research made available through the World Health Organisation (WHO), the Organisation for Economic Co-operation and Development (OECD), the European Commission or the European Observatory on Health Systems and Policies. However, countries vary with regard to the importance given to research that has originated externally (including systematic reviews and other forms of research synthesis) as opposed to research that has been produced nationally. Also, the role of international organisations differs with regard to the type of information they provide (e.g. country specific and cross sectional analysis provided by the European Observatory; comparative data on health systems and spending through the OECD), their mandate and the objectives of their activities.

Responses from several countries, including Cyprus, Greece, Ireland, Macedonia, Portugal, Romania, Switzerland and Turkey, indicate that external sources of health services research have a strong influence on policy making, perhaps stronger than domestically produced research. Responses suggest that a variety of reasons may be responsible for this, including the limited funding available for health services research in some countries, often reflecting larger macro-economic influences, the small number of research institutes and researchers working in this field and perceptions (justly or unjustly) about the standards, quality and relevance of local versus foreign research. However, there are also concerns that external research does often not sufficiently address the specific research needs and national context of (particularly smaller) countries.

In other countries, in contrast, policy-makers appear to largely rely on domestically produced research, for example, England, Finland, France, Norway and Malta. Policy-makers in these countries may also be interested in learning about research undertaken abroad but this tends to happen in addition to research generated locally, which appears to be more likely to be tailored to policy-makers' needs. Several countries reported that both external and national sources of health services research have been influential on policy-making (e.g. Bulgaria, Denmark, Germany, Slovenia, Spain).

Countries may also be involved in international organisations that generate international comparative research and syntheses. The governments of Belgium, Finland, Ireland, the Netherlands, Norway, Slovenia, Spain, Sweden and the Veneto Region in Italy, for example, financially support the European Observatory on Health Systems and Policies. The Department of Health in England funds a project that provides rapid-response, international policy comparisons for its policy-makers. OECD health data are widely used in all countries.

Arguably, some topics may also be more internationally applicable than others, perhaps especially those that are less dependent on national context. Health technology assessments, for example, typically draw on an international body of research and literature reviews. Conclusions are then adapted to national circumstances and preferences. National and regional agencies responsible for health technology assessment are internationally well connected, with many being members of the European Network for Health Technology Assessment (EUnetHTA 2010).

International experience may also feed into policy-making through channels other than international or national research bodies such as the media or policy-makers' own contacts to policy-makers abroad. In Germany, for example, experience from the United States, the Netherlands and

Switzerland were used extensively in political discussions around recent health reforms (Zentner and Busse, 2004).

As in previous sections, the data gathered for this project allow only limited insights into the balance of nationally and externally produced health services research.

7.4.4 Users of health services research in health policy

We here define “users” as organisations responsible for health policy-making (as opposed to individuals). Users of health services research in policy-making include: (1) governments, including ministries and agencies, (2) health systems organisations, (3) parliaments, and (4) independent sector organisations. The range of users largely reflects variation in political and health system governance (e.g. federalism, decentralisation of decision-making within the health system).

- 1 Policy-makers in governments and related agencies appear to be the key users of health services research. In almost all countries, ministry of health officials are the main “customers”. In England, the Department of Health is a key user of health services research; occasionally other departments, such as the Treasury (ministry of finance), may use research, usually focusing on particular high-profile topics. In Finland, municipal councils use research to inform decisions, e.g. relating to the organisation of primary care. Government or state agencies are also potential users of health services research, such as, for example, the State Institute for Drug Control (Státní ústav pro kontrolu léčiv, SUKL) in the Czech Republic, the Social Insurance Institution (Kansaneläkelaitos, KELA) in Finland or the Health Insurance Institute (HIIS) in Slovenia. Agencies cover a range of different functions in relation to the health system and health services governance, and are often involved in funding and/or conducting research as well as in decision-making. However, agencies vary substantially with regard to their degree of involvement in decision-making. In England, the National Institute for Health and Clinical Excellence (NICE), for example, makes decisions about the availability of health technologies in the NHS, while the High Authority of Health (Haute Autorité de Santé, HAS) in France or the Swedish Council on Health Technology Assessment (SBU) provide decision-making support for policy-makers only.
- 2 Health system organisations involved in policy-making are another group of potential research users. These include, for example, social or national health insurance organisations that are organised separately from government (France, Germany, Poland). In Germany, many of the governance decisions are taken within the corporatist sector, with the Federal Joint Committee (Gemeinsamer Bundesausschuss, G-BA) being the main decision-making body representing the top associations of the social insurance funds, physicians and hospitals in addition to (non-voting) patient organisations. At regional level, strategic health authorities in the English NHS and hospital districts in Finland may use health services research. Locally, hospitals or health service managers as well as health care personnel can be users of research. In England, the NIHR has a range of mechanisms to try to get findings from its health services and clinical research programmes taken up and used within the NHS.
- 3 In several countries, parliament is a user of research during the process of developing legislation (e.g. Bulgaria, England, Finland, Lithuania, Slovenia, Switzerland), Parliamentary committees, such as the Health Select Committee in England, may also have an important role in reviewing and questioning the development and implementation of health policy, drawing on research and testimony from researchers and other experts. In France, this function is performed by the Court of Auditors (Cour des comptes), a constitutional body responsible for reviewing government

policy on behalf of parliament, in addition to the High Council for the Future of Health Insurance (Haut conseil pour l'avenir de l'assurance maladie) and the Inspector General for Social Affairs (Inspection générale des affaires sociales).

- 4 Independent sector organisations include, for example, patient organisations (e.g. Czech Republic, Spain, Turkey), professional organisations (e.g. Ireland) and other interest groups that have a position (and perhaps influence) on policy-making, for example, by shaping public opinion. This includes private sector organisations, such as private health insurance companies.

7.4.5 Activities that aim to strengthen the use of health services research in policy-making

This section examines the links between health services research and policy, outlining some of the types of involvement of health services researchers in processes of policy development and the mechanisms that support the dissemination of research findings, encourage policy-makers to engage with research or promote 'linkage and exchange' between policy-makers and health services researchers.

