

## Health Services Research: Lessons from Abroad - Report

### Opening speech by Lenie Kootstra: International perspective on health services research

Prof. dr. Paul van der Maas, chair of the RGO, welcomed all participants and especially the foreign guests to the conference on health services research. Lenie Kootstra, director of the International Affairs Directorate of the Ministry of Health, Welfare and Sport, started the first presentation. She inspired the participants by posing three statements: (1) Social tasks for public health and health care are leitmotif for health services research, (2) Getting research into policy & practice requires better 'linkage & exchange' (Jonathan Lomas), and (3) Health services research agenda requires international scope and concerted actions. As many other countries, the Netherlands have set a long term agenda for the health sector. In Kootstra's view, health services researchers should be driven, or at least inspired, by these policy and practice problems and challenges. Furthermore, both researchers and knowledge users, such as policymakers and health care managers, should dedicate themselves to optimal use of knowledge, for instance through the concept of 'linkage & exchange' by Jonathan Lomas. Since many health problems are similar world wide, it only makes sense to jointly face the social tasks at hand, according to Kootstra. She named a few examples that were already taken up by various international organizations. One of them is the joint Dutch proposal in the 7<sup>th</sup> Framework Programme for a big agenda setting conference on health services research in 2009. Kootstra assured the audience they will hear more about it if the proposal gets accepted. Kootstra ended her speech by saying that this meeting and the advice, that the RGO will give the ministry shortly, are important steps in a joint learning process.

### Colleen Flood: The role of health services research in Canadian health policy

Subsequently Colleen Flood, scientific director of the CIHR-Institute of Health Services and Policy Research in Canada, introduced the audience to the Canadian health care system and the role of health services and policy research in Canada. In Canada the individual provincial governments are responsible for health care and education, while the federal government collects taxes and finances the majority of research. This situation of divided responsibilities and interests sometimes causes a 'catch 22' situation, in which the various parties hold each other responsible for a certain problem. This is one of the biggest difficulties in Canada. The Canadian Institutes for Health Research (CIHR) is the largest funder of research in Canada and has a budget of approximately CAD800 million. Its organization is similar to the NIH in the US with 13 virtual institutes across the country, one of them being the Institute of Health Services and Policy Research (IHSPR). 70% of the CIHR budget is spent on investigator-initiated research in an open competition, whereas 30% goes to strategic initiatives chosen by the CIHR or its institutes. Although the success rate for health systems/services research has increased slightly over the years, relatively little money is spent on this type of research compared to biomedical and clinical research (~4%). At the provincial level multiple funders fund health services research. However, most funders are more keen to develop capacity and infrastructure rather than to sustain these. Furthermore, there's little awareness on who's funding which research, resulting in a disconnect between federal and provincial funding organizations. Together with the Canadian Health Services

Research Foundation (CHSRF) the CIHR-IHSPR organizes a national consultation process, called *Listening for Directions*, to identify priority areas. After priorities have been set however, there's little coordination. Flood therefore believes more in innovative funding tools to give stakeholders, such as policymakers, more influence in determining research agendas. One of those funding tools in Canada is the *Partnerships for Health Systems Improvement* (PHSI), that requires interaction between decision-makers and researchers, including a 1:1 matching from decision-making partners. In order to further link researchers and decision-makers, the CHSRF focuses on training decision-makers to be receptors for research evidence. Moreover, Flood is all for including representatives from the government, patient organizations and health care organizations in the board of the CIHR-IHSPR, which now mostly consists of researchers. That way, more attention may go to translation of research apart from the smartest research proposals. In addition, she believes that research should be more multidisciplinary, mixing health services researchers, biomedical researchers, clinical researchers etc. The contribution of health services research to health care policy and practice is hard to rate, according to Flood; so far impact from investments in health (services) research can only be demonstrated by story telling (CIHR-IHSPR Knowledge Transfer Casebook and CHSRF Received Wisdoms: how health systems are using evidence to inform decision-making). For various reasons implementation of research results can sometimes be frustrating. Therefore in Canada there's an increasing call for investment in research in change management. Flood concluded her presentation with a plead for more international collaboration, so that research money is spent efficiently and researchers are not doing the same things in different countries.

