

Evidence-informed health policy-making: On everybody's agenda – but how far are we in reality?

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&

European Observatory on Health Systems and Policies

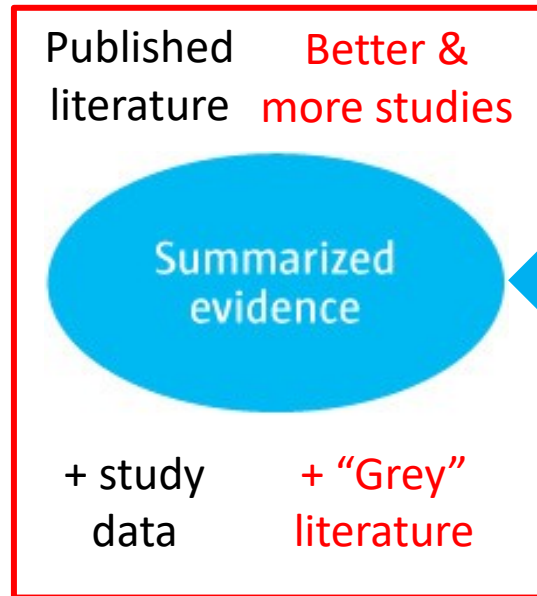
Introduction

- For about the last 25 years, the notion that health policy should be evidence-based, or at least evidence-“informed”, has gained momentum, most visibly through academic-policy partnerships such as the European Observatory on Health Systems and Policies.
- On the system level, Health System Performance Assessment (HSPA) is seen as an instrument to inform policy.
- However, which evidence is exactly needed (especially to assess the attributable health outcomes of the system) and in which ways policy-makers are most effectively informed is less often discussed.

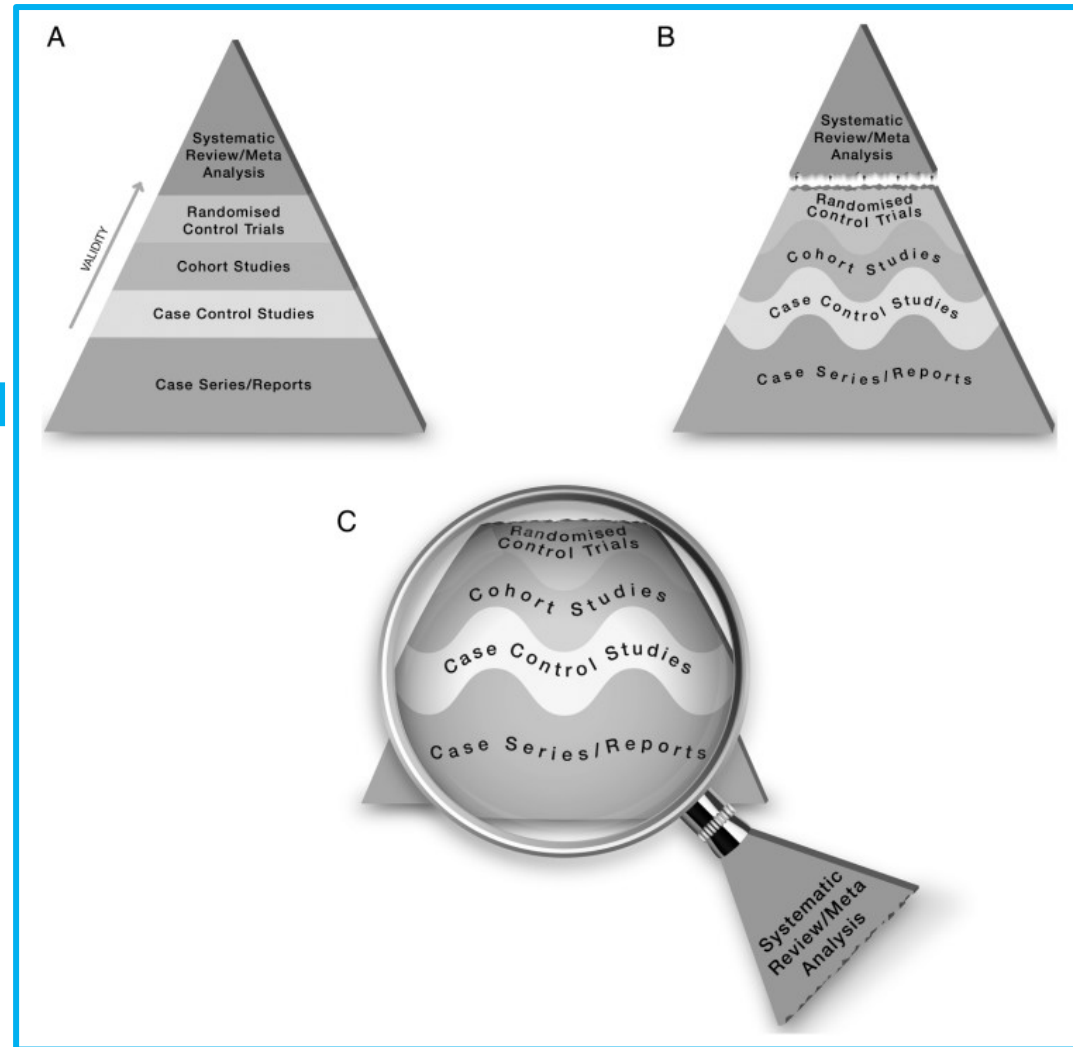
Wat is « evidence »

- Evidence-based medicine (EBM) = “conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients” → implies hierarchy of evidence
- But (at least) two notions of evidence: (1) as sign—e.g., the DNA sample that proves that the killer was related to the victim—and (2) as justification—e.g., the evidence presented in a court, which justifies the jury’s decision to declare the defendant guilty.
- Evidence-informed health policymaking is an approach to policy decisions that aims to ensure that decision making is well-informed by the best available research evidence. It is characterised by the systematic and transparent access to, and appraisal of, evidence as an input into the policymaking process.

What is “evidence” for evidence-based health policy? Is it really the same as for evidence-based medicine?

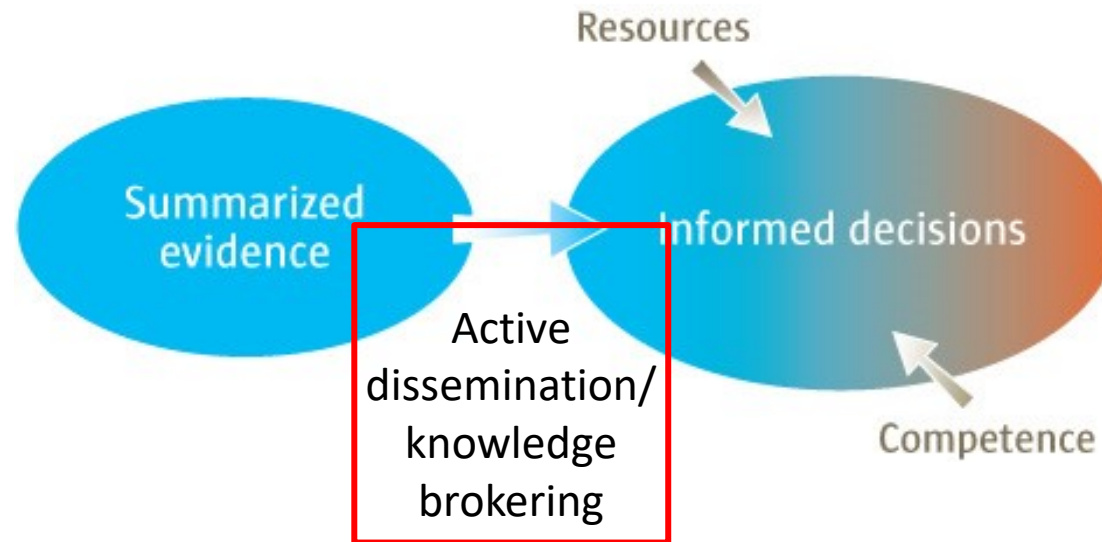


1st task of
Evidence-based
health policy
experts



What is “evidence” for evidence-based health policy?

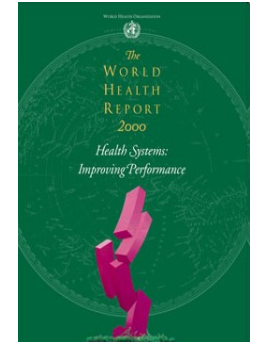
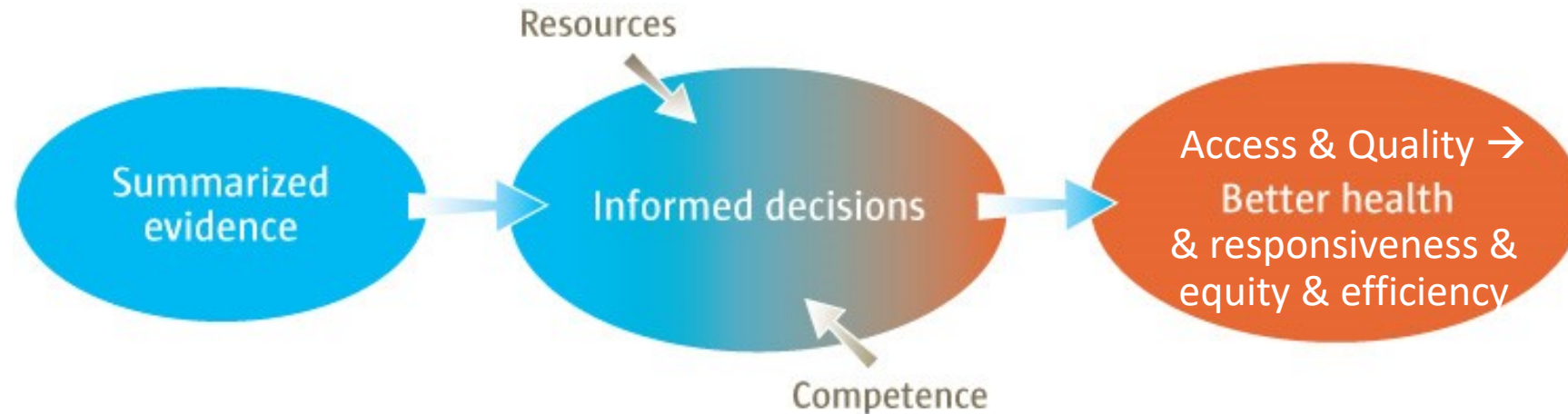
How is it supposed to influence policy-making?



