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Contributions of Qualitative Research to Health Services Research and Policy

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Qualitative research

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- Wide range of definitions and approaches
- Answers the **why** and ***how*** questions
- Uncovers complexity from the micro-level to the macro-level (Black 2009)

Black 2009 *J Health Serv Res Policy*; Denzin & Lincoln 2000; Sofaer 2002, *Int J Qual in H Care*

Overview of presentation

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- Contributions of qualitative research:
  1. Behaviours of health service users
  2. Evidence into practice
  3. Policy in action
- Three tips on quality qualitative research

1. Behaviours of health service users

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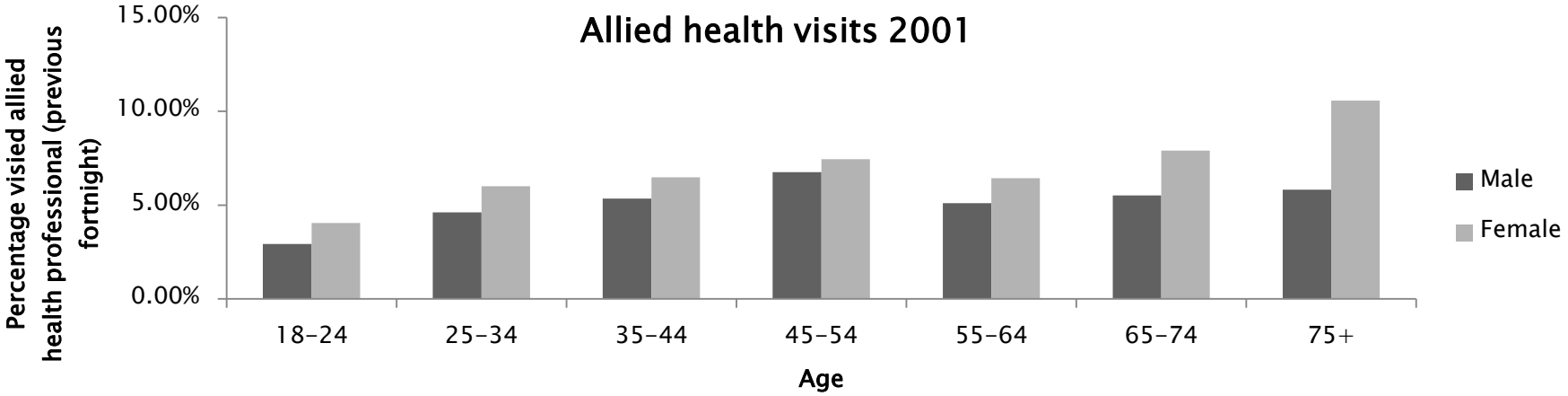
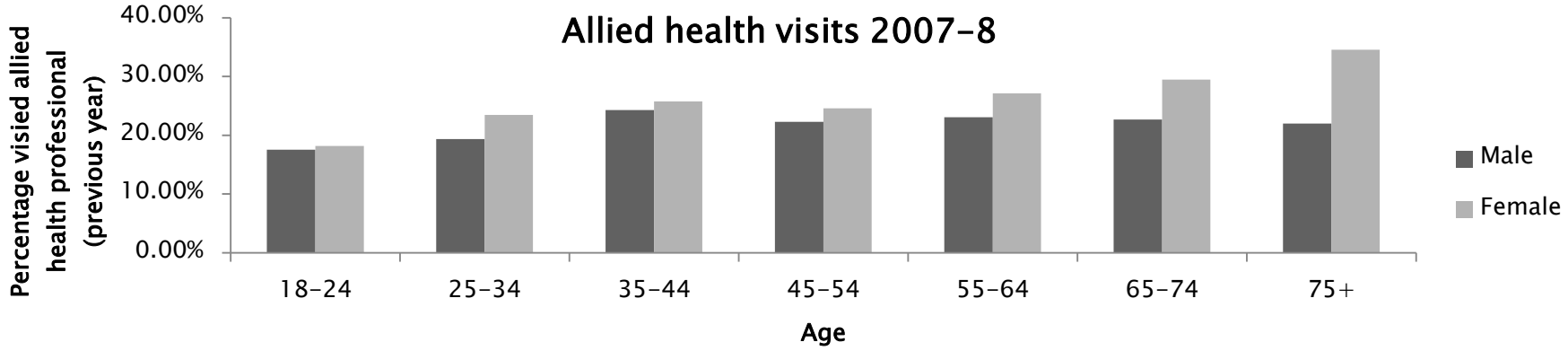
Analysis of NHS data:

