Transferability of health services and policies

Learning from international experience

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WORKSHOP II: REPORTING, INTERPRETATION, AND POLICY USES

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Ellen Nolte
Are cross-country comparisons ‘special’?

- A distinct method, alongside experimental, statistical and case study methods
- All scientific research is comparative
- Cross-country comparisons:
  - explicitly examine the differences or similarities between national (sub-)systems and policies
  - face distinctive set of challenges because of their focus on ‘large macro-social units’ (*Ragin 1987*)
  - deal with entities of considerable complexity such as approaches to financing, service delivery, regulation, performance assessment, etc.

*Source: Cacace et al. 2013*
There are different rationales for undertaking cross-national comparisons

- Learning about national systems and policies
  - Explore similarities and differences
  - Typically descriptive while forming basis for more analytical studies

- Learning why systems and policies take the form they do
  - Explain an observation (a ‘puzzle’) from which to generalise by identifying factors that appear relevant to generating a particular outcome
  - Typically generate or test hypotheses, develop typologies, track policy trends over time, explain the past
  - May be of limited practical use for policy makers

- Learning lessons from other countries for application elsewhere
  - Help to clarify and understand given political event or process by comparing with similar events or processes elsewhere
  - Typically focus on particular policy challenge common across countries; seek to identify ‘best practice’ and/or potential for policy transfer

Source: Cacace et al. 2013
Potential for international learning

- Can provide "an experimental laboratory for others"
- Allows alternative options to be considered
- Allows for mutual learning
- Enables cross-fertilisation
- Provides opportunity to transfer models and ideas
- Confirms the positive/negative
"Learning about": Descriptive studies

Systematic, structured descriptions can provide basis for subsequent analysis

Use of structure identifies areas that are unclear or poorly thought out
“Learning from”: Analytical studies

Why, how, what works (best), what are the contextual factors that are necessary for it to work in that setting?
“Benchmarking”: Quantitative studies

Comparative analyses of measures of processes (determinants of health care expenditure) and outcomes (health services/system performance)

Source: Nolte & McKee 2012
The European Observatory on Health Systems and Policies supports and promotes evidence-based health policy-making through comprehensive and rigorous analysis of the dynamics of health care systems in Europe.

Read more
There are challenges in doing cross-national health system comparisons . . .

- Can be superficial unless based on detailed understanding of health systems and settings
- Can be based on what’s counted—routinely collected data—rather than what’s important
- Can be used in domestic policy debate to inspire emulation or repudiation
- Misinterpretation of phenomena and misleading conclusions
- A lot of measurement but not much understanding
- Contextually ill-informed debate
Significant relationship: a country’s FIFA ranking and its ranking by the WHO

Figure 2  Scatterplot of World Health Organization (WHO) and Fédération Internationale de Football Association (FIFA) rankings of European countries, weighted by population.

Source: Appleby and Street, 2001
A health care system to die for

Rudy Giuliani warned us about what would happen if a Democrat wins:

You have got to see the trap. Otherwise we are in for a disaster. We are in for Canadian health care, French health care, British health care.

And that would be a terrible thing:

In “Measuring the Health of Nations: Updating an Earlier Analysis” (Health Affairs, Jan/Feb. 2008), Ellen Nolte, Ph.D., and C. Martin McKee, M.D., D.Sc., both of the London School of Hy compared international that is, deaths from potentially preventable care.

And you see what that tells us:

FINDINGS

To Explain Longevity Gap, Look Past Health System

By JOHN TIERNEY
Published: September 21, 2009

When I brought up Dr. Preston’s work to Ellen Nolte and C. Martin McKee, two prominent European critics of the American system, they suggested that he was taking too limited a view of health care. They said the system should take responsibility for preventing disease, not just treating it.
There are challenges in doing cross-national health system comparisons . . .

- Definitions vary and contexts differ: Are we comparing like with like?
  - e.g. what is a ‘nurse’? Does ‘integrated care’ mean the same in different countries?

- Availability, comparability and appropriateness of data: are we measuring what is important, not just what is available?
  - e.g. # hospital beds

- Timeliness of comparison

- Attribution of impacts to policies
  - e.g. impact of health care on population health; time lag policy-impact; disaggregating policy ‘packages’
One hospital....

**Features** (2008)

127 beds

- ~3,600 inpatients/a  
- ~3,800 outpatients/a

3 specialist departments

**Staff:**

- ~17 physicians  
- ~60 nurses

somewhere in Germany

Source: Mühlenkreiskliniken, Qualitätsbericht 2006
Karolinska University Hospital, Stockholm

**Features** (2014)

- 1,600 beds
- 1.6 mill patient visits/a
- 105 600 admissions/a
- Staff: 15,800
- 2,540 scientific articles published together with Karolinska Institutet (2014)
- Budget: SEK 16.2 billion ($ 1.9 bill) (2014)

*Source: www.karolinska.se (accessed Sept 2016)*
There are challenges in doing cross-national health system comparisons

- Where to learn from
  - e.g. picking winners; comparing to ‘like’ such as tax-funded systems or the opposite; what is considered ‘alike/opposite’?