2nd task of
Evidence-based
health policy
experts

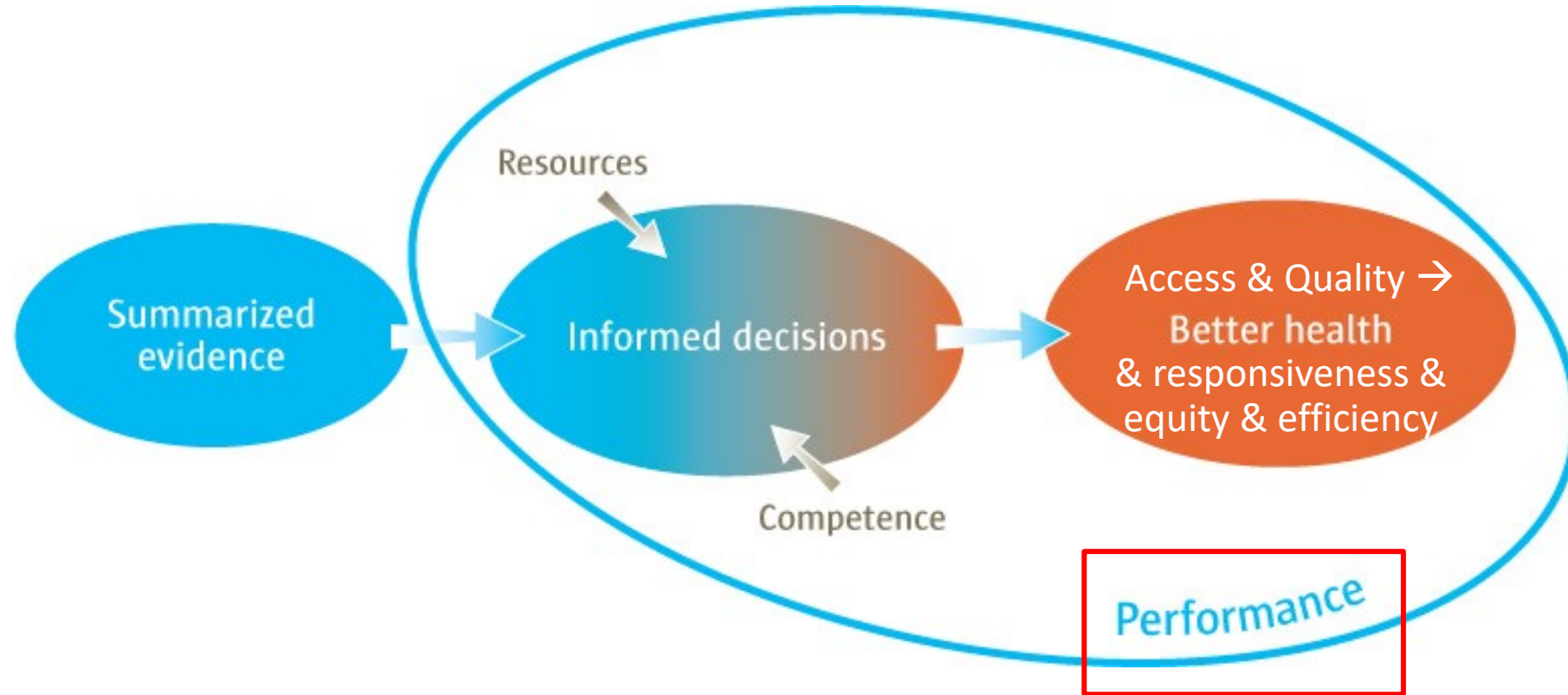
What is “evidence” for evidence-based health policy?

How is it supposed to influence results?



What is “evidence” for evidence-based health policy?

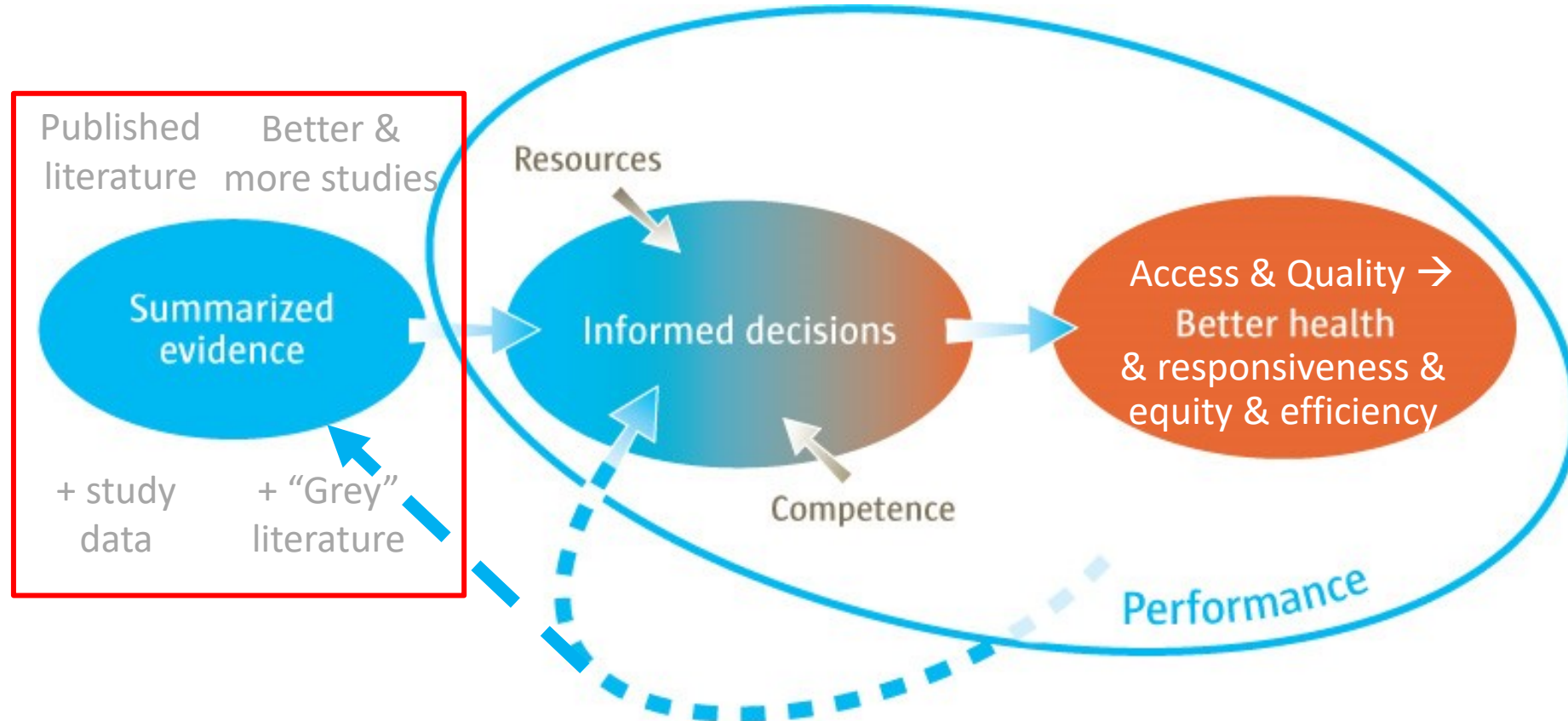
The importance of a feed-back loop (& non-RCT evidence)



3rd task of Evidence-informed
health policy experts
(CAVE: usually no control group
→ causal interference?)