7.4.5.1 Involvement of researchers in policy-making

In most countries, health services researchers are involved in policy-making in a number of ways. However, contributions of researchers to policy-making tend to be occasional and temporary; regular and routine involvement appears to be less frequent. Most commonly, researchers are commissioned to undertake research projects, for example, as part of a larger research programme or on a specific topic, by a government or health system organisation, in line with research and policy priorities identified by these organisations.

Occasionally, researchers are directly commissioned by government organisations, such as ministries of health or health agencies, to provide research reports to inform a pending policy decision (e.g. Cyprus, Denmark, England, Estonia, Finland, France, Germany, Greece, Ireland, Italy, Macedonia, Netherlands provided examples). Sometimes, individual researchers are also invited to provide expertise in a personal capacity, for example, as a policy advisor in a ministry of health (e.g. England, Estonia, France) or as experts in parliamentary hearings as part of the legislative process (Estonia, Finland, Germany, Netherlands). Yet personal involvement appears to be relatively rare and mostly limited to senior researchers.

In some countries, health services researchers are also involved as members of advisory committees of governments or parliaments. For example, the Supreme Health Board (Oberster Sanitätsrat), an advisory body to the Federal Ministry of Health in Austria, includes at least one health economist. In Germany, the Advisory Council on the Assessment of Developments in the Health Care System (Sachverständigenrat zur Begutachtung der Entwicklung im Gesundheitswesen) is composed of seven senior members of the health research community, including an economist and another social scientist. The council reports on selected health system developments every two years. Membership of health services researchers in advisory committees was also reported from Italy (e.g. High Health Council, Consiglio Superiore di Sanità), Lithuania (National Board of Health, Nacionalinė Sveikatos Taryba), Slovenia (Health Council, Zdravstveni svet) and the Netherlands (e.g. the Commission for Effectiveness studies, commissie doelmatigheidsonderzoek). In England, NICE's appraisal committees include researchers, especially health economists. Health services researchers are also involved in the Central Council

of Health, an advisory board to the Ministry of Health and Solidarity in Greece.

Other forms of involvement include the employment of health services researchers, temporarily or permanently, within policy-making organisations. In Slovenia, a number of junior researchers have been seconded as part-time experts to the ministry of health. The Ministry of Social Affairs in Estonia has recently created a department dedicated to information and analysis with the objective to perform rapid analyses and to support the uptake of research by ministry officials. The Department of Health and Children in Ireland is supported by a small research division, which includes several health services researchers. Increasing permeability of professional boundaries have been reported for the Department of Health in England, which in recent years has recruited growing numbers of non-civil service professionals, mostly NHS managers, but also economists and, occasionally, researchers (Greer and Jarman, 2007).

Arguably, researchers working in government agencies or research institutes are often most directly involved in shaping government policy. In Finland, for example, health services research is largely undertaken in government-owned research institutes, such as the National Institute for Health and Welfare (THL) or the Finnish Institute for Occupational Health (TTL). In the Netherlands, the National Institute for Public Health and the Environment (RIVM) provides expertise and decision support to the Ministry of Health, Welfare and Sport in the field of health, nutrition and environmental protection, including some health services research. Since 2006, the RIVM publishes the Dutch Health Care Performance Report on behalf of the ministry of health (Box 7.3). The National Institute for Health and Clinical Excellence (NICE) in England largely commissions research from universities, such as health technology assessments, but the Institute also undertakes its own research and modelling on a smaller scale. In Poland, the Agency for Health Technology Assessment advises the Ministry of Health on decisions relating to drugs and medical procedures.

Box 7.3 Researchers' involvement in developing a framework for health system performance indicators in the Netherlands

In the early 2000s, the Ministry of Health, Welfare and Sport in the Netherlands committed itself to monitor the performance of the Dutch health care system and to publish a range of performance indicators in a report every two years ("Dutch Health Care Performance Report"). The report assesses performance in relation to quality, accessibility and costs of health care, using 110 indicators (in 2008; 125 in 2006), some of which are benchmarked against international comparators.

The performance framework and indicators were developed jointly by researchers and ministry officials, involving a multidisciplinary academic research group (6 researchers) and ministry of health officials, forming a small strategic co-ordination group and a larger intra-departmental project group (comprising 30 MoH officials) (Ten Asbroek et al., 2004). The process was facilitated through numerous meetings between teams, including almost weekly meetings by the research team and regular meetings of researchers and the strategic co-ordination group at two-week intervals.

Although the process was largely initiated by the ministry, which at the time was interested in developing a system that allows the monitoring of changes in health care provision, researchers were involved from the onset. Both researchers and ministry officials had also been involved in earlier OECD work on performance measurement and quality assurance, with researchers, arguably, being in the role of promoters of performance indicators as a health system monitoring tool.

In those health care systems, in which decision-making is largely devolved to corporatist bodies, research institutes may be associated with these corporatist bodies, such as sickness funds or provider associations. In Germany, for example, some of the large sickness funds have established research institutes, such as the Scientific Institute of the General Regional Sickness Funds (WIdo). Other research institutes associated with corporatist self-governance are the Institute for Quality and Efficiency in Health Care (IQWiG), the Agency for Quality in Medicine (Ärztliches Zentrum für Qualität in der Medizin, ÄZQ) and the Federal Office for Quality Assurance (BQS Institut für Qualität und Patientensicherheit). In the Netherlands, some professional associations and health insurers have also built some research capacity, in-house or through collaboration with research institutes and universities (e.g. the Royal Dutch Society for Physical Therapy, Koninklijk Nederlands Genootschap Fysiotherapie).

Although researchers may be based in government organisations or government-funded research institutes or within the corporatist sector, this does not mean that they are directly involved in policy-making or that policy decisions necessarily reflect the research findings they produce. However, the institutional proximity of research and policy-making is likely to increase the chances that policy-makers are involved in setting the research agenda and are aware of the research in progress. This in turn has raised concerns in some countries with some suggesting that research produced in government-related environments may be less likely to critically question government policy (e.g. Slovenia).

