Health Services Research to orient policy making

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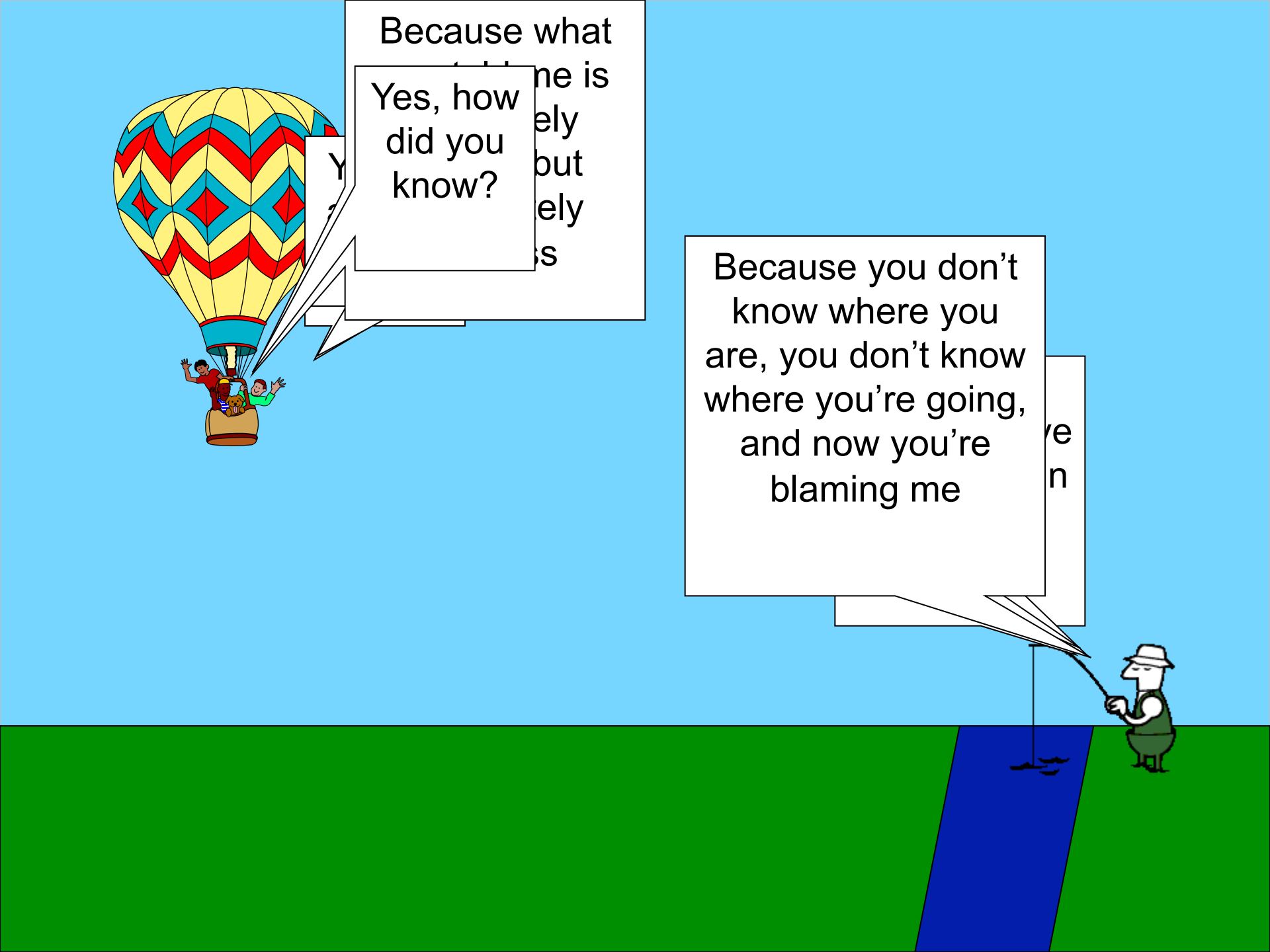
My background……..