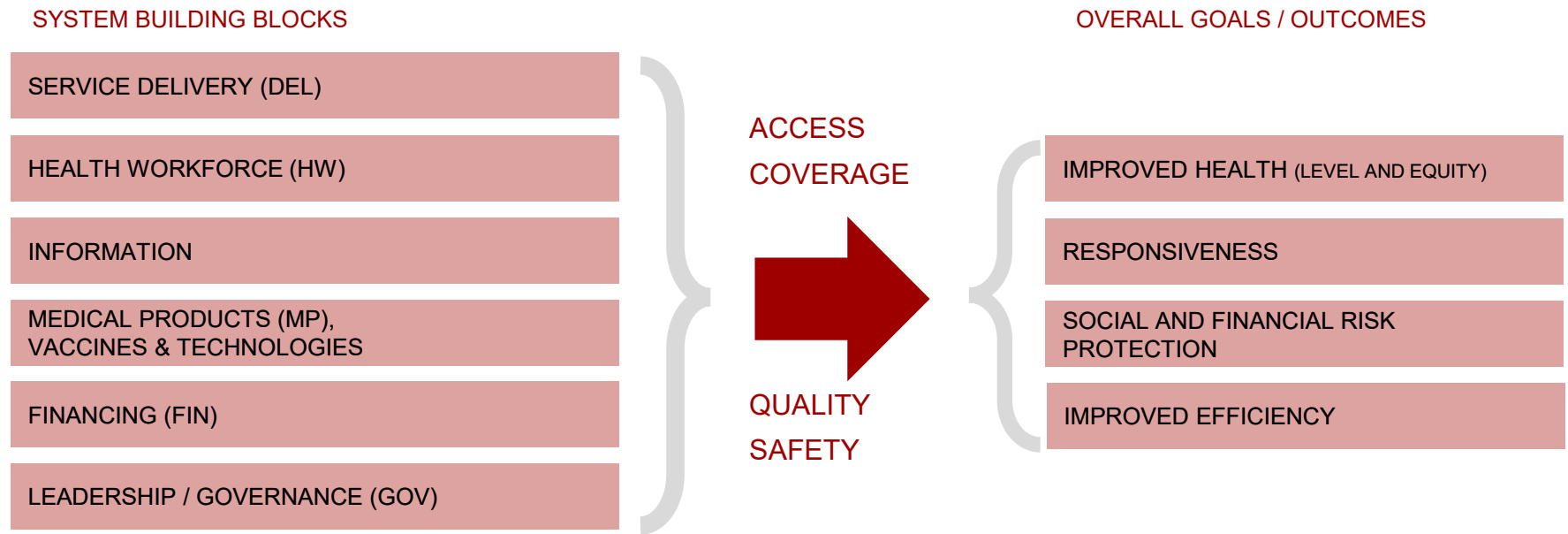
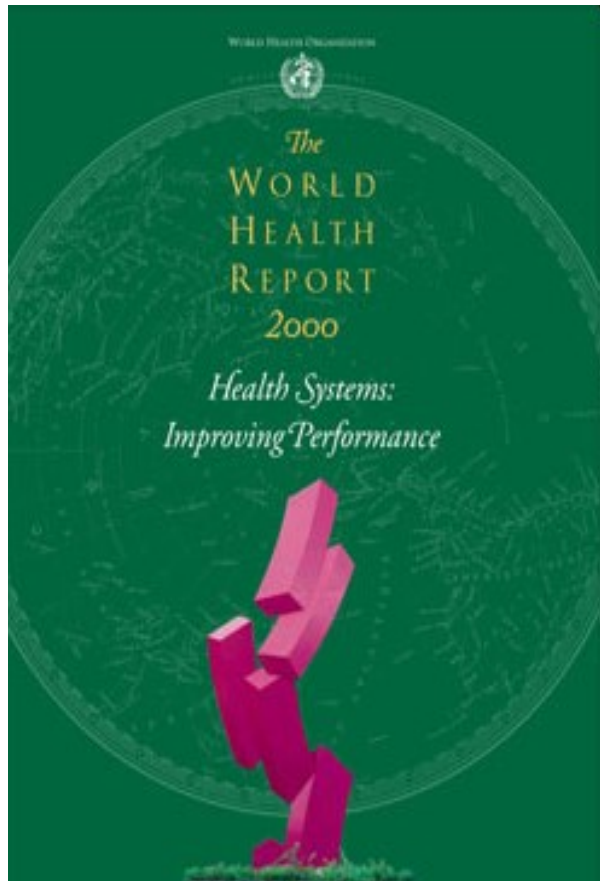
What is “evidence” for evidence-based health policy?

The importance of a feed-back loop (& non-RCT evidence)

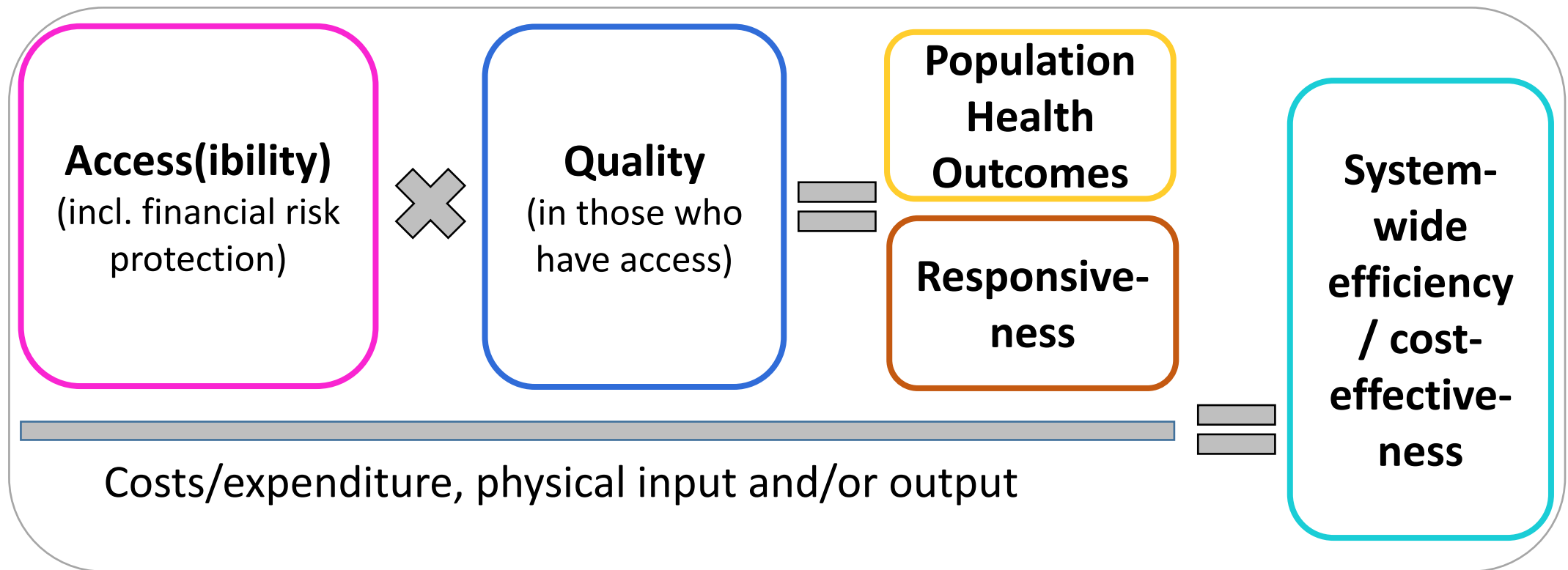


Performance assessment as evidence
(“evidence-generating health system”)

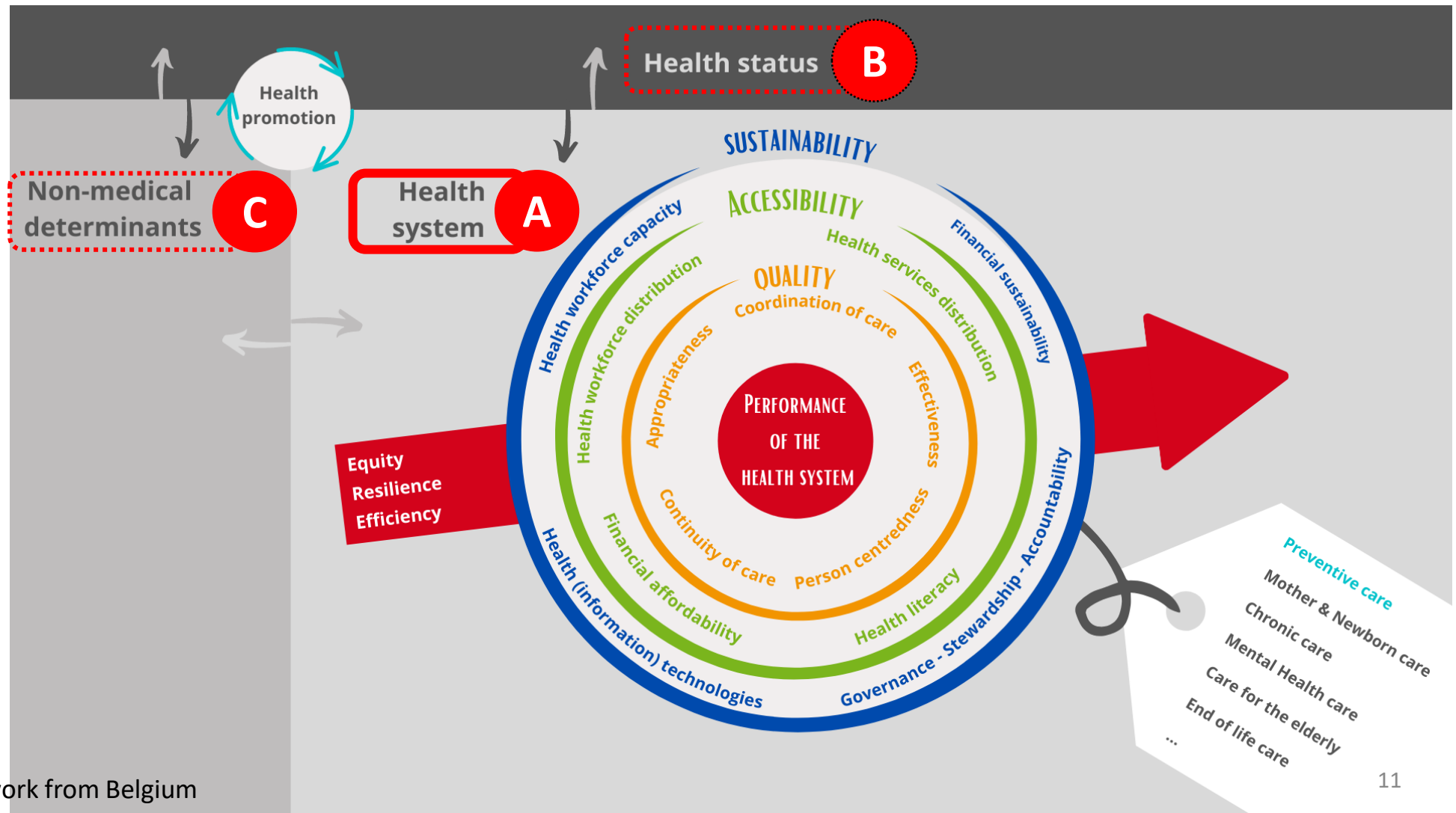
“Performance” needs (a) an understanding about system goals and (b) which elements (e.g. “building blocks”) contribute to achieving them