In a few countries, health services researchers appear not to be involved in policy or only in a very limited capacity (Austria, Cyprus, Czech Republic, Switzerland).

7.4.5.2 Responsibility and accountability for promoting and using health services research

In most countries, responsibility for promoting the use of health services research is difficult to locate, with no organisation or individual being seen as responsible for promoting or ensuring the uptake of research. Most commonly perhaps, researchers are seen as being responsible for ensuring that research findings are distributed and accessible to interested parties, including potential users in policy and practice.

While the publication of research results in academic journals is an important step to assure the quality of research, this by no means guarantees that policy-makers are aware of these findings. Even if the information reaches policy-makers' desks it may well not be read. Thus, research funders in many countries, such as the research councils or the National Institute for Health Research (NIHR) in England or the European Commission, increasingly demand more sophisticated dissemination strategies, that include, for example, plain language policy briefs attuned to the reading habits of decision-makers, workshops for policy officials or systematic reviews commissioned on specific topics relevant to policy decisions (Allen et al. 2007).

In a few countries, the use of research evidence is understood as a responsibility of the policy-maker, although there are typically a number of important caveats to this. In England, for example, policy-makers in the Department of Health are responsible for ensuring that health services research (in so far as it is commissioned by the Department) is aligned to the needs of the NHS and is made available to potential users. However, despite good intentions there is no mechanism that ensures that civil servants and others use the resulting evidence from health services research to inform policy decisions. Although there may be an expectation that government decision-making takes research evidence into account, often reflected in substantial media and public scrutiny, for most policy decisions, policy-makers are not formally required to demonstrate that they have used evidence from research.

There are, however, a number of examples of decisions that are underpinned by a process that requires a formal appreciation of the available evidence, such as decisions regarding health service coverage in the English NHS, which are based on guidance developed by NICE, or the development of National Service Frameworks (which identify evidence-based standards of care in priority areas such as for the treatment of cancer, cardio-vascular disease or stroke to inform commissioners and providers of services) by the English Department of Health (DH, 2010). Similar requirements for coverage decision are in place, for example, in Estonia, France, Germany and the Netherlands. Also, the government is answerable to a Parliamentary committee, the House of Commons Health Select Committee, charged with the tasks of reviewing and scrutinising government health policy, for example, in relation to patient safety. Its reviews are mostly focused on high profile issues, based on ex post policy analysis. Researchers are frequently called to give evidence to the Health Select Committee.

In Germany, government officials are not formally required to use evidence from health services research in policy decisions. However, legislation requires the Federal Joint Committee (Gemeinsamer Bundesausschuss, G-BA), the highest decision-making body of the corporatist self-governance sector, to take evidence from research on effectiveness into account when making decisions about the coverage of health services through social health insurance (e.g. for

pharmaceuticals). The committee, however, is not required to follow the evidence and can give priority to other considerations (although in practice this is rare).

In Italy, decisions relating to service coverage (the Essential Level of Assistance), waiting lists and drug regulation are required to be based on evidence. Government officials in Slovenia are not formally accountable for using health services research, although there is an expectation that proposed legislation is supported by evidence, exposing the government to criticism if it fails to do so (e.g. in the case of the last Health Services Act, introduced in 2008). Switzerland also reported that evidence is most likely to be used in policy processes that involve the development of legislation through parliament.

In some countries, governments committed themselves to make better use of evidence in policy-making, for example, in England (Cabinet Office, 1999). The Finnish government is supported by an Advisory Board for Sectoral Research, comprising the permanent secretary of each ministry (deputised by the official responsible for performance management in research of each ministry) and five additional members chosen for their expertise in research and research utilisation. The main role of the Board is to steer and co-ordinate sectoral research between ministries (MoE, 2010). Advisory boards to governments, and more specifically ministries of health, with a general health care advisory role or with a specific mandate, also exist in Austria, Finland and Germany.

7.4.5.3 Mechanisms to support research dissemination

A number of countries reported that there were no specific mechanisms in place to promote the dissemination of research to make research findings more accessible to policy-makers (Austria, Cyprus, Czech Republic, Greece, Lithuania, Portugal, Switzerland, and Turkey).

National agencies in Italy are required to make all publicly funded research available through their websites. Government research institutes, such as the Institute of Health Carlos III in Spain, the National Institute of Public Health of Slovenia and the Health Insurance Institute of Slovenia operate databases of systematic reviews and summaries of research with the aim to make findings more accessible to a larger audience, including policy-makers. In England, the government, through the National Institute of Health Research (NIHR), funds a number of activities, including several research centres responsible for disseminating research findings, for example, through providing systematic literature reviews and plain language research reports (e.g. UK Cochrane Centre; Centre for Reviews and Dissemination at the University of York).

In Germany, databases for research are largely operated by universities, for example, through the Health Services Research Clearinghouse of North-Rhine Westphalia (Clearingstelle Versorgungsforschung NRW), which is jointly run by a number of universities involved in health services research in this area. A database for health technology assessment is hosted by the German Agency for Health Technology Assessment (Deutsches Institut für Medizinische Dokumentation und Information, DIMDI). The Centre for Health Services Research (CHSR) at the University of Athens, Greece, facilitates the electronic dissemination of health services research findings.

