



EUROPEAN COMMISSION
HEALTH & FOOD SAFETY DIRECTORATE-GENERAL

Health systems and products
Healthcare systems

EXPERT GROUP ON HEALTH SYSTEMS PERFORMANCE ASSESSMENT

4TH MEETING

9 OCTOBER 2015, 9:30-16:30

**VENUE: MINISTRY OF HEALTH
BERLIN**

Participants: Austria, Belgium, Bulgaria, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Italy, Latvia, Lithuania, Luxembourg, Malta, the Netherlands, Portugal, Slovakia, Slovenia, Sweden, the United Kingdom, WHO Euro, OECD, European Observatory of Health Systems and Policies, European Commission.

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1. WELCOME AND INTRODUCTORY REMARKS

Representatives from the German Ministry of Health opened the meeting and welcomed experts in Berlin.

The Chair introduced the Agenda. The morning was dedicated to the presentation and discussion of two national experiences (Germany and England), whilst the afternoon was to discuss international topics: main outcomes of the FP7 EuroHope report, and WHO Euro agenda on integrated care. The last part of the meeting was to discuss the development of the work on the two priority areas identified by the group: quality of care and integrated care.

The minutes from the 3rd meeting of the group were approved. The agenda of the meeting was approved unanimously.

2. QUALITY IMPROVEMENT THROUGH DATA: THE NATIONAL PROGRAMME FOR ASSESSMENT OF HEALTHCARE QUALITY IN GERMANY; THILO GRÜNING, MD MSc, FEDERAL JOINT COMMITTEE (HEALTHCARE)

The quality of care is within the remit of responsibility of various institutions on different levels of the German administration. The key players are: the Federal Joint Committee, regional authorities (Länder), doctors' chambers, scientific organisations.

The Federal Joint Committee is the highest authority of self-governing health insurance system. It publishes directives and guidelines binding for health care providers and health insurers. The Committee's activity is supported by the Federal Ministry of Health.

Quality assessment is done using more than 400 indicators from more than 30 areas of medicine. In case of common procedures, data is gathered by regional authorities and then sent to the Committee. Decisions on mix of indicators and areas are taken by the Committee every year and changes are introduced. To ensure quality and coherence of collected information, target population is precisely described.

Of six aims of quality of care listed by the Institute of Medicine, four are targeted: safety, effectiveness, patient centeredness and timeliness. Efficiency and equity are not taken into consideration.

More than 3.2 million records from more than 1,500 hospitals are collected every year. Each hospital receives feedback information on quality of its services against set benchmarks.

If the results are not in the range of the normal ones, a Structured Dialog is launched. This is a kind of peer-review in which hospitals are asked to explain their results. When a given hospital underperforms constantly further steps are possible after the Dialogue, e.g. informing Länder authorities on bad performance, publishing information on missing quality targets, etc. Closing of hospitals may be an ultimate radical solution; however the aim of the assessment is not to close hospitals but to improve quality.

Results of quality assessment are sent to hospitals but also published in internet. Since 2005 hospitals were obliged to publish their reports every two years. Since 2013 they have to do it on yearly basis.

Discussion after presentation focused mainly around relations between DRG system and care quality, paying for quality, assessment of care provided to patients after hospital discharge.

3. CAN WE GOVERN HEALTH CARE WITH QUALITY DATA? THE AGENDA OF THE NEW INSTITUTE FOR QUALITY ASSURANCE AND TRANSPARENCY IN HEALTH CARE (IQTIG); CHRISTOF VEIT, MD PHD, DIRECTOR, FEDERAL INSTITUTE FOR QUALITY ASSURANCE AND TRANSPARENCY IN HEALTH CARE

The aim of this intervention was to present the Institute for Quality Assurance and Transparency in Health Care (IQTIG), established in 2015 it will fully operate from January 2016.

This is not the first institution responsible for this field in German health system. The IQTIG's goal is first of all to improve care for patients; its costs will not be the priority. Focus will be both on inpatient and outpatient care. The Institute aims at improvement, information and regulation.

The most important in IQTIG's activities will be feasibility, efficiency and justification. Since they do not cure patients, it will be feasible to help those who do it. The Institute will assess what are efficient measures to improve quality of care. Clearly, refusing a health care provider the right to offer some services could be done only on the basis of well-grounded fully-justifiable reasons.