- Women are more likely to use allied health services than men
- Size of gender gap is greater post-retirement age
- Strong positive effect of health insurance - most pronounced for persons in good health

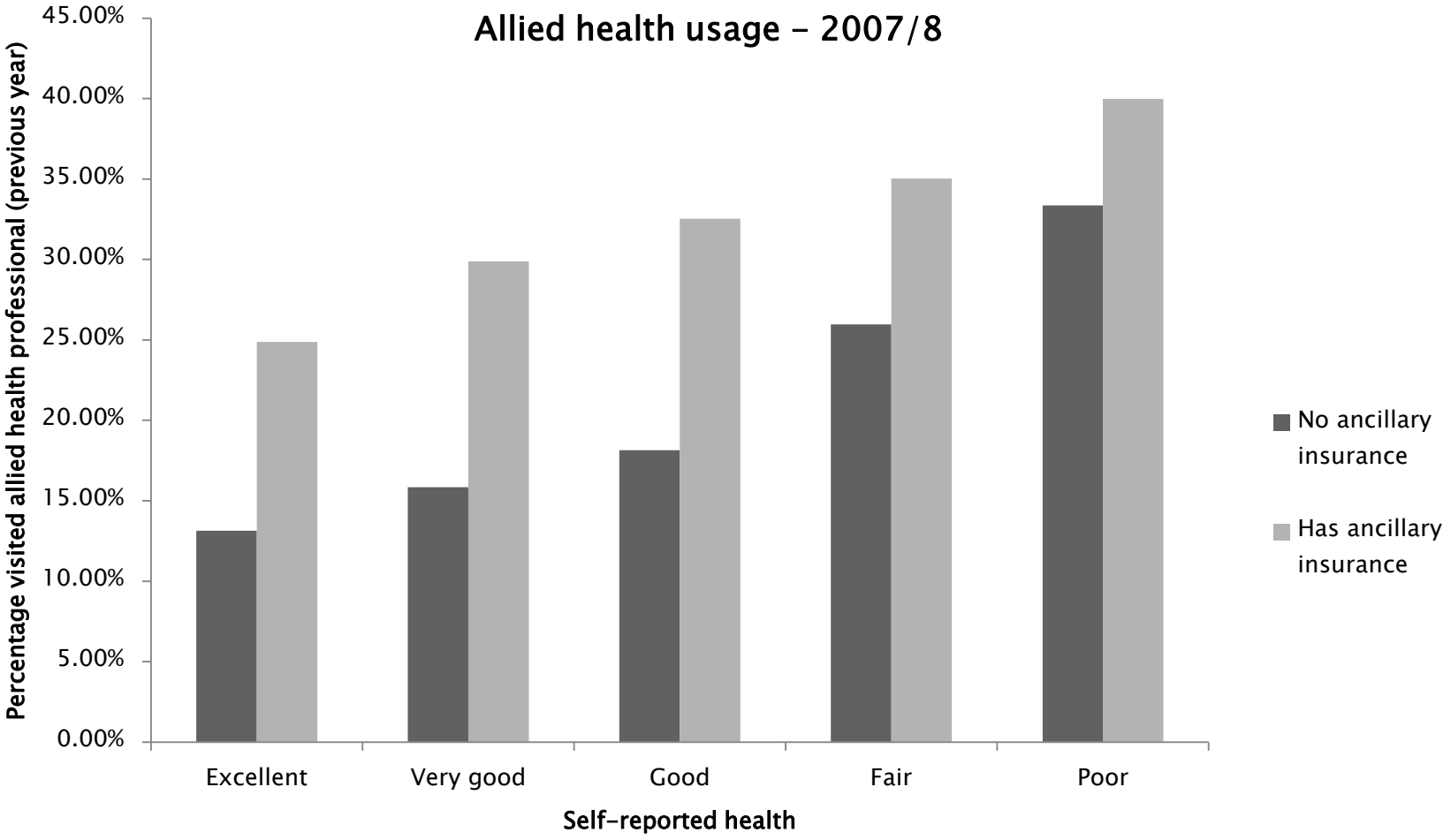
Foster, Haynes, Haines *et al* (2011), APHCRI Report

