Report on the Hearing of the Expert Panel on Effective Ways of Investing in Health Brussels, 3 October 2017

Background

The Expert Panel on Effective Ways of Investing in Health is producing three reports on effective ways to invest in health. This hearing was about the first one of these reports, entitled a 'Report on tools and methodologies for assessing the performance of primary care'.

Hearing – opening presentations

A Commission official Mr Andrzej Rys gave an introductory speech. He noted that primary healthcare is a big part of the Commission's work and that a reflection process is ongoing in EU Member States. He explained that the idea of this Expert Panel on Effective Ways of Investing in Health is to help the Commission and EU Member States better understand challenges in healthcare systems. Today's discussion was about a report on tools and methodologies for assessing the performance of primary care. The report is being written by the Expert Panel with the help of expertise from academics and practitioners, a unique experience in knowledge development in Europe.

In a few weeks, the Commission will also present a paper on the state of health in the EU complete with 28 country profiles. Primary healthcare is part of that exercise.

Professor Jan De Maeseneer, the Chair of the Expert Panel, summarised the main points in the report on tools and methodologies for assessing the performance of primary care. He set out ten domains and their corresponding dimensions of primary care and gave examples of indicators that could be used across the EU. The appendix of the report contains hundreds of indicators, collected from validated questionnaires and used in surveys.

He pointed out that there are many indicators, that more than half are doctor-oriented and that, for example, few look at other disciplines in primary care, e.g. the integrated role of community pharmacists. The indicators set out in the report are intended as examples that aim to inspire EU Member States and are not prescriptive.

Some key points in the report with regard to indicators:

- Multidimensionality – it is important to look comprehensively at relevant issues (e.g. access, continuity, patient experience etc.) and not just easy issues
- All stakeholders need to be involved in the design of the procedure leading to the data collection so that they take ownership of it.
- Indicators need to be evidence-based.
- There needs to be a shift from monitoring to evaluation through systematically benchmarking results.
- Timeliness – it is important to fill in surveys at the appropriate moment.
- Transparent disclosure – people have the right to know what the quality of primary healthcare services is and that it is reported in an appropriate way.

Comments from the stakeholders

Special Group for the PACO (a division that evaluates how patients move from primary care to hospitals and throughout the community back to specific care) – James Goldberg

The report was presented very carefully and clearly.

The biggest problem today is to integrate information technology and information capacity with the aspirations of precision medicine so that precision medicine can be have a true methodology so that we can understand the value of each patient from the primary care decision to the specific medicine to be used.

In terms of the methodology it is important to use data to come up with recommendations that are based on evidence based (patient) data that is kept confidential. This should then be shared by all the communities nationally.

Progress will not be made in this if only indicators and not data are presented. From now on, every presentation should clearly present the subject, data, the patient population definition, the exact regulations in the country that define that in terms of primary care, the exact costs suggested within the country in terms of regulations of public and private contributions and the costs realised in terms of private contributions (e.g. co-payments).

In Europe, primary care is sometimes private and sometimes public. Every presentation should set out if it is addressing a public or private solution.

Data should be taken, presented confidentially in the Union and discussed so that we can move to recommendations based on data and not based on indicators.

Socialist Mutualities of Belgium - Joeri Guillaume

To avoid 'garbage in garbage out' procedures, it is important to use standardised codification rules as well as internal and external quality control of the registration of this data. Then you can do something with the data at the basis. In order to have a real transparent disclosure, also a financial disclosure of what the patient needs to pay is needed, requiring adaptations to current privacy legislation.

Medicines for Europe – Adrian Van den Hoven

Collecting data based on these indicators is an interesting idea and is very positive, in particular in relation to the efficiency of the services of healthcare practitioners. There will be many challenges to collect that data but it is a good start.

One area where there is a huge amount of data (e.g. about volumes and sales) that is missing from the report is in the pharmaceuticals sector. Almost every EU Member State has some form of electronic prescribing system or if they do not they are introducing it. This data can be anonymised so that no identifiable patient-related data needs to be revealed here.

Another area that could be looked at relates to the inefficiencies regarding access to medicines. An example here is the penetration of generics in countries, i.e. why it is so high in some countries and so low in others.