- Researcher
  ("academic")
- Civil servant
  (researcher)
- research applied to policy making


Yes, how did you know?
Because you don't know where you are, you don't know where you're going, and now you're blaming me

Goal of the presentation

- To explore the mismatch between HSR and policy, using two issues currently under the spotlight in the Italian context:

- regionalisation of surgical procedures

- inappropriateness in clinical practice

The policy context

- Costs containment strategies

- Stopping health professionals turn-over/ recruitment
- Blocking salaries
- Health services restructuring
- Eradication of «waste» in clinical practice

The volume-outcome relationship

- Documented and investigated since 1979
- Mostly in cross-sectional studies (i.e. documenting correlation, rather than causal relationship)

The rationale of regionalisation policies

- Managing scarse resources

  - High technologies
  - Highly sophisticated professional skills

- Rare diseases

- Better quality of care

Regionalisation of interventions and procedures

- Several studies showing that higher volumes are associated with better outcomes (usually mortality)
- Overall relatively poor quality of the evidence base
- Not clear the explanation of the volume-outcome relationship

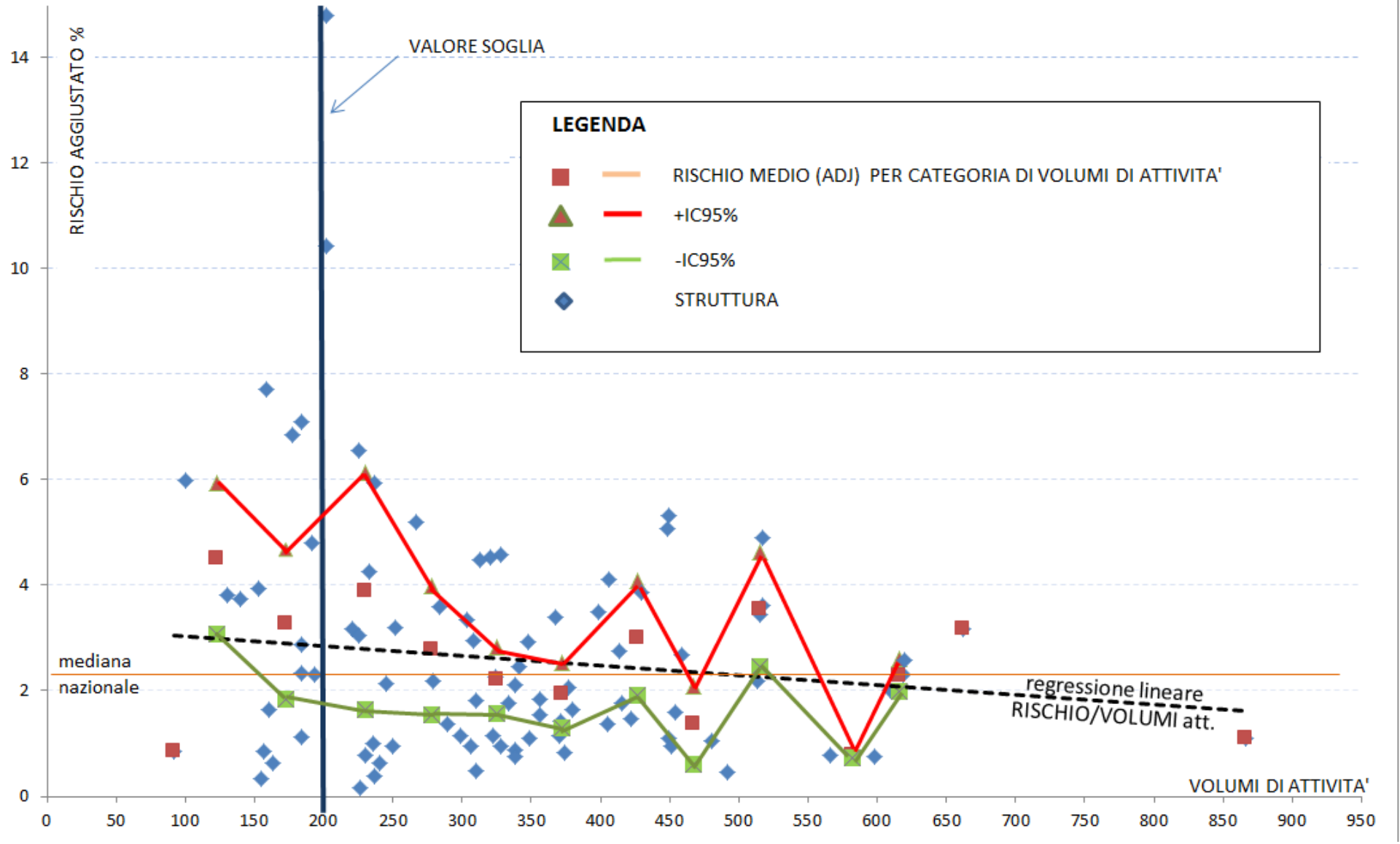
Volume-outcome relationship. Why ?

