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HOW RESEARCH CAN ASSIST WITH PLANNING AND PROBLEM-SOLVING IN PROVISION OF HEALTH SERVICES

by

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Subject: Structure and management of biomedical and health services research

Objective: Exploration of the mechanism/systems by which health research is linked to policy objectives (note: health research taken here to include fundamental, clinical and health services research).

Particular relevance to WHO:

Assistance with progress goal of Alma Ata declaration
Focussing European countries' attention on health needs and how research (in three countries and other countries?) - basic fundamental, clinical, and related to health service delivery can help to resolve problems of meeting health needs.

Background

Increasing concern in ACMR (and other WHO bodies) that research should be coordinated. Behind this concern was pre-occupation with major health needs of both developed and developing countries and the extent to which research programmes were selected to identify these and indicate solutions. Annex I is a rough note summarising ACMR's train of thought over the past four years.

ACMR' 24/82-8, p.5 "Effective mechanism for setting national priorities for research do not exist in the majority of Member States".

The point can be made in a different way. Both health care and health care delivery would greatly benefit from the application of analysis and research to specific problems identified within them.

Present thrust

Member countries are believed to be facing unparallelled pressure on funds because of the world recession. Inevitably health services come under fire; are they good value for money, can or should the spread of "high tech" services be slowed down or halted in order to concentrate on primary and preventive measures (same of which are also high tech?) The ability of health services to decrease morbidity has been questioned, showing that provision of health care is not immune from political and economic scrutiny. As well as defending existing services, and improving them there is also the need to ensure that such limited funds as are available for development are used in the most effective way.

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Three papers were commissioned by WHO in a follow-up study of the structure and management of biomedical research in Europe which was initiated as a result of ACMR's interest in the field. All three papers covered at different lengths the legal and financial basis of research management, the institutions concerned, career structure and education of research workers. Those who compiled the reports were required to describe research policy. Denmark stated that it had "no specific medical research policy", Czechoslovakia that it "endeavoured to co-ordinate all scientific research plans,...to integrate all institutes and to achieve co-ordination of research institutes at an international level". Austria made no attempt to deal with the question of policy, limiting its reply to a list of funding bodies and university and other departments in which research was taking place. None of these papers casts any light on the importance attached to setting national priorities for research nor the mechanisms used to select problems, carry out the studies and modify administration or medical practice accordingly. It is possible that the information required, in particular the focus on the interaction between service policy and research cannot be obtained through a description of mechanisms and systems. These are bound to concentrate on the anatomy, whereas the physiology is more important. It barely matters whether a Government Department, an independent Research Council, voluntary bodies or academic departments are handling the funds. What does matter is that the health administrator, the clinician and other professional staff giving care are provided with the tools they need to judge whether services present or future are the best possible under the circumstances.

Health service provision

Robert Maxwell has commented (*) that a cross section of surveyed countries (18 in Europe and USA) repeatedly shows health policymakers and administrators compelled to make difficult decisions in the half dark, and their implementation efforts are hampered or defeated by structural forces over which they have no control. He identified four principal ways of correcting the situation - better information, eliminating the incentives to waste resources, coordination of interdependent sources, improved issignment of responsibilities for resource use. It is the first of these with which this paper is concerned. Masses of data are collected and available for all sorts of purposes but for various reasons those data are often not useful for making fundamental decisions. Routine statistics on hospital/health service use give no indication of unmet need (and are generally very deficient as far as primary care is concerned) nor of the effectiveness of one form of treatment compared with another, nor what resources are required to provide various levels of service.

Individuals or corporate concerns with responsibility for delivering care are often criticised for not taking into account the results of results of research in their fields. The problem is sometimes that the

(*) Health Care: The Growing Dilemma

levels; they may be germane to policy making at national level or highly relevant to the provision of services at the local or community level.

Some of the problems

In an ideal world all policy and planning decisions would be made on a basis of hard facts, fully evaluated and proven ways of delivering services with health administrators and health personnel (including medical staff) prepared to work to the blueprint. Fortunately for the health of both patients and medical practise the process of innovation and experiment never stops but this accentuates the needs for better information. Does early discharge from hospital increase morbidity? Have acrylic implants any long term hazards? Is the safe level of alcohol intake the same for women and men? What components of antenatal care can significantly improve maternal and child health?