Every country in Europe restricts access to expensive medicines. That is a reality even if governments will deny it. When you have price competition, those prices come down, those restrictions to access (e.g. it may be that several doctors have to sign) are lifted. And this dramatically changes access.

Also possible is to look at where data exists and where it is easily comparable across different countries. Medicines for Europe would be willing to contribute to that part of the debate.

Federation of nurses in Europe working in the health sector – Hubert Van Caelenberg

It is positive that, in the context of the debate about investing in healthcare, the Commission is putting primary care at the top of the discussion.

In terms of education, for example of doctors and nurses, there is specialisation going on for those working in hospitals and not those working in primary care. The highly qualified are working in hospitals. That should be part of this discussion.

In relation to the European Social Pillar, there is a question about who will do the coordination between DG SANCO and DG Employment. Here there could be a paragraph about coordination. This link with the European Social Pillar will bring something positive.

Eurohealth Net – Cristina Chiotan

It is important to understand the context of the patient's condition and living conditions.

Health literacy is important and needs to be more carefully addressed.

One difficulty is that the challenges ahead in health may not be well reflected in indicators. In relation to migration populations, cultural differences is an area where the challenges are increasing. Two questions here: Are medical professionals prepared to respond to the needs of these populations? Also sometimes they [the migrant populations] do not know the health provisions that they are entitled to. This makes it difficult for health professionals to work, aside from other cultural considerations. And how can this concern be captured?

Another question is how inequalities can be addressed between Member States. With the free circulation of people and patients, it is very hard for a person to understand and access a system in another country. And there is the challenge that sometimes patients go directly to emergency services and we fail to ensure continuity of care, e.g. for people with chronic diseases. That could be an area to look into.

One option is an indicator looking at to what extent you are collaborating with the social system or if there are formal agreements. In Belgium there are no formal agreements but things work informally quite well in terms of primary care teams. A framework could be useful but you have to think if this approach will be an increased burden for GPs.

In terms of GPs, it is valuable to look at the time allocated per patient, which is very much linked to how they are paid.

Another example of a challenge relates to private and public care. For example, dentistry is privatised in most countries but in Sweden there is a strong public system. A study was carried out asking health professionals why they are not going private. They said that they preferred to have a work

contract, training, holidays etc. A question here is: Do we want primary care to be private or is it better for the quality of care to have a public system?

The idea in the report of broadening the scope of indicators is a good one. For example, happiness could be looked at as an outcome. This is difficult to reflect in the indicators but there could be data in the European quality of life survey that will soon be published by Eurofound and also the European Health Interview Survey (EHIS) survey from Eurostat.

Another challenge is that access to medicine is often centralised and the needs of patients are not taken into account fully. A question here is how the role of the patient can be strengthened and how inequalities between groups, regions and countries can be addressed.

John Hopkins University – Karen Kinder

You cannot assess time spent with the patient without an understanding of the morbidity burden of the patient load (e.g. some come with multi-morbidity issues and some come with a simple cold).

There is a lack of discussion about a health information technology infrastructure in the report. It is important to assess if there is an e-health strategy which ensures standard operating classification systems so that there is communication between the systems. Electronic Medical Records (EMRs) and Electronic Health Records (EHRs) are proliferating worldwide. EU leadership is needed to create a national data dictionary, a minimum data set and create a database and not go back to an old-fashioned survey method.

Another omission from the report is a primary care assessment tools (PCAT) developed by Dr Barbara Starfield in the 1990s. This is a gold standard of performance assessments used around the world.

European Brain Council – Vinciane Quoidbach

With regard to transmural care particularly for indicators related to continuity and coordination of care, there is a need for regulations because we hear a lot about formal and informal care networks.

What are the human and financing incentives about primary care being central in those care networks? It is particularly challenging for chronic conditions and multi-morbidity but also especially for mental health considering that in transmural care we look more and more at the environment of the patient but also that GPs are more and more involved in the trajectory of care.

World Confederation for Physical Therapy - David Gorria

We should address the different health systems across Europe because that affects the way in which primary care is organised in every country.

The multidisciplinary approach for primary care delivery is a good one. It is important also to refer to education. If we want to have other health professionals in the first row, we need to provide them with the skills and knowledge. They should have a right to treat patients themselves and also an obligation to refer patients to other professionals where needed. Medical professionals need education in relation to this professional autonomy.

