EUROPEAN COMMISSION
HEALTH & FOOD SAFETY DIRECTORATE-GENERAL

Health systems and products
Healthcare systems

EXPERT GROUP ON HEALTH SYSTEMS PERFORMANCE ASSESSMENT

3RD MEETING

5 MAY 2015, 10:00-17:00

VENUE: ALBERT BORSCHETTE CONFERENCE CENTRE
ROOM 4C (FOURTH FLOOR)
BRUSSELS

Participants: Austria, Belgium, Bulgaria, Croatia, Cyprus, Czech republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Italy, Latvia, Lithuania, Luxembourg, Malta, Netherlands, Poland, Slovakia, Slovenia, Spain, Sweden, WHO, OECD, European Observatory of Health Systems and Policies.

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1.   INTRODUCTORY REMARKS BY THE CHAIR

The Chair opened the meeting stating that health systems performance assessment remains an important issue in the EU context. Previous meetings have covered a lot of aspects and there needs to be progress in order to identify synergies and areas where already acquired experiences, methodologies and tools might be applied in Member States.

The Chair thereafter introduced the Agenda. This includes presentations of two Member States' experiences (France and Netherlands), of the OECD report on cardiovascular diseases, and of the ECHO project. The objective of the meeting was also to discuss the possible outline of the report on quality of care to be produced during 2015 and also the way forward concerning the sub-groups on quality of care and integrated care established after the 2nd meeting of the expert group on health systems performance assessment (the group).

The minutes from the 2nd meeting of the group were approved. The agenda of the meeting was approved unanimously.

2.   PRESENTATION OF THE FRENCH EXPERIENCE ON FINANCING INCENTIVE TO IMPROVE QUALITY OF CARE IN HOSPITALS (FÉLIX FAUCON)

The presenter relayed the French experience on financing incentives in order to improve the quality of care in hospitals. In brief, the French system has introduced financing mechanisms which reward good performance on quality of care. It was argued that if one pays for quality then there may be an incentive to have over-quality coinciding with over-cost. There was an emphasis on the reputation

effect which may induce overspending, but not necessarily provide optimal quality. Therefore, there needs to be a mechanism that incentivises the health care provider to reach the optimal quality of health care.

The focus is not to "blame and shame", but rather to incentivise healthcare providers which are making a good effort to continue their good work. To participate in the ranking, providers already have to have good level of quality; the indicators are constantly updating.

On gaming, the best approach appears not to penalise adverse events: penalties might induce healthcare providers not to report adverse events. Instead, providers need to have an individual approach in order to address adverse events.

The presenter then showed the algorithms, calculations and methodology of the indicators used to rank 200 public and private hospitals in 2014. Public satisfaction surveys are also being planned to be introduced as an indicator. Finally, the ranking is planned to encompass more hospitals in the years to come.

2.1. Discussion

The chair thanked the presenter for the interesting presentaton which did not only show the advantages but also the risks of measuring quality of care. Subsequently, the following points were discussed.

- The size of the premium was discussed; the bonus rewarded to 200 hospitals went from Euro 50,000 to 500,000. The first hospital in every category receives an extra bonus. The bonus depends both on the positon in the ranking and on the size of the hospital.
- The enforcement of private and state hospitals; private providers often volunteer to participate.
- How to identify the different hospitals: different criteria are used to identify the hospitals, e.g. the budget or the legal status. Case mix has also been discussed.
- The importance of public dissemination. It was explained that the results are published every year.
- Hospital accreditation and how public satisfaction surveys might be used for the future for these purposes.

3. PRESENTATION OF THE DUTCH EXPERIENCE ON HEALTH SYSTEMS PERFORMANCE ASSESSMENT (MICHAEL VAN DEN BERG)

The report is the 4th edition since 2006; recently an article has been published on lessons learnt the past 8 years.

The Dutch system has managed competition between healthcare providers, which depends on negotiation with healthcare insurers. The report has a nationwide focus and uses the OECD conceptual framework, which was developed in cooperation with the RIVM. The report uses 65 different data sources to develop 140 indicators. The selection of indicators is based on both a bottom-up and top-down approach. The report is mainly addressed to policy makers.

Several developments within the Dutch health system had been positive (e.g. reduction in standard hospital mortality since 2007). Inter alia, hip fracture surgeries, midwife interaction, caesarean

sections, standard hospital mortality and waiting times (accessibility) were exampled as possible indicators.

There is an effort to address the increased spending on the healthcare system since the Netherlands spend the highest amount per capita on health care in the EU. Furthermore, there are instances of wide variation between providers.

In summary, many aspects of the Dutch system are at a good level, but variation between suppliers still remains. Furthermore, transparency could potentially be improved in certain cases.

As a summary, the presentation provided the following lessons learnt:

1. Conceptual framework: To provide a common language with policy makers; what the health system is and what you are going to measure.
2. Repeated measurements: Important to keep measurement up to date as to avoid that indicators are dropped.
3. Combining information already out there: Perspectives, a lot of info out there, but not necessarily any compilation (e.g. care for the elderly under pressure, objective indicators needed).
4. Patient experience, patient safety, long-term care. Patient as a source of information, safety and its effectiveness common threads of the whole report
5. Good relations with the OECD and the WHO and other relevant networks are important.
6. Continuous exchange of research is important.