The Norwegian Knowledge Centre for the Health Services (Nasjonalt kunnskapssenter for helsetjenesten) was established in 2004, merging the Norwegian Centre for Health Technology Assessment, the Foundation for Health Services Research and parts of the Division for Knowledge Management in the Directorate for Health and Social Affairs. The Centre's primary role is to provide HTA reports, systematic reviews and other research overviews to support the government, regional

health authorities and health care providers to use evidence in policy and practice (Kunnskapscenteret, 2010). In addition, the Norwegian Electronic Health Library provides access to health services research and other professional information for health care personnel and policy-makers (Helsebiblioteket, 2010). In Ireland, the Health Research Board is expected to take a role in research dissemination in future. The IReSP in France is also expected to facilitate the uptake of research through providing research syntheses as well as policy recommendations. In Denmark, an online publication database is available for the field of health technology assessment, operated by the Danish Centre for Health Technology Assessment (DACETHA, 2010). In the Netherlands, ZonMW (Nederlandse organisatie voor gezondheidsonderzoek en zorginnovatie, Netherlands Organisation for Health Research and Development) operates a database of all projects it has funded, as does the Royal Netherlands Academy of Arts and Sciences).

Databases of published research, reviews and guidelines can play an important role in making information available to a variety of audiences. While databases can be used to manage a variety of information, they seem to be particularly well established with regard to health technology assessments and clinical guidelines. However, research from the Netherlands has shown that databases may be much less influential in relation to decision-making in health policy, possibly because policy decisions often have complex information needs and thus require more flexible arrangements (de Bont et al., 2007).

7.4.5.4 Mechanisms to support the use of health services research by policy-makers

Only a few countries reported that there are mechanisms or initiatives in place to support policy-makers in using health services research, and these vary widely among countries, ranging from formal and/or routine mechanisms to occasional and/or singular initiatives. A number of countries reported that they have no mechanisms for promoting the use of health services research to influence policy (e.g. Austria, Croatia, Cyprus, Czech Republic, Greece, Macedonia, Slovenia, Spain, Switzerland, and Turkey). However, the absence of mechanisms is difficult to verify and may be subject to differences in interpretation.

Formal mechanisms include, for example, requirements on policy-makers stipulated in national legislation. In Germany, legislation has created the framework for decision-making in health care, which includes an appreciation of research evidence only in relation to decisions about health service coverage, quality assurance and performance measures as well as concerning disease management programmes. Within this framework, the appraisal of evidence has been delegated to the Institute for Quality and Effectiveness in Health Care (Institut für Qualität und Wirtschaftlichkeit im Gesundheitswesen, IQWiG), created in 2005 to support the corporatist decision-making bodies. Formal requirements to use health technology assessment to inform coverage decisions also exist in England and France; in a number of countries, requirements may not be formal, although there is an (increasing) expectation of evidence use (e.g. Finland, Italy, Slovenia).

Advisory boards to governments and parliaments, as well as research institutes and knowledge centres at arm's length from government often have a role in supporting the uptake of research by policy-makers. In Lithuania, for example, the National Board of Health comprises representatives from the academic community, the independent not-for-profit sector and health sector organisations. The board is accountable to parliament and required to prepare an annual health report about the state of health care and the health of the population in Lithuania, supported by findings from research. However, policy-makers are not required to follow recommendations made by the Board. In Belgium, since 2004, the Belgian Health Care Knowledge Centre (Federaal

Kenniscentrum voor de Gezondheidszorg, KCE) also provides evidence-based decision-making support based on health services research (including health technology assessment and the production of clinical guidelines) at arm's length from government. As noted earlier, in Germany, the Advisory Council on the Assessment of Developments in the Health Care System prepares a comprehensive report on selected health system issues every two years. These reports are considered influential, although it is difficult to establish a direct link between the findings in these reports and subsequent policy activities.

In Portugal, the use of health services research is mainly supported by specific initiatives, such as the creation of a government task force on a given policy topic. These occasional and perhaps more voluntary commitments are likely to be relevant in other countries as well. Arguably, they do not constitute formal mechanisms for research utilisation, although they are likely to have an important supporting function.

In the German corporatist sector, the Federal Joint Committee provides some support to members by providing training in research methods and appraisal in relation to coverage decisions. Some training in research utilisation for ministry officials is also available in Bulgaria.

7.4.5.5 Linkage and exchange between health services researchers and policy-makers

Mechanisms of linkage and exchange comprise activities that aim to promote interchange between researchers and policy-makers, both at organisational and personal level. Linkage and exchange strategies have received substantial attention in recent years, following the realisation that activities which either focus solely on research production and dissemination (research push) or on research uptake (policy pull) are of limited effectiveness (Mitton et al. 2007; Lavis et al. 2003).

Few mechanisms or initiatives have been reported to promote linkage and exchange between health services researchers and policy-makers. No linkage and exchange mechanisms were reported from Austria, Belgium, Croatia, Cyprus, the Czech Republic, France, Germany, Greece, Macedonia, Portugal, Spain, or Turkey. Yet, again, these differences in reporting may be associated with differences in interpreting the concept of 'linkage and exchange'.

In some countries, linkage and exchange are largely promoted through (multi-) professional networks that provide an organisational platform for both researchers and policy-makers. These networks, for example, organise meetings targeted at both users and producers of health services research. In Italy, for example, the Italian Society of Health Technology Assessment (SIHTA) has taken on the role of promoting the links between academic research and policy. A similar forum exists in Denmark through the Strategic Council for Health Technology Assessment (Strategisk Råd for Medicinsk Teknologivurdering), representing the Ministry of Health, the National Board of Health, the regions and municipalities and the medical faculties, and the Scottish Health Technology Group, comprising organisations of the NHS Scotland, as well as industry, academic and lay representatives. The Scottish Health Technology Group acts as an advisory body to the Scottish Government Health Directorates, with the aim of developing evidence-based guidance for policy and practice as it relates to the uptake of health care technologies in the Scottish NHS (SHTG, 2010).

In a number of countries, networks seem to be most established in relation to health technology assessment and, corresponding to this, coverage decisions (e.g. Denmark, Italy, Slovenia, Switzerland).

Other forms of linkage and exchange involve the creation of forums for both health services researchers and policy-makers, especially those that are ongoing and involve regular meetings. In the Czech Republic, in 2008, the government initiated a “roundtable” as a forum for discussion of the future direction of health policy, bringing together health care experts and policy-makers, representing four political parties. Over a one-year period, the “roundtable” produced a number of reports and managed to successfully raise the awareness of policy-makers of the contribution of research to policy. However, the roundtable was discontinued after one year due to lack of continued support from the Ministry.

