Opinion on tools and methodologies for assessing the performance of primary care

Expert Panel on effective ways of investing in health

Health

Expert Panel on Investing in Health

Provides independent non-binding advice on effective ways of investing in health

Established by Commission Decision 2012/C 198/06 following the Council conclusions of June 2011 'Towards modern, responsive and sustainable health systems'; renewed in 2017.

Expert Panel Opinions to date	Requested by	Adoption
Best practices when commissioning from private providers	ECFIN	May 2016
Typology of health policy reforms	ECFIN	May 2016
Disruptive Innovation	SANTE	Feb 2016
Access to health services	SANTE	Feb 2016
Cross-border Cooperation	SANTE	July 2015
Competition among health care providers in the EU	ECFIN	May 2015
Quality of health care / Patient safety	SANTE	Oct 2014
Definition Primary Care	SANTE	July 2014
Criteria to assess performance of health systems	WPPHSL - Sub-group on HSPA	Feb 2014
Assessment of a PPP study	SANTE	Feb 2014

The Panel is currently working on benchmarking access to healthcare, performance assessment of primary care, and innovative payment models for high-cost innovative medicines.

http://ec.europa.eu/health/expert_panel/home_en

Background

The EU -Expert Group on Health Systems Performance Assessment was established in November 2014, at request of the Council Working Party on Public Health at Senior Level. The Expert group decided in 2016 to focus on the assessment of the performance of integrated care (report under finalisation), with a special focus on primary care.

A subgroup of Experts appointed by Member States is preparing the report, based on a Survey, that will be published at the beginning of 2018.

Mandate submitted to the Expert Panel in January 2017

The Expert Panel on effective ways of investing in health is requested to provide its views on:

1. Dimensions and domains to be taken into consideration in assessing the performance of primary care.
2. Specific indicators to be collected and analysed to give a better understanding of the performance of primary care.
3. How the analysed indicators are fitted for policy making: do they allow the identification of specific levers and policy actions to respond to the highlighted issues?
4. Advice for an EU agenda on performance assessment of primary care: goals, opportunities, activities, and possible deliverables.

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TABLE OF CONTENTS

European Commission

Report of the

EXPERT PANEL ON EFFECTIVE WAYS OF INVESTING IN HEALTH (EXPH)

on

Definition of a Frame of Reference in relation to Primary Care with a special emphasis on Financing Systems and Referral Systems

Health and Consumers

Opinion on Definition primary care – Definition

Core-definition

'The Expert Panel considers that primary care is the provision of universally accessible, integrated person-centered, comprehensive health and community services provided by a team of professionals accountable for addressing a large majority of personal health needs. These services are delivered in a sustained partnership with patients and informal caregivers, in the context of family and community, and play a central role in the overall coordination and continuity of people's care

The professionals active in primary care teams include, among others, dentists, dieticians, general practitioners/family physicians, midwives, nurses, occupational therapists, optometrists, pharmacists, physiotherapists, psychologists and social workers.'

Table 1. Domains and dimensions in Primary Care (PC)	
Domains	Primary care dimensions
1) Universal and accessible	• Population covered by PC services • Affordability of PC services • Geographic access and availability of PC services • Accommodation of accessibility; acceptability of PC services • First-contact accessibility and availability; accommodation • Timeliness and responsiveness of PC services (e.g. PC consultations)
2) Integrated	• Integration of public health services and approach in PC: e.g. community-oriented primary care • Integration of pharmaceutical care in PC • Integration of mental health in PC • Integration between PC and social care
3) Person-centred	• Person-centred care, shared decision making, focusing on the "life goals" of the patient • Patient-provider respect and trust; cultural sensitivity; family-centred care • Consider patients/people as key partners in the process of care • Maintain a holistic eco-bio-psycho-social view of individual care

Table 1. Domains and dimensions in Primary Care (PC)	
4) Comprehensive and community oriented	• **Comprehensiveness of services provided (e.g. health promotion, disease prevention, acute care, reproductive, mother and child health care, childhood illness, Infectious illness, chronic care (NCDs…), mental health, palliative care)** • **PC takes into account population and community characteristics** • **PC is integral part of the local community**
5) Provided by a team of professionals for addressing a larger majority of personal health needs (quality)	• Quality of diagnosis and treatment in PC for acute and chronic conditions • Quality of chronic care, maternal and child health care • Composition of the inter-professional team • Health promotion; primary and secondary prevention • Patient safety • Advocacy
6) Sustained partnership with patients and informal caregivers	• Policies for coordination between professionals and informal caregivers • Policies to support informal caregivers • Patient engagement over time • Participation of informal care givers/citizens in the development of PC services • Participatory power of patients/informal care givers/citizens

Table 1. Domains and dimensions in Primary Care (PC)	
7) Coordination of people's care	• **Coordination between primary and secondary care: appropriateness of referrals, gatekeeping, integrated patient records, protocols for patients with chronic conditions** • **Coordination between primary and social care** • **Policies for respite care**
8) Continuity of people's care	• Continuity of care (longitudinal, informational and relational) • The provision of care throughout the life cycle • Care that continues uninterrupted until resolution of an episode of disease • Role of PC in continuity and interaction with Emergency Departments