Age and Sex


Allied health visits 2001
Percentage visied allied health professional (previous fortnight)
15.00%
10.00%
5.00%
0.00%
18–24
25–34
35–44
45–54
55–64
65–74
75+
Age
Male
Female


Allied health visits 2007–8
Percentage visied allied health professional (previous year)
40.00%
30.00%
20.00%
10.00%
0.00%
18–24
25–34
35–44
45–54
55–64
65–74
75+
Age
Male
Female

Allied health use by health and insurance



Qualitative pilot study

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Interviews with 23 patients in two general practices

1. Discretionary care – willing to take advice from GP but:
   - Perceptions of value for money
   - Expectations
   - Valuations of benefits

2. Preference linked to highly personal preferences

Foster, Mitchell (Paper under review)

If we are sick we go to the doctor, we would never hold back on that. But for a physio which is something that is not life threatening, but I would hesitate if I had to pay the lot
(Male 79, asbestosis)

We did claim on Medicare…but I wasn't very impressed…I didn't feel [physiotherapist] had done anything because all I was doing was some silly exercises….I put it down to not a very pleasant experience. I felt it was a waste of time and a lot of money for nothing. (Male, 78, heart disease)

I said to [physiotherapist] if I was to have more frequent visits and can't get the five visits, I'd be prepared to pay if I'm going to benefit (Female 88, musculoskeletal pain)

2. 'Evidence to practice'

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Research indicates:

- Poor uptake and compliance
- Variances in practices
- Unexpected trial outcomes

Gohl *et al*. 2007 *Milbank*; McLaw *et al*. 2009; Teare *et al*. 2001 *BMJ*

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Addition of Biphasic, Prandial, or Basal Insulin to Oral Therapy in Type 2 Diabetes

Rury R. Holman, M.B., Ch.B., F.R.C.P., Kerensa I. Thorne, M.Sc., Andrew J. Farmer, D.M., F.R.C.G.P., Melanie J. Davies, M.D., F.R.C.P., Joanne F. Keenan, B.A., Sanjoy Paul, Ph.D., and Jonathan C. Levy, M.D., F.R.C.P., for the 4-T Study Group*

From the Diabetes Trials Unit, Oxford Centre for Diabetes, Endocrinology, and Metabolism (R.R.H., K.I.T., A.J.F., J.F.K., S.P., J.C.L.) and the Department of Primary Health Care (A.J.F.), University of Oxford, Oxford; and the Department of Cardiovas-

ABSTRACT

BACKGROUND

Adding insulin to oral therapy in type 2 diabetes mellitus is customary when glycemic control is suboptimal, though evidence supporting specific insulin regimens is limited.

METHODS

Lawton et al. Trials 2011, 12:108
http://www.trialsjournal.com/content/12/1/108

TRIALS

RESEARCH Open Access

Challenges of maintaining research protocol fidelity in a clinical care setting: A qualitative study of the experiences and views of patients and staff participating in a randomized controlled trial

Julia Lawton[1*], Nicholas Jenkins[1], Julie L Darbyshire[2], Rury R Holman[2], Andrew J Farmer [3] and Nina Hallowell[4]

Abstract

Background: Trial research has predominantly focused on patient and staff understandings of trial concepts and/or motivations for taking part, rather than why treatment recommendations may or may not be followed during trial delivery. This study sought to understand why there was limited attainment of the glycaemic target (HbA_{1c} ≤6.5%) among patients who participated in the Treating to Target in Type 2 Diabetes Trial (4-T). The objective was to inform interpretation of trial outcomes and provide recommendations for future trial delivery.

Methods: In-depth interviews were conducted with 45 patients and 21 health professionals recruited from 11 of 58 trial centres in the UK. Patients were broadly representative of those in the main trial in terms of treatment allocation, demographics and glycaemic control. Both physicians and research nurses were interviewed.

