



EUROPEAN COMMISSION

HEALTH & FOOD SAFETY DIRECTORATE-GENERAL

Health systems, medical products and innovation

Performance of national health systems

EXPERT GROUP ON HEALTH SYSTEMS PERFORMANCE ASSESSMENT

22ND MEETING

26 JUNE 2020, 09:30 – 13:30

VIRTUAL MEETING

MEETING MINUTES

Participants: Austria, Belgium, the Czech Republic, Cyprus, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Lithuania, Malta, the Netherlands, Norway, Portugal, Romania, Slovenia, the European Observatory on Health Systems and Policies, the OECD, the WHO Europe and the European Commission

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1. OPENING OF THE MEETING

The Chair (Andrzej Ryś, European Commission) opened the meeting with presenting briefly European Commission's proposal of the new Multiannual Financial Framework 2021-2027 modified in order to help the EU to tackle COVID-19 crisis. The EU4Health Programme is one of important elements of this framework, with proposed € 9.4 billion for boosting preparedness for health threats and strengthening health systems. More than twenty-fold increase of the Health Programme in comparison to the current one (2014-2020) is a clear indication that health gains significance in the EU. Health authorities should not miss the chance to use it for reforming the systems.

The Expert Group adopted the agenda and the minutes from the 21st meeting.

2. MEASUREMENT AND ASSESSMENT OF HEALTH SYSTEM RESILIENCE

Federico Pratellesi (European Commission) presented an account of the main changes to the semi-final draft of the health system resilience report by the Expert Group. In comparison to the previous draft that was presented at the 21st meeting, the content of the latest version was revised and expanded in several parts, also to give more prominence to some relevant elements of the report's topic that the COVID-19 pandemic brought into focus. The COVID-19 pandemic put under severe stress health systems all over the world, including most countries in the EU, and highlighted the existence of several fragilities across national health systems that either were previously undetected, or which importance had been underestimated before the onset of the health crisis. While the health crisis empirically tested and revealed the 'amount' of

resilience to epidemiological shocks that health systems were endowed with prior to the crisis, the report highlights the importance of developing assessment tools and indicators that allow for a prospective assessment of resilience. The report thus analyses the methodological difficulties and opportunities for the development of such prospective assessment tools, and presents an account of national experiences with assessing health system resilience extrapolated from the results of an internal survey on the subject that was conducted before the onset of the COVID-19 crisis. Both the theoretical overview and the evidence from the survey reveal that methods developed so far by EU countries to assess prospectively health systems resilience to various shocks are still at the very early stage of development. Consistent with the theory, all countries unanimously report three fundamental preconditions for building resilience in their respective health systems – effective health workforce planning and continuous professional education, appropriate health system financing mechanisms and the existence of effective and transparent health system governance practices. As per the scope of the assessments of resilience, almost all countries report focusing on public health and emergency care, and on assessing their respective health systems’ *preventive resilience* capacity to epidemiological shocks. The third part of the report, developed by the European Observatory on Health Systems and Policies, puts the documented theory and observed practice of resilience together by presenting (i) a range of possible strategies for building health system resilience, and (ii) a systematic overview of health system ‘assessment areas’ that countries should consider while developing their measurement and assessment frameworks for health system resilience in the future.

When inquired about possible conclusions to the report in light of the elements presented above, members of the Expert Group proposed, among others, to recognise explicitly that health system resilience presupposes a temporary decrease in performance, and that building resilience does not consist in the attempt (impossible by nature) to systemically shield health systems from each and every disruptive event that might impact a health system. On the other hand, conclusions should focus on the fundamental features that have the greatest potential to make health systems inherently less vulnerable and more capable of recovering from shocks of any type. Moreover, members highlighted the major contribution of timely and effective information flows within and across different health systems to achieving health system resilience – an aspect that revealed its importance especially during the first phase of the COVID-19 crisis. As per the measurement part, which is of relevance for one of the annexes to the report, members suggested to include a differentiation of resilience metrics between those that already exist and/or can be developed based on routinely collected data, and those that do not currently exist and would require novel data collection to be developed. As regards health workforce, resilience assessments should go beyond calculating the health professionals who are currently active and should include mobilisation capacities (i.e. system’s ability to employ e.g. last years’ students or the military).

In the coming days, the Expert Group will receive a version of the report that would include full list of conclusions and a set of recommendations. The Group’s members will have a week for their possible comments. After that, the HSPA Secretariat will fine-tune the report for its publication. Activities after the report’s release will include webinars (probably one in July and

the other in September 2020) to present its main findings. In the light of COVID-19 pandemic, the work on resilience will continue with a view to producing an annex to the report in the coming months.

Jon Cylus (European Observatory on Health Systems and Policies) presented the [Health System Response Monitor](#) (HSRM), a tool analysing country responses to COVID-19 in the WHO Europe Region. Its main aim is to fill a gap in reporting how health systems reacted to and mitigated the coronavirus crisis. As regards its form, it is similar to the Observatory's other tool – the [Health Systems and Policy Monitor](#). The HSRM covers the following areas: • analyses addressing countries' policy questions, • key trends and patterns, • updates on countries' policies, • examples of good practices • and key documents. Analysis of the shocks in the HSRM is a cycle of • preparedness, • identification of threat, • response • and lessons learned. The tool have already resulted in a set of briefs that cover topics like criteria for COVID-19 testing; employment of test-trace-isolate-support activities; removing financial barriers in accessing coronavirus-related health care or organising non-COVID-19 health services. At least at this stage, the aim of the tool is to capture responses by the countries and to collect the evidence. It is obvious that actions of the authorities are very much context-related; therefore, analytical comparisons or benchmarking would be difficult to make directly.