Table 1. Domains and dimensions in Primary Care (PC)	
9) Primary Care Organization	• **Accountability: a formal link between a group of providers and a defined population (list-system, geographical area, …)** • **Primary care payment and remuneration system (e.g. capitation, FFS, P4P);** • **The presence and strength of market forces in PC;** • **Office and facility infrastructure (e.g. information systems and medical technology, Point-Of-Care testing);** • **Organizational components of coordination and integration: structure and dynamics (job descriptions and team functioning, management and practice governance, clinical information management, organizational adaptivity and culture (traditional command-and-control versus Complex Adaptive Systems Approach), team-based organisation;** • **Volume and duration of PC provider consultations, home visits, and telephone consultations;** • **Organisational aspects of referrals to medical specialists; referrals to specialised trajectories (e.g. in mental health, occupational health,..)** • **Quality of management** • **Primary care budget in relation to total health care budget**
10) Human Resources	• Needs, supply, profile and planning of PC workforce; • Status and responsibilities of PC disciplines; role of academic institutions and professional associations; • Training and skill mix; • Human resources management, including provider well-being, competence and motivation; • Role of nurses (task delegation and substitution, competency sharing); • Role of community pharmacists in PHC and pharmaceutical care; • Role and function of managers • Income of PC workforce; • Development of undergraduate and post-graduate specific (interprofessional) training

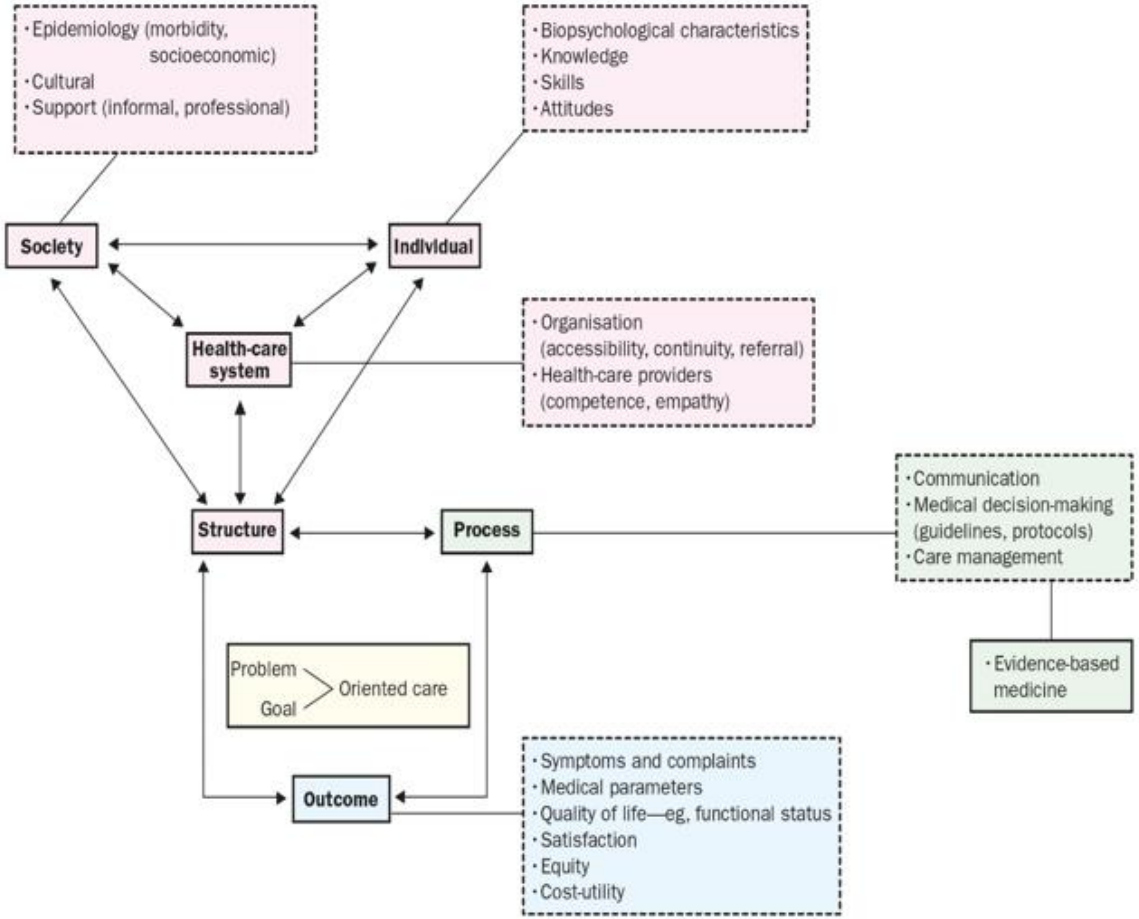
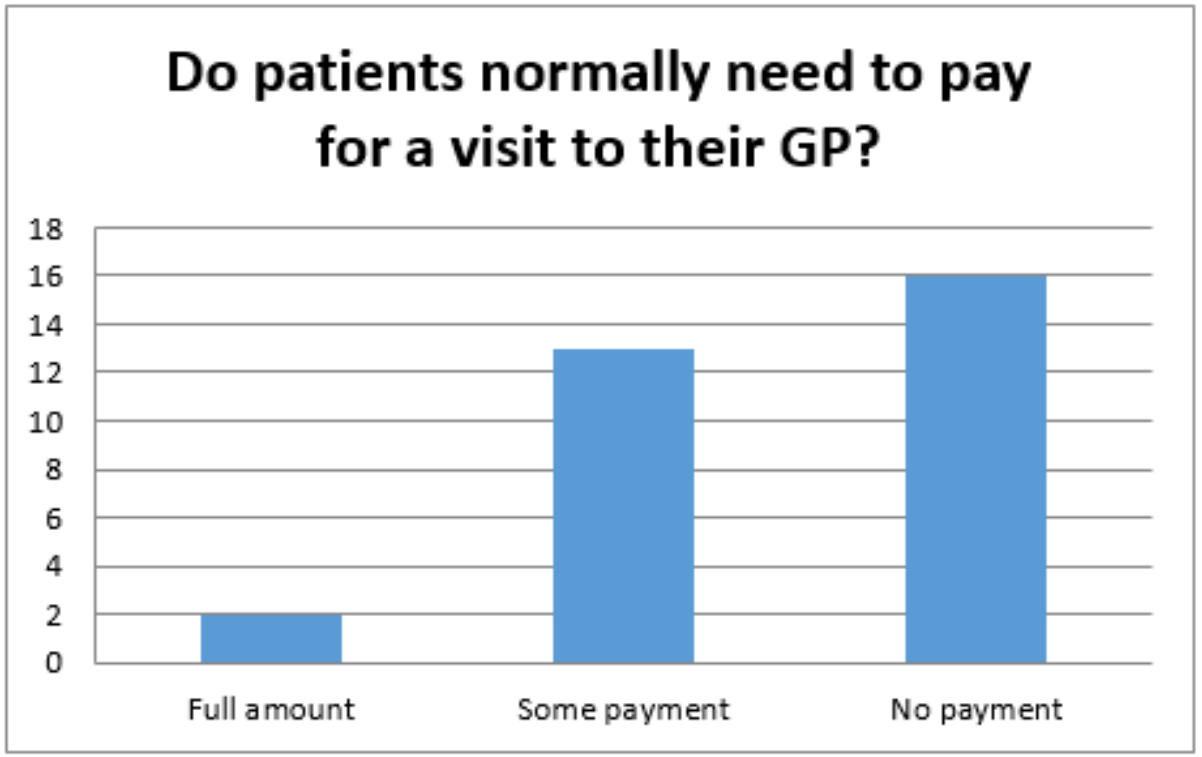


