

Health services research: helping tackle Europe's health care challenges

POLICY BRIEF

April 2011

Health services research plays an important role in supporting Europe's need to innovate to meet the health care demands of its ageing populations. It does so by studying the use of health technologies, service delivery and performance - by practitioners, providers and whole health care systems - in order to compare, learn and improve.

This policy brief provides an overview of future major research priorities based on policy-makers' and researchers' views at a national and European level. It offers possible directions for improving the contribution of health services research to policy.

www.healthservicesresearch.eu



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Working conference “Health services research in Europe”, 8-9 April 2010

The aim of HSR-Europe is to evaluate and improve the contribution of health services research (HSR) to informing health care policy. It was funded as a Support Action to the Seventh Framework Programme Pillar 3 (Optimising the delivery of health care).

The project included the preparation of an inventory of research in the principal areas of HSR through a detailed review of the academic literature. Results were then compared to the priorities for health services research, as identified by health policy experts from across Europe through an online survey and a working conference in April 2010 in The Hague, the Netherlands, which attracted over 300 participants from Europe and beyond.

The resulting list of priorities for future health services research aims to inform the next EC Framework Programme, and to provide guidance and inspiration for setting research priorities at a national and European level. Further information about the working conference, including examples of policy supportive health services research, is available on the website www.healthservicesresearch.eu.

1 Challenges facing European health systems

European health systems face several challenges over the coming decades that ask for innovative solutions. The first is the increasing demand for health care that arises from technological developments, demographic changes and rising expectations. The pressure this is putting on budgets, regardless of the method of funding health care, means that all countries are facing uncomfortable decisions.

The second challenge is the well-recognised need for better integration of care both within the health sector and with other sectors, most notably social care. One consequence of longer life expectancy is an ageing population with more of us living longer and needing care for long-term and non-communicable conditions. This is shifting the emphasis from the need for acute, hospital care to care in our homes and in community settings. In most countries the integration of the multiple services that people need has to be improved. There is also a need to strengthen preventive care to ensure that more people will remain active and in good health over the course of their lives.

The third challenge, which is related to the second, is of providing more patient-centred care. Health services still tend to be designed and run to meet the needs of providers, particularly hospitals. This partly reflects the traditional power of the medical profession that has extended from a legitimate influence on clinical decisions and care to that of shaping the organisation and management of services and systems. The result has been services that prioritise professional views rather than a balance that accommodates the perspectives of the users of services.

The fourth addresses the quality of care. In every country, patients sometimes receive care that is unsafe or ineffective or inequitable or even inhumane. The challenge of assessing all these dimensions of quality, and of implementing measures to improve quality, is increasingly recognised and being addressed. But there is a considerable deficit to correct as such activities have tended to be neglected in the past with more emphasis being put on technological innovation as the way of improving care.

Fifth, the same demographic developments that will increase demand for care will also mean that health care systems are competing for a dwindling working-age population with fewer and fewer potential health care workers available within Europe.

Finally, there is the challenge of improving the efficiency and productivity of health systems. Within every country, wide variations exist in the efficiency with which limited resources are used. Whether it's the staffing levels in operating theatres, the case loads of community nurses or the settings for care, differences in costs exist that cannot be justified by patient needs or case-mix within and between countries. Such variations in efficiency have a significant impact on both health care expenditure and outcomes.

2 Health services research: what is it and how can it help?

Health services research (HSR) can help decision-makers address the challenges they face and provide scientific evidence to inform policies and practices. As the definition used by AcademyHealth in the USA (Box 1) makes clear, its strength lies both in the wide range of disciplines that it encompasses and the broad array of factors that it addresses in its attempt to understand and to evaluate health care. The disciplines include medicine, epidemiology, and social sciences such as economics, sociology and policy analysis. HSR, with its focus on health services, complements the equally important contributions made by basic science (laboratory) research, clinical research, and public health research.

BOX 1: DEFINITION OF HEALTH SERVICES RESEARCH (HSR)

“HSR is the multidisciplinary field of scientific investigation that studies how social factors, financial systems, organisational structures and processes, health technologies and personal behaviours affect access to health care, the quality and cost of health care and, ultimately, the health and wellbeing of citizens”

To understand health services, HSR adopts three contrasting but interconnected perspectives:

- at care provision level (micro) – health technology assessment (Box 2)
- at organisational level (meso) – service delivery and organisation research (Box 3)
- at system level (macro) – health care policy analysis (Box 4)

It is only by considering the challenges health care systems face at each of these levels that their complexity will be understood. HSR aims to be a valuable partner in European Innovation Partnerships to help devise appropriate policy responses.

