Health Services Research: Evidence-based practice

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ORAL PRESENTATIONS

O1
Making research and evaluation more relevant and useful in the real world: favoured solutions and uncomfortable realities

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There has been a recent upsurge of advocacy from trialists and policy ‘modernisers’ for far more use of RCTs as the basis for health and wider public policy. This is exemplified by the UK Cabinet Office’s report ‘Test, Learn, Adapt’ (2012). Mainstream policy makers are now being told that they should make policy by experimenting like scientists. Drawing on experience as an applied health services researcher and policy adviser in government, I will attempt to stimulate reflection on the following questions: how can we explain the timing of this phenomenon; how realistic and helpful is it; and where does it leave the contribution of evaluation in policy?

O3
Health system challenges in implementing universal health coverage: Asian perspectives and experiences

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In line with the global trend towards providing universal health coverage (UHC) as a primary tool in achieving sustainable development in the post-2015, post-MDG era, many low- and middle-income countries in the Asian region are in the midst of developing and implementing various schemes and strategies to achieve UHC. Given the diversity in health system structures, resources and capacities, the implementation of UHC in these countries poses major challenges to health service delivery. Indonesia, the fourth largest country in the world, rolled out its UHC plan, called JKN (National Health Assurance) in early 2014 and faces formidable logistic and administrative challenges with regards to access to medicines, human resources, financing, governance and scaling up health service delivery. Key implementation challenges include those associated with issues of equity, quality and sustainability. The Indonesian experience in rolling out UHC may also be compared to other countries in the region which have implemented UHC with varying degrees of success (e.g. Thailand, Vietnam, Taiwan, India, Malaysia, etc.). In the spirit of ‘reverse innovation’, it is also hoped that lessons learnt from UHC implementation in these countries will provide valuable learning lessons for each other, and for the success of UHC more broadly.

O4
Health systems: the challenge of adapting and responding to the accelerating health transition in low income countries

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In low-income countries, and particularly those in Africa, there are two important landscapes that have changed profoundly in recent years. One is the architecture of global health with its resulting increase in both the volume and complexity of health financing at country level. The second is the accelerating health transition in such countries where the past decade has witnessed declines in child mortality and increases in life expectancy at paces that have never been seen before in any period of history in any society. These health gains are not just a result of improving socio-economic development, but are consequent to important changes in health services and systems that have improved access to and coverage of several efficacious and cost effective essential health interventions funded in part by global health initiatives.

The dynamics of this health transition naturally result in very different and continually changing patterns of risk factors and attendant burdens of disease. Unfortunately the improvements in health systems in such countries have not yet included the necessary changes in, or even development of, appropriate means of monitoring the dynamics of the disease and risk factor patterns on a routine basis suitable for forward planning and policy making that will adequately steer development of the future health systems needed to respond to these dynamics. We remain too dependent on burden of disease modelling based on intelligent, but not sufficiently empirical real time data at country level on disease and risk factor dynamics. This is particularly so for cause of death data of acceptable coverage and quality in low-income countries where premature mortality still constitutes the largest share of disease burden DALYs. At the same time, the share of burden constituted by disability is rising rapidly from a much more varied set of causes and risks which are also changing due to demographic transition and other evolving phenomenon such as urbanization and globalization. These dynamics will require very different health systems and policies. This presentation will discuss the need for linking three critical health information sources; 1) radical new approaches to routine longitudinal civil registration and vital statistics for disease burden monitoring, coupled with: 2) periodic national risk factor surveys that link to: 3) new approaches to monitoring district level health service coverage of services needed in response to the changing burdens and risks. Integrating across these data sources would provide the missing information strategy for evidence to feed more responsive health system planning and policy making needed for achieving universal health coverage.

O5
Contextual influences on the role of evidence in health policy development: insights from India and Nigeria

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Descriptive analysis of service use covered by long-term care insurance in Japan - based on population-based claims data
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Background: Japan has the population with the highest proportion of aged people in the world and it rapidly continues to grow due to long life expectancy and a low birth rate, while traditional supports for elderly people are eroding. In response, the Japanese Government initiated mandatory public long-term care insurance (LTCI) in 2000. Little has been published on the report of evaluation of LTCI with population-based data besides our previous report [1]. To make the provision of long-term care services effective, it is important for policy makers to have accurate evidence regarding the actual usage of services covered by public long-term care insurance (LTCI).

Methods: The nation-wide claims data of February 2009, excluding data of some municipal bodies which were not available, was analyzed with official permission by Ministry of Health and Welfare. We evaluated the average expenditure and frequency of long-term care use covered by public LTCI and frequent patterns of services use by age, gender and care level.

