

**EUROPEAN COMMISSION**

HEALTH &amp; FOOD SAFETY DIRECTORATE-GENERAL

Health systems, medical products and innovation

**Performance of national health systems****EXPERT GROUP ON HEALTH SYSTEMS PERFORMANCE ASSESSMENT****12<sup>TH</sup> MEETING****7 DECEMBER 2017, 09:00-16:30****VENUE: JUSSIEU- ZAMANSKI TOWER ROOM****PARIS, FRANCE****MINUTES**

Participants: Austria, Belgium, Cyprus, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Netherlands, Norway, Poland, Portugal, Slovakia, Slovenia, Sweden, United Kingdom, European Observatory on Health Systems and Policies, WHO Europe, OECD, European Commission.

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**1. OPENING OF THE MEETING**

After opening the meeting by the [REDACTED] (Ministry for Solidarity and Health) welcomed the participants on behalf of French hosts. She stressed the importance and usefulness of HSPA in policy making in France as well as need for co-operation and mutual learning in Europe.

The agenda was approved.

**2. DISCUSSION ON THE DRAFT REPORT ON PRIMARY CARE**

[REDACTED] (DG SANTE) presented the general structure of the report and recommendations inquiring how the report could be made more useful for Member States. The HSPA Group's members were invited to express their views on how to make HSPA a triggering factor of change in primary care. Question of using HSPA as a basis for on-going reforms was raised too.

There was broad agreement on the conclusions and recommendations of the report. It was suggested that the report puts more emphasis on some challenges faced by primary care in the shift to the performance-based models: pressure on primary care to take more responsibilities and the impact on working conditions of primary healthcare practitioners and on capacities to deliver according to higher and new expectations (attractiveness of primary professions,

esteem for primary care professionals and recognition of their importance, staff and skills deficit, new approach to training through contextualisation, insufficient resources accompanying the change, etc.). The impact of the transformation of primary care on other segments of care was highlighted. Ideally this should be grasped by the primary care report. The HSPA may be also a powerful tool to deal with challenges at subnational level. To put a right accent on the discussed challenges for primary care, a suggestion was made to cluster indicators in the report around: accessibility, outcomes and capacities of primary care. There is a need to distinguish what should and what could be measured when HSPA of primary care is concerned.

It was concluded that the recommendations will be made more focused and punchy, building a strong case for primary care and stressing how HSPA can support a stronger primary care with spill-over effects for the overall healthcare. The recommendations will also be slimmed down to highlight the main challenges.

Revised draft of the report, including discussion in Paris, will be sent out to the group. Possible comments are expected until January 8<sup>th</sup>, 2018.

### **3. REPORTING ON COUNTRY EXPERIENCES**

This agenda item saw two presentations delivered to the group.

The first presentation by [REDACTED] (FR) provided an overview of the governance of the health system in France and its barriers to fostering accountability in care. The presentation highlighted the complexity of the governance of the French health system: management responsibilities are shared between the state and social health insurance (SHI), the former having a stronger role than is usually the case in systems based on social insurance. The system is considerably centralised, and relies on territorially organised state entities to coordinate the implementation of national policies at the local level.

As per accountability, [REDACTED] pointed out that the French healthcare system has been designed, for various reasons, in a way that puts pressure almost exclusively on the supply side. Since 2011, a pay-for-performance scheme called ROSP (*rémunération sur objectifs de santé publique*) was implemented. According to this scheme, GPs receive a bonus on top of their normal fee-for-service income, taking into account the amount of people treated by the doctor and a number of other quality indicators. Data from 2012-2016 shows that while the scheme has improved performance in some areas, for others (e.g. preventive medicine) no changes and even slight regressions seem to have occurred. In hospitals, an analogous system called IFAQ (*incitation Financière à l'Amélioration de la Qualité*) was expanded in 2015, together with an initiative called "E-SATIS" which uses metrics of patient satisfaction and experience in hospitals. These HSPA frameworks are used to rank and reward the best performing hospitals, both via financial and non-financial incentives (i.e. reputational rewards).