Also, some policy staff in ministries or other organisations involved in decision-making may have a professional background in research, which may increase their propensity to use or encourage the use of research findings (Estonia, Germany). In England, professional mobility between academia and policy making roles appear to have increased over time in the field of health policy as the Department of Health has become more open to secondees, although the effects of this trend are not clear. Similar trends have been anecdotally observed in the Netherlands and in Finland.

There are few examples of brokerage roles of individuals. In the Netherlands, the RIVM is represented at the Ministry of Health through a liaison person, this person is physically based at the ministry and supported by a team. The Department of Health in England also employs a small number of research liaison staff, whose role it is to co-ordinate the multiple research needs of policy-makers and to maintain contacts in the research community.

7.4.5.6 Barriers to the use of health services research in policy

This section provides an overview of the barriers to the use of health services research in policy-making, identified by country respondents. In what follows, barriers are grouped into those associated with the production of research and those associated with the policy process; however, on occasion these overlap. Although questionnaire included an assessment of enabling factors of the use of research in policy, few informants reported on facilitators. Thus this section will focus on barriers only.

Barriers identified by respondents related to the use of research included:

- 1 ***Limited capacity in health services research***: Low levels of funding and limited institutional capacity were identified as a barrier in a number of countries, particularly in recent (and aspiring) members of the European Union. However, scarcity of expertise and research experience in the field of health services research was also noted in other countries, reflecting limited opportunities for training and employment. The problem of retaining qualified researchers was noted as an additional challenge in one country.
- 2 ***The relative slowness of the production of research***: The speed of the policy process often allows only small “windows of opportunity” for researchers to bring research to the attention of policy-makers; it was noted that research may not be available when it is needed or useful to policy-makers. Responses from some countries indicated that the different timelines in research and policy can prevent the use of research.
- 3 ***Mismatch of research and policy questions***: Research questions tend to be focused on specific (researchable) questions and are guided by theoretical frameworks. However, projects may not always produce findings that are relevant to policy-makers or can be straightforwardly

applied in specific situations. It was noted that many researchers are not aware of the possibilities and constraints of policy-making (i.e. limited time for preparation and reflection; consideration of other forms of evidence; need to reconcile conflicting interests; influence of values, ideas and ideologies).

- 4 **Presentation of research:** Research is frequently presented in a format required for publication in peer-reviewed journals (e.g. with an emphasis on methods and the discussion of limitations), which is unfamiliar and difficult to follow for non-academic audiences and often too time consuming to be read by policy-makers. Many research organisations do not incentivise publication in “user friendly” formats, such as plain-language summaries and policy briefs, as academic careers are mostly built around publication in scientific journals.
- 5 **Lack of career incentives for researchers:** As noted before, researchers often have few career incentives to publish for policy, because of the pressure to publish in peer-reviewed scientific journals rather than in professional and managerial publications. This may be particularly relevant in countries in which researchers (in universities) are public servants and do not need to prove that their work has an impact to progress professionally.

Barriers related to the policy process:

- 1 **Decentralised decision-making and political fragmentation**, involving a larger number of actors and potential research users, both in relation to decentralised political systems (e.g. with states or provinces being responsible for health care policy) and corporatist systems. Political instability, such as frequently changing governments and high turnover of policy personnel, can also prevent policy-makers from developing knowledge in research use, and undermine efforts to establish links between research and policy communities. Fragmentation at the centre of government, for example, through involvement of a several executive bodies and agencies, can also contribute to the challenge of disseminating research effectively.
- 2 **Unsupportive political culture:** Respondents from several countries indicated that the policy process is largely dominated by competition and bargaining between political parties. While research may play a role in policy-making, evidence is often used in political contest. It was noted that policy processes are not always entirely rational and transparent, thus not lending themselves to decision-making informed by research. In its most extreme forms, the absence of a supportive political culture creates a situation in which policy-makers entirely fail to appreciate the potential of health services research.
- 3 **Absence of a supportive culture in policy organisations**, including government ministries: Capacity to produce, identify or synthesise research is often limited, insufficiently funded and poorly supported by organisational structures (e.g. in-house research teams; research liaison officers; research databases). Also, the expectations of policy-makers with respect to what research projects can achieve are sometimes incompatible with the realities of research production, indicating policy-makers’ lack of familiarity with research methods and processes.
- 4 **Absence of formal requirements to use research findings:** There are few examples of decisions for which the use of research is formally required. A number of countries increasingly use health technology assessments to support decisions about the coverage of health services in publicly-funded health care systems; however, these are not always mandatory. With a few

exceptions, formal requirements to use research are absent in other areas of health policy-making, although policy-makers in some countries appear to increasingly be expected to be aware of available research.

- 5 ***Lack of co-ordination of funding:*** The absence of priority-setting mechanisms means that policy-makers are often not involved in decisions on the allocation of research funding and their research ‘needs’ may not be linked to the research funding mechanism.

7.5 Discussion

7.5.1 Main findings

This chapter is the first attempt to describe the nature, and extent of the links between health services research and policy in European countries. Using a broad definition of health services research as a “multidisciplinary field of scientific investigation that studies how social factors, financing systems, organizational structures and processes, health technologies, and personal behaviours affect access to health care, the quality and cost of health care, and ultimately our health and well-being” (Lohr and Steinwachs, 2002; p. 16), this chapter has largely focused on policy-making at the national level, with little attention given to regional and local policy and decision-making (although as many respondents pointed out, health professionals and health care managers often constitute an even larger and more diverse group of potential research users than those working in ministries of health and national health care-related agencies). The chapter may also under-appreciate the role of the European Commission in funding and shaping health services research, yet the information available did not allow deeper insights into this area.