*Nick Black: Health services research in England*

Nick Black, professor of health services research at the London School of Hygiene and Tropical Medicine in England), started his presentation by clarifying his perspective on health services research and its organization in England. The micro, meso and macro level research in England are funded in connected, but distinct programmes, namely Health technology assessment (HTA), Service delivery and organization research (SDO), and Policy Research Programme (PRP). The funding bodies in England largely determine what research is done and how the infrastructure is organized. The principal funding agency is the National Institute of Health Research (NIHR), recently established and financed with NHS funds. The NIHR funds applied research, such as health services research. Apart from that, the Department of Health funds the Policy Research Programme. In addition, several charities fund health research. In total there's about £1.3 billion available for health research in 2007-8. About 90% of that is spent on biomedical research via open competition and approximately 6% is available for health services research. Most health services research is commissioned, modest funds are available for capacity development, a few units/centres are funded and starting in 2008-9 there will be some responsive funding available. The English have made quite an effort to improve the relationship between research, policy and practice. Black thinks that they are actually close behind the Canadians in this respect and showed five examples of how they managed this. Firstly, the NIHR Advisory Board is chaired by the Chief Executive of the NHS and includes not only researchers but also health care managers and patient representatives. It advises the government on applied health research. Secondly, topics for health services research are identified through surveys of managers, practitioners and patient organizations. Priority setting varies between research programmes; for the HTA

programme priorities are set by researchers and clinicians, for the SDO programme by managers, patients, practitioners and researchers, and for the policy research programme by policy-makers and civil servants. The awareness among decision-makers of the importance of a programme such as SDO is high, probably due to their involvement in priority setting. In 2005 an HSR Network has been established to organize health services researchers and give the health services research community a voice. More recently also a network of NHS Trusts, keen to support health services research and to use research evidence, SDONet, was established. The goal is to bring the three parties, the SDO funding programme, the HSR Network and the SDONet, more and more together. The impact of health services research on policy and decision-making is variable, according to Black. Most importantly, he prefers to speak about evidence-informed or evidence-influenced rather than evidence-based policy and management. Many researchers in England are both naive and arrogant, a pretty deadly combination, Black thinks. He says these researchers believe that, after having published their results, policy-makers should be happy and act upon the results, and if they don't they must be stupid. That's why Black believes that not only policy-makers should be taught to understand the value of research, also researchers should be educated in policy-making, for scientific evidence is but one of the many things policy is based on. Likewise, there is not a linear relationship between health services research and its impact on policy and practice, according to Black. It makes no sense to look at policy and practice and search in retrospect which research formed the basis for that and the other way around. Black's statement is that health services research has had an enormous impact on health care and health services, which can be seen by comparing health care and health services now and thirty years ago. One of the current examples in the UK is the explicit rationing through cost-utility comparisons by the National Institute of Health & Clinical Excellence (NICE), which is informed by the HTA programme and vice versa. To conclude, also Black believes there are various opportunities to collaborate internationally and to share experiences.

Reinhard Busse: Health services research in Germany and the role of the EU

Reinhard Busse, professor of health care management at the Technical University of Berlin in Germany, started with some definitions, because health services research cannot be translated into one German word. At the macro level there is *Gesundheitssystemforschung*, comparable to health systems research. At the meso level they speak about *versorgungsforschung*, or care research. Only the micro level research is named HTA, as in English. In Germany policy advice through Advisory Councils is highly valued. Although the belief in wise professors is high, also in Germany evidence-based policy making is developing rapidly. Interestingly, in Germany the government provides a framework for the health care system, but the actors in the system have the power to make decisions, with only little intervention from the government. It is therefore the actors in the system, organized in the federal joint committee, that need to use the available evidence and commission research, e.g. to their Institute for Quality and Efficiency (IQWiG). The Advisory Council advises the minister only on large changes in the system. The minister can also commission research to the IQWiG, but needs to pay for its services. Next to the IQWiG, the Federal Joint Committee has its own scientific department. Despite the fact that there are many health services researchers in Germany, they are hardly visible internationally due to little international publications. According to Busse, they prefer writing expertises, not necessarily based on the best available evidence, instead of scientific publications for the (inter)national