BOX 2: EXAMPLE AT CARE PROVISION LEVEL: WHICH INTERVENTIONS SHOULD BE PROVIDED?

The incidence of pressure sores can be reduced by caring for high risk hospital patients on alternating pressure mattresses. As these cost about £4000, hospitals are tempted to use a cheaper alternative, an overlay on an existing mattress, which costs only £1000. However, researchers demonstrated, by means of a randomised trial, that the more expensive mattresses are more likely to be cost effective than the overlays.

BOX 3: EXAMPLE AT ORGANISATIONAL LEVEL: DOES ALL CARE NEED A DOCTOR?

A two year wait for patients referred to hospital with carpal tunnel syndrome could be reduced to six weeks by transferring responsibility from orthopaedic surgeons to a nurse practitioner. Outcomes were just as good and patients appreciated the greater continuity of care - assessment, treatment and follow-up was all provided by the same person.

The following sections 3 to 8 of this policy brief describe the major areas of research that for each of these levels need to be further developed. In addition this includes the cross-cutting themes of measuring the quality and performance of health care and of the use of research to support policy. This identification of areas is based on reviews of past and current research and on a process of setting priorities involving stakeholders from both a national and a European level. The final section of the policy brief offers possible directions for improving the contribution of health services research to policy.

BOX 4: EXAMPLE AT SYSTEM LEVEL: HOW SHOULD CARE BE FINANCED?

International studies have shown differences between social health insurance systems across Europe. They demonstrate which failures in risk selection occurred

in the risk-adjusted allocations to sickness funds; and they clarified the role of health insurance in health systems funding and its impact on various criteria such as the equity of the health system, mapping its effects on the poor or sick.

3 Priorities for analysing health care systems

Much can be learnt from considering health services at the macro-level of national health care systems. It allows consideration of organisational structure, the method of financing care, the planning and regulation of the system, the development of adequate facilities and staff, the policies to protect and improve health, and policies to respond when people fall ill.

In Europe there is a growing interest in health systems research, particularly in international comparisons which can provide valuable information for policy-makers on what can be expected from such changes.

In the context of growing economic and political pressures on European health systems, identifying threats to the important social goals of health systems will be a major task for health systems research orientated towards policy.

There are three particular priorities for future studies at the level of health systems.

Evaluation of health care reforms

In the light of the many health care reforms across Europe, there is a need to develop and implement methods for assessing the impact of changes such as the shifts from national health systems to social health insurance systems, from not-for-profit to for-profit providers, and from free care at point of use to co-payments. A number of key outcomes need to be considered (Box 5), assessed against explicit goals considering not only intended but also unintended effects and effects on the performance of the whole health system taken in account.

Research is also needed to understand how reforms can be successfully implemented, taking into account the transition period from inception to full implementation.

BOX 5: KEY OUTCOMES FOR EVALUATION OF HEALTH CARE REFORMS

1. **Health of the population:** e.g., mortality, avoidable mortality, infant mortality.
2. **Effectiveness of health care:** e.g., delivery of care according to evidence-based standards.
3. **Access to health care:** e.g., waiting times, travel times.
4. **Inequalities in health:** e.g., differences based on income, education, residency status, gender.
5. **Costs:** at micro (individual), meso (institutional) and macro (system) levels; financial sustainability of health systems.

In addition, methods for evaluating health care reform need to be developed (Box 6). Example questions in this field are:

- Do health inequalities increase when co-payments increase? For example, differences in avoidable mortality between lower and higher incomes.
- What is the actual share of different drivers of health expenditure in European countries? For example, technological development, the share of for-profit health care facilities, and the needs of an ageing population.
- How can health care developments be understood from a regional level? For example, what are the consequences of decentralising responsibilities for the delivery of care? And how can larger and smaller geographic entities be compared, including smaller member states which sometimes lack the critical mass to provide certain specialised health care procedures?

BOX 6: METHODOLOGICAL CHALLENGES IN EVALUATING REFORMS

Agreeing a common set of performance domains:

health status, responsiveness, satisfaction, financial protection, sustainability, and equity, including the role of potential intermediate domains - for example access, quality, and efficiency - to allow sound international comparisons.