Ranking, as a tool to improve care quality, is not the best option since not all patients will be able to reach every provider; the goal is rather to ensure that high quality care is offered at each establishment. Decision on including a given hospital in the public health system is taken by regional authorities; only entities chosen in this way may have contracts with sickness funds and receive payment from public resources. Quality of care is one of aspects taken into consideration in selection process. On the other hand exclusion from health care market is possible only if it is proven that provider threatens patients' safety. This shows relation between quality of care and existence on the market.

A potential way of enhancing quality of care is to pay for performance (high quality). This method has its drawbacks too. First of all, health professionals should be convinced to importance of high quality; if they observe it only because they are paid for that it will not work in long-term perspective. The other problem is to pay less for worse quality. It is also counterproductive on long-term since it justifies it – payment is lower but provision of care of such quality is still financed. Better is to pay more early adapters and after some time to cut payments for those who still did not adapt. As a result everyone is interested switching to new solutions when using them is still rewarded.

Patients are very interested in the quality of the care they receive; quality reports must be prepared from their perspective to make the Institute's work as useful as possible. According to German legislation, providers are obliged to inform patients about the risk of treatment but without benchmarking. Information on risk in one place does not give much without comparison. Regulations should change in this regard.

Introducing only these requirements which everyone should meet is not enough. Best performers should be promoted and this means that thresholds which only the best can reach are needed as well.

During the discussion which followed several subjects were touched, e.g. relation between quality of care and professional liability insurance premiums, influencing providers' behaviour by changing quality indicators, use of DRG payment for improving health quality, centres of excellence.

4. OUTCOMES FRAMEWORK – ITS GOAL, HOW IT WAS DEVELOPED AND HOW IT IS INFLUENCING THE SYSTEM; KEITH DERBYSHIRE, UNITED KINGDOM, DEPARTMENT OF HEALTH, CHIEF ANALYST

The presentation was about England's approach the assessing performance in outcomes in the health system. It consisted on four sections: the strategic aims of the NHS Outcomes Framework, how the NHS Outcomes Framework was developed, the NHS Outcomes Framework in practice, and lessons learned.

1) Strategic aims – the Health and Social Care Act 2012 set the ground for a reform of the health system, which aimed at increasing transparency and reduce political interference in operational matters. The Government's expectations of the NHS would be set in terms of outcomes, with the NHS free to determine how to deliver improvements. The NHS Outcomes Framework would be central in setting direction, monitoring progress and holding the NHS to account. It has three aims: 1) to provide a national level overview of how well the NHS is performing, wherever possible in an international context; 2) to provide an accountability mechanism between the Secretary of State for Health and the NHS Commissioning Board; 3) to act as a catalyst for driving quality improvement and outcome measurement throughout the NHS by encouraging a change in culture and behaviour, including a renewed focus on tackling inequalities in outcomes.

NHS Outcome Framework is one of three outcomes frameworks; the other two focus on public health outcomes and adult social care outcomes. The NHS outcome framework is structures along five domains, which cover three performance dimensions (effectiveness, patient experience, safety).

2) Development of the NHS Outcomes Framework – an open consultation took place in 2010, on the proposed purpose, structure and approach. The consultation triggered over 700 responses, which mostly supported the focus on outcomes and welcomed the approach. An advisory group was set up to

support the ongoing development; the framework has been kept under review and changes were made every year. Currently it has 68 indicators.

3) The NHS Outcomes Framework in practice – some indicators were presented, showing their trend over time. The framework is recognised as a key accountability mechanism between the Secretary of State and NHS England; the latter is demanded to demonstrate progress against each domain and all indicators. The framework presents both challenges and opportunities; among the main challenges are time lags (both in data production and in actions to produce outcomes), stability of the tool over time, issues with international comparability of indicators.

4) Lessons learned – four main lessons were highlighted: a) need for influential advocacy on the need and usefulness of an outcomes framework; b) define the purpose of the framework and stick to it; c) consult with different stakeholders for their views; d) remain committed to the framework.

The following discussion touched, *inter alia*, upon the role of people expectations in defining the outcomes, the role played by hospitals in the broader system, the issues in assessing overall performance of hospitals, and the process of checking indicators.

5. PRESENTATION OF THE MAIN FINDINGS OF THE EUROHOPE PROJECT (FP7), MIKKO PELTOLA, SENIOR RESEARCHER AT NATIONAL INSTITUTE FOR HEALTH AND WELFARE, FINLAND

The aim of EuroHope project financed with FP7 was to investigate variations in health outcomes in selected conditions. The exercise was based on administrative data from Finland, Hungary, Italy, the Netherlands, Norway, Sweden and Scotland. Patients were followed from the beginning of their treatment until full recovery. Analysis of cases was to enable preparing a set of indicators to improve the treatment of these conditions.