community. In the 1990's public health research networks, among which health services researchers, were established, funded by de Federal Ministry of Research. Because not many researchers made it to European programmes, the initiative is not regarded very successful. Several times the Advisory Council has demanded more health services research. Indeed, the Federal Ministry of Research together with sickness funds has installed a programme on care research (2001-2007). Nowadays joint competency networks between biomedical researchers, clinical researchers and health services researchers have developed to put more emphasis on translation of research into practice. Although this programme is successful, there is a problem with the appraisal of research proposals, mainly from health services researchers. Another, researcher-driven, HSR Network has been established, in which also clinicians are involved. Successful annual health services research congresses are organized by this network. Furthermore, the Physicians' Chamber Scientific Advisory Council has developed a programme for health services research. So although health services research is not as well developed as in Canada or England, the need for this type of research is well understood in Germany. There are several initiatives involving a broad range of actors, however there is no overarching programme. Subsequently, Busse informed the audience on the status of health services research in Europe. The distinct programme for health services research in the fourth Framework Programme has been cancelled under the influence of basic researchers. However in the sixth Framework Programme there has been room for policy-oriented research. In the seventh Framework Programme the three pillars of basic research, clinical research and public health research have been re-established, although obviously the money is not equally distributed. Apparently, the EU is sensitive to well founded proposals from researchers. The European Observatory on health systems and policies was founded 10 years ago to bridge the gap between policy needs and health services research. Members are mainly governments, but also others such as the WHO and the World Bank, and have a direct influence on research across Europe. With that Busse thanked the audience for their attention.

*Peter Groenewegen: Main issues to be addressed in The Netherlands*

After a short break, Peter Groenewegen, professor of spatial and social aspects of health and health care at NIVEL, introduced the Dutch system to the audience, obviously mainly for our international guests, but also providing some details about health services research in the Netherlands, derived from a survey by the RGO. Public health services research in the Netherlands is provided by a few large research groups, and several smaller groups, implicating that the research infrastructure is fragmented. The annual budget for health services research is comparable to that in Canada and England, being approximately 7% (€60 million) of the total public budget for health research. As in Germany, but in contrast to Canada and England, there is not a specific programme for health services research in the Netherlands, although researchers can apply for funds in many different ZonMw-programmes. A main difficulty in the Netherlands has been the role and potential contribution of health services research to health policy and practice. Obviously, the influence of research varies with the circumstances, which are continuously changing. The circumstances that currently hamper the contribution of health services research to evidence-informed policy and practice are the suboptimal connection between researchers and decision-makers, the suboptimal balance between commissioned versus free research, and the suboptimal capacity building, according to Groenewegen. Recently, the Ministry of Health, Welfare and

Sport has developed societal challenges, to which health services research can contribute. Researchers are willing to be responsive to these challenges, says Groenewegen. At the same time, Groenewegen feels that researchers should be responsible towards society and address issues that are important for society, but currently not policy priorities. Groenewegen ended his speech by saying that there are many things to be learned from other countries and he asked the audience and foreign guests to come up with feasible approaches for the Dutch system on how to improve the research infrastructure, the manner of priority setting and organization of the interaction between knowledge-providers and knowledge-users.