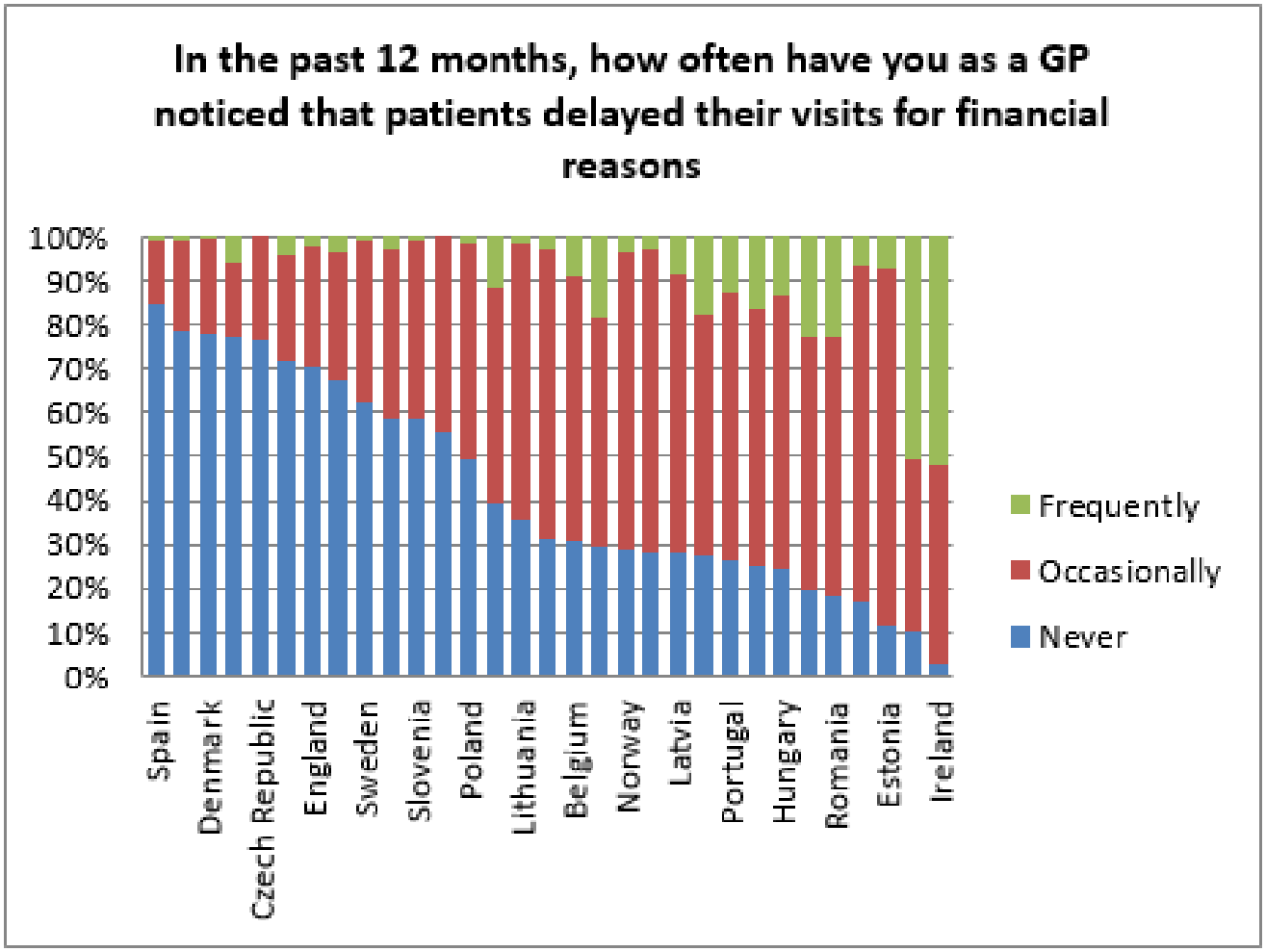
Figure 1: Theoretical framework of structure, process, and outcome (De Maeseneer et al., 2003; courtesy The Lancet)