A lot of data is collected in national health systems but it is not fully exploited because often authorities do not have capacity or plan to analyse and use it. Hospital discharge registers, drugs prescription and death registers were source of information. Quite common and expensive-to-treat conditions were chosen for analysis.

Indicators for given diseases were prepared at national, regional and hospital level. Not all countries agreed for publication of results of analysis at hospital level. Results show differences in effectiveness of treating the same condition in different populations. Lack of homogeneity of results is not surprising but it turned out that these variations are not always possible to explain logically.

Factors like density of population or wealth were taken into consideration to find answers. In general differences between regions were greater than between countries. Since there was not possible to answer all questions at regional level next inquiry was done at the hospital one.

Summing up, variations are very often surprising; it is not possible to explain them as results of differences between system since they appeared in case of some conditions but were not confirmed in case of others. It turns out that data should be collected in many countries and it should be further analysed by specialists to explain observed variations.

Discussion centred on methods of work, data used and relations between EuroHope and ECHO projects.

6. THE WHO'S ACTIONS ON INTEGRATED CARE, PRESENT AND FUTURE PERSPECTIVE, DR HANS KLUGE, DIRECTOR, HEALTH SYSTEMS AND PUBLIC HEALTH

WHO Europe shared information on its agenda on integrated care. In general, health systems' situation in the European Region is satisfactory: many national health systems show resilience and ability to cope with challenges.

WHO Europe's activities, in line with global WHO mandate, are to be more concentrated on patients in coming years. First of all transformation from reactive to proactive care will be promoted to tackle 21st century challenges. Main points of action will be treatment, public health, social care etc.

The second issue is protection of people from impoverishment due to bad health. These two goals can be reached by investing in workforce strengthening, better access to effective and innovative pharmaceuticals and technologies and enhanced quality of health data.

Currently, there is a debate on how to assist policy makers in introducing changes in health systems. In October 2013 "Strengthening people-centred health systems in the WHO European Region" initiative was launched. There were two meetings of focal points for this subject organised in 2014 and 2015. One stakeholders' conference took place in 2014 and the second is planned for 2016.

Apart from helping in implementing changes, WHO Europe plans to provide tools to measure effects of care integration. In this regard co-operation with European Region Member States, the European Union and other organisations is being developed.

After the presentation promotion of participation in people-centred initiative and practical points on co-operation between WHO and HSPA expert group were discussed.

7. STATE OF PLAY ON SUBGROUPS' WORK AND NEXT STEPS, FEDERICO PAOLI, FILIP DOMAŃSKI, DG HEALTH AND FOOD SAFETY

The sub-group on quality of care is working on a report collecting national experiences and lessons learned thereabout. Seven Member States sent already their contributions, which are in their way to be incorporated in the report, together with extracts from country quality reviews prepared by the OECD. In the coming weeks the secretariat of the group will circulate a preliminary draft of the first two chapters of the report.

Meanwhile, in response to a proposal made in the previous meeting, the secretariat in cooperation with the European Observatory and the OECD is organising a policy focus group on CVD and diabetes, to reflect on the reasons behind observed variations across Member States and the possible policy actions which can be taken in response to them. The focus group, open to all members of the expert group, is scheduled on the 3rd of November. A second draft of the report, including the findings of the policy focus group, will be transmitted to the expert group before its meeting in December.

With reference to integrated care, the sub-group has already had three phone conferences to discuss methods of work and work plan for 2016, as well as an issue of care integration assessment. The sub-group shall deliver next year a report on common features of integrated care, problems with implementing such care models and an indication how to measure and assess successes and failures in this regard.

Both sub-groups co-operate with experts from WHO Europe, OECD and the European Observatory and will base their work on national experiences too. Work plan for 2016 should be endorsed to the expert group for adoption during its next meeting on December 4th 2015. The day before a workshop will be organised to define working lines on integrated care.

8. CONCLUSIONS OF THE MEETING AND SCHEDULING OF FUTURE MEETINGS

The policy focus group on cardiovascular disease and diabetes will take place on the 3rd of November in Brussels.

The next meeting of the expert group will take place in Brussels on the 4th of December, 2015. The sub-group on integrated care will meet in Brussels on the 3rd of December.