Results: Most patients were committed to taking insulin as recommended by 4-T staff. To avoid hypoglycaemia, patients occasionally altered or skipped insulin doses, normally in consultation with staff. Patients were usually unaware of the trial's glycaemic target. Positive staff feedback could lead patients to believe they had been

Qualitative research insights

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Interviews: 45 patients, 21 staff from 11 of 58 centres

- Overturns assumptions that poor patient adherence is the culprit
  - Patients on the whole displayed good adherence to regimes

- Staff rejected the ‘one size fits’ all approach
- Personalised care based on:
  - Patient circumstances and preferences
  - Clinical knowledge and experience

- Highlights nature and meaning of ethical dilemmas and varied ways in which these are managed

Lawton *et al*. 2011

3. Policy in action

- Delivery end evaluation

- Practical knowledge for policy about the realities of day to day practice
  - Interpretation and management of national policy objectives in local delivery contexts
  - Enables government to improve policy design and intervene better

Foster *et al.* 2008 MJA; Greenhalgh *et al.* 2004

Chronic Disease items for Individual Allied Health Services

Aimed to increase public access to private sector allied health services coordinated by patient's general medical practitioner (GP)

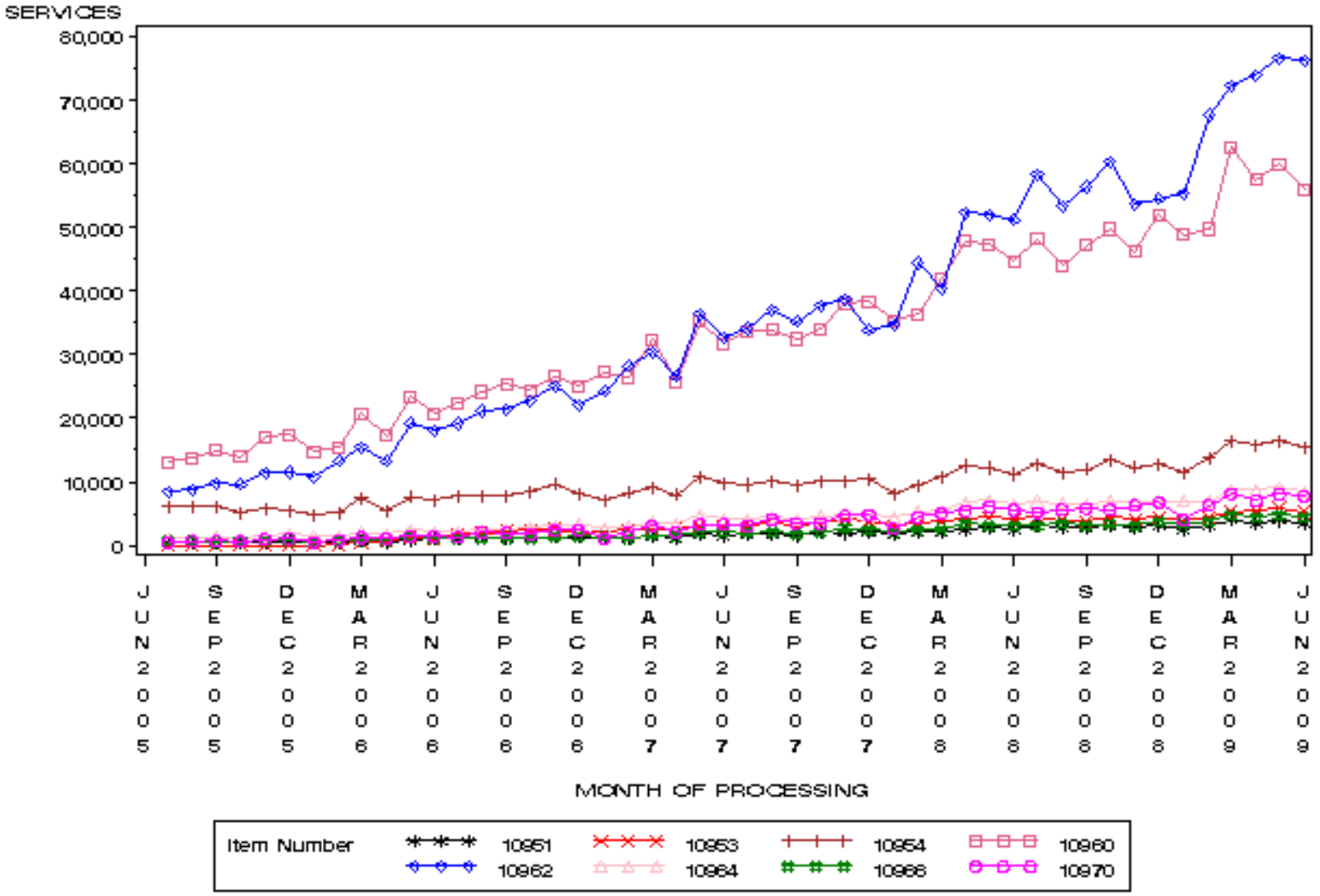
Patient eligibility

Have a chronic or complex medical condition/s present for more than 6 months

Regulatory framework

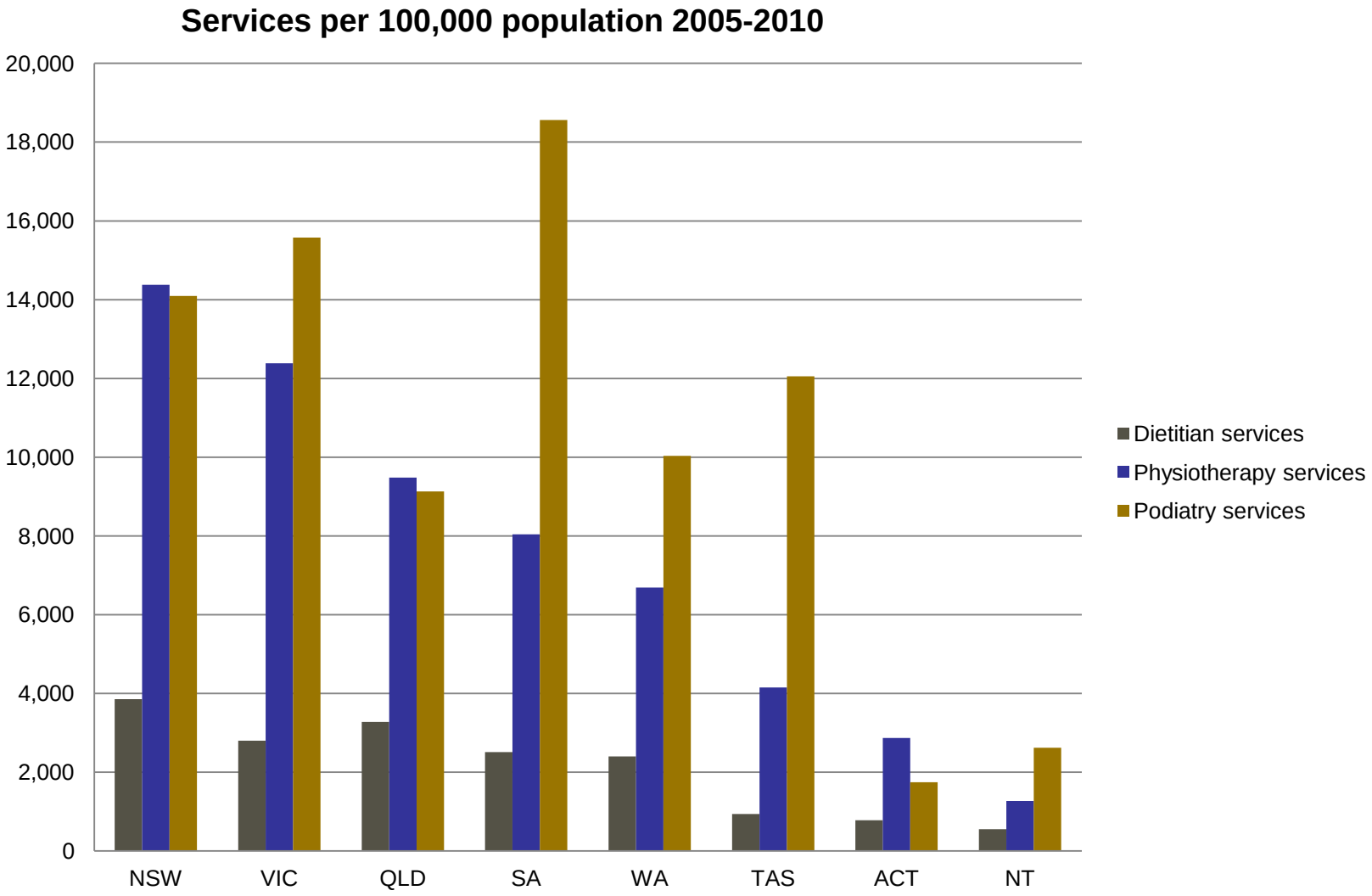
Agree with GP about GP Management Plan with Team Care Arrangement	Eligible AHPs registered with Medicare	Up to 5 allied health consultations in total in one year	Rebate 85% of government scheduled fee or a fee-free service if directly billed