The report in its entirety can be found on: http://www.healthcareperformance.nl

3.1. Discussion

Following the presentation the following points were discussed:

- Transparency. At the present, data provided are most often anonymous, but there are initiatives for further cooperation on transparency.
- Distribution of data sources.
- How to address outliers. The report may be used as a tool for decision makers to address potential outliers, but that is not an objective of the report itself.
- Dissemination and attention in mass media: its importance and how to ensure uptake.
- The complexity of measuring efficiency notably in relation to time lags.
- Issue of individual identifiers of patients in order to follow the process.

4. PRESENTATION OF THE OECD REPORT "CARDIOVASCULAR DISEASES AND DIABETES: POLICIES FOR BETTER HEALTH AND QUALITY OF CARE" (NIEK KLAZINGA)

The presentation highlighted different initiatives by the OECD on health systems performance assessment. A report on Cardiovascular Diseases (CVD) and diabetes is expected to be presented after the summer 2015. The presenter, highlighted that work on quality of care by the Group have common features with work currently performed by the OECD.

The presentation exemplified the incidence of AMI fatality which is decreasing in all member countries of the OECD. However, the decrease is not at the same rate in all 35 OECD member

countries. Cancer survival (5 year cancer survival rate) has also been reported where data shows that not only cancer survival about financial measures, but also about governance.

In the same light as exampled above, the aim of the upcoming CVD and diabetes report is to produce findings where one aim to answer inter alia: What can be learned about the capability on CVD e.g. costs, lifestyle, quality of care indicators, survey on health systems characteristics performance information. In the coming report there will be explorative work and an aim to show "value for money".

Conceptually, the CVD report has a whole system perspective. What is the burden? What does your primary care system perform; ambulatory care; acute care; chronic care etc.? Mortality of CVD is declining overall. Prevalence of diabetes is also decreasing, but burden is still substantial. Policy seem to be working, CVD salt reduction policies and anti-smoking policies were exampled.

The issue of primary care and avoidable hospital admission was highlighted where there is an issue of finding comparative administrative data. Furthermore, there is a need for further granulated data in order to address for instance expenditure on CVD diseases.

The presenter also highlighted chronic heart failures which investigate the independent determinant adherence within countries. The work is explorative with limitations try to compare.

5. PRESENTATION OF THE MAIN FINDINGS OF THE ECHO PROJECT: EUROPEAN COLLABORATION FOR HEALTH OPTIMISATION (ENRIQUE BERNAL-DELGADO)

The ECHO project focuses on the use and experimentation of existing data collected over time. This included inter alia the analysis of time trends in the performance of healthcare providers. Around 200 million episodes have been recorded.

Critical point in the ECHO project was to establish an average measure, within and across countries, where all the data has to be integrated in to a single data infrastructure. The ECHO demonstration project is thematic and broad with 50 indicators comparable in different thematic areas.

The project has departed from the OECD framework. Different issues regarding the responses within the database were presented. In all, the data do not only show variations but also important messages for policy making. For instance different trends and procedures are mapped related to socioeconomic data as well as demographic data.

6. DISCUSSION ON THE LAST TWO PRESENTATIONS

Following the presentations by OECD and ECHO the following points were discussed.

- The complexity and importance of risk-adjustment factors and stratification in order to avoid misclassification and errors in comparison.
- The need for more detailed and specific data.
- The critical importance on how to use this data to implement changes within countries.

- Issues on quality of data. Registries are sometimes not complete and sometimes difficult to agree on key clinical data.
- The opportunity to impose data collection by law.
- International comparisons potentially have a ceiling. There is an issue of observing variations and try to depict the causality using aggregated data. What does the variation in a certain context actually mean?

7. PRESENTATIONS BY THE SUB-GROUPS: CURRENT SITUATION AND WORK-PLAN (FEDERICO PAOLI)

Two sub-groups were set up to reflect on the priority topics identified by the expert group: quality of care and integrated care.

The subgroup on quality of care met virtually (by phone conference) on the 27th March. It intends to share experiences in relation to the assessment of quality of care. Moreover the sub-group will discuss and analyse commonalities, differences between Member States, inconsistencies and identification of unexploited areas in assessing quality of care.

A second objective of this sub-group is to populate a web-based platform using findings such as: reports, guidelines and other research on quality of care which will be possible references for the report. The sub-group on quality of care plans to present a report that identifies tools and methodologies to assess quality of care to the Expert Group on HSPA in December 2015.

The sub-group on integrated care met by phone conference on the 28th of April. Its tentative mission is to agree on a definition of integrated care, based on existing literature as well as on country experiences. The sub-group also intends to populate a web-based platform using findings such as: reports, guidelines and other research on integrated care which can be used as references for a possible report in 2016. Finally, it plans to establish a framework for further assessing the performance of integrated care systems in the course of 2016.

7.1 Discussion

The majority of the members of the expert group called for maintaining a strong collaboration with the international organisations involved in the process. The group also stressed the need to overview the work of the sub-groups, and to be constantly kept updated on the developments.

It was proposed to have a policy dialogue on CVD/diabetes report within the work on quality of care. The main purpose of the dialogue would be to explain the observed variations in the analysed indicators.

Several experts highlighted the importance to build a bridge between analysis and assessment, and policy making.

8. CONCLUSIONS OF THE MEETING AND SCHEDULING OF FUTURE MEETINGS

The next meeting of the expert group will take place in Berlin on the 9th of October, 2015.