- Learning by doing
- Economy of scope (i.e. specialisation)
- Selective referral

The rule and its exceptions

- Low volume with good quality outcomes
- High volume with poor outcomes

BYPASS AORTO CORONARICO: MORTALITA' 30 gg



Policy issues research did not explore

- What explain the exceptions ?

- The effects of changing volumes
  - on outcomes
  - on costs
  - on the organisation of care
  - on health professionals

HSR-Policy making dialogue about regionalisation of surgical procedures

- HSR does not answer the relevant questions
- But policy makers do not care……

Some common assumptions about inappropriateness

- It's a matter of individual physicians'behaviour
- It means that we are doing too much (i.e. lots of money could be saved !)
- It can be fixed with tougher managerial control (and with economic incentives/ penalties)

Inappropriateness: The causes

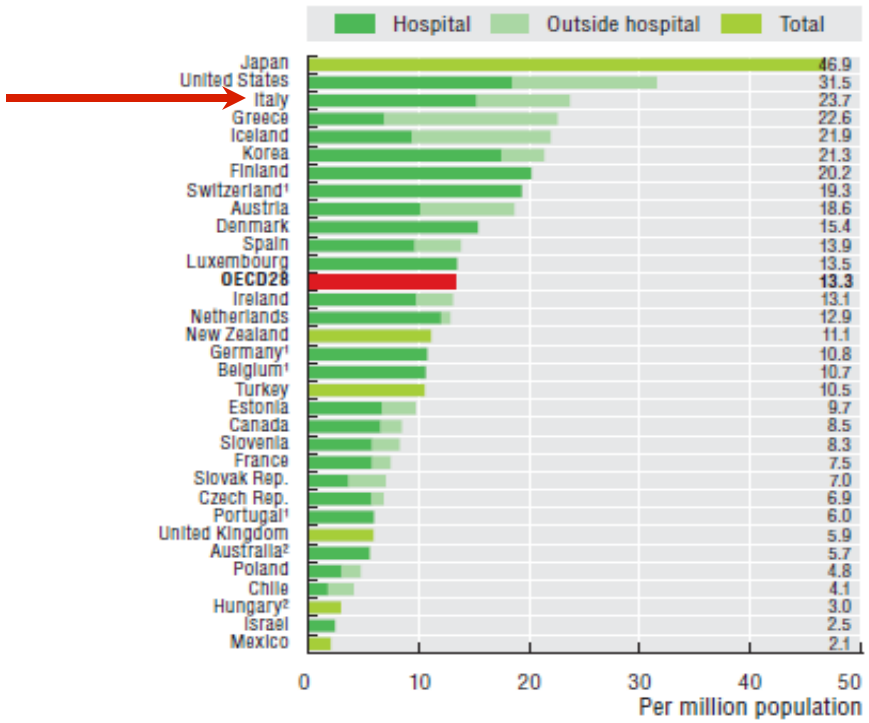
- Is it really only individual clinicians' fault ?

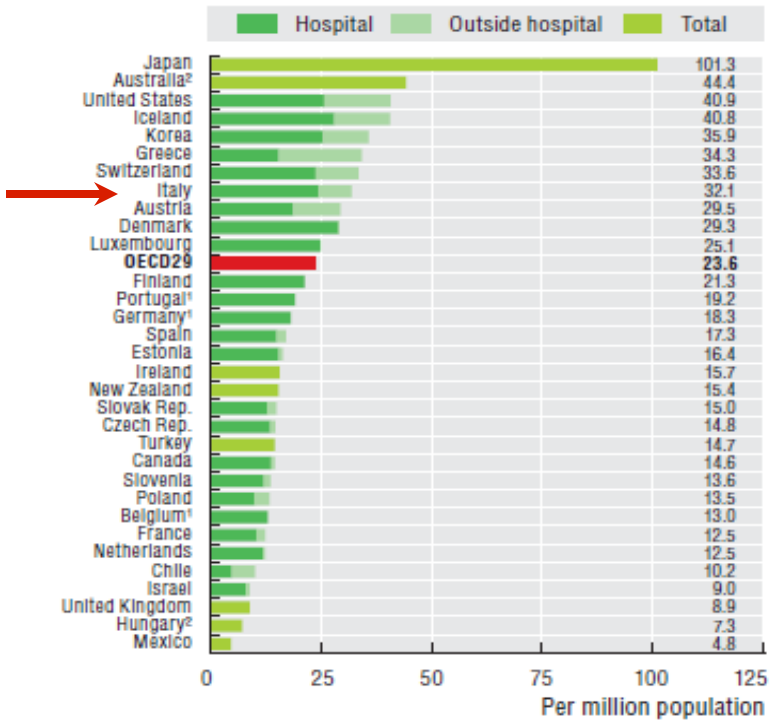
Determinants of healthcare providers'behaviour