Number of consultations per quarter for 8 most utilised CDM allied health items June 2005 to July 2009



Cant & Foster. 2011 *Aust Health Review*

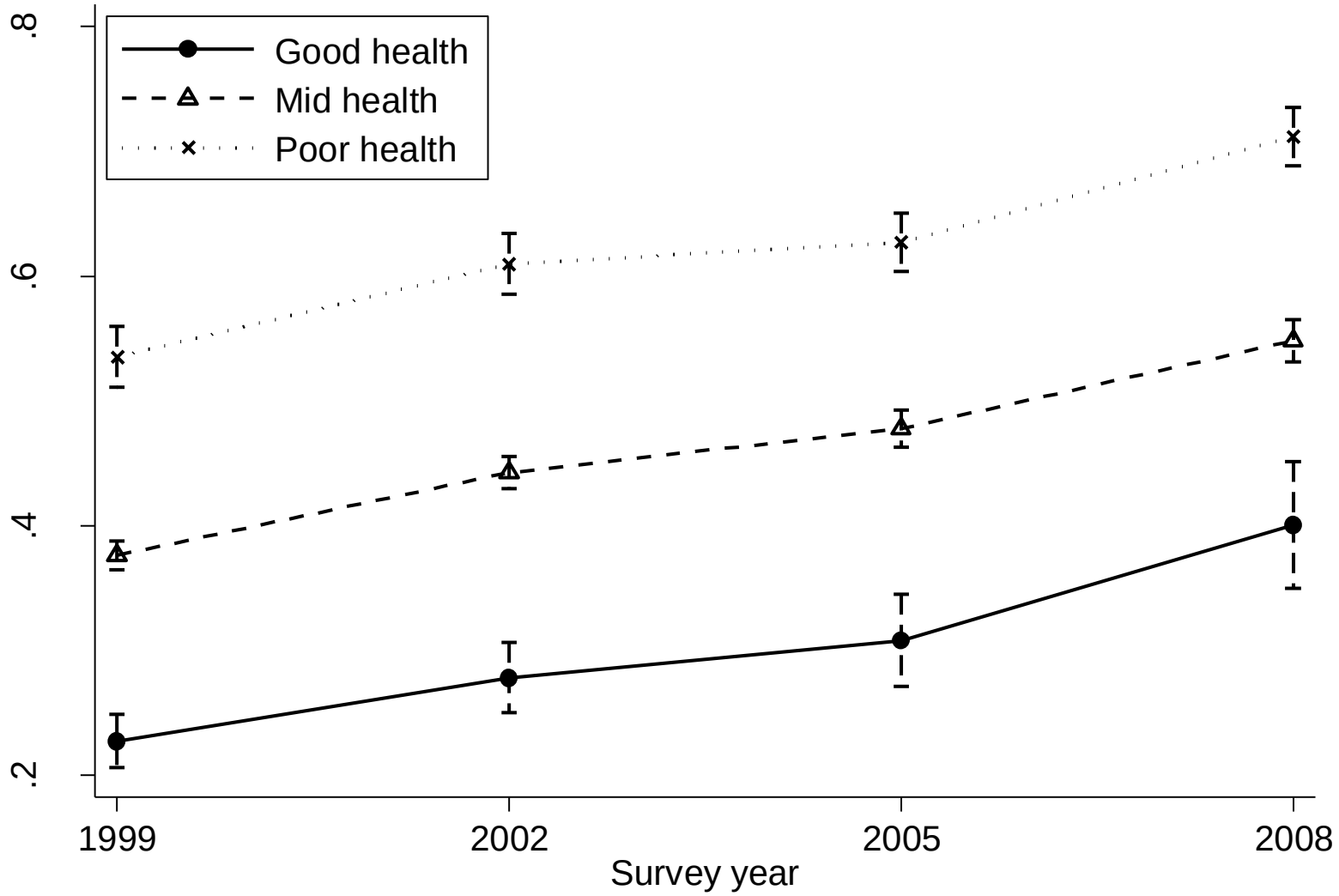
Differences in uptake across States for 3 most utilised CDM allied health items 2005-2010



Allied health use: longitudinal data

- Musculoskeletal conditions most consistently associated with AHP use in NHS data
- Diabetes largest effect in 2007-8 NHS analysis
- Large differences in women's use between states in ALSWH data
- Effect of Medicare policy?