Selecting performance indicators: these should ensure comparability across countries offering the potential to aggregate data in order to create indices.

Identifying data sources: routine data, data from research.

Establishing interdisciplinary research

Agreeing on the concept of best evidence:

definition of acceptable study designs for assessing intended and unintended effects of reforms.

Public versus private funding, plus privatisation /commercialisation

The funding and provision of health care in European countries is commonly a mixture of public and private sectors. Their relative contributions vary considerably and alter over time. There is a trend, either real or perceived, towards privatisation in many European countries, the effects of which on access, quality and outcomes have been little studied. "Which of the two performs better: private or public?" is a question that is dominant in many policy-making discussions. Health systems research needs to address this emerging issue and provide evidence to help policy-makers make informed decisions about the roles of public and private sectors in health systems (Box 7). This would lead to research questions such as:

- What are the effects of transferring health care facilities from not-for-profit ownership to for-profit ownership on avoidable mortality?
- What are the effects of transferring health care facilities from not-for-profit ownership to for-profit ownership on the costs and quality of providing care and the financial sustainability of health systems?
- What are the effects of competition in the delivery of health care on health, access and financial sustainability of health systems?

BOX 7: PRIORITIES TO BE ADDRESSED IN RESEARCH ON PRIVATE-PUBLIC FINANCE AND PROVISION

Markets and competition in health care: objectives and effects, both intended and unintended, on access, quality, health outcomes, responsiveness etc.

Privatisation: definitions and conceptual issues, objectives and effects, both intended and unintended, on accessibility, quality, health outcomes, responsiveness etc.

Performance comparisons: private versus public providers.

Regulation in health care: objectives to meet the societal goals of welfare systems, implementation and effects.

Workforce management and migration

This third key area is workforce management and workforce migration. There is a requirement for better planning of workforces and workplaces, changing professional profiles and shifting of tasks (Box 8). Most of these issues are influenced by changing social attitudes towards family structures and the roles of men and women. Example questions are:

- What are the effects of investments in health care structures on the availability and international mobility of health care personnel?
- What is the impact of weekend migration on the quality of care?
- How internationally comparable are available forecasting models, especially given the changing workforce demographics and international workforce mobility?

BOX 8: PRIORITIES TO BE ADDRESSED IN RESEARCH ON WORKFORCE MANAGEMENT AND MIGRATION

Migration of the health care workforce: What are the effects on the country of origin and on the target country? What are the needs, tools and experiences for the international management of health care workforce migration?

Changing definitions of professional tasks: What are the effects of the delegation of physician activities to other professionals and delegation across disciplines?

Management of workforce: How can workforces and workplaces be planned and forecasted, to meet the short term and long term needs of Europe's ageing population?

Gender issues of the above. Do all countries and professions face a similar pattern of feminisation and what are its consequences, among others in terms of workforce supply?

4 Priorities for studying the organisation and delivery of services

Across Europe, service providers differ considerably in size and structure, varying from large general or specialised hospitals to small primary care centres and solo practices. Empirical evidence about the best way to structure and organise care is of value and importance in helping develop policies to improve health services.

Our review of past and current research on health care organisation and service delivery suggests that it does not reflect the future priorities perceived by European experts. To date, the focus has been on the hospital sector, reflecting its dominance in terms of its share of national health care expenditure. In contrast, primary care has been under-researched despite being seen as a means of containing health care costs, improving quality and reducing inequity. There is an urgent need for more evidence on the best way to configure hospital and primary care services, and to change the way both sectors operate.

Four areas of research (Box 9) are regarded by researchers and policy-makers as priorities for

the future. The highest priority is that of inter-organisational relations, reflecting the need for chains of care rather than isolated services. It also highlights the importance of the tension between co-ordination, collaboration and competition. Despite this, it is the area that has received the least attention as judged by past publications and current EU-funded research.

Within each of the four areas, specific topics can be identified (Figure 1) - with the two most important priority areas being to understand more about the shift from secondary to primary and community care, and how to achieve continuity of care across organisational boundaries. Other priority areas such as 'patient involvement', 'workforce' and 'chronic disease management' also need further investment at national and European level. While the importance of some topics has already been recognised by EU-funding bodies, others, such as shifting from secondary to primary care, have not.