The most prominent finding is how little information is available about health services research, and the health services research and policy relationship. This is particularly true with regard to the amount of funding available for health services research, which is largely due to problems distinguishing funding for health services research from funding for other health-related research. Still, it is evident that the level of funding varies widely among countries. A comparison of spending would only be meaningful if related to a country’s national income or total spending on health care. In most countries, a large proportion of funding for health services research is provided through public resources, mostly provided by national governments. To a lesser extent, private and external sources of funding play a role in some countries, although these sources of funding may be more relevant in countries with small public budgets for research in general and health services research in particular.

Most countries do not set priorities for health services research centrally, although there are typically a number of mechanisms in place to select research projects for funding (e.g. peer review and expert panels). Strategic priority-setting can provide a powerful link between policy and research, in particular if policy-makers are directly involved in the process (Hanney et al., 2003).

In most countries, universities play the major role as producers of health services research, yet institutional capacity to undertake research varies greatly. Government research institutes also produce health services research, often as part of a larger remit (e.g. public health). Due to the institutional proximity to policy-making, these research institutions may be crucial ‘brokers’, linking research and policy. This role appears to be particularly developed in relation to government organisations in the field of health technology assessment, with recent efforts in some countries to

widen the scope of assessments to include interventions such as health policies and policies addressing health determinants that lie outside the health care system (Velasco Garrido et al., 2010). However, the role and functions of these organisations are likely to vary considerably, as does the way they influence policy.

Although most countries offer some form of training in health services research (though with very variable capacity), this is often part of public health training programmes or training in particular sub-disciplines such as health economics or epidemiology. So far, only four countries out of 30 which responded appear to offer bespoke training in health services research (England, Malta, the Netherlands and Scotland). Health services research-specific journals are published in only three countries.

Overall, the picture that emerges is one of diversity with health services research being more comprehensively developed in England, Scotland, Germany and the Netherlands than in others, as judged by the extent of opportunities for funding, training, networking and publishing.

The range of research users at the policy level largely reflects the institutional governance structure of health systems, with central governments usually being the main users. In countries, in which health system governance has largely been devolved to corporatist bodies, professional and provider associations, are the principal users of health services research, such as the Federal Joint Committee in Germany. Likewise, in countries in which political decision-making is largely devolved to regions and/or municipalities, local or regional governments are important users of research, such as municipal councils in Finland. Decentralised policy-making increases the number of potential research users, thus creating a larger and more complex interface between research and policy. A larger number of users may create more opportunities for research uptake. However, these organisations are presumably smaller and may individually have less capacity to utilise research and liaise with researchers.

In most countries, health services researchers are involved in policy in a variety of ways, including through commissioned research projects, providing advice to ministries and parliament or involvement in government research institutes. Again, the degree and scale of involvement varies substantially between countries.

Only a few mechanisms and activities to support the use of health services research have been identified. This is not unsurprising, given the general scarcity of literature on interventions of knowledge transfer (Ward et al., 2009a). It appears that these mechanisms are both difficult to research and difficult to report, perhaps also because they are often not well recognised. Thus, it is hard to tell whether mechanisms are absent or only underreported, although we assume that in most cases the first option is most likely. On occasion, the distinction between mechanisms that support research dissemination (research push), update (policy pull), and linkage and exchange that was made earlier in this chapter, based on the conceptual literature, appears to be quite arbitrary, with informants mentioning the same mechanism in relation to all three functions.

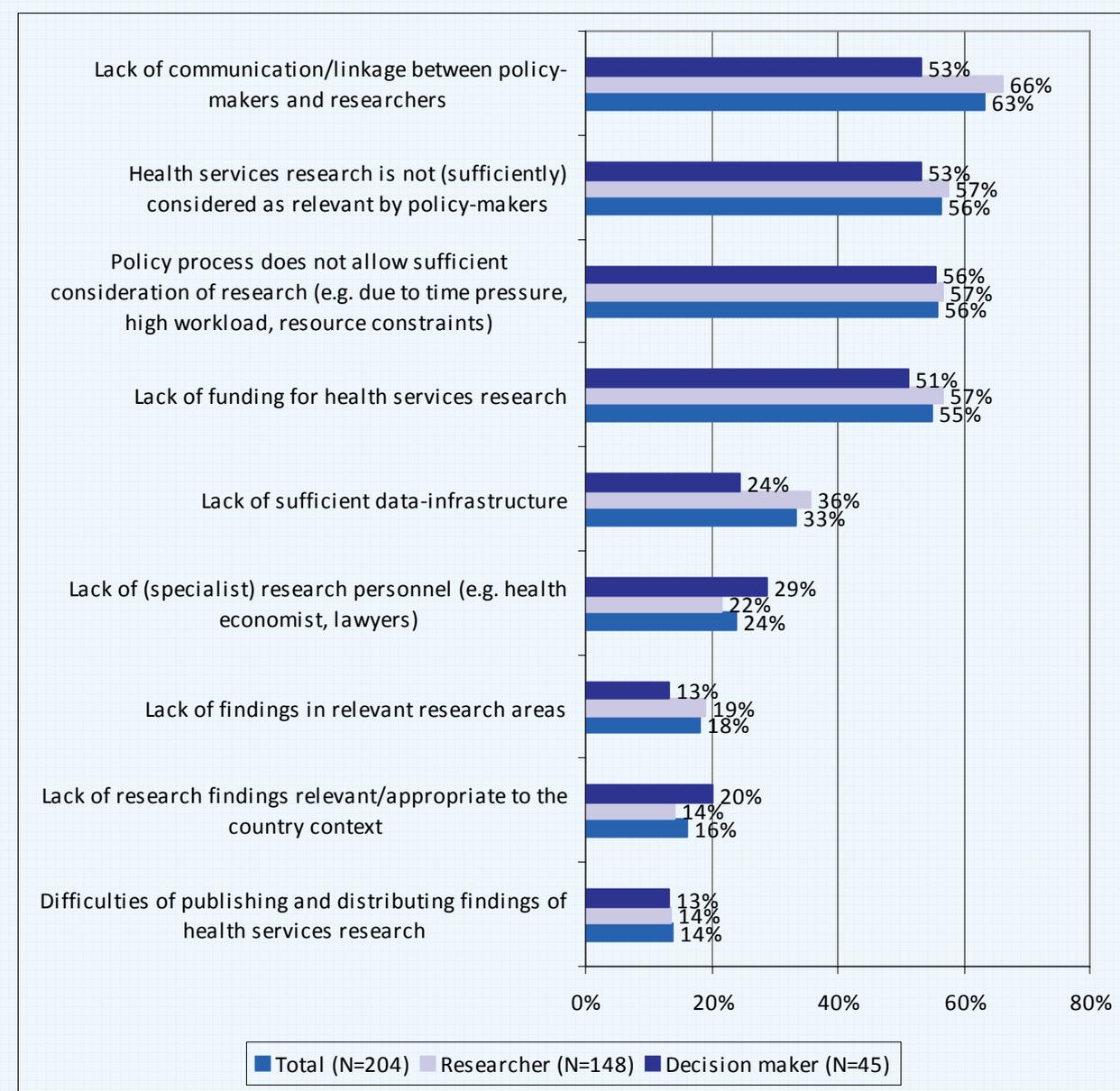
Government-related research institutes seem to have a major role in 'bridging the gap' between research and policy communities. Both as producers and users of research they are centrally placed at the research-policy interface and have the potential to maintain an essential brokerage role. However, the functions of government related research institutes are often complex, their roles as brokers requiring further exploration (e.g. Ward et al., 2009b).