Guillaume Dedet (OECD) presented an overview of the ongoing work on the forthcoming publication "*Health at a Glance: Europe 2020*" with a focus on the first (out of two in total) headline thematic chapter of the publication, which is going to analyse how resilient countries have been to the COVID-19 crisis. Mr Dedet explained the rationale for the selection of this topic in collaboration with the European Commission, its structure and the changes that were made as a consequence to the 'default' structure of this year's report. The chapter will be composed of three parts • containment and mitigation, • health systems' responses • and lessons learned. Data used for preparing the chapter will cover period from February to May 2020. The report will be published in November 2020.

3. MEASUREMENT AND ASSESSMENT OF ACCESS TO HEALTH CARE

Kenneth Grech (Malta, Member State co-Chair) chaired the second part of the meeting.

Katarzyna Ptak Bufkens (European Commission) summarised the work on the HSPA report on measuring access to health care done so far. The report will consist of three chapters • theoretical one, • on results of the survey on measuring access in the national context • and on patients' vignettes, which will be a tool to capture patients' perspective of problems in accessing health care, depending on various personal and clinical characteristics. Two first chapters of the report have already been finalised and consulted with the Group. The first chapter shows possible directions in refining the measurement framework at European and national level through: • development of the analysis of the redistributive impact of in-kind health benefits taking into account equivalence scale for accumulative distributive effects (life-cycle perspective with more intensive use of care at old age, redistribution from more affluent to less

affluent groups, from healthy to ill); • patient vignette as a tool better capturing experience of accessing health care at individual level with the interplay of various personal and clinical characteristics of patients, (the feasibility of scaling up this approach will be developed on the basis of work feeding into chapter 3); • complementary national tools, which are an opportunity to put sharper lenses to problems in accessing healthcare, which are specific to national or subnational context and which can drive a better policy responses to health inequalities adapting the provision of services to needs of disadvantaged groups and persisting unhealthy behaviours clustering among less affluent parts of the population; • adjustment of existing tools: EHIS, EU SILC, Mutual Information System on Social Protection tables with a view of making them produce more granular data on access to healthcare, both in relation to patient characteristics and access to specific services. The chapter integrates case studies from Belgium, Ireland and Finland on various approaches in embracing more detailed evidence, which were presented at the 21st HSPA meeting. The suggestion received in writing from members on integrating time lags in the interpretation of data (e.g. how to capture the effect of shocks in the short term and mid- to long-term consequences of the pandemic) is welcome and Katarzyna asked for examples of indicators and approaches used. As far as the second chapter is concerned, it largely builds on the results of the survey on national experience, the results of which were presented at the 21st HSPA meeting. The chapter takes into account all the additional contributions and comments received from the Expert Group members in writing. It is structured around: • the SWOT analysis of more refined accessibility metrics; • policy impact of HSPA on access to healthcare; • dimensions of accessibility covered by HSPA; • potential of existing data sources and mechanisms of putting into perspective more granular data; • state of play in capturing various personal and clinical characteristics in existing ways of measuring access to healthcare; • ways of assessing the completeness of healthcare coverage. Katarzyna also presented possible conclusions of the report, proposing to highlight the importance of better tools of measuring access in making a difference, especially for groups experiencing persisting problems. Conclusions can stress that the better accessibility metrics can be conducive to more effective policy responses through adapting the healthcare coverage parameters, ways of providing services, adjusting services to address the persisting prevalence of health inequalities.

The discussion that followed, confirmed that plans to link EU-SILC and MISSOC are very ambitious, since for the time being these tools are not harmonised and disclose contradictory picture of levels of unmet medical needs. Nevertheless, the improvement of existing surveys should be part of efforts in getting better data on access to healthcare. Streamlining of reporting in MISSOC tables may be an easier way to improve data at European level. The OECD report [Waiting Times for Health Services](#) could be part of the report prepared by the HSPA Expert Group. Use of digital tools for shortening the distance between patients and health providers deserves more analysis, also in the context of COVID-19 pandemic and the change in the role digitisation plays in services' provision. The report could also put more emphasis on health literacy from the provider's perspective as an important factor of access to quality care. Insufficient quality may impair access to healthcare and in this context the report could refer to challenges related to overmedication explored in the recent Italian study.

Ewout Van Ginneken (European Observatory on Health Systems and Policies) proposed how the patients' vignettes could find its place in the access report. The concept of vignettes is not a new one in research on decision making in medicine or in health systems. He proposed the following steps in preparing and using the vignettes in the report: • selection of areas of health care covered, • drafting the vignettes, • their validation by medical experts, • conducting survey with vignettes, • and analysis of the replies. He stressed that the timing of the HSPA report on access is very demanding and testing the vignettes by early September may be not realistic, so if this timeline is kept, the scope of the research should be reconsidered.

During the discussion, the experts expressed their preferences for the choice of the vignettes with very positive consideration of a vignette measuring access to mental care with the distinction between severe and moderate health conditions, a vignette measuring access to experimental treatments for cancer patients and a vignette measuring access to COVID-19 care. There is no doubt about a need to include also chronic care; however, its complexity may make preparing a vignette that would bring significant results very difficult. The selection of vignettes should be decided shortly after the meeting and the scope of work adapted to the timetable. It was however stressed by some Members that September might be too tight to carry out a test of the vignettes according to the proposed approach.

4. CONCLUSIONS OF THE MEETING

Initially, the 23rd HSPA meeting was planned in Dublin on September 17th, 2020. Due to changing and uncertain epidemic situation in Europe, this will probably not take place. In the coming weeks, the HSPA Secretariat will inform the Expert Group about the date and the form (probably virtual) of the next meeting.