According to the above framework the core elements of primary care can be classified as follows:

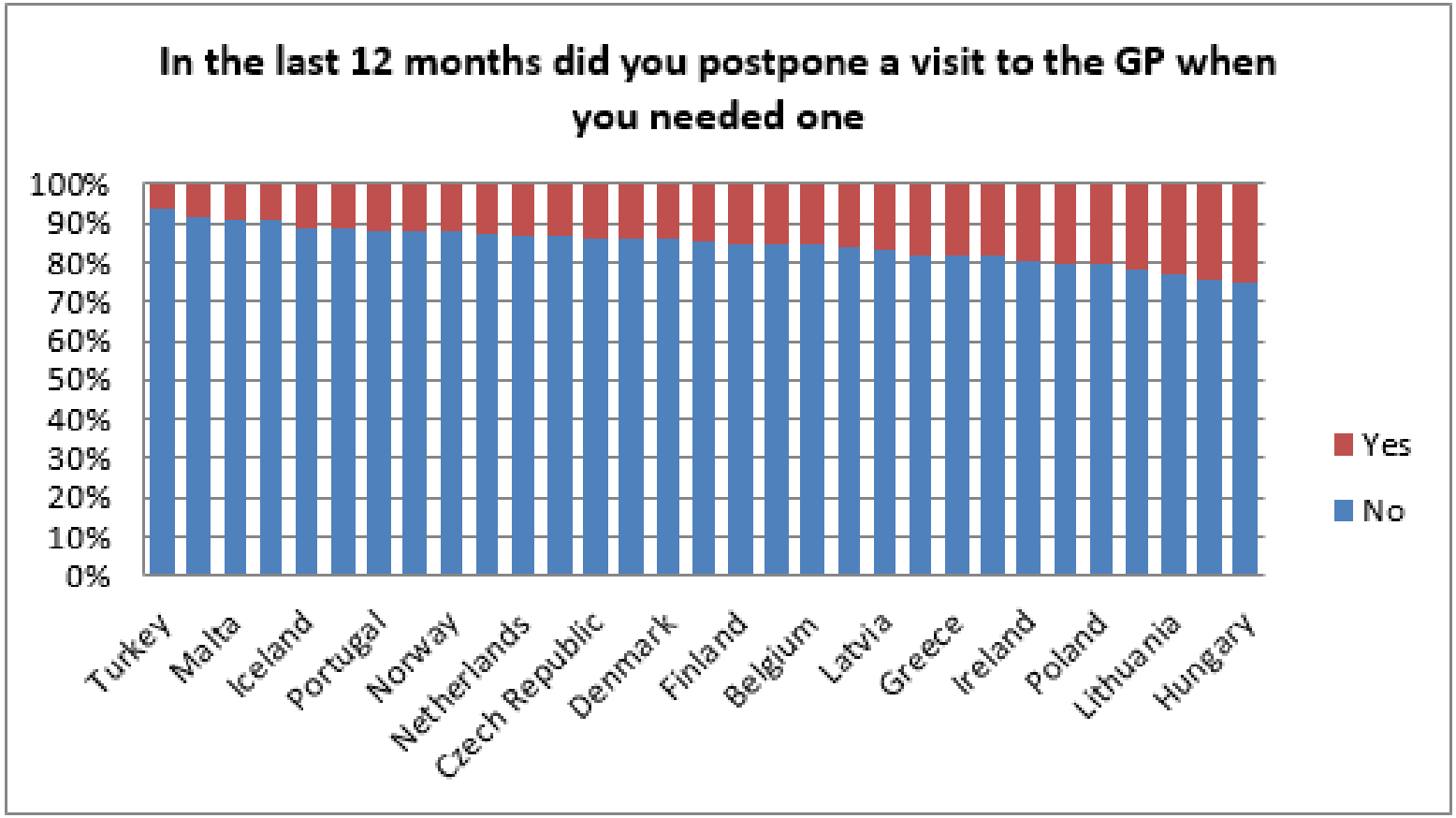
Table 2. Core elements in primary care	
Universality	Structure
Accessibility	Structure
Organisation of professionals and workforce	Structure
Integration	Process
Sustained partnership	Process
Coordination	Process
Continuity of care	Process
Person-centeredness	Outcome