For performance assessment, we need a clear view on how these intermediary and final goals are interrelated

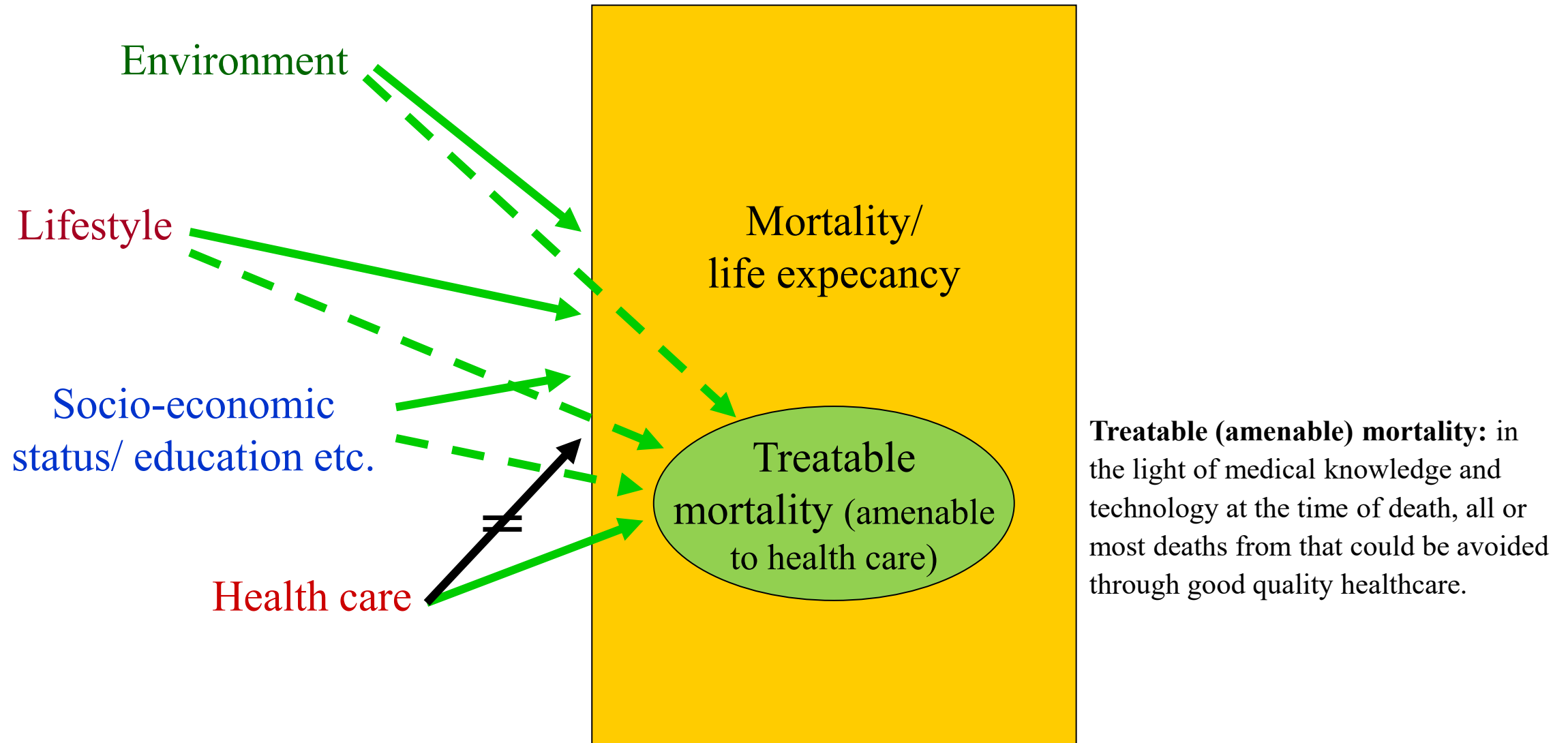


Obviously for (A) HSPA as such, we need (B) health status reporting (burden of disease) and (C) Health Impact Assessment of non-medical determinants – separate but thought together ...

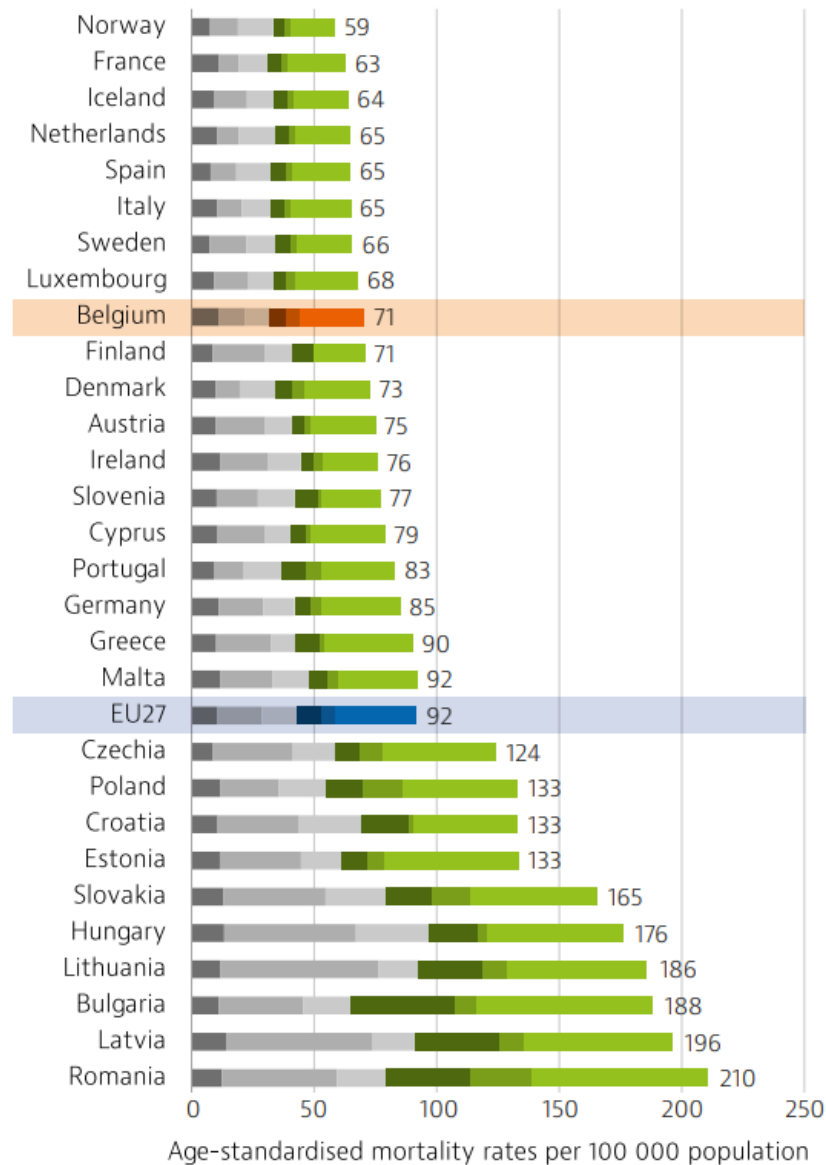


A prerequisite:

How can we calculate the health system contribution to health?