- *Patients'characteristics*
- *Professional factors*
- *Healthcare system's policy and administration*

Barriers to adoption of research findings

- Structural (i.e. policy and administration)
- Organisational (e.g. inappropriate skill mix, lack of facilities or equipment)
- Peer group (e.g. local standards of care not in line with desired practice)
- Professional (e.g. knowledge, attitudes, skills)
- Professional - patient interaction (e.g. problems with information processing)
- Patient (e.g. knowledge, attitudes, skills)



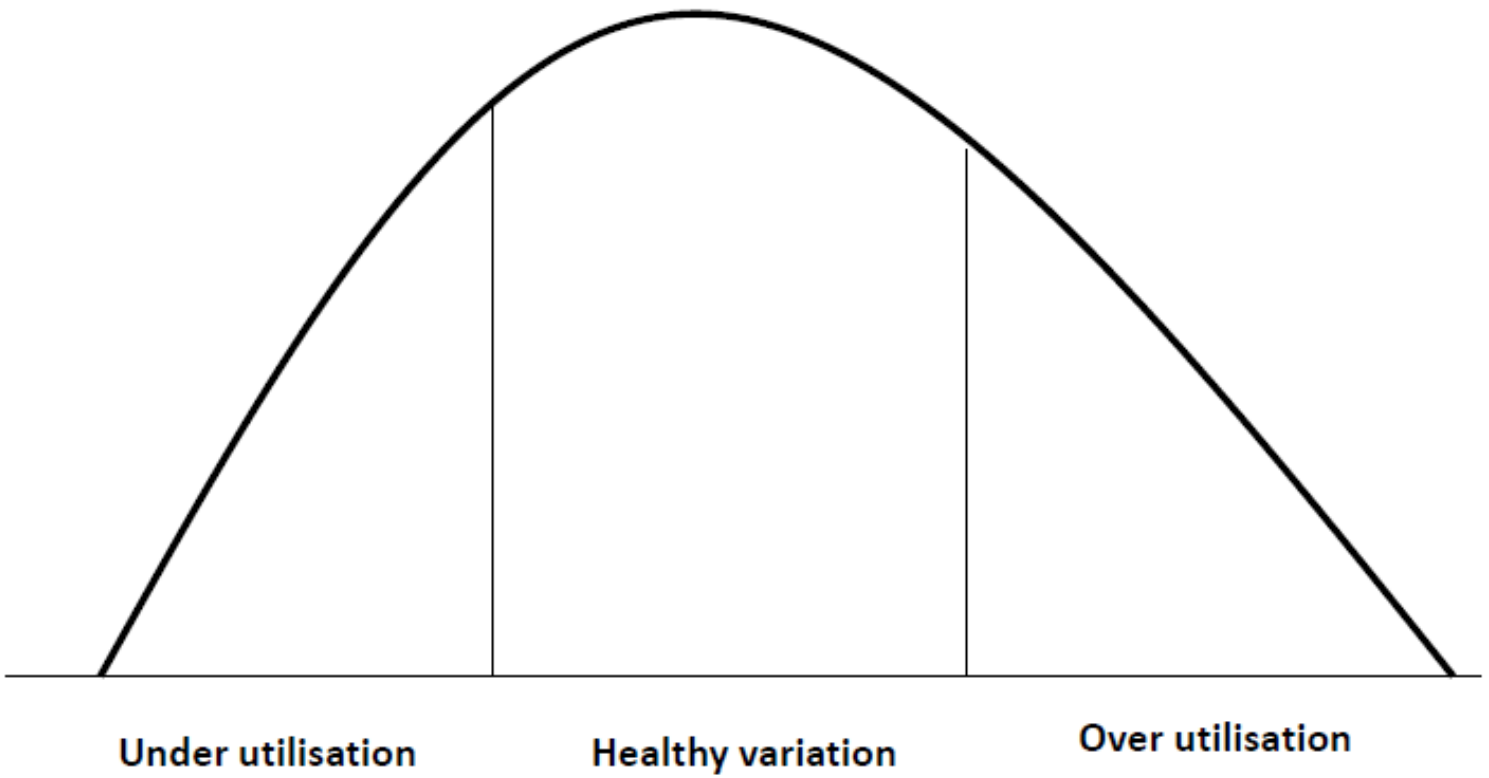


Health at a Glance 2013
OECD INDICATORS

Inappropriateness: The implications

- Does it mean only «doing too much»?
- The double face of variations in clinical practice styles