Payment of the full amount in France and Ireland. Some payment in Belgium, Bulgaria, Czech Republic, Finland, Germany, Latvia, Luxembourg, Norway, Portugal, Sweden and Switzerland. No payment in Austria, Cyprus, Denmark, Estonia, Greece, Hungary, Italy, Lithuania, The Netherlands, Poland, Romania, Slovakia, Spain, Turkey and The United Kingdom.
(Kringos et al., 2010)



(Schäfer et al., 2011)



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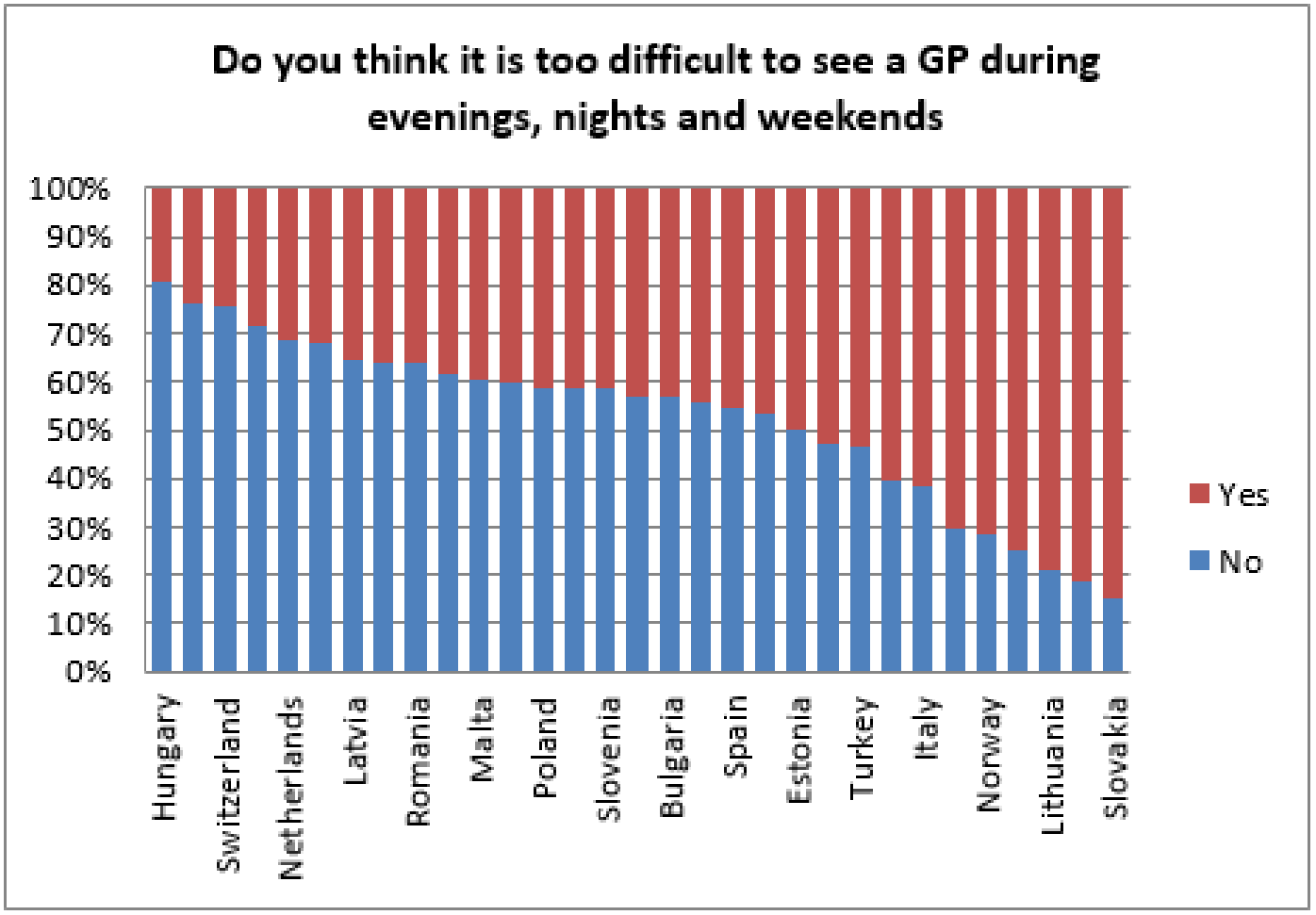
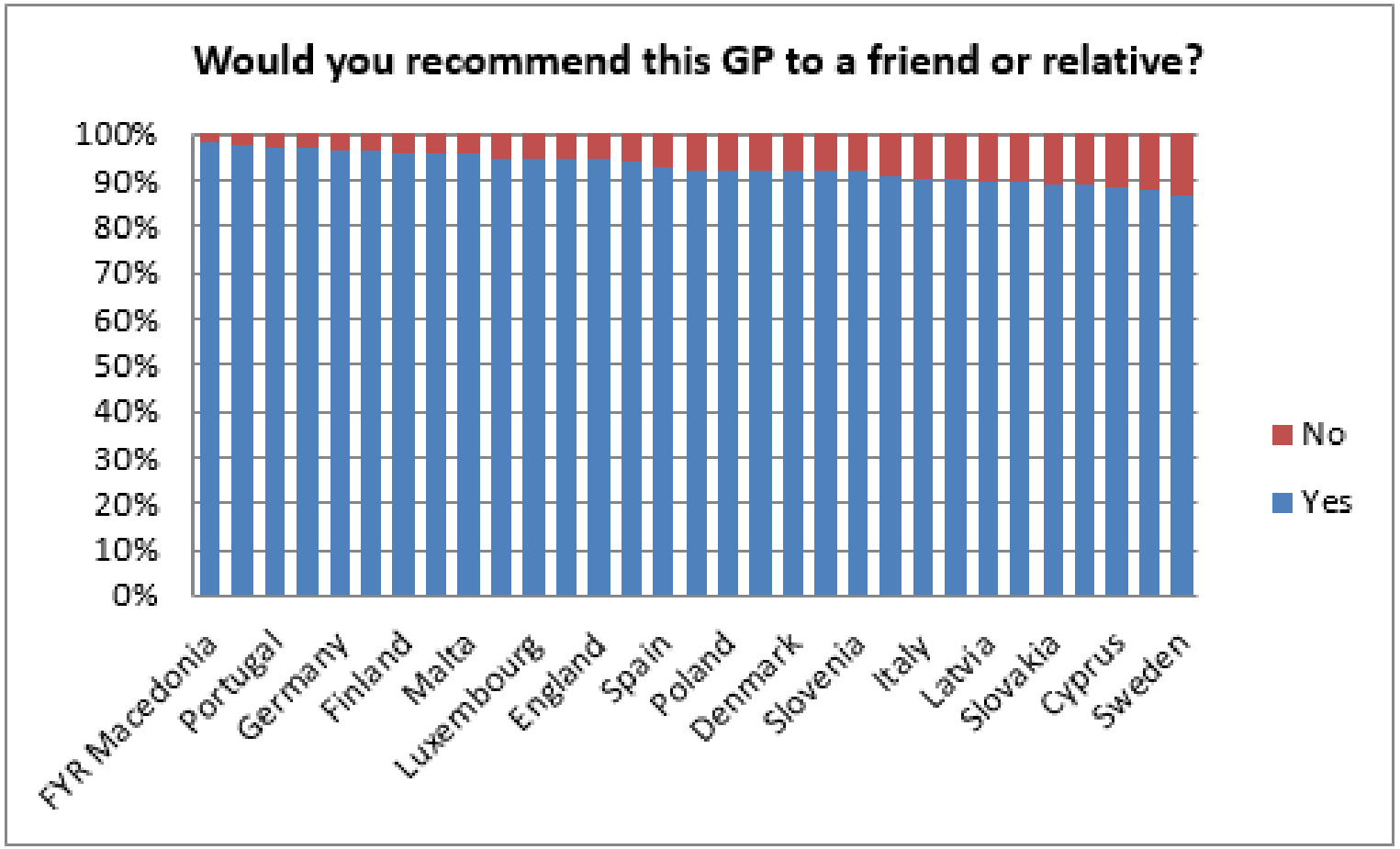