Medicines for Europe – Catarina Lopes Pereira

Relating to patient-related experience measures (PREMs) and patient-related outcomes measures (PROMs) through specific surveys in the report, how do you see these surveys that translate what patients care about in innovation for instance or for example better quality of life? How do you translate these surveys into a decision on supporting this data, so a decision on paying for these medicines that the patient preferred?

European Community Pharmacists - Antonio Grasso

The scope of the assessment is often focussed on the GP and we need to look at the contribution of other health professionals in primary care.

In terms of geographical access to primary care, pharmacists are present in rural areas and often community pharmacists are the only point of contact for people.

In terms of the extension of access, pharmacies are often open 24 hours a day and offer services such as home services and night duty.

A key question is the way in which technological infrastructure is used in primary care and how practitioners use it and are computerised in their daily work. In this respect, community pharmacists use an extensive computer network to collect electronic patient data and are making more and more effort at national level to share these patients' records with other professionals.

National Association of Pharmacies (Portugal) – Sonia Queiros

Pharmacies are a proximity network. They are already collecting a lot of data. Some of that data can be used to improve efficiency. For example: prescriptions in some special areas, safety issues, effectiveness issues. Pharmacies can be an important source of data to inform decisions in the healthcare system.

World Academy of BioMedical Sciences and Technologies – Giuseppe Tritto

Relating to primary care organisation, with the evolution of innovation technology, one question is if we want a model based on ICT or not. Another question is how to deal with the issue of the price of pharmaceuticals.

Patient education information is important. If we want good delivery of primary care, we need a strong policy of patient education information. This is different whether we are providing information to a person in France or Poland for example.

Medical/healthcare tourism is a major phenomenon. A lot of people are coming from outside Europe from the East and receive western medicine. If we want to control primary care in a universal, accessible and equitable way, this is an important consideration.

Multidimensional – if want to organise team in a multidimensional way, you have new jobs such as informatics or bioengineering. How can new jobs be integrated in this model and how much does that cost?

Special Group for the PACO (a division that evaluates how patients move from primary care to hospitals and throughout the community back to specific care) – James Goldberg

The EU must not only activate patients but provide an educational presentation of what the courses are in different countries in different years to become, e.g., a nurse. Key questions are how one can compare educational courses and how they are developing. Are they using internet education or not? This is very important.

Once we have a comparison of courses in each country as a report (e.g. for doctors, nurses etc.) then we know the level of knowledge and what we expect as an excellent answer to the needs of the population. Then we will know which educational institutes area made for the patients.

We should understand and evaluate the education of 3, 5, 7, 9 and 12 year olds. A question here is how we can teach our children, who all have mobile phones. A question here: How in 2017 can we have a five year programme in the EU to evaluate education programmes for how to teach children about, for example, obesity, drugs and health, to prepare them for the future.

Philips – Agnieszka Daval

Philips provides solutions to support continued/integrated care.

One of the main barriers that Phillips has come across while deploying its solutions and could be taken up in the report is the education of health professionals. The habit of working together around a patient is missing and they are not taught about that in medical schools. Many health professionals in many countries also lack the digital skills that are needed to support integrated care. This could be taken up as an indicator.

Another of the main barriers is about the financing of care. As long as we finance 'silos of care', it will be very hard to come up with 'integrated care'. That is something that Phillips sees in its daily work. There are elements about this in the report but this could perhaps be strengthened.

Mental Health Europe – Alva Finn

The approach in the report about integrating care, especially for mental health, is a good one. There is a disconnect between what you said about integrating mental health and when it went to the indicators, which were more about having more mental health workers in primary care. We need that but the reality is that we are a long way from that in every single EU Member State. Mental health is still seen as very specialised.

What we really need are doctors to be able to understand mental health as they understand physical health and to be able to deal with mild forms of mental health problems at primary care rather than having to refer them on.

Questions for indicators might be: How many people were asked about mental health when they when saw their GP? What did the GP do then?

Another problem is that now GPs are empowered to prescribe pharmacological interventions but they do not generally know much about psychosocial interventions.

HL7 Foundation (standards organisation for interoperability of health data) – Catherine Chronaki

It is important to look at communities around healthcare. For now, we work in silos and there is a disconnect. A question for an indicator could be: How do people feel about blended models of care where digital health is part of the care process? In the Netherlands apps are used by people before they meet a primary care practitioner. We see people using apps at home. We need to understand how this health technology changes our lives and how to deal with data.