BOX 9: FOUR PRINCIPAL AREAS OF RESEARCH

1. **Intra-organisational control**, focusing on how organisations arrange their work internally. It includes topics such as workforce skill-mix and changing service provision.
2. **Inter-organisational relations**, which includes topics such as the continuity of care between organisations, and balanced geographic networks of services.
3. **Patient relations**, including sub-topics such as patient involvement and participation, patient compliance and patient delay, and demand management.
4. **Governance and accountability**, referring to topics such as assessment of quality and safety, relationships between professionals and managers, leadership and the regulation of provider organisations.

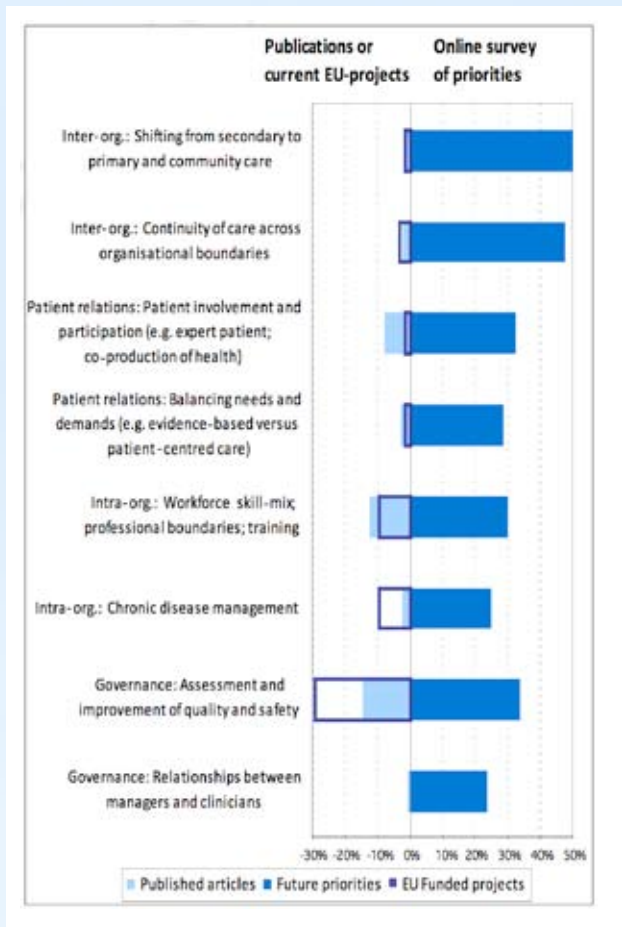


Figure 1: Comparison of European research and priorities on health care organisations

To illustrate the issues that need to be addressed, Boxes 10 to 12 provide examples for three of the topics that experts most often identified as priorities.

BOX 10: THE INTEGRATION OF CARE ACROSS ORGANISATIONS

The supply of health services in member states is often fragmented, while the health problems that patients present require co-operation between different providers and integration of care in pathways. It was for this reason among others that the WHO in its 2008 World Health Report, 'Primary care, now more than ever', called out for more integrated responses to tackle the health problems that many countries face. Specific questions include:

- Does integration improve patients' outcomes, patients' experiences and efficiency?
- What are the best forms of integration, under what conditions, and for which patient groups?
- Can we achieve integration in new organisational forms, such as care networks?

BOX 11: PATIENT-CENTRED CARE AND PATIENT INVOLVEMENT

European citizens increasingly expect to be treated as autonomous individuals and to be involved in decisions that affect their health and treatment. Both at a national and at a European level attention needs to be paid to patient rights, patient mobility, and access to information, especially in cross-border care. Specific questions include:

- How can patients be empowered to obtain patient-centred care and under what conditions do new health technologies contribute to more patient-centred care?
- How can the tension between evidence-based guidelines and patient-centeredness be resolved?
- How can instruments for collecting patient viewpoints be refined and standardised, taking into account geographical and cultural variation in what patient-centeredness entails?

BOX 12: SKILL-MIX, ORGANISATION AND DELIVERY OF CARE

As highlighted at Ministerial conferences both during the Belgian (2010-2) and Hungarian (2011-1) Presidencies of the European Union, Europe faces challenges in supplying enough human resources with the right qualifications and competences to care for an ageing population with complex health problems (see also box 8). Questions that research needs to address include:

- How do the competencies of health care professions vary across Europe?
- What are the consequences of changing skill-mix for the quality of care?
- What are the effects of inter-professional training, for example among doctors and nurses, on professional boundaries and co-operation?