#### Reactions by Flood, Black and Busse

The discussion started with reactions of the three international guests. They all have valuable advice for the Dutch system. Flood believes that health services research should integrate with other health research, without being bypassed, in order to fully benefit from each discipline. Furthermore, Flood thinks that health services research may benefit from new ways of funding, less top-down but not open. Long term goals should be taken into account when funding research. Also knowledge translation should be funded, according to Flood, because it requires hard work and a lot of investments in relationships. Lastly, Flood feels that more should be invested in data collection and connection. Black thinks that the situation in the Netherlands is not so much different from that in England. He feels that once the people in charge are convinced of the importance of health services research, the funds will follow undoubtedly. Important is to develop capacity, Black said, because researchers get lost in and because of the system. Also Black thinks it's wise to invest in facilities such as databases. To improve the interaction between researchers and knowledge-users, Black thinks researchers need to be taught about the policy process. He does approve of integration between researchers and knowledge-users, but he warns about taking it too far; there should be room for centres of excellence, which are necessary for methodological progress. Furthermore, Black is not concerned about the balance between commissioned and free research; even with commissioned research he is able to do the things that he wants to do, he argued. Busse agreed fully with Black that there should be room for excellence; basic research is necessary and will be used in a later stadium to improve health care. Busse argued that funds should be divided over a few good research groups. Spreading out the money too much, would be a waste, he said. Also capacity building is an investment in the future and will result in more timely answers later. Busse advised to invest where universities have already invested, because that's where the expertise is. Lastly, Busse pleaded to finance the best proposal, not the one that best falls within the priorities set. For example, EU-funds are rather flexible, so that the best proposals usually qualify within the delineated area.

#### Discussion

Mackenbach started the discussion, supported by Vos, by asking: 'what is the urgency?'. Groenewegen claimed that the problems that health services research encounters may not be that urgent, however are chronic and should be dealt with nonetheless. Others, like Grol, believe that there are indeed a few urgent problems, such as the difficulty with capacity building. Flood is confused about this discussion about urgency; she believes that there are *important* things to do, rather than *urgent* things. Van der Maas added that a few urgent problems, which the Ministry posed itself, are the societal tasks and that dealing with those is

important. Van Kammen mentioned it is also about setting priorities; about studying different roles in the changing system and the necessity to develop management models for the health care system. To improve the visibility of health services research over e.g. biomedical research, Hazes suggested to show the link between the research and improvement of health and health care. Flood believes that the correlation is extremely hard to prove and Black added that health services research is only one link in people's health. Heijnen wondered what the Netherlands should do about the performance of the Dutch system that lags behind compared to other countries, e.g. concerning maternal death, whereas more money is spent than ever. He feels that this is the value of health services research. Black put these international comparisons into perspective; he argued that the Netherlands have probably provided more honest data than others. Kievit is convinced that, to enhance capacity, young researchers should be shown clearly what health services research is all about. Capacity can only be created by attracting young talent. Black agreed fully and added that in the US and Canada, but not in England, many doctors perform health services research. Knottnerus asked whether the speakers expect an increase in questions for health services researchers. Black answered that there are two types of health services research: (1) evaluating policy and (2) providing information before policy is made. According to Black there's a lot to gain for the second type of questions. Smid, director of ZonMw, asked whether further refinement of the methodology is necessary, mainly for meso and macro level research. Flood answered that the CIHR funds this and that it's very popular. Busse agreed that methodological improvement is necessary. IJzerman inquired how the guests feel about technology; should, in addition to evidence based medicine, policy and health services research, also technology be integrated? Black finds this very important; the horizon scans in England form an important input for health services research, because the researchers need to be ready to go, as soon as a particular technology is introduced. Hofstraat remarked that health services research needs to enhance the scope towards an innovative entrepreneurial one and take a prognostic view. Bal put attention to the role of the health care field; in the Netherlands €0.25 per doctor's hour is spent on improvement of quality of care, however it's hard to persuade hospitals to invest similarly in health services research. Grol was interested in what the international guests feel is the ideal model for partnerships between researchers and policy-makers. Black didn't want to give one single solution; every case should be regarded individually, he argued. Busse feels that the lack of one particular health services research programme is beneficial. And Flood approved of direct partnerships in a project and thinks a good balance is important. Lastly Smit, representative of patient organizations, added that the Canadian federal system is very similar to the EU and its problems. Furthermore, he believes that the cost of technological progress set to €80,000/QALY is a threatening perspective for patients.