The questions are legion and the resources in terms of money and people able to tackle them are distinctly limited. Researchers have their own particular skills and interests and may not find questions which the policy makers want answered particularly interesting. Timing can be very difficult. Politically the answer may be required yesterday. Ethically it may be too late to mount the definitive research, e.g. the evaluation of folic acid in the prevention of neural tube defects. Health authorities are often advised by their own expert professional and technical staff who may be convinced that a service is desirable and should be offered before data are available on economics, risks, or effectiveness. Maintaining standards in commissioned studies is clearly important since "bad research never benefited anybody" (A. Buller). Health services research particularly is still a young field without a long history of tried and tested tools and people able to use them. Sometimes the policy staff are tempted to snap up a project which seems to be geared directly to their problems with little thought for the competence of the team putting it forward. Arrangements have to be made referee studies, to observe and check their progress and to assess the results. These are some of the problems that arise when Government departments are handling research on a customer/contractor principle. Other questions are raised in the paragraphs that follow and in Annex II.

The customers or clients

Who needs research in connection with health policy and health service provision? Government departments, health administrators (at national, community or hospital level), clinicians and others concerned directly with providing services are the main customers.

There are broad public health issues, e.g. nutrition, safety and effectiveness of vaccines, which are clearly matters of continual concern and usually for Governments to take the necessary central action. Health administrators need to know the costs and effectiveness of services and specialties particularly of developments within them which have to be paid

many factors involved and their importance have not been subject to scientific analysis and experiment.

How can research or special studies assist? What policy makers and administrators look for is a little light to add substance and form to options which otherwise look shadowy. Incidence studies will help towards estimating the size of the health burden; evaluation of different methods of treatment will indicate costs and effectiveness and acceptability.

> Analysis of the role of different disciplines in case of groups of disabled and disadvantaged folk will indicate training needs. The success (or failure) of early treatment of disease and of preventive techniques is specifically necessary if the claims of primary and preventive medicine on one hand and curative procedures on the other are to be balanced.

When studies along these lines are mounted they often cause the existing information (hitherto regarded as next to useless!) to be looked at again. Sometimes it can be taken apart and put together again in a different and helpful way.

Arrangements for aligning research with service needs

Government departments have to develop policies in the health field which relate as closely as possible to people's needs. The type of research which will be required may be, on the one hand fundamental or basic, and on the other applied and practical. It may be survey work and data collection or it may require an experimental framework and intervention under strictly controlled circumstances.

> The division between clinical and health service research is not absolute and there is little point in trying to define health services research too sharply. A similarly wavy line separates clinical from fundamental basic research. Research in all 3 categories may be necessary in tackling health problems. Some difficulties may arise when the grant giving powers and responsibilities of different bodies are sharply delineated and are used as an excuse not to fund research urgently needed by policy makers.

In those countries where research funding comes from a variety of different sources it is unlikely that any one category of research instrument (Research Councils, universities, research institutes and agencies, commercial firms or in-house staff) will be able to meet all the research requirements. All or any of these may be involved. With this degree of spread imperatives emerge: 1) those with responsibility for service provision must identify and give a priority rating to those problems which are amenable to research 2) Research teams or units with an interest and capability in the appropriate fields have to be identified and acquainted with policy problems 3) Findings from research commissioned in this way have to be assimilated at various

for from new money or economies elsewhere. Important clients for directed research are those directly responsible for the care of patients, some very difficult fields, e.g. drug addiction, the care of the elderly, mentally infirm have problems which should be exposed to analysis and the possible benefits of directed research but have not always attracted the scientific attention which their grave social consequences suggest they merit.

A second large area in which the clinical team is the customer for research is the better use of resources. It must be remembered that significant innovations in medical practice have taken place not because administrators have advised a more cost effective way of providing treatment but because clinicians themselves have questioned and modified traditional ways - and introduced day care, early discharge and other more intensive ways of using health capital. The role of research is to test the modification in a controlled experiment which will often prove its applicability, convince doubters and suggest other areas to which it could be extended.