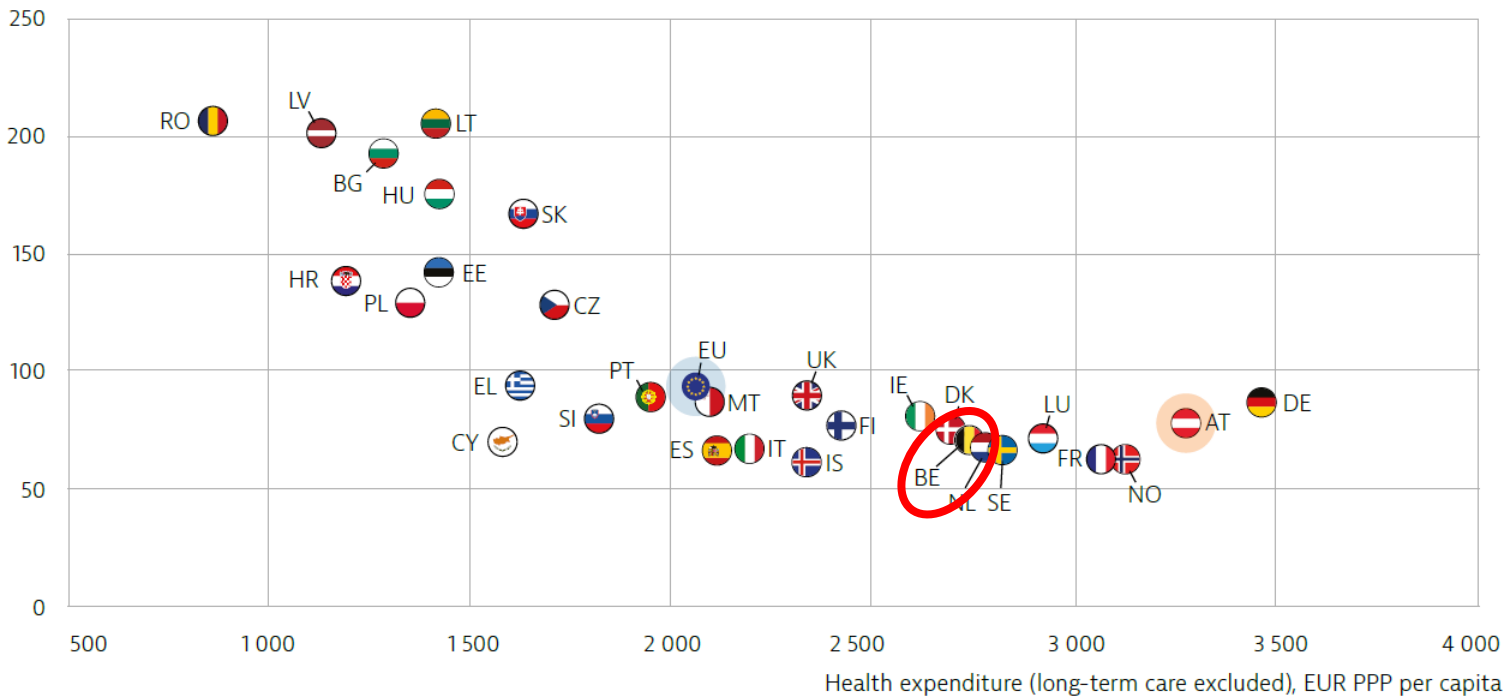


Treatable causes of mortality



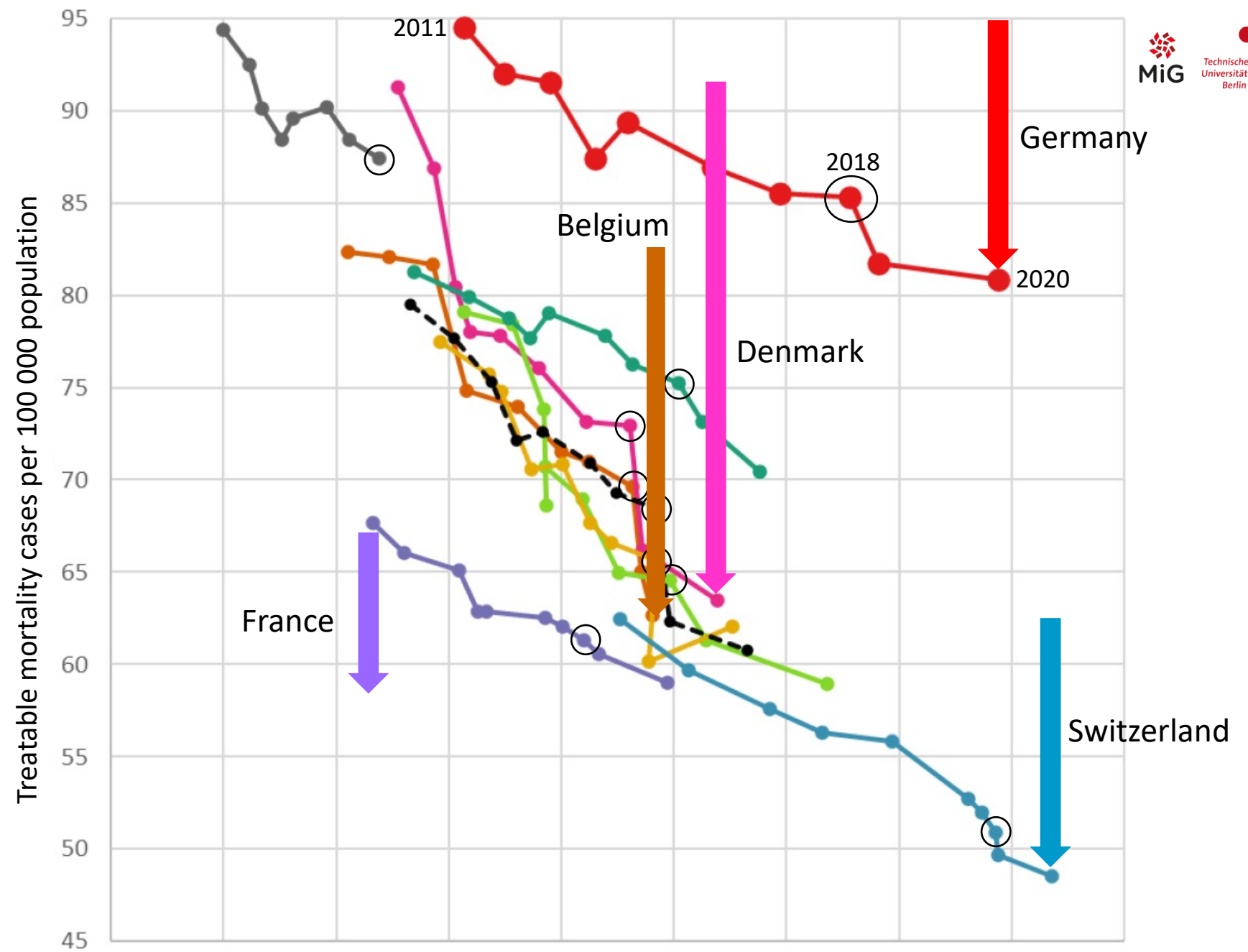
More spending, better performance? The cross-sectional view

Treatable mortality per 100 000 population



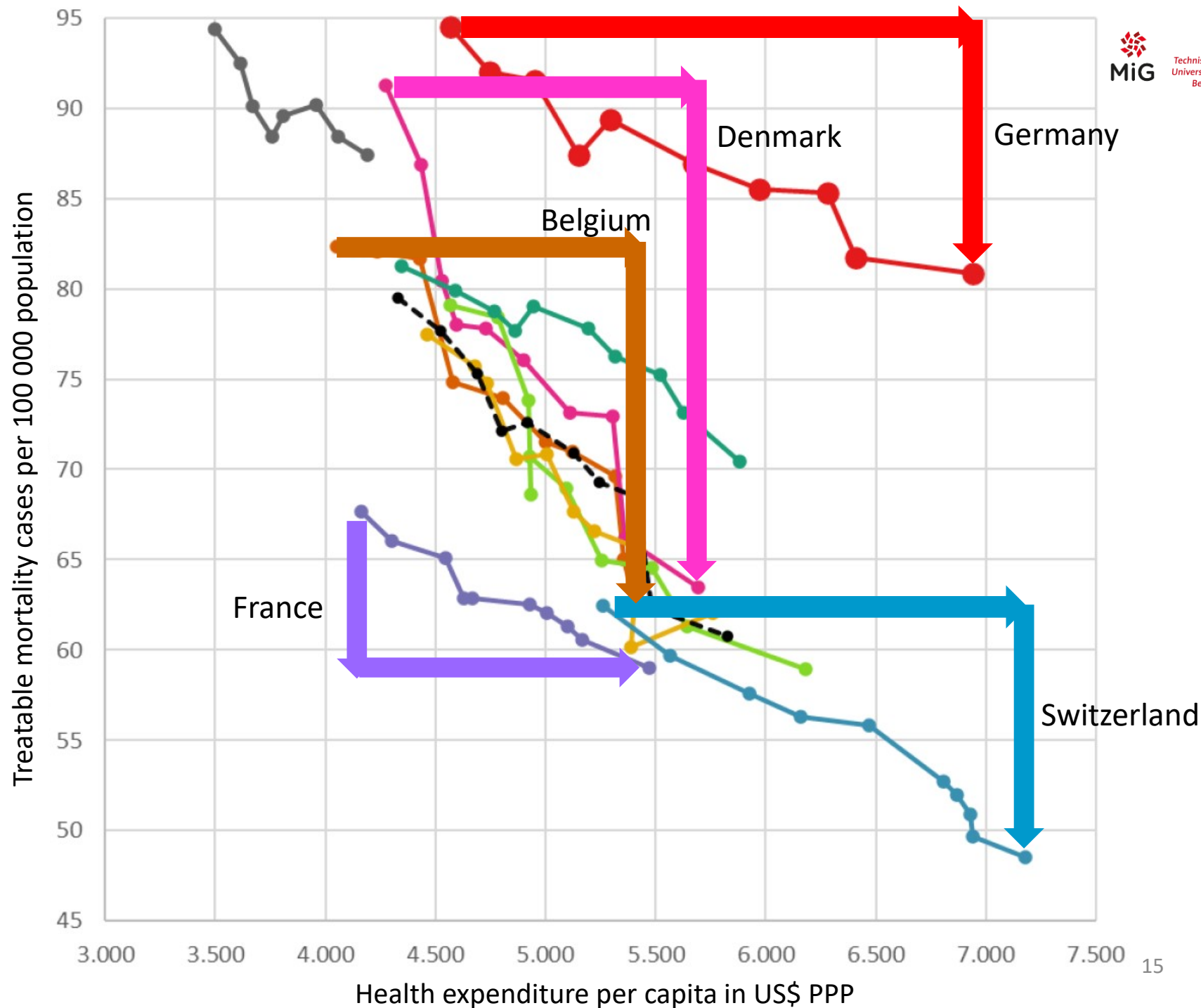
More spending,
better performance?