- Learning for what?
  - e.g. to inform policy thinking; enlarge policy repertoire; avoid mistakes made elsewhere; back up ready-made solutions

- Importance of context
  - e.g. different rationales for policies in different settings; feasibility and acceptability of policy change; potential for ‘improvement’; institutional setting and culture
  - need to consider situational (e.g. economic downturn), structural (e.g. institutional setting), and cultural factors (e.g. societal values)
Where to learn from: Moving care outside hospital

- Many countries interested in transferring some types of care outside hospital
- But little systematic information on how different countries deliver care outside hospital

**Aim:**
- To explore arrangements in place in eight countries
- To provide a basis for a more informed discussion on the future of healthcare outside hospital
Countries were selected to provide variation

➢ Variation in healthcare financing
  ▪ Social health insurance (France and the Netherlands) vs. taxation (Australia, Denmark, England, Finland, New Zealand, and Sweden)

➢ Variation in access to specialist services
  ▪ Spectrum running from extensive gatekeeping that controls access to specialist and diagnostic services to direct access to specialist care
The review informed policy thinking at the Department of Health

Specialist care more locally

6.3 Care is delivered closer to home in many other countries. For instance, Germany has virtually no outpatient appointments carried out in hospitals.

We have looked at the lessons we can learn from international best practice:

International example
In several countries, including Australia, France, Germany and Switzerland, many specialists provide services outside hospital. In Germany, polyclinics – under the re-branded name of Medizinische Versorgungszentren (MVZ, medical care centres) – were re-introduced to the health care system in 2004. The renewed interest in polyclinics among policy-makers has been stimulated by their potential to enhance co-ordination of care. A minimum of two physicians from different specialties are required to set up an MVZ. Teams usually include at least one general practitioner but can also involve nurses, pharmacists, psychotherapists or psychiatrists, as well as other health care professionals.

Additionally, the MVZs are free to contract with other health-related organisations (for example those providing home-based care).

Another well-known example of integrated care closer to home is Kaiser Permanente in the US. Kaiser uses far fewer acute bed days in relation to the population served than the NHS, and 3.5 times fewer bed days for the 11 leading causes of bed days in the NHS. Lengths of stay are more important than admission rates in explaining these differences. Lower utilisation of acute bed days is achieved through integration of care, active management of patients, the use of intermediate care, self care and medical leadership.
Polyclinics to replace traditional doctors' surgeries

Simon Alford, The Sunday Times

The traditional doctor's surgery could soon be replaced by a new batch of "polyclinics", according to the health minister charged with reviewing the NHS.

If a trial of the new centres in London, which house GPs alongside other health professionals under the same roof, is successful they could become commonplace across the country.

Plans are being drawn up for at least 150 new centres across the capital alone. Many of the services to be offered are currently only available in hospitals.
Policy learning from abroad: why it is more difficult than it seems
Stefanie Ettelt, Nicholas Mays and Ellen Noote

This article explores the process of policy learning from abroad from a knowledge utilisation perspective, using examples of health policy making in the Department of Health in England. It argues that information about policy abroad is often heterogeneous and difficult to obtain systematically and therefore does not fit easily with notions of evidence-based policy making. While some officials interviewed for this study did regard policy examples from other countries as a substitute for evidence, especially in areas in which there was little research evidence, others appeared to see less confidence about its validity, and instead used information as a way to question the evidence base. The variability in strategies and their pressures on time and resources demonstrates that generating ideas to inform policy making is an iterative process using this information that thus raises questions about the extent to which looking abroad contributed to genuine policy learning.

Introduction

Learning has been central to the work of academics (Rose and Bulpitt, 2003; Bulmer, 1990) and the three main reasons for this are equity in society, novelty in other countries and much discussion of policy transfer between countries, particularly in social policy. While policy ideas have always travelled across the world, advances in information technology have enabled policy ideas and examples to spread more quickly and frequently. This has caused much interest in understanding how these transfers have happened and why they appear to be more successful in some cases than in others. Second, learning from other countries appears to fit with the notion of ‘evidence-based’ policy making, a movement in public policy governance which has taken hold in a number of countries, including Britain. Indeed, “outward-looking” policy making was actively promoted as part of the agenda to ‘modernise’ government in the early years of the first Blair Labour government (Cabinet Office, 1999a).

This article explores the process of learning from abroad from a knowledge utilisation perspective (Rich, 1997), using examples of health policy making in the Department of Health in England. The article is organised according to three initial questions:

- How did officials access information about policies in other countries?
- How was this information processed, understood and interpreted?
- What was its role in policy making?

Key words: policy learning • international comparisons • knowledge utilisation

Assessing quality in cross-country comparisons of health systems and policies: Towards a set of generic quality criteria

Mirella Cacace, Stefanie Ettelt, Nicholas Mays, Ellen Noote

Assessing quality in cross-country comparisons of health systems and policies: Towards a set of generic quality criteria

1. Introduction

There has been a long-standing interest in cross-country comparisons of health systems and policies among policy analysts and policy makers. However, while the body of literature in the field has expanded over time, less attention has been given to the systematic assessment of the quality of studies in the field. Arguably, the concept of ‘quality’ itself is problematic, given that it is multi-dimensional and means different things to different audiences and in different circumstances. While there are assessment tools for some types of research on networks (1,2), these are not designed to capture the particular challenges of cross-country comparisons of health systems and policies. Furthermore, research on health systems and policies constitutes a diverse inter-disciplinary field of study, with much variation in relation to rationales for research, disciplinary perspectives, foci and levels of analyses, and methodological approaches.

In this paper, we attempt to identify criteria that may serve as a useful guide to assess the quality of cross-country comparative health policy research. Our interest in this topic was stimulated by participation in the European Observatory on Health Systems and Policies (EHPG), a group that has met
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