Overall, there is a need for systematic mapping of variations in health care practice, for understanding their causes and assessing their consequences for the effectiveness, safety, humanity, equity and efficiency of services. While each country can study the organisation and delivery of services in their own system, there is much to be gained from international studies. The wide variety of ways of organising services in different countries provides Europe with a wonderful 'research laboratory' to assess and determine the impact of diverse models of care. The opportunity this natural experiment presents needs to be exploited in the future if the benefits that could accrue from research on the organisation and delivery of care are to be realised.

5 Priorities for better assessing health technologies

The development of health services in Europe is strongly influenced by new technologies with the potential to improve the health of populations through more effective care. However, not every technological innovation results in (cost-effective) health gains. There are many examples of technologies which have not produced the expected benefits or have even proved to be harmful. Also, technologies which prove to be effective create a challenge since their application may require additional finance and other resources, or require existing resources to be redistributed. Thus, it is necessary to ensure that health technologies are evaluated properly.

Health technology assessment (HTA) involves systematic, wide-ranging evaluation of the implications of technologies to inform the formulation of safe and effective health policies that are focused on the patient and achieve the best value for money.

While it is impractical to try to draw up a research agenda for all the technologies that will need assessment over the coming years in Europe, it is possible to identify the methodological challenges that need to be addressed. Three major areas were identified based on literature searches and consultations with country experts. First, meaningful assessments not only depend on a solid research base within clinical research and evidence based medicine, but to ensure meaningful assessments, research into the broader consequences of utilising health technologies is equally needed (summarised in Box 13). Secondly research in HTA methodology is required, as the demands for HTA are growing and new applications of HTA arise (Box 14). Thirdly HTA is aimed at providing input to policy-making in order to inform the formulation of safe and effective health policies and should therefore be supported by solid research on best possible ways of informing policy-makers about prerequisites for and consequences of the utilisation of health technologies (Box 15). As such there is a clear analogy with Health Impact Assessments, evaluating policies, plans or projects in different sectors in terms of their potential consequences on the health of a population. As both approaches are targeted at sound assessments to assist policy-makers, experiences can be shared to

increase the probability of evidence being appreciated and used.

BOX 13: RESEARCH INTO THE WIDER CONSEQUENCES OF USING HEALTH TECHNOLOGIES

To ensure meaningful assessments, research into the wider consequences of utilising health technologies is needed. This includes research concerning economic, ethical, organisational, social and legal consequences of the widespread introduction of specific health technologies. To achieve this, methods need to be developed and incorporated into HTA. This will enhance the usefulness of HTA to policy-makers.

BOX 14: DEVELOPMENT OF NEW APPROACHES TO HTA

- 1. Different ways of producing HTA to accommodate policy needs:** rapid assessment of technologies; use of assessments in hospital budgeting; joint European production of core information with subsequent national, regional or local adaptations. These forms need to be tested in different settings and modified further.
- 2. Developing assessment of health technologies continuously through their life cycle:** to accommodate disinvestment in health technologies; to assess their relative effectiveness; to support coverage of new technologies with further development of evidence.
- 3. Broadening the spectrum of technologies assessed:** to include assessment of public health interventions, organisational interventions and information and communication technologies.

BOX 15: IMPROVING THE INFLUENCE OF HTA ON POLICY

1. **Theory guided research on the links between HTA and policy-making** to understand ways of optimising such links in order to improve the utilisation of HTA.
2. **Developing ways of involving stakeholders**, particularly patients and the public, at a strategic level and in relation to the production of HTA reports.
3. **Assessing the impact of HTA on decision-making** and on health care services so as to develop better ways of producing and disseminating HTA and interacting with policy-makers at all levels.

6 Priorities for improving performance indicators and their use in benchmarking

Measuring the quality of care through performance indicators and using this information for comparing, learning and improving (benchmarking) has become a central component of today's health care policies. The notion of stewardship and governance through performance indicators has been endorsed by ministers of health in the WHO/Europe region in the Tallinn declaration in 2008. More recently ministers of health of OECD countries, which include the majority of the EU member states, stated the following in the final communiqué of their ministerial meeting in Paris on October 7 and 8th 2010:

We welcome the development of a set of indicators which help us to compare the quality of health care across countries and we look forward to them being further improved in the future. However, this will require better health information systems, and more effective use of the data that are already collected. The Forum on Quality of Care held before our meeting shows that we must reconcile the legitimate concerns of our citizens to protect their privacy with the need to monitor health care episodes involving multiple care providers. In addition, we must use information on quality of care to improve health sector performance. If all health care providers match the quality achieved by their better-performing peers, the gains would be of benefit to all health system users and funders. Although quality of care has improved in some areas, we need to address remaining barriers which stop us from realizing gains in the quality of care.