On the "demand" side (i.e. patients) for care, [REDACTED] highlighted the existence of an "asymmetry of responsibility" for which it is difficult to implement provisions based on a

"carrot and stick" approach to moderate demand for care in France. [REDACTED] provided a telling example of a 2014 court ruling establishing the unconstitutionality of a clause that would see the SHI stop paying for the cost of CPAP devices for patients with sleep apnea whose devices' utilisation rate falls below a certain level. In this context, developing a system of patient accountability faces hurdles of political, technical and even cultural/philosophical nature.

Comments from members of the group touched upon i) the role of practitioners in educational programmes and the potential of non-financial incentives, ii) nudges and reputation as instruments to enhance health systems' performance, iii) the possibility that providing care services completely free at the point of access may lead to their inefficient use, and iv) the need to bear in mind that data collection is a labour burden, and that its intended target audience must believe in the reliability of data for rankings to have the desired effect.

The second presentation for this agenda point saw [REDACTED] and [REDACTED] from a Medical and Diagnostic centre in Siedlce (PL) present the design features of a performance assessment tool that their medical centre has developed to track the performance of their primary care facilities and provide GPs with financial incentives for good performance. Primary care physicians in Poland are typically the entry point into the health system, and their role has considerably grown in the last years. The main design features of the performance assessment tool which was presented showed the importance of categorizing patients in different clusters based on their disease burden.

Additionally, the stratification became a helpful tool for creating the individual treatment plan. Thank to this solution, every medical professional can easily apply the standardised treatment plan.

MDC's performance assessment tool for GP's takes into account several factors such as:

1. number of patients in each age range for GP's population
2. number of issued green charts
3. number of different health check-ups
4. number of DRG visits with thorough medical examination etc.

Every GP receives the Monthly GP's score card. Remuneration base is calculated on the basis of number of patients in each age range for GP's population. Bonus is dependent on several factors part of the listed above. GP's scorecard also contains comparison of actual working hours and working hours calculated statistically on the basis of size of GP's population. Included information reflects the general aims. Each element must be systematically measured. Thanks to that GP receives additional incentive reinforcing directly his individual involvement.

In line with expectations as a result of the implementation of redesigned financial settlement for GP's the proportion between the base and bonus remuneration has significantly changed. Initially, in 2003, it was 95% for base and 5% for bonus. In 2017, it is 65% for base and 35% for bonus.

Similar solutions were introduced for non-physician professionals (nurses, midwives, paramedics and medical assistants). The financial incentive depends on individual involvement in work. This system is more complicated comparing to the one for GP's, due to the fact that work of this group of professionals can be measured on the level of each basic procedure. The system is structured on the basis of the listed principles. This system consists of many single procedures which are performed by this group. Every procedure has got priority and standard execution time assigned. Target is calculated for each employee on the basis of working time and it is reduced proportionally to non-working days. There are three priorities of the procedures: green (the lowest), yellow and red (the highest). What is more, initial calculation of bonus is adjusted during Quarterly, annual and Internal Audit assessment of employee's performance. Each professional has got a guaranteed bonus for all the points performed, but calculated on the basis of the lowest rate. Reaching target is a precondition for achieving additional bonus for yellow and red points that represent high priority crucial procedures. The system gives incentives for professionals to combine procedures in order to create comprehensive chain of procedures, thus deliver a complete high quality medical service.

As a result of non-physician motivational system implementation, a significant increase share of "red" points has been noticed. This trend is beneficial for patients, employees and company due to the fact that red procedures contribute highest value for health and generate positive financial impact for both professionals and company. What is more a positive shift from yellow points to red points can be seen. The share of green points is slowly decreasing. These are necessary basic procedures that cannot be reduced in delivering medical service.

#### **4. ASSESSMENT OF EFFICIENCY OF CARE**

■■■■■ (OECD) presented a summary of the findings of the "*Tackling Wasteful Spending on Health*" report.

The report recommends that strategies to curb wasteful spending must reflect two principles: i) to stop spending on services and processes which are either harmful or do not deliver benefits – for example, unnecessary surgeries, and to ii) swap inputs when less costly alternatives of equal value exist – for example, by encouraging the use of generic drugs, developing advanced roles for nurses for chronic patient management, or ensuring that patients who do not require hospital care are treated in less resource-intensive settings.

By linking actors to key drivers of "waste", the report identifies three main categories of wasteful spending:

- I. Wasteful clinical care, which covers (avoidable) instances when patients do not receive the right care. This includes duplicate services, preventable clinical adverse events – for instance, infections acquired during treatment – and inappropriate care –

for instance, medically unnecessary C-sections, imaging for uncomplicated lower back pain and prescriptions of antibiotics for viral infections.