Results: In this study, 620,091 males (34.2%) and 1,193,425 females (65.8%) were observed. The proportion of males decreased with age from 54% in the 65-69 age group to 16% for those 100 and older. The average expenditure on long-term care use per person is 10,540 yen for males and 11,055 yen for females. The expenditure increases with age for both genders, and males are more likely to use services than females under 75, which becomes reversed at 75 and older. However, the distribution of users’ age and gender varies by types of services. Regardless of age cohorts, males are more likely to use visiting nurse and visiting rehabilitation. The frequent patterns of service use are daycare only (15%), helper only (9%), daycare and rental device (7%), daycare and helper (6%), rental device and helper (6%), but these patterns also vary by gender and age.

Conclusions: This is the first study of detailed descriptions of service usage covered by the LTCI with population-based claims data. Policymakers and researchers can utilize these patterns of service use to predict future demands for long-term care and to conduct the policy evaluation.

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Reference

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Development and pilot testing of a National Men’s Health Index
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Recent men’s health reports from Asia, Australia, Canada and Europe have consistently shown that men have higher morbidity and mortality compared to women in most health conditions. There are numerous factors that may contribute to this and they range from men’s behaviour, socio-economic to health system factor. To date, there is no systematic way to document and compare men’s health determining factors and their impacts on men’s health. Policy makers do not have proper guidelines to accurately identify and prioritize on the key factors that affect men’s health status in individual country.

To overcome this problem, we propose the concept of the National Men’s Health Index (NMHI), which aims to assess men’s health status and its social health determinants of a country. Men’s health status consists of several categories including survivability, physical and mental health, which is divided further into indicators such as life expectancy, communicable, non-communicable diseases, injuries and suicide rate. The overall NMHI score indicates the wellbeing of men in the country while the sub-score will provide an indication of physical and mental wellbeing. These health determinants are factors that influence the NMHI score and they are made up of lifestyle risk factors, socio-economic status, safety, environmental and health system, which are measured by parameters such as literacy rate, smoking prevalence, pollution index and health expenditure.

The NMHI will be developed systematically in 4 steps. Firstly, two systematic reviews will be carried out to review the existing composite health and non-health indices as well as to identify established indicators of men’s health. Secondly, NMHI model will be developed based on the systematic reviews and the expert opinions. Thirdly, a Delphi survey will be conducted with men’s health key opinion leaders in the world to prioritize the men’s health indicators. Fourthly, the NMHI model will be revised and weighted accordingly before pilot testing. The NMHI scores of each country will be ranked and this will be correlated with the various social health determinants to explain the score. We believe that NMHI can serve as a guide for policy makers to identify gaps in men’s health and help them to prioritize health policy for men in their country. The NMHI will also allow countries to share experiences and effective strategies with one another and to monitor men’s health progress.

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Does multi-disciplinary team (MDT)-working variation impact on cancer patient care experience? Results of a cross-sectional survey in Quebec, Canada
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Background: Multi-disciplinary team (MDT)-working is recognized as a key modality for providing cancer services in the province of Quebec (Canada) and elsewhere [1]. Evidence suggests that the quality of teamwork varies across cancer teams and this may impact on care-providing process, and ultimately on patient care experience [2]. The objective of the study is to evaluate the effects of MDT-working on cancer patients’ perceived experience of care.

Materials and methods: Data were collected in 2010–11 in 15% of Quebec’s oncology outpatient clinics. Sites (n=9) were purposively selected on the basis of the intensity level of MDT (higher or lower). The sample included 1,379 adult cancer patients (response rate 80%). Perceived experience of care was documented by means of a self-administered questionnaire divided into six validated sub-scales: timeliness of services (TIM), communication (COM), patient-centered care (PCC), quality of physical environment (QPE), continuity (CONT) and results of care (RES). Multiple logistic regression models were used to estimate the extent to which patients’ ratings of their care experience differed between levels of MDT-working.

Results: Patients who were treated in clinics where the MDT-working level is high were 3.99 times (95% CI: 1.89-8.41) more likely to rate positively TIM and also more likely to have a positive opinion of COM (OR: 2.37; 95% CI: 1.25-5.45), of PCC (OR: 2.11; 95% CI: 1.05-4.24) and of CONT (OR: 2.18; 95% CI: 1.07-4.47). Patients’ perception of QPE and RES were not related to the level of MDT-working. Various patients’ characteristics (age, level of education, perceived health status) and organizational attributes (team mandate with regard to oncology services, geographic location, team size) were associated with patients’ ratings of their care experience.

Conclusions: This study suggests that MDT-working can improve various aspects of perceived patients’ care experience. Significant challenges remain in order to draw clear conclusions about the key elements of MDT-working and its benefits and they will be discussed.

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