The longitudinal view (2011-2020)



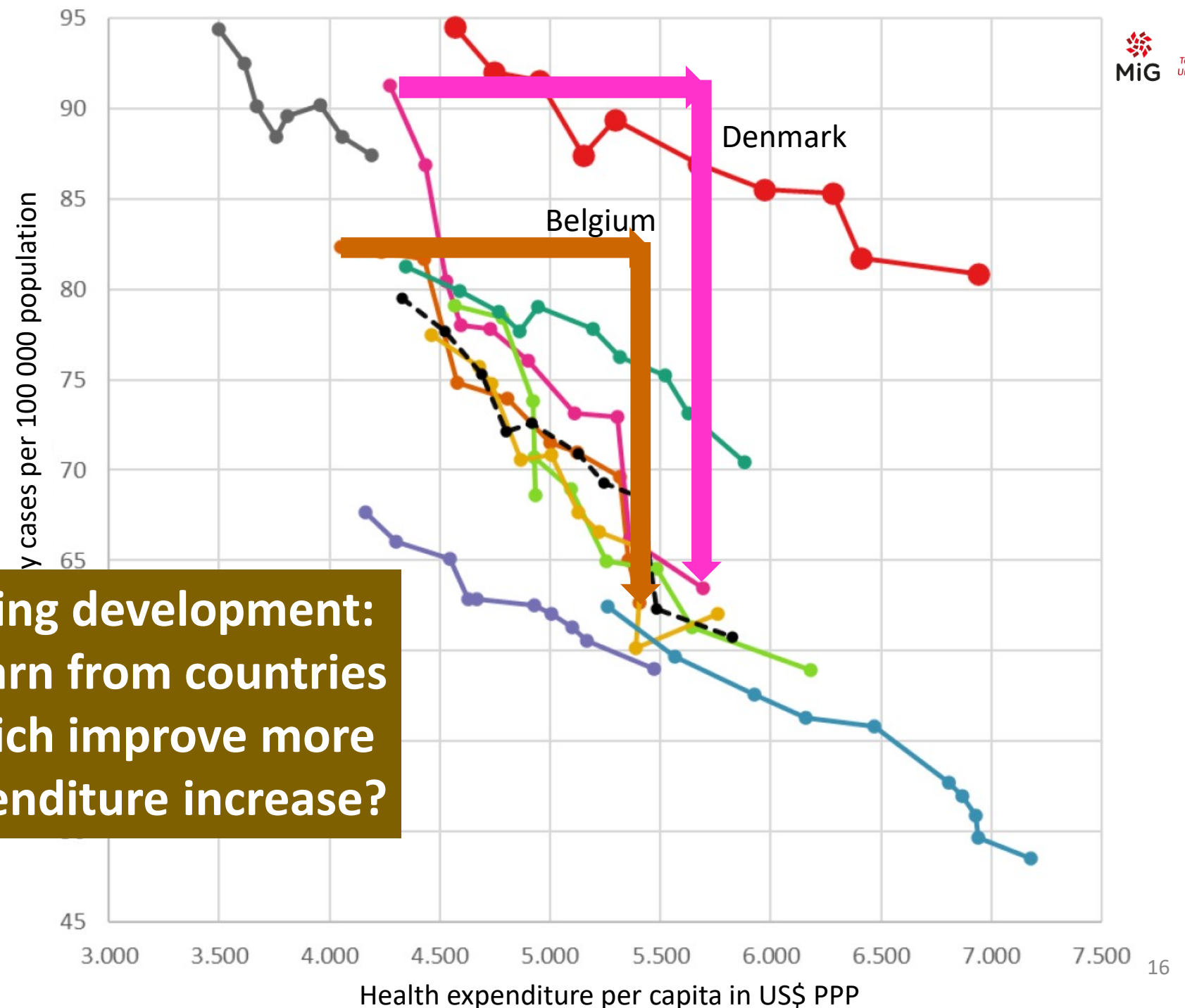
More spending,
better performance?

The longitudinal view (2011-2020)



More spending,
better performance?

The longitudinal view (2011-2020)



**Comparing development:
what can we learn from countries
which improve more
for less expenditure increase?**

A few examples of best practice

Unfortunately,
we see too few
analyses of the
relationship between
research evidence and
policy uptake/ utilization

Categories		Description
(1) Strong direct evidence		
<u>positive</u> consistent (i.e., only positive, neutral and/or indecisive findings based on the conclusion of the authors)	<u>negative</u> consistent (i.e., only negative, neutral and/or indecisive findings based on the conclusion of the authors)	Consistent findings in two or more empirical studies of appropriate design and high scientific quality (i.e., RCTs with low potential for bias)
(2) Moderate evidence		
<u>positive</u> consistent (i.e., only positive, neutral and/or indecisive findings based on the conclusion of the authors)	<u>negative</u> consistent (i.e., only negative, neutral and/or indecisive findings based on the conclusion of the authors)	Consistent findings in two or more empirical studies of less appropriate design and/or of acceptable scientific quality (i.e., RCTs with high potential for bias)
(3) Limited evidence		Only one study of appropriate design and acceptable quality available, or inconsistent findings in several studies
(4) No evidence		No relevant study of acceptable scientific quality available

Fig. 3 Categorization of evidence. Source: Authors' own, adapted from Øvretveit [25] and Greenhalgh et al. [26]

		EVIDENCE		
		Strong direct evidence (positive)	Strong direct evidence (negative)	Limited Evidence
		Moderate evidence (positive)	Moderate evidence (negative)	No Evidence
UTILIZATION	Widespread	Success	Hazard	Overadoption
	Cautious	Underadoption	Vigilance	Prudence

Fig. 2 Six-field table for the classification of diffusion patterns based on utilization and evidence. Source: Authors' own, adapted from Denis et al. [12]

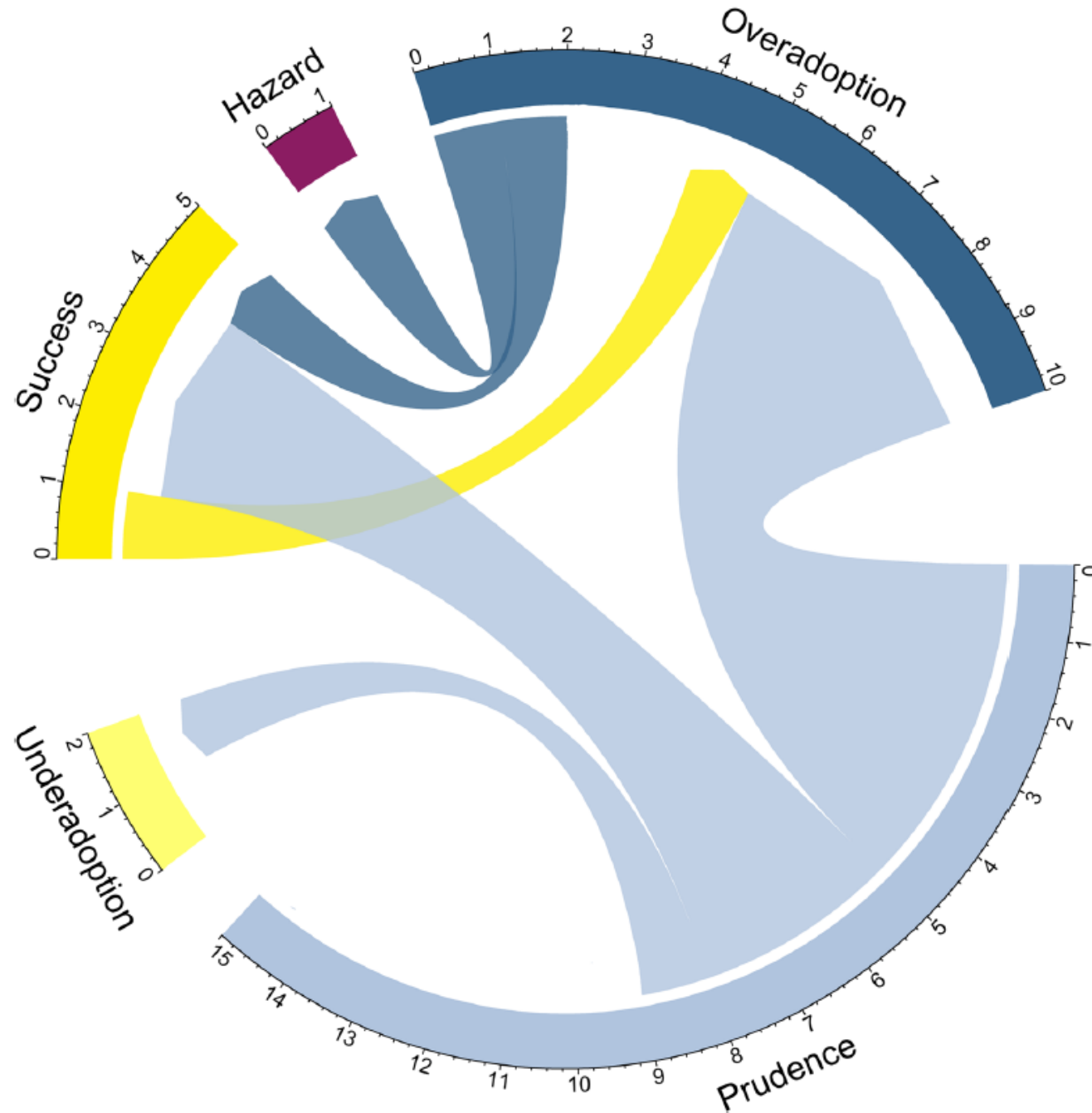


Fig. 7 Status changes between start and end point of the observation period for considered technologies