Health services research can help both in the development of performance indicators and the actual

use through benchmarking. A study of the literature and consultations with experts identified a large number of existing research initiatives within Europe although the distribution of research initiatives over the European countries appears uneven. The discussions during HSR-Europe's working conference in The Hague confirmed that on performance indicators and benchmarking:

- Research should focus on the development of indicators, covering issues as an indicator's validity, reliability, relevance. It should also focus on their use, among others in terms of effective embedding in policy and management.
- As a consequence of the above, health services research on these topics should always involve participation of the potential users.
- Scientific approaches are required from both a bio-medical or epidemiological angle on the one hand and from a social sciences approach on the other.

Further progress of HSR on performance indicators and benchmarking is hampered by the lack of available data. Experts agreed that the following issues need to be addressed:

- The use of Unique Patient Identifiers to help connect separate databases.
- Further standardisation of coding.
- The use of present-on admission codes in administrative databases.
- The recording of secondary diagnoses in administrative databases.
- The use of secondary data from electronic health records.
- The use of standard measurements for the

experiences of patients and citizens.

- The continued collaboration between Eurostat, WHO and the OECD on the availability of internationally comparable performance information.

HSR on benchmarking and performance indicators at the European level would benefit from strengthening the clearing-house function on research findings, training of researchers and appropriate scientific publication media. There is an increased emphasis on data collection and monitoring in health systems. Therefore the opportunities arising from a growing amount of data and e-health information need to be exploited better by designing information systems that can be used by health care providers and regulators, as well as health services researchers. The results of research on benchmarking and performance indicators should also be systematically shared with policy-makers and managers of health services and systems to make sure they are appropriate within the local context. Networking should be stimulated at a European level between the research groups involved in this kind of work and the growing number of national and regional institutes involved in the measurement and reporting of quality.

To develop the field further, three main themes were identified that should be addressed in future research programmes (see Box 16).

BOX 16: THEMES TO BE DEVELOPED IN THE AREA OF PERFORMANCE INDICATORS AND BENCHMARKING

1. The testing of validity and reliability of more outcome-oriented performance indicators related to avoidable mortality, cancer care, primary care, hospital care, mental health care, prevention and health promotion, palliative care and long term- and social care.
2. The effectiveness and efficiency of embedding performance indicators in various governance, monitoring and management models at both the health system, health services and professional level, and related to this, the transfer of findings to end-users and experiences with the misuse or non-use of indicators.
3. The effectiveness and efficiency of linking performance indicators to other national strategies and policies such as accreditation and certification, practice guidelines, audits, quality systems, patient safety strategies, national standards on volume and/or quality, public reporting, pay-for-performance and patient and consumer involvement.

7 The use of health services research in policy

As an applied area of research the use of health services research strongly depends on effective relationships between researchers, policy-makers and other stakeholders. Yet, there is almost no knowledge on whether, and if so, how, health services research is currently being used in Europe. Information from country experts indicated that health services research faces the same challenges in informing policy-making that have been identified in other policy fields, including a mutual lack of understanding of the role and work environments of policy-makers and researchers, differing expectations of the contribution of research, weak communication and tenuous relationships.

The main reasons for the limited use of health services research are related to:

- *Funding and priority setting:* Government funding for health services research varies widely among countries, ranging from none to over € 150 million per year. However, few countries have mechanisms which explicitly direct their health services research funding at policy priorities.
- *Capacity building:* Few countries offer bespoke multidisciplinary training in health services research. Most countries provide some training opportunities in areas that contribute to health services research,

such as health economics and medical sociology. However, opportunities to acquire the comprehensive set of skills necessary to study health services are largely lacking.