Source: Schäfer et al., 2011



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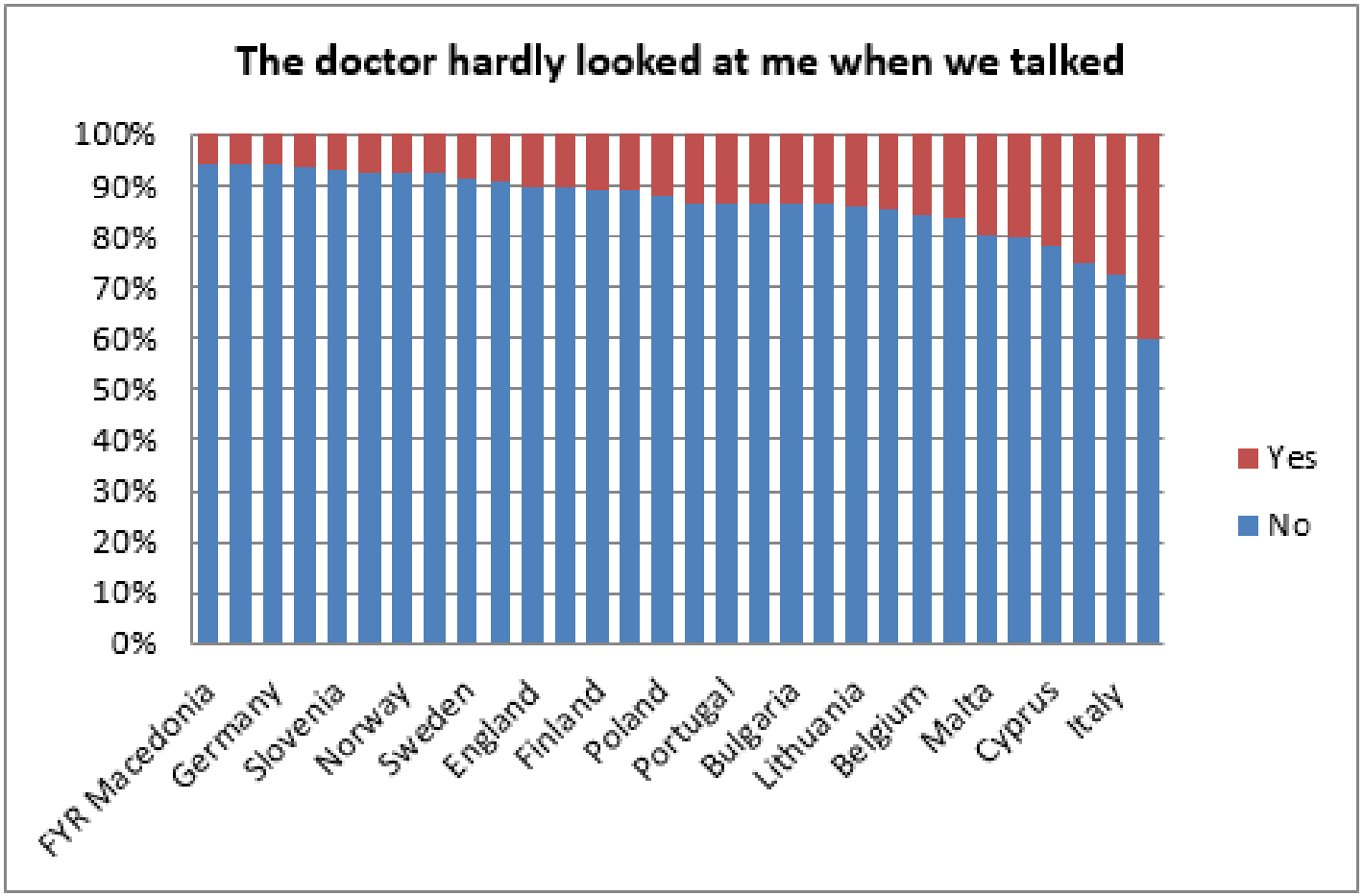