... in this case,
comparing
classification
before/after
evidence
became
available

Skill-mix Innovation, Effectiveness and Implementation

Improving Primary and Chronic Care

Edited by Claudia B. Maier, Marieke Kroezen,
Reinhard Busse and Matthias Wismar



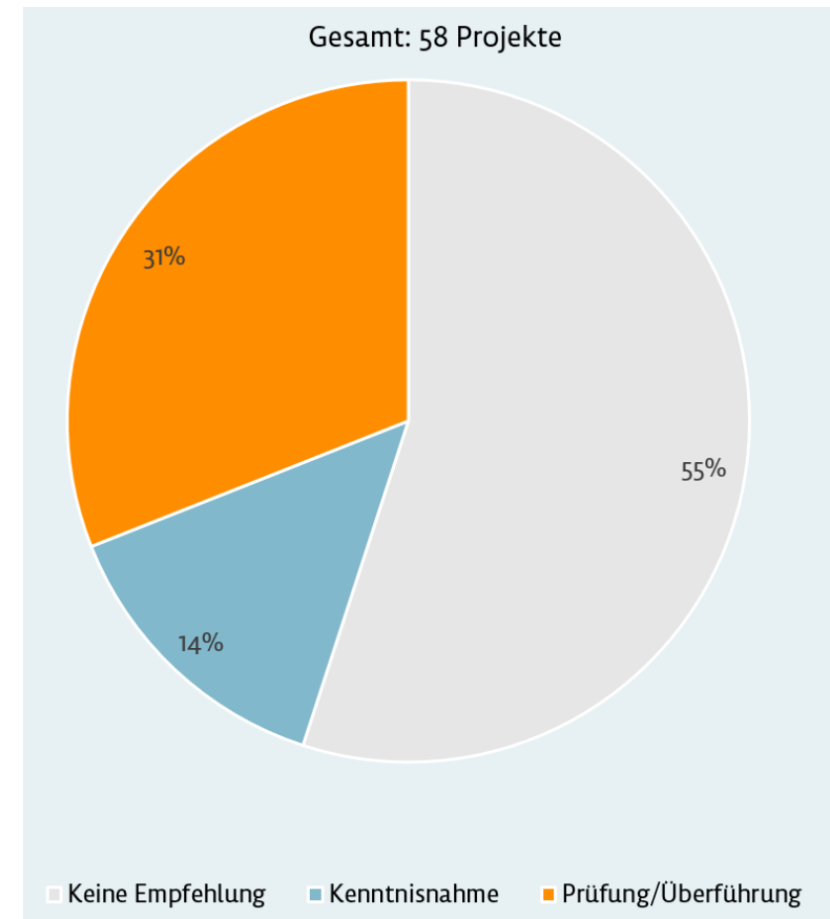
We need more systematic reviews of policies, clearly stating population (indication), intervention, controls and outcomes

Table 6.1 *Skill-mix interventions involving pharmacists for single chronic conditions*

Skill-mix interventions			Outcomes			
Content of interventions and skill-mix changes	Source(s)	Chronic condition [Sources]	Profession(s) in comparator group [Sources]	Patient-related outcomes [Sources]	Health system-related/resource use outcomes [Sources]	Profession-specific outcomes [Sources]
Pharmacist-involved care to improve patients' self-management including: health education, consultation, collaborative drug therapy management, initiation or titration of drug therapy, collaborative practice model, direct care under clinical guidelines, multidisciplinary diabetes management, home visitations, patient self-management training programmes	[1–9]	Diabetes [1–5]; Various chronic conditions (COPD, depression, diabetes, CVD) [6, 7]; CVD/hypertension [8, 9]	• Usual care, professions not defined [1, 3, 5, 6, 9] • Pharmacists, primary care physicians or nurses [2] • Usual care generally from physician [8], but also nurses and pharmacists [4] • Primary health care professionals or no comparable service [7]	• Reduced HbA1c levels* [2–4, 6, 7] • Reduced SBP and DBP* [6–9] • Reduced LDL-C* [4] • Improved medication adherence* [3, 8, 9] • Increased attainment of goals for HbA1c [6] • Improved quality of life* [3, 5] • Some evidence of improvements in quality of life for patients with asthma, heart failure and high risk of medications related problems (three of eight studies) [7] • Improved modifiable lifestyle risk factors and improvements in HbA1c levels [1] • No difference in all-cause mortality [6] • No significant improvements in COPD and depression outcomes [7] • Decrease in number of medications prescribed, an improvement in testing and statin prescribing for patients with hyperlipidaemia [7]	• Some evidence of reduced costs for collaborative care models and when pharmacists provide pro-active consultation for high-risk patients and new/changed prescriptions [1] • Intervention dominant (cost-effective) [5] • Improvements in eliminating therapeutic duplication [7] • Similar rates of office visits, emergency department visits and hospitalizations compared with usual care [6]	• Increased adherence to American Diabetes Association standards of care for most care types [1] • Improvements in guideline adherence for prescribing for physicians (compared with no intervention) [7]

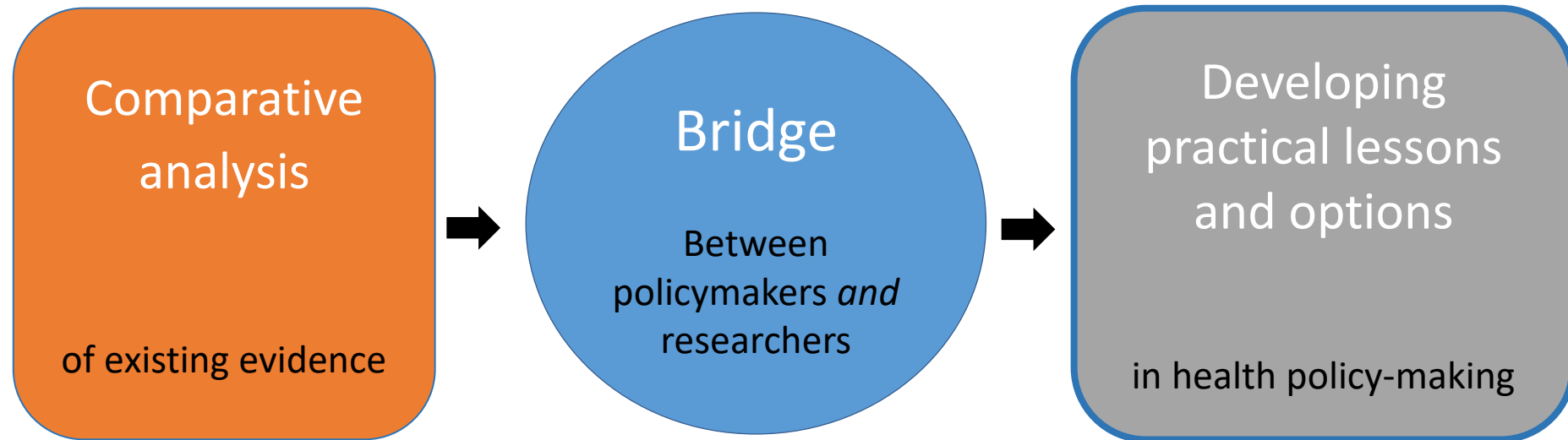
And if there is really no evidence yet?

- As much as I like KCE's work, I propose a look to Germany's Innovation Fund, which spends € 200 million a year, most of it to test new modes of provision in trials to test what should be rolled out system-wide.
- A smaller part are studies to identify promising innovations (to be tested).
- While most projects do not identify true innovations, a few do (e.g. telemedicine in intensive care).