- *Networking:* Opportunities for networking between researchers and policy-makers and for publishing findings relevant to policy from health services research are limited. For example, there are only three scientific journals specifically dedicated to health services research in Europe (and these are published in English and German). There are also few national health services research associations and conferences, although in most countries there are meetings of researchers from the constituent disciplines.
- *Incentives for researchers:* Most activities to promote the use of health services research focus simply on conventional dissemination of research, often through encouraging researchers to publish findings in a manner palatable to policy-makers. While these are important initiatives, researchers still often lack incentives to engage with policy-makers.
- *Encouragement for policy-makers:* Few activities are directly aimed at improving the uptake of research by policy-makers, though there are sporadic examples of co-location of researchers in policy organisations and other efforts to improve 'linkage and exchange' of people and findings between the two communities. A number of governments have established bodies that undertake or commission health services research. These seem to be well placed to link policy and research, but there is an almost complete absence of guidance and opportunities for policy-makers to improve their skills in using research.
- *Accountability:* Governments and other key system agencies are typically not held to account for using, or not using, evidence from health services research when making decisions. In most countries, the onus is on researchers to bring findings to the attention of policy-makers. There are few examples of a mandatory requirement for decision-makers to use evidence in health policy-making. Most relate to decisions about inclusions and exclusions from the 'basket' of publicly funded health services, using health technology assessment.

BOX 17: DIRECTIONS FOR FUTURE RESEARCH ON THE LINKS BETWEEN HEALTH SERVICES RESEARCH AND POLICY

1. **Improved knowledge of how HSR is undertaken and used in different countries:** taking into account differences in health system architecture and policy-making processes with a view to improving use of health services research.
2. **In-depth study of the politics of health care policy-making processes in different countries:** to understand better how different political and administrative institutions and traditions shape the ways evidence is used. Research would need to focus on a small number of countries, based on interviews with policy-makers and researchers, and the analysis of policy documents and/or the media.
3. **Identifying best practice in knowledge transfer:** the uptake of HSR will benefit from identifying 'best practice' and the factors which determine the 'transferability' of these mechanisms to other countries. There is an emerging body of research, mostly from outside Europe but it is not clear to what extent these findings apply to countries that are as economically, culturally and politically diverse as countries in Europe. While some resources that support the uptake of research in policy are virtually global (such as the Cochrane Collaboration), other mechanisms are more likely to benefit from regional (e.g. European) or even local efforts and investments.

8 Strengthening health services research and its linkage to policy

Health services research is an important source of empirical evidence for decision-makers who seek solutions to new societal challenges and policy problems. Findings from health services research can help to improve the quality and efficiency of health services. However, to achieve this, the links between health services research and policy need to be strengthened at a national and European level in three ways: funding, capacity building, and developing links between researchers and policy-makers.

Funding

- *Priority setting and strategic planning:* Funding health services research is a public investment and should be treated accordingly. This implies determining strategic priorities for health services research in line with current and likely future policy initiatives and involving policy-makers as well as researchers in this process at an early stage.
- *Level of funding:* As public funding for health research is mainly targeted at biomedical research, much more is spent on understanding disease and developing treatments than on how these treatments are delivered and services effectively organised to maximise benefits for a population's health. A better balance will help both the implementation of proven treatments and establishment of change in health systems.
- *Co-ordination of funding:* Funding for health services research is often fragmented between various funders, including the different levels of government. As a result there is large potential for duplication of research efforts and waste of scarce resources. Co-ordination between funding bodies would make research funding more efficient and targeted to the needs of policy-makers and practitioners across the health system. An example in the field of HTA is a web-based overview of planned and ongoing projects from each HTA agency participating in the EUnetHTA network.

Capacity building

- *Building research capacity:* The health services research community is small in many countries and more investment is needed to strengthen its capacity. This includes investments in multi-disciplinary training, including lifelong training opportunities for health professionals, and efforts to build and maintain a research community organised at a national and European level.
- *Collaboration and comparison:* While some countries may have lower capacities than others, no single country is large enough to find all the answers to all the problems. By co-ordinating research efforts between several countries, for example through collaborative activities funded by the European Commission, essential experiences can be shared. Such comparisons should ideally include countries that recently joined the EU, current accession candidates, including Turkey, as well as the countries of the former Soviet Union.
- *Multidisciplinary research is crucial.* Providing the evidence to guide improvements in the organisation of health services and health systems is unlikely to be achieved by a single academic discipline given the complexity of health care problems and the required policy solutions. Multi-disciplinary efforts should therefore be strengthened by fostering multi-disciplinary research teams. This should include regular interaction with health professionals and health care managers.

Linkage & exchange

- *Enhancing presentation:* Health services research needs to be conducted and communicated in such a way that funders and policy-makers can understand it, appraise and apply it. Short, accessible summaries of research in the local language are especially helpful when decision-makers can be assured that conclusions are supported by more evidence. Helpful

too is to know where to find this work, or whom to approach, if more information is needed.