The contractors or researchers

Those carrying out research will normally be found in academic departments, research institutes, as attached staff in a health service institution, occasionally as in-house staff in a Government department or health authority. Their funds may come from a number of sources - government, private or charitable, industry, and may be in the form of programme or project grants, tenured appointments, grants-in-aid, or combinations of these. The research worker may be prevented from accepting new commissions because of anxiety about the terms or because the research required does not fit naturally with his existing programme. Perhaps a more formidable barrier to closer alignment of policy needs and research is the difficulty of achieving a dialogue between the two sides. Who represents the differnt groups? How are researchers to meet representatives of many specialities and many disciplines? Who decides on the priorities between the research needs of the elderly, or the mentally handicapped, or the evaluation of early detection of breast cancer? The morale of those concerned with research of direct relevance to health service policy may suffer if the results are pre-empted (*). Those who carry out the research may also be highly critical of the way in which results are conveyed to those who most need to have them and by the apparent inertia and lack of enthusiasm with which pertinent results are greeted.

Conclusions

There are real dividends to be obtained from considering how research can assist with planning and problems solving in provision of health services and in specific fields of health care which have not attracted much scientific attention. There are difficulties;

(*) By 1981 concern had switched to ...doubts whether research commissioned by the DHSS "is being conducted in a genuinely objective fashion or whether it is being selectively used to bolster a pre-determined position taken by the administration" (LANCET, July 18 1981, p. 159; quoted in "On the Black Report" (Gray, Mooney, Weis), p.34

the formulation of researchable hypotheses, attracting people to work on specific problems, putting the results into practice.

How different countries tackle these will clearly depend on the way research is financed and health services organized. No mechanism, or structure can be recommended at this stage as the most desirable and effective way of achieving results although there is likely to be considerable common ground when problems areas are identified.

ANNEX I

1979

Research programme (particularly health service programmes) to be geared towards monitoring studying problems and trends with a view to producing solutions.
Extend R and D out of traditional fields to care of elderly and mentally ill. Stressed importance of joint planning of research programmes by "national research bodies".
From health economics workshop general conclusion to avoid unnecessary growth in manpower and hospital beds - presumably with objective of containing expenditure. The same group recommended interdisciplinary research planning and evaluation and a broader base, e.g. inclusion of demographic epidemiological and labour market considerations. Meeting on health services research stressed the drawbacks of traditional concepts of health and illness, the planning group on information systems for research promotion dwelt on information retrieval systems for ongoing research (Danish system includes 80% and is supposed to include health services as well as clinical studies).

WHO need for analysis of national research structures stated (NOTE: reasons for this need are not stated. What are they? Problem is more likely to be how they work to initiate and deliver research on specific policy subjects than what they actually are).

1980

Stressed importance of health services research, "a priority research concept reaching into all areas treated by the other planning groups"; lack of information on health planning and evaluation, need for recognition of inter-disciplinary nature of health services research, lack of coordination and collaboration between governments and research groups.

1981

Emphasis on systems of information; organization of health care in order to achieve Alma Ata declaration. Regional emphasis on life style, EACMR's function seen as the provision of advice on the general direction of the research programme.

1982

Subcomittee analysed regional programmes and asked pertinent questions including extent to which research inputs were related to WHO's goals, and how the results were to be disseminated. Suggested developments and testing of health indicators, lifestyle indicators and disability indicators, emphasized application of new knowledge in health planning and evaluation to national problems.

ANNEX II

1) Do Health authorities (national or local) identify health and health service problems with which research could be expected to assist?

2) Who decides which questions to pursue?

3) How are researchers attracted towards solving (public health) health service problems? (The research itself may have little original content and be less than exciting intellectually)

4) How can policy imperatives and principles of supporting research (looking for originality etc.) be reconciled?

5) How much work should a grant giving body put in towards getting the research proposal into a form which is likely to be acceptable to referees?

6) What arrangements should be made for peer review of research related to health service policy?

7) What arrangements are necessary for urgent admissions of special studies because of a political or public health imperative?

8) Should there be special training and career arrangements for those involved in health services research?