The European Observatory and its knowledge-brokering role

The mission of the European Observatory on Health Systems and Policies



Core Mission: to support and promote
evidence-based health policy-making
informed

Observatory key principles to knowledge brokering

The European Observatory on Health Systems and Policies is a high-quality knowledge broker based on following principles:

Translate

Reorganise the evidence in a way that appeals to policy makers and in a language they understand

Trust

High-quality evidence and a neutral stance recognising the real context and pressures of health systems

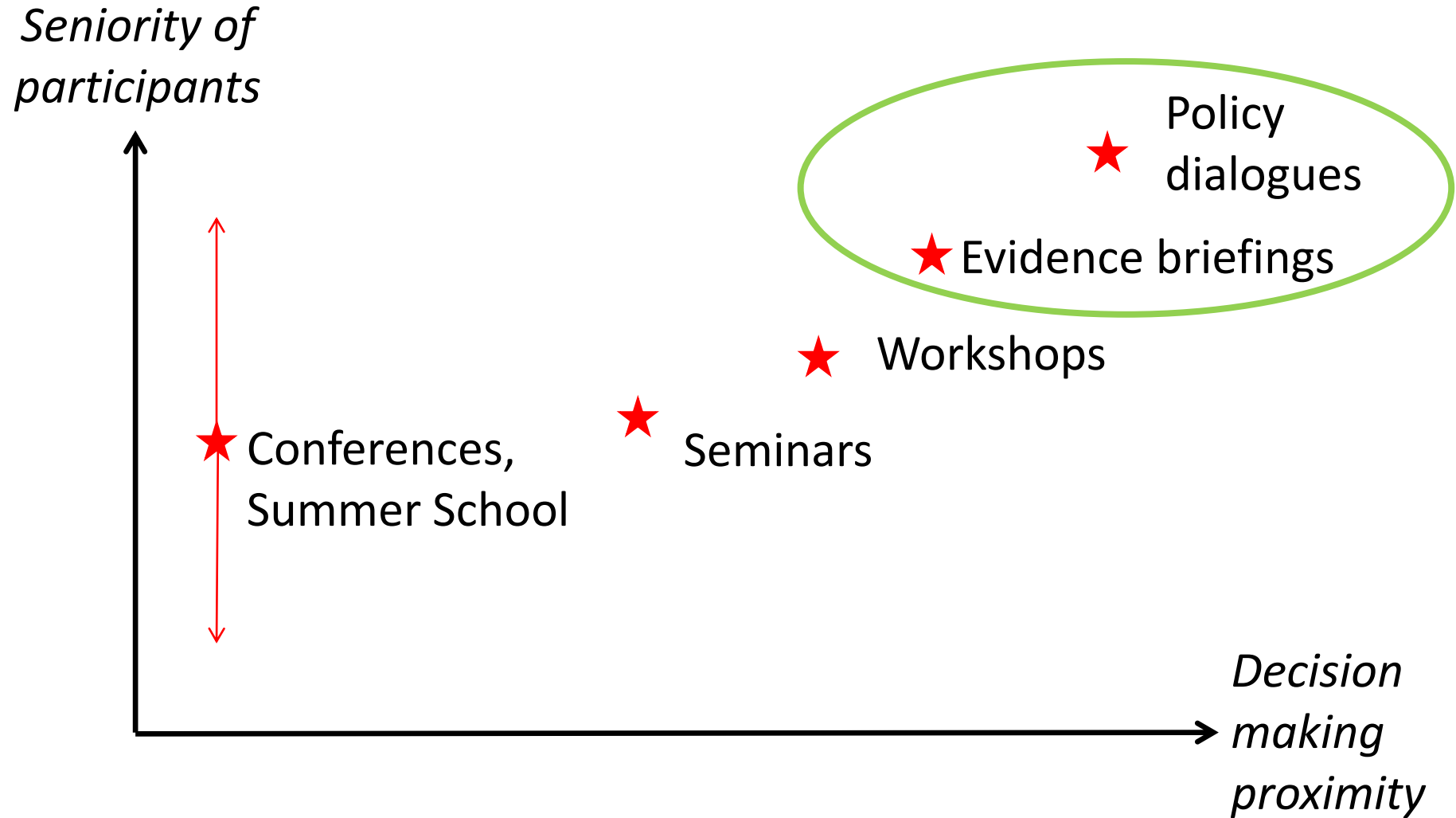
Tailored

to the specific needs of policy makers

Timely

response to policy maker's needs and requests

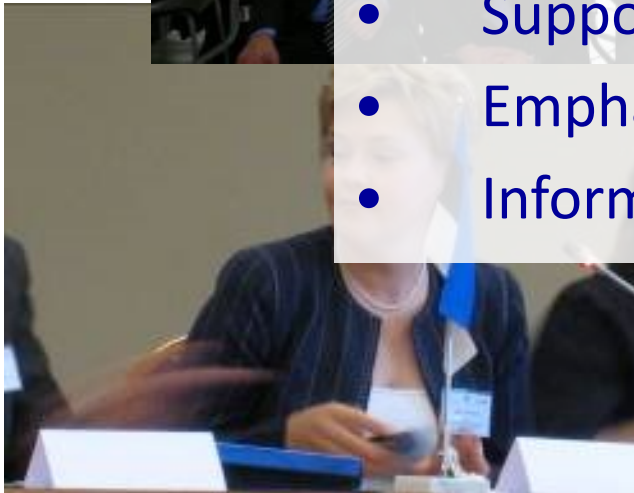
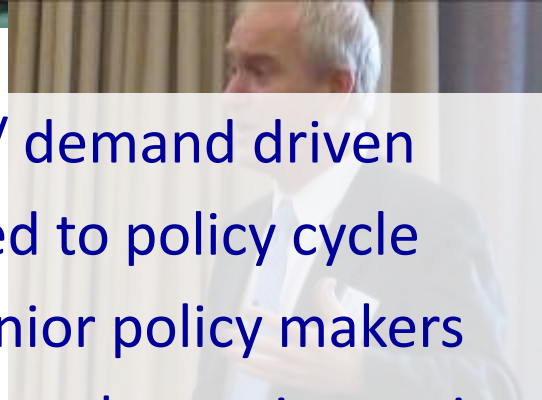
Observatory range of face to face dissemination formats





Policy dialogues

- Key strategic questions / demand driven
- Rapid response / adapted to policy cycle
- Target small group of senior policy makers
- Supported by evidence on alternative options
- Emphasis on implementation
- Informal character, Chatham House rules, neutral platform



Future topics, not only at KCE (1)

Topic 1: Human Resources for Health

- TODAY

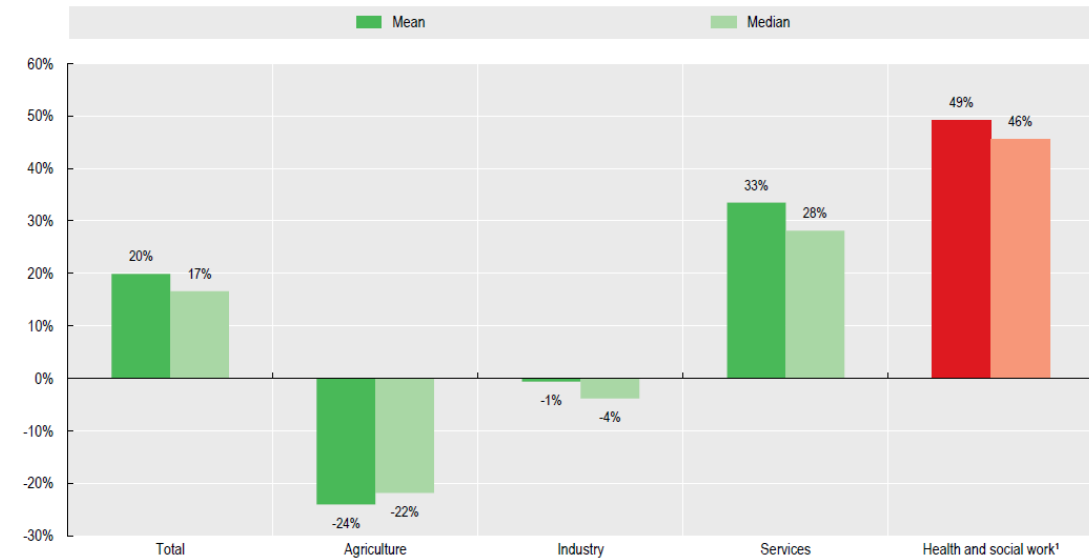
(How) can we retain and recruit enough workforce? What is the right skill-mix? Can we substitute certain tasks to be done by other professions? Outcomes on patients, professionals, system ...

- TOMORROW

How can we replace human resources through technologies, while retaining/improving access, quality, health outcomes and responsiveness?

Almost unnoticed: human resources +50% in 20 years

Figure 8.2. Employment growth by sector, OECD average, 2000-19 (or nearest year)



1. Health and social work is classified as a sub-component of the services sector.
Source: OECD National Accounts.

Future topics, not only at KCE (2)

Topic 2: Low-value care/ waste

- TODAY
(How) can we define and measure low-value care/ waste? (How) have countries tackled this problem?
- TOMORROW
Which services/ providers should be reduced/ abolished to improve access, quality, health outcomes, responsiveness and efficiency of the health system? Which are successful ways to do so?

Table 1. Terms and Definitions of Low-Value Care

	<i>"All patients" potentially receiving the technology</i>	<i>All patients belonging to one or more well-defined subgroups (by age, indication ...)</i>	<i>"Certain patients" (individual medical criteria or preferences are relevant)</i>
Harm > benefit	SAFETY		
Benefit not proven	EFFECTIVENESS	FOCUS OF "LOW-VALUE CARE"	APPROPRIATENESS ("INDICATION QUALITY")
Benefit not better than alternative (e.g., outdated)			
Benefit better but cost-outcome relation worse		"COST-EFFECTIVENESS"/ "COST-BENEFIT"	
Equal benefit but provision inefficient (e.g., inpatient instead of day-care)	EFFICIENCY*		

* Assuming equal patient benefit/ "value"; if this is not necessarily the case, it would be more accurate to speak of "productivity."

In conclusion,

1. “Evidence-informed” health policy requires an agreed understanding of “evidence”,
2. should be built on a framework designed around policy-makers’ needs, i.e. evidence on accessibility, quality, population-wide outcomes, responsiveness and efficiency/ value-for-money,
3. widen the range of data sources and methodologies, and
4. use a range of formats to reach policy-makers – and improve policies, and thus health system performance.
5. Topics will change from “how to secure more and better” to “how can we achieve more with less”, i.e. less workforce, fewer services, less money ...