- *Building relationships*: Both researchers and policy-makers should invest time in building relationships, for example through shared training and other networking activities. These opportunities should foster mutual understanding and familiarity with the potentials and demands of work environments, both of policy-making and of research. They should also involve mutual consultation at all stages of the research process, not only before the start but also after the completion of the project.
- *Timeliness of research*: Research and policy need to determine the optimal speed of providing answers and the optimal product that can be given within that time frame. Research teams and institutes should be set up to be able to provide responses to policy-makers' requests in a timely way to increase the chances of research being used. This will not be possible in long-term research projects, which require substantial amounts of time if they are to achieve valid and reliable results. But in other situations the responsiveness to policy-making cycles can be increased, for example, by providing rapid syntheses of evidence on a given policy question (see Box 18).

BOX 18. THREE SOLUTIONS TO SOLVING THE PROBLEM OF TIMING IN RESEARCH AND POLICY LINKAGE

1. Different Health Technology Assessment products and their time frames.

Within the field of HTA different types of assessments have been developed to respond to the sometimes rapid needs of decision-makers. Examples are:

- Full HTA is a thorough assessment which typically takes 1-2 years to produce depending on the scope of the topic.
- Rapid HTA, is less thorough but, concentrating on major aspects, is developed to reduce production time and is typically done in about 6 months.
- Adaptation of foreign HTA reports is developed to re-use the work done by other HTA institutions and to reduce the time of production. Adaptation can be done within months.

- Mini-HTA is developed as an HTA-inspired tool for decision-support to specific aspects and can be produced within weeks.

2. On-call facility of the English department of Health

Recognising that robust information on health systems in other countries can provide valuable lessons for the English National Health Service (NHS), the department of health commissioned an academic team to provide an 'On-call Facility for International Health care Comparisons' starting in 2005. By making use of an international network of country experts it promotes the provision of high quality analyses at relatively low costs. In the last years the facility has provided information on a large diversity of topics to inform the department of health's rapidly changing policy agenda.

3. One- versus two-stage research projects

The most recent project calls in the Seventh Framework Programme provide a distinction between one-stage and two-stage submission procedures. In the first case proposals need to include sufficient detail directly, which makes this procedure particularly useful for well-defined problems that need a relatively fast answer. In the second case parties can first present their planned work as a short proposal, evaluated against a limited range of criteria. Proposals with a satisfactory score are then invited to submit a full proposal. While this requires a longer procedure through time, it does allow for more room for inputs by researchers themselves, as well as providing a lower threshold for relatively new parties that want to become actively involved in internationally comparative research.

About this Policy Brief

Health care policy-makers in European countries face a number of major challenges, including the ageing of the population and the economic sustainability of health care systems. Health services research (HSR) can help provide solutions to these challenges, as many important policy ideas, such as integration of care or health insurance reforms, have developed from HSR.

This Policy Brief provides a summary of key directions in which future research needs to be developed, including:

- *The need for more research on the effects of health care reforms on major health outcomes, such as changing the funding of health insurance or privatisation of care.*
- *The need for understanding of the optimal relationship between hospital care and primary care and community care better, in order to ensure service provision that is safer, of higher quality and more patient-centred.*
- *The need for research into new approaches to health technology assessment and to the economic and organisational consequences of introducing health technologies.*
- *The need for improved effectiveness and efficiency of performance indicators and their linkage to other governance policies.*
- *The need for increased understanding of how HSR is being undertaken and used in different countries.*

In addition, to improve the use of research in policy, a number of strategies need to be developed further, including a better balance between different types of research funding, the involvement of policy-makers in early stages of the research process and tools to avoid the duplication of studies in different countries, for example on the effectiveness of care provision, and learning from best examples in, among others, HTA regarding rapid assessments of research evidence.

This policy brief is intended for both producers and users of HSR at a national and international level, for example, decision-makers in health care settings, public or private funders, national and international (European Commission) policy-makers, as well as stakeholders and experts at various levels across Europe.

If you want to learn more, please visit www.healthservicesresearch.eu to access our final report 'Health Services Research into European Policy and Practice'.

It is also possible to visit <http://jhsrp.rsmjournals.com/> or contact hsr_europe@nivel.nl to inquire about receiving a copy of the July 2011 Supplement issue of the Journal of Health Services Research & Policy, which contains a selection of articles with key results from the project.