Quality of data is essential. We need to understand and engage with data. Indicators are an old way of looking at things. Some questions here include: What about patient-reported data? What about rare diseases? How do we imagine primary care interacting with these volumes of data? How do we ensure that they are connected and are improving our lives rather than drawing wrong conclusions for specific interests?

Eurohealth Net – Name unclear

Attention should be given to how digital health is developing and to assessing the pros and cons.

We need to be patient-centred. We need to take from all the health technology developments what is of use for patients and doctors and not overburden them with technologies. We should take care about how they are applied for primary healthcare. The key is to improve the lives of patients, the elderly and informal carers and so on.

There is an indicator in the report about the extent to which GP primary care teams carry out preventive activities such as testing and screening. Could we look at to what extent the GP or primary care teams carry out educational type activities such as life style changes, diet changes, physical activity and so on?

World Academy of BioMedical Sciences and Technologies – Giuseppe Tritto

Regarding data, we want medicine centred on patient but we also want a lot of data to analyse the system.

For the patient/health operator, we are in a doctor/patient relationship. The information is more important. It is a collection of data that can be integrated to identify the person. Then we can identify the subset of population on which we can trigger a specific solution or identify the people at risk when they arrive in primary care.

It is important that, in the model we propose, we separate big information for the economy/industry/insurance from information relating to particular people.

Special Group for the PACO (a division that evaluates how patients move from primary care to hospitals and throughout the community back to specific care) – James Goldberg

Pharmacists can make big data as people ask them questions and ask them for suggestions. Pharmacies should therefore be part of our primary care consideration.

It could be useful for this group to understand the evaluation criteria for drugs to be accepted or approved by the FDA (the US Food and Drug Administration) or European equivalents in our

documents. This would allow us to understand the difference between the criteria for the approval of drugs and use of drugs.

Conclusions of the day/key messages

Professor Margarett Barry (Ireland) summed up some of the key messages and comments from the audience.

Professor De Maeseneer's presentation highlighted that the exercise of identifying performance assessment indicators is about to what extent it will provide information about the strength and quality of primary care in Europe. From the feedback received at the hearing today, it is clear that we need to consider what type of model of primary care is needed in Europe in the 21st Century. We also need to consider that indicators, while useful, may be perceived as being a bit old-fashioned and risk being behind the curve as they tell us about the present and the past rather than what is needed for the future.

The following key points were highlighted for consideration:

- The importance of Health Information Technology and Electronic Data:
    - The need to examine existing electronic data sets was highlighted and how these data could be accessed and used for decision-making, including addressing the complex issues of privacy regulations.
    - With regard to national databases, there is quite a lot of electronic prescription data at national level that could be further mined.
    - An e-health strategy and digital health from all perspectives is important.
- Educating Primary Health Care Professionals for Multidisciplinary Practice:
    - The importance of how we educate and train health professionals was highlighted if we want to embrace multidisciplinary practice within primary care teams. We need to look at how to integrate inter-professional training when educating doctors, nurses, physiotherapists and other primary health care professionals. If we wish to move to multidisciplinary healthcare, then the educational curricula and training systems in Europe need to reflect this and prepare students for multidisciplinary practice.
- Financing of Care:
    - In terms of financing systems, there need to be incentives for providing more integrated models of care rather than financing silos.
- Health inequalities and Inequities in Provision of Primary Care across the EU region:
    - The issue of inequities in health care provision was highlighted, both within and between EU Member States. The impacts of this and the question of how to interpret data in the context of these inequalities was raised.
    - The issue of health literacy was also highlighted, as this is a major driver of health inequities, encompassing not only access to information but also having the skills to critically appraise and apply this information within a social context.
- Mental Health indicators: there is a need to include indicators of mental healthcare, including from the patient perspective. For example, including an indicator such as - "is mental health asked about as part of the regular consultation?"

- Relevant Tools: The Primary Care Assessment Tools (PCATs), developed by Prof Barbara Starfield, which are used globally, need to be referenced.
- Questions of how to include patient surveys were raised, including how to deal with 'subjective' and 'objective' indicators and the interpretation and integration of these data.