- II. Operational waste, which occurs when care could be provided using fewer resources within the system while maintaining the benefits. In other instances, costly inputs are used instead of less expensive ones, with no additional benefit to the patient. This is often the case when patients seek care in emergency departments, end up in hospital due to preventable exacerbation of chronic disease symptoms that could have been treated at the primary care level; and
- III. Governance-related waste, which pertains to resources that do not directly contribute to patient care. This category comprises unneeded administrative procedures, as well as fraud, abuse and corruption.

██████████ (European Observatory on Health Systems and Policies) presented publication Observatory's publication "*Health system efficiency: How to make measurement matter for policy and management*".

The study observes that while the basic idea of efficiency is easy to understand – maximizing the "outputs/inputs ratio", in practice it is difficult to operationalize this concept in real-life management situations. While the desire for greater efficiency in healthcare motivates a great deal of decision-making, the routine use of relevant efficiency metrics to guide decisions is often lacking. The study therefore provides a framework for thinking about health system efficiency which aims at facilitating the development of indicators that are relevant for both policy-makers and managers.

While there are relatively few indicators for measuring allocative efficiency, policymakers arguably have more levers related to allocation of expenditure rather than technical efficiency – as a matter of fact, it would be perfectly possible to have a technically efficient institution (e.g. clinic) operating within an inefficient system in terms of allocative efficiency.

██████████ (DG SANTE) presented a background paper on efficiency of health systems, which was circulated to the group's members in advance of the meeting. The objective of the presentation was to start a discussion on how to structure the group's work on this topic in 2018 and to gather feedback from the group as to:

- 1) what should be the value added by the HSPA Expert Group to the discussion on health systems' efficiency, and what should therefore be the main thematic area of focus of next year's report; and
- 2) how the group should organise its work (i.e. whether the organisation should reflect the one from previous years, setting up a sub-group and a summer course to work on the development of the group's report).

Proposals from members of the group ranged from focusing on the further development of methodologies to measure efficiency, to producing a summary of "country examples" with the

potential of showcasing and exchanging best practices. Other specific proposals from the brainstorm included further exploring the concept of "waste", developing a methodology for assessing the efficiency of disease prevention policy, assessing the efficiency of mental health care, assessing the impact of inactivity/long-term unemployment on health, and further studying the interplay between health system efficiency and quality of care.

The Group agreed that the choice of focus of the next report should ensure maximising value added in relation to the previous reports: on quality of care, integrated care and primary care (forthcoming). The report should be devised also as an instrument of advocacy for promoting HSPA as a tool for policymakers.

The Group agreed on setting up a sub-group similarly as it was the case when the previous reports were prepared. The deadline for members interested in joining the sub-group was set for January 12<sup>th</sup>, 2018.

## **5. STATE OF HEALTH IN THE EU**

Andrzej Ryś (DG SANTE) presented the *State of Health in the EU* (SoH) initiative, a multi-annual project by the Commission that aims at providing policy makers, interest groups and health practitioners with factual, comparative data and analysis of health and health systems in EU MS. He presented the *Companion Report*, which draws cross-cutting conclusions, links common policy priorities across EU MS and explores the scope for mutual learning.

██████████ (OECD) and ██████████ (European Observatory) took the floor to walk the Group through the extensive process of research and co-ordination that took place to develop the 28 Health Profiles and to present their methodology.

## **6. PREPARATION OF THE JOINT MEETING WITH EIT HEALTH**

██████████ (FR) presented an account of the history and mission of EIT Health, a knowledge and innovation community established by the European Institute for Innovation and Technology (EIT), an independent EU body set up in 2008 to promote innovation and entrepreneurship across Europe. The EIT Health network brings together academia, research institutions and private sector entities to form cross-border partnerships that foster the development of new products and services. ██████████ mentioned that the following day's joint seminar would see about 120 participants from academia, industry and policymakers from the French institutions and three working roundtables.

## **7. CONCLUSIONS OF THE MEETING, A.O.B.**

The Chair thanked all members for their participation and reminded the group that the next meeting will take place on February 23<sup>rd</sup> in Brussels.