(Schäfer et al., 2011)

Table 2. Examples of comparative key-indicators along its key domains	
Domains	Examples of Indicators
1) Universal and accessible	• **% of the population fully covered or insured for PC costs and medicines prescribed in PC** • **Total expenditure on PC as % of total expenditure on health** • **Amount patients have to pay for a GP/PC consultation and amount reimbursed** • **% of patients who rate GP/PC Team care as not very or not at all affordable** • **Difference between region, province or state with highest and with lowest GP/nurse/social worker/… density** • **Average number of days waited to see a GP/PC provider when confronted with a health problem**

Table 2. Examples of comparative key-indicators along its key domains	
Domains	Examples of Indicators
2) Integrated	• **Extent to which GPs/PC Teams carry out preventive activities such as: Testing for sexually transmitted diseases; Screening for HIV/AIDS; Influenza vaccination for high-risk groups; Cervical cancer screening; Breast cancer screening; cardiovascular risk assessment.** • **Is there a structured cooperation between PHC and social care?** • **Does the pharmaceutical care integrate the contribution by GP/community pharmacist/nurse e.g. through an integrated pharmaceutical record?** • **To what extent are disciplines like occupational therapy, physiotherapy, speech therapy,… integrated in PC Teams?**

Table 2. Examples of comparative key-indicators along its key domains	
Domains	Examples of Indicators
3) Person-centred	• **Duration of regular visit (minutes) of different types of providers** • **% of patients who rate that they i) trusted the GP/nurse/social worker/…; ii) were involved in shared decision making ; iii) were satisfied with PC visit.**

Table 2. Examples of comparative key-indicators along its key domains	
Domains	Examples of Indicators
4) Comprehensive and community oriented	• **Extent to which patients visit a GP for first-contact care for specific health conditions; people with a first convulsion; suicidal inclinations; alcohol addiction problems.** • **Is FP/GP the only medical discipline in PHC?** • **Are there activities related to Community Oriented Primary Care?** • **Is there palliative care at home organised?**

Table 2. Examples of comparative key-indicators along its key domains	
Domains	Examples of Indicators
5) Addressing personal health needs (provide high quality PC)	• **% of infants vaccinated within PC against e.g. diphtheria; tetanus; pertussis; measles; hepatitis B; mumps; rubella; % population aged 60+ vaccinated against flu; HPV vaccinations** • **The defined daily doses of antibiotics use in ambulatory care per 1000 inhabitants** • **Percentage of individuals with COPD or asthma who have had a lung function measurement during the last year** • **Percentage of diabetic population with blood pressure above 140/90 mm Hg observed in the last 12 months** • **Percentage of patients stating that the treatment contributed to achievement of their life-goals**

Table 2. Examples of comparative key-indicators along its key domains	
Domains	Examples of Indicators
6) Sustained partnership with patients and informal caregivers	• **% of informal caregivers who receive support from primary care** • **% of patients reporting help by informal care givers** • **Presence of organisations of informal caregivers in a community**

Table 2. Examples of comparative key-indicators along its key domains	
Domains	Examples of Indicators
7) Coordination of people's care	• **Is there a gate-keeping system (access to specialists through referral)?** • **Do patients need a referral to access the paramedical and nursing disciplines, to access social care?** • **Is it common for GPs to have regular (electronic) face-to-face meetings (e.g. at least once per month) with the following professionals? Other GP(s); Practice nurse(s); Nurse practitioner(s); Home care nurse(s); Midwife/birth assistant(s); PC physiotherapist(s); Community pharmacist(s); Social worker(s); Community mental health workers; medical specialists.**