With that, the chair ended the discussion and thanked the participant and speakers for their fruitful contributions.

### Finally

The RGO-committee will consider all recommendations and proposals of this day and incorporate them in the advice to the minister, which is expected to appear this summer.

Attendees

- dr. O.A. Arah, AMC, Amsterdam
- dr. R. Bal, Erasmus MC, iBMG, Rotterdam
- drs. C.C. van Beek, Dutch Healthcare Authority (NZA)
- drs. H.W. Benneker, former executive director RGO
- drs. I. van Bennekom, Federation of Patients and Consumer Organisations (NPCF)
- drs. P.A.H.M. Berendsen, Netherlands Organisation for Scientific Research (NWO)
- dr. A. Boer, Health Care Insurance Board (CVZ)
- dr. D. Delnoij, Centrum klantervaring in de zorg
- R.G.P. Doeschot, Health Care Insurance Board (CVZ)
- dr. G.M. van Etten, Netherlands Platform for Global Health Policy and Health Systems Research
- prof. dr. T. van der Grinten, Erasmus MC, Rotterdam
- prof. dr. P.P. Groenewegen, Netherlands Institute for Health Services Research (NIVEL)
- prof. dr. R.P.T.M. Grol, UMC St Radboud, Nijmegen
- dr. J. Hansen, Netherlands Institute for Health Services Research (NIVEL)
- prof. dr. J.M.W. Hazes, Erasmus MC, Rotterdam
- drs. S. Heijnen, Netherlands Platform for Global Health Policy and Health Systems Research
- G.M. van Heteren, BMC
- prof. dr. J.W. Hofstraat, Philips Research
- drs. C. Hoogendoorn, DBC-onderhoud
- prof. dr. M.J. IJzerman, University of Twente
- dr. ir. J. van Kammen, Netherlands organisation for health research and development (ZonMw)
- prof. dr. J. Kievit, LUMC, Leiden
- prof. dr. J.L.L. Kimpen, UMC Utrecht
- prof. dr. J.A. Knottnerus, Health Council
- drs. L. Kootstra, Ministry of Health, Welfare and Sport
- dr. J.F.E.M. de Kroon, NWO/WOTRO
- drs. J. Lelij, Ministry of Education, Culture and Science
- dr. S.H.M. Litjens, Advisory Council on Health Research (RGO)
- prof. dr. P.J. van der Maas, Advisory Council on Health Research (RGO)
- prof. dr. J.P. Mackenbach, Erasmus MC, Rotterdam
- dr. J.N.D. de Neeling, Advisory Council on Health Research (RGO)
- dr. R.W. van Olden, GlaxoSmithKline BV
- prof. dr. H.M. Pinedo, Netherlands organisation for health research and development (ZonMw)
- dr. T. Plochg, AMC, Amsterdam
- dr. A.B.M. van Poucke, DBC-onderhoud
- prof. dr. S.A. Reijneveld, UMC Groningen
- prof. dr. H.G.M. Rooijmans, former president of RGO
- dr. W.M.M. van der Sande, Advisory Council on Health Research (RGO)
- prof. dr. J.M.G.A. Schols, Tilburg University
- drs. H.J. Smid, Netherlands organisation for health research and development (ZonMw)
- dr. C. Smit, Stichting informatie dierproeven
- dr. ir. H.A. Smit, Centre for Prevention and Health Services Research (RIVM)
- dr. H. van Stel, UMC Utrecht

- prof. dr. M.J. Trappenburg, Utrecht School of Governance
- ir. J. Ton, LUMC, Leiden
- dr. ir. C.M. Vos, Ministry of Health, Welfare and Sport
- prof. dr. C. van Weel, UMC St Radboud, Nijmegen
- prof. dr. G.P. Westert, Centre for Prevention and Health Services Research (RIVM)
- prof. dr. D. Wiersma, UMC Groningen
- ir. A. Wijbenga, Health Council
- dr. ir. G.A. Zielhuis, UMC St Radboud, Nijmegen