ABSTRACTS

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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Results Up to 133 community pharmacies in Kampala city were included in the study. Almost all (n = 127, 96%) community pharmacies practised drug substitution. The most common forms of drug substitution were innovator medicine to generic medicine (85%) and generic medicine to other generic medicine (82%). Up to 92% of the pharmacies substitute “over the counter” drugs while 56% substitute medicines on prescription. Only 24% of the pharmacies did not consult the prescriber before drug substitution and majority (75%) considered the price of the drug before drug substitution. Knowledge of drug substitution policy was low and many (61%) dispensers thought Uganda has no national policy on drug substitution.

Conclusion Drug substitution involving both innovator medicine to generic medicine and generic to generic medicines is widespread in community pharmacies in Kampala city. The drug regulatory authority should focus on therapeutic equivalence studies and safety profile of approved generic products to better protect the public from substandard medicines.

References

P85
Developing a clinical practice guideline implementation strategy based on needs, evidence and theory
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Background Clinical practice guidelines (CPGs) are used to standardize care according to evidence-based recommendations. However, the implementation of CPGs in the real world varies; a possible reason for this is the lack of a systematic approach to the implementation of CPG. We, therefore, aimed to develop an intervention to improve the implementation of a local hypertension CPG based on the needs of healthcare professionals (HCPs), best available evidence, and theories.

Materials and methods This study was conducted in 2013 at an urban hospital-based primary care clinic in Malaysia which used a paper-based medical record system. The 2008 national CPG on hypertension was used for the research. The intervention was developed based on: (1) findings from an audit and needs assessment study involving the PCPs, pharmacists, nurses and the administrators; (2) literature review of the effectiveness of various CPG implementation strategies in primary care; and (3) the theory of planned behaviour.

The research team convened to summarise the key findings from the needs assessment study and reached a consensus on two major issues: lack of accessibility to the CPG and collaboration among the HCPs. The literature review highlighted the need for a multi-faceted strategy which should include dissemination and implementation.

Results A needs, evidence- and theory-based intervention was developed after a few iterations and feedback from the users. It comprised several components. Firstly, two training sessions were conducted by two senior academicians to increase the PCPs’ knowledge on the assessments and treatment of hypertension based on the CPG. Secondly, a quick reference guide summarising key recommendations from the CPG was placed on table tops as well as on the computer screen of each consultation room for easy access and reference. Thirdly, prior to the consultation with the doctor, the patient completed a self-assessment form and this was followed by the measurement of anthropometric parameters by the nurses. Requisition forms for investigations recommended by the CPG were placed together with patient medical records for ease of access and to facilitate doctors in making a treatment decision. Finally, a personalized checklist was placed in the patient medical record to serve as a quick reference and reminder to the doctor and it included items such as cardiovascular risk assessment.

Conclusions This study showed that it is feasible to develop a CPG implementation strategy based on needs, evidence and theories. We are in the process of evaluating the intervention.

P86
Tools to manage the decision-making process in operating rooms
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Background This study aims to build tools to manage and support decision making processes in operating rooms and related units. Activity-based costing (ABC) was used in complement with performance measurement tools. The tools constructed were validated in five different hospitals in Chile; in this study we present the results from one of these hospitals.

Methods We analyzed and created a model to deal with and better manage current problems in operating rooms such as inefficiency in the use of resources, low productivity, extended waiting times, and the elevated costs associated with providing surgical services. By gathering data from the surgical process, we built a dictionary of activities, identified the cost-drivers and the cost object to trace the overhead cost using the ABC methodology. In combination with the information obtained we identified indicators to measure performance associated to operating room use, using @risk software to simulate the optimum performance for continuous improvement.

Results Based on the application of the data we found a disparity between the actual hospital costs and public health care insurance coverage suggesting a need to improve operating room efficiency to achieve sustainability. We also found gaps between the observed and ideal performance indicators and noted that time is a major factor.

Conclusions The results of this study shows that implementing ABC and performance measurement tools lead to operational improvements and better strategic decisions about rationalizing services, and improve hospital self-management.

P87
Unique challenges experienced during the process of implementing mobile health information technology in developing countries
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Background Healthcare in developing countries faces a number of challenges due to economic constraints, poor infrastructure, a shortage of trained clinical staff, extreme climate and geographical barriers among others. Information and communication technologies are seen as one approach to address these issues and improve inequalities in healthcare facing low and middle income countries. In particular mobile Information Technology (IT) is being explored as an underarching framework due to its portability, flexibility, low cost, and widespread network coverage [1]. However implementing mobile IT in this context presents a number of unique barriers. Current research in this domain focuses on barriers of generic IT adoption without considering the specifics of mobile technology. Furthermore, there is a lack of emphasis on the different