Table 2. Examples of comparative key-indicators along its key domains	
Domains	Examples of Indicators
8) Continuity of people's care	• **Do GP-practices have a patient list system? Or another form of defined population?** • **% of patients reporting to visit their usual PC provider for their common health problems** • **% of GPs/PC Teams keeping electronic clinical records for all patient contacts routinely.** • **% of patients who are satisfied with their relation with their GP/PC provider** • **Do PC practices receive information within 24 hours about contacts that patients have with out-of-hours services?**

Table 2. Examples of comparative key-indicators along its key domains	
Domains	Examples of Indicators
9) Primary care organisation	• **PC payment system, revenues, and operating costs** • **Percentage of income of GPs through FFS, Capitation, Salary, P4P** • **Average income of 1FTE GP compared to average income of specialist; of PC nurse compared to hospital nurse,…** • **Quality control audits** • **Clear Vision and Mission statements of PC Teams** • **Existence of continuous quality improvement processes** • **Is there an organisation at meso-level of the support structures for PC, e.g. in Primary Care Zones,…** • **Is there an organisation at macro-level of PC e.g. a regional/national Institute for PC?**

Table 2. Examples of comparative key-indicators along its key domains	
Domains	Examples of Indicators
10) Human resources in primary care	• **Average number of working hours per week of GPs/nurses/pharmacists/social worker/..** • **Average age of practising providers in PC** • **Total no. of active GPs as a ratio to total no. of active physicians** • **Total n°. of nurses active in PHC compared to total number of nurses in PHC, secondary and tertiary care**

Defining a performance assessment system for primary care: *procedural steps*

- **Multi-dimensionality**
- **Shared design**
- **Evidence-based**
- Shift from monitoring to **evaluation**, by systematic **benchmarking** results
- **Timeliness**
- **Transparent disclosure**

Discussion

- A lot of indicators are constructed, that do not take into account the specific contribution made at the primary health care level, when indexing access and quality of care.

- There is a difficulty to include variation in context (e.g. data on characteristics of the population and society, the health system, the social welfare system,…) when comparing outcomes.

Box 3: Presentation of context when reporting outcomes			
Domain	**Item**	**Information**	**Presentation**
Health System	Structure	Yes/no primary care based	Narrative
	Insurance	No/restricted/comprehensive	Narrative
	Financial barriers	Yes/no co-payment, deductible	Narrative, Euros
	Availability services	Waiting lists, shortages	Narrative, numbers/
			population
	Provider payment	Capitation/item for service/	Narrative
		Performance incentives	
	Patient's contractual	Preferential provider/rostering-	Narrative
	relation with provider	Panels of patients/free access	
Social welfare	Pensions	Yes/no	Narrative
	Unemployment benefits	Yes/no	Narrative
	Sickness benefits	Yes/no	Narrative
	Community support	Yes/no	Narrative
	services		
Population	Demographics	Age	Standard age classes
and society		Sex	F/M
		Social class	Standard class
		Education	
		Ethnicity	
		Religion	
	Population health	Life expectancy	
		Main causes of death	
		Dominant health problems	
Objectives of	Diagnostic	Rule-in/rule-out/risk	Narrative
interventions		assessment	
	Therapeutic	Preventive/curative/palliative	Narrative
		functioning	

Source: van Weel (2017) *Primary Health Care Research & Development,* 18: 183 – 187.

Discussion

- A lot of indicators are constructed, that do not take into account the specific contribution made at the primary health care level, when indexing access and quality of care.
- There is a difficulty to include variation in context (e.g. data on characteristics of the population and society, the health system, the social welfare system,…) when comparing outcomes.
- Special attention is required for the classification of the "goals" as formulated by the patient (ICPC-2; ICF).
- ‘Influence ‘ of e.g. payment systems on data-collection (P4P).
- Use a “reasonable” number of indicators and targets.
- Finally, in any system of data collection and indicator selection, there is a risk of "reductionism". “Not everything that is countable, counts, and not everything that counts, is countable” (I. Newton)

Recommendations (1)

- EXPH recommends the use of tools and methodologies that really encapsulate the essence of primary care in the framework of the broader health care system.
- EXPH identifies 10 domains.
- EXPH proposes a set of indicators, both comparative key-indicators and descriptive additional indicators, respecting, at least three criteria: alignment of indicators with objectives of the health system, ability to routinely collect the information related to the indicator, and reliability of information.
- To stimulate the further development of performance assessment in primary care, European Union should strengthen its goals and activities in the field of (primary) health care in order to secure for all citizens, access to relevant, high-quality, cost-effective and sustainable service delivery.

Recommendations (2)

- The creation of a widespread EU learning community would be a powerful step to develop appropriate tools and methodologies for assessing the performance of primary care and transparently inform the public on the findings. The European Social Pillar and the Sustainable Development Goals may offer the policy framework to develop these activities, which can be built upon the experience of the EU-Expert Group on Health Systems Performance Assessment.
- Quality of care is related to human resources. A big effort should be made to better understand the determinants of professionals' motivation and engagement. Actions creating good working conditions avoiding burn-out are needed. Performance assessment systems should not erode professional motivation. This is also closely linked to the management skills that should be activated to organise and manage the correct use of performance information and put in place strategies and actions that enhance primary care.
- Finally, EXPH affirms its view that strengthening primary care will contribute to improved population health and well-being and greater social cohesion in the European Union.

Thank you

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