The barriers to the use of health services research in policy reported in this study echo those identified in the literature, such as issues about timeliness, the mismatch of research and policy questions and the absence of appropriate incentives for researchers to engage with the policy process (Innvær et al., 2002; Oxman et al., 2009). While we assume that barriers vary among countries (most visibly perhaps with regard to differences in funding, priority-setting and research capacity), some of the obstacles to research utilisation for policy are similar in most countries. Findings from this study were also corroborated by a survey of decision-makers and health services researcher, undertaken as part of this project (Box 7.4). Reported barriers to research uptake may also be affected by what is known through previous research.

Box 7.4 Barriers to the use of health services research in policy – An online survey of decision-makers and researchers

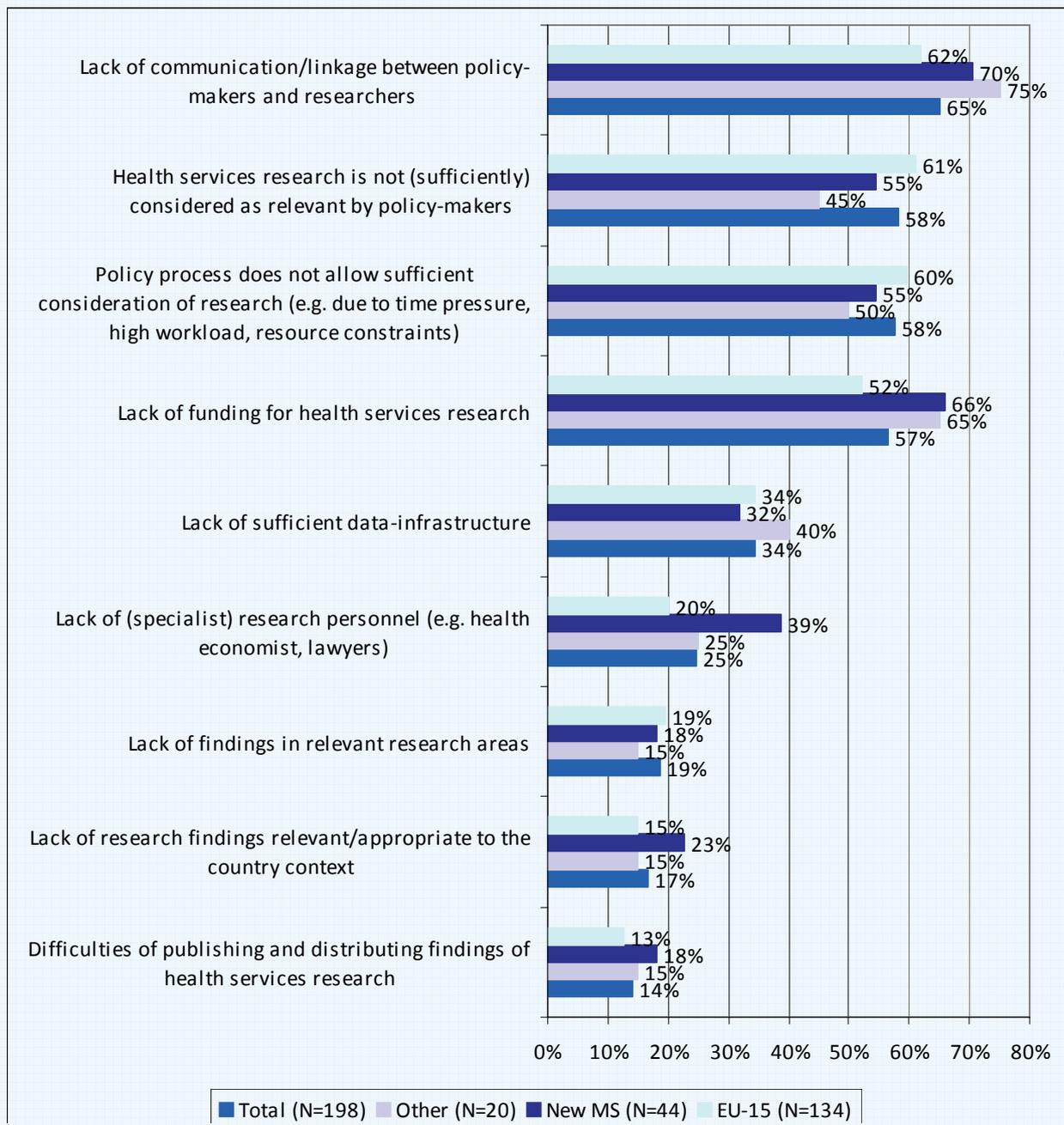
As part of this project, an online survey of decision-makers and health services researchers was undertaken in 2010 to understand the priorities of both groups in relation to health services research and policy. Respondents were also asked to identify the reasons why, in their view, health policy research was not used in policy-making as much as one might expect. Both researchers and decision-makers identified a lack of communication, and linkage, between policy-makers and researchers; lack of awareness of the potential of research by policy-makers; pressures arising from the policy process; and lack of funding for research as key reasons for the under-use of health services research (Table 7.2).