Variation in clinical practice



The Relationship Between Geographic Variations and Overuse of Healthcare Services

A Systematic Review

Salomeh Keyhani, MD, MPH,† Raphael Falk, MD, MPH,‡ Tara Bishop, MD,§ Elizabeth Howell, MD,‖ and Deborah Korenstein, MD¶*

Conclusions: The limited available evidence does not lend support to the hypothesis that inappropriate use of procedures is a major source of geographic variations in intensity and/or costs of care. More research is needed to improve our understanding of the relationship between geographic variations and the quality of care.

Medical Care • Volume 50, Number 3, March 2012

Inappropriateness: The remedies ?

- Is making rules and norms, attaching to them economic incentives/penalties, really the solution ?
- The features of
- the problem at stake
- health professionals

Some problems of economic incentives

- Effective, in general, but
- Effect does not last long
- Reliance on external motivation (from knights to knaves…)

Will a market deliver quality and efficiency in health care better than central planning ever could?

BMJ | 13 MARCH 2010 | VOLUME 340

"You are either so stupid that you have to be directed by targets, audits, and inspection or so venal that you are motivated only by success and profit. It's a grim picture "

Neal Lawson

Models of governance

- ✓ ordering what to do (command & control)
- ✓ putting at risk your money (economic incentives/penalties)
- ✓ putting at risk your reputation (naming & shaming)
- ✓ putting you on the market (choice & competition)

USES & ABUSES OF PERFORMANCE DATA IN HEALTHCARE.

dr foster.
Intelligence in healthcare

Published April 2015

Performance measurement can have a range of unintended adverse consequences:

- ***Tunnel vision*** – focusing on aspects of clinical performance that are measured and neglecting unmeasured areas
- ***Adverse selection/ inequity*** – avoiding the most severely ill patients or excluding disadvantaged groups
- ***Bullying*** – intimidating staff to achieve performance targets or to adjust data
- ***Erosion*** – diminution of intrinsic professional motivation as a key driver of high-quality healthcare
- ***Ceiling effect*** – removing incentives for further improvement and potentially influencing top performers to reduce quality
- ***Gaming*** – distorting the process of care in order to meet targets or manipulating data to misrepresent actual performance
- ***Distraction*** – challenging, obfuscating or denying data which suggests under-performance instead of fixing performance problems

An alternative ? Clinical engagement

✓ «the active and positive contribution of doctors within their normal working roles to mantaining and enhancing the performance of the organisation, which itself recognises this commitment in supporting and encouraging quality of care»

The relationship between organizational culture and performance in acute hospitals

Rowena Jacobs [a,*], Russell Mannion [b], Huw T.O. Davies [c], Stephen Harrison [d], Fred Konteh [e], Kieran Walshe [f]

Social Science & Medicine 76 (2013) 115–125

This paper examines the relationship between senior management team culture and organizational performance in English acute hospitals (NHS Trusts) over three time periods between 2001/2002 and 2007/2008. We use a validated culture rating instrument, the Competing Values Framework, to measure senior management team culture. Organizational performance is assessed using a wide range of routinely collected indicators. We examine the associations between organizational culture and performance using ordered probit and multinomial logit models. We find that organizational culture varies across hospitals and over time, and this variation is at least in part associated in consistent and predictable ways with a variety of organizational characteristics and routine measures of performance. Moreover, hospitals are moving towards more competitive culture archetypes which mirror the current policy context, though with a stronger blend of cultures. The study provides evidence for a relationship between culture and performance in hospital settings.

HSR-Policy making dialogue about inappropriateness

- HSR provides several relevant information pointing to the complexity of the issues, while policy makers look for simple answers and tools

Some problems in the relationship between research and policy making

- On the research side

- Research not timely
- Limited generalisability of findings
- Research is often lacking…..
- Research is often controversial
- Policy makers not the usual target of academia
- A simplistic view of the policy process

Some problems in the relationship between research and policy making

- On the policy side
  - Lack of scientific background
  - A simplistic view of research
  - Complexity of the policy process

Any way forward ?

- Let the guys in the balloon and the fisherman meet, early….