Foster, Haynes, Haines *et al* (2011), APHCRI Report



Vertical bars represent 95% confidence intervals for the estimate

CSIRO PUBLISHING
www.publish.csiro.au/journals/py
Research
Australian Journal of Primary Health, 2009, **15**, 326–334

Better than nothing? Restrictions and realities of enhanced primary care for allied health practitioners

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Abstract. Participation of allied health professionals (AHP) in the Enhanced Primary Care (EPC) program is increasing. However, access to allied health services is strictly delineated under the EPC program and AHP face unique practice realities in providing care to patients with chronic conditions. This paper examines the discretionary practices adopted by AHP in response to the realities at the policy–practice interface and situates the discussion within a description of their experiences with EPC. Semistructured telephone interviews were conducted with a purposive sample of fifteen AHP. Participants were selected from a larger cohort who responded to a questionnaire about EPC. The EPC program was perceived as a positive start, although some aspects were problematic. Participants reported that the restriction on the number of subsidised sessions was not conducive to providing a good allied health

Allied health views

"…you have to be pragmatic and rational under limited funding that you have access to. I guess it's not best practice

(Physiotherapist)

"I view it almost as like charity work it's like pro bono you do it because you have an ethical responsibility you certainly don't go looking for this sort of work to run a business on"

(Occupational Therapist)

"I can't afford to not do it because it's one of the biggest referral sources, but my current plan is to severely reduce the bulk billing that I…I only have a very small percentage of bulk billing positions and people will have to wait to be fitted in"

(Physiotherapist)

Foster et al. 2009 *Aust J Primary Health*

Checklists for improving rigour in qualitative research: a case of the tail wagging the dog?

Rosaline S Barbour

Qualitative research methods are enjoying unprecedented popularity. Although checklists have undoubtedly contributed to the wider acceptance of such methods, these can be counterproductive if used prescriptively. The uncritical adoption of a range of "technical fixes" (such as purposive sampling, grounded theory, multiple coding, triangulation, and respondent validation) does not, in itself, confer rigour.

In this article I discuss the limitations of these procedures and argue that there is no substitute for systematic and thorough application of the principles of qualitative research. Technical fixes will achieve little unless they are embedded in a broader understanding of the rationale and assumptions behind qualitative research.

Summary points

Checklists can be useful improving qualitative research methods, but overzealous and uncritical use can be counterproductive

Reducing qualitative research to a list of technical procedures (such as purposive sampling, grounded theory, multiple coding, triangulation, and respondent validation) is overly prescriptive and results in "the tail wagging the dog"

None of these "technical fixes" in itself confers rigour; they can strengthen the rigour of qualitative research only if embedded in a

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BMJ 2001;322:1115–7

QUALITATIVE RESEARCH

Critically appraising qualitative research

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Six key questions will help readers to assess qualitative research

Over the past decade, readers of medical journals have gained skills in critically appraising studies to determine whether the results can be trusted and applied to their own practice settings. Criteria have been designed to assess studies that use quantitative methods, and these are now in common use.

In this article we offer guidance for readers on how to assess a study that uses qualitative research methods by providing six key questions to ask when reading qualitative research (box 1). However, the thorough

longer elicit trends or themes not already raised by previous participants. Thus, to sample to saturation, data analysis has to happen while new data are still being collected. Multiple sampling methods may be used to broaden the understanding achieved in a study (box 2). These sampling issues should be clearly articulated in the methods section.

Were the data collected appropriately?

It is important that a qualitative study carefully describes the methods used in collecting data. The appropriateness of the method(s) selected to use for the specific research question should be justified, ideally

Quality qualitative research

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1. Well-thought out and clearly defined
   - Questions, design, methods, analysis

2. Feasible and deliverable within time and funding constraints

3. Expert-driven

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