Table 7.2 Barriers for the use of health services research, identified by decision-makers and researchers, in percent



Box 7.4 - continued

A particularly large proportion of respondents from new member states of the European Union (EU), as well as those European countries that are not (yet) members of the EU, gave particular priority to expressed concern about the lack of communication and linkage; the lack of funding for health services research; and the lack of specialist health services research personnel. Respondents from countries constituting the EU-15, in contrast, gave higher priority to addressing the barriers associated with the policy process and the lack of awareness of policy-makers for the potential of research for informing policy, although these were also identified by about half of respondents in other EU and non-EU countries.



Only a few respondents mentioned facilitating factors, such as efforts to promote the use of research, the fact that policy-makers and researchers often are members of the same social and professional networks (perhaps especially in small countries and small research and policy communities) and the existence of mechanisms for strategic research commissioning. Concerns about researchers becoming too closely involved with policy-making, potentially leading to undue influence by policy-makers on the priorities and content of research, highlight the need for strategies to ensure a sufficient degree of independence and effective management of conflicts of interest (e.g. through disclosure of competing interests and publication of financial flows; Oxman et al., 2009). It also highlights the need for awareness of the subtle balance between health services research that is relevant to policy-makers and the importance of sufficient distance to allow for independent inquiry and criticism of policy.

7.5.2 Strengths and limitations

This chapter is based on a survey of 30 European countries, most of which have not previously reported on health services research and its use in policy. The chapter cannot be exhaustive due to its methods and the resources available, but it provides a first overview of capacity and activities in this growing and significant field of applied research.

Data are currently available for 30 of the 34 included countries. The study also has had to rely on responses from country respondents to survey questions rather than primary data collection in each country, to ensure the inclusion of a large number of countries, as requested by the European Commission, within the resources available. Respondents were health researchers in each country knowledgeable in the field, though, in most cases, it was only possible to request information from one expert per country (with few exceptions) because of time and resource constraints. Responses inevitably varied in completeness, depth and detail. The nature of the questionnaire approach also means that it is difficult to establish whether omissions reflect a lack of knowledge on the part of the country expert or lack of time on the part of the expert to collate the requested information or absence of information on a topic. With a few exceptions, respondents were members of the academic community since such individuals are far easier to identify than officials in ministries and other agencies, thus the knowledge, views and experience of policy-makers are commensurately under-represented.

The data collected were not specific enough to allow any comment on the relative production and use of different areas of health services research, apart from some indication that health technology assessment may be a sub-field in which application to policy is particularly developed.

7.5.3 Recommendations for further research

While a broad brush survey of a large number of countries can provide a high level impression of activity and use of health services research, a proper understanding of how health services research is being undertaken and used requires studies looking at fewer carefully selected countries in greater depth, involving interviews and other field work rather than reliance on individual informants.

In particular, future research assessing the relationship between health services research and policy making in different countries could usefully take differences in health system architecture and related policy-making actors and processes rather than research as the analytical starting point, given the importance of governance and health system organisation for how health services research is funded, undertaken and used. This would acknowledge the fact (which is reflected in

many of the responses) that much of the policy process is shaped by actors and politics, and that ultimately policy-makers make the decision” (Hanney et al., 2003; Blendon and Steel Fisher, 2009).

A policy process perspective would also allow the research to distinguish the uses of health services research at different stages of policy-making, such as agenda setting, policy formulation and policy implementation in different types of health care systems (Lavis et al., 2002). As part of the current study, we did not attempt to collect data about the policy process in individual countries, although we expect that processes vary, reflecting different political and administrative traditions and structures (i.e. context). How these structures define the use of research and how they differ among countries could be the object of further research, focusing on a smaller number of countries and based on interviews with policy-makers and researchers, and the analysis of policy documents and/or the media.

7.6 Improving the relationship between health services research and policy

Returning to the framework that has largely structured this work, we conclude that there are several key areas which should be considered in efforts to strengthen the use of health services research in policy-making at national and European level.

Developing capacity in health services research

- Given that countries vary substantially in the maturity of this field of research, any changes should be geared to the stage of development and level of recognition of health services research in each country. There will be no ‘one size fits all’ approach possible for developing national capacity, although there may be a role for external research funding and support, such as through the European Commission or WHO.
- Given that priority-setting in health services research is absent in most countries, there should be efforts to establish approaches to align research with the needs of policy-makers through priority-setting and strategic planning. Arguably, priority-setting is particularly relevant in countries, in which financial resources for research are very constrained.
- Opportunities for strengthening international exchange and mutual learning should be explored, including the creation of a European platform for health services research through a European Association for Health Services Research and/or an annual European Health Services Research Conference.

Improving the capacity of users of health services research

- Opportunities for improving the willingness and ability of policy-makers to use health services research should be considered. Efforts to improve research use skills could include, for example, tailored training in research methods and the use of bibliographic databases.
- There may also be opportunities for improving the integration of the use of research into policy processes and for creating a more research-friendly culture in policy organisations which should be further explored. An example could be the checklist for research use developed in Canada (Lomas and Brown, 2009) or experiences of research and policy co-location, as in the Netherlands.

Enhancing activities that support the use of health services research in policy

- Efforts should be made to strengthen the relationship between health services researchers and policy-makers both at national level and internationally, for example, by strengthening/

establishing national and European forums for exchange.

- Further developments could include establishing new organisations at the interface of health services research and policy, such as government research organisations or knowledge centres for health services research.

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